Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mercher, 17 Tachwedd 2010
Wednesday, 17 November 2010

Cynnwys
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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg. Mae hon yn fersiwn ddrafft o'r cofnod. Cyhoeddir fersiwn derfynol ymhen pum diwrnod gwaith.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included. This is a draft version of the record. The final version will be published within five working days.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Veronica German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Irene James	Llafur Labour
Ann Jones	Llafur Labour
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Dr Philip Banfield	Obstetregydd a Gynaecolegydd Ymgynghorol Consultant Obstetrician and Gynaecologist
Sally Baxter	Bwrdd Iechyd Prifysgol Betsi Cadwaladr Betsi Cadwaladr University Health Board
Neil Bradshaw	Bwrdd Iechyd Prifysgol Betsi Cadwaladr Betsi Cadwaladr University Health Board
Mary Burrows	Prif Weithredwr, Bwrdd Iechyd Prifysgol Betsi Cadwaladr Chief Executive, Betsi Cadwaladr University Health Board
Dr Duncan Cameron	Paediatregydd Ymgynghorol Consultant Paediatrician
Dr Richard Lewis	Ysgrifennydd Cymru, Cymdeithas Feddygol Prydain Welsh Secretary, British Medical Association
Jonathan Osborne	Dirprwy Gadeirydd Cyngor Cymru, Cymdeithas Feddygol Prydain Welsh Council Deputy Chairman, British Medical Association
Dr Chris Stockport	Meddyg Teulu, Clarence Medical Centre General Practitioner, Clarence Medical Centre

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

Stephen Boyce	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.05 a.m.
The meeting began at 9.05 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone. I welcome Members and the public to the meeting. I remind everyone that headsets for simultaneous translation and sound amplification are available in the public gallery. If anyone has any difficulties in using these, the ushers will be able to provide some assistance. Committee members, members of the public and witnesses may wish to note that the simultaneous translation feed is available on channel 1, while channel 0 provides the language being spoken. I would be grateful if everyone could ensure that mobile phones, BlackBerrys and pagers are switched off, as they may interfere with broadcasting and other equipment. If it is necessary to evacuate the room in the event of an emergency, everyone should follow the guidance of the ushers. I also remind witnesses that the microphones are operated remotely; you do not have to press any buttons—they should magically turn on an off.

[2] We have received apologies for absence this morning from Lorraine Barrett. On behalf of the committee, I think that we would all want to send our condolences and deepest sympathy to Lorraine at this very sad time for her.

[3] I invite any Members to make declarations of interest under Standing Order No. 31.6. I can see that there are no such declarations.

9.06 a.m.

Ymchwiliad i'r Ffordd Mae Adolygiadau'r GIG yn Cael eu Cynnal—Casglu Tystiolaeth
Inquiry into NHS Reviews—Evidence Gathering

[4] **Darren Millar:** We will start with the evidence that has been provided to us by the Betsi Cadwaladr University Local Health Board. I welcome Mary Burrows, chief executive, Sally Baxter, assistant director of strategy and engagement, and Neil Bradshaw, director of planning, from Betsi Cadwaladr local health board. Thank you for your attendance today. The paper and the annexes that you have provided have been circulated to Members, and we have done our best to digest them; there was a lot of information. If we may, we would like to move straight to some questions on your paper.

[5] You provide details in the written evidence of the process used by Betsi Cadwaladr local health board for engaging with the public about why service changes are needed. You make reference to the interim guidance, which was published in October 2008. It may be difficult to do so, but could you briefly give us an overview of that process and explain how it is applied in the reviews that are currently ongoing in north Wales?

[6] **Ms Burrows:** These guys are the experts here; for matters of detail, committee members might like to ask Sally and Neil. I will summarise the overview. You have seen from the written evidence that it is to validate an approach that Dr Gozzard introduced in October 2008; so this is not a new process. It uses a methodology that brings stakeholders together, using expert groups and stakeholder groups through a process that used to be a modified research and development process. Fortunately, the interim guidance was issued at the same time that we started setting up the process, which we originally started in March 2009; we undertook three reviews, which we have referenced in the submission. I think that I need to say, for the record, that there are not 11 reviews under way; only three reviews were previously concluded, and two reviews are under way now. The orthopaedics' review has just concluded, although I believe that there is further work to be done. I think that it was said that we had 11 reviews under way, but that was not the case.

[7] It goes through scan, focus and summarise; we have a project board that is set out for the two current reviews that are under way. The review of maternal and child health services is co-chaired by Dr Harrington, who is a consultant paediatrician, and Mr Leeson, who is the acting chief of staff for obstetrics and gynaecology. Therefore, it is clinically led and has stakeholders in a multi-disciplinary project board. For emergency general surgical services, the chair is Andrew Jones, who is director of public health and also a consultant.

[8] On the guidance, we make sure that we fulfil our obligations in terms of bilingualism. We make sure that everything is translated, and we have a communication plan. You would have seen from our documents that we have a project initiation document and all of that. For the record, I would like to make a correction: we did not employ a public relations company to manage the maternity and child health review. That is not correct, and it is important that people understand that.

[9] We use health impact and equality impact assessments. That is part of the process. We are not even far enough into the process for any of those to have been undertaken at this stage, because we are at the very early stages of the scanning phase and trying to work through some of the focus. As Sally will tell you, we are in what we call ‘step one’. We have also made sure that the process, because we work very closely with the community health councils as the arbitrators of issues, has been approved. They helped us in terms of challenging it and it has been independently evaluated. Again, the evidence is in front of you. Is that a quick summary?

9.10 a.m.

[10] **Darren Millar:** Thank you for that. That is a good place for us to start.

[11] **Ann Jones:** You have corrected some evidence that we have had, which is good. We have also heard from primary care providers mainly, who think that the arrangements that are in place when these reviews are started could be better, so that they are better informed. Do you think that there is a fault at the first hurdle? Should you be having further consultation or should everybody be in at the first hurdle? Where does it all fit in? Where do people start to dovetail into—

[12] **Ms Burrows:** Are you talking about primary care or people in general?

[13] **Ann Jones:** Primary care at the moment, but it comes on to the issue of at what point service users become involved.

[14] **Ms Burrows:** Again, I may bring these guys in. One thing that I have noticed in all of this is that there is not a good definition of our understanding of engagement and consultation. In fact, I have read statements that have been issued recently in which the health board has been told that it is not consulting on things; actually, no, we are not consulting on things, because there is not a case for change in terms of the substantive guidance. We are in the process of engagement, so your point, Ann, is about how we use the word ‘consulting’ and the interpretation of it. If one thing comes out of this committee that would help the NHS and the public, it would be the difference between ‘engagement’ and what is meant under the law by ‘consultation’ in formal arrangements.

[15] In terms of primary care, I remind the committee that this is not a new process. In fact, one of the first three reviews that we started in March 2009 was on primary and community care, because that had never been done in north Wales. A key plank of the NHS strategy is to get services close to home. The second one was on adult mental health; if I am honest, I wish that I had as much media interest in adult mental health as I have had on

maternal and child reviews. That was an area that had not been looked at, and we have made significant progress with huge service and patient user involvement. The third element—this triggered the emergency surgery and orthopaedics element—was the hospital element of unscheduled care; simplified, that was about how many accident and emergency departments we have. That was never bottomed out in north Wales, as you know, Ann, through the secondary care review.

[16] In all of those, primary care has been part of the stakeholder and expert group, and it has been variable in terms of attendance. Just to set it out for the committee, the approaches that we use are the local medical committee and the regional medical committee. I have a letter in my evidence here—I apologise that we did not share it—from Dr Eamonn Jessup from Prestatyn, who is a GP in the area and chair of the regional medical committee, and who also represents the LMC. He wrote to me in June offering to help and saying that if we needed to do it electronically, we could do so. We recognise that there are a number of ways of bringing in independent contractors; they do not have to engage and they are not directly employed within the organisation, but, nonetheless, they are very important and are the cornerstone of a lot of the work that we do. I have been approached and have been working with the Royal College of GPs. Dr Saul has come forward again and I have been in meetings with Dr Lyndon Miles, our vice chair, on engagement there. Our vice chair is a GP, as is one of our independent members, so they work with some GPs in the community.

[17] We try to get information out through our primary care unit. Dr Cameron was very helpful in giving evidence of e-mails that we sent through to practice managers. We have around 500 primary care practitioners to get hold of. We have used practice development sessions, which I have attended. Our clinical programme groups have some GPs on the board, and I have written personally to GPs—although you probably do not have that evidence—asking them to please get personally engaged. We use personal relationships. Sally used to be the chief executive at Denbighshire local health board, so she knows different ways of doing it. It is variable and it is not perfect. We were told by some GPs that we send too much information. If we could find a way of trying to engage across Wales, that would be great.

[18] **Ann Jones:** So, what you are saying is that you are in an engagement status at the moment. If we just concentrate on the fact that you are in an engagement process, do you think that the timescales in that process are sufficient to allow you to take up the concerns of the people with whom you are engaging, bearing in mind that you are engaging with a small number of people because they are supposed to be representing others? So, the stakeholders are there, but the general populace has not been involved at the moment, because we are just at the engagement stage. Is there sufficient time in the stakeholder engagement process for all the issues to come out before the board is able to decide whether it should amend or do something with its current services?

[19] **Ms Burrows:** What time frame do you have, Ann? What do you think the time frame is?

[20] **Ann Jones:** I do not know; I am asking you. Do you have sufficient time for all your engagement to take place?

[21] **Ms Burrows:** Yes. As we said in our submission, the three-cycle model that we use is an iterative one. So, looking at the hospital element of unscheduled care, we originally thought, using the methodology to the letter, that we would complete that within 120 days, but it took us a year. So, we regroup, reflect and listen. I have met paediatricians, and they need time. The consultants, child psychiatrists and child and adolescent mental health services were also in the room, and agreed that they need to be involved in the discussions, because it is not just about in-patient paediatric care, for example, it is about the whole journey.

[22] To come to the point, we originally said that it would be done by November, and we would expect to take a briefing to the health board, because we would do that anyway. I need to make it clear to the committee that it is only the board that will take any decision, whether the decision is to go to consultation or not, or even to take a paper. We have never had to go to public consultation, because we have never changed a service significantly. Looking at the three reviews that we have completed, it was all about improving the safety and quality of care and trying to work through the changes. So, there will be an update to the board in November, which will capture all the comments of the public, because we have been recording those, and we will report back on the engagement, because we need to give clinicians time, separately. As we are giving clinicians more time than other stakeholders, the community health council has challenged me and has said that the NHS must not be seen to revert to type and have all the clinicians decide what to do. There is a fine balance when it comes to engagement. So, it will take as long as it takes, Ann. That is the point.

[23] **Ann Jones:** That is what I was trying to get out of you. There is no set timescale. If you need to extend—

[24] **Ms Burrows:** We have extended.

[25] **Ann Jones:** You mentioned that you have extended one of them.

[26] **Ms Burrows:** We have extended both of them.

[27] **Ann Jones:** Okay, that is great.

[28] **Darren Millar:** On the make-up of the stakeholder groups, how do you determine who is a stakeholder and who is invited to join the stakeholder group at the start of a review process?

[29] **Ms Burrows:** Could I ask Sally to answer that?

[30] **Darren Millar:** Yes, of course.

[31] **Ms Baxter:** The start of the process is about identifying the stakeholders, and it differs depending on the service issue that is being considered. So, the project chair and project board will consider at the start who it is appropriate to involve. We have a set of people who we would go to initially for representation and nominations, and who we work with on a regular basis, including the clinicians, the staff involved, the community health council, primary care through the local medical committee, the voluntary sector, local authorities, patient representatives, and so on. I am summarising; there would be a longer list of people. We would then work through it to see whether additional parties needed to be involved in that particular service issue, and we would ask those people on the project board and the stakeholder group whether they could identify other people who need to be involved, to make sure that they are involved. Part of the iterative nature of the process is identifying the stakeholder group, and it can expand and grow as time goes on as people come forward with a need or wish to be involved. So, it is possible to flex that and include people in that process. There are differences of approach, depending on the type of service, which I referred to at the start. So, in the case of maternity and paediatric services, for example, there is a defined group of people who have an interest; there is a community that is easily identifiable in relation to that service. Emergency general surgery is slightly different, because it affects a wide spread of the population across the region of north Wales, but a relatively small number of people as a proportion of the overall community. So, finding a particular means of engaging in relation to that type of service is challenging, and we are working through that. However, we have patient representatives on that group to contribute to the process.

[32] **Darren Millar:** In your submission you refer to the make-up of stakeholder groups. You say that clinical programme groups include 'in some cases patients and/or service users'. The guidance makes it pretty clear that members of the public should be involved at all stages. So why does your submission say that patients or service users would be consulted just in some cases? It is on page 3 of your weighty submission.

9.20 a.m.

[33] **Ms Baxter:** As a routine, we invite to the group the community health council, which has a role in representing patients' interests. It helps us to identify patients who might have an interest in taking part. We have identified patient representatives from patient focus groups that we work with on a regular basis to feed into this, and we are happy to extend that to include other representatives as needed as the process goes forward. It is a fairly routine part of this.

[34] **Ms Burrows:** What you are referring to are the clinical programme groups and not the project board for the service reviews. We have 11 clinical programme groups that are led by clinicians, nine of which are consultants. These are their management boards and the management board for, for example, mental health would, quite rightly, include service users not only to engage on the delivery of the service, but to share their views about their experience, which helps to inform clinicians face to face about some of the things that they need to improve. So, Darren, that is the management arrangement; it is not the same thing.

[35] **Darren Millar:** Okay. What about the involvement of elected representatives in the stakeholder groups? Are they involved?

[36] **Ms Baxter:** They are not routinely involved from the start of a project, partly because of the separate discussions that we would have with elected representatives in other fora. Discussion with elected Members somehow suggests that they would wish to remain dispassionate and outside the process to be able to feed in at a later stage as part of the political process. Taking information out to Members is a routine part of this. Briefings have been provided to AMs and MPs. Mrs Burrows has written directly to AMs and MPs to keep people updated on the process of what is happening, so it is a different level of engagement on that. However, it is not necessarily appropriate for elected Members at the starting point to sit in the workshops developing things.

[37] **Ms Burrows:** However, there have been occasions, such as when I did the workshop in Llandudno a year ago on unscheduled care, when there have been councillors around the table with me as well as representatives from the voluntary sector and patients.

[38] **Darren Millar:** At what point would you decide that it was appropriate to include councillors? That is not clear, is it? You have said that you will try to include as many stakeholders as possible that you can identify, but there is no formal process to identify which stakeholders it might be appropriate to invite to the table, is there?

[39] **Ms Baxter:** Going back to what I was saying in relation to that, we have gone out to other fora and met elected representatives so that they can engage in the fora that they have set up. So, there is attendance at different committees and at elected Members' fora in different parts of the region to link in and discuss things with a broader group of elected Members. They have an opportunity to have their say.

[40] **Darren Millar:** I am talking about stakeholders in general.

[41] **Ms Burrows:** I know what you are getting at.

[42] **Darren Millar:** Frankly, the accusation has been made that, in some NHS reviews in all parts of the country, stakeholders are perhaps cherry-picked—and I recognise that these are broad accusations—in order to come up with certain conclusions through the review process. How can we have confidence that stakeholders are independently minded and forming their own conclusions based on robust information that is presented to them? Is there a formula for the selection of stakeholders?

[43] **Mr Bradshaw:** I think that it is very difficult to have a formula for the reasons that Sally gave. Obviously, it depends on the circumstances. We are talking here about reviews related to specific service changes, and, therefore, the people with whom we need to engage will depend on the topic of discussion. One of the key points to make is that stakeholder engagement is not the only means of gathering information and comment on whatever it is that we are looking at. It is part of the process, and it is also the case that, if you are a stakeholder member, you are often there representing a much wider constituency. The other thing that we do with regard to the reviews is set up a website, and we put the comments, information, and discussion papers on that website. We make that freely available. Mary referred to the fact that what is fundamentally different about this is that, historically, the health service has tended to come up with a plan and then consult on it. What we are trying to do is help people to develop that plan, or rather to get people to help us to develop that plan. So, we are not coming up with a preconceived solution. We are saying, 'This is the problem; help us to find a solution'.

[44] We accept that it is an iterative process. It is a good, robust process in terms of giving us a framework, but some of the detail around engagement has to be iterative. You start off with what you think looks reasonable as a stakeholder group, but that will change over time as we receive comments and feedback. It is the same issue as with timescales. You set a target timescale, because if there is a problem you want to be able to solve it and you do not want to carry on *ad infinitum*, but you recognise that you may have to talk to other people and get other stakeholders involved, and that it may take longer to get the data and information so that the board can come to an informed decision. It is difficult to be prescriptive; you have to take it case by case.

[45] **Ms Burrows:** If people come forward and want to get involved, we say that that is fine. We want to look at the area of autistic spectrum disorder, and it will come down to the issues that we raised about proportionality. That will be a specific group of people, but we know that when we engage with that specific group, they will say, 'Have you thought about not only the National Autistic Society, but this voluntary group that works in Ynys Môn that would like to be involved?' We would say that that is fine and build it up.

[46] It is also about scale. When we were in Llandudno, at one point we had 400 people in the room. So, there are issues about managing that and giving people the opportunity to capture it. Some of these events can be quite challenging for the professionals and they can be quite challenging and intimidating for patients. So, there are balances to be struck and that is why we review, reflect and ask whether we could do it better and what we could do for the next one. That is why this will be helpful.

[47] **Darren Millar:** In a little while, we will go into more detail on the interim guidance that you are currently following, but, before that, I bring in Veronica.

[48] **Veronica German:** I am particularly interested in how you are engaging with GPs, because we have received evidence from them that they feel as if they were almost an afterthought and some of them did not even know about the reviews that were going on about the process, or the information came late to them. You have mentioned that it may be better for them to have an electronic means of—

[49] **Ms Burrows:** That was what the LMC suggested to us.

[50] **Veronica German:** Is it your duty or the LMC's duty to be in touch with all the GPs to ensure that they are aware of the process and that they have knowledge of what is happening in sufficient time to prepare and put evidence together or to be able to participate in the process?

[51] **Ms Burrows:** The LMC is the negotiating arm of the BMA, as I think that you are aware. We need to be clear about that. That is what the BMA has asked us to do; it would like things to be channelled through the LMC. One side of me says that that is absolutely right and that is what we do, but not everyone is engaged through the LMC and, in some respects, not necessarily with the BMA. So, we try to go to all of the practices. The practice concerned had been involved in previous reviews, we have just appointed one of its partners as one of our assistant medical directors for primary care, and some of us know the partners. So, if there were such concern, I am slightly disappointed that they did not pick up the phone and say, 'We're really worried that we haven't been engaged'. However, I cannot do anything about that. As I said, we are trying to engage in almost every way that we can.

[52] I understand that, in some of the evidence, it was said that the e-mail addresses are wrong. That worries me, because we got them through the Powys-run business support centre, and if that is the case then probably many e-mail addresses in Wales are wrong, because we use that as our hub for e-mail addresses. There are various issues about how we get through to them, which we have tried to address. Could we have done it better? I was concerned, when I went through this—I was on holiday watching a lot of this come through and got involved in this when I was abroad—with looking at whether we followed up on things. Sally has given me reassurance, and I believe her, that, when certain names that we would have expected to respond did not come through, there was follow-up and contact was made. We have evidence of where e-mail correspondence happened and where phone calls were made. I cannot undo what has been done, and I am sorry for that, but I hope that we have righted that. Dr Stockport is now on the project board and I believe that he is giving evidence shortly.

[53] **Veronica German:** That is one GP, but you have a larger number than that. It is about the way that you see them fitting into this. You see them fitting in through the LMC or as individual stakeholders—

9.30 a.m.

[54] **Ms Burrows:** No, I did not say that. I said that the LMC would prefer that we go through it. That is great, provided that it gets people. However, if it does not get people, it is a case of being damned if you do, and damned if you do not. We try multiple approaches, and we have great respect for the individuals in the LMC and the local negotiating committee, which is the negotiating arm for the consultant body of the British Medical Association. I have met with all of the medical staff committees. I try to attend all of them, and the GPs are there as well. So, we try every way to get them engaged. To be honest, we are all adults here and this is a two-way process. Some will engage and some will not, but we will keep at it because it is our responsibility.

[55] **Darren Millar:** We can ask the GPs themselves about this later.

[56] **Ms Burrows:** Yes, and I respect their particular view of things. That is fine; I understand it.

[57] **Darren Millar:** Sally, do you want to come in?

[58] **Ms Baxter:** I would like to add something on that particular point. Mary is absolutely

right; we have asked the LMC for nominations, and this goes back to the point about cherry-picking. We have asked the LMC to identify people not selected by us. Additionally, we have gone out to our practices. There are notes from the LMC that this was discussed. The service reviews were discussed earlier in the summer, as the reviews kicked off. So, the practices were aware. In cases where the messages were not heard, we have that followed up. In any communication or engagement, if we are sending out messages and people are not hearing or receiving them, we have to make a more concerted effort. We have asked the GPs with whom we have been discussing these things to help us to work through what would be the best way for them in order to make this situation better, given that we have 121 practices across a large geographical area. We understand the challenges for primary care. We have offered to support locums to cover clinical sessions. Locums are not ideal for GP surgeries; we know that. We have offered to time meetings differently. We also have the problem of balancing the interests of the primary care community through holding evening meetings against the interests of consultants and members of the public who might prefer daytime meetings. One benefit of the process that we are going through is having those people in the same room and learning together. It is very powerful for patient representatives to hear directly from clinicians, and vice versa, to help get a rounded discussion of the issues at hand.

[59] So, we have said to various GPs that, if there are better ways of doing this, they should help us to work through them. We have started to hold evening meetings with them in order to have a specific primary care focus and to add into the process. That is why we have allowed more time to take things forward. It is absolutely vital that we make efforts to engage. If the GPs are not happy with what is happening, we need to work through why that is the case and build on it. That is certainly in hand.

[60] **Val Lloyd:** The time for this issue seems to have passed, but I would like to address it for the record. Chair, you raised the question of the representation of elected representatives—I am sorry for the clumsy way in which that is phrased. There is formal representation for them on community health councils, is there not?

[61] **Darren Millar:** Yes, I accept that. I was just asking more widely about the involvement of elected representatives.

[62] **David Lloyd:** Hoffwn ddechrau drwy ddiolch i'r tystion am eu tystiolaeth ysgrifenedig, a oedd yn gynhwysfawr tu hwnt. Yn naturiol, yr ydym wedi clywed tystiolaeth o nifer o ffynonellau. Cafwyd awgrym bod y wybodaeth a gyflwynwyd i'r sawl a fynychodd y digwyddiadau i randdeiliaid, yng nghyd-destun yr adolygiad o wasanaethau mamolaeth ac iechyd plant, yn tueddu i ffafrio rhai opsiynau ar gyfer newid ar draul opsiynau eraill. Sut y mae'r bwrdd iechyd yn sicrhau bod y wybodaeth a gyflwynir yn ystod y broses ymgysylltu yn gytbwys ac yn gynhwysfawr?

David Lloyd: I would like to start by thanking the witnesses for their written evidence, which was extremely comprehensive. Naturally, we have heard evidence from a number of sources. There has been a suggestion that the information presented to attendees of the stakeholder events for the maternity and child health review was biased towards certain options for change, at the expense of other options. The question that stems from that is: how does the health board ensure that information presented in the engagement process is balanced and comprehensive?

[63] **Ms Baxter:** Mae rhan gyntaf y broses yn cynnwys cefnogaeth gan Iechyd Cyhoeddus Cymru, sy'n cyflawni llawer o waith i ni o ran casglu tystiolaeth ac edrych drwy'r ddogfennaeth i sicrhau ein bod ni'n deall bob agwedd o'r mater wrth law. Nid ydym wedi rhoi pob peth i'r pwyllgor. Mae

Ms Baxter: The first part of the process includes support from Public Health Wales, which does a lot of work for us in gathering evidence and looking through the literature to ensure that we understand every aspect of the matter at hand. We have not submitted everything to the committee. We have several

gennym nifer o bapurau technegol sy'n rhoi cefnogaeth inni. Mae hynny'n sicrhau bod gennym farn annibynnol ac mae'n sicrhau cydbwysedd drwy gydol y broses.

technical papers that support us. That ensures that we have an independent view and it ensures balance throughout the process.

[64] **Andrew R.T. Davies:** Thank you for your evidence this morning and the detailed paper that you provided. I would like to go back to a point that Marry Burrows made. Mary, when you were responding to a question from Veronica German, you touched on the fact that you were on holiday at the time when all of this started. Would it be right to assume that where you started was not a place that you wanted to be, and that the consultation process has become more robust as it has moved forward? Is it therefore right to say that, at the start, things were not as you, as chief executive, would have liked?

[65] **Ms Burrows:** The first thing that I would say is that it is not consultation; it is engagement. I return to that point because it is really important. On my comment about the holiday, these guys tell me that I am not supposed to use my BlackBerry over the holiday, but I was getting information that some of the clinicians were concerned, and Dr Cameron in particular, for whom I have a high regard. There was some concern that people were being boxed into a corner, which is not how the process should operate. I was disappointed that, actually, I did not get a phone call prior to all of this happening, because of personal relationships, but again, we are where we are.

[66] I am not quite sure, if I am honest, what has gone wrong as regards perceptions. When I was at the medical staff committee at Ysbyty Glan Clwyd a couple of weeks ago, we had this debate with the consultants, and the view was put forward by one of our orthopaedic surgeons that it was not like me to defend management, but actually, our orthopaedic reviews have been good. One of the paediatricians said that it may be the way in which the process had been managed as opposed to the process itself, and what we are looking at here is the process itself, and not necessarily how it has been managed. I need to be quite clear that I do not stray outside the terms of reference. I will come back to the point that we have used the process, and the perception is that the information has not been accurate or sufficient, and people felt that they were being rushed. That was never the intent, hence the use of an iterative process; this would have been our fifth review.

[67] I wish we were at a different point, but having said that, we now know how well social networking works. I have never seen so much public and community engagement in all my life, and one can see that is a good thing for society and the democratic process. That is fine, and there are some lessons to be learned. My only regret is that members of the public have been approached by individuals and asked to go on public platforms to share their stories, which I find quite difficult, and to take on the health board, and they have refused. I am quite pleased about that, because this is not about politics, or trying to do down public services—these are real people with real stories and real lives, and clinicians who work with them every day. That was a very long answer, and it probably did not answer your question correctly.

[68] **Andrew R.T. Davies:** The gist seemed to be that maybe you were not starting from a desired place.

[69] **Ms Burrows:** It was in the desired place, and we signalled that to the board in March—and remember, the board is the key governing body here—when Sally and Neil brought the outcome of the review of the three accident and emergency departments, which was to keep them, and rightly so, because there was a suggestion during the secondary care review that we should only have two, and if you have driven around north Wales, you will know that it is pretty obvious that there are issues around that that had never been resolved, and that created problems with recruitment.

[70] Sorry for the long story. The board took the decision, and we hold to that and the work that was done, led by a consultant anaesthetist. What was not resolved was maternal and child health, because those issues had not been resolved in the secondary care review. You will see in our submission that we tried a year earlier to move forward with the obstetricians and paediatricians, but they could not, so it was felt that a proper review was needed. We thought that this was the vehicle to do that. Orthopaedics was also signalled. These were part of a plan that was set out, and we implemented it in June and July when we started the process. We have stopped it, paused, taken stock, and gauged the feeling around this. My view is that it is a very emotive subject. No-one raised the issues about closing three accident and emergency departments publicly. We started with four options and ended up with 11 at the end of the process, which, as I said, took a year. That is a long time in the health service—we found the other day that one review took seven years, which is just ridiculous, and we are not in that environment anymore. A year felt like a long time to conclude that.

[71] **Andrew R.T. Davies:** You have touched on the length of time of reviews and the paper that you put forward, and Welsh Assembly Government guidance, states that instead of just doing it as and when events occur, there should be a continuous process of consultation and engagement—I merged the two as one there. The WAG paper talks of them not being one-off exercises. How does the board go about developing that continuous process so that there is continuity and confidence in that process?

9.40 a.m.

[72] **Ms Burrows:** These meetings makes you reread a lot of the stuff that you have done over the years, particularly the interim guidance, and all of us here—including many of the senior team, my 11 chiefs of staff, members of the board and others throughout the organisation—are in a continual process of engagement, such as with local service boards and through other formal mechanisms. Neil, Sally and I feel privileged to be a part of the community fora in Denbighshire, which are multi-agency engagements with small communities where we talk about a range of public issues. I know that Neil has found that to be a hugely rewarding experience. We talk about local government, housing, education and the health service. So, we use every single forum. I have been at practice development sessions, where we talk about some of the issues that we face, how we will work on those together, and we consider the expectations of patients and individuals. I guess that the point about continuous engagement is that there are a number of ways to do it.

[73] It is then a matter of where continuous engagement, in stage 1 and stage 2, brings things together, and when does that morph into something more formal, which is what I would construe as an option—which I would call 'material', due to my legal background—that should then be a decision for the board to say that it needs to go to public consultation? The key thing that I should say on continuous engagement is that we work closely with the community health council.

[74] **Andrew R.T. Davies:** The community health council has been substantially reorganised recently. Are you confident that your process of continuous engagement is robust, durable and has confidence?

[75] **Ms Burrows:** Yes, but I would say that, would I not? That is me. However, I will ask Neil and Sally to give their views, because they engage on a daily basis and it will be in a different context.

[76] **Ms Baxter:** The challenge of continuous engagement is about how we build in the different layers and levels that you need for different matters. We have talked about proportionality and the response. We can, and do, go to local neighbourhoods and

communities to have discussions. That is a large area and we are building on that work across north Wales. We are building on the successes to date and spreading that experience across the area. We do that to discuss general issues on a regular basis with local communities.

[77] When we move into looking at specific strategic issues, such as these, there is a need for a different layer and a different level of engagement that allows sufficient time to debate the complex issues. In the community fora in Denbighshire, which have been mentioned, we have a couple of hours in the evening and anyone from the local community can come along to raise questions about any of the public services. This develops a good relationship. They know that they will have answers to their questions about what is going on. However, that is not enough time to develop and debate the issues that we are currently considering. We need to be able to layer that, to build that up and to add in these additional processes to discuss and review specific strategic issues. We think that the process that we have allows us more time to bring clinicians, patient representatives and voluntary sector groups together to do that and to build on that process. When we look at the new guidance and move into that, recognition of the need for different layers and levels of engagement is important, as is proportionality.

[78] **Mr Bradshaw:** I would just add that we should not forget the formal mechanisms that exist within the structure of the new health boards. We have the stakeholder reference group and the professional forum, which are both wide and representative, but which involve professional bodies and wider stakeholders. So, they are formal mechanisms. Sally and I go to those meetings and report progress in terms of reviews, give them information in terms of reviews and discuss those reviews with them, and we also discuss wider issues. We also have the formal planning committee with the CHC, and Sally and I meet it on a six-weekly basis to discuss operational and strategic issues.

[79] As Mary said, we are also starting to develop a number of different routes, particularly with local authority partners—and the community fora in Denbighshire are a good example—where we go out to the wider public. Coming back to our own management structures, within our management board we have wider representation. For example, we have representatives on the staff side, but we also have representatives from local authorities sitting in our weekly management teams. So, there are all sorts of levels of engagement throughout north Wales.

[80] **Darren Millar:** The issue that concerns us most is public engagement, but we will come to that later in more detail. Val, I think that the question on the distinction has been answered.

[81] **Val Lloyd:** I was simply going to ask whether the distinction between the two stages of engagement and consultation is sufficiently clear, but I think that you have probably answered the question in far more depth.

[82] **Darren Millar:** The witnesses said ‘no’, essentially. You said that you would like more clarity on that, which is one of the issues.

[83] **Ms Burrows:** The public and people working in the NHS would like that, because we use the words loosely, understandably, but they mean different things to different people.

[84] **Darren Millar:** The interim guidance gave some examples of symptoms of poor engagement, or consequences of poor engagement. It talked about public distrust of efforts to reform and improve the health service, and public suspicion that the NHS merely wanted to cut costs. It is fair to say that both of those perceptions are out there in north Wales at the moment, in terms of the review processes that are being embarked on with these two particular issues. The guidance also talks about the need for full and open engagement with the public, not just with stakeholder groups. What constitutes ‘full and open engagement’? Is

there any advice given on that by the regional office in north Wales or by Ministers' officials? Does any information come to you as a health board about what constitutes 'full and open engagement'? What information is available from the Minister to health boards on these issues?

[85] **Ms Burrows:** There is no regional office in north Wales anymore; that was changed. The Minister does not communicate directly with me, nor would she, and she would not issue anything unless it was issued through her officers, which would come out as guidance. We have the guidance, which is the interim guidance.

[86] **Darren Millar:** The interim guidance says that you should have full and open engagement with the public and patients before an official public consultation. What does that mean? How have you interpreted 'full and open engagement'?

[87] **Ms Burrows:** It is our three-cycle review. I am sorry, but I am misunderstanding the question.

[88] **Darren Millar:** It does not talk about a three-cycle review in the guidance.

[89] **Ms Burrows:** No, but that is how we have interpreted the guidance. Dr Gozzard introduced a science of improvement methodology, as I mention in my submission, but that has been modified because it was a research and development process, and we think that it is a really good approach to use. It was externally validated by the National Leadership and Innovation Agency for Healthcare because we want to find the best way of using the guidance. More importantly, we actually do believe in engagement; we do believe that the future of the health service should be through what I call 'co-production'. Let us be honest, engagement can be very powerful, but it can also be very challenging for individuals because it is a different way of working for the NHS. This is the method that we have come up with. We think that it is a good method and the feedback that we have received from the other reviews by clinicians and members of the public has shown that they have valued and enjoyed it. We have had people come back for more, if I can put it that way. So, I do not want something prescriptive to tell me exactly how to do it, because it is for each health board to decide.

[90] **Darren Millar:** That is the answer that I was looking for: you do not want prescription in terms of how to deliver.

[91] **Ms Burrows:** No, because different communities will need different things.

[92] **Darren Millar:** The interim guidance also talks about specific consultations and the need to tailor it to your stakeholders, to which you have referred. It also says that we should ensure the involvement of children and young people in the review process. Can you explain how children and young people have been involved in the ongoing review of maternity and children's services?

[93] **Ms Baxter:** Again, that is a challenge in terms of engaging directly with a large number of young people. The process that we have used has entailed going through community groups that are working with children and young people. We need to build on that if we go forward with any options for significant change. We have also involved and engaged the children and young people's partnerships in discussions, and they have young people's fora attached to them. So, we have spread that message by working with partners in existing groups to take that forward. On whether we need to do more if we undertake a formal consultation, the answer is, 'Yes, of course', and we need to build on that to take it forward.

[94] **Darren Millar:** In terms of the engagement partner, you have drawn a distinction

between engagement and consultation. To be fair, the distinction is unclear in the guidance, and I can see that you want to have more clarity on that. In terms of stakeholder engagement, if it is very ambiguous in the guidance as to who you should choose, there is a risk that you could leave someone out because you did not feel that it was appropriate to involve them at a particular stage, yet someone else might have felt that it was unfair that they had not been involved, so they were suddenly involved at stage three, or after a fourth or fifth stakeholder meeting because someone had flagged it up, and they ended up feeling as if they had missed out on all the other parts of the process that had taken place.

9.50 a.m.

[95] I accept that you have said that prescription is not something that you would welcome, but would it not be easier, frankly, to just include everyone and then for people to drop out, rather than for you to include a small number and then have to add people in as the process goes forward?

[96] **Ms Burrows:** I will bring in Neil in a second, but to back to the guidance, we have included in our standard list—if I may put it that way—the voluntary sector, local authorities and so on. Therefore, there is a standard list. However, I could say to you, Darren, that we have a population of nearly 700,000; therefore, it is a matter of what is manageable. The more the merrier, quite frankly, but as I said earlier, you must then manage expectations of that. If you want to talk about autistic spectrum disorder, like I said, that will involve a small group of people who can actually talk about that, who have that experience. As Sally says, if you want to talk about general surgery, most people will only experience general surgery when they need it, and it is another matter to understand the intricacies of rotas, training and issues such as whether vascular and breast surgery become sub-specialisations. It will take a bit of time for people to get up to speed. That is the issue; if you say, ‘Yes, we will involve everyone’, and you could do that through an open forum, which would be one way of doing it, you will then have to try to channel that down so that you can start to get some meaningful engagement to start to look at the case for change, if there is a case for change, around safety and quality.

[97] **Mr Bradshaw:** The key issue is about flexibility; it is about not being prescriptive at the start of the process as to who should be a stakeholder and with whom you should be engaging. Should we start off with everyone and let people drop out, or should we go the other way around? There is definitely a syndrome of engagement fatigue. If you are not careful, and if you try to involve everyone all of the time, people will not know what is important, what they need to get involved in, and what is important to them. We have tried to identify who the key stakeholders are to begin with and we have added to those as people have come forward, saying, ‘I need to be involved in this; this is really important’. It is a bit of a balance, to be perfectly honest, but we do need to make sure that we just do not do so much engagement that it is impossible for people to become engaged because they are swamped.

[98] **Darren Millar:** You have to do so much engagement, do you not, because it is supposed to be continuous engagement?

[99] **Mr Bradshaw:** Yes; you do—

[100] **Darren Millar:** Therefore, there will be that fatigue, will there not? There will be people who pay an interest, and actively engage on a regular basis. Frankly, they will be fatigued at the end of it, will they not, because it is continuous public and stakeholder engagement? It is not a stop-start process, which is frankly the point that the interim guidance clearly makes, and that you have made in your submission. Therefore, to suggest that if you always invite everyone, they will be less inclined to get involved, is certainly not in the spirit

of the interim guidance. Let us move on. I now call on Dai Lloyd.

[101] **David Lloyd:** Pe bai opsiynau'n cael eu dewis gan y bwrdd iechyd ar sail diogelwch a chynaliadwyedd yr holl wasanaeth, awgrymodd tystiolaeth ysgrifenedig i'r ymchwiliad hwn na fyddai hynny o reidrwydd yn arwain at ymgynghori â'r cyhoedd, hyd yn oed pe bai newidiadau sylweddol yn cael eu gwneud i wasanaethau. A allwch egluro ac ydyw hynny'n wir?

David Lloyd: Written evidence to this inquiry has suggested that if options were chosen by the health board on the basis of the safety and sustainability of the whole service, this would not necessarily trigger a public consultation, even if major changes were being made to services. Can you clarify whether that is the case?

[102] **Ms Baxter:** Mae'n wir ei bod yn bosibl gwneud hynny. Mae'r cyfarwyddyd yn cynnwys paragraffau sy'n dweud ei bod yn bosibl trefnu a newid pethau heb orfod cynnal ymgynghoriad os oes perygl i'r gwasanaeth neu i iechyd a diogelwch cleifion. Byddai gwneud hynny'n ddifrifol iawn. Nid yw'n rhywbeth a ddefnyddiwn yn aml a phe bai perygl i hynny ddigwydd, byddai'r bwrdd yn trafod gyda'r cyngor iechyd cymuned cyn gynted ag y bo modd i sicrhau ei fod yn deall yr hyn sy'n digwydd, a bod modd i drefnu pethau a chael newyddion ynglŷn â'r hyn sy'n cael ei wneud. O ran yr adolygiadau hyn, yr ydym yn ceisio gwneud y gwaith cyn cyrraedd y pwynt lle byddai'n rhaid gwneud rhywbeth sydyn i ymwneud â'r gwasanaeth.

Ms Baxter: It is true that it is possible to do that. The guidance contains paragraphs that state that it is possible to arrange and to change things without having to conduct a consultation if there is a risk to the service or to the health and safety of patients. It would be very serious to have to do so. It is not something that we use often and if there was a danger of that happening, the board would discuss it with the community health council as soon as possible to ensure that it understands what is happening, and that there is a way of arranging things and obtaining information on what is being done. Regarding these reviews, we are trying to do the work before we reach the point when we would need to take urgent steps in relation to the service.

[103] It is a very rarely used part of the guidance. We are making efforts to move through rational planning before reaching that point. We cannot sit back and do nothing when we have identified an issue that needs to be addressed. So, we are trying to address these upfront as early as possible and to have plans in place. None of us wish to have to make sudden service changes to prevent health and safety issues arising, because that is not the best way to run any service, let alone a health service.

[104] **Ms Burrows:** A quick example of that, which was quoted in a recent article, was around the two dementia boards in Meirionnydd and Pwllheli. The chief of staff, who is a consultant psychiatrist, called me at 8 p.m. and said that he had no locum cover because we had not been able to recruit into that area and the senior house officer who was a locum had resigned. We had concerns about the supervision of the consultant locum and the psychiatrist said that it was unsafe to maintain services for acutely ill patients and that he felt that he needed to close the two units. I fully supported that decision and called my chairman to say what we needed to do. The next day, which was a Friday—I remember it very well—I spent the whole day discussing the issue, starting with the community health council in the morning, then Assembly Members and local authorities, providing support to him and his team. Patients and their families, who had to undertake long journeys of two hours to see their loved ones who were quite ill with dementia, were going to be disadvantaged because we could not provide a safe service. We review that every week and discuss it and we have been under scrutiny. That is an example where we have done that. However, we use that very rarely and we always ensure that we have taken good advice. When a consultant psychiatrist tells me that it is not safe, then I take his advice.

[105] **David Lloyd:** Yn dilyn ymlaen o hynny, a yw hi’n ddigon eglur pryd mae angen cynnal ymgynghoriad ffurfiol?

David Lloyd: Following on from that, is it clear enough when a formal consultation is required?

[106] **Ms Baxter:** Mae hwn yn gwestiwn anodd iawn. Yr ydym wedi bod yn trafod hynny gyda’r cynghorau iechyd cymuned a’n partneriaid am flynyddoedd. Mae’n gwestiwn anodd ei ddatrys o ran y canllawiau ynglŷn â phryd y mae angen ymgynghoriad ffurfiol. Ein proses ni yn y bwrdd iechyd yn y gogledd yw trafod materion sy’n codi gyda’r cyngor iechyd cymuned a cheisio cytuno ar bryd y dylid cynnal ymgynghoriad. Yn y diwedd, y cyngor iechyd cymuned sy’n penderfynu ac yn rhoi barn a chyngor i ni ar wneud hynny.

Ms Baxter: That is a very difficult question. We have been discussing that with the community health councils and our partners for years. It is a difficult question to answer with regard to the guidance as to when a formal consultation should be held. Our process in the north Wales health board is to discuss issues that arise with the community health council, and to try to agree on when a consultation should be held. Ultimately, it is the CHC that decides and gives its opinion and advice to us on how to do it.

[107] **Irene James:** How important to the engagement and consultation process is the contribution of the CHCs, and how are they involved in north Wales service reviews?

[108] **Ms Burrows:** They are very important. In particular, we need to recognise that they are the arbiter and their independence is crucial, but we also need to have a good working relationship with them. We are very fortunate in north Wales that we all had good relationships with the former community health councils, and bringing them into one organisation under the new arrangements has strengthened that. I can very easily pick up the phone and speak to the chairman or the chief officer to go through some issues. Behind closed doors, we do have some robust conversations, as we rightly should. Coming back to consultation—and this is the debate that we have had with the community health council—decisions are taken every day in order to try to manage the service but if, for example, someone goes on maternity leave, a doctor does not show up, or a nurse goes off sick, do you have to publicly consult the community about that? That is where it is really difficult in terms of what is in the best interest of the service in terms of running it safely. It comes back to the point in section 4, the involvement of the community health council and what you need to do in terms of proper public consultation on what I would call material or significant changes. Sally has had a lot of interaction on that and, again, these guys are my experts on the community health councils, which I think are hugely important.

[109] **Mr Bradshaw:** One of the things that members of the CHC in north Wales take very seriously is their independence, and we recognise that within the processes and structures that we put in place. So, for example, although they are on project boards, it is quite clear within the terms of reference that they are there as observers. So, they are there scrutinising; they are imparting advice and helping us in terms of shaping decisions, but it is quite clear in terms of the governance arrangements that we put in place that they have a scrutiny role as well.

[110] **Darren Millar:** Of course, local authorities also have a scrutiny role. I was pleased to note that you, as a health board, had been visiting local authorities in north Wales in order to allow them some discussion on some of the reviews.

10.00 a.m.

[111] **Ms Burrows:** Yes, and in Conwy, I go to into their private sessions where we are able to debate. For the record, I do not know whether this is worth noting, but they abandoned CHCs in England where I worked before, and I thought that was a mistake. I was pleased, when I came to Wales, to see that community health councils had been kept, because of the

independence and scrutiny that they provide. So, it is a good thing that we have them.

[112] **Ms Baxter:** In north Wales, the community health council has over 70 members from the six area committees, who fiercely defend the interests of their local population. We have some robust discussions with them in relation to that. It is another means of getting that diversity of view into the process.

[113] **Andrew R.T. Davies:** You might not know the answer to this—I am speaking from the point of view of south Wales, as my region is South Wales Central—but there have been difficulties in relation to our CHC in finding local government appointees who want to sit on it and be proactive. Has the CHC in your part of the world managed to fill its quota? The ability to have members engage proactively in the process is critical to the success of the CHC in scrutinising and being a patient advocate.

[114] **Ms Burrows:** I believe that you will be interviewing them on 1 December, so they will be able to give you a proper answer. I know that there are councillors on it, because we have conversations, but I do not think that it is right for me to answer that.

[115] **Veronica German:** In your written evidence you talk about the 'proportionality of response' in relation to the interim guidance, and mention

[116] 'the need to focus engagement appropriately towards different communities of interest'.

[117] How can the draft guidance that is currently out for consultation address those issues to improve the situation?

[118] **Ms Burrows**: I am not sure that we are in a position to answer on the draft guidance, because we are still working on the interim guidance, and the draft guidance has gone out for consultation. We are not really prepared at this point to talk about the draft guidance, because we as a health board—

[119] **Veronica German:** You have not responded—

[120] **Ms Burrows:** No, we have not responded, and we need to have a chat about what our response will be.

[121] **Darren Millar:** You could still share a view on how you think that could be dealt with.

[122] **Ms Burrows:** We can do so in relation to the old guidance. I would prefer to do it in that way, so that I do not breach where we are with regard to the consultation. I would like Sally to answer that, because we have had a good conversation about proportionality, and she can explain that better than I can.

[123] **Ms Baxter:** It is a difficult question, and it is challenging for us, given the large area that we cover and the many different communities across north Wales. Much has been made in the reviews about the different nature of communities, which we are very aware of and are working with. For me, it is about recognising the need to have different methods of engagement to target different processes for different communities in different places and at different times. We talk in the health service about the right care in the right place or setting at the right time, and we need to take the same approach to engagement and working on that.

[124] I mentioned emergency general surgery earlier, which affects a small proportion of the population and, clearly, people do not know that they are going to partake of it until it

happens. Therefore, targeting that community of people who have an interest is challenging. We are looking at working through patient groups and community representative groups, and are trying to identify people who may have a particular interest in that area. That is very different from some of the other work that we are doing on localities, for example, whereby we are working with 14 localities in north Wales, looking to develop primary and community services. That is a much more geographically focused way of taking things forward. So, that is the balance that has to be struck in recognising the different layers that you need to engage effectively on the different subject matters.

[125] **Darren Millar:** Further guidance on that would be helpful.

[126] **Ms Baxter:** The recognition that one size does not fit all in any circumstances would be helpful.

[127] **Ms Burrows:** There needs to be some flexibility.

[128] **Darren Millar:** Do you have any further questions, Veronica?

[129] **Veronica German:** I think that we covered the answer to my final question in the questions that you asked earlier, Chair.

[130] **Darren Millar:** Do Members have any further questions? If not, I will bring this item to a close. Thank you, Sally, Mary and Neil for your attendance.

10.04 a.m.

Ymchwiliad i'r Ffordd y mae Adolygiadau'r GIG yn Cael eu Cynnal—Casglu Tystiolaeth
Inquiry into NHS Reviews—Evidence Gathering

[131] **Darren Millar:** I am delighted to welcome representatives from the British Medical Association, namely Dr Richard Lewis, its Welsh Secretary, and Jonathan Osborne, the Welsh council deputy chairman. Welcome to you both, gentlemen. You have submitted an evidence paper, which has been distributed to Members, so, given the time, we would appreciate it if we could go straight to questions. In your written evidence, you express some concerns about the timescales for the service reviews being undertaken in north Wales. What more can you tell us about these concerns and about what you believe would be a reasonable timescale for such reviews?

[132] **Mr Osborne:** Thank you for inviting us today. The opportunity to express our opinions on the provision of consultant-led emergency services, which is hugely important to patients in north Wales, is enormously appreciated. When these reviews were initially announced, there were some fairly tight timescales. The general surgical review, which was probably the most difficult of all the reviews, was done on a shortened timescale of only 45 days. This has subsequently been changed and improved, following pressure, but we felt that it was very inadequate to deal with this matter. When you remember that every review needs to bring the relevant evidence first—the costing evidence, which means the infrastructure costs of changing things; and the evidence of health inequalities, which means evidence on what is going to happen to a huge urban population of socioeconomically deprived people if they lose the services—it is very hard to get the evidence for the start of the review. In fact, that evidence has still not been considered with some of the reviews going on. So, the timescales have been very short, but we are pleased to say that this has now been revised. There have been recent indications that the timescales have been extended.

[133] **Darren Millar:** Who sets the timescales? You have just mentioned a timescale of 45 days for what is quite a detailed review process—and just to be clear, we are focusing on the process here rather than any particular issues that might arise from the reviews. However, clearly, if there is a major issue on the table, a longer time will be needed to look at it, to take proper evidence and to have proper engagement with stakeholders. So, are stakeholders involved in setting the timescales or are those determined by the health boards?

[134] **Mr Osborne:** My understanding is that they are determined by the health boards.

[135] **Darren Millar:** Okay. However, we have just heard evidence from the chief executive that seemed to indicate that the timescales are only indicative, that they are flexible and that, if an issue arises, they are more than happy to extend the timescales in order to ensure that the right decisions are made. Are you confident that stakeholders have sufficient influence to enable them to say that the timescale is wrong? From your experience of other reviews in north Wales, in addition to the ones on the table at the moment, are you confident that you can influence the timescale and see it extended when necessary?

[136] **Mr Osborne:** We are very pleased that, following a lot of pressure, the timescales have been revised. So, now, we are reasonably confident that further time will be taken.

[137] **Dr Lewis:** Darren, I think that the timescales seem to be dictated by guidance. There are timescales contained in the new proposed interim guidance on whether they are reviews or consultations. I heard Mrs Burrows's evidence, and it is welcome to hear that health boards in Wales will take sufficient time to consult, particularly on very complex matters, and to ensure that they listen to stakeholders and, I would hope, to stakeholders' petitions when they feel that the timescales have been insufficient for taking account of all the evidence that could be submitted to reviews or consultations.

[138] **Darren Millar:** However, for a major review such as the one that you outlined for the general surgical review, a 45-day timescale is pretty poor, is it not?

[139] **Dr Lewis:** It is inadequate.

[140] **Mr Osborne:** We felt that it was totally unrealistic.

[141] **Darren Millar:** In your evidence, you mentioned that you are concerned about the use of a PR company to deal with media relations and to inform the public during the review process that is ongoing in north Wales. In her opening remarks when giving evidence, Mrs Burrows made it clear that no PR company had been engaged specifically to deal with review processes. Do you want to comment on that?

10.10 a.m.

[142] **Mr Osborne:** Yes. It is our understanding that a PR company named Equinox was employed by the health board to deal with communication matters over the review period. We did not feel that this was a helpful development. We looked at what PR companies are used for, and they are not used to distribute good news but usually to spin bad news. We felt that the main role of this PR company would be to spin cuts as improvements and to focus on the delivery of key messages from certain authorised outlets rather than having an open and transparent debate. So, we were very pleased when the company's employment was finally discontinued.

[143] **Ann Jones:** The BMA has been critical in its paper of the arrangements that Betsi Cadwaladr University Local Health Board made for stakeholder meetings on service reviews. Are you told why a review is happening in the first place? For example, in maternity care,

there is a high incidence of perinatal death, so, surely, we have to review why that happens across north Wales. Are you told why a review is happening in the first instance, so that you are able to get engaged in the process? Are you given all the evidence as to why a review is happening, or do you just find out through the rumour mill?

[144] **Mr Osborne:** Our understanding of the reason behind the reviews was that the board was in something of a straitjacket. The Assembly Government had told the board that there was to be no relaxation on elective targets—in other words, for elective patients. There was also a no-redundancy policy. This means, effectively, that the only way of saving money is to lose staff as they leave. This directly affects front-line services. This policy was putting the board in an unsustainable position. It had to instigate reviews in order to look at services—

[145] **Darren Millar:** I remind the witnesses that we are not talking about the particular intricacies of north Wales, but about the review process generally. I ask the witnesses to confine their answers to the question of whether they are satisfied that they receive a proper explanation, as stakeholders, regarding why a review needs to take place.

[146] **Mr Osborne:** The case made was that current services were unsustainable. We felt strongly that that case had not been made, and that it needed to be made. The case was also made that there was a financial imperative to do something about the fact that current services were unsustainable.

[147] **Ann Jones:** Therefore, you were given an explanation as to why the reviews were taking place. I have cited the high incidence of perinatal death across north Wales, and that is an instance of an issue where a review would have to take place. I believe that you are saying that you are given clinical reasons for holding reviews. Whether you agree with them or not is another matter, but you are given that information before the process starts, are you not?

[148] **Darren Millar:** That is not quite what the witness said, is it? On the reason for the reviews, the witness suggested that some were triggered by the need to make savings and redeploy staff, rather than for a clinical reason.

[149] **Mr Osborne:** Exactly. It was not a clinical reason; it was the imperative to manage within a reduced budget.

[150] **Ann Jones:** So, to clarify: the reviews that are taking place in Betsi Cadwaladr are of a purely financial nature, and have nothing to do with clinical safety. Is that what you are saying?

[151] **Mr Osborne:** Our feeling is that the overriding driver for this is the need to achieve 20 per cent savings within four years.

[152] **Ann Jones:** So, this is purely a financial issue, and nothing to do with clinical safety.

[153] **Darren Millar:** I think that he is saying that that is felt to be the main driver. That is the perception.

[154] **Ann Jones:** The BMA's paper is very critical of the way in which meetings have taken place. In what ways have they been unsatisfactory? Could you suggest a better way of holding these consultations?

[155] **Mr Osborne:** The orthopaedic review went quite well and two went fairly badly—the general surgery review and the paediatric and maternity review. In the one that went well, the people running the service—consultants and general practitioners—were brought together to discuss things and work out some realistic options that could be put to stakeholders. In the

reviews that went badly, that was not done; the first thing that the professionals knew about the process was to find themselves at stakeholder meetings where everyone was asked to come up with an infinite variety of options. There was a general feeling that there was a pre-set agenda, especially when some of the people presenting the initial information seemed to have a slant towards particular solutions.

[156] **Darren Millar:** Why was there inconsistency between approaches, as regards the opportunity to discuss things privately first before going to the stakeholder meeting? Is there any explanation for that?

[157] **Mr Osborne:** The orthopaedic review had been going on for considerably longer and it had a more relaxed timetable. I have no idea why the consultants who are running the services in the other reviews were not asked to come up with some sensible options before they went out to stakeholders.

[158] **Ann Jones:** We have heard evidence from the board that one size does not fit all. What it meant by that, I think, was that it would look at a review process for subject A in a certain way, and for subject B in a different way. Do you agree with that approach, or do you want a prescribed process review timeline so that you would know that every review would be conducted in the same way, regardless of the subject matter? Is that what the BMA wants?

[159] **Dr Lewis:** There has to be greater clarity regarding the way in which reviews or consultations are conducted. We heard from the health board that there is confusion even over the terms that are being used, with respect to the committee. Feedback from members that we have spoken to in north Wales suggests that there is confusion over what exactly a review is meant to do. I would echo what Jon said, that members are telling us that not all options are necessarily on the table during these review processes. Therefore, it was of concern to members that this review would speedily come to ‘a consultation’. I note that the draft guidance for engagement and consultation on changes to health services now wants this to occur only in exceptional circumstances in the future. From feedback from members, these processes seem to be inadequate in ensuring that everybody understands exactly what the remit is, what is being proposed, what options are on the table and what the potential timescales are for any changes to be made. While this committee is looking specifically at Betsi Cadwaladr University Local Health Board, there are obviously lessons for the whole of Wales.

[160] **Darren Millar:** We are taking evidence from other parts of Wales.

[161] **Ann Jones:** This is not just about Betsi Cadwaladr University Local Health Board: this is across Wales.

[162] **Dr Lewis:** There are lessons to be learned across the whole of Wales on this style of consultation, or review, call it what you like.

[163] **Darren Millar:** We are taking evidence initially from Betsi Cadwaladr University Local Health Board.

[164] **Andrew R.T. Davies:** Thank you for your evidence. I note what you say, Richard, about mixing up consultation and engagement. Call it what you may: most lay people would probably call it all sorts of things, but they understand that it is a process that will lead to an end result. When people see a service under threat, they become alarmed, especially the professionals involved in the service.

[165] In your evidence, you say that you would like the local medical committee to be to the first port of call when GPs are consulted on this and we heard some evidence on this from

the board a little earlier. How would you see the local medical committee being engaged and being a quality forum for that engagement, projecting your members' views?

[166] **Dr Lewis:** It is important for health boards to appreciate fully the nature of local medical committees. It is clear, from the evidence that I heard earlier, that that is not the case. Local medical committees are bodies that are established under statute; they are not the negotiating arm of the BMA. In fact, they are not bodies that belong to the BMA in any form. They are created within the health statute in Wales. A fundamental misunderstanding such as that leads to questions about whether or not you engage with these bodies properly. LMCs are democratically elected representatives, under statute, for general practitioners in the area. Therefore, in my opinion, whether they are engaged or not is not optional. It is essential that they are engaged early in review processes, particularly where those review processes impact on primary care services. However, even when secondary care services are involved, that will affect the ability of general practitioners to admit their patients, and will cause general practitioners concern over the safety of their patients when they are struggling to find, potentially, a place to send patients in an emergency.

10.20 a.m.

[167] **Andrew R.T. Davies:** To take that a little further, that is quite a misunderstanding, is it not, of how the local medical committee is constituted? Sitting here as a layperson, listening to the board's evidence, I certainly had the impression that, from the board's perspective, it was the collective negotiating arm of the BMA. However, that clearly is not the case, as you have said in your evidence—although you might have that contradicted later—that it is a statutory body, set up under statute, and therefore, the doctors on the committee would not necessarily be your members. Why would such a misunderstanding occur from such leading lights in a health board?

[168] **Dr Lewis:** I am afraid that I cannot answer that question. Why it misunderstands the nature of the local medical committee is a question that needs to be posed to the health board.

[169] **Darren Millar:** Just for the record, the Betsi Cadwaladr University Local Health Board, under a paragraph entitled 'Local Negotiating Committees (LNC) and Local Medical Committees (LMC)', states:

[170] 'These bodies represent consultants and GPs respectively concerning their contractual relationships with the NHS.'

[171] I presume that that is not their exclusive purpose.

[172] **Dr Lewis:** No. That is not their exclusive purpose. The local medical committee certainly has a role in interpreting contractual arrangements, but the BMA's negotiating arm for Wales, with regard to general practitioners, is the Welsh General Practitioners committee. However, as it is a UK contract, the majority of negotiations are done on a UK basis, but not through local medical committees.

[173] **Darren Millar:** Okay. Thank you.

[174] **Veronica German:** To take that a little further, when I was asking earlier about how the board contacted GPs, we were told that your preferred route would be the LMC, and, indeed, you state in your evidence that the first option would be the LMC. As with any elected body, it represents a lot of others. Is it then the responsibility of the LMC to ensure that all of the GPs are contacted regarding reviews, or is it the responsibility of the local health board to contact them directly? In your evidence, you stated that some GPs had no idea of what was happening, had very little idea of the timescales, and were contacted very late. I

was not clear, from the evidence that we heard earlier, as to where that responsibility lay.

[175] **Dr Lewis:** I think that it is a twin-track approach. It is certainly not the responsibility of the LMC necessarily to pass on messages from health boards. It is important that health boards take their information and engage appropriately with local medical committees. We have good networks of communication with GPs through local medical committees. Through newsletters, e-mail communications and the meetings, there is a responsibility on them to spread the message, to discuss the issues that are tabled to the LMC at that particular meeting, and they would strive to communicate that information more widely. However, I think that the health boards across Wales have a responsibility to communicate directly with general practices—as they do over many issues, not just reviews—but they obviously have to communicate health warnings or general information in any case. I believe that there are well-worked-out methods of communicating with all general practices. Again, while I appreciate that GPs are included in stakeholder groups, the feedback that we had from GP members is that they have very often been asked very late in the day, with notification being given the day before a meeting, and with meetings arranged on Mondays or Fridays, when general practices are particularly busy. When the BMA sets up meetings that involve secondary care clinicians, we are given notice by health boards that we, or, at least, our members, must give at least six weeks' notice in order for people to cancel clinical commitments to get out to the meetings. Therefore, I do not think that it is unreasonable that primary care clinicians should be afforded the same courtesy in order to give them an opportunity to rearrange their days so that they are also able to engage appropriately in review processes.

[176] **Veronica German:** We also heard that the board was trying to arrange meetings at different times in the evenings and to find different ways of communicating. As far as the process goes, and in general, do you think that should be put in guidance, making it clear that different methods of engagement should be used to engage with—not consult; I will try to use the right term—primary practitioners?

[177] **Dr Lewis:** There is clearly a need to ensure that a wide range of engagement mechanisms are undertaken, and not just with GPs, but with other stakeholders, including the public. The health board is clear that it was trying to use as many avenues is possible to do that. What it needs to reflect on is that previous reviews, which we have heard about from my colleague Jon and others, went very well, so why did the processes that were employed then not work so well in this case? It may have been the management of the process, but for general practitioners, as for other clinicians who are on the front line, it is important to be sensitive to how you can use a wide range of mechanisms to engage with them appropriately in and around their clinical commitments.

[178] **Darren Millar:** Before Veronica moves on, may I clarify this? It seems to me, from what has been said so far, that there was a pre-stakeholder stage, almost, with clinicians coming up with options to present to stakeholders, which was missed in these two specific reviews, compared with those that had gone smoothly. Secondly, stakeholder meetings would be called at what appears to be short notice, with insufficient time for general practitioners and consultants to prepare and plan for them, compared with what happened with the other reviews. Is that a fair summary?

[179] **Mr Osborne:** That is correct. Our GP members have reported that they were involved as an afterthought and that they were often notified of a meeting the night before without, necessarily, being informed of a venue or a time. There was a general feeling of, 'Goodness, yes, we need to involve the GPs', but they should have been absolutely central to the whole thing.

[180] **Dr Lewis:** May I add one further point, Chair? I have noted already that LMCs are statutory bodies, but I also note that, in the draft guidance for engagement and consultation on

changes to health services, on page 8, under section 5, paragraph 30, they are not listed as one of the stakeholders that would be consulted, which is, again, quite surprising, given that they are statutory bodies.

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

[182] **Veronica German:** I would like to probe further into the continuous public engagement aspect. We have just talked about reviews and the type of engagement that you would like to see there. The interim guidance emphasises continuous public engagement, not just engagement when changes are being considered. To what extent does that occur in north Wales and across Wales in general?

[183] **Mr Osborne:** We welcome the idea of continuous public engagement. The reason why this review is causing so much worry is because we are talking about emergency services. That was never up for discussion in previous reviews. The public is giving the impression that it is not sufficiently involved. You can see that in the fact that there is a Facebook group of 12,000 people to discuss the reviews. To a certain extent, that engagement has not happened and that is also reflected in the amount of press interest on this particular topic.

[184] **Darren Millar:** When is the right time to engage fully with the public? We hear about the need to engage continually with the public. What that means is, it appears, a bit cloudy and no one is quite sure what 'continuous public engagement' is, but the stakeholder meetings are not open to every member of the public. At what point in the process should there be much wider public engagement? We have heard that the engagement process with stakeholders and the public goes up to a certain point, and there is wide consultation thereafter if a significant change is proposed. Is that the right way around or should there be wide consultation followed by the development of any ideas after the public consultation to hone them down to a decision?

10.30 a.m.

[185] **Mr Osborne:** What has alarmed everyone about these reviews is that a number of plans have been promulgated, without the professionals necessarily getting together, which are frankly dangerous. That has caused huge alarm. If the opportunity had been taken to bring the consultants who run the services together first to find some reasonable options that were possible, then the public could expect to have some reasonably thought-out plans presented to it. What we have seen, however, are plans that have entered the public arena via the stakeholders that were clearly not worked out at all—there were no costings, no serious look at the process, and half the evidence had not been collected. There was a general impression of disorganisation as a result.

[186] **Darren Millar:** So, the big problem with these two particular reviews is not necessarily the lack of public engagement by the health board, but the way in which it missed out that first, important stage that had been part of the other reviews, which had gone well, namely the consultation with the clinicians directly involved in those services prior to the stakeholder engagement.

[187] **Mr Osborne:** Yes.

[188] **Darren Millar:** Veronica, have you finished your questions?

[189] **Veronica German:** Yes.

[190] **Val Lloyd:** Staying with the guidance, it seeks to ensure that both the engagement

and the consultation exercises address all interests, such as those of equality, diversity, geography, culture and language. Obviously, you have talked so far about your professional interests, which obviously should be considered. However, do you think that these exercises meet these requirements, both in north Wales and elsewhere, and if not, how could that be achieved?

[191] **Dr Lewis:** It is important that all those interests are met. In general terms, the guidance that has been issued—and the BMA will respond substantially to it—seems to represent a move towards this substantive continuous engagement. It is difficult to know what that means, and exactly how you track it to ensure that you have continually engaged, and show with whom you have engaged. I might be continually engaged with at the moment, on various health service changes, but if so, I am not aware of it. I am not sure how you would be aware that you are being continually engaged with. The confidence that people can take from a formal consultation is that at least a clear process is outlined—you know who you have contacted, and what responses you have had back. There appears to be a shift away from this more formalised process, with the proposed new guidance suggesting that formal consultation should be used only in exceptional circumstances, when there has been substantial change. That is a real worry to the BMA, and I think that it should be a worry to the public, because it would not be clear, using less formal mechanisms, whether or not those people who are in difficult to reach places, potentially, have all been properly approached or reached regarding the consultation.

[192] **Val Lloyd:** In the middle of your answer, you seemed to imply that it would be possible to reach all these different interests through formal consultation, but not through engagement.

[193] **Dr Lewis:** No, I was not necessarily suggesting that. What I am suggesting is that those two processes should not be mutually exclusive. There is extreme advantage and a surety in having a formal process, as well as making every effort to engage with people informally and ensuring that you have the appropriate mechanisms. It is difficult to contact everyone, I am sure, and to identify all the people who would have a reasonable interest in particular reviews, but I do not think that it is impossible to achieve. I am not saying that one is better than the other, or that one could achieve our goals better than the other—you need both. The informal engagement eventually informs the formal process far more fully, so that you will have a greater degree of interest from the public and other health professionals if they have been exposed to the informal processes to the extent that they feel able to participate in the more formal processes.

[194] **Mr Osborne:** To echo what Richard said, we are very concerned about the new interim guidance for consultation. It appears that it will be very difficult to get a formal consultation in future. There is a ‘get out of jail free’ card for health boards if there are urgent issues—although that is not really defined—in that they may be able to do this without a formal public consultation. However, the wording says that the changes need to be substantive and exceptional for a public consultation to occur, and that is a matter of interpretation by various people. It appears that the period of public consultation has been shortened to four weeks on average, rather than the normal three months. So, there is great concern that there may not be a proper formal consultation on changes of enormous magnitude to the emergency services of the people of north Wales.

[195] **Val Lloyd:** We heard from Mrs Burrows about a time when a quick decision had to be made on professional advice. So, there are reasons for some of the things that you mentioned. I agree with you overall that you need full engagement in consultation, but there are emergency situations where you must act.

[196] **Mr Osborne:** Yes, if the hospital is burning down, and so on, but a reason that is

often advanced is safety. Where staffing levels have been deliberately run down in a particular instance in an acute service, you can then say that the unit is unsafe and you can make a decision to close it on safety grounds, having engineered the situation first in which there is a lack of staffing and avoid the need for a normal public consultation.

[197] **Val Lloyd:** So, you are saying that people will be acting duplicitously?

[198] **Mr Osborne:** That is entirely up to you to interpret.

[199] **Val Lloyd:** That is what it sounds like.

[200] **Mr Osborne:** I am saying that that mechanism is available to the health board.

[201] **Darren Millar:** To clarify, as the interim guidance stands at the moment, who audits health boards to ensure that they are complying with existing guidance? Is that being done or not? Who is responsible for keeping an eye on the health boards and making sure that they are following through? Is it the community health councils, the Minister or someone else?

[202] **Mr Osborne:** For the record, the BMA values the independent role of community health councils in Wales—it has been a real win for Wales in retaining community health councils. However, we need to ensure that their independence is preserved and that they are properly engaged in a greater way than even the interim guidance suggests. In moving to the new guidance, there appears to be a diminution in the powers that community health councils could hold to challenge decisions that have been made, particularly with regard to urgent changes, as I think the guidance suggests. Again, it is a matter of interpretation of what 'substantial', 'exceptional' and 'emergency situation' mean. It is fully open to interpretation, but the guidance in its original form—which has been in effect since the health service was incepted—says that it is for pandemics, a hospital burning down or totally unforeseen circumstances. For instance, I do not think that having an insufficient number of junior doctors in Wales is an unexpected or unpredictable problem, but it has been used as a reason on many occasions to underpin the need for urgent change to services. We should have been planning for that a long time ago. Nor do I accept that the sudden financial difficulties in which we find ourselves are unexpected or unpredictable. While they may be creating difficult times, that is not the reason why this guidance was created, particularly with respect to implementing an emergency change to services, where the health and safety of the public or staff is considered to be a concern.

10.40 a.m.

[203] **Darren Millar:** Okay, you have made that point.

[204] **Andrew R.T. Davies:** Do you think that the reorganisation has diminished—to use your word, Richard—community health councils' ability to scrutinise and to fulfil the role that perhaps their predecessor organisations used to be able to fulfil, in part because of the bedding down process in the first place and, secondly, because of the far larger geographical area, particularly in the case of north Wales, that they have to cover?

[205] **Mr Osborne:** I am probably not in a position to comment on whether the change to structures has enhanced or diminished their ability to undertake their roles. What I would say, however, is that it is important that they are structured in a way that allows them to fulfil the roles for which they were set up. So, if individual community health councils feel that they have insufficient resources to ensure that they can cover the patch that they are responsible for, to take account of the various health service changes or proposals, or to get involved in stakeholder groups or whatever, then they should petition accordingly.

[206] **Andrew R.T. Davies:** I appreciate that you are not in a position to comment personally, but what is the BMA view on the question that I put to you?

[207] **Mr Osborne:** I do not think that it has a specific view on that with regard to the reorganisation, Andrew. We submitted evidence surrounding the reorganisation of community health councils, but I do not recall that particular issue raising concern for us, other than the need to ensure that whatever they moved to was fit for purpose.

[208] **David Lloyd:** I think that my question has been answered in a most comprehensive fashion, which has completely floored me with regard to thinking of any supplementary questions to put to our excellent colleagues from the BMA. [*Laughter.*]

[209] **Irene James:** How would the draft guidance need to be amended to take account of the issues that you believe have been raised by the current service reviews in north Wales?

[210] **Dr Lewis:** We feel that the definition of what urgent service changes are should be much more clearly defined. The community health councils should, as of right, be able to ask for a public consultation, and it should not be so difficult for them to do so. In other words, it should not be so tightly prescribed. They should also be able to refer matters to the Minister in a much more straightforward way, because it is currently very difficult for them to do that. We also feel that the period of public consultation should be a full three months.

[211] **Darren Millar:** Are there any more questions from Members? I see that there are not. Are there any closing remarks that the witnesses would like to make before we move on to our next item?

[212] **Dr Lewis:** I would just like to thank you very much for the opportunity to come here to present evidence to you. We feel that one or two important messages arise from this. First, the reason why this review has caused so much upset is because, for the first time ever, the assumption that emergency services are sacrosanct has been challenged. We therefore feel that the Assembly Government needs to consider this issue and have some clarity as to whether it is more important to preserve emergency services for the critically ill or to keep on with this business of targets. That is why we are here today with so much concern about this review.

[213] Secondly, as regards any future reviews, as we have outlined, it is enormously important to engage front-line consultants and general practitioners in the first instance in order to come up with workable options for public engagement. It is also important to involve medical staff committees, local negotiating committees and local medical committees, because they are the voice of the profession locally, and they must therefore be at the heart of the review process. Thank you very much.

[214] **Darren Millar:** Thank you, gentlemen.

10.44 a.m.

Ymchwiliad i'r Ffordd y mae Adolygiadau'r GIG yn Cael eu Cynnal—Casglu Tystiolaeth
Inquiry into NHS Reviews—Evidence Gathering

[215] **Darren Millar:** We will move swiftly on, because the clock is against us. We have been running over time with some of our witnesses, but we have some leeway with regard to time, and it important that we gather proper evidence.

[216] We will now take evidence from the Clarence Medical Centre. Dr Chris Stockport is a general practitioner in that medical centre in Rhyl. You have kindly supplied us with a paper, which has been circulated to the members of the committee. We will move straight into questions on your paper, if we may. You have highlighted problems of poor communication with GPs and with their attendance at stakeholder meetings to consider the review of maternity services and child health in particular. Can you talk a little more about these issues? We have received some conflicting evidence this morning. The health boards seem to suggest that GPs have been fully informed all the way through about stakeholder meetings, yet your evidence seems to contradict that. Can you tell us why that is the case?

[217] **Dr Stockport:** Yes. Thank you for taking some time to listen to me. I will briefly give you some of the background. Clarence Medical Centre is a busy general practice. It has 16,500 patients, lots of elderly patients and lots of patients who live in challenging circumstances with deprivation. It was also pointed out this morning that we are a practice that, in the past, has been very involved in management processes within the health service in north Wales. We continue to have that interest. For that reason, we were particularly concerned that we became aware of the current review processes that are being undertaken by Betsi Cadwaladr University Local Health Board at a very late stage.

[218] We first became aware of the magnitude of the review process being undertaken towards the end of September. That was when colleagues from secondary care asked whether we had an opinion and whether we were aware of the processes. At that point, we were not. The first thing that we did was to contact the health board by sending a letter to Mary Burrows. Copies of the letter were also sent to local Assembly Members in north Wales. We have received some criticism for doing that, but having spent the previous few days speaking to other GP colleagues who were also unaware of the magnitude of the review processes being undertaken and, with hindsight, realising that our relationship with Betsi Cadwaladr University Local Health Board was not as good as the relationship that we had had with the former Denbighshire local health board, we were concerned as to why we had only found out about those processes at that point.

[219] **Darren Millar:** Let us get this right. As we understand it from Betsi Cadwaladr University Local Health Board, the review process started at around the beginning of the summer. However, you are saying that, as a local general practitioner who had worked very carefully with the health board on reviews of other service areas, you were not notified until the end of September.

[220] **Dr Stockport:** That is correct. After we sent the letter to Mary Burrows, we subsequently had a meeting with Lyndon Miles and Geoff Lang, who are both from BCU. During that meeting, they suggested that attempts had been made prior to our involvement in September to seek GP involvement. I can categorically say that we did not receive that communication. We had quite a good communication structure within the former Denbighshire local health board. We had a practice managers' e-mail group, which consistently worked, and we had practice manager meetings, which continue to be held on a monthly basis. These review processes were not discussed there and the e-mails that were apparently sent out were not sent out through those channels.

[221] **Darren Millar:** So, although these reviews were significant and were of public and clinical interest, they were not on the agendas of the local GP groups that were meeting with the health board, and you were not notified until the end of September. What method of communication did the health board suggest that it had used in order to attempt to contact you?

[222] **Dr Stockport:** The health board explained that it had sent several e-mails, which it said it had also sent to the local medical committee. All that I can say is that we did not

receive those. I subsequently went through all of my e-mails to make sure of that.

10.50 a.m.

[223] **Darren Millar:** So, it did not pick up the phone, it did not write a letter and there was no other attempt to communicate, other than via electronic mail?

[224] **Dr Stockport:** That is correct, and it surprises me a little bit, because as a practice, we have never once refused to get involved in any processes, either after finding out about them, or at the specific request of the health board, and there are countless examples of where we have gone out of our way as a practice to engage in improving local health care. So, had someone picked up the phone or written to me, I can tell you, without a shadow of a doubt, that I would have been involved in that process.

[225] **Darren Millar:** We had information that suggested that other reviews in north Wales had gone very well, such as the orthopaedic review, for example. Was there a difference in terms of the communication on that with you as a local GP, compared with these other two reviews?

[226] **Dr Stockport:** I cannot recall for certain, but I am confident that I received e-mails about the orthopaedic review at a fairly early stage.

[227] **Darren Millar:** Okay. Thank you for that.

[228] **Andrew R.T. Davies:** Thank you, Chris, for your evidence this morning, both oral and in the paper that you provided. You have most probably heard the questioning of the British Medical Association and the board about the role of local medical committees. There was a difference of opinion over how they were constructed, or how they stood in statute, nevertheless, they would seem to offer a good opportunity through which a process could be conducted. Would you be supportive of the BMA's view that those committees should be the first point of call in the process because, collectively, they represent a very broad spectrum of the profession?

[229] **Dr Stockport:** I am supportive of the idea of LMCs being involved; they need to be involved as a matter of course, rather than by accident. I do not necessarily agree that they should be the only point of contact with GPs. If people were to pick up the phone, write or even e-mail me through the right channels, I would have other things to add, and many of my colleagues would say the same. So, although LMCs are there for a purpose—and this is one of those purposes—there are plenty of other ways of engaging GPs.

[230] **Andrew R.T. Davies:** I am not saying that the evidence is saying that it should be the only port of call, but that it would be a useful first port of call in the process. Would you concur with that evidence? From that, a wider discussion would then take place. What are the tools that could be used to engage more widely? Do you have any ideas? Communication, in your case, completely broke down, from what I can gather.

[231] **Dr Stockport:** From a GP perspective, there are some established networks and slightly less established networks through which opinions can be obtained. As I said, in Denbighshire we have a monthly practice managers meeting, which is a useful forum for disseminating requests for information and for receiving them back. Most of us as GPs have a fairly informal network through which we can share ideas outside the LMC, so it would be quite easy to canvas opinions from other GPs. From a public perspective, GPs need to be involved in this process, first to represent the perspective from primary care, but also because I am the person who has to deal with Mrs Jones and her three-year-old child having an acute asthma attack with no car to be able to get them 40 miles down the road. Unless I am

involved in that process, or unless Mrs Jones is involved in that process, it will not necessarily be given due credence within a process that is very secondary-care-driven.

[232] **Andrew R.T. Davies:** Surely these channels of communication that you talk about are not alien to the health board in relation to engagement and consultation. One of the things that I said to the health board earlier was that the guidance says that there should be a continuous process of engagement or consultation, so it should not be a case of only coming to these organisations or channels periodically.

[233] **Dr Stockport:** I would not have thought that it was an alien process. Sally Baxter was here earlier, and she was the chief executive of the former Denbighshire local health board before the re-amalgamation. We had a very good working relationship with that board; we felt that it genuinely wished to engage when it was undertaking significant pieces of work. So, my relationship with Sally has historically been good. There was a framework there that would have allowed the input of other interested parties. What is different now is that we have amalgamated into one big health board, and I suspect that some of the processes are just too big to engage properly at such an early point. Some people in management roles in BCU have only recently been appointed, and without building up those relationships between colleagues on different sites and colleagues in the community, such a massive undertaking is difficult.

[234] **Darren Millar:** On the issue of your not having been contacted until September, in the evidence papers that were provided by the Betsi Cadwaladr local health board, it talks about a project board being established to look at maternity and children's services. Your name is on the list of those people who are on the project board. The document is dated 16 August 2010. Why would your name be on a list in a document that is dated 16 August 2010 if you had not attended any meetings and were not aware of any groups?

[235] **Dr Stockport:** After we sent a letter to Mary Burrows and our subsequent meeting with Lyndon Miles, I contacted Jane Trowman, who is the assistant head of planning and who is responsible for this project body—in fact, I think that she is the author of that document—and expressed my willingness to be engaged in whatever way I could usefully be engaged. Subsequently, at the beginning of October, just after the second stakeholder meeting, I received correspondence from the secretary of the board inviting me to the next project board meeting. That was the first point at which I was engaged in the process. I did attend the second stakeholder meeting, but that was on 6 October. Prior to 6 October, I had had absolutely no involvement in the maternity project.

[236] **Darren Millar:** So, according to Betsi Cadwaladr local health board, the process started on 14 July, and according to the papers that it drafted on 16 August, you were a member of the project board, yet you were not aware of any involvement. So, you think that you have been added to the list retrospectively in October.

[237] **Dr Stockport:** On 16 August, I was not part of the project board.

[238] **Darren Millar:** So, this was produced after 16 August and not on the date on which it says it was produced in the papers that have been provided to the committee.

[239] **Dr Stockport:** I was not involved—

[240] **Darren Millar:** So, you cannot answer. I think that it is fair to say that it appears to be inaccurately dated. So, as a key member of the project board on behalf of local GPs, and the lead in respect of primary care, you were not invited to join the board until four months after the start of the process, which was scheduled originally to be completed by November, and less than a month before the scheduled completion date, which was set at the start of the process in July.

[241] **Dr Stockport:** That is correct.

[242] **Darren Millar:** That was just for the record.

[243] **Ann Jones:** You got to the second stakeholder meeting, having found out that no GP was present at the first. What other concerns do you have about the stakeholder meetings that have been convened by Betsi Cadwaladr local health board?

[244] **Dr Stockport:** I have been to two stakeholder meetings convened by it. I went to the second stakeholder meeting with regard to paediatrics and maternity, and was so concerned that, following that, I cancelled surgery and went to the orthopaedic stakeholder meeting that followed a week or two afterwards. That was very much a different process, but the one that concerns me is the maternity and child health stakeholder meeting. It was the second stakeholder meeting, and I went with one of my partners. So, we were the two GPs present—in fact, I think that the documentation shows that no GPs were present prior to that. It seemed that the presentations, for whatever reason, were jaundiced in their perspective. At that point, the project board was considering four options, having narrowed them down from a dozen or so. The four options included one option that would involve the downgrading of obstetric care and paediatrics on one of the DGH sites—either Glan Clwyd or Wrexham—and another option that would involve downgrading paediatrics to one site—

[245] **Darren Millar:** I am sorry, but rather than commenting on the specifics on the table, the key point is that there were four options that had been narrowed down, and you joined part-way through the process.

11.00 a.m.

[246] **Dr Stockport:** There were four options, but only two were discussed in any detail with the stakeholders present, who were then asked to consider ruling out any of the four options, to move the process forward.

[247] **Darren Millar:** Okay—

[248] **Ann Jones:** Can I do this bit? You have twice asked supplementary questions that I would have asked.

[249] **Darren Millar:** Go ahead.

[250] **Ann Jones:** Thanks. Did you see any difference in the process of the stakeholder meetings for the orthopaedic review, compared with the other reviews? Should it be a straight process, so that everybody knows that this is stakeholder meeting No. 1, No. 2 and so on? Should it be the same across the board for all of the reviews, or do you share the board's view that one size does not fit all and that you have to set review processes around the subject area being dealt with?

[251] **Dr Stockport:** I am sure that it is true that one size does not fit all, and some processes are likely to be more complex. I suspect that that was one of the issues that possibly made the orthopaedic review a little clearer to undertake. Some of the issues being discussed in orthopaedics are less contentious than some of the issues being discussed by the maternity and child health project board.

[252] **Ann Jones:** So, you think that the processes are different, and that is of concern because the process is not clear to anybody.

[253] **Dr Stockport:** If the process were transparent, I would have no concerns whether it would involve two, three, four, five or however many stakeholder meetings. It is the transparency that is the issue.

[254] **Ann Jones:** So, basically, you are saying that the process is not transparent.

[255] **Dr Stockport:** Yes.

[256] **Darren Millar:** Just to clarify, four options were on the table, but only two were presented to the members of the stakeholder meeting.

[257] **Dr Stockport:** Only two.

[258] **Darren Millar:** So the impression was that the board wanted to pursue two options more than it wanted to pursue the others.

[259] **Dr Stockport:** Around the table at which I was seated as a stakeholder and around the table at which my GP colleague sat as a stakeholder, the overwhelming belief was that those two options were the two that had clear merit because they were the two options that were discussed.

[260] **Veronica German:** In your evidence, you express some concern about the distinction between engagement and consultation. You think that to compare and contrast those two does not serve any useful purpose, and you want a more pragmatic attempt to involve the public and patients. The interim guidance emphasises the need for continuous engagement, and not just when a change is being considered. To what extent does that happen in north Wales at the moment? Should it happen?

[261] **Dr Stockport:** The last part of your question is the easiest to answer: yes, definitely, I think that it should. On the extent to which that happens at the moment, one of our difficulties is that Betsi Cadwaladr health board is a relatively new organisation. Organisations take a period of time to mature. Key people have only recently been appointed to key posts, so, engaging continuously against that background is going to be very difficult. I am not necessarily sure that I would hold the health board to task for the first few months of its life, provided that it was committed to having those issues resolved further down the line. We have some issues with regard to the structure of the clinical programme groups, and we feel that it perhaps does not allow primary care to be quite as vocal as it could otherwise be. Those feelings have been shared with the board.

[262] Regarding communication and consultation with the public, I suppose that 12,000 people on Facebook would suggest that, in this case, the desired level of communication was not achieved. The community health council has its place, although I do not feel that it solely represents the voice of the public. The short answer to your question is that I do not think that it has occurred. It is a very difficult thing to do, but it is something that, as a practice, we would be very keen to see.

[263] **Veronica German:** What about early stakeholder engagement when there is a change, as opposed to continuous engagement? You obviously do not think that you were consulted.

[264] **Dr Stockport:** Had the right people been involved in the first stakeholder meeting, the options on the table in the second stakeholder meeting would not have been so preposterous that most people in north Wales would object to them. That seems to be the feeling, given that 12,000 patients have objected to some of the options. I fully appreciate that those are not the only options on the table, but they are on the table nonetheless. There seems

to have been very little in the process about the equality impact, namely the effect that this could have on socially deprived areas. Also, I have not seen a great deal of information on the safety aspects of some of the options being considered, which concerns me.

[265] **Veronica German:** Do you, therefore, agree with our previous witnesses that there should be clinical engagement prior to going out to stakeholders, or do you think that those things should be happening at the same time? The previous witnesses said that, in previous reviews, there had been some kind of pre-engagement activity with clinicians in order to look at options that would then go out to a wider range of stakeholders. This was done, in particular, to stop any off-the-wall suggestions being discussed.

[266] **Dr Stockport:** The health board regularly refers to the fact that the process is clinically led within this new organisation, which means that the chief of staff is a clinician. However, I do not think that you can say that the maternity and child health review was clinically led: GPs throughout north Wales were saying that they were not involved, and their hospital colleagues were saying that they did not feel adequately involved either. There is some merit in having initial clinical discussions to rule out options that are technically not viable, yet the public needs to be involved at the earliest stage possible. I have always been taught, through medical school and as a doctor, that the idea of paternalism is long gone, and that if you sit and explain something to someone in a way that they understand, they can make decisions for themselves. That is a practice that I have followed day in, day out as a GP in north Wales over the last 10 years, and it has rarely failed me. If you involve the public at an early stage, and explain the reasons for things, people can make quite difficult decisions, and they are willing to do so.

[267] **Val Lloyd:** Good morning, Dr Stockport. I will stay with the issue of guidance, because we are looking at process as well as the specifics that you are talking about. The guidance provides for a second stage comprising formal pubic consultation, particularly where substantial service changes are proposed. Is the distinction between the two stages sufficiently clear?

[268] **Dr Stockport:** No. I do not understand the distinction between the two stages and, judging by previous discussions that I have heard this morning, I think that that view is held by a large number of people present today. There needs to be more clarity regarding the distinction between consultation and engagement, and regarding fairly nebulous terms such as ‘substantial’—that could mean all sorts of things, depending upon which side of the fence you are on. I am a matter-of-fact, get-on-with-it type of person; what the process is called—whether stage 2 or stage 3 has been reached, and whether it is referred to as engagement or consultation—does not matter as much to me as the final outcome, which is that everyone feels that their voice has been genuinely heard and that their opinions have been considered. If you fail to do that, you can end up with a jaundiced and one-sided perspective on an issue that is altogether different.

11.10 a.m.

[269] **Val Lloyd:** Thank you for the clarity of your answer.

[270] **Darren Millar:** I would like some clarity in relation to the stakeholder meetings. Options were whittled down to four options at stakeholder meeting one, and stakeholder meeting two was to focus it even further, to rule out some options and to reduce the number of options in order to move to some final recommendations for the board. Is that right? We have been told that there are many more options on the table and that it is a fluid situation whereby options will present themselves—

[271] **Dr Stockport:** That is clearly not my experience of the second stakeholder meeting

of the maternity and child health review or of attending every project board meeting since then.

[272] **Darren Millar:** That is not the way in which the other reviews—the review of orthopaedics, and so on—have been conducted, is it?

[273] **Dr Stockport:** I only went to the second stakeholder meeting for the orthopaedic process; I have not been involved in the project boards, so I am not altogether sure.

[274] **Irene James:** What issues should the new draft guidance address in order to take account of the issues that you believe have been raised by the current service reviews in north Wales?

[275] **Dr Stockport:** We have heard quite a lot about the three-cycle review being used by Betsi Cadwaladr health board in its attempt to meet the interim guidance. Undertaking projects that are as complex as some of those currently being undertaken within 3 months is a hugely difficult task even for a developed organisation. To have any chance of doing that, you must have clear engagement of all the necessary people from day one—not from day 60, or whatever. Also, a lot of the data that have been acquired along the way in these processes should be available from day one, to allow for making the best use of the subsequent 90 days. There needs to be a clear understanding of who should be involved in these processes to begin with and of exactly what processes need to be undertaken. One of the things clearly missing from the maternity and child health review was any consideration of equality, and how some of the decisions would impact upon people who do not have a car, single-parent families or people with similar issues. As I have previously said, I am not sure whether I understand the difference between engagement and consultation. I am not sure how helpful that is. It is helpful if everyone gets the opportunity to express their views. Over and above everything else, it needs to be transparent.

[276] **Darren Millar:** I think that that brings us to the end of this evidence session. Thank you, Dr Stockport. Are there any final comments that you would like to make?

[277] **Dr Stockport:** No, I am just glad that you have taken a bit of time to listen to me. Thank you.

[278] **Darren Millar:** We are very grateful. Thank you.

11.14 a.m.

Ymchwiliad i'r Ffordd y mae Adolygiadau'r GIG yn Cael eu Cynnal—Casglu Tystiolaeth
Inquiry into NHS Reviews—Evidence Gathering

[279] **Darren Millar:** We will now take evidence from Dr Duncan Cameron, consultant paediatrician, and Dr Philip Banfield, consultant obstetrician and gynaecologist, from north Wales. Welcome to you both, gentlemen. Thank you for the papers that you have already provided to the committee, which have been circulated to Members.

[280] I will go straight into questions, and you can elaborate as much as you want as we go through our evidence session. You highlight a number of issues around the engagement process for considering the maternity and child health review in north Wales. To what extent do you believe that problems arise from poor communication between the health board and consultants, rather than a failure to involve you in the processes at all? I do not know who would like to start.

[281] **Dr Cameron:** First of all, thank you very much for giving us the opportunity to come to address you here. We are very grateful. We are speaking on behalf of not just ourselves as consultants, but also patients, parents—especially mothers—and children. Your question was about engagement with the board and with consultants. Speaking personally, I do not think that that has been the major problem with engagement in the review with which I have been involved. Mrs Burrows comes along to the hospital medical staff committee on a regular basis. Those of us in the clinical arena were fairly readily engaged with that review. We were told the set-up and invited to represent our colleagues. So, I think that the engagement was reasonable. I do not know whether you would like to comment on that, Phil.

[282] **Dr Banfield:** I am not sure that the communication problem was at board level. From our point of view, it was a matter of the practicalities of implementing what the board thought was happening.

[283] **Darren Millar:** Okay. Do you want to elaborate a little more on that? How were you, as stakeholders, engaged in this key particular service review, and from what point were you engaged? We heard some evidence from the British Medical Association, for example, which suggests that, with previous reviews undertaken in north Wales, there has been a clinical discussion before the engagement of the stakeholders, to have some ideas to present to the stakeholder groups, rather than simply getting everyone together at a huge stakeholder meeting without any sort of idea about how to go forward.

[284] **Dr Cameron:** Yes, that is right. The orthopaedic review is held to have been moderately satisfactory so far. The difference is quoted as being because the clinicians all got together beforehand and thrashed out some basics—that is, the consultants, nurses and GPs. That may be because the issues that they were concerned with were less contentious, although I am not absolutely sure. The issues that were being addressed by the maternity and child health services review contained some potentially radical changes to the delivery of services, and so it may well have been a good idea to get all the consultants, senior nurses and GPs around a table to thrash out the reasons, a way forward, and how to handle it. It is potentially high-octane stuff in the public arena. As it happens, after things began to go wrong, we had a meeting of as many paediatricians as we could gather from across north Wales, and that was extraordinarily fruitful. Perhaps, in retrospect, we should have engaged on that exercise earlier. I am speaking for the paediatricians now.

[285] **Darren Millar:** Is that for you to prompt, as paediatricians, though, or is it a matter for the health board?

[286] **Dr Cameron:** To an extent, we are led by those in charge of the review: the review project manager and the project team.

[287] **Dr Banfield:** I have no issue with the 90-day cycle process. We took part in the unscheduled care process, which was excellent. However, it had fundamental differences from the structure that we would take part in. For instance, each of the cycles had an expert group that met separately from the stakeholder group, although both groups were large. As a conclusion, things like whether we should abandon an accident and emergency department were discussed fruitfully, and the conclusion was that full accident and emergency services should exist at all three sites. However, things that the clinicians said should be behind that, particularly core services such as maternity services and paediatrics, were left out of the final report with a view to progressing that review process. In the external report of that 90-day process, the company flagged up that, if it is a complex issue, the timescale needs to be longer. In particular, it felt that clinicians wanted more evidence before making a decision. It is that that seems to have been missing in the subsequent review process.

[288] **Darren Millar:** You have mentioned the formation of the expert group alongside the stakeholder groups. Has there been an expert group in respect of the maternity and children's services review?

11.20 a.m.

[289] **Dr Banfield:** No.

[290] **Darren Millar:** There has not. Why is there an inconsistency? Has any explanation been offered to you?

[291] **Dr Banfield:** No.

[292] **Darren Millar:** Okay. I just wanted to get that on the record.

[293] **Dr Cameron:** The work streams could be represented as some form of expert group, but I do not think that there was a clear parallel between the work streams feeding into the stakeholder meetings and the expert group that apparently met for the orthopaedic review.

[294] **Darren Millar:** So, there was an expert group for the orthopaedic review—that was to be my follow-on question—and that was the pre-discussion before it got to the stakeholder stage. The health board is clearly inconsistent in its approach to conducting reviews. That one went relatively well compared with these reviews, which did not. The issue seems to lie around the use of experts, namely the clinicians who are involved directly in managing and delivering those services.

[295] **Dr Cameron:** It would appear so.

[296] **David Lloyd:** The current interim guidance in the NHS on how to consult in an ideal world provides for a two-stage process, as we have heard all morning, comprising stakeholder engagement followed by formal public consultation. Is the distinction between the two stages sufficiently clear? Do you realise that there are two stages and that there is progression from one stage to the second?

[297] **Dr Cameron:** The process has become clearer to us during the course of the past few months, but I have to admit that it was not entirely clear to me beforehand. That may be no reflection on the health board, as it has to strike a delicate balance when considering such difficult issues as whether to close in-patient services in one hospital where there is a geographically spread-out population. If it involves the public right at the beginning, it may well get some vociferous responses. Interestingly, one element that came up in the maternity and child health review was the recurrent comment by members of the project team that they had expected people with placards to protest outside buildings. I really think that that was a reflection of how the public had not been engaged. It had been consulted, but it had not felt engaged, because as soon as the nature of the options under consideration became clear, there was definite protest, as you have seen with the massive petitions, the Facebook campaigns, the letters to the papers and the television interviews. It is a difficult one to play, and we understand the challenges posed for the health board in this, but there did not seem to be any public awareness of the magnitude of the issues under consideration.

[298] **Veronica German:** In your evidence, you express concerns that there will not necessarily be a public consultation if the reasons for change are to do with safety. Can you expand on your concerns about that?

[299] **Dr Cameron:** My colleagues and I—indeed, all of us in the service—were concerned that there was a momentum and an impetus to this particular review that was very fast. This

may not be a criticism of the review process, just of how this particular review was handled, but it demonstrated a vulnerability in the process. There was a momentum and a gathering of pace on this, which was signalled from the outset as a safety issue. Page 2 of the communication strategy says:

[300] 'In light of the potential safety issues associated with delivering services which do not comply with national standards the Health Board has agreed a target to complete this review by the end of October 2010'.

[301] In other words, it was pushing this forward as part of the safety agenda, which is fair enough. There are some safety aspects to this, but there was an uncomfortable feeling that that was going to be used as a way to avoid the need for public consultation. We felt very uncomfortable about that given the nature of the changes that could have gone forward. We are grateful that, subsequently, the project board and the health board have clarified that any material change to the service will be put before the community health council, and one would assume that the community health council would say that this would definitely need public consultation. So, there has been a shift, but, at the beginning of the second stakeholder meeting, it was not at all clear that public consultation would follow, even if very radical options were chosen.

[302] **Veronica German:** So, is there sufficient clarity in the guidance? I do not know whether you have seen the interim guidance, or the proposed guidance for the future of engagement and consultation, about when a formal consultation should happen. Is there too much room for manoeuvre, as it were?

[303] **Dr Cameron:** It has been fairly carefully phrased here. I am looking at the interim guidance, section 1, paragraph 10, and the duty to consult does not apply

[304] 'if the relevant NHS body believes that a decision has to be taken on an issue immediately in the interests of the health service or because of a risk to the safety or welfare of patients or staff'.

[305] Mary Burrows gave a good and entirely reasonable example of situations in which you cannot use public consultation, but, based on remarks by members of the project board, our perception was—and I do not know whether this would have happened—that it was not necessarily the case that this would go for public consultation. One might therefore draw the conclusion that the legislation is not tight enough to protect when radical changes are being considered. It is a question of how you read that sub-paragraph, I suspect. Sorry, Phil—were you about to say something?

[306] **Dr Banfield:** Could I correct something that was said earlier? Actually, the perinatal mortality rate in north Wales is not terrible compared with that in other hospitals in Wales. Wales has a lower perinatal mortality rate than England, but the UK as a whole has a worse perinatal mortality rate than many countries in Europe. So, it is an issue for the UK as a whole, and not particularly for north Wales.

[307] The safety issue has been flagged up because there is a sense within the workforce that posts on the shop floor are not being replaced and, in fact, are being directly blocked—

[308] **Darren Millar:** When you say that there is a 'sense' of that, could you be more specific?

[309] **Dr Banfield:** I will give you a good example. We have had a £300,000 midwife-led unit for about two or three years now, but it is rarely open because we do not have enough midwives. On the other hand, we are training midwives but not giving them employment.

That is what the midwives and the patients are struggling with.

[310] **Darren Millar:** Are you managing without that midwife-led unit, though?

[311] **Dr Banfield:** They are all delivering in a high-risk unit, and some of these models rely on people having experience of delivering in a low-risk environment. Everyone is stressed, and we try our best.

[312] **Val Lloyd:** I want to ask about the role of the community health councils. How important are they to the engagement and consultation process? What kind of contribution do they make, or could they make in future?

[313] **Dr Cameron:** They are crucial, and one hopes that they can represent the views of their patches very well, especially when issues of major import are being discussed. However, it is possible for CHCs, or even stakeholder meetings, which are massive gatherings—I think that there were 170 people at the one that we were discussing—to be not manipulated exactly but very forcefully led by the presentations put before it, in such a way as for the options to be pre-loaded. I suspect that the same applies to community health councils. I have not had a great amount of dealings with them, but my understanding is that they are pretty savvy individuals, and they can spot these things, to a certain extent. Nevertheless, at the second stakeholder meeting, there was a clear feeling for many of us that, unless a stand was taken, a decision could have been ratified or options ruled out at that stage, which would have had great significance for many patients and families throughout north Wales. Community health councils were at the stakeholder meetings, and I guess that their voices were heard among the tables, but I am not sure that they had an adequate platform to present the views of their constituents.

11.30 a.m.

[314] **Dr Banfield:** What has worried my colleagues about this is that when we took part in the review of unscheduled care from before, the public was separate to the community health council. Public service users and carers were clearly represented in the stakeholder groups. They seem to have been replaced by the CHC, not only in the process, but also in the management of that process.

[315] **Darren Millar:** Can I clarify that? We were told that members of the public, service users and patients were part of the stakeholder meetings. Are you saying that that is not the case?

[316] **Dr Cameron:** They were there as the CHC and among the voluntary bodies.

[317] **Darren Millar:** Are there any patients and service users who have no hat on, as it were, at the table?

[318] **Dr Banfield:** No.

[319] **Darren Millar:** That is at odds with the information that we have received.

[320] **Val Lloyd:** To clarify, that is partly the role of the community health council, as it has a range of stakeholders.

[321] **Dr Banfield:** It was different from the previous process, however, which clearly labelled patients, users and carers as a separate entity to the CHC.

[322] **Darren Millar:** So, the point that you are making is that it is inconsistent with the

reviews that have been held previously.

[323] Some of our Members have to go, as we have run slightly over time because we want to get all the evidence on the table.

[324] **Val Lloyd:** I do not think that we are quorate, Chair, as we only have representation from two political parties.

[325] **Darren Millar:** We are okay, apparently.

[326] **Val Lloyd:** I did not want to mess up the meeting. I will take the next question.

[327] There is a strong emphasis in the current interim guidance and in the new draft guidance on continuous public engagement, and not just when changes are being considered. You may have heard some of the earlier exchanges on this. Do you agree that this is important, and to what extent is this aspect of the guidance being implemented? Is it possible to implement it adequately?

[328] **Dr Cameron:** That is a very difficult one. There is a distinction between engagement and consultation, but it is quite a tricky one to grasp, and we have been discussing it a lot up in our neck of the woods. There has to be room for a public voice as soon as serious options are put on the table. You may be able to clear away a lot of unsuitable options or strategies early on with some common sense by sitting around the table with all the key stakeholders. One wants to steer a path between medical nursing healthcare paternalism and involving the public, and it is quite a difficult one for the reasons that we have already alluded to. However, the review in which I was involved was, unfortunately, somewhat lacking in this regard, and that may be a reflection on the architecture of the process itself or the way in which it was run; I find it difficult to judge that.

[329] **Dr Banfield:** The new guidance draws a distinction in saying that engagement is not consultation, but the consultation piece gives a rather elegant set of guidelines as to what consultation should be. To me, common sense would say that that should be in the engagement process, because you would save an awful lot of time if you knew upfront what the consequences of your decision-making would be. Our difficulty is in being asked to select options without any information about costs, how services would be provided somewhere else, or what the knock-on effect to patients or their families would be. I would have thought that those would be core data for making a decision, regardless of whether it is a process of engagement or consultation. If your engagement process is correct, your consultation should not create hassle for you.

[330] **Darren Millar:** So, given that consultation is clearly defined in the new revised guidance, you are saying that there should be a clear definition of what constitutes engagement.

[331] **Dr Banfield:** That would be easier.

[332] **Darren Millar:** You are also saying that some minimum information should be provided within that engagement process, such as the financial consequences of options and decisions, clinical consequences, patient consequences, and so on.

[333] **Dr Banfield:** Yes, that would be much easier.

[334] **Dr Cameron:** In the key briefings at the beginning of the maternity and child health review, it was stated that all project documents, briefings, questions and answers, and a forum to post comments and queries will be placed on a regularly updated intranet and internet site.

That is very good way of engaging the public and, to an extent, consulting with the public, and making the information public, by putting it out there for everyone to access. If that is complied with, then that would be an admirable way of engaging people, so that they can look up that information and get a clear idea.

[335] Unfortunately, my perception in our review is that this was a very heavily managed process and that documents were couched in very general terms. For example, the letter that we wrote and, incidentally, copied to Mary Burrows prior to the second stakeholder meeting is the kind of document that one feels should be on such a site, because it reflects concerns, opinions and so on. Unfortunately, it was not put on the site. It could be said that when we wrote, we did not invite them to put it on the site, but it should nevertheless be part of the general debate. So, getting back to the original point, the electronic media and intranet and internet websites are ideal for engaging and allowing the public to feel that it has an idea of what is going on.

[336] **Val Lloyd:** We must remember, however, that not everyone has access to the internet, and I say that with regard to reaching everyone.

[337] **Dr Cameron:** Yes, absolutely; that is a good point.

[338] **Darren Millar:** You are quite right, Val. We have an awful lot of not spots in north Wales, for example, as far as broadband access is concerned. We know that only too well, do we not?

[339] So, some key concerns of yours, which you have recorded and documented in a letter to the health board, were not put on the website. Why was that? Was that deliberate or was it an omission? Was there a deliberate attempt not to alarm the public, or an attempt to obscure some information? Did you receive any explanation for that?

[340] **Dr Cameron:** I do not think that it was deliberate; I think that it was perhaps a misjudgment. We basically felt that momentum was gathering with the possibility that options could be ruled out, including the option to keep three sites open, sites that had evolved over many years and had worked reasonably well. So, it was felt that any slimming down of that was going to be ruled out, without the full gathering of information, without the impact assessments or even the costings of the alternatives being put forward. To put it bluntly, we realised that we were in a fairly warm frying pan, but there was a danger that decisions could have been taken that would mean us hopping into a blazing fire, and ending up with an uncosted, potentially just as expensive, or even more expensive, system that would offer poorer quality.

[341] So, that was the nature of our concerns. It may be that my letter—and I say 'my letter' because I was the one who sent it on, but it was sent on behalf of my colleagues—was fairly tough talking and it may have been too radical to be placed on an internet site. Nevertheless, it appeared not to have been acknowledged in the subsequent stakeholder meeting; no reference was made to it and it was not tabled. So, having been notified at the beginning of the process that all views would be welcomed, when we put forward views, we felt that they were deemed to be views that did not need to be heard and they were therefore not aired at the stakeholder meeting.

[342] I know that this committee is looking at the process itself, and although what I am doing is criticising how it went in this particular review, I think that that highlights the vulnerability of the process to what we feel are not entirely clear practices on a level playing field for all options to be considered.

[343] **Darren Millar:** That certainly does not sound to be in the spirit of the guidance,

which states, when talking about engagement of local communities, that the NHS must earn trust, and that

[344] 'proposals for specific changes should be brought forward within the context of continuing, long term, full and open engagement'.

[345] It does not therefore seem that the process is entirely open in the way that you describe it, with your views having less of the limelight than the views of others that seem to arrive at certain conclusions. That is what you are saying, is it not?

[346] **Dr Cameron:** Yes.

[347] **Dr Banfield:** An example of that is the way the summary outputs from the meetings read very much like press briefings. My colleagues have had to ask for the presentations from the first stakeholder meeting to be released to them and the presentations from the second stakeholder meeting are still not available.

11.40 a.m.

[348] **Dr Cameron:** I think that they have subsequently been made available. I agree with Phil that there has been a fairly sanitised version of how this has been presented. Once again, this is about this particular review, but when you are legislating or advising on how such processes should be run, there should be fairly clear guidelines on how issues should be reported. You would have thought that the second stakeholder meeting was a tea party from reading the briefing that came out. In fact, it was a fairly stormy meeting at the end.

[349] **Andrew R.T. Davies:** The questions that I was going to ask have all been answered. However, you touched on the fact that the guidelines need to be more prescriptive, especially in relation to timescale and process. Am I right in inferring that from your answer in relation to the way in which the guidance is issued by the Welsh Assembly Government to local health boards, for example?

[350] **Dr Banfield:** Yes.

[351] **Dr Cameron:** Yes, I think that that is right.

[352] **Andrew R.T. Davies:** I suppose that there is the dilemma of trying to give flexibility without being too prescriptive. It is a matter of trying to strike that balance.

[353] **Dr Cameron:** It is very difficult to get that balance.

[354] **Andrew R.T. Davies:** Val Lloyd and I know full well, from being members of the Petitions Committee, that consultation can mean many things to many different people.

[355] **Dr Banfield:** On the other hand, Jon Osborne hit the nail on the head by saying that the consultation period has been shortened to almost four weeks. So, you can still maintain flexibility by setting a minimum that is not four weeks. For example, it is possible to set a minimum of 12 weeks.

[356] **Andrew R.T. Davies:** You have touched on my next point, but I will give you the opportunity to expand on your answer, if I may. Given what we have seen with this review, what would you like to see over and above the information that you have imparted to the committee already with regard to WAG's input into the draft guidance that is currently being formulated? Would you like to add anything about how the guidance could be more robust?

[357] **Dr Cameron:** I think that Jon Osborne answered that in a very articulate fashion earlier this morning. I am not sure that I would have much to add to what he has said. Indeed, Chris also put it very clearly that one hopes that when major issues are being faced, the public can be trusted to be involved fully and impartially in such a way as is needed to get the right decision about those difficult issues. It is a very complicated business to legislate or to guide on how a review process should be set up, but it is nevertheless possible for such reviews to take place and to be done well.

[358] **Andrew R.T. Davies:** It is not beyond the wit of man.

[359] **Dr Cameron:** Absolutely not.

[360] **Darren Millar:** I have one final question. We have discussed with previous witnesses the fact that the stakeholder groups seem to be growing as the process is developing. I asked them whether we should start by including everyone and then narrow the stakeholder groups down rather than starting with a few and expanding it to include the world or the galaxy, so that every man and his dog would have a say? What are your views on that? The public clearly wants to be involved at the earliest opportunity, be aware of any proposed changes, and have them explained in layman's terms—in simple, understandable language. At what point does the public get involved? I am finding this difficult to pin down. There is this suggestion that there should be ongoing public engagement, whatever that means—and you have said that there is no clear explanation of what that constitutes—but how and when do we engage with the public? What are your views as consultants? You have been through some of these processes and you have seen a successful review from start to finish. You have suggested that this has, perhaps, been less successful, so when and where should the public be involved? Should it just be in stakeholder meetings; should there be patient representatives at those meetings in addition to the community health councils? How should it work? Do you have any ideas before we close the meeting?

[361] **Dr Banfield:** The previous reviews have involved patients. The trust has previously run with expert patients, and almost every governance committee has a patient on it as a representative. Our experience is that, if you want patients to come and help us with something, you do not get all 700,000 of them piling in; you probably get one or two offering to help. It is often a salutary thing to listen to someone who has lost a baby, or someone who says, 'You are doing this wrong; do you realise that this is the effect that it is having on my family?' That is much more powerful than having 150 people scribbling things down on charts, because it is what we are here for. So, I think that the public can be engaged. I do not see it as an issue; it was done in the previous unscheduled care review.

[362] **Dr Cameron:** In answer to the question, if the public had confidence that, in the event of material changes, there would definitely be a public consultation, they would allow a smaller group of stakeholders—including some members of the public—to begin the process of examining the options and gathering information. However, if they felt that the review process was not proceeding fairly and was going slightly off the rails, they would be justly irritated, to put it mildly.

[363] **Darren Millar:** The threshold for consultation is also an interesting matter.

[364] **Dr Cameron:** Yes, it is a very difficult issue.

[365] **Darren Millar:** It is about whether consultation should be the norm rather than the exception with many of these things. Of course, under the new guidance, if that is the way forward, it is only going to be conducted under exceptional circumstances.

[366] Okay, that brings us to the end of this item. I thank the witnesses for their evidence,

both written and oral.

[367] **Dr Cameron:** Thank you very much indeed.

[368] **Dr Banfield:** Thank you.

[369] **Val Lloyd:** Chair, I want to discuss the scope of the inquiry, but it might be counter-productive to do so in this setting. I wonder whether I could do so via e-mail. I too have another meeting now, and so I will e-mail all committee members about this. I would like a fruitful and calm discussion on the matter, so it would be better if every Member was aware of it. To expedite this, would you agree that I may express my concerns and suggestions in an e-mail?

[370] **Darren Millar:** Yes, please e-mail them to me and I will circulate the message among the Members.

[371] **Val Lloyd:** Thank you very much.

[372] **Darren Millar:** There are some papers to note. I will assume that they have been noted, and I declare the meeting closed.

Daeth y cyfarfod i ben am 11.47 a.m.
The meeting ended at 11.47 a.m.