



Cynulliad Cenedlaethol Cymru The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol The Health and Social Care Committee

**Dydd Iau, 11 Hydref 2012
Thursday, 11 October 2012**

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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 reported 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

Mick Antoniw	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Sally Baxter	Dirprwy Gyfarwyddwr, Strategaeth ac Ymrwymiad, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Assistant Director, Strategy and Engagement, Betsi Cadwaladr University Local Health Board
Neil Bradshaw	Cyfarwyddwr Cynllunio, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Director of Planning, Betsi Cadwaladr University Local Health Board
Kathryn Davies	Cyfarwyddwr Therapiau a Gwyddorau Iechyd, Bwrdd Iechyd Lleol Hywel Dda Director of Therapies and Health Science, Hywel Dda Local Health Board
Heather Eardley	Cyfarwyddwr Prosiectau Cenedlaethol, Cymdeithas y Cleifion Director of National Projects, Patients Association
Dr Brendan Harrington	Pennaeth Staff, Grŵp Rhaglen Glinigol Gwasanaethau Plant a Phobl Ifanc, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chief of Staff, Children and Young People's Clinical Programme Group, Betsi Cadwaladr University Local Health Board
Geoff Lang	Dirprwy Brif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr, yn bresennol ar ran y Prif Weithredwr Deputy Chief Executive, Betsi Cadwaladr University Local Health Board, in attendance on behalf of the Chief Executive
Ann Lloyd	Ymddiriedolwr, Cymdeithas y Cleifion Trustee, Patients Association

Chris Martin	Cadeiryd, Bwrdd Iechyd Lleol Hywel Dda Chair, Hywel Dda Local Health Board
Trevor Purt	Prif Weithredwr, Bwrdd Iechyd Lleol Hywel Dda Chief Executive, Hywel Dda Local Health Board
Chris Wright	Cyfarwyddwr Gwasanaethau Corfforaethol, Bwrdd Iechyd Lleol Hywel Dda Director of Corporate Services, Hywel Dda Local Health Board

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

Llinos Dafydd	Clerc Clerc
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da a chroeso i gyfarfod y Pwyllgor Iechyd a Gofal Cyndeithasol. **Mark Drakeford:** Good morning and welcome to this meeting of the Health and Social Care Committee.

Cynlluniau Ad-drefnu Byrddau Iechyd—Bwrdd Iechyd Lleol Hywel Dda
Health Board Reconfiguration Plans—Hywel Dda Local Health Board

[2] **Mark Drakeford:** Yn rhan gyntaf y bore byddwn yn derbyn tystiolaeth gan Fwrdd Iechyd Lleol Hywel Dda. Felly, croeso i Chris Martin, cadeirydd y bwrdd; Trevor Purt, y prif weithredwr; Kathryn Davies, cyfarwyddwr therapïau a gwyddorau iechyd; a Chris Wright, y cyfarwyddwr gwasanaethau corfforaethol. Croeso i chi i gyd. Fel arfer, gofynnwn i chi am rai sylwadau agoriadol byr. Ar ôl hynny, byddwn yn troi'n syth at aelodau'r pwyllgor, a fydd yn gofyn cwestiynau. **Mark Drakeford:** In the first part of the morning we will be hearing evidence from Hywel Dda Local Health Board. So, I welcome Chris Martin, the chair of the board; Trevor Purt, the chief executive; Kathryn Davies, director of therapies and health science; and Chris Wright, director of corporate services. Welcome to you all. As usual, we ask you to make a brief opening statement. After that, we will turn straight to committee members, who will ask you questions.

[3] **Mark Drakeford:** The usual thing that we do is to ask you whether there are any brief opening remarks that you would like to offer to us, and then I will hand it over to Members. I am sure that there will be many questions that Members would like to explore with you during the next hour and a half.

[4] **Mr Martin:** Thank you for the invitation this morning. Bore da i chi i gyd. I have a few words by way of introduction. I thank you for the opportunity to share and discuss the formation and the development of our proposals as part of our consultation 'Your Health, Your Future—Consulting our Communities'. You will be aware that we have started our formal consultation on 6 August for a full 12 weeks, after extensive discussions with our

clinicians over the past few years and the unprecedented listening engagement exercise held earlier this year with local people, staff and stakeholders. We have reflected on those discussions and refined and shaped our proposals in the light of what we have heard.

[5] ‘Your Health, Your Future—Consulting our Communities’ is our response to the Welsh Government’s five-year vision, ‘Together for Health’, with an aim of providing world-class healthcare services for the populations of the three counties of Ceredigion, Carmarthenshire and Pembrokeshire, along with the communities of north Powys and south Gwynedd. Our vision is to provide the highest quality healthcare in the most appropriate setting, with a real shift to primary and community provision and less of a reliance on secondary care, with improved outcomes for all. However, it has to be safe, sustainable and affordable.

[6] In fact, we want to be recognised as Wales’s leading integrated rural health and social care system. We face significant challenges in the NHS, particularly within Hywel Dda LHB, which I am sure that many of you will be familiar with: increased demands due to the demography of our population; our rurality; transport challenges; providing care across the four hospital sites across our three counties; recruitment and retention of doctors, especially in some specialities, such as emergency medicine and paediatrics; sustaining training rotas; and, indeed, the list goes on. Change is never easy, but change has to take place to secure sustainable services. We have made great progress over the past few years, but there is much more to be done. For many of us, it will be a different way of working, but a right way of working for our rural community.

[7] Some of the changes, we hope, will happen more quickly than others. However, it is a three-to-five-year plan. So, you will not necessarily see changes to some of our hospital services until we are satisfied that we have the appropriate services available in our communities. We will set up an implementation board and utilise gateway methodology with clinical programme groups designing service pathways alongside the development of a patients’ council. I am sure that we will go into more detail on that over the next hour and a half. This, in fact, is the most important healthcare consultation process that we have ever seen in mid and west Wales. As an organisation, we take our statutory responsibility seriously. I hope that, after this session, you will be reassured that we have tried our best to engage and consult as widely as possible. Not everyone will agree with the final outcomes, but we have made sure that we deliver high-quality, safe and sustainable services that meet the needs of our population across the three counties and beyond. This is too important not to get it right. Diolch yn fawr iawn.

[8] **Mark Drakeford:** Diolch, Chris. Thank you very much for that. We will now move straight to questions. I call on Mick.

[9] **Mick Antoniw:** Good morning. There is a summary of the purpose of the consultation and engagement process that is set out very well in a letter that I have seen from the Commissioner for Older People in Wales, which states that decision making should be seen to be, and experienced as being, fair, transparent and carried out with due consideration of the rights and needs of those who are directly affected. Perhaps, as a way of opening, as I have one or two other questions that I would like to follow through with, I will ask this: to what extent have you been able to accommodate that aspiration within your engagement and consultation process? To what extent have you openly and directly been able to consult with the people who are most affected by the changes that are likely to occur?

[10] **Mr Martin:** Perhaps I could turn to Chris who will give us the detail around what we have done in that specific age group. I think that that would be helpful.

[11] **Mick Antoniw:** I am not just focusing on that age group, but on the principle.

[12] **Mr Wright:** It is a job to recognise the principles. We recognised early on, using the ministerial guidance that was issued in March 2010, what we needed to do. I think that how you need to do it is something different. We engaged, early on, the Consultation Institute, which is recognised as the expert in the field of consultation, and we have used its guidance throughout the process to make sure that we recognise, first, the audiences that we need to reach and seek opinions from, and, secondly, the methodologies that we need to use to get those views. So, both our engagement process and the consultation process use multi-channels. There is not just one method of communicating; there are several. I could take you through all the detail of that, if you wanted. We use printed, online and broadcast media. We also use face-to-face events—deliberative events—so that we can talk to people, as opposed to the public meeting scenario where you have a lot of people, but you do not actually take many views because you cannot have a proper conversation with people. What you get are specific questions on specific topics and that limits the debate somewhat. So, we have gone for a largely deliberative process to make sure that we can have those detailed conversations.

[13] **Mick Antoniw:** In terms of the evaluation of the process—and, of course, there is a particular interest in this for those who represent areas where we are just beginning to go down this road—how have you evaluated the quality of that consultation? Do you have any analysis of the number of people you have actually been able to contact? What percentage of people has actually understood the issues and so on? Have you actually appraised the quality of your engagement in the consultation process?

[14] **Mr Wright:** Again, we recognised that that would be a very important part of the process, so we engaged Opinion Research Services Ltd, which is a market research company based in Swansea, to undertake all the analysis for us. We have the detailed statistics and they were alluded to in the evidence that we presented pre-meeting to committee members. In the engagement process, we had direct contact with over 120,000 households. For instance, we had contact with several hundred through public engagement events, and we had direct contact with any number of stakeholder groups. So, we have all of that detail. We then analysed what people were saying to us. Again, the evidence that we took from the engagement was that our vision was largely supported by the population, but that there were inevitable concerns about certain elements, particularly the potential impact on secondary care and specific hospitals, and the transport issues that we perennially face in Hywel Dda Local Health Board.

[15] When we went into consultation, we applied the same principles: that we needed robust analysis of all the data and information that we received. So, we are largely replicating the engagement process, with the addition, during consultation, of large public meetings, with one being held in each of the three countries. The process will be largely similar at the end of consultation, which closes on 29 October. ORS will analyse all the feedback that we receive. Whether we receive it directly as a health board, whether it is received online, or whether it is received directly by ORS, everything is fed to ORS and it will analyse it and then present it back to the board. It will be our job to make sure that the feedback is reflected in the final decision-making process. We have a process in place to do that.

[16] **Mick Antoniw:** With regard to the engagement part of the process, it is always easy to look back with hindsight, and perhaps I am looking forward to what is happening in other areas at the moment, but, if you were to try to identify things that you might or could have done better as a part of that learning process, what would they be?

[17] **Mr Martin:** The challenge for us, throughout the listening engagement, was that people thought that we were in consultation. One of the big challenges for us was trying to explain the process that we were undertaking, that we were out explaining some of the principles around what we were trying to achieve in terms of the change that was going to

take place and that we were sharing the themes that emerged from our clinical colleagues as part of the work that we had done inside the organisation. People believed that we were in consultation then.

[18] On reflection, we needed to get the message across better that it was about listening and engagement. We learnt a lot from that in terms of how we manage meetings. We made sure that we had public meetings this time and were able to go into communities and listen to them in that forum. We were trying to make sure that we had a whole range of different techniques in order to get the qualitative and quantitative feedback required. We were heavily criticised during the listening engagement that we were not going to public meetings, so we decided that we should do it this time. It was a difficult process for some of us, but I think that people respected the fact that we were able to go out and put the case forward.

[19] We looked at that technique in a way that was different. We had a panel from the health board and invited the pressure groups. They have been not outside the process, but inside it this time. Politicians were invited to reflect on what they had heard in the evenings, and the community health council was asked to come along as well. The CHC has been very involved in this process. ORS has given us technical support, but the CHC has been helpful and supportive throughout the process. Last Monday, we had another mid-term review of our consultation to reflect on what has gone well and what has not gone so well. In fact, it has endorsed what we have done so far, so that was good in that respect.

[20] **Mr Purt:** What Chris has pulled out—both of them—is that it is a mixture. What has worked well for us has been the ability to deep-dive into communities. We had complete open doors for six hours and people came in from across a whole range of different age groups and backgrounds. It has happened during working hours and home hours. We had full-blown public meetings, which were largely around what are seen as the big pressure issues. We feel that we have been able to get into a whole range of groups and must have had over 50 meetings for the current process, let alone the previous process. We have done the same with our staff groups, which has been useful. We have also done the same with our stakeholders. We have been using local authorities and some of the other major stakeholders that we have in terms of education around our patch. We have also engaged with our younger people, because that was always a key area. One of the issues that came out of the engagement exercise was the misalignment between age groups. We were not reaching enough younger people, so we have deliberately stepped up our issues about how we work with schools differently to ensure that there is an understanding around young people. It is a complete mixture. I do not think that one size does fit all, and we have used everything from social media through to basic paper advertising in an attempt to try to get the messages through.

[21] **Mark Drakeford:** Lots of Members want to ask questions on this issue. I will go to Elin first, then Rebecca, then Kirsty in this round, then we will have more. Before I do, the people responsible for the sound and the recording are picking up a mobile phone signal in this room, which is interfering with the equipment. Would people check that they have not inadvertently left their phones on?

[22] **Elin Jones:** My question is not on this issue.

[23] **Mark Drakeford:** Rebecca, is your question on this issue?

[24] **Rebecca Evans:** It is on this issue. I have just inadvertently turned my phone on.

[25] **Mark Drakeford:** We will go to Rebecca then Darren on this broad issue of how consultation has been conducted, then I will turn to Elin and Kirsty who have separate issues to pursue.

9.45 a.m.

[26] **Rebecca Evans:** You have all rightly acknowledged the importance of going into communities and having a proper conversation with people. You mentioned that you have held over 50 meetings. Were those all organised by the health board, because I am aware that a great number of meetings have been organised by local community groups of different types? Have you been invited to those meetings, and how many have you attended? If you did not feel that it would be appropriate to attend, why was that?

[27] **Mr Purt:** There are a couple of answers to that. We have gone to meetings that have been organised by other people, but you must appreciate that with the size of the geographic area that Hywel Dda covers, as you well know, and the number of meetings that town councils, rural councils and others have called, it has been practically impossible to attend all meetings. We have tried to bring together the leaders of the town councils for a separate session with us. We have also brought areas together that would have a natural affiliation in terms of the subjects that they want to talk about. However, where we know we have had engagement issues—I am very careful in trying not to get into the consultation issues around this—regarding subjects of concern in areas such as Tenby and south Pembrokeshire, we have gone to those meetings with people from our county teams, because we are structured in a way that means that we have county leadership across our three counties. It has been a mixture of the county leadership that has been engaged locally, backed up by people from the main team where appropriate. So, yes, we have attended meetings that were not ours, but not all of them, it would be fair to say; at one stage, we had stopped counting at about 250 invites.

[28] **Rebecca Evans:** I want to mention petitions as well. We receive a great number of petitions regarding health reconfiguration. Have you received petitions, and, if so, how do you consider them and what weight do you give to them?

[29] **Mr Purt:** I am sure that colleagues around the table will recognise that I have already given evidence to the Petitions Committee on issues regarding Llanelli. We are very cognisant of what petitions we get. We take those into account in our deliberations, particularly between the engagement stage and consultation stage. As we are currently in consultation, every submission that comes in will be taken as part of the final report that comes to the board when it makes its decision in a few weeks' time. We have tried to recognise that some of those petitions are very heartfelt and show the high esteem in which services are held within those communities. Where possible, we have tried to respond to those petitions in a positive and helpful way, by helping the petitioners to understand some of the pressures and why the changes are being suggested. In the same way, the petitions are taken as part of the ORS response and will be considered as part of it.

[30] **Darren Millar:** Compared with the way in which you have operated your public meetings, there has been a very different approach in north Wales, where people have been required to register their attendance before the meetings have commenced. It was explained that that was because of health and safety concerns if too many people turned up, which I was quite surprised at. As a result, they have had very low numbers at many of their meetings. You said that you had received hundreds of people at some of your meetings. Have you had to turn people away, and, if so, if demand has been strong for further engagement in those areas, have you organised further public meetings?

[31] **Mr Martin:** We have not had to turn people away. It is a judgment call on how big the venue is to understand how many people will come. Maybe by luck or good judgment, we have been able to facilitate those meetings so that no-one has been turned away. Attendance at the three big public meetings varied from 250 people in Llanelli to 500 in Haverfordwest, and we managed the venues in such a way so that that worked very well. When we had our CHC mid-term review, I was happy that we did not need to hold any more of those big formal

meetings because of the same reason that you asked the question—no-one was turned away. In terms of the more intimate meetings, again, we have had an open-door policy, so people have arrived when they felt they could arrive, and we have been there from 2 p.m. through until 7.30 p.m. We extended the hours because some of the criticism around the first part of listening and engagement was that we were not there in the early part of the evening when people were coming home from work or whatever. So, we have extended the hours. I was in Pontyberem the other night until 7 p.m. and, again, we were not turning anybody away. It has worked particularly well. That was fine for the listening and engagement, and, indeed, for what we have done so far within the consultation as well.

[32] **Darren Millar:** You mentioned earlier, Trevor, that you had about 250 invitations to speak at other people's meetings. What are the criteria by which you determine which of those meetings you attend? You have said that you have topped 50 so far.

[33] **Mr Purt:** Obviously we cannot go to everything we are asked to attend, Darren, so, if we see a theme that is coming through from those attendances, we go back to the local town councils, for instance, and bring the clerks together, or the leaders of the town councils, and offer to do a briefing session and engage with them as a whole. Where we think we have some significant issues that need to be communicated properly—and, again, I come back to issues such as Tenby and south Pembrokeshire—we have gone to those meetings at their behest with a team, which we think has been very helpful.

[34] Picking up on Chris's point, where we have seen an ongoing need, and we have come to an end of a 7.30 p.m. meeting and there are still people with unanswered questions, we have gone back to that place again. So, we have doubled up in some of them. The big advantage of the way in which we have been handling some of these meetings is that people do not feel pressured in terms of what they can and cannot ask because we have enough people there that we can talk to two or three people at a time or to a dozen people at a time. So, what we are doing as part of responding to where we have actually had requests to attend is signposting people to the nearest next meeting where there will be health board representation, so that they can come and raise their questions there.

[35] **Darren Millar:** Have there been concerns about the safety of your personnel at those sorts of meetings? One reason or excuse for not attending other people's meetings in north Wales from the Betsi Cadwaladr board, which we will see later, has been concerns about the safety of individuals. Have you experienced any such problems?

[36] **Mr Purt:** Chris can pick that up. It would be unfair to say that that has not occurred, and we have had some police support at a couple of our meetings because there was a concern, but Chris will have the details.

[37] **Mr Wright:** It was a very emotive day in Llanelli and we felt we needed some police support because it was quite a threatening atmosphere. However, I think we had enough of our own staff there and we had had enough training to know how to deal with that. We learned from that and the drop-in sessions now are clearly advertised as such; what happened on that particular day was that 450 people turned up at 9 a.m. rather than our having a regular flow, so it was very difficult to manage in terms of what we had set up. We understood the emotion, but we felt that the atmosphere at times during that morning was not pleasant, it has to be said.

[38] **Darren Millar:** Okay. I have just one final question on your engagement. To be fair, I visited Hywel Dda LHB area during the engagement process and I was quite impressed by the way in which you were reaching out and encouraging people to register with your feedback mechanisms and so on in order that they could engage at an early stage before the public consultation. However, what engagement did you have with local authorities on the

impact on their social services, for example?

[39] **Mr Purt:** I will respond to the second part first, if I may. In terms of the local authorities, from the very early stages, I was briefing local authority chief executives and directors of social services, and I know that my chairman was in contact with the leaders of those councils. Also, during our engagement process, we facilitated full council meetings. I am thinking particularly of Elin's patch, where we went to Ceredigion and it was a full open council meeting in public, where we briefed councillors before we even got into the consultation. I have subsequently been back to another full council meeting where we have briefed during the consultation process. So, we have engaged very clearly at that level with our local councils.

[40] I just wanted to pick up on the point about our engagement with our population. There is an opportunity here; part of what we have been driving through our model is, effectively, a membership model. We are trying to get people to sign up to be supportive of Hywel Dda LHB in the future too, so that we will have 1,000 people—and hopefully more than that—who we can keep coming back to as a continuous litmus test of how our services feel, whether the touchstones are right, and whether they provide us with some advice and expertise on how it is feeling for them and their family. I am trying to select those people, depending on what the service models will need to be. It will range from younger people right the way through to members of our retired population so that we can have members of the public from whom we can continue to take feedback over the next five to 10 years.

[41] **Mark Drakeford:** Rydym yn mynd i Elin nesaf, ac wedyn Kirsty a Vaughan. **Mark Drakeford:** We go to Elin next, and then Kirsty and Vaughan.

[42] **Elin Jones:** Hoffwn eich holi am y broses o drafod gyda'r fforwm clinigol cenedlaethol— **Elin Jones:** I want to question you about the process of discussing with the national clinical forum—

[43] Are the headsets working?

[44] **Mr Purt:** The audio is quite faint.

[45] **Kirsty Williams:** You can turn it up.

[46] **Mr Purt:** It slides—too technical for me. [*Laughter.*]

[47] **Elin Jones:** I could shout, I suppose. [*Laughter.*]

[48] Hoffwn eich holi am y drafodaeth rydych wedi'i chael gyda'r fforwm clinigol cenedlaethol. A allwch chi esbonio'r drafodaeth honno, oherwydd, hyd y gwelaf, nid oes unrhyw gofnod cyhoeddus o'r trafodaethau y mae'r byrddau iechyd yn eu cael gyda'r fforwm clinigol cenedlaethol? Felly, allwch chi amlinellu'r broses a hefyd ddweud wrthym a oes unrhyw anghytuno wedi bod rhwng y fforwm clinigol cenedlaethol a chi fel bwrdd o ran eich blaenoriaethau ar gyfer ymgynghori? A fu'n rhaid ichi newid unrhyw opsiynau roeddech yn eu cynnig i'r cyhoedd? I want to question you about the discussion that you have had with the national clinical forum. Could you explain that discussion to us, because, as far as I can see, there is no public record of the discussions that the local health boards are having with the national clinical forum? So, could you outline that process and also tell us whether there have been any disagreements between the national clinical forum and you as a board as regards your priorities for consultation? Did you have to change any options that you were proposing to the public?

[49] Mae gennyf un cwestiwn arall ar fater gwahanol. Yn eich dogfen ymgynghorol ffurfiol, cynigir opsiynau i'r cyhoedd er mwyn iddynt ddatgan barn arnynt ac er mwyn iddynt ddweud pa opsiwn maent yn ei ffafrio. Fodd bynnag, yn eich dogfennau a'ch cynlluniau, ceir nifer o newidiadau i'r gwasanaeth nad ydynt yn destun cwestiwn nac yn opsiwn ffurfiol yn yr ymgynghoriad. Sut mae rhai newidiadau i'r gwasanaethau yn destun opsiwn ymgynghori ffurfiol ac nid eraill? Sut ydych chi wedi gwahaniaethu o ran hynny?

I have another question on a different issue. In your formal consultation document, options are proposed on which the public are asked to express their opinion and to say which option they prefer. However, in your documents and plans, there are many changes to the service that are not subject to a question or a formal option in the consultation. How are some changes to the services subject to a formal consultation option and not others? How did you differentiate in that respect?

[50] **Mark Drakeford:** A allwch chi ddechrau gyda'r fforwm clinigol cenedlaethol cyn symud at yr opsiynau yn y ddogfen a statws yr awgrymiadau?

Mark Drakeford: Can you start with the national clinical forum before moving on to the options in the document and the status of the suggestions?

[51] **Ms Davies:** I will start on the national clinical forum. We have had two very productive meetings with the national clinical forum—one during the listening and engagement process, which, if I recall correctly, was just before Christmas last year, and the other in early June of this year. The debate in terms of our proposals and our clinical strategic direction has been robust and helpful. There has been helpful discussion and challenge in respect of our proposals to mitigate some of the medical recruitment challenges that we face. We have explained the unique challenges that we have in Hywel Dda in terms of rurality, the strategic importance of Bronglais and how perhaps on first look one model may fit Hywel Dda, but we need to look at patient flows on a much wider scale. So, we have used the advice mechanism provided by the national clinical forum in a productive way. We received a letter from the chair of the national clinical forum, after the debate in June, which stated:

[52] 'To conclude, the Forum believes that the proposed options for consideration through the formal consultation process are clinically appropriate and safe.'

10.00 a.m.

[53] It was encouraged to see how far the ideas had developed, through the listening and engagement process, into the final proposals that we put forward through the clinical strategy document. So, from a personal perspective and from a Hywel Dda perspective, our relationship with the clinical forum has been a very productive process.

[54] **Mr Martin:** May I suggest, Chair, that we send you this letter as a matter of record?

[55] **Mark Drakeford:** Thank you; that would be helpful. Before we leave the national forum, I will see whether Elin wants to come back on what we have been told so far and then I will check whether any other Member has a supplementary question on that specific issue, because we probably will not get back to it otherwise.

[56] **Elin Jones:** I think that you have answered what would have been my supplementary question, which was about the fact that a hospital of the nature of Bronglais does not have the throughput of numbers to meet some of the royal college guidelines. The royal colleges, in some form or another, sit on the national clinical forum, so they have accepted that there is a unique case, almost, for a hospital in that geographical location and that they have to consider that the safety aspect of having a hospital in that location means that some of their 'one size fits all' guidelines have to be worked around in some way for a hospital like Bronglais. There

may be others in Wales that fall into that category as well.

[57] **Mr Purt:** We fought hard, Elin, as I think that you know, to make Bronglais our regional centre for how mid and that part of west Wales can function. It would be fair to say that, in the early stages of our conversations with the national clinical forum, it was an education both ways. We have fought very hard to explain exactly how Bronglais sits within Hywel Dda and its position across mid and west Wales. Having done so, the forum has now recognised that the solutions that we are putting forward are absolutely the most appropriate solutions, with Bronglais being part of a network of hospitals in Hywel Dda, but carrying the responsibility for providing services to a far wider region than is covered within our geographic boundaries.

[58] **Elin Jones:** Was there anything that you wanted to propose or to keep about which the national clinical forum said ‘Sorry, that’s not appropriate or not safe’?

[59] **Mr Purt:** I do not think there has been. We have fought our corner about not coming forward with a model that would fit a slightly different template, driven by some of the royal college issues, that is not fit for what we need to do in our service. So, the difference between December and June, I think—I am choosing my words carefully, Chair—has been an education that has gone both ways about how the service needs to reflect the dynamics of the economy in which it sits.

[60] **Mark Drakeford:** There is a fine line that we have to think about, as we go on in our discussions, between not being drawn as a committee into the specifics of either your plans or the plans that we will hear about later. We are, really, interested in the process. I take the last discussion to be an example of the part that the national clinical forum has played in the process that we have been exploring, but it is the process of consultation that we are concentrating on this morning. That was fine—

[61] **Elin Jones:** I will not mention Bronglais again. [*Laughter.*]

[62] **Mark Drakeford:** No, no; that is fine. Does anybody else want to ask a question about the part that the national clinical forum plays in the process? I see that nobody does. In that case, we will go to the second part of Elin’s question before going to Kirsty. Elin’s second question, really, was about the status of the different proposals that are contained in the consultation document and how you differentiated between some that are slightly more formally expressed for consultation and others that do not quite appear in that way.

[63] **Mr Purt:** Chris can provide some of the detail. Simplistically, from the board’s perspective, if we are planning significant service change, that is absolutely right for public engagement and public consultation. There will be times, unfortunately, when, because of either shortages of staff, recruitment issues or something unexpected that has cropped up that we have not been able to plan for in the way that we would want to, some service changes may have to happen quickly. In most of those cases, we will attempt to engage with our CHC colleagues and with our staff, who in many ways have been the ones who highlighted the problem to us. In those cases, some service changes should occur, which we would hope would be temporary, until we can address some of those issues.

[64] **Mr Wright:** There is not much to add to that, other than that there is a line to be drawn between significant service change and operational service development, and that is where we have tried to draw the line. The document outlines some things that we are just intent to get on and do, and some of those are based on what we heard during the engagement phase—that is, we had 75% support for our vision of community services. The majority of that work we just need to get on and do, and deliver, to support the rest of the strategy. The development, for instance, of a catheter laboratory on our patch is something that we just need

to get on and do, and not ask permission to do it. That is where we have tried to draw a distinction. What do we need to do to add to our services operationally, to improve them, that could not be perceived as significant service change? What is significant? We ask the question on what we perceive to be significant. During the process to get to consultation we did run these things past the CHC, and we did not have any specific objections to what we were calling significant, and what we felt was operational.

[65] **Mr Martin:** The other thing, if I may, Chair, is that mental health is probably an area that people were very passionate about as we were going through the listening engagement. We have our own strategy around mental health and improvement, so that is running alongside the work that we are undertaking here as well. That was something that came through the consultation and the listening engagement as part of the process.

[66] **Elin Jones:** I understand the answers. What is confusing to me is that, when you say that there are service changes in here that you are just carrying on with, they are quite significant—such as, for example, a community hospital closing and moving to a different model of care in that community—but there are no formal options for consultation. So, as I understand it, you are assuming that that just carries on and is not part of a formal consultation at all, and will not be referred to a Minister at any point. Everything that is in the text other than the formal options is not an issue that could be referred to either the CHC or the Minister at any point.

[67] **Mr Purt:** I do not think that that is what we are saying. What we are saying, to take another example, is that we know that, at any one point in time, about 40% of our hospital beds are filled with people who could and should be catered for elsewhere—either in the community or at home, with better support packages. That is obviously something that is going to change services; we are going to be investing in our primary and community services so that we are not using the wrong end of our pathway to deal with some of those issues. What Chris was alluding to, in terms of people supporting the direction of travel into investment in primary and community services, is that we know that it is the right thing to do, and it is not about a service change, necessarily; it is about ensuring that the clinical pathway is delivered in the most appropriate place. If that means that we need to invest in those services and be less reliant on hospital beds, that would not be something that we would consider to be a major service change; it would be something that is eminently sensible to do, and something that I would expect everyone to support, because it is about caring for people in the most appropriate place in the most appropriate way.

[68] **Elin Jones:** Could I ask a specific question on this, because it highlights the issue that I am trying to tease out?

[69] **Mark Drakeford:** Give us the example that highlights the process point.

[70] **Elin Jones:** You have a formal question option on the closure of Mynydd Mawr Hospital and the transfer to another model of care, but you do not have a formal question on the closure of Tregaron Hospital and that transfer to another model of care. This is not a point of disagreement politically, but I am trying to understand how you differentiate between those two issues, which seem quite similar to me. If I can just add this to the mix, on the Tregaron question, I have become more confused because there is no formal consultation on the closure of the hospital, and it is not in your plans as a formal consultation question, but the Minister tells me separately that she cannot take any decision on Tregaron funding possibilities because it is out to formal consultation. It is not, as far as I can see, because it is not one of the options. I know that that is very detailed—

[71] **Mark Drakeford:** No, no; it would be helpful for us to understand why these two things have been pitched differently. Also, could you pick up Elin's other point? Does that

mean that the Tregaron example would not need to be subject to a CHC agreement at the end of this process and that it therefore could not arrive on the desk of the Minister?

[72] **Mr Martin:** I think that the CHC will always have the option to take any decisions made by the health board to the Minister. I think that that is always an option. If there are issues that are unacceptable, or if there are issues of process and so forth, they can always be referred to the Minister. The CHC has that option. In fact, it has an option on our consultation, as well. So, it could escalate to the Minister if it felt it appropriate.

[73] On Tregaron, and Cardigan as well, we felt through the listening engagement exercise that there was a consensus and a feeling that everybody was supportive of that, so we did not call it out as part of this next formal consultation. Through the listening engagement exercise, everybody was very supportive, as you can imagine, of replacing Cardigan hospital, and the one at Tregaron as well under the Cylch Caron project.

[74] On the other issue that you highlighted, about communication with the Minister, I am just picking up on some of those communications, and I will deal with them with the Minister in terms of understanding why she believes we need to wait until after the consultation. From where we were sitting, we believed that the consensus was there, and it would be something that we were waiting for a decision on from Welsh Government.

[75] Certainly, however, just to reiterate: where there was consensus through the listening engagement, we did not go to a formal part as part of the consultation.

[76] **Mark Drakeford:** I am very reluctant to try the patience of the leader of the Welsh Liberal Democrats for much longer. [*Laughter.*] She has been waiting very patiently, but there are two other Members who want to ask something very specific on this issue of the consultation process. Darren and Lindsay, I will take both of your questions together and we will have one answer, and then, definitely, Kirsty.

[77] **Darren Millar:** My question specifically relates to any guidance that you may have received from Welsh Government about which bits you put into the consultation and which bits you do not. I did notice that the difference between Betsi Cadwaladr's plans and yours is that it is consulting on what are relatively small changes to its community hospitals, including the withdrawal of an x-ray service and the withdrawal of a minor injuries unit. It is putting that out to full consultation, whereas you appear not to be doing likewise in the case of Tregaron, for example.

[78] Secondly, those of your proposals that are out for consultation include a number of options. You indicate a preferred option, but you do set out at least two options, usually, in the paper. However, in north Wales, there are no options—it is simply 'this is our proposal'. What guidance was there from the Minister or from the Welsh Government directly relating to what you should include in these plans?

[79] **Lindsay Whittle:** I know that we are talking about the process of consultation for this reconfiguration, but how dominant were the financial considerations during that process?

[80] **Mr Martin:** First of all, if I can pick up on the guidance, we are the statutory body and we have to make the decisions that we believe should go out to consultation. We have worked within the guidance that Chris referred to; I am sure that he can refer to it again. That is what we have worked within. So, it is our interpretation of the guidance that has led us to the consultation. I think that different statutory bodies will have a slightly different view on how they deal with individual cases, and it is difficult for me to comment specifically on Betsi Cadwaladr's cases. We have, however, called out the minor injuries change in Tenby and south Pembrokeshire as part of the process.

[81] As for the financial consideration, we are absolutely clear that the key driver for service change is safety and sustainability. We need to work within our statutory function, which is to deliver safe, sustainable services within our financial allocation. So, the key driver has been safety and sustainability, particularly for our community in west Wales. However, the financial consideration is, of course, a key part of that overall discussion. As such, we have called out, in one of the financial, technical documents that are part of the consultation, that we believe that there is a saving to be made over the next five years. It is not a huge saving, but a significant saving that will help us

[82] Let me just re-emphasise the fact that this is about safety and sustainability, particularly for us in west Wales.

[83] **Mark Drakeford:** If we have a chance, we might come back to that question a bit later on, because it is quite a big question and I do not want to delay moving into the next part of this session. So, Kirsty has the next set of questions.

[84] **Kirsty Williams:** Good morning. Several times this morning, you have mentioned the issue of staff recruitment, which has been a major driver behind many of the changes we are seeing throughout Wales. Therefore, what has the process of engagement been between the local health board and the postgraduate deanery with regard to its expectations and how those expectations have fed into your proposals?

10.15 a.m.

[85] Secondly, what engagement has there been and what has the process been with regard to discussions with other local health boards, either from their perspective in that they commission services from your health board, or, perhaps even more importantly, the way in which their proposals for change impact upon your decisions, because we are at different stages depending on the location in Wales? So, for instance, your document makes assumptions about what services look like in south Wales, but those assumptions may not hold true when south Wales gets to the end of its plans. So, what discussions have you had with local health boards about what their services may look like?

[86] Last, but not least, one would hope that these formal proposals are an honest and a deliverable proposition for the public. There would be nothing worse than going out and coming to an agreement, raising expectations about what services look like, only then to go back to the population in 12 months' time and say 'We cannot deliver on this. We had a caveat in our document and we said that it would be subject to staff recruitment.' What risk analysis or risk assessment have you made of the deliverability of your preferred options? If the CHC gives you the go-ahead and the Minister gives you the go-ahead to proceed on that basis, what analysis have you done to assess whether they are deliverable?

[87] **Mr Purt:** I will try to remember all three questions in one go, Kirsty. In terms of the recruitment and the deanery, recruitment is a bit like a curate's egg; there are elements of recruitment that we do not have an enormous issue with, but there are others that are absolutely driving some of the issues across the whole of Wales. We know that that is principally in relation to accident and emergency doctors and some aspects of neonatology. However, we know that, in general surgery, for instance, it is not a particular issue. So, we are very cognisant of what our service demands will look like. For the last three years, we have been trying to go one stage beyond that and look at our public health data. When you and I met the first time, I tried to explain that we are using our public health information to try to look through a crystal ball to see what our services will need to look like in 10 years' time and then ensure that we do not have to go through these processes again. So, part of the reason for investing in primary and community care relates to chronic disease issues and ensuring that

the pathways are absolutely right.

[88] The deanery has been alongside us all the way on this. Some of our models are now either predicated on centralising training rotas or they relate to areas where we know we will not be reliant on having trainees. So, we will go straight into middle SAS grade doctors, because that is the only way that we will run the service. I think that answers a little of the third question as well. We have been as focused as we can be at this stage about making sure that the service models that are coming out of the consultation are not reliant on deanery issues and that the deanery agrees with it. One of the associate deans works for us and has been embedded in this process to ensure that, where we have gaps, they are being teased out. So, in the same way that we went down the route with Professor Harmer on the national clinical forum, we have done the same with the deanery. However, I want to come back to the point that, where we think that there might be an issue about trainees, we are doing one of two things: we are either not predicating it as being a trainee post when running our rotas, or centralising some of our services for training purposes and then rotating through our sites. The deanery thinks that that is a model for the future, because it gives a degree of exposure in a series of different environments, rather than having exposure to one small part. Let us be candid—west Wales is not as attractive as Cardiff to attract trainees, but offering them a different type of experience, whether it is rural, semi-urban and working with our community teams, will give them a different learning exercise. Our conversations with the postgraduate dean at Swansea have been very positive, as the deanery wants to develop services and courses with us in the future.

[89] With regard to the relationship with health boards, you are absolutely right that there are three plans, namely those of Betsi Cadwaladr LHB, ours and south Wales. They are not done in glorified isolation. For instance, I sit on the programme board for south Wales, and Chris has chaired a couple of those meetings, so I am part of the chief executive cadre that has been plugged into the south Wales plans from the beginning. I understand what south Wales is doing, it understands what we are doing and we understand where the pinch points are. Our services are completely aligned to what its models are telling us they will deliver. We are fairly unusual in the sense that we are not a huge exporter of services outside our boundaries. Those that we do export tend to be tertiary, so they go to Cardiff or Swansea. Our closest board is Swansea, and a lot of our discussions have been about how Swansea can help us to facilitate the retention of services that currently go across the border.

[90] The other thing I would say about the south Wales plan is that it is not a complete plan, in the sense that it only looks at four specific areas, namely trauma, paediatrics, obstetrics and accident and emergency, so it does not look at the whole picture. It is up to individual health boards to decide how they weave those four areas into their local plans. I know that Swansea will be issuing a separate plan, which is more encompassing like ours and that of Betsi Cadwaladr LHB. Powys LHB has been heavily involved in the design for our plans, particularly with regard to the north of our patch, as has Betsi Cadwaladr LHB. For a year, our planning directors and those of Betsi Cadwaladr and Powys LHBs, have ensured that the relationship has been cemented in gaining clarity of what the demands will be on our service.

[91] You made the point in your question that we are a receiving organisation in that it is dependent on information that flows from our colleagues regarding what our services need to look like and what they want to commission. It would be remiss of me to attempt to try to plan and design a service that is not cognisant of what a client may want us to deliver, and it would also be wrong of me to include something when I do not know whether or not they will take it. It has been an evolving issue over the past couple of years, and we have been at this as a health board for over two years. However, we have been completely plugged into the south Wales plan.

[92] **Ms Davies:** To add some detail on workforce recruitment, we need to be cognisant of the fact that many of the solutions for our models going forward are not based on traditional medical models; they are community-based models that have the GP and primary care at their core. We are developing much more enhanced roles for nursing by investing in community nursing staff and community therapists, thereby enhancing and remodelling the whole workforce. It is very important to focus not just on the medical end, however important we recognise that medical recruitment is at this point in time; it is about looking at the issue in its broadest sense.

[93] **Mark Drakeford:** Given that these are quite complicated questions, we shall pause for a moment. We will definitely come back to how the process has dealt with the issue of deliverability. Before we do that, I will see whether Kirsty wants to follow up on anything so far on how the relationship with the deanery has fed into the process, and how the process has encompassed the plans of bordering LHBs. Do you want to ask a supplementary question on those, Kirsty?

[94] **Kirsty Williams:** No, that is fine.

[95] **Mark Drakeford:** Does anyone else want to come in on either of those two points?

[96] **Rebecca Evans:** I have a question on the workforce. You are obviously an important employer within the region. How are you consulting and engaging with staff across the different grades, and not just medical staff, and with the unions and representative bodies on your plans?

[97] **Mr Purt:** There are two different levels. Let us take the staff side in terms of the formal meeting process for a second. All the way through our engagement and consultation process, we have been having regular meetings with the staff side; it has been a regular issue that has been on the agenda for staff side meetings, and I have attended and presented at some of those meetings, as have most of my colleagues, I think. So, it has been an ongoing relationship with the trade unions right from the beginning. I have also had some bilateral conversations around this with the British Medical Association and with the Royal College of Nursing.

[98] In terms of staff groups, it is an interesting question. In some respects, staff groups are our population as well. They have been engaged twice. They have been engaged through the process in terms of all the things that we are doing on our public-facing side, but again, all the way through our engagement, as well as the consultation now, a series of staff meetings has been held in each of the hospitals within communities and local teams, where they have had full briefings. We have done this on a repetitive basis over the last year or 18 months. If you go right back to one of the things we submitted in evidence, which was around how we started this process two years ago in terms of the original analysis of strengths, weaknesses, opportunities and threats, and the clinical teams, then our staff groups were involved in that as well; it was not just medics who were driving this. As Kath has just said, we believe that the answer to a lot of our issues is around investment in our primary and community services and less reliance on secondary care. We have been absolutely focused therefore on ensuring that we have got the message through to our GPs, our community teams and our practice nurses and managers—I have spoken twice now at gatherings of practice managers—and got it through as far as we can into all the groups.

[99] **Mr Wright:** As part of the consultation process, we have focus groups with staff at two levels: one for middle-grade and junior doctors, and one for administrative and clerical staff, so they can participate in deliberative events. Often, staff may feel that they do not have a voice, because they may embarrass themselves or feel threatened in a larger environment, so we have had focus groups across the whole area at those two levels, in which staff have been

participating.

[100] **Darren Millar:** I was very pleased to hear that the deanery has been supportive of a different model than they have been used to in the past in terms of training for doctors. To what extent has the BMA in particular been helping to encourage and promote that through engagement with you and other health boards? Things are very different in Wales because of geography, but I get the sense that from the existing consultants, who have been there for many years, there is some resistance to a change in the model and pattern of working, particularly across a number of sites. To what extent is that a barrier towards any change?

[101] **Mr Purt:** Change is always difficult. I do not think it matters where you are in an organisation or at what level; change and cultural ways of working are always things that will have to be dealt with in terms of how we engage with our individuals, how we bring them along and how we ensure they are part of the solution. What we have been trying to signal through this morning, and over the last couple of years, is that we are engaging with people. We have tried to engage with some of our harder-to-reach staff groups and, where possible, we are ensuring that they are part of the solution. We are finding peers within those groups, and if those consultants are with us and understanding what it is we are trying to do, that takes us a long way down how we deal with those cultural issues, Darren.

[102] One of the things for me is that we have signalled very clearly through our document, and hopefully through the things we have been saying, both in public meetings and with our staff groups, that this is going to be ultimately delivered and designed by them. We are giving people the overall direction of travel. The direction of travel is a system that is based on primary and community delivery, with secondary care backing up where necessary and only used where it needs to be required. That means that we are going to have to change how we do things, and I think that it will be delivered by multidisciplinary teams that work across the Hywel Dda LHB area, rather than within single pockets, as has historically been the case. I accept that it will be difficult, which is why, as the chair has said, this will take five years to deliver. It has to be evolution and not revolution.

10.30 a.m.

[103] **Mark Drakeford:** Mr Martin, you were going to pick up Kirsty's third point, which is the extent to which your processes have been able to assess the risk of being able to deliver all of this when it is finally agreed.

[104] **Mr Martin:** It will be the role of the implementation board to ensure that the gateway process works and, first, that that risk assessment is undertaken. Going back to Trevor's point, it will be about our clinicians leading the direction of travel in shaping what those services will look like, working it within the multidisciplinary teams in order to do that. However, it will then be for the implementation board to undertake that risk analysis as part of that incremental approach to what will happen as part of the process. So, the implementation board will sit alongside the main health board. It will be chaired by one of my independent members, who will then need to ensure that there is a reassurance mechanism in place that says, 'This can now go forward.' As I explained in my opening remarks, it is important that we get the right services in place before we change the services. So, that is how we will deal with it.

[105] We manage risk every day, do we not, in terms of risk assessment of existing services? As we go forward, waiting for the outcome of the consultation, we will then be able to undertake further risk assessment on that going forward. So, it is an incremental process. We have risk-management processes in place. That is what we do now and as we incrementally change the service, we will then take that on board, linked to the implementation board as part of that process. It looks as though I have confused you, Kirsty.

[106] **Kirsty Williams:** I am not sure that I understand what a gateway analysis is. I am concerned about a situation where we take the public down a certain route, spend all of this time, energy, resource and money on engaging, only to say to the public at the end of that, ‘Well, we would have liked to have done that and it was our honest intention to do it, but actually when it came to setting up the implementation board, shock, horror, the implementation board said to us that it could not be done.’ By your own admission, we are talking about remodelling the entire workforce. This is not one service change, and I know from my own experience that remodelling the workforce in one locality can cause many difficulties. By your own admission, you are remodelling the entire workforce. I want to be certain that you are certain that you can, having gone through all of this, deliver on your own options.

[107] You know what you want to achieve and what the end of this road looks like. I just want a level of assurance that you have tested that to its ultimate point and that you are quite clear, regardless of having an implementation board and of it being an incremental exercise, that you can do this with the workforce and the money that you have and that it is not dependent, like the south Wales plan is, on building a brand new hospital, which we do not have yet. I want to know that this can be delivered because it would be a complete betrayal, would it not, to go back to people again and say, ‘That is what we were going to do, but actually we cannot do it.’?

[108] **Mr Purt:** That is one reason why we have been less radical than some were expecting us to be. It has to be deliverable. We are of the view that it is deliverable. The gateway mechanism is an implementation process to give confidence to stakeholders and to the board that the right things have been put in place before a service changes. Ideally, that will live within the timescale of the overall project plan, but, to be clear, that is not being driven by a timeline, but by elements of that milestone process having to be adopted first. So, it if means that a building has to be built and that staff have to be trained and recruited to a different way of working and that we then have to go through a complete change in terms of how the pathway is delivered, then those are the gateways that will have to be put in place before I will agree to a service being changed from that location to this new way of doing it. That is the only way in which we can do it. Historically, the service across the UK in the NHS has always said, ‘We want service change—trust us and we will put this in afterwards’. That is not how I want to do this. We want to show clearly that we are investing in the right parts of the system first before the service changes. That is why there will be a focused implementation board, which will report to the board. There will be a mixture of stakeholders on it, including the local authority, community health councils and our own staff, and they will clearly see that those milestones have been achieved and the service is ready to move.

[109] **Vaughan Gething:** I just wish to return, to tidy them up for myself, to some of the points about clinical engagement, both prior to the engagement and post engagement but pre-consultation. I am interested in what you said in answer to Rebecca Evans’s questions about how that has been done. You are talking about shifting people into primary community care, so I wonder if you could tell us how you have specifically gone out and consulted with those members of staff, both those who work for you but also those practitioners who are not all necessarily staff of Hywel Dda Local Health Board. How do you reflect their views, given that I understand that you are supposed to reflect the clinical view in the proposals that you put forward? How do you present those to the public?

[110] That then follows on to my next point, which is about how you engage with professional bodies. You have talked about the national clinical forum, but there are, of course, a number of other professional and independent bodies. How have you engaged with them in the pre-engagement and the pre-consultation processes? Lastly, moving on to the area of safety and sustainability, what does that mean?

[111] **Mr Purt:** I will answer the first point and ask my colleagues to come in on the others. It goes back to May 2010, when we started this process. We started it recognising that Hywel Dda was not sustainable in its current format. The services had gaps. We had the bed dependency in secondary care to which I have already alluded, which was the wrong way of delivering a service. We also had clinicians across the whole of our patch coming to us complaining that the service was not as they wanted to see it, including primary care.

[112] We started with a series of workshops, which were themed along particular areas, from primary care, obstetrics and surgery through to unscheduled care. We held 10 workshops that started to look at the strengths and weaknesses of the service that we were providing across Hywel Dda. Those workshops were an open invitation to all our clinicians who were involved in those particular areas. What tended to happen was that each hospital tended to identify three or four consultants and/or senior nurses or allied health professionals to attend. General practitioners would identify people who had special interests in each area, so they attended at each of those themed workshops, even back in those days.

[113] At the beginning, you had workshops with 30 or 40 people, which included GPs, community staff, nurses and doctors in secondary care and some service users. We started at that point, and we asked representatives from those groups to present where they saw their current services being strong or weak, and where the threats and opportunities were. We then distilled that into a series of think tanks, taking it to another level. We distilled the risks and good bits from that, and we asked some of the same people, volunteers, to come and work on what it would mean if we wanted to deliver a service and a one-hospital solution across four sites to deal with what we saw as the problem of sustainability in future. That culminated in a two-day clinical engagement the following year, so it took a year to get to that point. At that event, we had the people who had driven the solutions and representatives of local authorities, the CHC, the Wales Deanery and of the Royal College of Nursing. Even at that point, some of the trade unions were getting plugged in, as well as the staff who were a part of the process as well. That two-day event took us down a series of avenues that started to flesh out what we thought the options would look like, and became the precursor to the engagement stage before the consultation. So, by the time we got to June, which was about 15 months into the process, we had started with the strengths, weaknesses, opportunities and threats workshops and gone right the way through to that process.

[114] We then held a series of pre-stage consultation events, which was our engagement exercise for all the levels that we have talked about, so with the public, stakeholders and our staff side. That started to look at what the options might look like—and there were as many as we could think of at the time—and to agree how we would rank those. We thought about what the criteria would be if it came to changing a service on a site: what were the site-selection criteria? We agreed on that, and what that started to look like. We tried to weight that. That was a common discussion, which included the CHCs, local authorities and the staff side, about how they would prioritise and weight those issues. So, if we ever got to a point at which the board had to state a preference, we would already have a mechanism agreed by a stakeholder group that was as wide as we could possibly devise. It had agreed on what the criteria and the weighting would be. There would then be a ‘simple’—he says, tongue in cheek—way of applying that, of saying what the options were, what the data that came from those options were, and the criteria that had been agreed and weighted. You apply the two together and you end up with, effectively, suggestions on the board’s preferences. That takes us to a particular point. Should I just pause there, in case there is anything on that, before we go to the next level?

[115] **Vaughan Gething:** I am also interested in how you engage with external professional bodies on the proposals and suggestions that you are coming out with, certainly at the consultation level, where those are pretty much fully formed.

[116] **Mark Drakeford:** I am just looking at the clock, because we are heading into the last 10 minutes, so maybe we will need to summarise a few of these answers as we go along, Chris. So, will you give us a brief answer to that?

[117] **Mr Wright:** At a professional level, our executive directors are engaging with the external regulatory bodies and professional bodies. Those bodies are also a part of the key stakeholder group that we are targeting, to seek consultation responses from. They are engaged on a day-to-day basis on where we are going, through the professional leads, and then they are also invited to contribute to the consultation. Is that summary enough?

[118] **Mark Drakeford:** Yes.

[119] **Vaughan Gething:** I am interested in how you balance making consultation meaningful with being honest, especially with regard to the point about safety and sustainability. How do you balance presenting proposals to the public to be consulted on and, at the same time, saying ‘These are the options that are safe and sustainable’? How do you then deal with potential requests for options that you may not see as being safe and sustainable? How do you explain that in a way that the public can engage with? There is a danger that you just turn up and say, ‘These options are not safe and sustainable so we will not do them’, rather than going down the explanatory route of saying, ‘Here are the criteria on which we judge them, in light of patient outcomes and the service that we provide’.

[120] **Mr Wright:** I will have a go at that. With regard to our options appraisal—and this may answer some of Kirsty’s earlier question—we appraised all the site options that we felt there were around particular service areas, and discarded those that we did not think were deliverable or would provide a safe service. We will put any subsequent alternative options that are put to us through the consultation process through that same mechanism and re-check our own preferred options. So, there is a clear process that will be visible to the public as part of the final reporting mechanism. All options will have been assessed against the same criteria, using the same standards.

[121] **Vaughan Gething:** Will those be reported back?

[122] **Mr Wright:** Yes.

[123] **William Graham:** Clearly, this is an event on a fairly unique scale, to put it mildly. You have been engaged in it for the past two years, and you have quite reasonably stated that it will be another five years before it gets to full implementation. You have obviously engaged with the public and you have told us that you are aware of a certain level of apprehension, shall we say? Will you describe to the committee how you think your process could have been improved, even at this stage? How have you been able to retain the confidence of the people whom you serve?

10.45 a.m.

[124] **Mr Martin:** I will try that one. We reflected a lot on our listening engagement exercise, to see what did and did not work well. We worked with the CHC to try to refine the process that we undertook as part of this. The challenge is how to make sure that it is meaningful to the public, while recognising the point that Vaughan has just made on having safe and sustainable services. There is a balance to be struck between recognising the strength of feeling and the passion within the locality, and making sure that we deliver the best possible care for the whole of the three counties. You will not be surprised to hear that, when we go to one county, the people there understand that change needs to take place, but they do not want it to be in their county, and it is similarly so in another county. We have to try, as

part of this process and as Hywel Dda health board representing the three counties, to take the helicopter view that is appropriate for the three counties. That is why Trevor and I are keen to make sure that the next part, which is the feedback from the consultation, is considered and that when we have alternative options they are also considered and put through the same criteria. I hope that that would give the public the confidence that we have considered other options and made sure that we have looked at all the other things that have emerged through the process. It is a testament to our organisation that we have listened and have changed our consultation in the light of what we heard through the listening engagement exercise, of which we have given you a couple of examples in our brief.

[125] It has to be meaningful. It should not be a numbers game, because that is probably not a helpful way of doing it. However, it is important that we listen and respond professionally to what emerges, and that that, in turn, is presented to the board. The great thing for me was that most of my board members were there in our public meetings to listen to the passion of the debate and to understand what people feel within those communities. I come back to it, though: we have to find the right solution for Hywel Dda.

[126] **Mark Drakeford:** Chris, you are a veteran of 2006, when lots of these arguments were being rehearsed in slightly different ways, although they were fundamentally not that different. What was learned from that experience? Do you think that things are better this time? The committee is interested in getting the best possible consultation processes happening throughout Wales. Could you take a minute in which to compare and contrast the two experiences? Did we learn anything from what happened last time? Has this been better in any way?

[127] **Mr Martin:** It is definitely better this time. Five years ago, we looked at just one part of the patient pathway and focused on the acute services element. Throughout that process, we were told that we could not change hospitals until we had sorted out primary community services. This time, as big as the process and the job will be, we are looking at the whole system rather than just one part in isolation like we did last time, because you cannot do that. I firmly believe that we learned from that process. I am a veteran of it and I want to make sure that we get it right for our populations. As I said in my opening remarks, this is too important not to get right. We have, for a long time, not had the bravery to make some of the difficult decisions that we need to make that will provide safe and sustainable services going forward. That is what drives our team to do the best that we can.

[128] The most important thing is that it has to be meaningful. This time, we have tried to meet with the pressure groups. Last time, we felt as though they should be outside the process. This time, we have them inside the process, because what they have told us is really important. I have met with them on many occasions. Elin, you were at the same meeting as I was in Aberystwyth. That has also been different this time, because we learned from the last time and tried to make sure that they understand some of the key challenges that we face and recognise that debate is really important. Lessons have definitely been learned across the whole system. We now have integrated organisations, too, which makes a huge difference.

[129] **Mark Drakeford:** Kirsty has a point on this, and then if there is anything that has not emerged in our discussion that you think we should be aware of, there will be a minute at the end for you to draw those things to our attention.

[130] **Kirsty Williams:** Like democracy, all this has cost you money, so I am just interested to know how much money the health board has spent on this engagement process.

[131] **Mr Martin:** We have spent probably around £200,000 on the listening engagement and consultation process. It is a significant sum of money. We tried innovatively to find different ways of doing it, which have clearly cost that money. Dare I say it? We are damned

if we do and damned if we do not, and we have a statutory responsibility to make sure that we can do the best that we can in terms of that engagement and, more importantly now, as part of the consultation. I firmly believe that it was money that we needed to spend to make sure that it was a meaningful process.

[132] **Mark Drakeford:** I thank you all on behalf of the committee for what has been a very useful and wide-ranging session. A lot of points have been covered, which we found helpful. There is a minute left in case there are any themes that you think have been an important part of your experience going through this process that we have not managed to touch but that you want to make sure that we do not forget.

[133] **Mr Purt:** What about resilience? [*Laughter.*]

[134] **Mark Drakeford:** That is an important point.

[135] **Mr Martin:** That is a very fair point. It is a huge undertaking on behalf of the organisation. I pay tribute to a lot of people in this organisation who come out to the public meetings and to other meetings. It has been a huge undertaking, but it will be worthwhile. So, we pay tribute to our colleagues, particularly the clinical champions, who have been fantastic in the way that they have been helping and supporting this process.

[136] **Elin Jones:** Just to check, Chair, will we be getting a copy of the national clinical forum letter to Hywel Dda? We have the equivalent letter of the clinical forum to Betsi Cadwaladr, which was quite a challenging letter. So, it would be useful to see the content of the Hywel Dda letter.

[137] **Mark Drakeford:** Yes, Chris offered us a copy earlier on.

[138] **Mr Martin:** We will deal with that.

[139] **Mr Purt:** It might be helpful for you to have a copy of mine before I leave, and then you can circulate a hard copy.

[140] **Mark Drakeford:** Yes, there is a copy making its way around the table. We will get copies made in the break so that we can have it for the next session.

[141] Thank you for being with us this morning.

[142] Mae gennym egwyl fer am 10 munud, tan 11.05 a.m.. We now have a short break for 10 minutes, until 11.05 a.m..

[143] North Wales will then be able to beam in through the video link. As we know, they are bound to do so, without a hitch of any sort. [*Laughter.*]

*Gohiriwyd y cyfarfod rhwng 10.52 a.m. a 11.07 a.m.
The meeting adjourned between 10.52 a.m. and 11.07 a.m.*

**Cynlluniau Ad-drefnu Byrddau Iechyd—Bwrdd Iechyd Lleol Prifysgol Betsi
Cadwaladr
Health Board Reconfiguration Plans—Betsi Cadwaladr University Local
Health Board**

[144] **Mark Drakeford:** Croeso yn ôl i'r **Mark Drakeford:** Welcome back to the cyfarfod. Rydym yn canolbwyntio ar meeting. We are focusing on the health

gynlluniau ad-drefnu'r byrddau iechyd. Croeso i gynrychiolwyr Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr. Gyda ni mae Geoff Lang, sydd yma ar ran y prif weithredwr, Neil Bradshaw, cyfarwyddwr cynllunio, a Sally Baxter, cyfarwyddwr cynorthwyol strategaeth ac ymgysylltu. Yn ymuno â ni dros y system fideogynadledda mae Dr Brendan Harrington, pennaeth staff, gwasanaethau plant a phobl ifanc. Croeso i chi.

boards' reorganisation plans. I welcome representatives of Betsi Cadwaladr University Local Health Board. With us are Geoff Lang, who is here on behalf of the chief executive, Neil Bradshaw, director of planning, and Sally Baxter, assistant director of strategy and engagement. Joining us by video-conference is Dr Brendan Harrington, chief of staff, children and young people's services. Welcome to you.

[145] Hoffwn wneud un neu ddau bwynt ymarferol cyn inni ddechrau. Nid oes angen ichi wasgu'r botymau ar y meicroffonau; byddant yn dod ymlaen wrth ichi ddechrau siarad. Gofynnaf i bawb droi eu ffonau symudol i ffwrdd, gan eu bod yn effeithio ar ein systemau. Yn ôl yr arfer, gofynnaf i chi—a dechreuwn gyda Mr Lang—a ydych am wneud unrhyw sylwadau agoriadol. Ar ôl hynny, trof at aelodau'r pwyllgor i holi cwestiynau.

I would like to make one or two housekeeping points before we start. There is no need to press the buttons on the microphones, as they will come on when you start to speak. I ask everyone to turn off their mobile phones, because they affect our systems. As usual, I will ask you—and we will start with Mr Lang—whether you would like to make any opening remarks. After that, I will turn to the committee members to ask questions.

[146] Dr Harrington, I know that it is sometimes more difficult to take part over the airwaves, but I will be looking out for you. So, if at any point you want to make a contribution, just indicate to me that you would like to do so and I will try to ensure that we offer you the chance to do that. However, Geoff, we will start with you.

[147] **Mr Lang:** Good morning, and thank you for the invitation to come to the committee today. We are grateful for the opportunity to share with you where we are in what has been quite a significant journey of engagement, moving through to the consultation. As you will have seen from our submission, we have been working in these service areas for over two years. It has been a lengthy process that has followed the spirit of the Welsh Government guidance to the letter in terms of consultation and engagement. It has proven to be a beneficial process, but, nonetheless, a challenging one in its requirements. I am sure that it is an experience that we will learn from as a board and one that NHS Wales, when other health boards have finished, will learn from and reflect on how the guidance fits us for the future.

[148] I will not go through the submission in detail, Chair. I will just draw out a couple of points in terms of our engagement process. We placed importance upon clinical leadership and our clinicians being at the heart of our planning process—shaping our plans and working with broader stakeholders in the development of those plans. We have attempted, from the outset, to engage with clinicians, partner organisations, patient groups and others, to make sure that, in developing our plans, we had the broadest possible inputs and views, such that when plans came to the board for its consideration for consultation, they had already been widely tested and influenced by stakeholders beyond the board. We hope that the documentation explains that to you and no doubt in our conversation today we will explain more of that.

[149] We are at an interesting and crucial point, in that we are over halfway through our consultation. We are now into the last three weeks of that process. We are still actively listening and adapting as a result of that consultation, which finishes at the end of this month. There is much work still to do to make sure that we hear the appropriate views and give people the opportunity to contribute. However, we have set out in our papers quite a

comprehensive and wide-ranging approach, and perhaps we can add the flesh to the bones as we go through the session.

[150] I do not think that there is much more to say, other than to thank you for the invitation. I hope that the preparatory paper was helpful and that we will be able to pick up the issues that Members want to question us on.

[151] **Mark Drakeford:** Thank you. We will move straight into questions. Kirsty is first.

[152] **Kirsty Williams:** I will ask you similar questions to the ones that I asked Hywel Dda Local Health Board earlier this morning. The first is on the nature of the engagement that you have had with the postgraduate deanery. I note that the clinical forum had lots of interesting things to say about your plans to use training posts to fill rotas and the issues around staff recruitment and retention. Therefore, what are your views on how you have engaged with the postgraduate deanery?

[153] Secondly, could you explain what your level of engagement has been with other local health boards, either with regard to them commissioning services from you or in your assumptions on how you will organise your services, taking into account what happens in other parts of Wales? For example, if you take the plans of all boards into consideration, you will know that the total number of obstetric units is a lot more than what the national clinical forum feels appropriate. The clinical forum also has a lot to say about the sustainability and the deliverability of your plans as they are currently formed. What risk analysis have you done as an organisation to ensure that your preferred options, as they are outlined in your consultation with the public, are an honest and deliverable proposition?

[154] **Mr Lang:** I will start in relation to the deanery. It is fair to say that, as we work through our planning process, the position of the various deaneries evolved, and we were getting updated information right through the process in terms of their position on training. We picked up some strong information through the clinical forum, as you indicate, in terms of deanery positions and training positions, and we reflected that in our thinking. It is also fair to say, in relation to the deanery, that there is an element of work in progress still here, in that while the headlines of some of the plans are clear in terms of numbers, the detail is not yet clear. So, work is still ongoing in terms of working through the service solutions. For example, where the deanery has indicated limiting the numbers of particular trainees in certain specialties, we are not always clear about the precise impacts upon each unit and the precise timings of those changes. So, we are still working through some of that, but, where we had that information, we took that into account. One of our key issues, which was drawn out in the discussion with the national clinical forum, is that, while training is important, and it links very tightly to service—indeed, in the past, they have been inextricably linked—those links are beginning to change in their nature and have to change in their nature to deliver comprehensive services.

11.15 a.m.

[155] We are having to, and are actively exploring, service delivery models that decouple, to a degree, the principle that we have had in our main hospitals in north Wales, namely that each hospital trains in each area, which is an integral part of service. We are now looking at service solutions where training will be on a limited number of sites, but that does not mean that you cannot deliver services on other sites. It brings a different set of challenges and we are having to work those through in some detail and that is part of the implementation work that we are doing.

[156] We have had information from the deanery, and, where we have got that, we have reflected it in our plans. It leaves us with challenges, and what we have not done, it is fair to

be clear at the outset, is to have a position where the deanery position on training has dictated the service model. That is an important factor for us and brings another dimension of risk and challenge, but it is only one dimension. Some of the issues relating to training numbers and what guides training are not necessarily the same as what would guide a good, locally accessible service. There are distinctions in that, which we are working through. If you want examples, no doubt Dr Harrington could talk in specifics about paediatrics and neonatal services and how that applies to those.

[157] So, we have engaged with the deaneries and have taken into account their views, but we recognise that some of our solutions are not wholly and simplistically aligned with deanery assumptions about training. We have broader population service challenges to serving north Wales in terms of access and we are looking at alternative models in terms of different structures in the medical workforce and different use of advanced nurse practitioners and other skills that can still deliver accessible services and have training narrowed down to a fewer number of sites. On other LHBs—

[158] **Mr Bradshaw:** I will pick that point up. On the work in south Wales, Mary Burrows, our chief executive, is part of a group that is overseeing and developing the proposals in terms of south Wales, where, although there is less impact in terms of service deliverability, nonetheless, we need to ensure that our plans complement one another rather than go in opposite directions, perhaps more pertinently along our southern borders with Powys and with Hywel Dda LHB area.

[159] We have been working as directors of planning for around a year as we have been developing and sharing our plans and looking at the interdependencies of the plans and their impact. As we have gone into the formal consultation process, we have been supporting one another in terms of attending formal public meetings to ensure that, where questions are raised in relation to services that are being provided either by us or by Hywel Dda, there is someone who can respond to that. For example, representatives from Hywel Dda were at our meeting in south Gwynedd, in Tywyn, and were able to give answers and reassurances on questions that related to services from Bronglais hospital, because, clearly, the population in the south Gwynedd area would look to Bronglais hospital initially for its acute services.

[160] Similarly, the three health boards attended a public meeting in Machynlleth, which looked at the impact of all three local health boards and we are continuing with that. We have two further public meetings next week in Powys, where we will present our proposals in one, and, in another, we are sharing a platform with Powys on our joint proposals. So, quite a lot of work has been going on in the last year and we have been conscious of the need to ensure that we complement each other in terms of the services that we are providing and ensure that our plans are not creating contradictions or difficulties.

[161] **Mark Drakeford:** Shall we pause there before we do the third part of Kirsty's question to see whether Kirsty has any supplementary questions on the deanery and cross-border planning?

[162] **Kirsty Williams:** I am concerned that we have managed to get to the public consultation phase after all the engagement exercises and that we are still in a situation where there is ongoing dialogue and a lack of clarity on issues around the postgraduate deanery and the use of trainees. Hywel Dda representatives were able to come here this morning and say that they had dotted the i's and crossed the t's regarding their relationship with the deanery; they are clear about the expectations of the deanery and where they will and will not have trainees and how that will affect their plans. You are saying that you have had useful feedback from the forum and are having ongoing discussions with the Wales Deanery. How have we got to this stage in the formal consultation process and you have not been able to lock all of this down during the engagement stuff that should have informed the consultation document?

[163] **Mr Lang:** Apologies; my comments were around the whole range of service-review work that we did. On the elements on which we are formally consulting, we are very clear about the deanery's position. The principal impact relates to neonatal training, and Dr Harrington can comment on that. My general comments were about the whole range of service reviews that we did, and an evolving position of us looking at risks and issues in other services. Where we are consulting, the principal change in terms of the deanery impact is on neonatal training, and Dr Harrington can respond on that.

[164] **Mark Drakeford:** Dr Harrington, by all means do so, but I want to be clear with you and everyone else that the committee is not exploring the specifics of the north Wales plan this morning. What we are interested in is the processes of consultation that you are going through with your local population that leads you to the conclusions that you have put in front of them and how you are testing proposals with them. If you want to tell us something about neonatology as part of your consultation, that would be very interesting—how you formed those plans and how you—

[165] **Dr Harrington:** Perhaps I could say something that is more about the qualitative relationship with the deanery, which is what I think Ms Williams was asking about. We are completely clear about what the deanery would like us to do. It is important to say that, in my particular specialty, it is not talking about reducing the number of trainees training in Wales; it is about the distribution of those trainees. The deanery has made it very clear that it would like the trainees to be concentrated in fewer sites. It has indicated to us that that would be on two sites, versus the three in north Wales at present; we are absolutely clear on that. What it has not indicated is a timeline.

[166] Furthermore, the deanery has gone beyond the present proposals, but in a less distinct way, to say that using its long-term forecasting of changes in paediatric training nationwide in the UK—not just in Wales—it can foresee a time, although, again, no timescale whatsoever was given, when there may only be sufficient trainees to be concentrated in one training centre in north Wales. It has included that almost as a discussion point for the future and not for present planning purposes. So, there are points on which we are very clear, but I would also concede that there are points, such as a timeline and the longer-term future, on which, between the two of us, we are not clear. Perhaps even the deanery cannot be clear on those points at this stage.

[167] **Mark Drakeford:** Thank you. I think that Vaughan has a point on this.

[168] **Vaughan Gething:** Yes, thank you, Chair. How do you present that difference between your view and that of the deanery and how does that impact on how you present to the public the future robustness and sustainability of the service that you are mapping out now and on whether you are really setting out a service that is sustainable in the long term? How do you present that difference in views to the public? Again, there is the point about the consultation being an honest one, in which you are upfront with the public about what you are proposing—how and why—and how that is set out in the document.

[169] **Mr Lang:** The first point for me is that what we are proposing is not a consultation about where we train doctors; it is a consultation on how we deliver services. I think that we are clear with the public in our documentation about where we propose to put those services. We have alluded to, and have discussed in our meetings, the challenges of recruitment, and looking at alternative professional disciplines in the way that we organise services. We have not led with the issues with the deanery because we are leading on how we deliver services. Training is an important part of that, but it is but one part. We have been honest with people that there are challenges in relation to how we do that and how we cover those areas where we will not have training for the future—

[170] **Mark Drakeford:** Sorry, I do not want to interrupt you, but the microphones in the room are not working. We just need to pause for a second to get them back up again. I am not sure whether Dr Harrington can hear us at all.

[171] **Dr Harrington:** We can hear you. From our end it sounds as though one person's microphone is still active and that it is the only one still picking up sound in the room. We can hear a lot of incidental quiet noises and Geoff's voice sounds quite faint.

[172] **Mark Drakeford:** Thank you. We will just have to have a break for a moment to fix this.

[173] **Dr Harrington:** I would be able to carry on at that level because I can hear Geoff.

[174] **Mark Drakeford:** Thank you, but we are not able to broadcast while the microphones are not working. We hope that they will be working again within a couple of minutes.

*Gohiriwyd y cyfarfod rhwng 11.25 a.m. a 11.27 a.m.
The meeting adjourned between 11.25 a.m. and 11.27 a.m.*

[175] **Mark Drakeford:** I hear that everything is working. Shall we just make sure of that? Geoff, could you just say a sentence, please?

[176] **Mr Lang:** Can you hear me now?

[177] **Mark Drakeford:** Yes, you are on. Dr Harrington, can you still hear us?

[178] **Dr Harrington:** Yes.

[179] **Mark Drakeford:** Thank you. Geoff, please resume from where you were in answering the question Vaughan put to you.

[180] **Mr Lang:** On whether we have been open with people that there are challenges involved in the options we are consulting on, yes we have been and, in our consultation document, we allude to the fact that there are real challenges in delivering the model of service. However, we have been very clear with people that that is about the service, and, when the board considered the options in front of it, there was a very real tension between the drivers and forces from the deanery in reducing training numbers and the real messages coming through from our clinicians and stakeholders and those who have been involved in engagement about what would constitute good accessible services in north Wales, and we are having to manage those risks. So, we allude to those in our consultation document.

[181] We made the national clinical forum responses publicly available and we have drawn people's attention to those, so we are not hiding from those challenges and we are being quite honest with people that we have got to work through this and come up with innovative solutions. Our clinicians are working with us on this and they believe that they can find solutions and that is what we will do in implementing this plan. So, we are not hiding the risk. We are being quite transparent that it is a risk. However, what we are trying to explain to people is that the alternative that the board considered would, in its view, have compromised access and the breadth of our service in north Wales to such a degree that it was less preferable than facing up to the risk and challenge in having to focus very clearly upon it.

[182] **Mark Drakeford:** Thank you very much. Elin, do you want to follow up that point on the national clinical forum?

[183] **Elin Jones:** Yes, I want to develop the issue to do with the Wales Deanery and the clinical forum's view on the two-site model for the delivery of various services being preferable to a three-site model for emergency surgery, a full accident and emergency department and consultant-led obstetrics. You are now consulting on a three-site model. The clinical forum itself has said that it will provide a response to the consultation and it may well be that it is similar to its view in the letter you published from it in July this year. It may be that its preference would again be for a two-site model for delivery of some of these services. In conclusion to this consultation, if you were to take the view that a two-site model would be preferable, would that require further consultation if that were significantly different to the proposals in the current consultation? Given the fact that all of this information is there already, would that be the end point, or would it require further consultation? That is just in terms of the transparency of the debate that is happening at this point.

11.30 a.m.

[184] I have just one other quick question. I asked the Hywel Dda health board, this morning, questions on the national clinical forum, but I did not have the advantage of seeing its letter from the clinical forum in advance of that discussion. It has been very helpful to have seen your letter; so, thank you for providing that. Given the alternative models of training that you have alluded to in your discussion with the Wales Deanery, there is a suggestion in this letter that that could possibly be substantially more costly to deliver; therefore, how are you scoping the cost implications of a three-site model with a changed training scenario?

[185] **Mr Lang:** To respond to that, I think that we need to be very clear that, at the time we met with the clinical forum, we presented a range of service review areas—clinical review areas—some of which have progressed to consultation, some of which the board consciously decided not to consult upon. So, I think that there is a really important distinction there. When we talk about acute paediatrics, obstetrics, gynaecology and non-elective general surgery, the board made the conscious decision that, in the light of the strongly held clinical and stakeholder views that had come through from the engagement, and also being aware of the challenges that the clinical forum had given to that in terms of deliverability, our clinicians should keep working to deliver the three-site model. So, we are not consulting on that. If, in the scenario that you painted, there is a response from the clinical forum that says, 'We do not know why you did not consult on these areas, and we think that you should still be on two sites', that is a separate issue. If we were to propose to move in that direction, it would be another consultation. We need to be very clear about that.

[186] In terms of the implications, the board directed the clinicians, who had been working on those areas, to undertake further work, to go through those risks in great detail, to cost up their proposals, and to bring back their plans, which would show how we could deliver this in north Wales. Again, as part of the consultation, we have made it very clear to people that there are still risks in those areas and we are still working them through, but we are not consulting on the change.

[187] In terms of the areas within the consultation document, we will obviously have to look at the responses as they come in. However, my understanding of the situation is that we will take responses on the specific issues in the proposals, and that is what the board will debate and discuss. If comments come through on broader issues, such as paediatrics and obstetrics, we will feed that through to our clinicians and the work that they are doing. However, it will not influence the outcome of this consultation because it is not part of this consultation.

[188] **Mark Drakeford:** At the moment, we are still finishing off the original questions that Kirsty put to you. So, I just want to make sure that we do that, then I will go to Darren

next. Kirsty had three questions for you: the first was on the deanery, which I think that we have probably now exhausted; then there was the question about how your plans had been factored into discussions with neighbouring health boards, which we have heard about, so I am happy with that; and the third question concerned how, in your processes, you have built in an assessment of the risk about deliverability. At the end of all this, what confidence will you be able to give your local population that the plan that you agree is a plan that you can actually implement?

[189] **Mr Bradshaw:** In terms of the areas of service and service model that we are consulting upon, we have looked at the key risks in terms of deliverability and sought how we could mitigate those. For example, our proposals in terms of community services require some capital investment; however, we have been discussing our capital investment requirements with the Welsh Government for in excess of a year now, so they are actually factored into the forward looking all-Wales capital programme. There is nothing, from a capital perspective, that is being proposed by this model that is going to be a surprise. We are not making assumptions, thinking, ‘We can do this, provided that we get the capital’; we have had the discussions about the capital. While capital remains challenging in terms of a resource, it is there in the forward plan, which is quite important. Similarly, if we take the workforce as an example, again looking at the community model that we are proposing, it is based on pilot schemes that we have run in north Wales. So, we have experience in terms of the type of staff we require. Basically, in most instances, it is about our staff working differently, and we already have evidence and experience of how we can do that. So, we have looked at those key risk areas and how we could mitigate against them.

[190] **Mr Lang:** May I add one point to that? The criteria that we asked the clinical groups to work through in coming to their preferences and the options that they felt were appropriate may be helpful context. One of the clear criteria was deliverability, and that included workforce aspects and other aspects. The proposals that the board are moving forward with are only those that were considered to be deliverable by clinicians. Each of those has different risks, and we will have to work through some of those, as Neil said, but, as part of our development process, if an option was felt to be not deliverable, not sustainable or not acceptable, it fell at that stage. So, there was a clear assessment by clinicians that these would be deliverable options, albeit with challenge.

[191] **Kirsty Williams:** I am grateful for that. I appreciate that that is a process that you and your clinicians went through and you have come to a view. What gets concerning is that, having gone through that process in north Wales, you have come to the clinical forum and it has raised in its letter to you, on a number of occasions, the deliverability and sustainability of the plans that you have come forward with. What processes are you going through now in your deliberations on the areas where the clinical forum has been quite stark, in terms of obstetrics and paediatrics especially, about its view on their sustainability and deliverability? What happens in this process now that it has told you that?

[192] **Mr Lang:** Those two areas in particular are areas on which we are not consulting. As I indicated in my earlier response, when the board considered those areas where the strong clinical and stakeholder consensus was to maintain three sites in north Wales, the board commissioned the clinicians to go away to work through those risks and come up with a feasible plan. So, those clinicians are working through an ongoing trail of work, and they will come back to the board with their plans for how that can be delivered. We flagged up that there are risks with that. There is the potential that, at some point, that might fail—I think that we would acknowledge that—because we do not know the answers to all the questions, but we believe that it is the right service model for north Wales and, therefore, we did not feel that it was appropriate to give up on it without working through all those potential ways.

[193] **Mark Drakeford:** If you work through them all, and you come up with a plan that

you think is deliverable, will that plan have to be tested again by the national clinical forum? Is that part of this process?

[194] **Mr Lang:** I am not sure, to be honest.

[195] **Mr Bradshaw:** I would suggest that it would be good practice, because we would be responding both to the process that we have had to date with it, but also to any comments that it may make formally in terms of the consultation. You are quite right that it has raised the issue that there are risks in terms of the deliverability of the services that we are currently not consulting upon and do not intend to consult upon and, therefore, we would have to satisfy it.

[196] It is important to say also that if you look in the letter, you will see that it acknowledges that services should not be based upon training needs, and it very much agrees with the principles of what we are doing and understands some of the specific issues in north Wales. It is clear that it recognises that we should exhaust all opportunities to address some of the concerns that it has raised.

[197] **Mark Drakeford:** We will move to Darren next and to a new set of questions and then there may be follow-on questions that Rebecca will want to ask and then Lindsay.

[198] **Darren Millar:** First, I congratulate you for taking on the view of the national clinical forum and the royal colleges, which were very different to the pattern of services that you were planning in the consultation document. I also congratulate you on being honest in your document about some of the financial challenges that are ahead for you, as a health board. I think that you set out three significant challenges as to why you need to undertake some service change, and the financial challenge is included and I appreciate that.

[199] One of the things that concern me is that all health boards in Wales have to abide by some very clear guidance from the Welsh Government on how they conduct themselves through the engagement process and, indeed, the public consultation process, and yet the interpretation of that guidance seems to be very different in north Wales when compared with Hywel Dda health board, for example, from which we took evidence earlier. It is holding public meetings around its health board area that are free-for-alls, where anybody can turn up without having to pre-register their attendance, whereas in the Betsi area there is a pre-booking arrangement. It is also sending senior chief officers to attend other people's meetings as part of that public consultation programme, but in north Wales, your board is not. In addition, there are options set out within the consultation document from Hywel Dda, whereas you have taken the decision not to include options, but simply to say, 'This is what we want to do'. On the financial side of things, it appears that there is much more detailed financial information available for the public to scrutinise in the Hywel Dda board area than there is in north Wales. Given that you are both working to the same sets of public consultation guidance issued by the Welsh Government, why are you taking such different approaches?

[200] **Mr Lang:** Perhaps I will answer a couple of the general points, and then I think Sally will pick up some of the detail about the process. The guidance is clear as to the principle of what you should do. It is not explicit in every detail about how that should be enacted, and one of the things that we wanted to make sure was that our process was appropriate and robust and in the spirit of and following the letter of the guidance, so we did quite a lot of work before we started on that. We worked very closely with the CHC, but also invited the Consultation Institute to come to look at what we did to compare with good practice. So, in the design of our approach to engaging with the public, the meetings that we would have, and how those would work, we were in line with good practice that the Consultation Institute would support. I have to say that it was an explicit decision to encourage more of a conversational, interactive discussion with people. There are advantages with major open meetings, and disadvantages in terms of some of the content and engagement that you get

with people. It was a conscious decision to go for smaller groups because we wanted a qualitative discussion that we thought would be beneficial.

[201] On the financial issue, before I pass to Sally on the detail, that has come through. We made the headline statement. There is always a debate about how much detail you put in a public consultation document, and we have produced a series of supplementary papers as we have gone through the process. Finance is one of those papers where we have set it out in a little bit more detail; the fact is that the headline in the consultation document says that it is affordable, but people have said, 'Show us where you are saving the money and where you are spending it', so we have actually produced papers that do that. We have refined this as we have gone through and reacted to some of the responses that we are getting. We did not draw a line and say, 'Well, that's it now until 28 October'. We have adapted as we have gone through. Sally, you might want to pick up some of the detail about our approaches.

[202] **Ms Baxter:** Yes, if I may. Specifically regarding pre-booking for the meetings, Geoff has already referred to the fact that we thought that it was good practice to ask people to contact us, partly so that we could manage the process in terms of having a good, constructive debate with people. Many people have fed back that they have found the meetings useful in terms of having that constructive debate, so that there was an opportunity to put all their questions and to hear the answers from us. They have found that a useful discussion session, and it has given more information to people. It also enabled us to find out people's specific requirements in terms of any disability support, mobility support and interpretation, so we have been able to respond to people's needs more proactively than if it had it been a drop-in session; we have been able to have that range of approach available for people. So, I am comfortable with that approach that, as Geoff has said, has been identified as good practice by the Consultation Institute. We have had a Freephone line set up, so there is no cost to anybody to call in to book their places. When people have turned up at the meetings, and there has been space, we have accommodated them, and there has been no issue with that. I would say that the only meeting where we have had an issue regarding people being unable to come in because of space was one meeting in Flint, where there was a large gathering because a petition was being presented and they wanted to be visible. The petition was received, the march was welcomed and negotiation was undertaken with members of the march for some of them to come into the meeting so that a representative group was accommodated.

11.45 a.m.

[203] On the whole, we have looked at the figures, we have looked at the people who wanted to make bookings for the meetings, nobody has been turned away from those meetings and we have accommodated everybody who wanted to come in.

[204] **Darren Millar:** May I just check? What has the average attendance at those meetings been?

[205] **Ms Baxter:** It does vary across the patch. Some have not been very well attended, and we are looking at why that should be. We have had other meetings in those areas with different groups to capture more input and opinion. Some of them have been virtually full. So, overall, in the whole series, we have had 48 different meetings—48 different sessions—across north Wales and something near 1,300 people have attended them. Add to that the meetings that we have held with third sector groups, town and community councils fora, local authorities and different interest groups, in a process that we are still going through, and we think that we have had a considerable reach to talk to people about our proposals.

[206] **Mark Drakeford:** For those of us who are less familiar with what you have done, can you give us just the numbers? I do not in my mind have a clear idea of what a low number of people attending would be and what a high number would be.

- [207] **Darren Millar:** It was as low as seven, was it not, in parts of my constituency?
- [208] **Ms Baxter:** Yes, there have been some low numbers at some of the meetings. Seven is a figure that we have for one of the meetings, with as many as 95 or more at other meetings. So, it is a very broad range, depending on the level of interest in the issues.
- [209] **Mark Drakeford:** Thank you; that is helpful. So, it is as low as seven and as high as nearly 100.
- [210] **Ms Baxter:** Absolutely.
- [211] **Mr Bradshaw:** It is probably worth remembering that we had 48 meetings in 16 locations. In each location, there were at least three meetings, timed throughout the day. So, while some meetings might have been poorly attended because of the timing, others were better attended. It varied from as low as seven to as high as 95.
- [212] **Darren Millar:** Can you just clarify that when you say that you have had 48, that figure is divided by three in terms of the dates and locations, is it not?
- [213] **Ms Baxter:** It is 16 locations.
- [214] **Darren Millar:** So, it is effectively 16 public meetings repeated three times per location on the same day—at 2 p.m., 4 p.m., and 6 p.m.—is it not?
- [215] **Ms Baxter:** Yes.
- [216] **Mr Lang:** It is 48 meetings on 16 dates.
- [217] **Darren Millar:** Okay. One thing that I am struggling with is that there is much better public engagement, it would appear, when people can turn up to events to hear more about proposals without there being a pre-booked appointments system. I can appreciate that you want to accommodate any needs that individuals may have, but other health boards appear to have been able to accommodate people's needs and still have open-attendance public meetings. I get a lot of complaints about the fact that people have to phone to book, and there is a suggestion that that is a barrier to their ability to participate in the ongoing consultation. Where there has been low attendance, are you planning to hold further engagement exercises, particularly in view of the fact that there were some Royal Mail failures in the delivery of the little leaflet that was sent out to households?
- [218] **Ms Baxter:** Certainly. One of the things that we would like to do through this process is to look at attendances in other areas and see how comparable they are. I think that they are probably broadly comparable in terms of numbers of population to date, but we will clearly learn from that as we go forward.
- [219] In those areas where we have had low attendances, we have, as I said, looked at other means of contacting people. We have targeted specific groups and we are talking to third sector groups in those areas. In any case, we have a programme running right through the consultation period that is doing that.
- [220] The issue that you referred to regarding the Royal Mail was the additional step that we took above all the other press releases, with the launch of the consultation and the wide distribution of information, and I can give some details on that if it would be helpful. However, it was an additional step that we put in place to ensure that we had made all reasonable efforts to contact every household in north Wales. We did have some feedback

from people in a couple of areas that had not received their leaflets. We undertook an investigation with Royal Mail, which confirmed that there were postcodes in the Colwyn Bay area that had not received the leaflets—no, forgive me: it could not guarantee that they had received those leaflets. So, the Royal Mail has redelivered those at no charge to the health board, and we are now receiving some phone calls from those people and we are looking to have a further session for them. Depending on the numbers coming through and the best timing and placement for them, we will have another session.

[221] **Darren Millar:** The one area that you have not responded on is the rationale behind the board's decision to say, 'This is our plan', rather than present a number of options.

[222] **Mr Lang:** I will make just one final point in response to your previous question, and then I will come to this one. The other question was about the rationale for the small numbers at the meetings. We spent a lot of time talking to the Consultation Institute about how we could get good-quality engagement that is a genuine dialogue about things. One aspect of that advice was that smaller groups are better for that engagement than bigger groups, and that has been reinforced.

[223] Regarding options, as part of the stakeholder pre-engagement process, we worked through a range of options and we debated whether or not we should go to the board with options and consult on those. The strong message that we picked up from those involved in the process was that the board needed to show leadership. If the board believes that there is a right way forward, then the board should be straight and say so to people. There was a debate about whether we should go with a range of options that we were open-minded about, or where we had a clear view as a board, we should say, 'We think that this is the right direction, which we are commending for public consultation to hear people's views on it', so that we get views on the direction that the board believes is the right way forward. So, it was a judgment at the end of the day, informed by the strong message that if you have a range of genuine options, put them out there, but if you believe that a certain way forward is the right way forward and that is where you are heading in terms of proposing it to the public, be honest about it and say, 'This is our proposal'. That is where we found ourselves.

[224] **Darren Millar:** I have a final question. Many individuals in all sorts of different areas will organise public meetings of their own, including Assembly Members, councils and so on. The approach in Hywel Dda LHB was that it sent representation to those meetings to explain the health board's proposals. However, there has been reluctance in Betsi Cadwaladr LHB to send representation. What is the rationale behind that?

[225] **Mr Lang:** As Sally mentioned, when we started the process we set out a whole raft of groups that we would go to and formally engage with. We then received a series of comments, as you rightly say, where people said, 'We would like to have a local meeting; can you bring someone along to that?' We ultimately had to make a judgment as to whether we felt we were able and capable to respond to every request to have someone at every meeting to do that, or whether we were not confident that we could achieve that. Therefore, the judgment we took was to have the meetings and to encourage feedback from them, and we have actively sought that feedback. We also made sure that our information was available in order to receive that feedback, knowing that we had other meetings in communities that would also pick up feedback. So, it is not that we were cutting out a whole raft of responses, but that it has been managed in a different way. That was the position that we took on it.

[226] **Darren Millar:** The suggestion is that there has been hiding.

[227] **Mr Lang:** If you look at the number of meetings that we have had with various organisations, the number of times we have had sessions with the public and the work we have done with stakeholders and others, it would be difficult to say that we have hidden from

the issue. If people were organising a meeting, I can understand why they would want the health board to come, but we did not feel that we could accommodate that in the process.

[228] **Mark Drakeford:** Lindsay and William want to ask questions on this, and I will come back to you after that, Darren; I will give you one more go.

[229] **Darren Millar:** It is on that point, because it is important.

[230] **Mark Drakeford:** Okay, I will not come back to you after.

[231] **Darren Millar:** Public meetings are the ones that you have declined to attend. I accept that you have attended stakeholder meetings, but you have refused to attend every single public meeting.

[232] **Mr Lang:** We arranged our own meetings to engage with the public, and we fully respect that other people may want to arrange their own meetings in their communities. We are quite comfortable with that, and we are happy to get their feedback. For the meetings that we arranged—albeit with the caveat of the process, which some people have supported and others have not—if we found in a particular area that we had 400 phone calls for a meeting when we only had 150 places, we would have put more events on. That has not been our experience. People have organised other meetings, and we have respected that and we have received their feedback.

[233] **Lindsay Whittle:** Part of the reconfiguration is the older people's mental health strategy. How did you engage with older people and their families, and was it in plain Welsh and plain English?

[234] **Ms Baxter:** A lot of work was done in that particular field before putting proposals to the board. We engaged with social services, who were partners in the work that was done. We also engaged with the staff of local authorities and third sector groups, and service users and carers were also well represented at the different stakeholder meetings that were held. We have given information about the range of drop-in sessions held in different areas across north Wales and north Powys for mental health services as a whole. Service users and carers were certainly represented at those meetings and have been actively involved in the discussion before the proposals were put to the board.

[235] **Lindsay Whittle:** What about the families?

[236] **Ms Baxter:** Forgive me; when I say 'carers', I am referring to informal carers—the families of the people who would need care. They have been involved. We carry on with that. It is about working with service users and carers as part of our overall engagement strategy to ensure that we have representatives and that we hear their views directly.

[237] **Lindsay Whittle:** Is that done in good plain language in Welsh or English?

[238] **Ms Baxter:** Of course.

[239] **Rebecca Evans:** Returning to a couple of points that Darren made, particularly about the booking system for the meetings, I was one of the casualties of that system. I was unable to secure a place initially and was added to the waiting list. By the time I was offered a place, I had another engagement, so I was unable to go along and represent the views that had been given to me. That is some feedback to consider.

[240] I would be interested to know about the logistics of how you consult over a rural area, particularly with respect to Dwyfor, because that is the area that I represent. There were only

three meetings for 50 people each in Pwllheli. Why were there no meetings in other centres of population such as Porthmadog, Criccieth and Nefyn, so that people could have their say in those places? Why three meetings in Pwllheli but none anywhere else?

[241] **Ms Baxter:** The meetings were targeted to cover localities across north Wales. We looked to have a spread of meetings across the geographical area. Meetings were set up in a centre that people could get to, which is why Pwllheli was one of the areas that was chosen. We undertook a number of meetings in the whole south Gwynedd area. I accept your point that Porthmadog was not one of those places, but there were meetings in Tywyn and Blaenau Ffestiniog. There were a number of meetings that were targeted at the different localities that we have across north Wales; 16 dates were available across the whole of that area.

[242] **Rebecca Evans:** The Dwyfor area covers 30,000 people, so you would imagine that there would be views beyond Pwllheli. I will ask you the same question that I asked earlier this morning about petitions. I know that you have had a petition of 4,000 names regarding the Blaenau Ffestiniog memorial hospital. What response will you give to that petition and what weight will you give to the views expressed?

[243] **Mr Lang:** We have had a petition from Blaenau Ffestiniog, and one was presented to us at our meeting in Mold. We understand that there are at least two others in circulation at the moment. They have been formally acknowledged as part of the consultation process. As part of our standing orders, aside from the main consultation feedback, they will be reported to the board in public session as explicit petitions received by the board. The chair reports all of those in detail, and we will ensure that as part of the consultation analysis—as well as that separate reporting—the numbers and the weight of opinion that has come from those communities will be reflected in the response that goes to the board.

[244] **Rebecca Evans:** May I ask a question on a slightly different topic, Chair?

[245] **Mark Drakeford:** Before we move on, I wish to ask one last question. One might argue that from this morning, we have heard two rather different approaches to the business of consultation. The Hywel Dda Local Health Board approach, as I think it was explained to us, was to try to cast the net as widely as possible and capture, inside its own process, as much as possible of the activity generated by all the proposals—open meetings, sending people to other people's meetings and trying to capture as much as it could in its process. The representatives will say that there were downsides to that and things that they would do differently, so I am not saying that theirs was the right approach. Yours seems to be a different model, in which you set the rules, you decide to whom you will talk and what you will talk to them about; if they want to talk to you, they have to let you know beforehand that they are going to do so. You are happy for anybody who wants to talk separately to carry on doing so, and if they want to tell you what they have talked about, they can let you know. It seems to be a very different model. Sally, you spoke about some of its advantages and what the pluses are. Do you think that you have lost as well as gained things in the way that you have gone about it?

12.00 p.m.

[246] **Ms Baxter:** What I would like to reflect first of all is that it is not just the 48 different sessions across north Wales that have been part of our process. We have gone to other meetings that people have held, we have targeted third sector forums, town and community council forums, local authority workshops and different patients' groups, and we are now working through different equality groups. We are making sure that we are targeting a whole range of people, going out and speaking to them on their turf, if you like, in the groups that they have and presenting the consultation to them. We are perfectly happy to pick up any other issues that might come up from those meetings. I am not entirely sure about the

reference to speaking to them about what we want to speak to them about. We have taken our consultation proposals to them, quite clearly, but, in each meeting, people have raised different issues and we have had feedback about other aspects of the health board's services, and there are other issues that people might want to talk about. We are noting all of that feedback as well.

[247] In terms of the spread of meetings, it would be worth remembering across north Wales that there are six local authority areas, which means six sets of town and community council fora and six sets of third sector fora. So, the spread of people that we have contacted as part of the process—and listened to requests from them to discuss different issues—is very broad. We are quite comfortable with the breadth of the consultation, and with the opportunity for people to talk to us about issues that they want to talk to us about as well as solely the consultation proposals. Inevitably, we will learn things from the process regarding how that has gone. We understand that the booking system has caused some concerns for people. We are sorry if that has put anybody off from being involved. We are making attempts to follow that up with these other meetings to capture as many views as we can.

[248] **Mr Lang:** I would like to add one point that we have not touched upon, and which is another strand of the consultation, and that is the independent work that we have commissioned from Opinion Research Services to contact individual households, undertake stakeholder forum meetings and other methods of gathering opinion. That is another reach into the community and it demonstrates that we are trying to reach into the community. Inevitably, there is a debate about whether open public meetings or other ways are the right way to do things. As I said in my introductory comments, there may be a reflection on the guidance about whether we need to have a more standardised approach in Wales. We can genuinely say that we have taken advice to ensure that the methods that we have adopted are recognised, valid methods that should get a good dialogue with the community and enable us to get views back. From that perspective, I am quite positive about what we have done, but I recognise that there is a question about where the role of open public meetings sits in this.

[249] **Mick Antoniwi:** Is the model designed as it is because, effectively, you have the masterplan and you are not offering people options? Is that why the model has been designed in that particular way, because it seems to me that consultation is difficult when you are being offered a sort of take-it-or-leave-it solution?

[250] **Mr Lang:** I do not think that that has influenced the method that we have adopted. What we have tried to do is generate a number of ways in which we can have a meaningful dialogue about our proposition. Whether that is a range of options or a single option, we still believe that the methods that we are engaging are positive ones to have meaningful engagement and dialogue, and that is what we have been trying to achieve.

[251] **Mr Bradshaw:** The only difference—and what we are debating here—is that of the definition of an open public meeting. Our public meetings are open; the only thing that we have required is for people to phone and book in advance. That was based upon best practice and advice that we had taken. It is recognised elsewhere as being best practice as a way of making sure you have a meaningful debate. That is the principal difference between us and Hywel Dda LHB. Otherwise, I would say that we have engaged and sought to capture as many views as possible. The public meeting is not the only approach; there are many other approaches.

[252] **Elin Jones:** It may be best practice to pre-book to go to the Glastonbury festival, but I cannot see that it could be best practice to have to pre-book to go to a public authority's consultation event. I accept that you have accepted that possibly it was not the best way to gain public engagement, but I am finding it difficult to understand why you ventured down that route in the first place. I cannot subscribe to the fact that anybody could come here and

say that it was in any way best practice to pre-book for a public engagement by a public authority.

[253] **Mark Drakeford:** Sure, but you say that that is the advice that you had, Mr Bradshaw: you had taken advice and the advice was that that was the way to do it. People have different views on this.

[254] **William Graham:** On this point, did you take general advice from the Welsh NHS Confederation?

[255] **Ms Baxter:** Yes. There were discussions with the Welsh NHS Confederation throughout the process about engagement consultation and support, staff engagement and so on, so, there have been ongoing discussions regarding the process that we have taken.

[256] **Mark Drakeford:** Before I go back to Rebecca, there is one last question from me arising from what we have just been talking about. I think it was Kirsty who asked the Hywel Dda representatives how, although they were putting options in their case, if other options emerged through the consultation, for example, if someone came along and said, 'You should do it this way', that other option would be tested in the consultation process. Would it be given equal treatment in relation to the assessment of it, compared to the options that the board itself was advancing? They explained to us how those other options would be part of their ongoing consideration. Given the fact that you were offering people one option, you could argue that it is even more important that, if the process of consultation results in new views being put on the table, that those new views get a fair hearing through the consultation process. Could you explain to us how that would be done?

[257] **Ms Baxter:** First of all, regarding the single option, in a number of the service areas in the consultation documentation, where there have been options that have been closely considered, and where we have had different views expressed in reaching that point, we have spelled those out in the booklet. So, we have been quite clear, for example, regarding vascular services, that a couple of options were being considered and there are different views, that the board's view is that a certain way forward is the way we would like to pursue for consultation, but then in our consultation questionnaire we are asking people, 'Do you accept this view and if not, do you have alternative proposals?' So, it is clearly asking people for those alternative proposals. Again, it is part of good practice in consultation, that, if alternative proposals are put forward, the board will consider those. So, we are receiving different levels of feedback in relation to community services, and also some of the acute services that are being consulted upon. They will be considered by the clinicians, the clinical programme groups and the board, prior to any decision being made. That has to be part of the process. Equally, in our guidance on engagement and consultation, the community health council can put forward alternative proposals to us. That is a clear part of the process, absolutely.

[258] **Mark Drakeford:** Lynne, did you want to ask a question on this point?

[259] **Lynne Neagle:** I agree with what Elin has said. I think that it is a very strange way to do things and I cannot imagine that many people in my constituency would have gone along, because it is a bit like booking for a conference, with the expectation that you might have to speak, whereas some people might just want to go along to listen. Obviously, you had some meetings where you knew in advance that you were only going to have a very low attendance—you referred to one having only seven people present—did that mean that you were then able to go out and drum up support in those areas? Did you have any situations where all three meetings in a particular area were poorly attended?

[260] **Ms Baxter:** To answer you honestly, in relation to actively asking around to drum up

support, I cannot say that we took a very proactive approach in terms of large publicity campaigns if numbers looked low. However, we did contact local organisations to see whether they understood what was going on to try to encourage people to be there. Clearly, as part of this, we had a lot of discussion with people on the phone and also by e-mail correspondence to try to encourage people to come to the meetings. A press release was issued to local papers before each meeting was held, so a reminder was put out for people. We are grateful to certain areas where the community or town councils were very proactive with us in contacting people, so we are grateful to those bodies for encouraging attendance at the meetings. Where we have had low attendance, we have tried to look at why that was, and, in the case of Colwyn Bay, having recognised that it was an issue, we have responded by redistributing the leaflet and we are putting on an extra session there for people to be able to give their views.

[261] **Lynne Neagle:** So, does that mean that all three sessions in Colwyn Bay were poorly attended?

[262] **Ms Baxter:** I think that Colwyn Bay was one of the ones that was poorly attended, yes.

[263] **Lynne Neagle:** You would have known that in advance, through this pre-booking system, so you could, in theory, have taken some action at the time to drum up support, I think.

[264] **Ms Baxter:** Again, a press release was put out as a reminder in the local press to encourage people to attend. So, that was a step that was taken for every meeting, in any case.

[265] **Mr Lang:** We did not just rely on the leaflet. We have had—as you can imagine—very good press coverage and each time the phone number was being carried and the arrangements very clearly communicated, so there was, I think, a good general awareness of the issues running up to those meetings.

[266] **Ms Baxter:** I have an additional point in relation to some of the areas where attendance was poor. We are monitoring the responses we are getting by way of e-mail correspondence and returned consultation questionnaires. There is a good level of return from those areas. So, we are receiving feedback from those populations about their views on the priorities for those areas. Part of our ongoing process, with the community health council and the Consultation Institute, is monitoring the feedback from the consultation process and targeting areas if we are not receiving feedback from them. Although there was an issue with the meeting in Colwyn Bay, we have received a good deal of response through written letters—free-form text—and returned consultation questionnaires. So, we are making sure that we are receiving the feedback we need from the people in those areas.

[267] **Vaughan Gething:** There is a link here to the consultation and how you are running it. I share other committee members' concerns that pre-booking is not an effective way to engage with the public. On the point about how to make the consultation meaningful, going back to the point about presenting one option, I will use as an example your comments about wanting one site for vascular surgery. In your document, you say that you had more than one view from clinicians, but that your view is that there should be one site. Are you still of the view that that is an effective way to have a meaningful engagement with the public, many of whom are not aware of the difference between the view of your clinicians and the fairly broad statement in your document? Will you still proceed with the rest of your consultation on that basis of offering one option, rather than having alternative options with more pros and cons? Do you not see that as an alternative way? Also, what about the view of the Royal College of Surgeons on your proposals? What about giving the public enough information for them to engage with you on the judgment that you are then making in your single proposal?

[268] **Mr Lang:** Just to clarify, the view of the Royal College of Surgeons is an aspect that is not subject to public consultation, so—

[269] **Vaughan Gething:** It is information that might be useful to the public.

[270] **Mr Lang:** Perhaps. The guidance is that you should be very clear about what you are consulting on and what you are not, and that aspect is not included. In our discussions with people, we have said that there are areas that the board has determined not to change, although that is not without risk. We made that quite clear. On our discussions on vascular services, the example that you have used, what we have said, and we have alluded to it in the document and have explained in our meetings that there is a good evidence base to move from three sites in north Wales. The evidence base between two sites and one site is more marginal in terms of the benefit, and that is where the difference of clinical opinion lies. We have also taken on board comments from other areas. We have been really honest with people in saying that the board's judgment, and therefore what we are seeking views on, is that moving to one site would be the right thing to do. If we get responses back from clinicians—which we may well do, because they are part of this consultation in the same way as anybody else—and from members of the public questioning that and seeking the board to reconsider, as Sally said, we will have to take that on board. However, it is very important for us, having determined that that is the proposition on which we are consulting, to be clear and consistent on the proposition. The debate and discussion have evolved as we have gone through the process. If people have asked for more information, we have given more information. When they have asked whether our clinicians are supportive of this preferred model, we have been honest and said, 'No, there is a difference of opinion here'. So, I think that is a genuine, true statement of the position and reflects the role of the board in having to make a decision and put a proposition to the public, and then to genuinely hear their views. The test will be when the views come back in for the board to demonstrate how well that has been worked through and considered before any final decisions are made.

[271] **Vaughan Gething:** The point is that you may genuinely want to consult on that as an option, but do you not consider how ordinary members of the public, who are affected by the service and rely on it, would view a consultation where there is a single option? I would expect many members of the public to see that as a *fait accompli*. Presenting in that way, as, 'Here is the single option', is a barrier to effective engagement and consultation, rather than aiding it.

[272] **Mr Lang:** I can understand that view.

[273] **Mark Drakeford:** However, you have taken a different view.

[274] **Mr Lang:** We have taken a view on that.

12.15 p.m.

[275] **Mark Drakeford:** I think the point that Vaughan was making—this will be the last point on this, as we are moving to a different subject now—is do you think that, if you decide on a single-option model, for the reasons that you have given, there is a higher obligation on you, having decided on that course of action, to provide the public with the evidence that you have drawn on, which may not all be in one direction, in coming to that preferred option? If you have choices, the debate emerges through them. If you do not have choices and you have a preferred option, you have to provide the public with a higher level of information to allow them to understand how you have come to that option.

[276] **Ms Baxter:** That is a fair point. We had a strong approach in north Wales throughout

the previous engagement. We did a great deal of work in looking at the evidence base for the different service proposals, which are publicly available on the consultation website; that work has been available to the public for the last 18 months, since we have been working through these service reviews. All of that information has been in the public domain. The minutes of the discussions, the agendas and the papers relating to the different service reviews are in the public domain on our website and have been discussed at previous stakeholder meetings, culminating in the board papers in July, which contained the different options, which are also publicly available, with the explanations of the reasons why the different options were being put forward by the clinical working groups. It is a fair point, and yes, the information is available to the public.

[277] It is a fair view that a single option may be a barrier to discussion. However, that has not been my experience at the public meetings that we have had. We have had some really good discussions with people, who have been asking those questions. We have been discussing the evidence and reasons why our clinicians may have different views. People put a lot of faith in the views of clinicians, and it is interesting for them to hear that there are different views, even among clinical groups. I do not feel that it has stifled the debate. We have had a healthy debate on that. There has been a better understanding among the public and us about the issues and the impact on people.

[278] **Mark Drakeford:** We will have the last question on this from Elin.

[279] **Elin Jones:** I have a quick question on that. Your clinicians have a different view to the board on the options presented. Neonatal intensive care is an example of this; you have been transparent and said in your document that your clinicians preferred a north-Wales solution but that you preferred an out-of-Wales option. In the public meetings, are those clinicians who have a different view to your board given the right to air those views? Are they able to contribute as part of the board in the consultation?

[280] **Mr Lang:** Clinicians have come to the meetings and have made those contributions.

[281] **Elin Jones:** You have not sacked them.

[282] **Mr Lang:** Absolutely not. [*Laughter.*] It is important, for the sake of clarity, to say that, where we are consulting on an option that is not the clinical preferred option, we are clear that its clinical viability was supported; the clinicians supported it as a feasible option but not as their preferred option. The board did not go against clinical advice that an option was not viable and feasible. That is an important principle. It is then a judgment matter. Ultimately, that is the board's responsibility; it has to stand up and make those recommendations and proposals.

[283] **Mark Drakeford:** In the last 10 minutes, we will try to squeeze in two issues, which I hope are different. I will go to Mick first, who has not yet had a chance, and then Kirsty for the final round.

[284] **Mick Antoniw:** With an eye on other processes going on, what would be the two main lessons that you have learned? What things have not worked well and what things have worked very well? If you were starting this process again, what would you do differently and what would you definitely say are good ways of carrying out consultation, et cetera?

[285] **Mr Lang:** I will go back to the engagement process as well as the consultation, because we should look at the whole package. The work that was done within the health board, led by our clinicians, which involved a number of stakeholder events to look at the criteria of how we should assess what are viable options and how we should move on, is good practice. We can demonstrate a lot of learning and how the views of staff groups,

stakeholders, patients and relatives influenced our plans as they moved forward, which is positive. There is a lot to be said for the way in which we worked through that process and came to the proposals so that, essentially, by the time they came to the board, the viable options were supported by clinicians. There were some differences of views, but I think that that is really positive.

[286] Reflecting on the consultation, we are getting a good rate of response and lots of feedback. We will probably know only at the end of the process whether we have the coverage that we need. It is important to say that we have to reflect on the process and form a judgment as to whether we have the balance right, or not. We believe that it was a robust plan—we continue to believe that—but we will have to reflect on that and learn from it when we get to the end. Sally might want to comment on the amount of work that we did to identify stakeholders and people to whom we would target information. That was also very positive.

[287] **Ms Baxter:** We looked very closely, before and during the engagement process—before the consultation process—at our stakeholder lists, or database. We mapped the groups that might be interested and developed a scoping document that identified those groups, which was approved by the Consultation Institute. We have an extensive database of contacts across north Wales and we have proactively targeted information to those groups—not only statutory partners and voluntary sector groups, but a range of groups, such as Communities First groups, older people’s groups and individuals who stated an interest in being involved in the discussions. We have been as proactive as we can be in relation to identifying people with an interest and specific groups.

[288] We had a wide distribution, to which I referred earlier, of the documents and publicity. They were made available in libraries, one-stop shops, local authority receptions, all our health premises, voluntary sector groups, GP practices and pharmacies. So, the information has been circulated widely and we have been proactive. That is demonstrated—withstanding the concerns that you raise and that we acknowledge, regarding the attendance at meetings in some areas—as Geoff said, in the feedback received and in the number of responses. We know that we have had something like 10,000 hits on our dedicated website, 3,000 or 4,000 downloads of the document, as well as the hard copies that have gone out, and significant e-mail traffic and phone calls, to which we have responded. Clearly, we will judge this based on the responses that we have, at the end of the process, and learn from it. We can always learn from going through the process. There was an issue regarding the Royal Mail distribution; we made every reasonable attempt to ensure that we contacted every household—that was beyond our control and we are trying to rectify it. So, there are issues like that from which we can learn.

[289] **Kirsty Williams:** Could you outline what steps you have taken to engage with GPs? The document reflects a major shift of services into the community, and the inference from the clinical forum letter is that, perhaps, GPs have not been as embedded in this process as they would have liked. Could you outline that?

[290] I feel sorry, because you have been compared with and contrasted to Hywel Dda all morning. However, it seems to me, from listening to Hywel Dda health board this morning, that, having been battered and bruised by the 2006 experience, where it tried to pick out individual services, it decided on this occasion to go for a big-bang approach. So, the whole lot is up for grabs and it is all out for one consultation. It is doing it now and will take five years to change it all. It seems that your approach has been to pick off parts of the service, and that you have parked the really big, controversial stuff—not that I am saying that these issues are not controversial. It is quite clear, from the national clinical forum’s letter, that it feels that you will have to come back to that at a later date. Was that your deliberate strategy? You could not do it all in one go, as it is too big and too difficult, so you will do a bit of it now, knowing full-well that you will have to come back to a lot of the stuff that you have parked

and not gone out to consultation on at present. The clinical forum seems to suggest that you will have to do that.

[291] **Mr Lang:** I will take the last point first, then come back to your point on GPs. There are a couple of important markers. Pre-dating the health board, a lot of work was done with clinicians and stakeholders. Going back to *Designed for North Wales*, which was the comparable document, one of the issues nailed was the basic footprint of emergency care for north Wales. We do not think that that has changed. The board looked at access to emergency medicine and emergency departments and so on. That was very widely engaged on and discussed and had clinical consensus. We looked at it, and did not see that the footprint had changed. That was a conscious decision that was ratified by the new board when it came in as part of looking at its clinical strategy. It was considered to be the right thing to do.

[292] If you look at our engagement process, you will see that we did look at the thorny issues. I would like to think that, if you ask the clinicians who were involved in the process, they would say that it was a true and fair process that we went through and that we listened to people's opinions. It was extremely challenging and the board was extremely challenging, but the conclusion—looking at population need, the geography of north Wales and what the clinicians want to deliver and believe they can deliver—was that staying with three sites and not consulting was the right thing to do. So, I do not believe that the board parked issues. As I said in an earlier response, there are genuine risks that we must attend to and the board has issued a challenge to clinicians to work through those.

[293] On GPs, we have spent quite a lot of time on this. The comment that has been referred to—and I remember the comment being made by the GP representative on the clinical forum at the time—was that this was a lot of work and that we were predicating this on engaging GPs. We have done a great deal of work with GPs, particularly on the aspect of what we call enhanced care at home and keeping the GP central to that. That work has been based on our experience in north Denbighshire, where we did it first, and that has been very strongly supported by GPs. We have worked closely and engaged with the local medical committee and other GP groups to talk about that. That scheme is supported by the local medical committee and, where we have begun to roll it out—we have started in Anglesey and are looking at other areas—we are finding that we have GP support and engagement in that process.

[294] So, we have done quite a bit of work with GPs. There is more to do as we roll it out and, inevitably, it is a more challenging proposition to say that the service relies on 100-odd GP practices. However, when we looked at setting the direction and the vision for health for north Wales, primary care and community care raising their game and really reaching their potential were the absolute bedrock of the proposition. We believe that that is very sound and we think that, from the discussions that we have had with GPs in localities as well as the local medical committee, in principle, they are supportive of that. That is what they want to see in future as well. Therefore, I am confident about the engagement of GPs. It will not be without challenges, but we have had quite a lot of dialogue. The scheme was developed in partnership with GPs, so I am confident that, although the challenge was very clear from the clinical forum, we have a track record showing that, where we have done this work and where we are rolling it out, we are securing GP engagement.

[295] **Darren Millar:** I have a quick question on this. Some concern has been expressed by a number of local authorities that feel that some of the burden might be shifted to them as a result of the proposals. To be fair to the local health board, I know that you made an attempt to engage with local authorities very early on during your engagement programme. However, some may not have engaged as well as they could have done during that process. What action are you taking to ensure that they are fully embedded and briefed as things stand?

[296] **Mr Lang:** On the ground, with regard to the work that underpins our plan, our work in localities involves working very closely with officers from local authorities. So, at an operational level, this is happening. Often, we find an organisational disconnect between the top and the operational level. We have done specific work, going to each local authority. We have been to scrutiny committees and local authority elected member workshops to talk this through. We have been very clear about it. Again, it is about the enhanced care aspect of our proposals. We have been very clear and we have produced supplementary information to clarify the fact that our scheme is about replacing what would otherwise be hospital care. At any time that a person is receiving that care, the NHS will resource it. If that means that they need care support as part of the package to enable this to happen in their home, we will do that. We have been very clear about that.

[297] However, I have to say that, as clear as we have been, there remains scepticism about that. That is probably a reflection of the financial pressures that everyone is under and the concern about an ageing population and the ability to cope with and care for people in their own homes. However, strategically, if we do not take that step and if we do not enhance our primary and community capacity to make us fit to support people at home and help to maintain their independence, our challenges moving forward with this demographic picture will be far greater if we stayed with the current system and tried to push more people through our hospitals. So, I think that it is the right step. There is still work to be done, but we have been absolutely clear about the financial responsibility related to the plans, and it does not impact upon local authorities.

12.30 p.m.

[298] **Mark Drakeford:** On that note, I think that we will have to draw this morning's proceedings to a close. Thank you all very much indeed. Dr Harrington, thank you for joining us from north Wales and thank you very much to the panel here for answering some quite searching questions as the morning has gone on. It has been very useful for us and we are grateful to you for taking the trouble to be with us. Diolch yn fawr.

[299] Before Members leave, I will very quickly refer you to the letter that was circulated earlier this morning from Jane Hutt as the Minister for Assembly business, asking us whether we would be prepared to undertake some joint work with the Enterprise and Business Committee to scrutinise proposals to amend smoke-free premises regulations. My proposal to you this morning is that we accept that piece of work in principle, but that I, on your behalf, have some detailed discussions with Nick Ramsay as the Chair of the other committee, and then come back to you with some practical ideas as to how we might discharge that piece of work.

[300] **Darren Millar:** It is a very welcome development, Chair.

[301] **William Graham:** Do you have any idea of the timescale, Chair?

[302] **Mark Drakeford:** I will come back to you with the timescale and the things that are in our hands.

[303] **William Graham:** The timescale has been set.

[304] **Mark Drakeford:** Has it? What is the timescale? Presumably the Business Committee has spoken.

[305] **William Graham:** I am afraid that it has. I do not recall the detail, but it is available to you.

[306] **Mark Drakeford:** We will establish that and we can report that to you all as well. Thank you for that. We are back here at 1.30 p.m. for a strict maximum three-quarters-of-an-hour session with the Patients Association to discuss how consultation is best conducted. Diolch yn fawr.

*Gohiriwyd y cyfarfod rhwng 12.31 p.m. ac 1.32 p.m.
The meeting adjourned between 12.31 p.m. and 1.32 p.m.*

Cynlluniau Ad-drefnu Byrddau Iechyd—Cymdeithas y Cleifion Health Board Reconfiguration Plans—The Patients Association

[307] **Mark Drakeford:** Prynawn da a chroeso i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Croeso i gynrychiolwyr Cymdeithas y Cleifion, ac mae'n bleser mawr i mi yn bersonol i groesawu Ann Lloyd, ymddiriedolwr y gymdeithas, a Heather Eardley, ei chyfarwyddwr prosiectau cenedlaethol. Croeso i chi'ch dwy.

Mark Drakeford: Good afternoon and welcome to the Health and Social Care Committee. I welcome the Patients Association representatives, and it is my great personal pleasure to welcome Ann Lloyd, a trustee of the association, and Heather Eardley, its director of national projects. Welcome to you both.

[308] Thank you very much for taking the time to come to help with the committee's work today; we have been receiving evidence from two health boards in Wales that are currently carrying out major consultations on reconfiguration of services. As normal, if you want to make any brief introductory remarks, you can do so. Thank you very much for your paper, which we have had a chance to read. I will then pass things straight over to Members who will have questions for you. We have only three quarters of an hour, so we will have to move briskly through the business. Ann, are you going to say something to start with?

[309] **Ms Lloyd:** I will be very brief, Chair. The Patients Association is an independent healthcare charity and we have campaigned for the past 50 years to improve the lot of patients. We have a large helpline through which we get many requests for help or clarification each year. Patients say to us that they want access to good-quality healthcare and really good information but that, first and foremost, they want to be involved in shared decision making, not just about their health and wellbeing, but about the care and types of care they are likely to be able to access from the health services and their partners. We have expanded considerably over the past two years, which has enabled us to appoint people like Heather who are more actively working with some of the regions in England, to start with, to look to work with trusts hand-in-hand with the patients' groups and the stakeholders to improve the way in which patients are engaged and involved in planning and redesigning services, in accessing services and in taking a bit more ownership of the care that they are able to acquire.

[310] Our experience has been that that needs really good information, really honest and honourable communication, and real ownership and responsibility taken by all parties, but first and foremost the patients and their carers must be involved right from the beginning, and not part way through, to get the best types of results. Heather, being the expert in this field, will be able to give you lots of examples of the work that she has done and the work that is going on throughout the United Kingdom to try to ensure that people and citizens are more effectively engaged from the beginning in these deliberations on how care can be delivered effectively.

[311] **Mark Drakeford:** That was a very helpful way to start. Mick has the first question.

[312] **Mick Antoniw:** I am particularly interested in your experience—your background

experience and your recent experience. In a letter, the Older People's Commissioner for Wales summed up the nature or the principle behind the type of consultation process we are going through now. She says that:

[313] 'it is especially important that decision making is seen to be—and experienced as being—fair, transparent and carried out with due consideration of the rights and needs of those who are directly affected.'

[314] That seems to fit in exactly with what you are saying. Could you tell us a little about how what is happening in Wales at the moment, and our experience of different processes, compares with what is going on in other areas and satisfies those fundamental principles? What are we doing right? What are we doing wrong? How good is what is happening? Are we living up to what we should be doing? How does it compare with what has gone on in the past?

[315] **Ms Eardley:** We have read your papers. There are lots of good things happening here, and it is good to see how thoroughly you are consulting with your local population. There are lots of similarities, but to achieve a shift towards more of an equal partnership with parents, carers and citizens there is perhaps some learning to be done to ensure that it is not a consultation process after the event, but that they are involved right from the start. That really means a shift in that power relationship too, so it is about treating people as equals, and that is quite a big culture change for everywhere, really—the whole emphasis on patients' rights and responsibilities is something that will take a little time to develop.

[316] The way we have been working is very much more at a local level around working with local trusts on actually listening to patients' views on their current services in health, social care and more widely, and then involving them right from the start in that planning phase. It was interesting, looking at the two papers that we were presented with, particularly in terms of the timescales, that one of them mentioned clinical workshops at the beginning. Traditionally, that is the way that a lot of places have approached it, but it is really right at that stage that the public should be involved, rather than the clinicians making the decisions and then consulting with the public. It is very much about the public, patient representatives and carers being involved at that planning stage. Our view would be that, yes, there is lots of good practice, but there is lots of learning to be done too, in terms of shifting that and involving people right from the start.

[317] I do not know whether you want any examples.

[318] **Mark Drakeford:** It would be helpful if you could just give us an example of where you think that has happened successfully elsewhere.

[319] **Ms Eardley:** I do not know whether you have heard about what is happening in the midlands and the east. The strategic health authority there has set up a whole new programme called the patient revolution, and that is quite a new approach, really. Katherine Murphy, our chief executive, has been co-chair of that group. It wants to train up and prepare patient leaders, as it calls them, at every level of the system. That not only means patients being given much more information, and knowing where to go for that information at the GP consultation phase when they are first diagnosed, and when options for treatment are available, but being involved at board level within different services. So, with the patient revolution, they are looking at providing training, not only for patients, carers and members of the public, but for staff because it is a new concept for the staff in these organisations. It can also be quite threatening to suddenly have people questioning and challenging your practice and whether it is done properly. The midlands and the east are the first leaders in this, so that is quite an interesting concept that you might want to look into—it is called the patient revolution.

[320] **Ms Lloyd:** Heather has brought some of her booklets on the work that she did in the south-west, which have just been published. It might give you a flavour of the work and the change in practice that has been effected there. Again, that area has similar problems to Wales, in that you have a huge, long peninsula and quite vociferous communities, which have had a lot to say about the change required for their health services.

[321] **Mark Drakeford:** Thank you. It will be very helpful to see that. Elin is next, then Vaughan and then William.

[322] **Elin Jones:** We had two local health boards discussing their public engagement this morning. All of that discussion focused on public engagement. Do you have any views about patient engagement, as opposed to, or in addition to, public engagement? Everyone is a potential user of the NHS, but people who are current, active users of the NHS may have different views from the general public. How do you engage with current patients? That is something that did not feature in our discussions with the health boards this morning; that was only about public engagement.

[323] **Ms Eardley:** A lot of the work that we have been doing, particularly in the south-west, over the past 18 months has been very much about patient engagement. Traditionally, we have had our helpline in London, and we have been very much a campaigning charity, but we were given some funding by the strategic health authority in the south-west, which wanted to see whether we could have an impact on the local trusts. We were totally independent in the way that we went about that, but we approached each of the directors of nursing. We started off with acute trusts, but that is now widening out, and asked, 'Can we help you, in any way, in improving your patient experience?' In a very short space of time, we set up projects in each of the 18 acute trusts across that patch. They are very short, small-scale projects, but they have involved talking to patients and getting patients and carers involved in recommendations and then service improvements. There is a range of issues. In Cornwall, for example, they wanted to know how well they were performing against a set of standards for acute hospital care for people with dementia and their carers. So, we worked with the Alzheimer's Society and devised an interview framework around those standards, which was easy to use and understand, and then, working with some volunteers from the Alzheimer's Society, we went on to the wards—I did so myself—and interviewed patients and carers about their views.

[324] The trust there wanted to know about such things as recommendations around snacks and activities. It wanted to know more detail and find out what sort of snacks and activities people would like, whether carers are involved in decision making and so on. From that, we produced a report and we provided some recommendations. That trust, as part of its dementia action strategy group, has implemented those recommendations. We are just about to go back for the second time to check whether patients and carers have seen any difference.

1.45 p.m.

[325] I can give you examples of a whole range of different projects that we have set up. Another couple of trusts, such as one in Bristol, and a partnership trust in Devon, wanted to know why their patients did not think that the information around medication was good. So, using some of our volunteer ambassadors, we again designed an interview pro forma asking more detailed information about medication. We were given a list of people who had been discharged from hospital recently, so it was a random selection, and our ambassadors then interviewed those people over the telephone, doing a thorough interview of between 20 minutes and half an hour. We had some feedback from that and have produced a report, and its recommendations are now being implemented. We had a conference last week to present the findings, and one of the ambassadors who had been carrying out those interviews said that

it was so good to hear the trust explaining what improvements it had put in place, because you often do not hear the results of the consultation. So, there has been a whole range of things such as that.

[326] Another thing we have had quite a lot of success with is what we call community reporting. We did some work in Manchester with a community media company that trained some of our volunteers in the use of Flip cameras and audio. We now have a whole range of films and audio recordings, which are being used to inform the local commissioners. In fact, I used that approach last week in a meeting on integrated care. These people were not asked specifically about integrated care or whatever; they were asked for their views and experiences, and that is really powerful. So, that is making quite an impact.

[327] Another interesting model is something called the ‘mystery shopper’ or ‘mystery patient’, and that has really taken off. One of the trusts has tried that out, and a lot of other trusts now want to develop it. The local press invites patients who are about to be admitted to hospital to take part in this mystery patient process. They are given a very simple diary, which looks like an information leaflet so that the staff do not know that they are taking part. During their patient stay, they will report back, and by reporting back to the Patients Association, they feel that it is independent. We then analyse the data and feed the information back to the trust.

[328] The strength of it is in our independence, because we know that, if you want feedback from patients and carers, people worry about it affecting their services and are therefore not keen to report back directly to staff on the wards or wherever. By having an independent body such as ours, however, we have found that people are more willing to speak.

[329] **Elin Jones:** So, what you are saying is that public engagement does not necessarily capture patient engagement and that that needs to be done in a different and more focused way.

[330] **Ms Lloyd:** When I read the submissions, the one thing that struck me was that—you are quite right—the patient was not in the range of stakeholders described. We used to have a really good expert patient programme in Wales—in fact, it was vastly superior to anything else in the UK. I was just a bit disappointed that those expert patients did not seem to be to the fore—it was possibly that their involvement was just not mentioned. However, we did have a jolly good programme; involving those expert patients really fundamentally affected our long-term conditions strategy, and they are a great resource.

[331] **Darren Millar:** Following up the point about the expert patient programme, I know from having met them in the past in north Wales just how valuable their input to the process has been historically. I think that some patients have been involved in some of the stakeholder groups, but I think that the approach to patient participation has been pretty random. I wonder to what extent you think there needs to be some formal information, perhaps in revised guidance in future, on patient involvement in these sorts of consultation processes, or in the engagement processes before consultation—that would be a preferable place to start, really. Also, might there be a role for a patient representative on the boards themselves, to make sure that the patient experience is captured properly?

[332] **Ms Lloyd:** It is very difficult being a patient representative; you have to have a very good infrastructure to do it well. Certainly, a lot of the organisations, especially in the west midlands, are considering extending the concept of just having a patient representative on the board, so that it gets a wider spread, and so that they are properly trained and their contribution is evaluated effectively.

[333] The guidance that has come out in Wales is a great improvement on the old guidance

and it acknowledges the fact that people have to be engaged in a much more effective way much earlier in the process. However, patients and their carers will sometimes have a different perspective from the local community. I think that every effort should be made—we would say this, of course—to emphasise how important it is that their views, fears and expectations are captured early, and also to ensure that anyone who is, or is about to be, a patient accepts their responsibilities if they are part of this joint ownership of a problem that needs solving. We all know that change has to be effected, and the patient's voice might as well be used as a resource and not something that is just always complaining.

[334] **Vaughan Gething:** I was interested in picking up some of the points from this morning's session between the two health boards. One was about whether you have a view on how effective they have been in engaging the clinical voice with the patient voice and the wider public and how that compares with similar consultations about service design and change in England, for example. Equally, we heard two very different approaches this morning to wider public engagement. For example, one board had a series of open meetings and the other had a series of 'register to attend' meetings. Do you have a view on how effective those two methods could be and how they compare with other forms of trying to engage the wider public in other parts of the UK?

[335] **Ms Eardley:** I think that there is room for open public meetings, but, equally, you will only capture a certain type of person. That is the danger of those meetings. I think that there is a need for both, really. With regard to direct consultation about specific aspects of the service, I think that that is when you can actually get more direct feedback from patients experiencing that particular aspect. The other point about public meetings—and I have run public meetings myself—is that they are all well and good, but I always find that you do not necessarily get a good attendance or a representative group. So, it is about finding other ways also. I think that we need to do more of going out to local groups—not expecting people to come to us, but going to them, and using different forms of social media and communication, particularly with young people and people who are seldom heard. It is about having a mixture and not relying on one method.

[336] **Vaughan Gething:** What about the clinical interaction, with regard to the clinical case, if you like, and the variations within that, for service change? How have you seen what is working and what is happening here in Wales with engagement and then consultation, and how does that compare as a model with what is happening in other parts of the UK?

[337] **Ms Lloyd:** From what I have seen, I think that it is pretty similar. I have had only limited experience in England, recently, and that was in London, which has a particular style and set of issues to contend with. I know how much very hard work has taken place in the north to engage the clinicians and to ensure that there is clinical leadership and what a difference it made to some of our consultations in the past to have the clinicians leading the debate and the discussion, based on clear evidence. I know that a great deal of work has been undertaken in Wales to ensure that the clinical voice is respected and heard. It has taken a long time and a lot of effort from everyone, and we have found that most of the clinicians were very willing and able to take that lead role. There now needs to be a balancing of an individual's experience against the best clinical practice, because most individuals will want the best clinical practice. They should, from the beginning, be in a position, or be enabled, to have a positive conversation with the clinicians about the style and shape of the service that is available to them as an individual or as part of a community. Given the growth of the strength of the clinical voice in leading service change, it now needs to be balanced with a growth in the patient's and carer's voice about the type, range and quality of service they want.

[338] I am a firm advocate of the principle that you cannot go for second-class services under any circumstances. That is what all these papers have said, and rightly so. People do not want second-class services either, but they want to be assured that their voice is heard

effectively and reacted and responded to. They want to be assured that they understand explicitly and can plan the type and shape of service that suits them and their needs with the specialists and experts.

[339] **William Graham:** Could you give us some advice from your experience on how these reconfigurations can be helped to engage with hard-to-reach groups, particularly some ethnic minorities and mental health sufferers, many of whom are involuntary patients? How can that be worked into the system?

[340] **Ms Eardley:** Again, it is about going out to those people. I have had some personal experience of that sort of thing, where going to organisations such as race equality councils or local groups can lead to a very good response, whereas if you had invited them to an open meeting perhaps you would not have had such a good response. So, it is about finding those networks. We have a system of volunteer ambassadors, and we are increasingly getting people from different types of communities who can reach out to their local communities. The community reporter model that I mentioned is about training local volunteers to interview and talk to their local community. For example, a recovering alcoholic in the Salford project benefitted a lot from taking part in this process, and he was subsequently able to go out to people with a similar condition. So, it is about making much more use of those community networks and not expecting people to come to you. The term ‘hard-to-reach’ is our problem, in a way; those people are not hard-to-reach—we are the ones who find it hard to reach them.

[341] **William Graham:** So, you would say that a special effort has to be made for those particular groups.

[342] **Ms Eardley:** Yes.

[343] **William Graham:** Have you been surprised at the evidence received this morning that you have to pre-register to attend a consultation?

[344] **Ms Eardley:** Yes, that is surprising. It puts people off, I think.

[345] **Kirsty Williams:** You talk in your paper about ‘distress’ and ‘disillusionment’ at these change processes. Your paper and your evidence this afternoon seem to suggest that by early engagement with patients you can avoid that distress and disillusionment, but you cannot engage at that early stage with every patient and community. At some stage, you have to go out to communities with proposals. Even if there is a clinical consensus around that and there have been engagement projects and processes for the last however many months, you often still end up in a situation where there are petitions, placards and objections to the closure of a service, often from patients who have previously used that service. Can you give us any examples of a change process that, at the end of it all, has been able to bring together management, clinicians, patients and communities who have seen the change in the health service? However, is it just an inevitable consequence that when you try to change health services, you will end up with petitions, placards and protests, and, in the end, NHS managers and politicians have to plough on through regardless and make the change? I am hard pressed to think of a single example where, even with the best consultation in the world, we have not ended up with people objecting to change.

[346] **Ms Eardley:** I cannot think of an example off hand, but you can ameliorate the degree of opposition. You might still get minorities against the proposal, but if you can consult more widely and involve people from the start, you will meet with less resistance. It helps if you can use local people to explain to other local people. We have examples in Falmouth, Cornwall, of a health visitor who was involved in community development. However, with regard to large-scale change, I cannot give you one example at the moment because we have been dealing more with patient experience than the service design at a more

local level.

2.00 p.m.

[347] **Ms Lloyd:** I think that you will always get protests. However, we can try to balance that with the development of the patient champion-style of doing things. In that way, you are not just putting forward clinicians to explain to a hostile group on a Friday night what is happening to their services. You should try to ensure that you have a good network of individuals who have been engaged and involved and who will actually have some effect on the way care pathways will look in future based on their experience. They need to be given a role of responsibility for ensuring that the patient's voice for that group is heard effectively. In that way, your patient champions will start to balance this very difficult experience that we have all had of being utterly pilloried because we have gone out to consultation and nobody likes it and everyone thinks we are taking things away from them. We must try very hard to redress that balance.

[348] **Kirsty Williams:** In that case, why do we not seem able to achieve that? Some of the facilities that are now proposed for closure, as you well know, have been considered for closure at various points in their history over the past 15 or 20 years. If the answer is the patient advocate, the real person who gets up in the public meeting to say, 'It's okay, this is what we should do', what is it in the system that stops us from developing that role? In the case of some of the changes before us, this is not the first time they have come before politicians or NHS managers, so what is it in the system that is stopping us developing that role and making that change easier? In the past 13 years, I do not think that the change has been made any easier at all.

[349] **Ms Lloyd:** No, change has not been made any easier. People have worked very hard to try to bring about change, but I do not think that we have learned sufficiently well from best practice, and I do not think we have made the problems small enough to handle. For example, in the past, in some things, we made quite considerable changes that we never thought we would be able to make through much more local involvement. The Tenby experience is one striking example that I shall never forget. It was extremely difficult and there were huge protests in Tenby about the cottage hospital, which we were closing as we were redesigning the service. There was a great deal of opposition that had to be faced. That was overcome and a better solution was found in the end through the involvement of the local community through active leaders in the community who sat down and redesigned the service with the people who had to deliver it at the end. It was an experiment and it seemed to work. However, it was a very difficult experience to overcome those barriers and to think about trying to undertake the consultation in a very different way.

[350] That worked. However, it is easier on a very small scale, and I think that we might have to deal with this in bitesize chunks because people are so suspicious throughout the UK about changes in the health service, because they know about all the pressures and they just do not believe it will work. We cannot show them what we are talking about. I know that that happened in Powys as well. You could not show people what was being advocated. If we can be a bit more creative and innovative and find areas where change has been effected, not just in Wales but elsewhere, to show people what we are talking about in order to allay their suspicions, we can ensure that the patient's voice and the community experience go together with that change. It takes time, but, unless we all listen, time is wasted anyway because you just spend your energies on protest management.

[351] **Mark Drakeford:** It is not really my place to do this, but I will make a suggestion to you and you can say whether this has any resonance with your experience. Is one of the problems that we regard consultation as something we do on a specific set of proposals when what you really need is a process of continuous engagement? To give an example, to answer

Kirsty's question, in Wales, we have closed three hospitals in the Cynon valley and opened a new hospital in Cwm Cynon without any petitions, protests or lobbying of the Assembly. Locally, if you ask people how they managed to do this, they say that it is partly because there was a Cynon valley health forum that pre-dated all of those proposals, that people were used to having a process of engagement with those who provided health services, and there was at least enough confidence in that to allow people to talk through a difficult set of proposals. Is part of the problem the fact that we set up all of this great industry around a particular set of proposals, we work that through, however difficult it may be, and then we retire from it until the next round of difficulties?

[352] **Darren Millar:** I would like to make an observation on that point. There has been a local situation, in relation to HM Stanley Hospital in St Asaph, which has been resolved with local political support and community support, because it was quite clear that change needed to happen. So, it is possible, where things are explained to the public, that they can be convinced of the need for change. There is a temptation, sometimes, to gather around the table the usual suspects who have preconceived views on the way things ought to be and you are not able to arrive at a decent decision or a transparent decision as a result of that. In north Wales, this has historically been one of the areas where there has been a pre-consultation engagement process.

[353] **Ms Lloyd:** You are right, Chair. Your guidance majors on that continuous engagement, and that is one very positive way of overcoming some of the tensions of someone thinking, 'Oh, goodness me, we have come to the crunch now, we have to make a change and go out'. That is just a reaction. So, continuous engagement is the really effective way to do it.

[354] **Mark Drakeford:** We heard from the Hywel Dda Local Health Board this morning that one of the things it hopes to get out of its current engagement is a longer relationship with up to 1,000 or more people whom it has now been in touch with as a result of this consultation. The health board now knows a bit about who they are, has them on its register and wants to continue to talk to them. Does that sort of thing go on elsewhere? Do health trusts in England have more of a sense of an ongoing dialogue with their patient population?

[355] **Ms Eardley:** I do not know about every trust across the country, but local authorities are probably further ahead with this than the NHS at the moment. However, with the rise in the use of social media, e-mail, and so on, there is the potential to have much wider access to people, which perhaps did not happen in the past. I talked to those working in a GP practice the other day who had undertaken a recent consultation via e-mail and they had a good response, whereas they had previously expected people to come to a meeting and had perhaps half a dozen people around the table. So, it is happening more. I know that many local authorities have large databases of people whom they consult with. The NHS is beginning to start that process.

[356] **Mark Drakeford:** I would like to ask one other question, before I ask whether anyone else has any questions. I want to ask you a difficult question about representativeness. In these processes of consultation—if we were the people charged with carrying out the consultation—what confidence could we have that the views of the particular people we heard from in any way represented anything more than their own points of view? As an association set up to represent patients, how do you go about making sure that, if you comment on something or contribute to a debate, you are speaking on behalf of a wider group of people than those whose voices are easiest to get hold of?

[357] **Ms Eardley:** It is always a problem and you can never speak on behalf of everybody. However, you try to ensure that you cover most of the groups—and I notice that you use an equality impact assessment; it was mentioned here. Those sorts of tools are really helpful in

that they identify where the gaps might be and try to include as many groups as possible. However, it is very difficult to ever be truly representative.

[358] **Ms Lloyd:** One of the reasons we have confidence in being able to publish the views of patients more generally is that we have such open access now through our helplines and our advice lines, so we get a vast range of views, underpinned by a research methodology. We feel confident that, if we do go into print on anything or we give a comment to the press about a particular issue, we have the database behind us to be able to say, ‘Look, we had x number of concerns expressed about this, and y number of people gave their views, and this is what the consensus is at the moment’. So, what health bodies more generally need is a really sound database and a really good helpline through which comments and concerns might be provided, rather than just relying on a report on how many complaints you have and their nature. You need to get to them before you are dealing with a formal complaint. You need to be very open to having effective patient advocacy within your organisation so that you get a much broader range of views. One of the things that patients say to us is that they are frightened to death of complaining—not in Wales, I have to say—and are concerned about complaining that their mother is still in hospital, or whatever. That complaint has not come through anything like as much in Wales as it has in England and its regions. However, you need to have a more open approach to using the views of the patient, even if they are critical, in a positive way to reflect on and then make the necessary changes—or, respond to them about why something is not possible.

[359] **Mark Drakeford:** We have been beaten by the clock already. I am sorry that we have had such a quick session with you this afternoon, but it has been helpful for us, I think, to have that particular patient perspective on the way that consultations can be successfully conducted.

[360] **Ms Lloyd:** It is not easy.

[361] **Mark Drakeford:** No, but your evidence has been helpful for us.

[362] **Ms Lloyd:** We have left the ‘Partners in Care’ document and I will also e-mail Llinos our blueprint for patient engagement and some of the examples that sit against the advice that we are giving, if that would be helpful.

[363] **Mark Drakeford:** That would be very helpful indeed. Diolch yn fawr. I thank you both very much indeed, and I thank everyone else.

Papurau i’w Nodi Papers to Note

<p>[364] Mark Drakeford: Mae dau bapur gennym o dan eitem 5. Mae angen nodi a chytuno cofnodion ein cyfarfod a gynhaliwyd yn ôl ym mis Medi, a llythyr oddi wrth Gomisiynydd Pobl Hŷn Cymru. Diolch yn fawr.</p>	<p>Mark Drakeford: We have two papers under item 5. We are to note and agree the minutes of our meeting that was held back in September, and a letter from the Older People’s Commissioner for Wales. Thank you.</p>
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*Daeth y cyfarfod i ben am 2.13 p.m.
The meeting ended at 2.13 p.m.*