Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Mercher, 1 Rhagfyr 2010
Wednesday, 1 December 2010

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Veronica German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Irene James	Llafur Labour
Ann Jones	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Sandy Mewies	Llafur (yn dirpwyo ar ran Irene James am ran o'r cyfarfod) Labour (substitute for Irene James for part of the meeting)
Jonathan Morgan	Ceidwadwyr Cymreig Welsh Conservatives
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Pat Billingham	Prif Swyddog, Cyngor Iechyd Cymuned Betsi Cadwaladr Chief Officer, Betsi Cadwaladr Community Health Council
Carl James	Cyfarwyddwr Datblygu Gwasanaethau, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Director of Service Development, Welsh Ambulance Service NHS Trust
Dr Eamonn Jessup	Is-gadeirydd, Pwyllgor Meddygol Lleol Gogledd Cymru Vice-chair, North Wales Local Medical Committee
Christine Jones	Dirprwy Brif Swyddog, Cyngor Iechyd Cymuned Betsi Cadwaladr Deputy Chief Officer, Betsi Cadwaladr Community Health Council
Elwyn Price-Morris	Prif Weithredwr Dros Dro, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, Interim Chief Executive, Welsh Ambulance Service NHS Trust
Carol Williams	Dirprwy Brif Swyddog, Cyngor Iechyd Cymuned Betsi Cadwaladr Deputy Chief Officer, Betsi Cadwaladr Community Health Council

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

Steve Boyce	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Marc Wyn Jones	Clerc Clerk

Sarita Marshall Dirprwy Glerc
Deputy Clerk

Dechreuodd y cyfarfod am 9.01 a.m.
The meeting began at 9.01 a.m.

Ethol Cadeirydd
Election of Chair

[1] **Mr Jones:** Good morning. The first item of business today is the election of a Chair, in accordance with Standing Order No. 10.18. I call for nominations.

[2] **David Lloyd:** Yr wyf yn enwebu Jonathan Morgan. **David Lloyd:** I nominate Jonathan Morgan.

[3] **Mr Jones:** Are there any other nominations? I see that there are not. I therefore declare that Jonathan Morgan has been elected as Chair of the committee.

9.02 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[4] **Jonathan Morgan:** Thank you. I welcome Members to this meeting of the Health, Wellbeing and Local Government Committee. I am delighted to have been elected as Chair of this committee and to make a return to the committee that I chaired up until last year. It is very nice to be back here to contribute to the work of this very important committee.

[5] I pay tribute to Darren Millar, as the previous Chair of this committee and for his contribution as a member of the committee.

[6] Before I welcome Nick Ramsay to the committee, who I am sure will be joining us shortly, I will do the usual housekeeping announcements. I remind Members to switch off their mobile phones, BlackBerrys and pagers. We are a bilingual institution, so Members are welcome to speak in Welsh or English. Headsets are available; the translation feed is on channel 1 and channel 0 is for sound amplification of the floor language.

[7] If it is necessary to evacuate the building, please follow the advice of the ushers. I have not been advised of any fire drill this morning, but if there is an emergency, please follow the advice of the ushers.

[8] Although he is not here yet, I would like to welcome the fact that Nick Ramsay is also rejoining the Health, Wellbeing and Local Government Committee. I also place on record our thanks to Andrew R.T. Davies for his work as a member of this committee.

[9] I think that we have received apologies for absence from Irene James, and I am delighted that Sandy Mewies is substituting for her this morning.

[10] I ask Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none. Thank you.

9.03 a.m.

Ymchwiliad i Adolygiadau'r GIG: Casglu Tystiolaeth—Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Inquiry into NHS Reviews: Evidence Gathering—Welsh Ambulance Services NHS Trust

[11] **Jonathan Morgan:** We are proceeding today with our evidence gathering. I welcome our colleagues from the Welsh Ambulance Services NHS Trust: Elwyn Price-Morris, the interim chief executive, and Carl James, the director of service development. A warm welcome to you this morning. If you are comfortable, we will proceed straight into the questions.

[12] **Mr Price-Morris:** Yes, absolutely. Thank you for the invitation.

[13] **Jonathan Morgan:** You provide details in your written evidence of the continuous engagement process used by the Welsh Ambulance Services NHS Trust in relation to the development of the service workforce and financial framework. Can you briefly outline this process and tell the committee how it meets the requirements of the Welsh Government's current interim guidance?

[14] **Mr Price-Morris:** Thank you, Chair. I will begin and then ask Carl to deal with some of the detail for the committee. With regard to the trust's approach to engagement and consultation, we are an all-Wales service, which means that we are a countrywide service, but we are very mindful of the fact that we have to engage very particularly with all constituencies throughout Wales, with our partners in the NHS and with other organisations. Engagement is essential to the organisation in terms of us taking forward our business.

[15] Since around 2005, it has been a matter of business as usual for the organisation, but most recently, the board has taken the view that it needs to bring together its strategic and operational thinking into one place. Over the past three to four months, we have been working busily to create a single five-year statement, which is the service workforce and financial framework, setting out what we intend to do for unscheduled care and planned patient care services. The paper sets out an overview of that for you, and perhaps Carl could give a little further detail in terms of how we intend to take that forward.

[16] **Mr James:** I think that we are in a slightly different position to some of the other NHS organisations, as we speak, sitting here today. The service workforce and financial framework—our five-year framework, as Elwyn has just alluded to—sets our aspirations for the future. The SWAFF does not commit us to a service configuration review at this point; however, it does commit us to analyse a number of key issues. The three key issues for us at present are around: access—how the public accesses our services, particularly around the 0845 and the 999 numbers; response—how we respond to people's needs, particularly with the move towards more of a focus on clinical outcomes; and, lastly, but just as importantly, the assessment and treatment stage. Those are the three issues that we are looking at.

[17] What does that mean for us in terms of engagement? There are three or four key issues for us. As we go forward, we will enable our organisation to develop a real, strong conversation with the public, stakeholders and our local health board partners to start to tease out some of those key issues around what patients and service users need, how our current services are configured, and how we best design services around patient need as opposed to what we currently do, which is to provide a service and ask them how it is.

[18] Looking at the current guidance, which I have here before me, and its stages—identifying the need for change, developing options for change with the community, planning the consultation, quality-assuring the consultation arrangements, and listening to what people

tell us—I think that we will be going through them all over the next couple of years. At present, we are at the planning stage, where we are asking what big questions arise for our organisation, going forward.

[19] In respect of the question, to date we have followed the current guidance. We will be following the current guidance going forward and we also welcome the draft guidance that came out recently, which is very strong in principle about reinforcing that continuous conversation with the public and, where needed, going through the formal consultation process.

[20] **Veronica German:** As you say, you are a Wales-wide organisation and you have these very different types of care, with planned and scheduled care. Your continuous engagement must have some challenges in that respect. Can you tell us a little about those challenges and how you have addressed them, or intend to address them, to make this engagement process work?

[21] **Mr Price-Morris:** One of our new challenges is how we work with local health boards and other NHS partners. We have a new configuration of NHS organisations, as we know. It is helpful to us, as a trust, to be dealing with seven primary partners, but when we look at the work that we undertake in terms of unscheduled and planned patient care, we cannot do that in isolation. We would be looking for a partnership approach to engagement. There will be things on which we, as an organisation, will need to take a lead in talking about access and how we might establish an estates programme for the future, how we manage fleets and so forth, and to share with the public of Wales how we will address workforce issues and the upskilling of our staff over time. However, much of what we do is dependent on the local health boards in terms of relationships around the unscheduled care programme. One of the challenges for us is how we apply consistency as an organisation across Wales, in terms of standards with access and so forth, ensuring that we work with our local partners so that there is a sense of deliverability, which reflects the local needs that we work with.

9.10 a.m.

[22] Our structure, as an organisation, supports that in that we have a corporate function, which looks at all-Wales issues, but we also have regional and local structures that sit below that. Sitting within that, as an organisation, to try to overcome some of those challenges, we have established a partners in healthcare team within the trust. That is our primary link with citizen panels, citizen juries, local authorities, community health councils and so forth. It is about learning our way into this new NHS configuration of organisations, ensuring that we have a clear plan to address needs and concerns, and that we are able to listen and have a two-way conversation. It is a challenge as an all-Wales organisation. We have limited capacity, but we have to make that capacity work as well as we can.

[23] **Helen Mary Jones:** On this engagement issue, you mentioned briefly that being a national organisation and having to respond at a regional level presents you with challenges. Are there resource implications? To play devil's advocate, if you are having to engage at a regional level, what is the point of the national structure? Do we need it? Is there an argument for putting the ambulance service under the control of the health boards to ensure that that engagement is effective? Almost everything else is now under the control of the health boards, so are there advantages and disadvantages in responding to local need as a national body?

[24] **Mr Price-Morris:** There are a number of issues that fall out of that question. Taking the specifics of the subject matter today, we have to be clear that Wales has common standards and levels of access to services. It is incumbent upon a countrywide organisation such as the trust to ensure that those standards and compatibilities are in place. The one thing

that the national nature of the organisation can do is ensure that we apply a critical mass of planning support, not only to working with the Welsh Assembly Government at a national level, but also working at several levels below that. We have to understand that the planning relationship of the trust is not one-dimensional—in fact it has many dimensions that the trust is seeking to address.

[25] **Mr James:** One thing that we are grappling with is how we get the public enthused about the Welsh ambulance service, because we have had some difficult times—there is no doubt about that—but the conversation needs to move from one around response to one around how we perform for patients or service users. We are keen to have that conversation around clinical outcomes, patient experience, safety and seamless services throughout the health service, as I said earlier. We want to try to generate a different kind of discussion with our service users to ask what we can do better for them, because although we provide these services now, that does not mean that we will provide the same services for the next 10 to 15 years. One of the key challenges for us at the moment is to engage people and show them that they have a role to play in determining what services look like in the next five to 10 years.

[26] **Ann Jones:** We have received evidence from health professionals up in north Wales that they have concerns around the service reviews that are currently being undertaken by Betsi Cadwaladr University Local Health Board. To what extent has the ambulance trust been engaged with these reviews? Are you a stakeholder in them?

[27] **Mr Price-Morris:** The trust is a stakeholder and has a place on the Betsi Cadwaladr University Local Health Board stakeholder panel. In support of that, my regional director in north Wales has a close working relationship on a day-to-day operational level and on a planning level with the health board. He has an open invitation to sit on the board of directors at the health board, and that is taken up on a regular basis. I am very satisfied that we are being properly engaged at a planning level, and that the trust's views about the conveyance of patients in and around north Wales and the relationship with cross-border flows are being properly raised with us, and our advice and expertise is being fed in to that debate.

[28] **Ann Jones:** Do you take that place on the board? Do you have voting rights?

[29] **Mr Price-Morris:** It is a stakeholder panel—

[30] **Ann Jones:** No, you said 'on the board'. So, you do not sit on the university health board.

[31] **Mr Price-Morris:** I apologise. There are two parts to that. The first is the stakeholder panel, which we have a seat on. There is an invitation to join the board of directors, not as a member but as an associate and colleague.

[32] **Ann Jones:** Do you take up that invitation, so that you are in on the bottom rung, if you like, for any planning?

[33] **Mr Price-Morris:** We are there on both levels. As chief executives, Mary Burrows and I also have open dialogue.

[34] **Ann Jones:** There are several reviews in the pipeline, two of which are causing issues at the moment, as you know. What contributions have you made to the emergency services review?

[35] **Mr Price-Morris:** We certainly provided support and advice to the university health board during its early thinking on how it might address unscheduled care. One of the critical things for us is that we are increasingly arriving at a point of having a single annual

unscheduled care delivery plan, not only in north Wales, but for all health boards. That will ensure that we lock together the service requirements for the trusts and health boards in one place, so that everyone is clear about how they apply their resources on an annual basis.

[36] **Ann Jones:** Does that have statutory priority over a review? If a review was to say, 'We are not bothered about unscheduled care, and we can deal with that somewhere else', what would be the status of your annual unscheduled care report then?

[37] **Mr Price-Morris:** There are two levels to this. First, there is the service workforce and financial framework, which all NHS organisations have to apply. That sets out the individual organisation's strategic view about the future, and it influences the local annual plan. That local annual plan is part of the annual operating framework that the Welsh Assembly Government requires all organisations to deliver. In this particular instance of unscheduled care, there is every advantage for that to be done in partnership between the trust and the health board at a local level.

[38] **Ann Jones:** So, it would be a dovetailed plan that would fit the health board's unscheduled care plan as well.

[39] **Mr Price-Morris:** Absolutely.

[40] **Ann Jones:** So, they should mirror each other.

[41] **Mr Price-Morris:** That is the intention.

[42] **Ann Jones:** Okay, thank you.

[43] **Mr James:** We managed to agree between all seven LHBs that, for the first time, from April next year, we will have seven local health board plans for unscheduled care that are jointly planned, owned and delivered between the local health board and the Welsh ambulance service.

[44] **Ann Jones:** So, there will be seven different plans.

[45] **Mr James:** Yes.

[46] **Ann Jones:** Why not have one plan with seven chapters?

[47] **Mr James:** It depends on how you want to present the plan. The issue is whether we know what we want to do and what the priorities are.

[48] **Ann Jones:** So, if someone wants to do something different in another area, that would not be a part of your overall plan.

[49] **Mr James:** It has to meet local need, has it not? The needs in Powys will be very different from those in the Vale of Glamorgan, for example. So, it needs to meet national standards and requirements but also to create sufficient space and flexibility to enable local needs to be met.

[50] **Jonathan Morgan:** Before I move to Sandy Mewies's question, I want to raise a quick point for clarification. You talked about the north Wales review that looked at emergency services, and I was a bit hazy on your exact involvement with that. Were you involved at the planning stage of what the terms of reference would be, at the stage at which evidence needed to be provided on how the services should alter, or the stage at which the evidence was evaluated before coming to any conclusions? It would seem fundamental to me

that, given that one of your roles is to transport patients, you would be integral to that review. Could you just clarify your exact involvement?

[51] **Mr Price-Morris:** Indeed. The approach taken by the Betsi Cadwaladr University Local Health Board is to have a 90-day planning cycle that builds up three levels of work, namely evaluation, shortlisting, and preferred outcomes. The trust has been involved throughout those processes. I do not believe that we were involved in establishing the terms of reference, but they would have been shared with us very early and, had we had any concerns about them, we would have been able to raise them.

[52] **Sandy Mewies:** Good morning, Elwyn and Carl. It is nice to see you both. I am a late substitute to this committee, by the way, so you will not get much in the way of words of wisdom from me this morning.

[53] There has been a lot of talk about the north Wales service reviews and some concerns have been raised about them. Is it your understanding that the reviews were intended to get stakeholders to stimulate conversation and discussion on what was happening, rather than to decide on future outcomes? What is your view on that?

9.20 a.m.

[54] **Mr Price-Morris:** I can offer only a personal view that transcends my previous role as regional director. My understanding is that the health board has sought to engage to build an understanding of the case for change in north Wales, and that that was an evolving process. I have no knowledge to suggest that any other approach is being applied.

[55] **Helen Mary Jones:** Looking out from the north Wales situation, what involvement does the trust have at present with other NHS reviews across Wales? Do you have any observations about the way in which those reviews are being conducted? Are they being conducted differently in different parts of Wales or is there a consistent pattern?

[56] **Mr Price-Morris:** The trust is very much involved at a national level in national programmes of work, and I see that as the point at which consistency should be applied to the local interpretation of frameworks and directions. My sense of it is that there are issues for all health boards. There is some commonality of issues such as the demand for unscheduled care, the demand for planned patient care and how we operate the referral-to-treatment standard and other set requirements within difficult financial constraints. However, I see a genuine desire on behalf of all health boards to examine critically how their services can be delivered in the most effective way, not only in applying resources but also for patient outcomes across Wales.

[57] The ambulance trust is involved in the debate with all health boards. The debates are at different levels and had different starting points, but I can assure the committee that we are engaged with all health boards and that we are doing all that we can to help and advise, based on our quite extensive knowledge of the disposition and conveyance of patients around the Welsh healthcare system.

[58] **David Lloyd:** Trown yn awr at faterion sy'n ymwneud â chyfarwyddyd Llywodraeth Cymru ar gynnal adolygiadau yn y gwasanaeth iechyd yn gyffredinol. Diolch ichi am eich papur ysgrifenedig, gyda llaw. Mae'r cyfarwyddyd interim cyfredol ynghylch ymgynghori yn y gwasanaeth iechyd—a dyna rheswm arall pam mae angen

David Lloyd: We now turn to issues relating to the Welsh Government's guidance on the conduct of reviews in the national health service generally. I also thank you for your written paper, by the way. The current interim guidance on consultation in the NHS—and that is another reason why the Assembly needs more powers—provides for

mwy o bwerau ar y Cynulliad—yn darparu ar gyfer proses dau gam, sy'n cynnwys ymgysylltu â rhanddeiliaid cyn gynted ag y bydd newidiadau'n cael eu hystyried, ac yna ymgynghori'n ffurfiol â'r cyhoedd pan gynigir newidiadau sylweddol i wasanaethau. A yw hwnnw'n fodel defnyddiol ar gyfer rheoli newidiadau i wasanaethau?

a two-stage process, which includes stakeholder engagement from the earliest stage at which changes are being considered, followed by a formal pubic consultation when substantial service changes are proposed. Is that a useful model for managing changes to services?

[59] **Mr Price-Morris:** Drawing on a number of years' experience of having personally led about 12 full public consultations in my time with health authorities, I have critically evaluated a number of different models. The central theme has to be that engagement from the very early stages of conceptualising a change is absolutely essential. If one arrives at a point of going to consultation and it is the first time the public and so forth have heard about it, that will inevitably lead to a difficult consultation. The two-stage process seems to me, on a personal level, to be a sensible one. It draws on the independent role of community health councils to be clear about how they can help health boards and trusts through that process and ensure, by putting critical challenge in place, that the people of Wales and stakeholders are getting the information they need, so that an informed discussion can take place and informed decision making can result.

[60] **Val Lloyd:** Staying on the same subject, whenever substantial service changes are proposed, the guidance requires a formal public consultation. Is it quite clear what is meant by a substantial service change, or do you think that it should be made clear, if not?

[61] **Mr Price-Morris:** Again, drawing on my experience, it has always been one of the most difficult things to define what is and is not a substantial change. It depends on who you ask, and the most important people to ask are those who will be affected by the change. What is perceived as a service change in an urban area might be viewed very differently in a rural area, which is why it is important that CHCs and stakeholder reference groups are involved from early on so that that question can be determined as a part of the process. The best form of consultation and engagement is one that does not require a formalised process at the end because the planning stage has already arrived at a consensus through deliberations.

[62] **Lorraine Barrett:** Would it be helpful to NHS bodies if the new guidance were more detailed and prescriptive about the process and timescales for engagement and consultation on any changes to NHS services?

[63] **Mr Price-Morris:** It would be helpful for the guidance to be clear on any expectations about timescales. There is always a balance to be struck, in my mind, in relation to pace. It is important to have pace in planning and decision making because we cannot wait for ever to move things through. There needs to be flexibility, because some issues are far more complex than others, and there needs to be a degree of flexibility within the system. However, there must be checks and balances so that things do not drift indefinitely.

[64] **Nick Ramsay:** Do you have anything that you would like to add about the process for engagement and consultation on changes to NHS services?

[65] **Mr Price-Morris:** Not personally. I think that we have had a good coverage, have we not, Carl? You have been listening to the debate.

[66] **Nick Ramsay:** You were grilled earlier on the engagement issues, so that is fine.

[67] **Jonathan Morgan:** I thank you for joining us this morning. It has been extremely helpful and your evidence will contribute greatly to our report as a committee.

9.30 a.m.

Ymchwiliad i Adolygiadau'r GIG: Casglu Tystiolaeth—Pwyllgor Meddygol Lleol Gogledd Cymru
Inquiry into NHS Reviews: Evidence Gathering—North Wales Local Medical Committee

[68] **Jonathan Morgan:** I now welcome Dr Eamonn Jessup, who is the vice-chair of the north Wales local medical committee. A very warm welcome to you to the Health, Wellbeing and Local Government Committee this morning. I thank you for the written evidence that has been provided. If you are comfortable, we will proceed straight to the questions.

[69] You state in your written evidence that the local medical committee should be the primary point of contact for the health board when approaching general practice. What is the case for that in the context of service reviews and consultations, and does the LMC represent all general practitioners?

[70] **Dr Jessup:** I will take the last part of that question first. Yes, we represent all general practitioners. Engaging GPs is probably not the easiest thing to do, by its nature and its success. General practitioners are a diverse group of people, and so, ultimately, engaging over 400 general practitioners across the large area of north Wales is not always the easiest thing to do. Having said that, I believe that the local medical committee should be the primary point of contact for several reasons, one of which is to make it simpler for health boards to make contact with general practice as a whole. While many GPs are not always engaged with the strategic planning of the health boards, they are more engaged with the local medical committee than with most other committees.

[71] **Jonathan Morgan:** Thank you. Veronica German has the next questions.

[72] **Veronica German:** In your evidence, you state that your LMC meets every two months. Given the timescales involved in the engagement process, especially the one that we have been considering in north Wales, how feasible is it for the LMC to respond in a timely fashion, to be able to get out to those GPs?

[73] **Dr Jessup:** That is a good question. The LMC has always shown itself to be responsive. We have our own office and our own lay secretary, who is constantly available, by electronic mail and by snail mail. The officers have quite a lot of privilege in being able to appoint representatives, when and where appropriate, to different committees, and we have done that on occasion. It is difficult because, as I alluded to in my first reply, many general practitioners do not want to get particularly involved in the strategic planning of health services. As I wrote in my paper, they are the linchpins of the health service, and their 8 a.m. until 6.30 p.m. contracts largely mean that they have to do the groundwork of the everyday NHS, looking after patients. The fact that we meet every two months is not an obstacle to being able to arrange representation. That leads us to ask what the difference is between representation and gaining people to come forward for engagement, but I think that we will probably cover that later. However, we can still easily put out electronic mail, and snail mail, to the various practices across north Wales, to see whether anyone has a specific interest in putting their head forward to join any reviews that are going forward.

[74] **Veronica German:** We heard the week before last, when we were last taking evidence, from some GPs that they knew nothing about some of the reviews—well, they knew about the reviews, but they had not been informed about the meetings, or whatever it was that was going on. We asked whether it is up to the health board to inform directly every

GP practice of the engagement process, or whether it is the role of the LMC to pass out that information, to get those people engaged. Some people said that they knew nothing about it, or when they did knew, it was late, so that, even though they wanted to engage, they could not.

[75] **Dr Jessup:** They are identical to us. As an LMC, we knew nothing about the maternity review—we were not informed about it. We have gone through all our e-mails and snail mails, and we found that there was no invitation to the local medical committee to attend. We have asked our GPs across north Wales to trawl their e-mails to see what direct request there was for involvement in the maternity process, and only one e-mail had come out. As you can appreciate, GPs get an awful lot of e-mails. That e-mail said, 'If you have an interest in maternity and paediatric provision, perhaps you might like to put yourself forward'. The lack of engagement was not just with GPs as a whole; there was a lack of engagement with the LMC as well.

[76] **Veronica German:** So what do you believe they should do?

[77] **Dr Jessup:** My answer may sound as if I am being rather parochial about the LMC, but I am not at all. The only reason I put that forward is just to make it simpler, as one place to go for the health boards. There is no objection at all to local health boards seeking engagement across the patch. The difficulty is that they may well not receive much interest, dare I say, if a request just goes out from the health boards. They are likely to get more of a positive response if they come to the local medical committee. The other body that they need to bear in mind is the regional medical committee, which is a statutory committee, and which is made up of primary and secondary care physicians. Currently, I am the chairman for that in north Wales, and there was no engagement with us in the review processes. There are a variety of ways in which they can engage, but none of them are easy because of the disparate nature of general practitioners.

[78] **Veronica German:** So, you are saying that the best way for them to do it is through the LMC.

[79] **Dr Jessup:** I believe so, yes. It should be done through the local medical committee, if they are looking for primary care to become involved. I will try to avoid the terms 'engagement and consultation', but you may well ask me more about that later. If you want primary care involvement, the local medical committee is the way forward. If you want a general view and are seeking the views of secondary and primary care physicians, surgeons and obstetricians, you might consider going to the regional medical committee for that.

[80] **Veronica German:** How do you make sure that you are not just putting forward the usual suspects?

[81] **Dr Jessup:** That is always the question, is it not? That is always put forward: why is it always you that we see, Dr Jessup? You are absolutely right. The reason why it is always the usual suspects is that there are only a few who are brave enough to put their heads above the parapet, as I am doing today. We are anxious that we get people to come forward, in particular young doctors and female doctors, because often female doctors are part-time doctors and find it difficult to carry out extra duties outside their 8 a.m. to 6.30 p.m. contract. Our agendas and those of the health boards are identical: we want to engage as widely as possible with general practitioners across the patch. As an LMC, we do our best to engage, and to put out the feelers if there is a specific interest. For example, if there is a committee on echocardiography, we will know one or two GPs who have a special interest in that, and we will do our best to engage with those GPs and make sure that they attend the appropriate committees. That is the strength of the local medical committee.

[82] **Jonathan Morgan:** Before we move to Lorraine Barrett's question, which follows on from this theme, I know that Helen Mary has a supplementary question.

[83] **Helen Mary Jones:** To play devil's advocate, you describe a process whereby it is difficult for the local medical council to engage with GPs, and it is difficult for the local health board to do that. Is it possible that those GPs do not really want to be engaged, and they just want to get on doing their job, which is to look after patients?

[84] **Dr Jessup:** Yes.

[85] **Helen Mary Jones:** Would you agree that that is okay?

[86] **Dr Jessup:** Yes.

[87] **Helen Mary Jones:** I just thought that we had better put that on record.

[88] **Dr Jessup:** That is absolutely right; that is our job. I love my everyday surgery. I love nothing more than seeing my patients and trying to get them fixed. That is the thrill of my job.

[89] **Helen Mary Jones:** That is why people become GPs, not because they want to manage the health service.

[90] **Lorraine Barrett:** Following on from that, if changes are made that you feel are detrimental to the service that you are able to provide, you can have a gripe and say that you were not involved in those decisions that affect the way in which you work. When it comes to consultation, in any area, you cannot always reach out to every person or stakeholder that you need to. However, you are particularly critical of the arrangements made by the university health board regarding the representation and engagement of participants in relation to the stakeholder meetings to consider the service reviews. You have given us a flavour of what you feel has been wrong and how the health board has perhaps not managed to do that. In your paper, you talk about five areas of concern and about a lack of balance in stakeholder groups. Can you expand on some of the other aspects that have been unsatisfactory and how the health board might have managed the whole thing better? You are here representing GPs and the primary care sector, but are there areas of concern aside from the fact that GPs have not been consulted?

9.40 a.m.

[91] **Dr Jessup:** We have a lot of concerns. I will start with the word 'stakeholder'. I have a problem with that word. I do not know what a stakeholder is, because the documents talk about stakeholders and citizens and public representations. So, I do not know what stakeholders are. I start there. Politicians are not allowed to be present on the stakeholder groups. I am not looking to be nice and pleasant to you all, but I would have thought that it was better to get the politicians involved early on in these arrangements, rather than at the end. I cannot follow that. Recently, I have seen wonderful examples in north Wales of cross-party political work engaging the public. It has been tremendous to see. I just do not know. The starting point is to make clear what a stakeholder is, because we do not have that straight.

[92] Let us turn to engagement and consultation. Let us cut to the chase. They are the same; there is no difference. I do not think that I am a stupid man, but when I look at the papers, it is made clear to me that engagement is this phase and consultation is that phase. I read it, and I read it, and I read it, and I am no clearer. To me, if engagement is to be taken at face value, it is a process of consultation and providing information. How it has turned out in practice, in these huge stakeholder meetings, is to my way of thinking a tokenistic opportunity to make people feel involved in the process, and that is so wrong.

[93] I have drawn attention to papers that I have been able to research, one of which looked at clinical engagement, because these are all very different concepts. Clinical engagement, public engagement, political engagement: these are three completely different issues, and this is very important. Within the stakeholder groups, you have clinicians and the men in suits—all the managers—who can actually take time out to attend. Are they stakeholders, or are they yes-men? I do not know. However, there is a huge proportion of yes-men, but no politicians, no citizens, and no community leaders. There is community health council involvement and there are some clinicians around the edges, but these people's voices in this huge group of 120 people are diluted. It is a very difficult balance to get right, as everybody has got to have the appropriate say for their grouping. However, time must also be allowed for clinicians to be properly involved in the process so that what I would call crazy ideas are not put forward as proposals, which, I am afraid, is how the consultation has gone. I hope that that covers some of the issues that we see as a local medical committee.

[94] **Lorraine Barrett:** Thank you. It certainly gives us a flavour of your concerns.

[95] **Helen Mary Jones:** One of the other specific concerns that you have raised is the presentation of information at the stakeholder events, and I completely accept the points that you have already made about what a stakeholder is, because I have never understood that either. I suppose that you could ask whether it matters what information is presented if the wrong people are there anyway. However, with regard to any proposals that we might want to make to the Government, it would be helpful if you could tell us a bit more about what your concerns are about the information presented and the way it is presented, and if you could make suggestions about how that ought to be done. Supposing that we get to the point where we have the right stakeholders, whoever they are, how should they be given information, and what information do you feel they would need?

[96] **Dr Jessup:** The presentations issue was brought to my attention by a paediatrician and an obstetrician from the central area. When I had looked at them, some of these presentations seemed very important as they were about issues such as perinatal mortality and giving people an overall feel. As a GP, it has taken me a long time to get an idea of what levels of care are being provided in the three special care baby units across north Wales and to be able to present this information to the stakeholders. As I have explained, although some are clinicians and many are management who understand the finer detail, there are many people there who really do not have a handle on this and they are carried along by the momentum of the process. People need to know not only which presentations have been allowed, but which presentations were not allowed, whether it was because there was a time limitation, because they were felt to be inappropriate or because someone wanted to bring forward their own personal agenda. All of the stakeholders need to be aware of the facts about the presentations that are not brought forward.

[97] Along with that, there are some issues with regard to the press briefings that are given after these meetings. Many consultant colleagues and primary care practitioners reflected back to me that they did not feel that the press briefings adequately reflected the diversity of opinion that was expressed in the stakeholder meetings.

[98] **Ann Jones:** Betsi Cadwaladr health board has undertaken quite a few reviews. The two most prominent reviews are those that we have been engaged with. Have any of the other reviews been successful or effective and, if so, why has there been a breakdown now in the way in which this review has been handled?

[99] **Dr Jessup:** The maternity and paediatric services review seems to have come to proposals much quicker than the other reviews, which have currently gone very silent. I am not sure of the reason for that. I would suggest that the stakeholder issue has not been handled

satisfactorily in any of them. We tried to get clarity on how you decide who to invite as stakeholders. I have asked that question, and I asked it of the chairman of the surgical review within the local medical committee. I did not get a clear answer and I have not been able to get a straightforward answer to that, which is a problem.

[100] The request for representation and engagement from primary care was non-existent for the maternity and paediatric services review. In the orthopaedic and surgical reviews, it has been there, but it has been a bit late and hastily run out, which has not made it easy for GPs to attend. Many of the meetings have been at clearly inappropriate times. I must give credit to Betsi Cadwaladr with regard to one meeting that it held on 2 November at Glan Clwyd Hospital, for which 40 general practitioners turned up, along with around six or seven chiefs of staff of the clinical programme groups. It will suffice to say that those chiefs of staff got a very clear message on what general practitioners thought about the review process to date.

[101] **Ann Jones:** When the chief executive of the Betsi Cadwaladr health board came to give evidence on this very issue, she mentioned the reviews of orthopaedic, mental health and accident and emergency services as being very successful reviews that had been completed utilising the same process as the one that the board was attempting to use to complete the reviews of maternity and paediatric services and general emergency surgery. Why has it gone wrong? Why were those three successful and why are these two causing problems, if the board used the same process? Did it use a different process?

[102] **Dr Jessup:** Again, I would have to reflect that back to Betsi Cadwaladr, for it to answer on whether it has used the same process or not.

[103] **Ann Jones:** That is what it said.

[104] **Dr Jessup:** I have to take it at its word. If you are asking for stakeholders and you determine who the stakeholders will be, the success of that process might largely be determined by the stakeholders that you bring along to the process and the relevance that those people have. Primary care has been engaged, to some extent, with those processes. Perhaps, in part, it is that.

[105] The surgical review is the strange one because there was a 90-day consultation period that was suddenly shortened to 45 days, but now there is no time limit on it. It is very difficult for me to comment on the orthopaedic and surgical reviews because, to be blunt, I have seen no papers on them. To give an example, prior to coming to you, I sent a message to colleagues, asking who was on the review boards, because I had a flavour that one of the hospitals was under-represented. That message was sent to paediatricians, obstetricians and surgeons. They were not sure who was actually on the review boards, which gives you a flavour as to why I had not seen any papers from the emergency, surgical, or orthopaedic reviews. I believe that they are going along, but until we see proposals on which we are allowed to consult, it will be difficult to comment on that.

[106] **Helen Mary Jones:** I should probably know the answer to this, but I do not. Who decides who the stakeholders are? Is that something that you know the answer to, or is that something that we ought to ask?

9.50 a.m.

[107] **Dr Jessup:** That is exactly the question that I asked of Andrew Jones as regards the emergency surgical review, but I did not get an answer.

[108] **Helen Mary Jones:** Someone must decide, otherwise the invitations would never go

out.

[109] **Dr Jessup:** I imagine that it is a middle manager somewhere who sends out the invitations. That is the nub of the whole process and that is why the guidance is flawed. You must be certain who the stakeholders are, and you may need different stakeholder groups for different groups of people. That is when we can get some engagement. Doctors are trained in the art of non-verbal communication and we can pick up really quickly when people have just come along to give you loads of 'information' to tick a box and are not really interested in what you have to say. You only need to do that to a doctor once or twice and he or she will walk away.

[110] **Helen Mary Jones:** That is understandable. Is it therefore your view, Dr Jessup, that there should be stronger national guidance about who should be invited to these stakeholder meetings, taking on board what you said about the need for a different group of people, depending on the subject of the review? Presumably, if you are reviewing maternity services in Hywel Dda, you would need to talk to the same types of people as if you were reviewing them in Betsi Cadwaladr or wherever. Do you think that it would be helpful if there was clearer national guidance about who ought to be the stakeholders? I would love to be able to find another word for 'stakeholder', because none of us like it at all. Who should be the people who are brought in to be engaged at this stage?

[111] **Dr Jessup:** I very much agree. There is a need for clear guidance and some sort of ombudsman-type person—another dreadful phrase—to look at the pattern of stakeholders and to judge whether they are appropriate. My biggest question on this is: who are the stakeholders and why were all those people invited?

[112] **David Lloyd:** To develop that theme, I like your elegant exposition of engagement, and the philosophical concept thereof, both in your paper and during this morning's meeting.

[113] **Dr Jessup:** Thank you.

[114] **David Lloyd:** The fact is that with the Welsh Government interim guidance, we are stuck with a few definitions and a two-stage approach. I take on board very much that you see a continuum, rather than a separate two-stage process. However, the interim guidance states that the first stage is stakeholder engagement—I will not go after 'stakeholders' again because I want to concentrate on the 'engagement' bit of that phrase—when any change is being considered, and there is supposedly no action plan at that point. The second stage is public consultation, where substantial service changes are proposed. That is what we are left with at the moment with the guidance, and that is what the health boards have to work with. I take on board the philosophy that there are not two stages there, but that they are different parts of the same spectrum. However, given that there are two stages that the health boards must work to, can we carry on using those two definitions? Are the different definitions sufficiently clear to warrant a so-called two-stage process or should we just forget the whole thing about a two-stage process and just have a proper open consultation from day one?

[115] **Dr Jessup:** The first thing that you as the policy leaders in this must ask yourself is: why is there a need for public engagement at all? That sounds really stupid and basic, but it is a very important question. I suggest that you need the public to be involved so that you can carry the public with you in any decisions that come from the process. However, there is no 'public' at the stakeholder meetings and the problem with this whole process is that basic. So, if we take it forward that that is what you want, because most people and GPs would think that consulting the public is the purpose of engagement, then the public must feel properly involved. The process must not be tokenistic and must not get waylaid by peripheral issues, because that is the sort of thing that is happening.

[116] The other thing that I cannot get my head around is the use of the word ‘iterative’. I had to look that word up because I did not know what on earth it meant. The engagement process is an iterative one—that was a beautiful phrase. However, engagement cannot be iterative, because they have said that the engagement process is about informing people and gaining more opinions. How can you use a meeting at which you are gaining more opinions from people to shrink the proposals? The two things are at a dead ninety degrees to each other. That cannot be the way forward. So, that bit has to be worked out.

[117] The problem that we have with the process is that there were going to be three stakeholder meetings. Four proposals came forward, but from where? That is a good question. Suddenly, they went down to two at the end of a stakeholder meeting. How did they come to that conclusion? You also wonder how the number of proposals could shrink following an opportunity for involvement and participation. Those two proposals would then go forward to a review board and it is most likely that there would be a proposal that one or other maternity unit was going to be shut. Then, the proposal comes out for consultation: ‘Here we are, we are going to consult on this proposal that one maternity unit is going to shut in north Wales’. Please forgive me for asking, but how can you consult about that if that is the proposal? You cannot. This is majorly flawed and I suggest that it is a majorly flawed interpretation of the guidance, but I cannot comment on where the blame for that poor interpretation lies.

[118] **Jonathan Morgan:** I call Lorraine Barrett on this and then Helen Mary Jones.

[119] **Lorraine Barrett:** Briefly, I think that I now understand what I was going to ask you, because I thought that I had misunderstood you. When you said that there was no public involvement, you meant in the stakeholder meetings. When it comes to the consultation stage, it goes out to public meetings, does it not?

[120] **Dr Jessup:** You said ‘public meetings’.

[121] **Lorraine Barrett:** Meetings to which the public is invited; open public meetings.

[122] **Dr Jessup:** In your interim guidance, you use the word ‘exceptionally’. That poses a problem for me. Betsi Cadwaladr changes and closes wards—wards at Ruthin Community Hospital and mental health wards elsewhere were closed without engagement or consultation, to a large extent. So, that involves no consultation. When is it an exceptional circumstance? I do not know, and that poses a problem for me. The other problem that I have is with the term ‘public consultation’. Does that mean having a chat with the community health councillors? Our community health councillors are friends and they are powerful people. They are an independent voice, which is very important. However, in my book, a full public consultation does not just mean having a talk with the community health council; it means going out and having full public engagement, having full and, at times, fraught public consultation in town halls and schools. That is what it should be. One needs to be clear on what the term ‘public consultation’ means and how it can be interpreted.

[123] **Helen Mary Jones:** It is the Government’s guidance, not ours. It is worth making that point.

[124] I want to put to you what the Government is trying to achieve with the two-stage process and ask you whether there is any point to it. My understanding of what the Government is trying to achieve with the two-stage process is that the first stage ought to be open-ended. It ought to be about sharing concerns about an issue without a preconceived idea of what is going to be done about it. That comes directly out of problems that the previous Government had with consultations, certainly in the west, where people felt that consultations were entirely artificial because the then-trust had already made up its mind about what it was going to do. The idea of the two-stage process—forgive me, Chair, this is taking a bit of

time—is that you have an open debate and I understood that that should be with clinicians, members of the public and local representatives. What would be said there, for example, would be, 'We think that this service is no longer safe because medical practice has moved on; what do you think that we should do about it?'. A proposal should be generated from that process that would then go out for formal consultation, and that might say, 'We can't sustain a safe service over two sites; we've talked to people about that, they've come back to us and said this, and these are our proposals to try to address that'.

[125] Is there any point in trying to do that or will the reality always be that the service will go out with a set idea in its mind about how it will address that problem? Would it be more honest to go back to a situation in which the service comes out with a proposal containing what it thinks that it will do and consulting on that? From my experience as a Llanelli representative, that frequently results in a total bloodbath in the way that the public reacts, and then it becomes difficult for the service to make any change at all, even when the medical practitioners and the nurses are telling us that we cannot carry on as we are. Is there a point in trying to do the two-stage process and is there anything that we could suggest that the Government should change in the guidance to make that first stage more genuinely open, and so going with the problem rather than the solution?

10.00 a.m.

[126] **Dr Jessup:** The principle of the two-stage process is worthwhile. Planning in the health service has been dreadful for a long time. It has been plagued by inertia and slow progress. As a general practitioner or a hospital consultant, nothing much ever seems to change on the ground. It is often said that trying to change something in the health service is like walking through treacle. That is often the case, and we do worry that, with these large bodies that have been created, such as the Betsi Cadwaladr University Local Health Board, the inertia does not seem to have improved; it seems to have got worse. So, I think that what you have described has a lot of merit in being able to push these ideas forward. As it is, we are in trouble, because the message has gone out publicly that Betsi Cadwaladr LHB has said that there are no options, and we are back to square one. That means, to my way of thinking, that everything that has happened so far has been pointless, so a lot of people's time has been wasted in these meetings, and you think, 'What is the point? We are just where we were before'. It is horribly difficult to get the balance right between involving the public and having some strong guidance to work on. Where this is going wrong is that there is not proper engagement beforehand with the appropriate clinicians in primary and secondary care to work out a feasible plan. For example, any doctor will tell you that it is a non-starter to have a district general hospital in a rural area without a paediatric unit. It can be done in a city, when you have a paediatric department next door, but it cannot be done in a rural hospital, because there is no difference between acute asthma in an adult and acute asthma in a child: if you turn up in casualty, you have to expect the same sort of service.

[127] There were some basic issues that had to be brought into the open. I have to be so careful here, because I do not want to go back to the paternalistic stance that general practitioners can sometimes have—'It is our health service, and we want to be in charge'. Those days have gone, and thank heavens for that. We lead primary care teams now, and we are all practitioners, whichever craft people practice, and whatever background practitioners are from, whether it is nursing or therapy, or whatever, they should all have an equal say within those teams.

[128] Sorry, I probably have not answered your question directly, but it was a long question. I hope that I have given you a flavour of the answer.

[129] **Helen Mary Jones:** Just building on that, is what you are saying that some of these issues come back to information?

[130] **Dr Jessup:** Yes.

[131] **Helen Mary Jones:** It is about the quality of information that is given at stage 1, and whether people can really then have an informed debate that leads to stage 2. Is that part of the—

[132] **Dr Jessup:** Here is a simple suggestion, which I do not think has been thought of: why not put it on the web first? How simple is that? I would say that 80 or 90 per cent of the people attending stakeholder meetings for these reviews would be able to access the web, so put the papers for discussion and the evidence on the web. Then, people who would not otherwise be fully in the know will be better able to challenge it at a meeting. I often find, in any meeting, that the people who are quietest and least likely to put their hands up—junior midwives and doctors are often in this category—often have the most valuable contributions to make. When they put their hand up, they can say something that cuts to the core of the issue like no-one else. So, putting these documents and papers out electronically before a meeting—I am not going to use the word 'stakeholder' again, I am fed up with it—would be very valuable.

[133] **Helen Mary Jones:** Thank you, that is very helpful.

[134] **Val Lloyd:** When substantial service changes are proposed, the current guidance requires that there is formal public consultation. Are you certain what is meant by 'substantial service changes', or is there not enough clarity?

[135] **Dr Jessup:** It is as clear as mud, is it not? As I said, wards in community hospitals in north Wales are often closed with minimal consultation. I would not know whether closing a maternity and a paediatric unit would be considered a substantial change or not. It is too vague. There needs to be some sort of ombudsman—but believe me, I do not want to create an extra layer of bureaucracy for anyone—who can say that a proposed change is substantial. It should not be a committee that does that, because once you get a committee, you get special interests being served. I am sorry to say that here. There needs to be someone who can look at it all. That could be the chairman of the community health council, who could be the final arbiter of whether something is a substantial change. Someone independent has to say that, because what might be a substantial change for me as a GP, because it happens to be on my patch, may not be seen as a substantial change for someone on the outside.

[136] **Nick Ramsay:** The Welsh Government is currently consulting on guidance on consultation and engagement in the NHS. Given all of the interesting things that you have told us today, what would be your key recommendation to the Government in changing the guidance to take into account the results of the review that has been undertaken in north Wales?

[137] **Dr Jessup:** There are a number of things. First, there needs to be a definition of stakeholders. That would be the first major point that I would make. The stakeholders have to be defined very clearly at the outset. The second point relates to a word used in the interim guidance that I did not really understand. It said that formal public consultation would be used 'exceptionally'. I thought that that was too exclusive. I think that saying that formal public consultations should be used whenever there is a significant change to service delivery is another problem.

[138] With regard to the engagement process, you have to be clear as to what it is about. As I said earlier, an engagement process cannot possibly limit proposals; it is illogical. However, that is how it has been used. If that was not the intention of the legislation, then that needs to be made clear.

[139] **Jonathan Morgan:** I see that there are no further questions from Members. Therefore, Dr Jessup, thank you very much indeed for being with us this morning. It has been extremely helpful. As someone who resumed the chairing of the committee this morning and has not sat through the previous evidence sessions to date, I found that extremely helpful.

[140] **Dr Jessup:** Thank you. It was my pleasure.

10.08 a.m.

Ymchwiliad i Adolygiadau'r GIG: Casglu Tystiolaeth—Cyngor Iechyd Cymuned Betsi Cadwaladr
Inquiry into NHS Reviews: Evidence Gathering—Betsi Cadwaladr Community Health Council

[141] **Jonathan Morgan:** I welcome our colleagues from Betsi Cadwaladr Community Health Council. We are joined by Pat Billingham, the chief officer, Carol Williams, a deputy chief officer, and Christine Jones, who is also a deputy chief officer. A very warm welcome to the three of you this morning. Thank you very much indeed for giving up your time to be with us. I noticed a fair degree of interest in what Dr Jessup said during his evidence session, so you may want to reflect on that in some of your answers. I liked the suggestion that the chair of the community health council should perhaps act as the final arbiter in pronouncing on whether or not a change is substantial. So, you may want to think about that. If you are happy to do so, we will proceed straight to the questions. Could you briefly outline the role of the community health council in public engagement and consultation around NHS services and the changes to these services?

[142] **Ms Billingham:** As we said in our paper, one of the core functions of the CHCs is systematic continuous engagement with the local population and community groups. It is not an easy process to engage, certainly in north Wales, where there are around 670,000 people. Inevitably, some will slip through the net. However, we are still in an embryonic form and we are bringing some good processes from pre-April days and putting those into practice, but what may be good in one area of north Wales may not necessarily work in another area of north Wales. So, we are building our own engagement process.

10.10 a.m.

[143] **Lorraine Barrett:** Perhaps you should also tell Dr Jessup how you are engaging, because you state in your written evidence in relation to the NHS service reviews in north Wales that the three-cycle model is only one tool in a wider engagement process, and that you are concerned that it is not clear or apparent that discussions have been taking place elsewhere and by other means. That ties in with the thrust of what Dr Jessup said, although he may not have been aware of that. What other discussions have taken place in north Wales, how have they been organised and who has been involved in them?

[144] **Ms Williams:** We try to make it clear in our paper that there have been discussions for many years in north Wales regarding the state of the health service. As community health councils, we have observed that many stakeholders, if I can mention that word again, have been involved in those discussions since way back in 2006. As a community health council, we regard the ongoing reviews as just a follow-up of those discussions and as a method of looking at certain services in a different light. It is about narrowing down those discussions and focusing them on different service areas. However, we are aware that these discussions have been taking place for a considerable time.

[145] **Lorraine Barrett:** Are these discussions that you as a community health council have been involved in? Is that what you are talking about? If so, are the reports of those discussions made public or shared?

[146] **Ms Billingham:** They are. They form part and parcel of the discussions that are currently being undertaken as regards the various reviews, certainly with regard to emergency surgery and maternity services, the two hot topics, shall we say.

[147] **Lorraine Barrett:** So the public would be invited to share their views with you, and you would then feed that back to the health board, is that right?

[148] **Ms Billingham:** Indeed.

[149] **Ms Williams:** Part of the background to the 90-day or three-cycle model that is being used now is that it was used back in 2008 with regard to a clinical services review. We were very confident that the engagement model that was used then would be a very useful tool for engaging in the future.

[150] **Lorraine Barrett:** Did you feel that you were able to reach parts that the other consultations were not able to reach, and not just the public or stakeholders, if we are going to use that word? Were you able to do that thoroughly?

[151] **Ms Williams:** Our role at this stage needs to be made clear. We are currently monitoring the engagement; we are the health watchdog, and we are not undertaking the engagement per se—we are sitting back independently and keeping an eye on whether this engagement is taking place.

[152] **Ms Billingham:** We act a little like the conscience of the LHBs. We have a strange role. Prior to this committee, we have discussed what depth of engagement at this stage do we as a community health council undertake. The health board has put stuff on the table, and it has to prove to us what it is doing, take advice from us when we might say, 'You should be looking at this area or this particular group of participants'—I will avoid the word. It must be tailored to the service that you are looking at.

[153] **Ms Jones:** From the CHC's experience of sitting on project boards, we have observer status so we are not part of the decision making. We are completely independent, but we are around the table from day one, and that can only be a good thing.

[154] **Jonathan Morgan:** Before you proceed, I will just ask one question. Is there a lack of understanding among the public as to the role of the CHC? I will give you an example. I attended a public consultation in my own constituency last week to do with the shift of acute adult mental health services from Whitchurch to Llandough. It was chaired perfectly well by the Cardiff group of the CHC, but it looked awfully cosy. I know that the CHC is an independent body, but any member of the public sitting there would have been a bit baffled as to who was who and who was actually in charge of the service changes. I am wondering what needs to be done to add clarity to guidance, in the first instance, around who is responsible for what and, beyond that, what we do to better inform the public as to your role.

[155] **Ms Jones:** It would be beneficial if we were not called the Betsi Cadwaladr Community Health Council. If we were called the north Wales community health council, we would not be associated with the health board. Joe Public thinks that we are part of the health board.

[156] **Ms Billingham:** We are, to some extent, seen as an arm of the health boards—as a department, even—and that is worrying. As you say, Chair, how we go about changing that

perception in the public eye is something that we have to work on as CHCs throughout Wales.

[157] **Nick Ramsay:** You mentioned the three-cycle model and you have said that there are issues that need to be addressed to fulfil the requirements of the interim guidance. To what extent do you think those issues have been addressed? In your written evidence, you spoke about issues that the north Wales CHCs have identified.

[158] **Ms Billingham:** As I said earlier, there is a need to identify the services that you are looking at right from the off. For example, I will take maternity; it must start with the clinicians, of course—the people who deliver the service are the ones who know best how or what they can deliver within the restraints that they have. Then, as a CHC, we would say that the people you need to look at are the mothers, the young women and the users of the services, taking that across a whole region and drilling down. It will take a long time, but it will have to take as long as it takes to come up with the goods. Do you want to come in on the weaknesses?

[159] **Ms Williams:** We identified some of the weaknesses back in 2008 when this model was first put forward. Bearing in mind the size and population of north Wales, we were very concerned that it was a huge task to identify who the stakeholders should be, but there are lessons to be learned through this review and other reviews and it is a learning curve. We are pleased that the health board is taking on board the engagement that has taken place so far, and is using the model flexibly, which is what we were assured it would do; it has been proved that it is working.

[160] **Ms Billingham:** One point that we have brought up on every project board, on whichever review is being undertaken, is that communication is always the key. It is about how you explain and get over to not just the population of your region, but the clinicians themselves, what you are doing and why you are doing it. It must be communicated from the start. The hares have been set running and the two reviews in question are very emotive. They affect most people and it is very unfortunate that the communication side of things—getting the message across, saying ‘Hang on, don’t panic; we are looking at what we’ve got and what we can do with it and what clinicians we’ve got’—seemed to come too late. Trying to bring that back, to rescue it is never going to be easy.

10.20 a.m.

[161] **Ms Williams:** The subject matter and nature of the target audience have meant that people can engage through Facebook regarding maternity services whereas, under the orthopaedics review, service users probably would not use Facebook to engage. Engagement has happened by default, and we are happy that it has happened in that way.

[162] **Ms Billingham:** It is not structured engagement, though, is it?

[163] **Ms Williams:** No.

[164] **Nick Ramsay:** Do you think that, in spite of the problems with the three-cycle model, it is an effective vehicle for engagement?

[165] **Ms Billingham:** Theoretically, we do. We agreed with it from the start. It is about how you develop it. It is iterative, and it can be tailored and stretched. So, it is not prescriptive, and, as I said, it can be tailored.

[166] **Ms Jones:** That has been proven with the emergency surgery review, which was meant to be a rapid process lasting from 25 September to 25 November, but the chairman of the project board said that it would take as long as it takes to get it right. That shows that the

90-day cycle is flexible; you can pull it in or extend it.

[167] **Ann Jones:** On whose say-so is the 90-day cycle flexible? Is it that of the project board manager or the groundswell of opinion on Facebook?

[168] **Ms Jones:** It is the project board as a whole, because it has staff representatives, clinicians, the community health council and local authorities on it, and there may be GPs. It is about coming together and deciding—

[169] **Ann Jones:** So, the project board could recommend flexibility on the 90-day cycle, but the directors board of the health board could say 'No, we want 90 days'. Who has the final say on that?

[170] **Ms Jones:** I imagine that it would be the health board at the end of the day, but I do not think that it would do that, because it wants to involve the public and keep things open.

[171] **Ann Jones:** If it wanted things to be open, surely it would have made them open in the first place. We have just discussed the fact that communication has been lacking on this issue.

[172] **Ms Jones:** One example that I can use—it is not from the reviews—is that of Llandudno Hospital. There was a project board for the redevelopment of Llandudno Hospital, and there were five different work streams. It has done the 90-day cycle, it has had the three stakeholder events, and the strategy document has been approved by the health board and has come up to the Minister. There will now be another stakeholder event. So, instead of just having the three cycles, the health board is extending it to have a fourth cycle, The public and stakeholders can have a view on the way that the different work streams will go. In my opinion, it is very open.

[173] **Ann Jones:** It is flexible—

[174] **Ms Jones:** Yes, it is very flexible.

[175] **Ann Jones:** It is flexible if whoever is in charge wants it to be flexible. If I were in charge and I did not want it to be flexible, I could say 'No, you cannot have that flexibility; get on with it'. So, it is flexible subjectively. That is the point.

[176] **Ms Billingham:** Yes, to be honest. I would like to think that if we, as a CHC, felt, from messages that we were getting round the table, that we needed more information, we could say 'You have to extend this; you have to give time to bring the information forward'.

[177] **Ann Jones:** It is only subjective, though.

[178] **Ms Billingham:** It is indeed.

[179] **Jonathan Morgan:** Before we move onto Veronica's question, I will bring Helen Mary Jones in.

[180] **Helen Mary Jones:** I think that you heard part of the debate that we had with Dr Jessup about what a stakeholder is, and I think that Lorraine is right in saying that we cannot avoid using the word, although I think that we all shared some confusion about it. One concern that he raised with us, and I could see the point that he was making, was the question of who is the stakeholder and who gets invited to the meetings. Bearing in mind that we will presumably make recommendations to the Government about any changes that it should make to the interim guidance, and that the project board presumably decides who the stakeholders

are, would there be any value in the list of stakeholders being passed on to the community health council for it to say that some people have not been included who should have been, or to ask why certain people have been included because it might not affect them very much? There was a sense from the previous evidence that stakeholder groups were being slightly fixed—I do not want to put words in Dr Jessup's mouth, but I think that that is pretty much what he was saying. Would there be value in your having an independent role to say 'We do not like that list; we think you should include those people but not those'?

[181] **Ms Williams:** It is happening already; we are doing that already. As we have mentioned, we sit on the project boards, and we are having discussions round the table regarding who should be invited. It is very difficult to get people who represent every member of the public. It needs to be made clear that stakeholders or those who are invited to attend these events have a responsibility to engage further within their communities. It is not just about engagement happening at the stakeholder events. Engagement is happening through the whole process. It should not be seen as cherry-picking at all. There is continuous effective engagement.

[182] **Helen Mary Jones:** Is the guidance sufficiently clear on the responsibilities of the stakeholders who come to the stakeholder meetings? For example, is it clear that someone from the voluntary sector then has to go back to engage with people? Is it clear that that is what they are expected to do, because it seems that this perhaps has not happened?

[183] **Ms Billingham:** I do not think that it is clear enough to be perfectly frank. It is not.

[184] **Ms Jones:** The people around the table need to go back to their organisations and spread the word. With the community health council, with 72 members, Pat, Carol or I will report back from the various project boards, and we would expect our 72 CHC members to go out to their communities and seek public opinion.

[185] **Ms Billingham:** They are the one resource that we have within the communities. We rely on them.

[186] **Veronica German:** My question builds on this. In your written evidence, you said that, in north Wales, the engagement has been interpreted by many as selective consultation. I am assuming that you mean that this is not your view but that you can see that this is how people view it.

[187] **Ms Billingham:** That is their perception, yes.

[188] **Veronica German:** So, building on what you were just saying, is there something in the guidance that could be improved so that people could see or ensure that it is not seen as selective? You are saying that it is not selective and that there are all these people being engaged, but people have come to this committee who think that they are not being engaged. There is a mismatch somewhere.

[189] **Ms Billingham:** It is that old chestnut, is it not? What is engagement and what is consultation? That is the nub of it. It is incredibly difficult. The understanding of what is happening now is an engagement process. When does that engagement process become consultation? It is semantics. It is very difficult. Even our own members, bless them, have struggled with it. It is easy for us, as officers, because we have been working with the interim guidance since its inception. It is our bible, in effect; it has been all that we have to work with. What is engagement? If you are engaging people, involving them with the goal of generating mutual benefits, is that not consultation? Are you not asking us? I do not know how we can get over the definition. The Government tried in the interim guidance; it is trying in the draft guidance. It was hoped that, if you undertook engagement, in the true sense of the word,

because everyone would be engaged, informed and participating in contributing their four-penn'orth in the decisions on options and so on, there would not be a need for public consultation in the way that Helen Mary Jones has mentioned. However, if there was a perfect way, we would all be doing it.

[190] **Jonathan Morgan:** Are you happy with that, Veronica? Do you have any further points?

[191] **Veronica German:** No, I think that we have covered that.

[192] **Ann Jones:** The guidance says that there should be a public engagement officer in each of the health boards. Betsi Cadwaladr does not have one, but says that it is adding it to the job description of some other members. Do you think that that has contributed to the fact that there is a lack of public information in north Wales on what Betsi Cadwaladr is doing?

[193] **Ms Billingham:** It is bound to have an impact, to be honest with you.

[194] **Ms Jones:** It would make our jobs easier if we had a dedicated person to go to.

[195] **Ms Williams:** It would also make the project boards a lot easier. With the restructuring of the health service, people are adapting to new roles, and many are struggling with engagement. So, to have an overarching lead for public and patient engagement would be beneficial.

10.30 a.m.

[196] **Ms Billingham:** Engagement is an integral part of any review or potential service development change. It would definitely be beneficial to have a person in a department who focuses on engagement.

[197] **Ann Jones:** You have had many discussions with the health board about the need for a public engagement officer, and yet it has not listened to you. So, what is your next step? How long will you allow it to carry on doing this without a public engagement officer? At what point will you step in and say, 'No, this is wrong'?

[198] **Ms Billingham:** We have already stepped in to say, 'Look, with what is currently going on, there needs to be a dedicated person or a department to deal with this issue'. Having a director for governance and communications is one thing, but having a person to deal with public and patient engagement is vital.

[199] **Ms Jones:** It is a key role.

[200] **Helen Mary Jones:** Are you of the view that the role of the public engagement officer should not be recommended by the guidance, but made mandatory? If that is your view, do you have a view about how senior that person should be? My worry is about the fact that many organisations have a compulsory equality of opportunity officer, but if she—and it nearly always is a she—is at a very junior level, then the impact that she can have on strategic decision making is practically nil. So, should revised guidance say that every board needs to have a public engagement officer, and do you have a view about how high up the food chain that person would need to be?

[201] **Ms Billingham:** As colleagues have said, having public engagement officers would make life easer for us and for the health board. I think that such an officer should be fairly senior, so that they could go to the board and say, 'I need this, that and the other to do this job for you properly'. There is a need for that rank.

[202] **Ms Jones:** Carol and I are both deputy chief officers with the role of public engagement. There are only four officers for the whole of north Wales, compared with the health board, which has millions of staff. If we had a direct line to one person, that would make our lives a lot easier.

[203] **Irene James:** What feedback, if any, has the CHC received in relation to the way in which the service reviews that are currently under way in north Wales are being managed?

[204] **Ms Billingham:** We have had a fair bit of feedback from the public and from our own members. Perhaps Carol can expand on that.

[205] **Ms Williams:** We have had more feedback about the consequences of the reviews, rather than about the review process itself. It is not clear what the process is, and people are discussing the options more than the process. As we have said, it is good that people are being engaged and are talking, because that is what it is all about. It is about brainstorming and getting people's feelings and concerns out in the open, so that the health board can address them, which it is now doing. The options are still there, and the health board is going to take this forward and have further engagement, which we welcome.

[206] **Helen Mary Jones:** I want to return to the issue that has already been mentioned about what substantial change is and is not. You make some observations about how the interim guidance does not give clarity about the definition of substantial change. Do you have views about how the guidance should be amended to address these issues? I was very taken with Dr Jessup's suggestion that it should perhaps be for the chair of the community health council, someone outside the health board, to decide whether a change is substantial or not.

[207] **Ms Billingham:** It is a subjective issue, is it not? I can imagine that the chair of any community health council would be rather horrified to have that responsibility on their shoulders.

[208] **Jonathan Morgan:** Or even a chief officer. [*Laughter.*]

[209] **Ms Billingham:** It is a subjective issue as to what is substantial. As Dr Eamonn Jessup said, what can be substantial in an inner-city could be nothing in a rural area. Across north Wales, everything is substantial, because of the rurality, basically, and because of the size of the beast itself. Any change to services is seen as big, even down to the closing of two or three beds on a ward for whatever reason.

[210] **Helen Mary Jones:** Surely, you are not advocating that the closing of two or three beds on a ward should go out to formal public consultation.

[211] **Ms Billingham:** Not at all.

[212] **Helen Mary Jones:** Therefore, nothing would ever change. It is not just the north; we have the same problems in the west. Potentially, people in cities might say, 'That is what I think about Swansea'.

[213] **Ms Billingham:** It is very difficult.

[214] **Helen Mary Jones:** I completely take your point that it will always feel like a substantial change to somebody, but in order to get a bit more objectivity in that, should the guidance perhaps set out in more detail some examples of what would be a substantial change and what would not, without wanting to be too prescriptive, because I think that your point about different communities is a valid one?

[215] **Ms Billingham:** As you will be aware, it does already give the examples, to a point, does it not?

[216] **Helen Mary Jones:** Does it need to be more prescriptive?

[217] **Ms Billingham:** It will be difficult to do that, will it not? It will be very difficult to pin down what is substantial. Major changes to a district general hospital, for example, or the closure of a district general hospital, both are substantial. We know that. There is a grey area in services, is there not?

[218] **Helen Mary Jones:** So, you would see some merit in having an independent person bought in from the health board. Whether it would be fair on the chairs to ask them to do it or not, you would see some merit in it needing to be somebody outside of the health board.

[219] **Ms Billingham:** There is the recommendation that, on a local level, the community health councils and the health boards should come up with a protocol as to what is deemed substantial, tailored to their regions. We are still working on that.

[220] **Helen Mary Jones:** Do you feel that the guidance needs to be more prescriptive about the processes and timescales of engagement and consultation? Do you think that that would be helpful?

[221] **Ms Billingham:** Yes.

[222] **David Lloyd:** Yr ydych wedi ateb fy nghwestiwn i yn rhannol, a chafwyd cryn drafodaeth. Yr ydych yn sôn yn eich papur hefyd fod peth dryswch ynghylch y gwahaniaeth rhwng adolygu ac ymgynghori yn y cyfarwyddyd interim. A yw'r gwahaniaeth rhwng adolygu ac ymgynghori yn ddefnyddiol, yn eich barn chi, ac a yw'r cyfarwyddyd drafft newydd yn cynnig eglurder yn hynny o beth?

David Lloyd: You have partially answered my question, and there has been fair amount of discussion. You also mention in your paper that there is some confusion over the difference between review and consultation in the interim guidance. Is the distinction between review and consultation helpful, in your opinion, and does the new draft guidance provide clarity in that respect?

[223] **Ms Billingham:** I think that it needs to be firmed up in terms of the purpose of any conversations held between people around a table, whoever they are, whether they are stakeholders or clinicians, so that what they are talking about is not a done deal—to use a well-worn phrase. The problem with the draft guidance is the issue of how it is managed and dovetailed together. We have concerns, as community health councils, regarding the draft guidance. We are currently governed by the interim guidance, of course. The recommendation that we would make within the draft guidance is to firm up the distinctions.

[224] **Jonathan Morgan:** Do you have anything further to add?

[225] **David Lloyd:** No.

[226] **Jonathan Morgan:** I therefore call on Val Lloyd.

[227] **Val Lloyd:** Thank you very much for your written and oral evidence today. Do you have any further observations on how the guidance could be made more effective?

[228] **Ms Billingham:** The draft guidance?

[229] **Val Lloyd:** The guidance is interim, is it not?

[230] **Ms Billingham:** The interim guidance that we are working on?

[231] **Val Lloyd:** It is the same thing, really.

[232] **Ms Billingham:** The problem with this draft guidance is that it was not commonly referred to. It is only since April, and since certain reviews have been taking place, that people have been saying, 'Oh, yes; that'. For us, as I said, it was the bible. We are aware that it has suddenly hit the radar and people are thinking, 'Oh, crikey; there's this. We are supposed to be working to this. What are we supposed to be doing?' There are many areas—Dr Eamonn Jessup mentioned clinicians—in which it has not come to light until recently. They do not understand what it is saying to them. and we have to interpret certain areas as we see fit from a CHC perspective. We advise the LHBs on how we see this, and as the honest broker, we have to find a common ground with their interpretation of it.

10.40 a.m.

[233] **Ms Williams:** We have referred in every instance to the fact that you need to be open with the public when developing these changes or discussing the options that are available. I know that there is sometimes reluctance to having open and frank discussion about certain areas of the health service. However, people are sitting up and paying attention, albeit slowly. The significance of this document is coming to light more and more with every meeting that we attend.

[234] **Val Lloyd:** As experts on this, do you have any observations as to where it should be changed?

[235] **Ms Jones:** There should be more clarity in public engagement before you get to stages 5 and 6 of consultation, because public engagement is just the gathering of information and views, putting them on the table, going out to the public with the reports and moving it into public consultation, where you are picking the options on which the public can consult. The public needs certain guidance from clinicians, rather than a blank piece of paper.

[236] **Ms Billingham:** There should also be some firming up at the point when you have finished with the public engagement, whereby we as a community health council see that, having gone well, or not, it should nonetheless go to full consultation. The guidance does not state definitively that the decision lies with the community health council. There have been concerns—as expressed by Dr Eamonn Jessup and from other quarters, such as the British Medical Association—that if the health board comes to the CHC and says that, because it has talked to the CHC, then that is it: it has consulted and that is the end of it. No, no, no; it does not work that way. It does not say anywhere that that is what happens—that the CHC will look at the impact of any potential changes, the risk assessments, the evidence and the engagement, and then decide whether or not it needs full consultation. It needs to be defined.

[237] **Jonathan Morgan:** As a point of clarification, in your experience, on how many occasions has the health board not followed your advice, as a CHC, when you have suggested that there ought to be full public consultation?

[238] **Ms Billingham:** I cannot think of one occasion when that has happened.

[239] **Jonathan Morgan:** However, there is a risk that that could happen because it is not set out firmly.

[240] **Ms Billingham:** Indeed. People like Dr Eamonn Jessup say that what could happen is

that the health board could think that, because it is talking to the CHC, that is the consultation exercise ended. No. We know that, but it is matter of getting the message across.

[241] **Jonathan Morgan:** Are there any further questions? I see that there are none. Thank you for assisting the committee with our inquiry this morning. Your evidence has been extremely helpful.

10.43 a.m.

Cynnig Trefniadol
Procedural Motion

[242] **Jonathan Morgan:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[243] I see that the committee is in agreement. That concludes the public part of our meeting.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.43 a.m.
The public part of the meeting ended at 10.43 a.m.