Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 8 Gorffennaf 2014
Tuesday, 8 July 2014

Cynnwys
Contents

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Dr Peter Higson	Cadeirydd, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chair, Betsi Cadwaladr University Local Health Board
Alun Jones	Cyfarwyddwr Arolygiad, Rheoliad ac Ymchwiliad, Arolygiaeth Gofal Iechyd Cymru Director of Inspection, Regulation and Investigation, Healthcare Inspectorate Wales
Geoff Lang	Cyfarwyddwr Gweithredol Gwasanaethau Iechyd Sylfaenol, Iechyd Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Executive Director Primary, Community and Mental Health Services, Betsi Cadwaladr University Local Health Board
Grace Lewis-Parry	Cyfarwyddwr Llywodraethu a Chyfathrebu, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Director of Governance & Communications, Betsi Cadwaladr University Local Health Board
Yr Athro/Professor Trevor Purt	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chief Executive, Betsi Cadwaladr University Local Health Board
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Mike Usher	Swyddfa Archwilio Cymru Wales Audit Office

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

Meriel Singleton	Ail Glerc Second Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 09:00.
The meeting began at 09:00.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody. Welcome to today's meeting of the Public Accounts Committee. I have just a few housekeeping notices. I remind everybody that the National Assembly for Wales is a bilingual institution. Members and witnesses should feel free to contribute to today's proceedings through either English or Welsh, as they see fit—of course, headsets are available for translation and, indeed, for amplification of the sound. I would encourage people to switch off their mobile phones and any other electronic equipment, or to shift them into silent mode, and I would also just mention that the microphones are automatically worked, so nobody needs to touch them. In the event of a fire alarm, we should follow the instructions of the ushers. We have a full house today; no apologies have been received.

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** We have a paper from the director-general of the Department for Local Government and Communities, further to our work on the local government agenda, in terms of the financial challenges facing local government. May I take it that that paper is noted? I see that I may. We also have the minutes from our meeting held on 1 July. I will take it that they are noted.

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

[3] **Darren Millar:** I move that

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

[4] This is just for the next item of business, before we return to public session. Does any Member object? I can see that there are no objections, so we will move briefly into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 09:01.

The public part of the meeting ended at 09:01.

Ailymgynullodd y pwyllgor yn gyhoeddus am 09:20.
The committee reconvened in public at 09:20.

Trefniadau Llywodraethu Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr: Y Wybodaeth Ddiweddaraf am Adroddiadau
Governance Arrangements at Betsi Cadwaladr University Local Health Board: Updates on Reports

[5] **Darren Millar:** The Public Accounts Committee is now back in public session. We are on item 5 on our agenda, looking at governance arrangements at the Betsi Cadwaladr University Local Health Board. There has been, of course, an updated report, which was published last week. It was a joint report by the Wales Audit Office and Healthcare Inspectorate Wales, further to their report that was published in June of last year. I am very pleased to be able to welcome to the committee this morning Dr Peter Higson, the chair of the Betsi Cadwaladr University Local Health Board; Professor Trevor Purt, the newly appointed chief executive at the Betsi Cadwaladr University Local Health Board; Geoff Lang, the executive director of primary, community and mental health services at the health board, who of course was also the acting chief executive for a large period of the past 12 months; and Grace Lewis-Parry, who, of course, is the director of governance and communications at the Betsi Cadwaladr University Local Health Board, and of course that role includes the role of board secretary. Welcome to you all.

[6] Before we make any further progress in this meeting, I just want to make two points. Live tweeting of this evidence session is being encouraged today as part of the Assembly's public engagement work, so I would encourage any Members, witnesses and anybody else who might be watching these proceedings to participate in that. The committee's Twitter handle is @SeneddPAC or @SeneddArchwilio, and, of course, there are some hashtags, which Members are encouraged to use. They are #betsi, #welshnhs, #nhs and #senedd. I think that Julie Morgan just wants to put something on record before we start the proceedings.

[7] **Julie Morgan:** Yes. I just wanted the committee and the witnesses to be aware that my daughter was part of the team that looked into the C. difficile episode.

[8] **Darren Millar:** Thank you for that, Julie. Without further ado, we are 12 months on from a pretty damning report into the governance arrangements at the health board. While it is clear that there has been some progress from the joint report that was published last week, there is still an awful lot to do. Peter Higson, you have been at the helm, if you like, of the board for some time now. Why has there not been more progress?

[9] **Dr Higson:** Thank you, Chair. When I took over as chair in the first week of October last year, I found the organisation in quite a precarious state in terms of the turbulence of the previous few months, the loss of—well, the absence of—the chief executive and the loss of the chair and vice chair, and my immediate concern was to make sure that the organisation had a degree of stability in terms of what it had to continue doing in terms of performing and delivering safe care et cetera. Also, we had the winter period coming up and we had to make sure that we were ready for that. So, what I did immediately was to put in place some strengthening of the governance around the board and then, in discussion and working with Geoff, I looked at what we could feasibly do in terms of preparing the ground for the bigger changes that need to happen this year. Geoff was leading a significant piece of work looking at the management structure, engaging with people internally and externally and getting all of that ready and also preparing a lot of the work around the sustainable clinical services.

[10] So, I think it was a judgment call, to be honest, about the immediate pace of getting the board to function in a fit way as a board in terms of its meetings, papers and agendas—agendas et cetera were very much my priority—but also taking that judgment that some of the bigger changes would need to wait a little bit for two reasons. The first was that more preparatory work was needed. I did not feel in the autumn that the proposals for clinical services were well enough developed by that stage. They needed more engagement with clinicians and more testing. Also, I felt that there was the issue that we needed to recruit a new chief executive. Some of the changes, such as the management structure within the health board, I felt, had to have the chief executive's involvement because he or she—at the time we did not know who it was going to be—would need to live with that and actually feel comfortable that it would deliver. So, I was frustrated as well that the pace was not quicker, but I think that the judgment I took was, 'Let's keep the organisation safe and try to keep it running as well as we can do, make some improvements where we can and then prepare the ground for the big changes', which are going to happen now that Trevor is in post. I am sure that we will discuss that later.

[11] **Darren Millar:** We certainly will. However, before we do that, Dr Higson, could I just ask you a little bit more about the work that has been done to bring the board up to scratch in terms of the functioning of the board? Are you really satisfied now that you have individuals with the right capabilities and the capacity to be able to do the job around the board table? We noticed that there have been some concerns raised in the joint report regarding the engagement of some of the board members. It was a pretty damning report last year. I would have hoped that all board members would have pulled their socks up and engaged fully in the member development sessions—that does not appear to have been happening—and that you have the right people with the right skills around the table. We have also noted, of course, that you are bringing in additional external capacity to the board, which seems to suggest that the other people do not have the right skills that you need. What is the problem in terms of getting that engagement and making sure that the capacity is there?

[12] **Dr Higson:** The engagement has improved tremendously. The things that I put in place immediately were having meetings with the independent members on a monthly basis, appraisal, looking at development needs, and also commissioning two pieces of external support for the board in terms of the governance arrangements, which the Good Governance Institute is currently in the middle of doing. Secondly, there has been some tailored board development work, which was also started in April and is looking very much at the capacity, capability, and the behaviours of the board as a functioning entity. What that second piece of work is focusing on is learning from the mistakes of last year. It is not drawing a line under it and saying, 'Let's just move on'; it is going back to it and using it as a working example of where things go wrong, why it went wrong, what we need to learn from it, and how we resolve conflict in a constructive way rather than this divisive way that the board saw.

[13] There are three new members to the board, out of 11: there is me, the vice chair, and a university member, Professor Jo Rycroft-Malone. So, over a quarter of the board is new—in the last few months, anyway. My own personal view, and my own assessment, having been chair for around nine months, is that, with the previous board, independent members were not listened to as much as they should have been. They were trying to make points. The board was not listening and was not acting on them. I think that perhaps a weakness was that escalation did not happen sooner in terms of taking those further, but two of the independent members did, of course, go to the Wales Audit Office in September 2012 raising concerns about the functioning of the board. It strikes me as having been quite a dysfunctional entity, but independent members, in my experience, from what they have told me and what I have found, had been raising concerns. I think that what I am trying to move to now is that the board functions in a way where the challenge is constructive, and that we are getting that right mix of challenge, support and scrutiny. As with any board that went through what Betsi Cadwaladr University Local Health Board did last year, there was a tendency, when I started,

for it to be overly concerned with detail and not understand what assurance looked like. We have done work on that. What we are looking for in terms of assurance from the executive about the functioning and the safe running of the organisation is probity.

[14] I feel that the board is on that development path at the moment. So, part of my view is that board members were trying to do the right thing. There was not a very well-functioning board. We now have a number of development activities in place. In terms of the new board development programme, not everyone has attended the first couple of sessions, but that is due to personal reasons, holidays and ill health, but the majority has.

[15] **Darren Millar:** They are pretty lame excuses, are they not? It has taken 10 months to organise the board development sessions—after, I appreciate, the external work being undertaken—but to then have board members who were on the board at the time that was found to be failing not turn up and not engage properly in that process, and, particularly, the point that you have not addressed, for you to have to bring in people from outside and appoint them to the board, seems to suggest that there are still inherent problems with some of the board members. We saw the chair and vice chair of the organisation depart. Were there others who should have departed at that time?

09:30

[16] **Dr Higson:** In terms of attendance at the board development sessions, I have picked that up personally. I missed a session in May myself, because I had a personal event that had been planned before Christmas that could not be shifted. In terms of the additional committee advisers, my intention there was not about the capability of the board members, but more about the capacity. We have a large number of committees. We are spread quite thinly. It is a complex organisation, and I just felt that it would be very helpful. It is the first time a board in Wales has done this, but I do have a more fundamental issue about the time independent members are given to fill their role—a day a week, notionally—and the breadth and depth of what we expect them to do. So, the committee advisers are not voting members, they are not board members and they are very clear what their role is, but it adds an additional strand of challenge and scrutiny. So, my motivation was more about the capacity of board members to cover the breadth of what the board did, rather than necessarily the capability.

[17] **Darren Millar:** I am going to bring in some other Members now who want to come in, but there is just one final question from me before I do that. If other boards can manage with their members without having to bring in outside assistance to committees—and all NHS organisations in Wales are large and complex; certainly the health boards are large and complex organisations—why cannot yours, Dr Higson?

[18] **Dr Higson:** I do not have a ready answer for that. I have not talked to my chair colleagues about it, but I know that there has been some discussion generally about the time and the establishment. Mentioned, I think, in the PAC report last year—your report—was the overall capacity of board members to cover the breadth of what needs doing. I do think that it is an issue across Wales. In addition to committee attendance and other things—. Take the recent Andrews report and our response to it: we set up a programme of visits with independent members and senior staff, and we did over 50 in a two-week period. In a sense, people criticise the visibility of the board; you need the time to be visible and to do the things that I feel are important as well as attend committees, which is to go, look and see and get a real feel and engage with staff. I am of the view that capacity, generally, is not sufficient to cover the breadth of what boards in Wales need to be doing.

[19] **Darren Millar:** So, it is a capacity issue, not a lack of capability among existing board members.

[20] **Dr Higson:** It is primarily a capacity issue.

[21] **Darren Millar:** However, there may be some capability issues.

[22] **Dr Higson:** Those are subject to the appraisals that I am doing.

[23] **Darren Millar:** Okay. Thank you for that. Alun Ffred is next.

[24] **Alun Ffred Jones:** O edrych ar adroddiad yr archwilydd cyffredinol, a chan droi at adran sydd yn sôn am reolaeth ariannol a chynaliadwyedd, mae'n cyfeirio at bedwar argymhelliad a wnaed ym mis Mehefin 2013, sef A21, A22, A23 ac A24. Dyma'r brawddegau cyntaf sydd yn nodi'r cynnydd a wnaed ers hynny:

Alun Ffred Jones: Looking at the report of the auditor general, and turning to a section that talks about financial management and sustainability, it refers to four recommendations made in June 2013, namely R21, R22, R23 and R24. These are the first sentences that note the progress made since then:

[25] A21:

R21:

[26] 'Ni wnaed fawr ddim cynnydd'.

'Little progress has been made'.

[27] A22:

R22:

[28] 'Nid yw'r bwrdd iechyd wedi datblygu na chyflawni cynlluniau gwasanaethau'.

'The Health Board is yet to fully develop and deliver integrated service…plans'.

[29] A23:

R23:

[30] 'Methodd y bwrdd iechyd â llunio cynlluniau gwasanaethau na chynllunio ariannol cynaliadwy'.

'The Health Board failed to prepare sustainable service and financial plans'.

[31] A24:

R24:

[32] 'Nid oes unrhyw eglurder o hyd ynglŷn â pha fath o wasanaethau clinigol acíwt yr hoffai'r bwrdd eu gweld yng Ngogledd Cymru.'

'There is still no clarity on the preferred shape of acute clinical services in North Wales.'

[33] A ydych chi'n cytuno â'r feirniadaeth sydd yn yr adroddiad hwnnw am y materion hynny?

Do you agree with the criticism in that report on those matters?

[34] **Dr Higson:** Fe wnaf i ddechrau'r ateb ac wedyn trof at Geoff Lang a Trevor.

Dr Higson: I will start that answer and then I will turn to Geoff Lang and Trevor.

[35] Mae'r hyn y mae'r adroddiad yn ei ddweud yn deg. Rydym yn gwybod yn glir iawn beth nad ydym wedi'i wneud yn y chwe i naw mis diwethaf. Y peth pwysig nawr yw ein bod yn gallu symud ymlaen yn gyflym, gyda Trevor wedi dechrau yn ei swydd ganol mis diwethaf. A gaf droi at y ddau arall i bigo i fyny ar hyn, os gwelwch yn dda? Geoff yn

What the report says is fair. What we have not managed to do in the last six to nine months we know very clearly. The important thing now is that we can move forward quickly, with Trevor having taken up his post in the middle of last month. Could I turn to the other two to pick up on this, please? Geoff first, and then Trevor.

gyntaf, ac wedyn Trevor.

[36] **Mr Lang:** Thank you. In terms of the financial position, the board faced a very challenging financial position during the last financial year. At the mid point of the year, it was looking at a potential deficit position of £29 million. Additional resource was allocated in-year and, when we assessed the strength of the savings plans that we had in place last year to deliver that financial position, there were some inadequacies in those plans and further work was required to improve our financial position as the year went on. As the committee will no doubt be aware, we came to an end-of-year financial position that was a deficit of just over £2 million—0.18% of our budget. That failed our financial duty. That was despite rigorous efforts to control finances, but in the context of a very different balance within the organisation between the crucial need to manage our finances well and the need to keep a focus on quality and safety and on some of the governance issues that came through in the report in the previous year.

[37] So, we worked very hard; we made good progress in the second half of the year, but we were not able to achieve our financial balance. We made just over £40 million-worth of savings last year, in-year, which was quite a significant element, but we fell short of the year-end position. Looking at the three-year financial plan, we did work with Deloitte in the autumn of last year to help us shape that three-year financial plan to look at opportunities for savings, and we are currently working through and implementing some of those areas. When you pull that together with our clinical services strategy, which we have been working on through the autumn, what was clear in conversations that I had with the chairman—and the chairman alluded to this in his opening response—was that we needed to ensure that we had a coherent clinical strategy that was able to convey to the population, to stakeholder organisations and to our staff, the fuller picture of what the board was trying to achieve, and, therefore, how the various changes that we might have to bring about would fit in with that coherent clinical strategy. Two things were evident. One was that developing that fully coherent picture would take longer than we originally envisaged. We originally envisaged coming to the board around December time, with clear proposals, and it was clear to us that we needed to do more work with clinicians and others, discussing and debating the issues and shaping the proposals for the three-year plan.

[38] The second part of it, which I think is quite crucial, is that the context in which the board was operating with its staff, with its stakeholders, with local authorities and with elected members, was not a context within which the board was held in a particular degree of confidence in terms of the plans that it was developing, the robustness of those plans, the safety of them, and the governance that sat underneath them. I think that that is a hugely important contextual point about the timing with which we engage with the public and with our staff and broader stakeholders to talk about some very substantial service changes. Our view, and this is something that I discussed early on in the summer, after the report was published, with Paul Roberts, who came to assist us from Abertawe Bro Morgannwg University Local Health Board, was that there was work to be done in building confidence, in re-establishing those relationships, and in making sure that our plans that emerged were informed by stakeholders and our staff, so that we did not find ourselves in a position of being criticised for the very things that the report drew to our attention as deficiencies in the way the board was organised.

[39] So, those things meant that we were not in a position to pull together our three-year service plan within the time that we had intended to do it, and, therefore, the financial plan that sat alongside that was also not able to be pulled together in that way. That presented difficulties for the board. We were clear that we had a duty to submit our draft plan in January and our final plan in March. We had a draft of a three-year plan running through those periods, but it was clear that it would not achieve, without the full picture of service strategy, a balanced financial position over three years. Therefore, we turned our attention to an in-year

operational plan for 2014-15 that set out our priorities. That is what we are currently working to and what we are still working through on the strategic change and the development of the three-year plan. Trevor might want to share his thoughts on how that is going to progress from where we are now.

[40] **Professor Purt:** Thank you. I think what I particularly wanted to add, and Geoff has obviously covered quite a lot of it, is that I am three weeks in and the key for me is how we embed the three-year strategy now much more around our primary and community colleagues. So, for me there is an issue that I am taking to the board in July, and that is a very clear focus that the three-year delivery, in terms of our service plan, will be embedded in a primary and community-driven model of services. From that, we can then begin to ascertain what our secondary care services may look like, but key for me is actually re-embedding Betsi very much in partnership with our local authority colleagues and GPs. I think the new structure that we are planning to take to consultation by the end of this month, in terms of management and leadership within the organisation, will clearly refocus the direction of travel for the health board as a health board and not as a secondary care organisation. It will work in a much clearer and closer relationship with our partner organisations and with the voluntary sector. I come back to the point that, very much for me, it is around helping primary care to shape the future for what services need to be across north Wales.

[41] **Alun Ffred Jones:** A gaf i ofyn un cwestiwn? Yn amlwg, mae rhywun yn derbyn y cyd-destun ariannol anodd iawn yr ydych yn gweithio ynddo. Mae'r adroddiad ym mhwynt A24 yn sôn am wasanaethau clinigol acíwt a bod y methiant i gyflwyno cynllun yn peri pryder mawr. Rydych chi, gadeirydd, wedi sôn eich bod wedi penderfynu bod angen gwaith pellach ar y cynlluniau strategol hynny cyn eu cyflwyno i'r bwrdd a'r cyhoedd. Ai, felly, yr hyn yr ydych newydd gyfeirio ato, sef y cynlluniau hyn y byddwch yn eu cyflwyno ym mis Gorffennaf, a fydd yn dangos siâp y gwasanaethau clinigol acíwt hyn a gwasanaethau cymunedol hefyd?

Alun Ffred Jones: May I ask one question? Obviously, one accepts the very difficult financial context within which you work. The report in R24 talks about acute clinical services and that the failure to put forward a scheme is a cause of great concern. You, chair, have mentioned that you have decided that further work is needed on those strategic schemes before they are put to the board and the public. You have just referred to these schemes that you will be putting forward in July. Are they the ones that will show the future shape of these acute clinical services and community services as well?

[42] **Professor Purt:** It is really difficult to look at the acute services aspects until we have identified what it is that we want our primary care and our communities to start delivering in a different way. While there will be a natural progression into what secondary care looks like, I think that, for me, what is fundamental at this point in time is that, rather than reshape the secondary care aspects of our business, that we are really clear, particularly with our GP colleagues, how they want to take forward services for our wider population. The key issue for me is to re-embed Betsi back into a situation where it is engaging with GPs and our community staff and community hospitals. From that, we can shape the further acute services. We have already had a series of consultations around some of the larger issues. You could say that, fairly recently, some of the issues regarding maternity have been concluded. However, the rest of the secondary care services, by nature of what they are, will be determined by demand, and that will be determined in many ways by how primary care starts to address some of the issues that it sees, in terms of how it wants services to be delivered in the future.

[43] **Darren Millar:** We will take a little bit of time later to discuss the acute services side of things, but do any Members have particular questions about finances first? Aled, you have a question.

[44] **Aled Roberts:** Mae'r adroddiad yn A23 yn sôn am orwariant o £10.2 miliwn yn ystod dau fis cyntaf y flwyddyn ariannol. Rydyn ni wedi clywed am yr ailstrwythuro hyn o'r blaen i ryw raddau. Rhyw bum mlynedd yn ôl, roedd yna sôn am fyd newydd i ogledd Cymru o ran y grwpiau clinigol. Rwy'n meddwl, hwyrach, bod gwendidau mwy sylfaenol na jest ailstrwythuro. A gaf i ofyn i chi, felly, ymateb i'r hyn a glywais yn Ysbyty Maelor Wrecsam dros y penwythnos, lle roedd staff yn cwyno bod doctoriaid yn cael eu cyflogi fel *locums* a nyrsys yn cael eu cyflogi drwy asiantaethau? Ar un ward, roedd mwy na thri chwarter y staff yn cael eu cyflogi drwy asiantaeth. Mae eich ffigurau yn hanesyddol yn y gogledd yn uchel iawn o ran y gwariant ar *locums* a staff asiantaeth. Felly, beth yw'r sefyllfa ar hyn o bryd? A ydych chi wedi cymryd unrhyw gamau i leihau hynny? Y feirniadaeth gan y staff yw bod y sefyllfa yn gwaethygu yn hytrach na gwella.

Aled Roberts: The report in R23 talks about overspending £10.2 million during the first two months of the financial year. We have heard about this restructuring before to some extent. Some five years ago, there was talk of a new world for north Wales in terms of the clinical groups. I think that, perhaps, there are more fundamental weaknesses than just restructuring. May I ask you, therefore, to respond to what I heard in Wrexham Maelor Hospital over the weekend, where staff were complaining that doctors were being employed as locums and nurses were being employed through agencies? On one ward, more than three quarters of the staff were being employed through an agency. Your figures, historically, in north Wales are very high in terms of spending on locums and agency staff. Therefore, what is the situation at present? Have you taken any steps to reduce that? The criticism of the staff is that the situation is worsening rather than improving.

09:45

[45] **Dr Higson:** Nid yw beth sy'n digwydd ar y funud yn dderbyniol. Rwy'n mynd i droi at Geoff eto i bigo i fyny ar y manylion ac ymateb.

Dr Higson: What is happening at present is not acceptable. I will turn to Geoff again to give you the details in response to that.

[46] **Mr Lang:** In terms of agency and locum doctors and nurses, perhaps to start with nurses, from the autumn right until the current point, we have struggled significantly to recruit qualified nurses into the health board. It is the first time in recent years that we have had that difficulty, and we have found that external advertisements have not produced a field of candidates that would allow us to replace our nurses at the rate we need to. We are not alone in that situation; for example, our neighbour foundation trust just over the border in Chester has had the same difficulties, and it has embarked on international recruitment to bring nurses in. We have done that; we have been recruiting nurses in Spain in the last couple of months. That has proved successful. We have a cohort of nurses who will begin work in the health board in the next couple of months and that will supplement the cohort that is currently graduating and will be leaving the school of nursing at university in September, and we are recruiting those nurses as well.

[47] One of our difficulties in nursing has been a pure inability to recruit, and therefore we have had to rely on agency staff. We know that that compromises continuity of care, it potentially introduces risks that are greater than having your own staff there, and it is not a good environment for our permanent staff to not know who their colleagues will be at any particular time, but we are working very hard on that. We are assessing the impact of our international recruitment with our local recruitment, and we are currently considering whether we need to do a further tranche of recruitment in Spain. We have not decided to do that yet; we are currently thinking that through.

[48] On the doctors' side of things, there are specialties where we have difficulties recruiting. There are specialties where we struggle particularly, sometimes at the consultant

grade, but more at the middle grade of doctor—the staff grade; that is, the doctors who provide the backbone of the day-to-day clinical cover. There are a number of specialties where we find it very hard to get cover: emergency medicine is a particular one, as are areas such as psychiatry, and there are a number of other specialties where we have struggled to recruit. That does impact on our locum spend. We spend far too much on locum doctors and agency staff.

[49] We are trying to drive that down and looking at sustainable manpower models that will allow us to do it. However, at the moment, we face quite particular challenges, and those challenges are set in the context of running the services the way we run them. We come back to a discussion then about the strategic configuration of services and whether we can continue to provide the same number of services, in the same way, across the hospitals in north Wales. I think that, strategically, we have to bring about some change in that, but until we have gone through that process we are working in the current model. That means that we are introducing agency doctors and nurses at a rate that we would not ideally choose.

[50] **Darren Millar:** Aled, you may contribute very briefly, and could I ask for brief responses from the witnesses, because we have lots of Members who want to come in on finances?

[51] **Aled Roberts:** Beth am y gŵyn bod rhaid i bob swydd fynd drwy'r adran adnoddau dynol a bod hynny yn creu oedi o ryw chwe neu wyth mis, ac yn ystod y chwe neu wyth mis hynny bod yn rhaid i chi gyflogi staff o'r asiantaeth?

Aled Roberts: What about the complaint that every job has to go through the human resources department and that that causes delays of six to eight months, and that during that time you have to employ agency staff?

[52] **Mr Lang:** This was a particular criticism last year in terms of the time that recruitment took. There were specific measures that I put in place last summer to speed up recruitment processes to cut down the approval times. There are natural processes that one has to go through in terms of the timescale for recruitment, such as the appropriate security and safety checks for staff and clearances et cetera. One would not want to shortcut that, because that could compromise the quality of staff that one appoints at the end of the process. However, we have made specific efforts to reduce what was an unacceptable management lag, if I could describe it that way. From the point of determining that we might need to recruit a member of staff to getting a decision made that said, 'Yes, get out and recruit, and let's sustain the quality of our care', we had an unacceptable lag, and I took steps to ensure that the approval process was quicker and swifter, so that that lag would be reduced. However, some delays still occur because of the availability of candidates, safety checks or other checks, et cetera.

[53] **Darren Millar:** Peter, you wanted to come in.

[54] **Dr Higson:** Very quickly, Chair, I will just add to what Geoff said. One of the weaknesses of the board is that it does not market itself very well. It is the biggest health board in Wales; it has two universities; it has huge opportunities for medical and nursing careers; there is a lot of tremendous work going on, but it is all hidden. I took a paper to the board in March looking at recruitment generally, and I cannot disagree: our recruitment is overly bureaucratic. Despite the improvements that Geoff has put in place, we are not putting forward the case as to why one should come to work in Betsi Cadwaladr very well yet. We can improve that significantly. It will help when it is clear what the configuration of some services will look like. A criticism that I have is that, generally, the board is a very bureaucratic entity at the moment, partly caused by the management structure it currently has. However, I think that that is about to change. We will streamline things. I also found that there has been a tendency to only start recruiting once somebody has left, even though people

knew they were going.

[55] **Jenny Rathbone:** All that is pretty desperate. If you have nothing but agency staff operating at the weekends in a particular hospital, you know you have a recruitment problem. You do not need to agonise about it; you need to get out there and recruit immediately. My question was around the skill mix. If your sister organisation in Chester also has a problem recruiting nurses, what are you doing to recruit people who support nurses, who do not necessary need to be fully trained nurses? The things that people complain about are things like nobody giving them a pillow and nobody changing them if they are incontinent or helping them to get to the loo. These are things that do not require fully qualified nurses. What are you doing about that?

[56] **Mr Lang:** I have a few points in answer to your question. I do not think that we have an exclusive agency nursing or staffing arrangement. There are pockets where we have significant reliance, but I would not say that it is exclusive in any area.

[57] In terms of recruiting other staff, we have worked very hard on recruiting healthcare support workers. We have no real difficulty in recruiting healthcare support workers in north Wales. We have a vibrant bank group of staff who work flexibly for us to cover issues and shifts, and we are looking to develop those staff as much as we possibly can. We have also recruited permanent healthcare support workers. We are very much focused on the chief nursing officer's staffing models for healthcare, particularly in acute wards, and we are recruiting the qualified nurses to do that. We have the healthcare support workers in the numbers that one would expect. There is flexibility in what managers have in terms of supporting their numbers of staff to deal with basic care dignity issues, as you quite rightly say, that do not always need qualified nurses. There is that standard that has been set by the chief nursing officer, which we believe is an appropriate one to pursue, but it does require us to have a certain number of qualified nurses. That is where we struggle. It is not in the healthcare support worker domain. In terms of general nursing and midwifery assistance, we have a number of schemes that are ensuring that we have a steady flow of healthcare support workers and unregistered staff.

[58] **Jenny Rathbone:** You say that you have enough healthcare support workers, but why am I still reading about people saying that it took three days for them to have the pillow that they needed to raise their leg? If you have them, they are not being sufficiently well deployed. Obviously, you need qualified nurses to supervise those people, but are they being properly deployed and directed to get on with caring for people?

[59] **Mr Lang:** I think that we have instances—complaints and concerns such as that—where care is not at the standard that it needs to be. That is investigated and we look to change and improve services as a result of that. I do not think that we have a widespread position where there is not sufficient healthcare support worker input in our wards and clinical areas or that is regularly and consistently generating the sorts of problems that you referred to. I would not say that they do not occur. On particular shifts in particular places, we have those, and we have to look very hard when they occur and make sure that we improve services. I do not believe that that is a consistent pattern across our wards and clinical areas, but we have examples where care is just not good enough.

[60] **Jenny Rathbone:** Do board members visit at the weekend, which is when we know that problems are more likely to occur?

[61] **Dr Higson:** Yes.

[62] **Jenny Rathbone:** Good.

[63] **Darren Millar:** I would like to ask a question for the record. As I understand it, the health board has one of the highest nurse-to-patient ratios in Wales. So, you are actually doing rather well in trying to meet the nurse ratio targets that are being recommended by the Welsh Government. Is that correct? I just want a statement for the record.

[64] **Dr Higson:** In crude numbers, the number of—. What we cannot discern from the numbers is whether all of those people are nursing. You know, their nursing qualifications—

[65] **Darren Millar:** Okay. They are on the payroll, as it were.

[66] **Dr Higson:** Yes. They have nursing qualifications. However, I do not think that the current management structure supports agile deployment of nursing staff. The new structure will do so.

[67] **Jenny Rathbone:** Chair, I have further questions about the board, before we delve into in-patient care et cetera.

[68] **Darren Millar:** If we can just focus on finance for now, then I will come back to you, Jenny, in terms of further questions on the board. Sandy is next.

[69] **Sandy Mewies:** We are concentrating on finance now. Perhaps for me, one of the most important things is a fundamental structural change. I think that structure is important, because that is what delivers. People are structure, and that is what delivers the outcomes. If you get that right, your financial planning has to match. The two things absolutely go hand in hand.

[70] As a North Wales Member, I talk to people from offices such as yours on a fairly regular basis, so I know when changes are afoot. However, one of the things that all health boards were asked to do was to produce a three-year plan. That three-year plan has not yet been forthcoming from Betsi. I have said to Professor Purt before that I think that there is a huge weight on his shoulders, because a lot of decisions were left outstanding before he came. That was a board decision; that is entirely up to him and he will take responsibility for that. However, what has also just been mentioned by Professor Purt is that there is, as far as I can see, a complete change in the philosophy and structure at Betsi if, in future, services will start in the community and primary sectors and then look at what they need from the acute services sector. I assume that you will do that, matching up with your three-year short, medium and long-term planning. That is fundamental. It will address some of the issues, hopefully, that have been raised in the reports that we have heard.

[71] I personally think that this last report is a bit of a curate's egg. There have been some good things in it, but there are obviously things that are not. That is why you are here today: to answer what you are doing about the outstanding bits. So, what I would like to know is: how are you going to stabilise and ensure that your short, medium and long-term planning is solid and how will you use this 180 degree u-turn in the way that you do it and the way that your structure will be set out? How will you be happy and how will you evaluate and monitor that this is happening to ensure that your financial structure is working properly and that we will not be faced with £75 million-worth of shortfalls in future?

[72] **Dr Higson:** I will start and then pass on to Trevor. You are absolutely right—the financial situation of the board has to be sorted out, otherwise you can have the best plans in the world, but they will not be affordable or sustainable. So, integral to this process is getting the financial balance over a certain period.

[73] There are two points for context. First, the health board has never behaved like a health board; it has behaved like a trust delivering acute services, and its thinking and its

workings have been overly focused on acute services and has not taken that step back and looked at health needs—what primary care is doing et cetera—to the extent that it should. There is a sea change and a repositioning of the whole thinking of the health board as to what its role is. It has also spent very little time looking at what services are provided for our population outside of north Wales, in terms of the north-west of England, and the quality and safety of those services. So, we have to rethink the whole position of the health board.

10:00

[74] Secondly, it is about looking at what the population needs are over a longer period and putting what you said into a strategic context: where are we trying to take this health board? Setting out our stall, what are we here to do? What are we here to achieve and to deliver? It is getting very clear that we are commissioning services and delivering services through primary care, providing many of the services ourselves, and that thinking has not taken place in the board before. It has been overly focused on the delivery of acute services. That is important, but that is not the way that it should have been doing things. So, that is the other sea change—repositioning the whole board. However, it would be naive to say anything other than the fact is that the plans going forward have to achieve a sustainable model of services, both clinically and financially, that also delivers the right level of quality and meets the needs of the local population. It is a challenge, but it is one that I am confident that we can achieve.

[75] **Professor Purt:** Chairman, I know that you want to touch on finance, but I think that structure is coming through some of these conversations, and it might be helpful if I quickly touch on some of the—

[76] **Darren Millar:** If we can focus on finance, just for a second, and then we will return to the structure. There are a number of other questions to come on finance, but I think that, essentially, what we are interested in here is whether the budget processes are right. There were big caveats, for example, were there not, that were noted in terms of budget sign-off? Are the timings right? Are things being done in tandem in terms of operational plans? I am not sure that we are getting an appropriate answer from you at the moment, so I do not know, Trevor, if you—

[77] **Professor Purt:** I will pick up a couple of those, if I may, then—

[78] **Sandy Mewies:** Could I ask about one thing beforehand, because I do not want to let this go and for it to be forgotten? When you say that it is important to continue to work outside north Wales, I am assuming that you are talking about Fazakerley, Alder Hey, Christie's and Broadgreen, because it would cause concern among communities if you were not going to continue to do that. So, what you are saying now is that you will still be looking at working cross-border, because that is where some excellent, world-class services are found.

[79] **Professor Purt:** Clearly, as far as Betsi is concerned, it has to embed itself with its partner organisations across the border. I think that it has far more in common with Cheshire, Merseyside and Greater Manchester in terms of its flows than it does with the M4 corridor. I think that, from my perspective, there is a need to strengthen those, both in terms of education and training, which helps with some of the recruitment issues, but also in terms of the academic science networks. We need to embed Betsi very much in the north-west of England, so that it can take that learning from where it is happening well in England, bring it into Wales and help distil that through the rest of the country. So, it is a helpful comment in the sense that I think that Betsi needs to be seen, very much now, as a bulkhead in terms of working differently with its colleague organisations in the north-west of England.

[80] **Darren Millar:** Okay, if I can drag you back to these budgets—

[81] **Professor Purt:** In terms of the budgets, I think that one of the biggest expenditures that the health board has is dictated by primary care usage. It is GPs who are actually commissioning work from secondary care. So, the new structure, when it comes in, will move budgets down from the health board through localities to individual GP practices. They will be indicative budgets at this stage, but they will put GPs in a position where they can see what they are expending, they can see how they can change the service models—we know that 30% to 40% of our acute beds are filled with people who should not be there; they should be in the community or they should be cared for at home. So, there is an issue for me about GPs being much more focused in terms of having control over some of those budgets and the ability to influence how they can develop their own services with those resources. There is an opportunity to shift that balance of where the costs sit in our system.

[82] The budgets at the moment do not reflect that. So, the work that we are having to do now, and as part of the three-year plan, is to clearly align the strategic direction; it is absolutely right that we have changed the direction of travel. It will go to the July board, in terms of the framework for taking it forward. It will then pick up in terms of the Marcus Longley report in September, where the mid Wales and the west Wales issues will influence parts of our patch. My understanding, or my agreement with the Welsh Government, is that it can then be taken to the Welsh Government in January for a final sign-off. So, we are moving forward, but, clearly, what I am indicating today is that by moving budgets out from the centre into primary and community services, that frees up a whole way in which we can work differently. The current finance controls sit with the CPGs; that will not be where they sit in the future.

[83] **Sandy Mewies:** Evaluation—is it working?

[84] **Darren Millar:** May I ask this one specific question, before I bring Mike in, because it is very important? In terms of the budget sign-off process now, CPGs, as you have indicated, hold the ability to sign off their parts of the budget. Has there been a continuation of the problem that was identified last year in terms of the caveats on those? I see that there has not. So, all parts of the budget have been signed off by the CPGs.

[85] **Mr Lang:** Perhaps I can respond to that one, Chairman, on what we did this year, in terms of setting the budget. There were two or three themes in your previous comments as well about the connection between the service pressures and the targets that we try to achieve and the way in which we set our budgets. We had a far more transparent and open budget-setting process during the preparation for 2014-15 than we previously had. We went through all that information with colleagues, executive colleagues and colleagues in clinical programme groups. In previous years, we had a situation in which we set a budget and then realised that, for example, we had seasonal planning. The money was not there in the budget. Where do we find the budget? All those things were fed in, in dialogue, in terms of what we need, and they were reflected in the budget that went to the board. The approach that we have taken pretty much mirrors the reference in your report, which said that it is reasonable for a debate to take place before a budget, but that somebody has to take decisions and the budget is then the budget. That is what we have done. The budget is set by the board, and there is now an accountability framework by which we hold CPGs and corporate directors to account for delivering within the framework of that budget. That is the process that we have adopted.

[86] **Darren Millar:** And those budgets are owned by the people responsible for spending the money—yes?

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

[88] **Darren Millar:** Without question, they accept responsibility for those budgets.

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

[90] **Darren Millar:** With no caveats?

[91] **Mr Lang:** No caveats.

[92] **Darren Millar:** That is the important point. Sandy, did you want—

[93] **Sandy Mewies:** I was just smiling—yes, yes, yes.

[94] **Darren Millar:** I appreciate that. Mike is next.

[95] **Mike Hedges:** May I just carry on from that? Just to get it absolutely clear, when you and the board set a budget for, say, oncology in one of the hospitals, and it is then set, no-one can change it afterwards. The board's budget is the board's budget and it is not as it used to be—a point of negotiation as the starting point and then we move it on. The budget is set, and there is no change to it without it actually going back for a full board decision.

[96] **Mr Lang:** Absolutely. The budget is set. That is what is allocated to the corporate directors in the clinical areas in terms of their responsibility, and it would only be through discussion, either with the finance committee, which deals with some of those issues on behalf of the board, or the full board deciding to reallocate the resources to change those budgets. However, there is no behind-closed-doors negotiation and moving of money around; it is a very transparent process and we are very clear about the reserves that are held within the board and their purpose, and they are transparently mapped every month. So, everybody is clear about where the money sits and who is responsible for delivering what.

[97] **Mike Hedges:** There are two more questions, but one is very simple. May I just wish you luck in moving money from secondary to primary care? What has actually happened in recent years is that the share of money spent in hospitals has increased enough for GPs, which they do complain about quite vociferously—it has reduced, I mean. Far too often, the comment is: for health, see hospitals. How are you going to make sure that a greater proportion of the budget, or even the same proportion—? I mean, GPs at this stage would accept no worsening of their position in terms of the percentage of the budget spent on primary care as opposed to secondary.

[98] **Dr Higson:** If we look at primary care in a broader context, we will see that it is out of hospital care, and it is about a wider pattern of community services, including primary care, and not just GPs, but pharmacies et cetera. We are doing some work with GPs and others on the Llŷn peninsula, because of issues of retirement and the recruitment of GPs, to look to develop alternative ways of delivering out-of-hospital care, with primary care and GPs being central to that, but also including our community hospitals as part of that resource. So, I actually think that it is about getting the clarity as to what money we currently have—not just the GP contracted money, but the totality of that resource—how it is being used, how it can be managed differently, and how it can be focused on keeping people well and out of hospital when they do not need to be there.

[99] **Mike Hedges:** May I ask a question? Is Betsi Cadwaladr's problem its size? Is it too large, with too many hospitals and too diverse a population being covered, and is it too large a geographical area? Is that really the problem: that we have created a monster in north Wales that is unmanageable?

[100] **Dr Higson:** Having worked for 25 years in north Wales in the health service, I know that there are cultural differences between parts of north Wales, but I think that the important

thing is that Betsi Cadwaladr is irrelevant. I think that what is important are the local services that people receive and where staff feel their allegiances are. Yes, they are part of a large organisation, but they are focused on local delivery. The structure that Trevor is intending to consult on and put in place will rediscover and re-emphasise that localism. When I go around north Wales, people in Chirk do not care much about what goes on in Holyhead, and I do not think that they should, necessarily. What is important is that we are doing it right for them across the board. I think that the role of the health board—. In terms of size, the conundrum that we have is that you need a large population to justify some of the specialist services that we have in terms of the numbers of cases that come through. So, on one hand, we have, probably, a reasonable population to work with. We have three main hospitals; we will always have three main hospitals. They will all do some things the same, going forward, like emergency care, but if we can re-establish that as one hospital on three sites and try to do some work—which, again, I do not think the health board has done very much on, or has not achieved very much on, so far, in its first four or five years—to break down some of the historic rivalries between clinicians in north Wales, which are not helpful—. It is going to feel local for people in the next few months onwards.

[101] **Julie Morgan:** I was going to ask about what Mike said about the shift of the budgets from acute to community, and I just wanted to say that I think that that is the right way to go. However, I wanted to ask you some more detailed questions about the impact of trying to balance the budgets on actual patient care and whether you can identify any area where you have had to remove a planned service or where there were delays, for last year for example.

[102] **Mr Lang:** Contrary to where we found ourselves when we were here last year, commenting upon decisions not to progress with additional planned activity, we did not make any of those decisions last year. We were clear about the work that we planned to do. The resource was there to do that and the board was very clear that that gave us a pressure that we had to manage, in terms of other ways of saving money to deliver our financial targets as opposed to not undertaking planned care. So, we did not make decisions of that nature. There were problems and pressures in terms of the work that we were able to do during the winter period and, indeed, some of the issues about productivity and the number of patients that we operate on on particular lists meant that our planned care waiting times were not as good as we wanted them to be at the year end. However, we were not in the position we were in the year before, where we had taken a decision not to progress with additional work. We tried to commission additional work. We in fact did bring some additional external clinical input into our own facilities and some patients transferred to other facilities to have planned care during last winter. So, we were not in that position.

[103] In fact, the conversation we had about agency and locum staff is probably a good example of where we found ourselves spending more money than we would want to spend to support those rosters and clinical scenarios, but we were absolutely committed to the fact that it was our duty to ensure that we had the right clinical staff there and available to deal with patients. If that presented a financial problem, we had to find another way to deal with the financial problem as opposed to looking at it the other way round. So, my reflection on the past six months is that it has been a different environment and a different orientation between quality and safety and the duty to balance resource, and that orientation remains as we move forward. I am sure that it has been—well, it certainly has been—further emphasised by the chairman and, indeed, by Trevor since he commenced with the health board.

[104] **Julie Morgan:** So, you said that some patients had to wait longer. Is that the only thing you would identify as—

[105] **Mr Lang:** No. I think that, when we were talking about activity that we have not undertaken, that was a direct implication. There is no doubt that, during the winter period, we have talked about our difficulty in recruiting nursing staff. There were certain elements of

additional capacity that we wanted to bring online during the winter—surge capacity in terms of additional beds. We were not able to do that. That meant that we had a far more difficult period during the winter and some of our unscheduled care response and our ability to admit patients promptly, to deal with them promptly in emergency departments and to not have long waits, was compromised. Too many people waited too long for admission to hospital through the winter and there were a number of factors that had an impact on that, but ability to recruit staff was a key one. So there were a number of areas. I would not say that the only area in which things were not ideal was planned care; unscheduled care was very difficult. We were not where we wanted to be, and we have to ensure that we recover that position. There is a lot of work ongoing at the moment in terms of attending to that. With regard to the recruitment of additional nurses, we are taking very much a centrally co-ordinated approach to where those nurses are deployed, so that they have the most positive impact immediately in terms of clinical care and patient experience in the health board.

10:15

[106] **Dr Higson:** May I add to that very briefly? With Geoff, we put in place a follow-up workshop in May with other agencies, with the ambulance trust and local authorities, to look at the lessons learned over the winter—what the impact had been and what we could do better. Part of that is evaluating all the time what is working and what could be improved upon. It is important that that becomes embedded as the way that we do business, that we learn all the time and that, if something is not working as it should, we as a board should consider what we can do to improve it.

[107] **Sandy Mewies:** May I just pick up on that point?

[108] **Darren Millar:** There are a few people who want to pick up on different issues, but I am very conscious of the time. We need to make sure that we cover the areas that we want to question the witnesses on. So, I will allow a very brief question, Jenny, from you and from Sandy, and then we will move on to the quality and safety arrangements.

[109] **Jenny Rathbone:** Geoff Lang, you said that the budget has been set completely differently this year and that there are not people prevaricating about what they signed up to, and that it is a transparent process and everybody knows where the money is. However, four months into your financial year, the auditor general is saying that you are moving towards a substantial deficit. So, what has gone wrong?

[110] **Mr Lang:** There are two or three things that are relevant. We talked earlier in the session about the fact that we have not concluded our three-year plan, our service change and our detailed financial planning that sits alongside that to get us into balance. At the time that we agreed the budget, we estimated that, to deal with service pressures and to deal with the costs that we knew were in the system and costs that were coming our way, we probably needed to identify £70 million of savings. At the beginning of the financial year, we had identified only £20 million of those savings. We are still working through it to identify more savings. That is a piece of work that Trevor is putting a particular onus on us to deliver. He started as the chief executive expecting those to be developed. So, if you look at things on a pro-rata basis, it is not surprising that we have a higher level of overspend in the early part of the year, because we have not developed some of the saving schemes. We need to do that; we need to close that gap. We will have to do that by a combination of non-recurring measures and recurring measures. That is very much the focus as we move forward now, over the next couple of months. So, our overspend position does not reflect the fact that people have not accepted that the budget is the budget. The difficulty that people have is that, when one looks at the cumulative effect of savings, year on year, it becomes harder and harder to eke out a small amount of saving or a significant saving from the same model of service. So, that is the challenge that we face.

[111] **Jenny Rathbone:** So, you actually do have a plan for coming in within budget.

[112] **Mr Lang:** The plan to deliver the full £70 million savings this year is not yet finished. It is still being worked on.

[113] **Darren Millar:** I think that we have established that now.

[114] **Sandy Mewies:** I will be brief. Mike Hedges raised the issue of whether the organisation is too big and, Dr Higson, I am glad to say, talked about the importance of localism within services. However, having said that, the original report talked about a lack of communication between board and ward, and there were organisational problems in communication between sites. So, it is about the geography as well, and the clinical programme groups played a part in that. Yes, moving to localism is probably a very good way forward. There are risks involved, of course, because you will still want, I would imagine, the strategic overview to be the Betsi overview. So, how will that happen?

[115] **Darren Millar:** That is not strictly to do with finance, but I will allow the question anyway, and I will allow you to answer.

[116] **Dr Higson:** I will let Trevor pick it up in a minute, but that is the balance that we need. In a large geographical area, there is no right answer between the functional and local management of services. It is about getting the right balance and the right communication. All I can say is that the inherited structure for the first four years could never deliver what you have just said. It would have been unable ever to deliver coherent communication. To put it quite crudely, I think that Betsi Cadwaladr spent most of its time talking to itself.

[117] **Darren Millar:** That is a telling statement.

[118] **William Graham:** In terms of quality and safety, clearly, one of the main contributors will be your staff morale, which obviously contributes a great deal to the patient experience. You have told us that recruitment is challenging, which indicates, probably, that your morale is low. How do you intend to communicate what seemed to me to be very confident plans for the future to your staff, to make sure that morale is much better and that your recruitment improves?

[119] **Professor Purt:** I will pick up the first bit of that. Clearly, we have touched on it a couple of times; it is about the compelling vision for where we want to take Betsi as we move forward. That starts very quickly. There will be a staff consultation, which will be at the end of this month and the beginning of August, which will clearly do three things. First, it will start to re-engage people in the debate about exactly what the health board stands for, its direction of travel, its locus of operation and where it sees its priorities. It will also flag very clearly what the new leadership structure will look like, both at a local level and an across-the-health-board level. It will, again, clearly articulate the role and the value of clinicians in driving some of those changes. I think that the starting point for me is actually what comes out into the public domain with our staff, which is between 16,000 and 18,000 people, depending on the numbers that we look at, and then a wider catchment, if you include our GP colleagues and the rest of our community staff, of approaching 25,000 individuals. Clearly, the way in which we communicate going forward is going to be key, but I think that the start for me is around the compelling vision about exactly what the health board stands for. As Peter has said, I think that there has been a problem, historically, that it has seen itself as three competing acute organisations. We need to bring it back to one strategic organisation that has one hospital over three sites and, probably, three regions. It needs to work in a different way.

[120] **Dr Higson:** May I add to that? I think that the leadership of the health board—me

and the board—has to be sufficient to give the staff confidence again. Many staff feel that bad publicity, for obvious reasons, over the last year and the criticisms that they have had from people they know, has chipped away at their own morale. I think that a lot of it is down to how well we lead them, how well we listen to them, how well we listen to concerns that they have about things if they are not quite the way that they should be, and how well we devolve decision making back down from an overly bureaucratic system at the moment to one where staff feel ownership and control over what happens within the parameters of the health board. There is a lot about re-establishing good, solid management leadership, which I think will help to improve morale.

[121] **William Graham:** My second question is: how do you intend to engage the community that you serve in the plan that you have, and in bringing that forward to fruition?

[122] **Dr Higson:** Again, that is an area that I have talked to Geoff quite a lot about during the first few months, that I am now going to pick up with Trevor. BCU can seem quite distant and quite monolithic to the population. Again, part of localism is reconnecting with local people as well as delivering local services. We have to think of ways—there are things, which are not for today, that we are thinking of and discussing—of how we can get more—. I do not like the word 'engagement'. During my first nine months, people have desperately wanted to get involved in the NHS. We are somehow stopping them. They want to be a part of what is going on. They want to feel that they can influence, help and support. We need a model in north Wales, if not elsewhere, for the population to feel that there is a real connection, a real solid foundation, in which they can have continuous input into what goes on within the NHS. So, over the next few months, my ideas will emerge in that respect. It is a key factor for me; it is a reconnect. It is the people's NHS, after all, but I think that, at the moment, it feels as if it is a bit distant and too far away.

[123] **Professor Purt:** May I just add two quick things?

[124] **Darren Millar:** Very briefly.

[125] **Professor Purt:** As Peter said, I think that there are certainly models for membership in terms of a direct relationship between the population and Betsi. I think that that is one area that we will actually start to look at. I have touched on it slightly already, but I think that our relationship with local government needs to change. Think about the number of elected members—the number of elected councillors—that we can engage with their constituents. If we have advocates from our local government colleagues, I think that we can start to get our message, in a much more focused way, to the population as a whole.

[126] **Dr Higson:** Again, I will very quickly add that I commissioned a piece of work last autumn to look at our relationship with local government. That was concluded by May. We have had one session and we are having follow-up sessions with local authorities in north Wales about how we can re-establish a much stronger strategic partnership.

[127] **Darren Millar:** Aled Roberts is next and then Alun Ffred.

[128] **Aled Roberts:** Mae teyrngarwch tuag at y gwasanaeth iechyd yn y gogledd, ond rwy'n cytuno â chi bod lot o waith i'w gwneud i wella'r berthynas efo'r gymuned.

Aled Roberts: There is loyalty towards the health service in north Wales, but I agree with you that there is work to be done to improve relations with the community.

[129] A gaf droi'ch sylw chi at ba mor amserol yw'ch ymatebion chi fel bwrdd iechyd i faterion o ansawdd? O ran A20, yn yr adroddiad, mae sôn bod adroddiad

May I turn your attention to how timely your responses are to issues of quality? In terms of R20, in the report, mention is made of a critical internal report that was begun, I

archwilio mewnol beirniadol a gafodd ei ddechrau, rwy'n cymryd, ar ôl yr adroddiad tua blwyddyn yn ôl, ar gael mewn ffurf drafft ym mis Ionawr 2014, ac eto, dim ond ym mis Mehefin y cwblhawyd yr adroddiad archwilio, achos bod oedi cyn i reolwyr roi ymateb y cytunwyd arno. Felly, nid yw'r adroddiad wedi ei dderbyn gan y pwyllgor ansawdd o fewn y bwrdd eto. A gaf ofyn cwestiwn ynglŷn â pha fath o neges mae hynny'n ei rhoi? Rwy'n meddwl bod llawer iawn o feirniadaeth ynglŷn ag ansawdd y gwasanaeth yn y gogledd a'r oedi sydd cyn i chi dderbyn y gwasanaeth.

believe, around a year ago and was available in draft form in January 2014, and yet, it is only in June 2014 that the report was completed, because there was a delay before managers gave an agreed response. So, the report has not been accepted by the quality committee within the board yet. May I ask a question about what kind of message that sends? I think that there is a great deal of criticism in terms of the quality of the service in north Wales and the delay before you receive a service.

[130] Hefyd, hoffwn eich cyfeirio at A12, sy'n sôn am yr wybodaeth sy'n cael ei chyflwyno i'r bwrdd. Mae adroddiad yn dweud nad oedd y dangosfwrdd wedi ei gyflwyno i'r bwrdd tan fis Mai 2014. Hyd yn oed ym mis Mai, roedd y dangosfwrdd yn canolbwyntio bron yn llwyr ar dargedau haen 1 Llywodraeth Cymru. Rydych chi'n gwybod fy mod wedi bod yn gohebu efo chi ynglŷn â gwasanaethau strôc, ac nid oedd cyfeiriad at fewnbwn i'r uned o Lywodraeth Cymru. Felly, rwy'n meddwl bod problem o ran tryloywder y bwrdd a'r gwasanaeth iechyd yn y gogledd. Oni bai i chi gymryd rhyw gam ymlaen ynglŷn â thryloywder, rwy'n meddwl bod creu perthynas efo llywodraeth leol, er mor bwysig ydyw—. Y gwaith pwysig yw'r berthynas efo'r gymuned yn y gogledd, yn hytrach na chynghorwyr.

I also refer you to R12, that talks about the information that is put forward to the board. The report states that the dashboard was not presented to the board until May 2014. Even in May, the dashboard concentrated fully on the tier 1 targets of the Welsh Government. You know that I have corresponded with you in relation to stroke services and there was no reference to input into that unit from the Welsh Government. So, I think that there is a problem in terms of transparency of the board and the health service in north Wales. Unless you take a step forward in terms of transparency, I think that forming a relationship with local authorities, even though it is important—. The truly important work is the relationship with the community in north Wales, rather than with councillors.

[131] **Dr Higson:** Gwnaf droi at Geoff i ateb y rhan gyntaf ac wedyn fe wnaf bigo i fyny'r ail ran.

Dr Higson: I will turn to Geoff to answer the first part and then I will pick up on the second part.

[132] **Mr Lang:** Yes. In terms of the internal report that you referred to, that was with regard to serious incidents and concerns. That fieldwork was undertaken at the same time as we commissioned an external piece of work from the delivery unit—an expert piece to review the same information. The delay in signing off that audit report was caused by a combination of staff absence and poor communication—not acceptable. The important issue is that the report that we received from the external scrutinisers, which was received in around November time, covered the same territory, which was about how we handle complaints and concerns, whether we are doing that in a timely manner, and are the responses good, whether we are following up on serious incidents, learning from them, and spreading best practice, and how we are dealing more generally with our relationship with people who want to express views to us about the quality of care that they have had, or their experience.

[133] From November/December time, we have had in place a very focused management plan to reduce the backlog of concerns. It was one of the first things that the chairman put pen to paper about when he joined the health board. He made it very clear that delays in dealing with genuine concerns from patients or their families about their experiences in our health

board were not acceptable. There has been a very focused piece of work. We are still trying to eradicate a backlog. That backlog, as of December, was 593 cases that were overdue in terms of concerns. That is now down to 260 cases and will be eradicated by September. That is too long; it should not have taken that long, but we have had a very clear process. We have a weekly performance meeting with every clinical area and corporate area to ensure that they are doing that.

10:30

[134] Likewise, with serious incidents, there has been a backlog. They have been worked through and they will be eradicated by September and the lessons will have been learned. Importantly, what the internal audit report picked up was, taking serious incidents as an example, that the recording and initial investigation and documentation of an outline action plan was not sufficient to give assurance that lessons had been learned, changes would be made and the risk of that happening again would therefore be reduced. That is where we have put a lot of effort in now. We have clear systems in place where that is all recorded in our information system, Datix, which is the one that the NHS uses to record serious incidents, so that we can track through performance. There is a very rigorous quality assurance process before anything is signed off to say that it has been fully investigated, lessons have been learned and spread, and we have a monitoring process in place.

[135] You are right to draw attention to that report. The response should have been quicker. The only positive thing to say is that the same issue was subject to a separate external scrutiny report, and action plans were put in place and improvement is being delivered. Importantly, during that period, we have been trying to balance the clearing of the historic delay but not introducing new delay for concerns that are arising now and making sure that the number of concerns in the system is diminishing. As of January, we had over 600 concerns that we were still actively managing. That is now down to just over 400 in June. If we were working on a timely basis, it should probably be between 200 and 250 cases at any point in time that we are managing. We are working that through, and we will seek to get to that point, and we will get to that point, by September.

[136] **Darren Millar:** May I just ask if you can just distinguish between—? So, serious untoward incidents, what is the backlog there? How many—

[137] **Mr Lang:** Serious untoward incidents, there are—. At the moment, we have 37 such incidents that took place in 2012-13.

[138] **Darren Millar:** Is that an increase or decrease on previous years?

[139] **Mr Lang:** This is the residual number that is outwith the timeframe in which you would normally expect them to be dealt with. We have been tracking those that are delayed. There are no new incidents that are going beyond their timescale. We are managing them to time, and we are closing down the lessons learned and the spread of good practice. We have 178 incidents at the moment that are overdue, which should have been closed down but have not, and they will be closed down by September. Nine of our 12 operational areas where concerns and incidents arise will have cleared theirs by the end of July. There are a further three that have quite significant numbers where the most patients present and most clinical incidents arise, which will be cleared by September.

[140] **Darren Millar:** How does that relate to patient safety incidents? Is that a completely different category of incidents?

[141] **Mr Lang:** Serious untoward incidents are patient safety incidents.

[142] **Darren Millar:** I am not sure that I understand the figures. According to the recent report on complaints that was commissioned by the Welsh Government—

[143] **Mr Lang:** Sorry; I am with you now. Are you referring to the rate of incident reporting in the health boards?

[144] **Darren Millar:** I am referring to the number of incidents that are reported.

[145] **Mr Lang:** Sorry. Incidents are reported—and Grace can comment about how they are stratified—but there are certain categories that are categorised as serious untoward incidents. They are reportable to the Welsh Government. They must have clear formal reporting and analysis and closure. Those are the ones where we are overdue, and we are working through that backlog. Grace may be able to comment on the classification of incidents.

[146] **Ms Lewis-Parry:** The classification of incidents is done carefully by the clinical team to make sure that we understand whether they are mild, moderate or severe—there are other categories as well. When they reach a certain threshold, there is a clear line of accountability directly through to the Welsh Government, so they have to be reported on every single incident. The Welsh Government then holds us to account and we hold ourselves to account for making sure they are investigated properly, and those reports are then returned.

[147] **Darren Millar:** So how many patient safety incidents did you have in 2012-13, for example?

[148] **Ms Lewis-Parry:** I do not have that information here.

[149] **Mr Lang:** We will have to send the information, Chairman. It is a very significant number, because, as Grace said, they vary from minor issues to very significant issues. We can provide data on that and how that compares with previous years, if that would help the committee.

[150] **Jenny Rathbone:** May I ask a question?

[151] **Darren Millar:** Is it on this issue, Jenny?

[152] **Jenny Rathbone:** Yes.

[153] **Darren Millar:** I will let you come in then and then we will answer the other questions.

[154] **Jenny Rathbone:** You said that serious incidents unresolved from 2012-13 were 37. So, how many serious incidents are yet to be resolved from 2013-14?

[155] **Mr Lang:** One hundred and forty one.

[156] **Darren Millar:** Actually, there is no need to send a note to the committee on patient safety incidents. As I understand it, there were over 12,000 in 2012-13. The board must be monitoring these, Peter Higson, so how regularly do you receive an update on patient safety incidents and serious untoward incidents?

[157] **Dr Higson:** Monthly.

[158] **Darren Millar:** It is on a monthly basis.

[159] **Dr Higson:** Yes. If I can just pick up on that, Chair, part of the question about the—.

Again, when I took up post, one of the key issues for me is that we have quality and safety high up on the board's agenda all the time. The reason we are here is to deliver high-quality, safe care. What we have tried to do is to shape over the last few months the best way of reporting how well we are doing or where we need to make improvements without deluging and getting the wood-and-the-trees issue, in that there is just so much paperwork and so much information that we are missing the key areas. Hence we are going through this process of developing and trying to develop an integrated performance and quality report, with finance, hopefully, as well, so that we end up with one report that tells us how well we are doing, the key areas where we might have variances that are not acceptable, and what we are doing about them. So, I think that what is reflected in the WAO/HIW report here is the fact that we are still working on what is the best quality report on safety and performance that we can take to the board.

[160] **Darren Millar:** It is the dashboard sort of approach, is it?

[161] **Dr Higson:** I am not a fan of dashboards. Whatever you want to call it—

[162] **Darren Millar:** You are just making sure that there is a focus on the right things.

[163] **Dr Higson:** Yes, what I want is the key things. Also, importantly, my concern is what might go under the radar. So, we need to be very clear about what the tolerances are in terms of what is happening within the health board in terms of its provided services. That is the piece of work that I think is equally important, which says, if there is a slight variation month by month, that is probably all right, but if it starts drifting off—. I think that had the C. difficile issue and infections been monitored with the kind of focus that we have now on it, patterns would perhaps have emerged earlier, which would have called for earlier action. So, it is about getting that right balance as to what are going to be the key areas that are going to give us an indicator that this is a safe organisation, and what are the tolerances that we set as a board, beyond which you have to come back and say, 'There's an issue here'.

[164] Over the last nine months, the number of quality and safety issues about specific services, and things generally that I have insisted have come to the board, have gone up. I am passionately committed to dealing with these issues publicly, and continuing to deal with them until they are resolved, but also to having routine reporting so that we keep on top of what is going on. May I just also add that, since taking up post, I receive a weekly update on all of the concerns, serious incidents and correspondence with you and other people, so that I can keep my own grip on what is going on?

[165] **Darren Millar:** That is good to know. May I just ask, in terms of the information that comes to the board, because you have another part of Aled's questioning that needs to be responded to as well, are you confident that you are getting all of the data now as a board, and that they are accurate data? There was concern about underreporting for example, was there not, in the previous report? Is your question on this, Jenny? You may as well ask it now.

[166] **Jenny Rathbone:** Yes, it is on this. In the WAO's report, what was concerning was that you were getting lots of papers, but there was a lack of clarity about what exactly the action was supposed to be and it was drowning people in numbers rather than being clear about the action.

[167] **Dr Higson:** I am confident that the committees of the board, like the quality and safety committee, are getting all of the information that they require to be able to keep an oversight of that on behalf of the board, and that the report coming to the board, which I have just mentioned needs more work doing on it, will then be an accurate summary of quality and safety issues and performance across the whole organisation.

[168] **Darren Millar:** Are the data valid though? Are the data the right data, not just in terms of the information, but are they accurate data? If there was underreporting, for example, of C. difficile in the previous report that was noted, what action is being taken to make sure that you are getting the accurate data now?

[169] **Dr Higson:** The actions taken—. I think the whole tenor of the board has changed in terms of the level of evidence that we are asking for to support what is being presented to us. So, it is not just taking a summary number, but asking, 'Where is the evidence behind that?' On data quality issues et cetera, yes, I accept that—. I do not feel that there is any particular area where we are not getting good data. Perhaps the quality of the data could be improved in some areas, like it could across many things that we do, but I do not have doubts that we are not being told about the key—.

[170] **Darren Millar:** Okay. You are provided with the data by the board secretary. How do you make sure that the information that you present to the board is accurate, Grace Lewis-Parry? The C. difficile stuff last year was very worrying, obviously. The board was not receiving accurate information to inform its decisions. That may have been as a result of inaccurate reporting right from the ward level up. So, what has been done to change that to get it right?

[171] **Ms Lewis-Parry:** There are a number of things that have been done to try to make sure that the data quality is improved, such as making sure that audits and external checks and validation are being done. However, I think probably that two fundamental things have also changed. One is that, when it comes to board, as Peter has just said, the board is saying, 'What is your evidence? Where did you get that information from? Can you assure of the quality of those data?' However, the second big issue, which I think is very important, is making sure that we triangulate those data with what we know from other sources, because a data set may say one thing but what we are hearing through Assembly Member correspondence or through our staff surveys or through our ward-board walkabouts is something different. It is that triangulation that is as important, if not more important than looking at the data in isolation. I think that that is the way that Peter has tried to lead the board, to make sure that we are looking at those data in the round.

[172] **Darren Millar:** So, you can give us an absolute assurance that there is no underreporting going on to the board of serious incidents or deaths where a hospital-acquired infection is involved. You cannot give us that assurance.

[173] **Dr Higson:** No, I am agreeing with you. We can give that assurance.

[174] **Darren Millar:** You can give that assurance absolutely. Okay; that is the important thing.

[175] **Mr Lang:** Chair, I have a very brief point and I think that it is hugely important in terms of the shift from where we were last year to where we are now. The degree to which this information is being used on a daily, weekly basis throughout the organisation to monitor its own quality and be aware of what data is telling us about quality of care in certain settings is hugely important. Infection control information is passed through the organisation every day and every week to the executives and back down, and issues are picked up. It is a very live system. Also, we are introducing, and are in the second month of, a series of ward to board metrics. The original report talked about the gap between the ward and the board—how did the board know about the day-to-day indicators that impact on quality, safety and dignity? Those are now produced every month in every in-patient ward and are scrutinised at clinical team level and through the organisation. So, the information is becoming more a part of the way that we assure quality right through the organisation as well as at the board level.

[176] **Darren Millar:** Okay, we will park that there. Jenny is next and then we will go back to Aled.

[177] **Jenny Rathbone:** Accuracy is obviously essential, but I want to pick up on how you are going to improve the quality of the papers. Yes, the board gets the papers on time, in seven days, but do you see them in advance so that you can send them back if you do not think that the action required or the relative decisions to be taken are clear enough?

[178] **Dr Higson:** Yes. There is a discussion between me, the chief executive and board secretary about the papers about a month beforehand. Draft papers are looked at in terms of asking, 'Are they in a fit state to come to the board yet?', 'Do they actually fulfil what the board is looking for?'—I will mention it in a minute—so, 'yes' is the answer. Grace has a much stronger role now in weeding out papers if they are not fit for purpose.

[179] **Jenny Rathbone:** So, how often have you sent papers back to be redrafted or revised?

[180] **Dr Higson:** Every month. What I am looking for, and I think it is a style that I have come across in other boards, is that there has been a tendency in BCU to bring problems to the board without necessarily suggesting solutions. That is not the role of the board. The role of the board is to receive an issue, an analysis, evidence, options and recommendations, which can then be debated. I think there has been a tendency in the past to sort of bring it and dump it there and say, 'What do we do?' This led, I feel, to some of the behaviours of the board in the past to become overly operational—not looking at the right detail and getting overly involved in some of the delivery, which is not its role. So, there is more work to be done on that. I am completely ruthless on it—if the paper is not fit for purpose it does not get to the board. However, sometimes there needs to be some compromise.

[181] **Professor Purt:** I have started a process since I have been there where all the papers come to the executive team for an early sign-off before they get to the chair. That was not happening before. So, there is a unified approach from the executive team that clearly understands what the papers are saying so that we can actually help inform the chairman of the executive team's view as a whole rather than as individuals.

[182] **Darren Millar:** To clarify, at the moment you are publishing or distributing papers seven days in advance. Is that in the public domain as well?

10:45

[183] **Dr Higson:** Yes.

[184] **Darren Millar:** What do your standing orders say about the timeliness of publishing those?

[185] **Ms Lewis-Parry:** That is what our standing orders say: seven days in advance.

[186] **Darren Millar:** As I understand it, it is 10 days in advance.

[187] **Ms Lewis-Parry:** No, ours were changed—

[188] **Darren Millar:** Yours were changed—

[189] **Ms Lewis-Parry:** Yes, when we—

[190] **Darren Millar:** So, you are not following the model standing orders.

[191] **Ms Lewis-Parry:** When we had our model standing orders, which were sent to us by the Welsh Government, when we were established in 2009, that was one of changes that we made.

[192] **Darren Millar:** Okay, fair enough. So, you have not used the model standing orders; you have made some tweaks to them.

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

[194] **Darren Millar:** Okay, that is fine. Just in terms of your role, Grace Lewis-Parry, we made a strong recommendation that the role of board secretary should be completely separate to any of the executive responsibilities. That has not happened. Is there a reason that that has not happened with the board?

[195] **Dr Higson:** I think, again, that that goes back, Chair, to my initial comments about the running of the board during a period of instability and wanting to steady the organisation. Since Trevor was appointed in March, we have obviously had several discussions and also discussions about the proposed management structure. One element of that will be the establishment of a separate board secretary role.

[196] **Darren Millar:** It is good to get that on record. I call on Aled, and then we will come to Ffred.

[197] **Aled Roberts:** You talked about process and the accuracy of the data. What about the interpretation of the data? One of the issues as far as stroke services are concerned is that the delivery unit reports were talking about a lack of a clinical lead within the organisation. I really do not understand how you get to a situation where only 1.2% of patients are thrombolised at Wrexham within four hours and it is not picked up either at board level or, it would appear, for quite a long time, by the Welsh Government, which then has to send in a delivery unit to monitor monthly. Are there any other areas where that type of monitoring is having to occur, because the strength of the monitoring in the organisation meant that it did not pick up those issues?

[198] **Dr Higson:** May I pass to Geoff, because it is—

[199] **Mr Lang:** I think that, in terms of the specific example that you use of thrombolysis rates, they started very low in the health board—

[200] **Darren Millar:** Sorry, can we not go into detail—

[201] **Mr Lang:** Apologies.

[202] **Darren Millar:** If you can just speak briefly about what you are doing to make sure that nothing like that is missed.

[203] **Mr Lang:** We now have a weekly focus on stroke care and improvement in those areas. Are there other areas where the Welsh Government is looking at our current performance? Yes, there are, and we welcome that, because, actually, it is extra scrutiny and support, in terms of moving things forward.

[204] **Aled Roberts:** How many areas?

[205] **Mr Lang:** Off the top of my head, I could not give you an answer. I think that it would be better to give the committee a note that said, ‘These are the areas that we are being

supported in.' I would only get it wrong if I tried to quote off the top of my head.

[206] **Darren Millar:** That would be helpful. I call Sandy.

[207] **Sandy Mewies:** Thank you, Chair. [*Inaudible.*]—understand too, but one of the issues that floated around in the past for us was mental health. I am wondering what is happening now in the area of mental health and mental health teams.

[208] **Darren Millar:** May I just ask you to give us a brief overview of your response to mental health and, Trevor, if you can set out what you want to do, going forward, in summary, and then I have one final question that I need to ask for the record?

[209] **Dr Higson:** Chair, I was not going to say very much because I think that being chair and also having been a mental health professional gives me a little bit of conflict in terms of my views, so I will pass straight to Trevor.

[210] **Darren Millar:** Okay, Trevor, can you answer on mental health and the wider future of the organisation?

[211] **Professor Purt:** I will pick up mental health as part of that, although I have kicked off a review of mental health at the moment specifically, because I want some clarity around a few issues. In terms of the way forward, and this is caveated on the basis that it will go out to consultation with our staff and the documentation is still being concluded, the direction of travel will be to establish three regions—mid, west and east. They will be responsible for population health, for working with primary care and developing new services, for running our community services in our community hospitals, and working with our public health colleagues about being very clear on what is required in those three regions. They will match broadly two counties each, and they will, effectively, be commissioners of an acute service within Betsi Cadwaladr. We will be forming an acute services division to drive one hospital over three sites, with a revised clinical leadership that will stretch across the three sites. Each of the sites will maintain a clinical lead, a nurse lead and a managerial lead. So, quite clearly, we are doing a bottom-up as well as a top-down review in terms of how they will work together.

[212] As has been alluded, there is already a change in the executive team—we will be going for a director of corporate services and we will split the board secretary's role out. We have appointed a new director of finance, who will start in the first week of August. Interviews are being held for a substantive chief operations officer at the end of this month, and further changes are yet to occur. It is absolutely clear that we will hold mental health at the moment at the centre—it will not be devolved into the regions or into the acute structure. However, at some stage, we will move mental health into an individual directorate and then the three regions, the acute services director and the mental health director will be directly managed by the chief operations officer. So, for me, it is about having the shortest line of sight in terms of accountability and responsibility. Clearly, I want to have one individual around my executive team that holds the responsibility for delivering on our operational targets, but actually is leading the commissioning and the strategic direction of working with our partner organisations. That is it in a nutshell, Darren.

[213] **Dr Higson:** Very briefly, Chair, the board is clearly aware of a number of concerns about mental health services in north Wales and it has dealt with those very publicly, such as parts of the Ablett unit and Hergest unit. We have put in place very rigorous processes to try to get to the bottom of any issues there are, and to improve things. Generally, what Trevor has decided to do very much after our conversation is to have a wider look at mental health services across the patch more generally. The conundrum we have is that we also have some national UK award-winning mental health services, and it is about getting a feel of why

certain things have not worked and why they have not been as good as they should be. As well as addressing the specific issues that have been identified, there is possibly a more systemic issue to look at, which is what Trevor's review will help us with. It is an area that has probably not been invested in sufficiently in the health board in the last four years.

[214] **Darren Millar:** There is just one final issue. Some of the delays around addressing the concerns in the previous report were because of the issues around the departure of the previous chief executive. It is a concern to the committee that even though the former chief executive announced her intention to depart the organisation back in May of last year, the departure did not actually take place until December. In the remuneration report in the annual accounts, it is very clear to see that there has been a substantial payment on departure of the chief executive in the region of £270,000, on top of the pay she was already receiving. Do you want to tell us why it took so long, why that is such a significant sum and whether you think that that represents good value for money?

[215] **Dr Higson:** I am going to ask Geoff to start the answer, because it pre-dated my becoming chair.

[216] **Mr Lang:** Thank you, chairman. In terms of why the situation took so long to resolve, I think there are two or three key issues there. One is that it was a very complex situation in terms of the relationship between the former chief executive and the board, and some of the relationships within the board, some of which was referenced in the WAO report. However, the situation was, as I said, very complex. In terms of the decision-making process, it was very clear that, with the chief executive as was—the former chief executive—the responsibility for that decision rested with the chairman and the independent members of the board. They were given appropriate advice and considered how that might move forward, and then there was a need to ensure that there was engagement at Welsh Government level about the planned approach and the principles of that. Once that approach had been worked through to a certain level of detail with the former chief executive, that was then subject to an approval process with Welsh Government. So, some of the discussions, in that complex situation of working out what would be the board's preferred course of action and what the board was suggesting as to the way forward, took a number of months to work through. That got to a point of conclusion by August. That was referred to Welsh Government for scrutiny and there were further challenges back to the health board, which were responded to and, in early October, that was signed off. Then there was a period of final agreement with the former chief executive in terms of the details of the written agreement between both parties and how that would all be worked through, and that was concluded in December.

[217] **Darren Millar:** So, the discussions with Welsh Government in terms of its involvement about the size of the sum were concluded in the October—

[218] **Mr Lang:** We had the formal response from Welsh Government in October.

[219] **Darren Millar:** Is it normal that Welsh Government gets involved in these sorts of issues?

[220] **Mr Lang:** It depends on the sum of money involved. There are two issues. One is the peculiar circumstances when one is dealing with the chief executive. In normal circumstances, of course, the chief executive would be responsible for approving such decisions, but there are financial limits, particularly in terms of ending employment, to what any health organisation is able to sign off. This was clearly above those limits, and therefore it is routine practice for it to be referred to Welsh Government for scrutiny and for challenge.

[221] **Darren Millar:** So, that is routine practice.

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

[223] **Darren Millar:** So it has happened before in the organisation, has it?

[224] **Mr Lang:** Obviously not with a chief executive post, but for posts where the settlement value under the voluntary early release scheme triggers a certain amount of money, it has to go to Welsh Government, and we have sent posts previously to Welsh Government.

[225] **Darren Millar:** What is the threshold at which that is set?

[226] **Mr Lang:** I believe that it is £100,000, but I will clarify that, Chair, just in case I have got it wrong. It is of that order.

[227] **Darren Millar:** Ffred, you have the last question.

[228] **Alun Ffred Jones:** As a matter of fact, the payoff was £270,000. There is a pension, presumably, on top of that, is there?

[229] **Mr Lang:** The former chief executive left the organisation by agreement. Whether and when the former chief executive chooses to retire and take their pension is a personal choice. It is not something that the health board is involved in. There was nothing that the health board did that supplemented pension.

[230] **Alun Ffred Jones:** Do you acknowledge that there is huge public concern about the size, not just of this—call it what you will—agreement at a time when everybody else seems to have to do with less or sees services being cut?

[231] **Dr Higson:** The offer, just to be clear, was made the week before I took up post as chair. However, it was clearly my responsibility to oversee the negotiations and come to a final conclusion, which I did through the mechanism of convening an extraordinary meeting of all the independent members with our human resources director. I also invited the previous chair to join, which he did. So, we went through the offer that was made, any proposed changes to it and we agreed that, basically, the offer stayed as it had been in October. Some of the wording around some of the agreement was altered, although not significantly or substantially. I think that uppermost in my mind was that this was a very complicated and quite a tragic situation for many people involved in it, and it could have become much more protracted, to everybody's detriment and to the detriment of the health board, in particular, if a settlement was not reached. I think that it was a situation where, taking all the circumstances into consideration, it was a very large sum of money but it was a mutual separation—it was a mutual severance—and I think that, taking everything into account, it represented value for money, given what the total sum could have been had things become even more protracted.

[232] **Darren Millar:** Sandy has a question.

[233] **Sandy Mewies:** Simple question. I think that everybody is referring here to a newspaper story that perhaps some of the members of the committee would not be interested in, because I do not think they know about it, but may I just ask: was this payment scrutinised by the Wales Audit Office?

[234] **Mr Usher:** There has been some reporting in the media. I have heard two versions. The correct version, according the *Daily Post*, is that it was scrutinised by the Wales Audit Office. BBC radio yesterday reported incorrectly that it had been approved by the Wales Audit Office, and that is not our role—

[235] **Sandy Mewies:** However, it was scrutinised.

[236] **Mr Usher:** We have scrutinised it in terms of its legality and the process that has been followed, and we asked the health board to look at various factors in its value for money business case, and it did all of that, but the value for money has been—

[237] **Sandy Mewies:** Thank you. That clarifies it in the round.

[238] **Darren Millar:** That draws this evidence session to a close. Thank you, Peter Higson, Trevor Purt, Geoff Lang and Grace Lewis-Parry for your attendance. You will be sent a copy of the transcript of today's proceedings and a note from the clerks in terms of any additional information that you have agreed to provide. I am going to ask that the committee goes into private session just for two minutes in order to cap up on what we have done today.

11:31

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

[239] **Darren Millar:** I move that

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

[240] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:00.
The public part of the meeting ended at 11:00.