



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

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

Dydd Iau, 3 Hydref 2013
Thursday, 3 October 2013

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Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynnddi 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

Leighton Andrews	Llafur Labour
Rebecca Evans	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
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Yr Athro/Professor Peter Donnelly	Dirprwy Ddeon, Deoniaeth Cymru Deputy Dean, Wales Deanery
Dr Helen Fardy	Ymgynghorydd Pediatrig ac Arweinydd Clinigol Ad-drefnu Gwasanaethau Pediatrig, Deoniaeth Cymru Consultant Paediatrician and Reconfiguration Clinical Lead for Paediatrics, Wales Deanery
Jeremy Gasson	Ymgynghorydd yn Ysbyty Singleton ac Arweinydd Clinigol Ad-drefnu Gwasanaethau Obstetreg a Gynaecoleg, Deoniaeth Cymru Consultant in Singleton Hospital and Reconfiguration Clinical Lead for Obstetrics and Gynaecology, Wales Deanery
Dr Andrew Goodall	Prif Weithredwr Arweiniol, Rhaglen De Cymru Lead Chief Executive, South Wales Programme
Yr Athro/Professor Mike Harmer	Cadeirydd, Y Fforwm Clinigol Cenedlaethol Chair, National Clinical Forum
Paul Hollard	Cyfarwyddwr y Rhaglen, Rhaglen De Cymru Programme Director, South Wales Programme
Hamish Laing	Cyfarwyddwr Strategaeth Glinigol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg, ac Aelod o Dîm Rhaglen De Cymru Director of Clinical Strategy at Abertawe Bro Morgannwg University Local Health Board and Member of South Wales

Programme Team

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

Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk

*Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions**

[1] **David Rees:** Good morning, and welcome to this morning's session of the Health and Social Care Committee. Today, we are looking at the south Wales programme and the process of consultation in developing the reconfiguration service plans. The meeting is bilingual, and headphones can be used for simultaneous translation from Welsh to English on channel 1 or for amplification on channel 0. I remind everyone to turn off their mobile phones, please, and other electronic devices that may interfere with broadcasting equipment—certain equipment is exempt. In case of a fire alarm—there is no planned drill this morning—please follow the directions of the ushers. We have received apologies from Kirsty Williams for the first session this morning.

**Cynlluniau i Ad-drefnu Gwasanaethau Byrddau Iechyd Lleol—Cynllun De
Cymru: Rhaglen De Cymru
Local Health Board Service Reconfiguration—South Wales Plan: South Wales
Programme**

[2] **David Rees:** We have the representatives of the south Wales programme here to discuss the reconfiguration of service plans. I welcome Paul Hollard, the programme director for the south Wales programme; Andrew Goodall, lead chief executive on the team; and Hamish Laing, a member of the south Wales programme team and of Abertawe Bro Morgannwg University Local Health Board. I will ask Paul to make short opening remarks on the processes, and then we will move to questions from Members.

[3] **Dr Goodall:** If it is okay, Chair, I will make some of the opening comments on behalf of the team, as the lead chief executive.

[4] **David Rees:** In that case, we will turn to Andrew Goodall.

[5] **Dr Goodall:** Good morning. Bore da. Thank you, first of all, for the opportunity to come to talk to you. We have obviously had many different fora, briefings and public meetings as part of the south Wales programme, and this is just another part of the process for us. I would want to comment that it has been a unique exercise for us in Wales—five health boards and the Welsh Ambulance Services NHS Trust working together rather than simply in their own organisations. We are collaborating because of the serious concerns about fragile services. We know that the solutions have to come from beyond the boards individually; there are real issues that we have to work on together.

[6] We have tried to deal differently with clinical staff during this process. This has engaged clinicians directly, and we have been influenced in our preparation and planning by over 300 clinicians representing the different boards across south Wales. We have shared problems and developed solutions, and we have tried to facilitate these recommendations together; it has been about consensus. I want to emphasise that this is not about unanimity. However, the process of involvement has been critical to delivering where we have got to in this process to date and to ensuring that all of those clinicians have had a full involvement all the way through.

[7] I would also want to comment that we have tried to adopt a more open and transparent style, which is not, perhaps, traditional for the NHS. We have tried to allow those who are involved—the public, boards themselves and our local stakeholders—to be aware of the full level of detail around these plans. I think that you will all be aware of a lot of detail that we have made available, not least through our internet sites and through the public meetings themselves. We have had choices about our style and approach to this, and I think that we have made a few judgments along the way about needing to show that we were responding to some of the emerging issues. However hard some of the messages that we have tried to openly discuss, we have at least tried to do this very visibly.

[8] Just for committee members to be aware, we are not yet through the process. Although, over these recent months, we have prepared a case, developed options, engaged on them, filtered them and consulted on them, we have yet to get to the final decision making. So, today is really an update on the process and the progress to date. However, boards will still hold the local accountability for decision making and responsibility for the implications for their own local plans. However, this needs to remain within the collaborative approach that we have embarked on over these last 21 months in particular.

[9] I would hope—on our behalf—that a sign of some success is that we have had close to 60,000 responses as part of the consultation that we have done, which, I believe, is the largest number ever received on an NHS service configuration. I want to finish, Chair, just by saying that, even for those of us who have a lot of experience of service change, this whole process has felt very different, and we are very happy to answer your questions as part of the committee deliberations.

[10] **David Rees:** Thank you very much for those remarks; I also thank you for the written evidence that you have provided to the committee. I turn to Gwyn for the first question.

[11] **Gwyn R. Price:** Good morning, gentlemen. You just touched on the 60,000 questionnaires, letters and detailed submissions that you have had. In your submission, you say that the October date is now going to be missed and that it will be the end of the year before a decision is made. That is fair enough, with all of the responses and the need to take this very seriously indeed. However, further on, you say that if one of the community health councils is not satisfied, it can appeal to the Minister if it so wishes. Does that automatically stop the procedure going on, or does it stop it in that one area alone? Could you enlighten us on that?

[12] **Dr Goodall:** I will start talking about process, but I will ask Paul to pick up some of the implications for decision making. We have known, as we have gone through these last 21 months or so, that we started off because services are fragile. We have tried to make sure that we have been able to maintain services. One of the commitments that we have made on the process, by gathering clinicians, is that a decision is necessary. The fragile services that we embarked on discussing are still fragile services. We still have the same pressures on medical staffing. We have received so many public responses. One of our duties in terms of the regulations is to make sure that we give due regard to all of those and that we are able to use them as a formal part of our decision-making process. Going through 60,000 responses, some

of which are collective, but many of which are individual reflections on this area, will take time. We know that we have needed a little bit more time. Our current timetable is that we hope to be making provisional decisions during November and by the end of November, but we will have to make some judgments on the decisions and the framework that we need to use. Perhaps Paul could comment on what that looks like.

[13] **Mr Hollard:** Good morning. In terms of the CHCs, we have worked very closely with them; the team and I meet them on a fortnightly basis, recognising their independence, but taking their advice et cetera. What is quite clear is that the sovereignty of individual CHCs, as with the individual health boards, lies with them. So, the individual decision making by a CHC can lead to a lack of consensus on the outcome of the consultation. What we are working through is: what does the decision-making process entail? What information is needed? The information that we have for decision making is broader than the outcome of the public consultation. We have done lots of other work in terms of data, comments, clinical views and risk assessments et cetera. So, the decision-making material will be broader than just the outcome of the consultation exercise. You are quite right that if a CHC does not feel in a position to make a decision, or if it disagrees with the outcome or the recommendation of the programme board, then it can seek to appeal. We are hopeful that that will not happen, because we are continually discussing the issues that arise through consultation and post consultation. However, we have to protect the independence and scrutiny of the community health councils.

[14] **Gwyn R. Price:** My question at the end of that was: would it delay the whole procedure just because there is one—

[15] **Mr Hollard:** It could delay the whole procedure. We would have to consider as individual health boards and a programme board what a dissenter in one part of south Wales means for the ongoing work, bearing in mind, as Andrew has highlighted, that they are very fragile services that cannot be sustained going forward.

[16] **David Rees:** May I clarify that there is not one member of a CHC on the programme team?

[17] **Mr Hollard:** No; because of the scrutiny role of the CHCs, we meet separately.

[18] **David Rees:** Yes, I just wanted to clarify that.

[19] **Mr Hollard:** They are not members of the programme team and they are not members of the programme board either, because they have an independent scrutiny role.

[20] **David Rees:** You mentioned in your last answer that you have additional evidence that you are looking at as well as the responses to the consultation. Can you clarify a bit more regarding some of the evidence that you are looking at?

[21] **Mr Hollard:** Yes. We started, as you know, with an engagement exercise last year, which led to the consultation. During the consultation, we had quite a lot of feedback from public meetings et cetera that raised issues around patient flow, for example, and the natural flow from one hospital to another. Due to that, as part of our responsibility, when information has come in through the consultation, we have been doing additional work to look at whether that has an implication regarding the decision making. Similarly, we did some additional work around paediatric assessment services. When we went out to consultation, we raised the issue that the paediatric assessment services need further work. We have undertaken that work. That information will go to the programme board and form part of the decision making. So, as we have learned through the consultation and taken feedback from the public and other stakeholders, we have done further work and will take that into account in the decision-

making process.

[22] **Leighton Andrews:** I have a few questions resulting from what you have just said. May I ask about the work that you are doing around the assumptions on flow? Clearly, there has been a lot of evidence around that from the whole consultation process and I have seen that on the ground. Are you going to make that work public?

[23] **Mr Hollard:** Yes, we are. As you know, the additional flow assumption was that, if a hospital was not in the future providing consultant-led services, we would look to the nearest hospital. Therefore, that produced the data for the initial flow assessment. What we have checked with the Welsh Ambulance Services NHS Trust, for example, is that its assumption that ambulances would take the patient to the nearest hospital remains. However, what we do recognise is that members of the public have said that if they were making their own way to a hospital, they would not necessarily go to the nearest in terms of travel time or distance. So, we have listened to that. We have looked at the natural flows that have come from each of the LHBs. So, we have confirmed that and some of the community health councils have also confirmed that. What we are doing now is mapping the flow. When that is completed, we will be making it public. Alongside the initial flows, we will be showing the adjusted flows.

[24] **Leighton Andrews:** Clearly, if ambulance staff are making the decisions, that is one thing, but if people—with maternity services, for example—are able to elect to where they go, that is a totally different pattern, potentially.

[25] **Mr Hollard:** Yes, and that is the feedback that we have had. Also, prior to consultation, we did some focused work on maternity services, because we recognised that pregnant ladies have a different behaviour sometimes to what you would expect, so they would perhaps go to a hospital that is not necessarily the nearest hospital to deliver their babies. So, we have taken that work. Opinion Research Services undertook some focused work for us prior to consultation, and we have listened again, through consultation and the submissions that we have had, leading to our saying, ‘Yes, we will look at those potential adjusted flows’.

[26] **Leighton Andrews:** Okay, but that impacts on clinical models that you are looking at within the context of—

[27] **Mr Hollard:** It does not necessarily impact on the clinical model. We have been very clear in terms of the clinical model that would be provided in a local hospital that does not provide a consultant-led service. We have also been very clear about what the consultant-led service would look like. The question would be whether it changes the activity flow from one hospital to another.

[28] **Leighton Andrews:** However, could it not have a bearing on the safety issues around certain clinical models, for example in maternity or neonatal, depending on the size of the flows?

[29] **Mr Hollard:** Yes, there is an issue in terms of the size of the flow and the resulting activity, but the resulting activity is either an increased activity or a decreased activity against the original flow. So, what we are assessing is what that will mean.

[30] **Leighton Andrews:** However, there are some norms, are there not, that are expected?

[31] **Mr Hollard:** Yes, there are, and perhaps Hamish—

[32] **Mr Laing:** I think that the point that you are making, quite correctly, is that, for some of the safety and quality criteria, there are some benchmark or standard levels of activity that

are required, for example, to provide sufficient numbers for training, sufficient amounts of activity for clinical competence and so on, which were part of the original consultation. Those adjusted flows will need to be applied to those to see whether they make a material difference in terms of meeting those standards, which I think is your point.

[33] **Leighton Andrews:** Are you doing any work around acute medicine specifically?

[34] **Mr Hollard:** Yes. Again, part of the discussions and feedback that came out from the consultation process were concerns about what the local hospital provides if it is not providing the consultant-led services that are within the scope. So, the programme board agreed that we would do some further work around acute medicine, on the model that can be retained locally and, as you may be aware, the Royal College of Physicians has recently published the 'Future hospital: Caring for medical patients' report, which we will take into account as well. It is important to us that we retain as many services as we can safely, as locally as possible. Acute medicine is a large activity.

[35] **Leighton Andrews:** When will you publish that work?

[36] **Mr Hollard:** Again, prior to the decision-making process.

[37] **David Rees:** We will move on to a question from William.

[38] **William Graham:** In terms of the formulation and development of your consultation, you looked at current and future structures. Part of your public consultation for south-east Wales was predicated a great deal on the new critical care centre. That is an integral component of your public consultation, yet there is still no ministerial approval. Would you like to enlarge on that?

[39] **Mr Hollard:** I will start, Chair. The SCCC, if I can use that term for the specialist critical care centre, has been part of Aneurin Bevan health board and previously the Gwent region's local plans. What we recognised, when we looked at the population that we serve across south Wales, is that the need for consultant-led services in the Gwent area would remain because of the size of the population and the services that are required by that population.

09:45

[40] In the engagement phase last year, we identified three fixed points: Morriston Hospital in Swansea, the University Hospital of Wales in Cardiff and the SCCC planned for Cwmbran. So, we recognise that those three large centres would be fixed points. We did not have any concerns raised with us about the SCCC being identified and, again, we checked before consultation where the SCCC was in terms of the process for approval. Like any other major capital development within NHS Wales, it is going through a business-case process. We also recognise that, regardless of the SCCC, those services will need to be provided in the Gwent area. So, it is going through the process. The funding for the SCCC is earmarked within the NHS capital budget, and it is going through the normal process. So, we see no danger to identifying that as a fixed site.

[41] **William Graham:** Do you have a contingency plan in case?

[42] **Mr Hollard:** Yes. I might want to ask Andrew, as the chief executive of Aneurin Bevan Local Health Board to come in. What we have said that is those services are currently provided through Nevill Hall and, particularly, the Royal Gwent, and that would continue up until the development of the SCCC.

[43] **Dr Goodall:** If you will allow me, I will wear two hats for a moment in terms of speaking today. The specialist critical care centre has been part of all of the south Wales plan discussions. It has featured in all of the scenarios. We have had to have a level of confidence about discussions that have been taking place with the Welsh Government at this stage. However, as with all of the services across Wales, Aneurin Bevan health board will not be immune to some of the pressures around medical staffing issues and discussions with the deanery. So, as you would expect, we need to always understand what a contingency would look like and how that would work. Our intention has been to keep sites, to be able to move towards the specialist critical care centre and to keep them as local access, but we will have all of the same issues about recruitment and training-placement difficulties. So, as any professional health board would want to do, we will work through some of those contingency plans.

[44] As part of the south Wales programme, as with all of the different health boards, although there was a whole range of public meetings that took place that were framed as being for the south Wales programme specifically, we had a lot of opportunities to discuss these issues and to raise them. The one thing that I would say about the specialist critical care centre is that I would not want people thinking that it was simply about revisiting something from 2006 when some of these plans originally emerged. We have used the new organisation over the last four years, the south Wales plan and other discussions to make sure that it is still relevant now and that the proposals are still fit for purpose for all the discussions taking place under the south Wales programme.

[45] **William Graham:** I think that some of us will recall that, since the beginning of the Assembly, many of us have been encouraging having this critical care centre and that there have been various obstacles in the way, shall we say? So, my question must be: should it be, for various areas of fiscal constraint, that it is put off almost indefinitely, and because there have been 14 years already when it has not happened, do you think that your consultation will still be valid?

[46] **Dr Goodall:** On the specialist critical care centre, because we have active discussions going on with the Welsh Government and because we went out to consultation knowing that that was understood to be part of the plans, we do not think that that situation has changed. Some colleagues around the table will be aware of correspondence that we have received, not least as an organisation, that gave us that confidence to move forward. If you were asking whether I would need to revisit the local plans, the specialist critical care centre discussions and the Clinical Futures strategy gave Gwent a discussion about the critical mass of clinical staff that we needed, the centralisation of services and the need to engage with different community service infrastructures. All that would still stand, but there would be some issues about the consultation and how we had manoeuvred that through on a local basis. All I can say at this stage is that, at some point, somebody would have told us that it was not a good idea to proceed with it. We have been spending money under the capital programme to prepare all the plans, and we have been actively engaged with the Welsh Government.

[47] **William Graham:** Thank you for the reassurance.

[48] **Darren Millar:** I just wanted to ask a few questions about finance, if that is okay. I notice that in your paper, frankly, there is no reference to finance. I assume that it must have been a consideration, and I was wondering what impact finances are having on the development of the plans.

[49] **Dr Goodall:** Do you want to start, Paul?

[50] **Mr Hollard:** One of the things that we have been very mindful of is the level of investment in these services and the level of funding that we have in south Wales. So, if you

take the services that are within the scope of the programme, they are quite small at around 5.9% or 6% of what we spend in south Wales.

[51] **Darren Millar:** What would 5.9% or 6% be of your total expenditure?

[52] **Mr Hollard:** It is around £207 million out of the £3.5 billion.

[53] **Darren Millar:** So, it is still a very big sum, is it not?

[54] **Mr Hollard:** It is a big sum. However, what we also recognise is that we are spending a lot of money now in providing these services, albeit that they are fragile and we are not meeting the standards. Often, we are spending more money than we need to spend because we are unable to attract the medical staff into the type of model that we have got. So, we have looked at a high-level financial assessment, and what we have looked at—and it is in our consultation document—are some high-cost areas. We have looked at issues around the capital requirements of the ambulance trust, for example, and we have looked at medical staffing, at both what we would need to provide the current pattern of service and what we would need to provide the proposed pattern of service. We have also looked at midwifery staffing particularly, because of the increasing birth rate. We demonstrate that even the highest cost option is around £6 million less than we would have to spend now on our current pattern of service to provide those services to the standard that we need to.

[55] So, while people might say that it is an additional spend, it is actually less than we would have to spend to provide sustainable and high-quality services, even if we could get the medical staff, which we know that we would not. So, we have made a high-level assumption; what we have agreed as a programme board is that when we have identified the preferred option, after attaining the outcome of the consultation and all the other evidence, we will need to undertake much more detailed work around the financial implications, because at that stage, we will know the movement of staff and the capital requirements et cetera. So, we recognise that it is quite high level at the moment, in view of the timescale that we have had and the four options that we have consulted upon, and again, recognising the cost of delivering those services now, we do not think that that is inappropriate to take to consultation.

[56] **Dr Goodall:** I would also want to emphasise that we still hold the local accountability for the financial delivery plans. I know that the south Wales programme is sometimes assumed to be almost everything that we are delivering on healthcare services across the whole area. It is a focus on the fragile services, and they, of course, have to link back to the local plans of organisations, and that is where we need to be discharging our responsibility for making sure that the resources are aligned and that we understand what the financial impact could well be. So, there will be issues for organisations to understand those knock-on effects at this time. As with the decision making that we were talking about earlier, although we are doing things in collaboration, there still has to remain a local accountability around the decisions that are made on this. However, the finances will be expected, of course, to be understood by the boards, not least when they make their own decisions, but we are facilitating it through the south Wales programme as well.

[57] **Darren Millar:** What discussion has there been on finances? You say that it is a high-level plan; is it a back-of-a-fag-packet job? Where is the detail of it? I have not seen any detail. I appreciate that you are going to go to a more detailed piece of work once a firmer decision in terms of direction may be made, but even the auditor general keeps warning, on an annual basis, that the plans that he is looking at are going to cost more money in a no-money growth environment for the Welsh NHS. Frankly, do we take these figures with a pinch of salt? You are suggesting a £6 million additional cost; that sounds very small and it sounds like reasonable value for money, but what certainty can we take from those figures?

[58] **Mr Hollard:** No, I—

[59] **David Rees:** May I interrupt? I think that what Darren is trying to ask is: will those figures become public before the decision making so that they can be scrutinised?

[60] **Mr Hollard:** The figures that we have assessed up to the consultation are in the consultation document. There is a technical finance document on the website. What we are very clear about is that when we have made the decision as to which is the preferred model going forward, we will need to do more detailed work, because it is not just about the services that are in scope; there may be knock-on effects in terms of other services that we would need to take into consideration.

[61] **David Rees:** Will those more detailed figures be available publicly?

[62] **Mr Hollard:** They will be available publicly, but not prior to the decision to have a preferred option.

[63] **Darren Millar:** The NHS has been criticised regularly and roundly by the Auditor General for Wales, the Finance Committee in the Assembly and the Public Accounts Committee in the Assembly for its failure in terms of effective financial planning. How can the public have any confidence in the figures that you have arrived at to date? You do not even mention finance as being a feature of what you have considered in the summary report that you have presented to this committee today, which I think is very unusual, certainly. At least the other boards that appeared before us indicated that there was financial information available and made reference to it. Can you tell us how the public can have any confidence that you have your figures right?

[64] **David Rees:** Before you answer that, I will clarify that you were not asked to provide us with information on finance.

[65] **Darren Millar:** To be fair, I appreciate that it is about the process of the decision making. They have referred to all of the other elements that are being considered.

[66] **Leighton Andrews:** Chair, there are figures in the original consultation document. Perhaps Darren should read those.

[67] **Darren Millar:** Look, we—

[68] **David Rees:** No.

[69] **Darren Millar:** Chair, we are looking at a process today—

[70] **David Rees:** We have a question that has been asked, and I will stick to that question. However, I make the point that they were not asked to comment on the financial aspects when they were written to by the committee.

[71] **Darren Millar:** Okay. May I just clarify this, then, Chair? If this committee is looking at the process by which the south Wales programme board has arrived at its decisions, and finance has been a consideration, I find it very unusual that they have referred to all the pieces of information that have informed their decision making other than finance, which, frankly, is the elephant in the room.

[72] **David Rees:** You have made your point.

[73] **Dr Goodall:** One thing that I would say is that you have had individual health boards coming into this committee to be scrutinised on their processes, and they have been talking publicly about a whole range of services in their area that are part of a comprehensive local plan for their organisations. We still have that responsibility locally, as Aneurin Bevan Local Health Board; we still have a responsibility to have our local plan, our annual plan, and all of the detail of all the finances available, and to do that on a public basis. The south Wales programme has been where we have had to reach out from those local plans and bring together a discussion around some of these fragile services. Of course, there is a financial context to it, but the reason that we have focused on this is not because we are trying to use it as a mechanism for driving savings, but because we have started a discussion with our clinicians telling us that they do not feel that these services are sustainable. Through the process, we have done the financial assessments. We have the technical documentation available, but we, ourselves, realised that this was not about saving money; this was about trying to put the services onto a safer basis. We think that we have made a judgment, professionally so, about the cost that would be contained in trying to deliver that. We have not just looked at the existing services; we have had to look at whether we are meeting standards or not and also try to futureproof them for the future. So, I think that we have dealt with it in the context of a focus on fragile services rather than as a holistic plan, which is for a whole area. If I were to be scrutinised on one of my local plans and how Aneurin Bevan Local Health Board looks for the next three years or so, we would have all of that detail available for you to show the kind of decisions that we think we need to make. So, I think that there is an assessment here, which is financial, but I think that it is a slightly different context from the Hywel Dda and Betsi Cadwaladr discussion.

[74] **Darren Millar:** Chair, perhaps Mr Goodall will provide information as to the financial impact within each individual health board in terms of the assessments that have been done so far. I appreciate that the technical documents are available. I have looked at the technical documents, but they do not actually impact on the specific costs per local health board, which I think is an important perspective.

[75] **David Rees:** Are you able to provide that information?

[76] **Dr Goodall:** Yes; we are happy to work through that answer and give a very direct response based on the assessments that we did on the finances.

[77] **David Rees:** That is fine. I will take a question from Lynne next, and then from Lindsay.

[78] **Lynne Neagle:** I just wanted to ask about the role of staff in the whole process. The paper that you have provided highlights the unprecedented level of consultation that has taken place with staff at all levels. Are you able to tell us a little bit more about what you have gained from that, and how you feel that that has added particular value to the whole process?

[79] **Mr Hollard:** Perhaps I could pick up. We have engaged staff at all levels and in a variety of ways. So, for example, we have held a large number of clinical conferences, which have included lots of different types of staff, professional groups and other stakeholders et cetera. So, we have had the south Wales approach. On each individual health board, perhaps I can speak parochially for a second. For example, as director of planning within Cardiff and Vale University Local Health Board, I was holding staff discussions, meeting with staff on a regular basis and holding open-door discussions. I have had staff from all parts of the organisation, from housekeeping staff to senior medical staff within the health board. So, we have talked to staff in a variety of ways. Staff have also engaged through their professional bodies, and we have taken those submissions and discussions into account. So, we have engaged with staff quite a lot, both locally within each of the health board areas and across south Wales, through conferences et cetera. I do not know whether colleagues want to add

anything.

10:00

[80] **Dr Goodall:** We have also had to repeat a lot of those mechanisms; I would want to assure the committee that this was not about just a one-off meeting and then leaving the room afterwards. It has been a continuous relationship with many of the people involved in this over the course of the last 21 or 22 months or so. I still remember feeling that it would have felt unusual for staff being involved in something like this. As I said at the outset of the meeting, this is about health boards working collectively in a very different way to how they would perhaps have done that traditionally within their own organisations. It was the first meeting—and I remember being at the front of the clinical conference with around 300 people in it—where, to be fair, a surgeon from the audience asked where the secret plans were, because this was not an open process, and this was not about involving staff, and I guess some of that reflects some prior experiences that people would have felt that they had had. However, people have held very true to it. People have been very respectful of the process that we have gone through. We have certainly not been telling people that you come into a clinical event or a conference and it is a secret, but as you would have seen yourselves, people seemed to be very respectful up until we got to the engagement; actually, they allowed it to emerge in a very collective way. That relationship is still there now, so even in October, as some of the findings come out prior to decision making, we will be going back to all those staff originally involved to show them where we have got to in the process to date.

[81] **Mr Laing:** Perhaps I might just add that, in addition, within each health board, there has obviously been discussion with the partnership forum, and with the health profession forum, for example—that is another formal way of engaging with staff. I do not think that you touched on the clinical reference groups, which have been a really important driver and source of information. We had a clinical reference group for each of the clinical areas that has been doing detailed work, really making sure that, where there are standards and best practice and information from the rest of the UK and around the world, that they are being brought to bear. In addition, we have taken a lot of the data related to each specialty, and those data have gone back to the clinical reference group for them to look over and challenge, to make sure that they feel right for them based on their own clinical experience. I have been struck by the way that clinicians have engaged in this in a very positive way; not a parochial way, but with a genuine wish to see us delivering better quality care. Just to come back to Mr Millar's point, one of the things that clinicians are very clear about is that providing better, well-organised care is nearly always cheaper, because you are doing it right the first time. As clinicians, we are seeing a lot of wasted resource, putting things right because we have not structured our services to meet all the standards that we know they should meet.

[82] **Lynne Neagle:** Something that we have not seen with the south Wales programme is the kind of scenarios that we have seen in other health boards, where clinicians have expressed very vocal concerns about the plans. You have clearly done a lot of work involving staff, so to what extent are you able to say that you pretty much have the buy-in of the staff in the whole area?

[83] **Dr Goodall:** To go back to my introductory remarks, I wanted to remind the committee that what we have been looking for here is consensus, and of course you are looking for a very strong consensus in that respect. Even where there have been disagreements along the way, we have asked people, not least through the clinical reference groups, to make sure that they were giving the programme board—which is representing the chair and chief executives—a very clear set of recommendations at this stage. It would be wrong to pretend that it was a unanimous process. Clearly, you will always have some different opinions, but we have tried to accommodate those views and focus on the right issues, and, as I was saying earlier, we have had choices to make around the style and the

approach that we have wanted. If there is a problem, people need to define what it is and we will work with them on it, and then we will try to make sure that we can come out with a solution that is going to work.

[84] **Mr Hollard:** The other interesting thing for me in terms of the formal public meetings is that we have had clinicians from different health boards at the same meeting with a consensus view about the issues that we are facing. As Hamish has said, the clinical reference groups have been driven and led by the clinicians, and that has been extremely important. Even where we have faced some challenging times, if you look at our website, a lot of the videos that are on there are clinician-led videos. They have been very happy to explain to the public and to our other stakeholders the problems that we are facing. They are real problems, and it was they who generated the issues for us and said, 'We cannot continue as we are'. So, as Andrew said, it may not be universal, but certainly a vast majority of the clinicians have either been involved, have contributed, or have led the process. What we have done is to provide the ability to do that through the programme.

[85] **David Rees:** Leighton has a supplementary question on this and then we go to Lindsay.

[86] **Leighton Andrews:** I am trying to understand the process of reconciling the differences between clinicians a little better, because you rightly said that they are not unanimous, and there clearly is not a monolithic view on all of these issues. So, are there any areas where there have been significant differences of opinion, within the five boards, among the clinicians that you have had to resolve?

[87] **Mr Hollard:** I do not think there have been significant issues. One of the issues with the clinical models, for example, has been how near to the standard one can get with the current workforce. There have been discussions around whether we need nine doctors on a rota or 11 doctors et cetera. However, the fundamental standards, the quality standards and the workforce requirements have been considered across all the organisations, and there has not been any dissent. This is, I think, because the clinicians are very mindful of their responsibility to develop it and to deliver the clinical standards, and in these services in particular, they are very clear. So, there has not been a major issue; it is probably around the edges that we have had further debate.

[88] **Dr Goodall:** It would be right for us to recognise that, where the tensions will emerge, whether it is in the public, in the community or among clinicians themselves, having a debate that focuses only on sites is likely to lead to different views and different perspectives coming through. However, again, through all of the process that we had, we asked people, very much from the early stages, to just stand back. I know that there was a wish probably to look at a map of south Wales and to start trying to decide what the unit should look like, but we got people to accept where there was a problem in the first place and to focus on the clinical models and to set aside those issues around the individual sites. I think that that has been a strength in where we have got to so far. It does not take away some of those individual decisions.

[89] It would be right to say that, within the clinical reference groups, people did not simply turn up to the first meeting and then agree. They had to decide about general specialties and specialist areas, and the balance between those areas. However, despite those different views, all the groups were able to give us a very clear recommendation on the back of some quite different views being expressed in the room.

[90] **Mr Laing:** I would just add that one of the things that the process has done is to help clinicians in each of the individual health boards to have a wider perspective. It is easy to think that everything is like it is in your hospital, be they the challenges or the standards; you

just think it is like that everywhere. Actually, of course, it is not. By getting people together, I have been struck by how, over time, the clinicians have rapidly come to understand a much wider view of what the challenges are in south Wales and in Wales generally. That has helped a consensus for change. I am not aware of anyone, really, who is dissenting about the need for change broadly along these lines. I would agree with Andrew that, of course, people are attached to their local hospital, and there is a range of views on that, but we have not yet resolved that. In terms of the principles and the models, however, I am not aware of any significant dissent from any group.

[91] **Lindsay Whittle:** I have my own views on that, with respect. I do not want to be over-simplistic, but I think that if we had enough consultants, specialist clinicians and experienced staff in all of our hospitals, we would not be having this debate now. I think that that is a fact. I still do not think that we do enough to encourage people from other countries to come here, because we are not training enough of our own people. You and I have had separate meetings—and thank you for those regular meetings; they are very welcome for us in south-east Wales—about advertising and recruiting in Cuba, Germany and Canada. It is a rehearsed scenario, is it not? We would not be here now, and we would not have 60,000 people responding to us—and that is the tip of the iceberg, because, for every one who responds, there are probably five or six others who feel the same but do not take the time and trouble to put pen to paper.

[92] Coming back to my question, in one of the consultation meetings, one of the clinicians stated that the proposal would not lead to 24/7 consultant care, but that consultants would be on site for only 16 hours a day, and that middle-grade doctors would be managing patients during the night shift. Can you confirm that that is the case, because that would set alarm bells ringing? If you are going to sell something, if I am critically ill, I need to know that there is a consultant there 24/7. [1]

[93] **Mr Laing:** May I answer that? That sounds like a reference to a standard from the Royal College of Physicians, which believes that a consultant physician should be in the hospital—on-call, but in the hospital—for 16 hours a day. That is the standard. We are nowhere near that now; let us be clear about that. That is 16 hours a day, every day of the week; not just Monday to Friday. If we were to get there, it believes that that would dramatically improve the quality of care. There is a period of time during the 24-hour day when the number of acute medical admissions falls off quite markedly. It is about four hours, mostly in the middle of the night. So, the view is that it is not even necessary or desirable to have the consultant there 24/7. Of course, there is always one on call to provide advice in those four hours, if we get to that point, but having a consultant available to provide advice to the most acutely ill people as they come in to hospital, which is normally during that 16-hour period, would be a massive improvement on where we are now. So, you can be reassured that nobody was suggesting that there would not be a consultant for those four hours, but they might not be in the hospital for that lull in the middle of the night. [1]

[94] **Dr Goodall:** In the public meetings that we had—and people have to recognise that we would always have a different understanding of some of the services; we are involved in them very directly and have a feel for them—one of the things that we have had to deal with is the public's expectations and the public's understanding of some of the services that are already available. There is an impression among the public that there are, for example, consultants available 24 hours a day for some of these individual specialties. It is simply not a fact. It is one of the drivers for the change in the first place. When we go back to the case for change that we made, it was recognising some of the gaps that exist, particularly at the consultant level, but at the junior medical staff grades as well. So, even if the public feels that a local hospital has all of this available, we have been trying to make sure that we can discharge services safely, but there are pressures around the availability of medical staff.

[95] **Mr Laing:** To give another example, which, once again has a 16-hour figure in it, namely emergency medicine—or accident and emergency, as most people think of it—we have departments in south Wales that we describe as consultant-led and which the public thinks are consultant-led departments that have fewer than two consultants. You just have to do the maths, factor in a bit of annual leave and the fact that they work 40 hours per week, and that means that, for the vast majority of that working week, there is no consultant in that department. That is why the standards talk about nine, 10 or 12 consultants to provide those 16 hours per day for the most acutely ill people. We are not delivering that now—we are nowhere near it in some departments. Of course, those consultants are doing their very best to try to cover the working week and be there for the most important times, but two people cannot do that. It is not possible. [1]

[96] **David Rees:** Paul, would you like to comment?

[97] **Mr Hollard:** I would like to come back to Mr Whittle's remarks, because it is not just about the workforce. One of the very clear messages from our clinicians is that they need to have a level of activity and need to see a certain number of patients to make sure that their competence and skills are maintained. Across south Wales, the level of activity means that, even if we had all those doctors, they would not see the number of patients that would enable them to be reaccruited. So, they would not meet the standard. Therefore, it is not just about the workforce; it is about the number of clinical activities they do that is deemed to make them skilled and competent. Once again, if you look at the website that we have, that is made very clear in a couple of the videos. It is not a question of just having lots of doctors, because we need a level of activity in certain centres to make sure that those doctors remain competent. I just wanted to clarify that.

[98] **Lindsay Whittle:** I have one more question. Would you like me to ask that at the end, Chair?

[99] **David Rees:** Yes, at the end. We will now have questions from Rebecca and then Elin.

[100] **Rebecca Evans:** Access and equity are two of the key criteria that are guiding your approach to this, and they are certainly the issues that have been most raised with me by people living in south Powys—many of whom rely on public transport. That was the key issue that also came out in the Ystradgynlais meeting: that public transport was the main focus of people's concerns. So, to what extent are your plans reliant on public transport, which is essentially outside your control? I know that people will not take public transport in an emergency situation, but if you have a critically ill family member or an ill child, for example, then family visits are important.

[101] **Mr Hollard:** We have been working with Swansea University to map the current transport routes for all the options that we have. That has been really helpful. It followed on from some work that was done locally in Abertawe Bro Morgannwg health board. So, we have been working with Swansea University to map all the current transport routes, to look at the travel times in those transport routes. It has been really helpful as it has shown us the gaps. So, if we are changing the potential flows of patients, and therefore visitors, perhaps, we will be very clear about the gaps that would appear in those transport systems.

[102] The other thing that we are doing as a follow-on from the south Wales programme, and the work that we have done within the programme, is that we are working with the Welsh Government and its officials on the transport work that they are doing centrally. So, we are very mindful of the public transport issue.

10:15

[103] Alongside that, we have to be very mindful of the clinical pathway that patients will follow. We have made a commitment that, wherever possible, and when it is safe to do so, a patient will move back from a specialist centre into a local centre, because we are aware that public transport and access is really important. So, we will have a gap analysis. We are working with Welsh Government on what that looks like, not only within south Wales, but across Wales. We have also had some discussions with local authorities as to how we encourage transport networks.

[104] As part of the public consultation, we have also met with a lot of third sector transport providers. It was quite clear that some of that provision is quite sparse in some areas, but even where it is available, a lot of members of the public do not know about it. So, how do we encourage publication of all transport systems, whether that is in the public transport network, in community transport or third sector transport? We are very mindful of that, and we have done quite a lot of work to date. When we get to the preferred option, we can have more detailed discussions with local authorities at a local level, particularly if those patient flows, and therefore visitor flows, change.

[105] **Mr Laing:** From an ABMU perspective, as Paul indicated, this builds on some work that we commissioned for our population. It describes how things are now and assumes that nothing will change in transport if you move services. That is the point of it: it is a baseline. However, we have already shared that with our transport partners through our formal strategic meetings. There has been reasonable criticism before that we have sometimes made some service changes and then worried about addressing the public transport issue. What is very clear from what we are doing here is that we are trying to understand the public transport implications before we make service change by working with partners in transport, so that we can try to anticipate those changes better.

[106] From a clinical point of view, you are quite right that only a tiny percentage of people who are acutely unwell in general travel to hospital on public transport. However, there are implications for families and others who are less acutely unwell—like those using maternity services—who may use public transport. The average length of stay for a child admitted to hospital these days is about one night. For a woman having an uncomplicated delivery, it is probably a day now. The models assume that where there are prolonged lengths of stay, we would want to try to get people back to a hospital that was local. However, for most people, even if they did have to go a bit further to get the care, they would probably only be there a night or two at worst. So, hopefully, the implications for visiting are not quite as great as you might be concerned about.

[107] **Rebecca Evans:** What role do you envisage for an air ambulance, because with the greatest will in the world, it cannot operate 24/7, 365 days of the year, because of the weather, and so on?

[108] **Mr Hollard:** Some work has been undertaken to look at medical retrieval through air transport. Alongside that piece of work, which is not in the public consultation necessarily, we have agreed that we would need to develop a trauma centre service and a trauma network across south Wales. We will take the work that has been done to date to look at how it supports the trauma network and the trauma centre development, which will be starting when we have completed the decision making on this consultation. So, a lot of work is already being undertaken. We have looked at models in Scotland, et cetera, and this is broader than the south Wales programme—the whole of Wales needs to be engaged in that discussion. That is where we are currently with the air ambulance.

[109] **Mr Laing:** To provide some further reassurance, I am part of some of that work, and it is looking at much broader options than just helicopters. We have an excellent air

ambulance service, but it cannot always fly, as you rightly say. So, we are looking at a model that also includes rapid response road vehicles to support that. That will be quite an important component to get round the problems of flying in difficult environmental conditions.

[110] **Rebecca Evans:** Thank you.

[111] **Elin Jones:** I want to take you back to workforce issues. You said earlier that you were nowhere near the optimum workforce in the current configuration. So, in your preferred option of the five-site model, do you remain confident that a safe and sustainable workforce is recruitable and retainable for such a model, after the consultation that you have gone through?

[112] I have a few other questions on a few other areas. One is to take you again through your relationship with community health councils and the support that you will give them. You have said how challenging it is for health boards to work together in a south Wales programme, but for CHCs it may be even more challenging. We have seen how the relationship between a health board and a CHC can break down when it is only a one-on-one discussion, especially in west Wales, where you had the added complication of Opinion Research Services Ltd threatening legal action against a CHC. You are also using ORS. I want to ask you how much discussion you are currently having with CHCs. How are you, as professionals and professional clinicians, working to support what is a voluntary—almost—arm of the health family? How will you think of engaging and supporting them? What work have you done in preparing yourselves for that? Finally—

[113] **David Rees:** Can we come back to you? I will ask the witnesses to answer those points first, please.

[114] **Dr Goodall:** I suggest that we start off with the workforce response. Paul, could you start on sustainability in general? Hamish, perhaps you could comment on some of the practicalities of recruiting staff to that model, and then we will come to the CHC response.

[115] **Mr Hollard:** In terms of the workforce requirement, what is quite clear from the clinical reference groups is that one of our challenges in recruiting medical staff in Wales is the fact that we have spread the services across too many organisations. We recognise that the peer support is not there, so when you are talking about—as Hamish did earlier—two or three consultants trying to run a service, the ability to undertake research, attend conferences and have a work-life balance is not very attractive in some areas in south Wales. What the proposals do is bring together those services on fewer sites, particularly at the specialist end—we have to remember that we are talking about the specialist end of services here. Therefore, it becomes more attractive, because you can recruit consultants into a body where there are more than two consultants, where you have a work-life balance, where you are able to undertake your research and where consultants are able to pursue some of their specialist interests. Currently, that is not available to them, as they are bombarded by the activity that is in front of them because they work in a small group.

[116] The other thing that that knocks on to is the experience that trainees get. If you do not capture the enthusiasm of trainees to work in an area in Wales, they are unlikely, when they finish their training, to want to work in Wales, because they look at their consultant colleagues and think, ‘Is that what I’ve got to look forward to?’ It affects all medical staff.

[117] In terms of sustainability, we have been working almost in isolation, although there are some good examples of medical staff who go across services. I will give you an example: not so many years ago, we centralised upper gastrointestinal cancer services in Cardiff. There were lots of concerns about what that would mean to consultants who were not necessarily working in Cardiff. We have a network arrangement, so consultants will see their patients locally, will bring them to the centre, will maintain their skills through operating and will then

take their patients back and follow up on them. We are going to have to work more on a network basis. So, we will have medical staff who will work from a centre, but will work in other parts of south Wales to maintain their skills.

[118] The population that we care for is quite diverse across the whole of south Wales. Those diverse populations bring a lot of experience to medical staff, either in training or when they are undertaking consultant-led work. We believe that the proposals will become attractive, because we have listened to what trainees are telling us and to what our consultants are saying. As I said, trainees will often ask, ‘What is the pass rate in that area? What is the supervision like in that area? What are the opportunities in that area for me to undertake my specialist interest when I become a consultant?’ By creating fewer centres where we co-locate those staff, it becomes more attractive.

[119] **Elin Jones:** All of that is attractive in a five-site model, is it?

[120] **Mr Hollard:** There are discussions with the clinical reference groups and other stakeholders around that. We have consulted on four options—two four-site options and two five-site options. In terms of the best-fit option, which is the five-site model, we have said that we believe, from the evidence we have, up to consultation, that that is sustainable and deliverable. However, again, we will, when we analyse any further information that comes through the consultation, look at whether that changes that perspective.

[121] **David Rees:** Andrew, did you have a response on the CHCs?

[122] **Dr Goodall:** I was going to ask Hamish, just because he is a doctor and can give a little bit of an insight into these issues, whether it might be worth him giving a practical example of whether you can attract people to these new services in this way. I would then be very happy, Chair, to pick up on the CHC issue.

[123] **Mr Laing:** We are in a buyer’s market. The answer to your question depends a little bit on which service, which of these specialities and which grade you are talking about, because the situations are different. I am conscious that you are meeting deanery representatives later and you will no doubt get into detail about that with them. However, it is a buyer’s market, by and large, at the moment, for these specialties and we are not very successful at buying. That is because people have choice. There are posts available, for example, in emergency medicine throughout the United Kingdom. You can just about work anywhere you want if you are ready to be a consultant. So, we have to make them more attractive. There is an objective answer to your question, which is that, for some of these services, just aggregating people into smaller groups will immediately mean that we will meet standards and so on, in which case, that almost certainly is straightforwardly sustainable.

[124] However, there is some subjective judgment about how attractive it will look to clearly have an organised plan and to have configured into fewer places. There is a judgment about that, and, therefore, there will be a range of views. I will give you a parochial example from my own specialty. It is a specialty that was reconfigured. We moved 75 miles from Chepstow to Swansea a little while ago. We have gone from four consultants to 17. We get ranked top in the UK for training and we have no trouble attracting people to work. We are seen as an organised service that has a plan that provides high-quality care and high-quality training. As a result of that, our reputation is good and it makes it a lot easier to recruit high-quality, high-calibre staff who pass the exams. Then, the word gets out and more people want to come. If you are struggling to recruit, you are not always recruiting in the first or second round of recruitment, you are not always recruiting the best people, they may not do so well at exams, and so, quite quickly, you are in a vicious cycle of decline of people not wanting to come, because the word is that you do not pass exams if you go to work in Wales. So, there is a judgment and that is something we will hear through the consultation. However, our belief

is that it was sustainable to have five, which is why it was in the consultation.

[125] **Dr Goodall:** On the community health council issues, of course they have a formal and a legal role. We have wanted the CHCs to be part of our process throughout. So, they have had the opportunity to act as independent and neutral observers to the clinical conferences right from the very start. That included some of the national machinery, but allowed some of the local CHCs to see the nature of the discussion that happened. We have tried to make sure throughout all of this that we protect their neutral role, because they are going to have to make their own decisions on behalf of communities and one of their roles is to listen and act as advocates as necessary. Having said that, it has also been important for us to establish our own relationship with them both individually and as a group. So, we very regularly met with the CHCs collectively. We have had to make sure that, when we have gone out at various stages, whether it is the engagement aspect, or the nature of what the document should focus on, or how people would get assurance, or the consultation, they are content with that. The timetables, for example, are not simply health boards sitting in a room by themselves. They are timetables that have to be agreed with the CHCs, because they do take on a formal role.

[126] We also used the CHCs, not least for the very formal public meetings that were taking place across south Wales. They chaired those meetings, they facilitated them, and they made sure that we were, as professionals, having to sit in front of the communities and answer the very fair questions that were being asked by people. However, they will have their own part in this process to come. They need to get themselves into decision-making mode. We are saying at the moment that we will be aiming to be doing that through November. They also have to give their recommendations to our board discussions when we make our final decisions as health boards. It would be right to say that, even when we deal with CHCs on a local basis, they will often challenge us and have their own views and they will require us to give further information and details. We are multiplying this by five at the moment, and I guess that is slightly untested territory. The good news, from my perspective, is that, positively, they have stayed with us right through the whole process. We have stayed collective as health boards. They have equally stayed collective as individual community health councils, but they are going to have to listen to their own communities as part of that process.

10:30

[127] **Elin Jones:** I have a final question on another matter, and that is your relationship with Hywel Dda health board. The people of the Hywel Dda health board area rely on a number of the south Wales hospitals and decisions have been taken in the Hywel Dda health board area—there is the ministerial decision on A&E in Llanelli, and there is still no decision on obstetrics in Hywel Dda. I just wanted to know how you engage with Hywel Dda health board and the population in that area to ensure that whatever you deliver in the south Wales programme reflects the requirements of another population that is, technically, outside your area.

[128] **Mr Hollard:** The chair and chief executive of Hywel Dda are members of the programme board. In fact, the chair of Hywel Dda has stepped in when our independent chair has not been available to chair the meetings. We are working very closely in terms of its models of service and making sure that we are comparable, while recognising that there may be differences because of local circumstances. Particularly on the boundary areas, we are looking at whether the flows into or out of Hywel Dda impact on the models that we have. We are looking very carefully to see that we are working together across that boundary area, recognising that the reason why Hywel Dda was not in the south Wales programme was that it was in advance of the south Wales work. We did not want to hold up the work that it needed to do, because it had fragile services. So, Hywel Dda is a member of the programme

board, we work closely with it, particularly on the issues that cross the boundaries. In terms of public consultation, around 100 people from west Wales have formally contributed to the consultation and submitted questionnaires, so we have not held the consultation within south Wales. In fact, we have had comments and submissions from across the whole of Wales and even parts of England. We have not contained the consultation to south Wales, and west Wales residents have had the opportunity to contribute.

[129] **Mr Laing:** As a board director of ABMU, I can assure you that we have extensive bilateral conversations, because, in reality, the implications of plans in Hywel Dda are mostly on our health board. We have regular discussions with it. In fact, we are setting up a process to look at services on a regional footprint—we already support them with many services—and where that is likely to go in the future. So, we are having separate but very important conversations between the two boards.

[130] **David Rees:** At the very start, you said that you were re-looking at flows of patients. Is that going to include flows that may now come from Hywel Dda, as a consequence of the decisions there, as well?

[131] **Mr Hollard:** No. The adjusted flow issues have primarily come from the Valleys populations, and whether they go across valleys or down valleys. It does not really impact on the border between ABMU and Hywel Dda. It does not impact there. It is more around the central Valleys population. That is where the flows have been considered.

[132] **Dr Goodall:** We have, obviously, taken those original flows into account for the original consultation, so that was more of a change that we introduced recently. We did do the work as part of our engagement.

[133] **David Rees:** Darren, you have a question.

[134] **Darren Millar:** It is two questions, actually, Chair, if I may. They are very brief questions. A very different approach was taken to stakeholder engagement and public consultation in north Wales, compared to that for the south Wales programme, and, indeed, in west Wales. It appears to me that there have been improvements each time. I commend you on making those improvements and making yourself available to the public in what must be difficult for a sometimes, like stepping into the lion's den. Things have been very different. Do you think that the Welsh Government guidance on public engagement and consultation in the NHS is clear enough? It is clearly open to significant interpretation at the moment. While each health board has met its obligations under that guidance, the very different approaches lead me to believe that perhaps it is not necessarily fit for purpose.

[135] **Dr Goodall:** Obviously, we have been working with the new guidance. Our tradition would have been more about just having a fixed consultation period, just having one option on the table and trying to persuade everybody that that was the answer. So, there has had to be a change in style and approach. I guess, sometimes, there have been some frustrations over these recent months because people feel that we have gone out again, reminding them about the case for change, and they are wondering why. It is because we have had to recognise that there is an engagement process, the pre-planning stage and then the formal legal consultation that takes place. It would be right to say that we have learned from other colleagues as they have gone through it, as is right. That, obviously, includes colleagues within Wales, but we have also had the opportunity to look at broader learning about service configuration over the border in England and some of those approaches and aspects.

[136] The milestones in the guidance are pretty clear. There is, absolutely, a legal interpretation of the things that you need to do, and that is clear. It is more a question of how you approach it and what the style is. We felt that it was really important, in what are very

difficult discussions—and you are right, there have been some difficult public meetings and all of that—to be open and to allow everybody the opportunity to say the things they wanted to say. I think that we have approached it with a style that allowed everybody to be in the room if they had concerns, and, indeed, even to offer more meetings, if necessary, in some communities, if people had missed the first one. We have a few examples of that. I think that we probably exceeded the guidance in many respects, but that was the choice of the programme board.

[137] **Mr Hollard:** The other thing that we have been very mindful of is our equality responsibilities. So, while we have had formal public meetings and have been very open, alongside that—and it has not necessarily been recorded as a public meeting—we have used the third sector to engage with people who may not turn up at a public meeting. Very often, it is a certain type of individual or resident who will turn up at a public meeting, but there are others who have a lot to say and have important information for us, and, unless you engage even further, you will not get that richness. We have learned from the others, and, in some respects, going last has been helpful, because we have tried to remedy concerns that have been raised in other areas in Wales and in England.

[138] I think that the guidance is very clear in terms of the policy and the absolute requirement. What we need to continue to do within the NHS is to look at continuous engagement and discussion, because what has been interesting through the south Wales programme is that a lot of the concerns that the public has raised have not necessarily been about the south Wales proposals, but about other issues, and we learn from each other as health boards. So, some health boards have very set ways of engaging and with others it is more fluid. The way we have done the south Wales programme has, I think, demonstrated the benefit we get from just listening and talking to our residents about any issue, albeit that this has been about the south Wales programme.

[139] **Darren Millar:** Of course, this will not be the last change the NHS in Wales will see, and I wonder whether, as a programme board, you would welcome firmer guidance and more clarity on minimum expectations et cetera from the Welsh Government in the future. I know that north Wales and west Wales suggested that they would welcome that, and I wonder whether that is your view.

[140] **Dr Goodall:** What we would like to be doing is sharing our views of the things that we think have worked well and the particular decisions that we took along the process, and we are happy to broker that. I guess that part of today's session is about trying to do that for you, and to say that we have learned lessons. We have opportunities through other fora: the Wales Audit Office has asked us to try to describe the process to date, because it seems to have broader public-service implications. We would welcome the Welsh Government helping us to share those lessons. I am not sure whether the guidance itself would need to change, as such, but the style and approach that is taken is something that perhaps needs a greater emphasis.

[141] **Leighton Andrews:** Certainly, I would say that the experience has been a positive one, in terms of the range of views that have been expressed, and the ability to articulate those at meetings and so on. I have two questions based on something that Paul has said. One is on equalities. In your evidence to us, you talk about your equality impact assessment of this. To what extent are judgments on health inequality likely to inform the final outcomes? To what extent will your equality impact assessment be revised in the light of representations?

[142] **Mr Hollard:** Thank you, Leighton. On the website, we have presented the equality evidence that we had prior to consultation. So, there is an evidence file on the website of where we are in terms of what our population is, what its make-up is, et cetera, and the issues we have to consider in terms of the equality impact assessment. It is iterative, so you build on

that, and we are building on it through the responses to the consultation and the submission of the questionnaires. For example, the questionnaire asks for equality information so that we could gather that to look at the response of different protected characteristic groups. All of that is being built up as part of the suite of information that we will have on which to make decisions. We are working with the NHS Centre for Equality and Human Rights and we are getting advice from the Equality and Human Rights Commission to make sure that we are not only complying with the spirit of the equality responsibilities, but actually taking it as far as possible in terms of identifying the potential impact of all the options on the protected characteristic groups. It will form part of the evidence that we will have both for the programme board, but, more importantly, each local health board, in terms of understanding the equality impact of decision making. So, the evidence is there; it is being built upon and we will then produce that built-up evidence following the consultation exercise, and, again, that will be in the public domain.

[143] **Leighton Andrews:** The other question I have relates to what you said about some of the issues that are being raised in public meetings going beyond the scope of the south Wales programme. One of the most obvious ones, I guess, is the Welsh Ambulance Services NHS Trust. Clearly, there has been an ambulance review, but evidence was coming in, in the two meetings I attended, of issues around the nature of the response of the ambulance service, as well as the timing issues that we are all familiar with, and the way it is organised and delivered, particularly across the south Wales Valleys. I wondered whether you had any observations from the programme end on the extent to which the evidence coming in on that will influence your decisions on reconfiguration, and, also, how your own planning will feed into that overall review of the ambulance service.

[144] **Mr Hollard:** There are a couple of things. What has been different in the south Wales programme in comparison to the rest of Wales is that the ambulance trust is a partner with us. So, it has been part of the planning process from day one, really. It has produced a very detailed conveyance document, which, again, is available in the public domain. What we recognise, and what was really helpful to the public in terms of the public meetings, I think, was that we had ambulance staff with us when we were talking to the public and they were rightfully recognising the problems, particularly in some of the Valleys populations, not just in the Rhondda valley areas, but in other Valleys populations and some rural areas of the Vale, for example, where they are not responding at the level that they should. They recognised that. What they have been saying is that we need to invest in pre-hospital care and to be very clear about the role of paramedic staff. It is not just about the ambulance transport; it is about the treatment at the start of the problem that the patient has. If the patient is conveyed to the right place where there is someone with the necessary skill, competence, et cetera, to deal with the problem, then, actually, it makes it easier for them because, often, they are doing secondary transfers, so, they take a patient to a hospital, and, in some instances, they then have to take them to another hospital.

[145] In terms of the review, as you know, the McClelland review was happening during our consultation period. We have recently seen that, and, again, as part of the work of the programme team and the programme board, we will be taking those recommendations and looking at how they feed into the decision making. What is clear from the ambulance trust is that it is very clear that, in an emergency, it would take a patient from this area to this hospital. The question for us is how we make that easier, how we make sure that it is able to provide pre-hospital care appropriately, and then how we make sure, when we receive that patient, that we can deal with that patient efficiently. It has been very much engaged with us and has been part of the programme team and programme board, et cetera.

[146] **Dr Goodall:** Health boards will have to, obviously, respond to the ambulance service review in itself. The good news is that the ambulance service has been alongside us, but we will have a responsibility to commission the ambulance services that our populations need

and that is now very clear to us.

[147] **Mr Laing:** The recommendation that the emergency ambulance service should be seen as a clinical service, not a conveyancing service, is really important, because the thing that keeps most care local is not taking the person to hospital in the first place and being able to provide an alternative to hospitalisation, keeping people in their own homes.

10:45

[148] **Elin Jones:** I wanted to ask you about something that struck me as being particularly different in the consultation on the south Wales programme compared to the consultations for the other two health board areas. The nature of the proposals that you put in front of the population has led to a reaction that some communities, quite naturally, want to protect services in their own hospital areas and are inclined to say, 'Well, change the hospital services in another area instead of ours and keep ours'. That did not happen, of course, in the way that the Hywel Dda model developed, for example, because there was never a campaign, or responses to consultation, which said, 'Don't change A&E in Llanelli; change it in Bronglais instead'. So, because of the way that the proposals were framed, I can understand why this kind of reaction has happened. However, I want to ask: in your analysis of the consultation, how will you deal with responses of that nature?

[149] **Dr Goodall:** If I could start on that generally and then Paul will pick up on the decision-making framework. As I said earlier, even with our clinical staff, as they sat in different fora, we tried to make sure that they looked objectively at issues. We did not want them to feel that they had to negotiate their own hospital versus other colleagues. We have tried to have some of that spirit in dealing with the public and communities as well, at this stage.

[150] Having said that, we would not want it to feel like it is simply communities being pushed to choose over another community. I know that that would be a real concern for Assembly Members at this stage in terms of the decisions that we are likely to make. It is about trying to create the right kind of balance, but I would emphasise that, right from the start, through from the engagement into the consultation, we kept on reinforcing the case for change. Interestingly for us, from a public perspective, we have heard a lot back saying that people do get the change and understand it. It has almost reverted to a debate about, 'What is the right mix, finally, for us to make?' So, I think that we have some clear responsibilities in the decision making to show how we can ensure that there is a balance of the different community views. We have to make sure that it can stand up to statistical analysis and that we do not just say that one community voted one way and there were three times as many submissions from that community as another. It is probably worth your reflecting on the decision-making framework, Paul.

[151] **Mr Hollard:** Yes. In terms of the consultation, we have had a lot of discussion with Opinion Research Services around how it will present the information that we have now collected. We published that last Friday, so that, again, is in the public domain. Everyone can see the process that ORS will go through in analysing the responses and how it will present them. That is really important, because we are clear that it is not a popularity contest; we have to take the evidence that is available to us. So, when people have said, 'Don't put the change in this hospital, put it in this hospital', we have been very clear with the public and it has responded well, because we have said, 'Tell us why—what reasons do you have for suggesting that?' so that it is not, 'I just don't like this option, I prefer that option'. We have said, 'If that is your view, when you give your view, can you give some reasons behind it?'

[152] ORS is working with us to analyse all of the responses that we have had, because, as you are aware, the response has been huge. We have had responses from a variety of sources

and we have had some very detailed submissions from individuals, groups and professional organisations, and we will pull all of that together. What we will agree at the programme board on Friday—tomorrow—is what suite of information should be made available to everyone to contribute to the decision-making process. As I said, the public consultation is one strand. There are other pieces of evidence that we will need to bring together to inform that decision making.

[153] The other thing that we must be very mindful of is, when we went out to engagement and then to consultation, we developed a set of criteria that we would use to assess the options, which we did. So, when we moved from engagement, which had six potential options, and went out to consultation with four, we used the criteria to determine which two options did not give us good scores. We will always have to come back to those criteria, because they are what we have used to take us to consultation; we have to use them in determining the decision. So, safety, quality, sustainability, access, equity and strategic fit are the benefit criteria that we will always have to come back to, because they are what we have set the whole consultation on. I hope that has given you a flavour, but, if you want more detail on the analysis of the public consultation by ORS, it is now on the website; we published it last week.

[154] **David Rees:** On that point of the criteria that you have identified, will the weightings that you have allocated to those criteria be reconsidered as a consequence of the consultation, or will they stay the same?

[155] **Mr Hollard:** In terms of the weightings, we do not believe that they will change, because we did a very rigorous process to get to the weightings. So, they will not change. We will look at whether that is influenced by anything else in the consultation, but the weightings will not change.

[156] **David Rees:** We will have the final question from Lindsay.

[157] **Lindsay Whittle:** Thank you, Chair. None of us can foresee the future, but we do know that the population is increasing. It seems that the birth rate is increasing and we are also becoming a more unhealthy nation, by and large, I am afraid, or, at least, unhealthy due perhaps to illness, as well as other reasons, which we are trying to combat. Whatever decision you make, will this be a long-term pattern for services for at least a decade now so that there can be some stability, or will we see any further reconfiguration in the future?

[158] **Dr Goodall:** I think that it is inevitable that, in any area, there will be ongoing change. I look back at the last four years of service change that I have had to introduce simply in my own area, and it is of a different scale than we were delivering before. Over a third of my staff—up to 50%—have been through some kind of change process that has affected their job descriptions, the sites that they work on, and the services that they are involved in, and new community settings. So, I think that it would be wrong to say here that there can never be any other change. There will inevitably be other areas where, perhaps, critical mass is an issue. The availability of staff will require some changes, as has happened over the last years, starting with areas such as burns and plastics, for example.

[159] Looking forward, to reassure you, we are not looking just to have a service that deals with the current pressures and issues. As part of the process, we have obviously looked forward at demographic demand and profiles, and tried to build that in. So, we are trying to make sure that services are sustainable and can be delivered. We know that there are some very immediate pressures around some of our services, and we have responsibilities to do something about that. However, this is to try to put things on a long-term and sustainable basis in Wales. You referred to that kind of decade aspect, and that is what we are trying to do here.

[160] On looking forward 20 to 25 years, healthcare has changed so much, not least in terms of technology and advances, but the things that have happened in the last 20 years probably would not have been envisaged even if you had had the same review process back then. However, this is not about a fix for a year or two; it is about putting things on a stronger and sustainable basis.

[161] **Mr Hollard:** The other thing that you touched upon was population health and how we tackle the issues around population health. Some of the services that we are talking about are for conditions that have been caused through lifestyle, behaviour, et cetera. If we can start to work on the population health issues and change our residents' behaviour in terms of health, that will change the services that we provide in the specialist areas within hospitals. This is a very small part of what we provide in the NHS, and, actually, we need to pay more attention to the population health issues, because that will, very often, determine what the hospital services will look like in 10, 20 or 30 years' time. A large proportion of what we do now relates to behaviour and lifestyle, in contrast to some of the illnesses that we saw previously. So, an important issue for us as health boards collectively is not just to look at the high end, which is the specialist services that are fragile, in this programme, but to look at the whole issue around population health and how we improve that.

[162] **Lindsay Whittle:** Thank you very much.

[163] **David Rees:** Just to conclude, you mentioned that you have had discussions with the deanery about the programme and the specialist services that you are talking about in this programme. Have you also had discussions with the deanery on the other services, and the training for the other services, which obviously may be affected as a consequence of some services moving from particular sites?

[164] **Dr Goodall:** The deanery is a part of our programme board arrangements, so it has the opportunity to make sure that we are very clear. It is involved in the clinical reference groups in terms of lead clinicians. We also have local discussions with the deanery, which will not just feature a discussion about a concern from emergency medicine placements, but may raise issues about psychiatry, for example. So, we try to have a very rounded discussion with the deanery. Certainly, a very good relationship has developed, not least because we have had to focus on these really serious concerns over the last 21 months together. We, of course, pick up on other specialties that, similarly, may have issues about critical mass, or could indeed be affected in the future.

[165] **David Rees:** Thank you. I do not think that there are any other questions from Members. Thank you very much for your attendance today and for contributing to the committee's discussion. You will receive copies of the transcript for correction of factual errors. Thank you very much.

*Gorhiriwyd y cyfarfod rhwng 10:54 a 11:05
The meeting adjourned between 10:54 and 11:05*

**Cynlluniau i Ad-drefnu Gwasanaethau Byrddau Iechyd Lleol—Cynllun De
Cymru: Deoniaeth Cymru a'r Fforwm Clinigol Cenedlaethol
Local Health Board Service Reconfiguration—South Wales Plan: Wales
Deanery and National Clinical Forum**

[166] **David Rees:** Welcome back. I welcome the representatives of the Wales Deanery and the national clinical forum. We have Professor Peter Donnelly, deputy postgraduate dean of the deanery; Dr Helen Fardy, reconfiguration clinical lead for paediatrics, and, I understand,

also a consultant on nutrition at the University Hospital of Wales; Mr Jeremy Gasson, the reconfiguration clinical lead for obstetrics and gynaecology, and consultant gynaecologist at Neath Port Talbot Hospital; and Professor Mike Harmer, who is chair of the national clinical forum. Welcome.

[167] I will ask Professor Donnelly and Professor Harmer to give introductions, if they wish. Professor Harmer first.

[168] **Professor Harmer:** Thank you for the invitation to attend. I think that you wanted us to go through what the national clinical forum was for—I know that some Members will already be aware of that from previous discussions. The clinical forum was set up approximately two years ago by the local health board to provide an independent clinical source of advice to it in the development of its proposals. So far, we have met with all the health boards and, in this particular instance, we have met with the south Wales programme on several occasions to discuss some of the issues that it was developing. The concept of the meetings we have is that they are confidential, just to give some guidance as to what the forum might be thinking. Following that, when the consultation document comes out, we provide our response along with everybody else who are dealt with by the programme, in exactly the same way, and that response has been submitted. It has been very useful working with the south Wales programme, and we have been able to take on board many of the challenges that they face. Hopefully, we can provide an independent source of scrutiny to the programme.

[169] **David Rees:** Thank you, Professor Harmer. Professor Donnelly?

[170] **Professor Donnelly:** First of all, I would like to thank the committee for the opportunity to return to talk about the role of the deanery. Again, just to remind committee members, the role of the deanery is to recruit, commission and quality assure training programmes across all of Wales, and part of that is to ensure that we have training programmes that are sustainable and of high quality, to ensure that we can recruit and retain the best doctors in training. I think that there is an important distinction between doctors in training and substantive roles such as consultants, GPs, staff and associate specialists.

[171] Our dialogue and interface with the south Wales programme board has been quite extensive. The deanery is a member of the south Wales programme board. In addition, the specialty leads and reconfiguration leads will have attended all the clinical reference groups, the clinical conferences, et cetera. In addition to the agenda of service reconfiguration, we have monthly or six-weekly meetings with each of the health boards, usually at medical director level or associate medical director level, with chiefs of staff associated with whatever the agenda is. So, those are now taking place on, as I say, a four-weekly or six-weekly basis, where we talk about service reconfiguration, but we also bring in all of the rest of the training agenda and issues, so that we can work through those as we go through.

[172] **David Rees:** Thank you very much for your opening remarks. Thank you also for your written evidence to the committee, which we appreciate. I apologise at the start that you might get some duplicate questions from your previous attendance, because clearly there will be some overlap in some of the issues that will be discussed. I will open it to Members and ask Leighton to start.

[173] **Leighton Andrews:** Professor Harmer, will your submission be made public?

[174] **Professor Harmer:** It has been submitted to the programme board, and I believe that it will be made public along with all the other submissions that have come in.

[175] **Leighton Andrews:** Do you have a formal role later in the process in advising the

programme board on the outcomes?

[176] **Professor Harmer:** We do not have a formal role. We always offer our support and help if it is required, but there is no formal role in the implementation aspect of it.

[177] **Leighton Andrews:** Is there any problem with making your submission public now?

[178] **Professor Harmer:** I do not see a big problem. It is submitted. It is important that I will be attending the south Wales programme board on 22 October to make a presentation to it of that report, because I think it is often helpful to give a verbal discussion as well to the board. However, from our point of view, it has been submitted.

[179] **Leighton Andrews:** I am trying to understand: if you are a participant in the consultation, would you expect to have a formal role? Are you at any stage likely to have a formal role subsequently?

[180] **Professor Harmer:** It is not in our terms of reference. When the forum was set up, it was to advise in the process of developing the consultation document and then comment upon it. It does leave in there the opportunity for all the health boards to come back to the forum to seek further advice, particularly about the implementation, but it is not a formal part of our terms of reference.

[181] **Rebecca Evans:** You refer to the fact that you offer support to the health boards as they take forward this piece of work. Do you also offer a level of challenge to the health boards, and could you give us some examples of ways in which you have had to challenge the south Wales programme board?

[182] **Professor Harmer:** Absolutely. One of the things that we have had to look at is the number of units. One issue that is perhaps different in the way in which the clinical forum looks at things is because it has representatives of every aspect of care—all healthcare professionals are represented—it also has input outside the specialist areas. So, whilst the south Wales programme is looking at particular areas of emergency medicine, obstetrics, gynaecology and paediatrics, we also have representatives of intensive care, general surgery and general medicine, and sometimes their input is helpful to be able to say, ‘We understand why you wish to configure in this way; however, the knock-on effect for our particular speciality would be the following’. That is one of the things that we have been able to put in to the south Wales board to say, ‘That would actually pose problems for other specialties and perhaps you would like to give some consideration to that’. It has always been our case that we have wanted to look beyond what is actually being looked at in the consultation. What we have tried to do, in the initial discussions with the health boards, is to make sure that everybody is aware of the knock-on effects of any consultation.

[183] **Lindsay Whittle:** We heard from previous witnesses from the south Wales programme that preventative measures are important—I am sure we all agree with that—to try to keep people out of hospitals. Given that the service delivery model is now moving towards greater emphasis on care in the community, what is being done to more proactively recruit more GPs in some of our areas? We are at crisis point in some parts of the Valleys that I represent, with lots of GPs ready to retire. There is a programme on television—I have not seen it because I do not seem to get home early enough these days—called *The Indian Doctor*, which talks about the heady days of recruitment in the 1960s, which was very successful. Do you have any initiatives like that?

[184] **Professor Donnelly:** General practice is an area that is a challenge, particularly in Wales. We have to recognise that and it is something that is on our radar and has been for some period of time. In terms of the recruitment, we are charged with recruiting 136 new

trainees per year into the training scheme. We just about filled this year; I think that we are four short and the four happen to be almost the entire Aberystwyth GP training scheme. This is a particular challenge for us in Wales. I guess that the way I always look at this is to ask what product we are trying to sell. That question applies to all specialties: what is the experience that we are trying to sell to prospective candidates? That is a challenge. In rural settings, general practice has changed. We are now talking about a reconfiguration of services where specialist services will be consolidated. There are questions around GPs' immediate access to diagnostics, for example, and there are still questions around what an integrated care model may be—is it more GPs or is it advanced practitioners of some shape? It is a huge challenge.

[185] In a UK context, England has made a decision to increase the number of GP trainees and the number of GPs coming through. So, I would just say, frankly, that the jury may be out, in that it may be advantageous to us if it is not able to find substantive posts for those trainees who are coming through—there may be a wider market for us to be able to attract trainees into practice.

[186] **Lindsay Whittle:** If I may, I will just follow up on the training. I heard earlier about accreditation, which I must confess that, as a non-professional-medical person, I was unaware of. What is the situation there? Are we concentrating on putting more trainees on specific sites, and how will that affect other hospital sites?

11:15

[187] **Professor Donnelly:** Perhaps I will introduce the subject and turn to some of my colleagues to give some details around specialties. I think that you just need to stand back and look at how the educational environment has changed for training over the last 10 years. There have been step-by-step changes. The direction of travel has been that it is increasingly prescriptive. The trainees now have a curriculum, so for every year that they are training, they have a curriculum to map to. If they do not get the experiences, the procedures and the numbers of patients going through, they will be likely to fail to progress. They have an annual appraisal, and if they do not tick those boxes in terms of types of patient breadth and case numbers, they will delay their progress. That has a knock-on effect in terms of the reputation of Wales as a place to train. It also has a knock-on effect on those trainees in terms of requiring extended training time, which means that we may then have to move them to different hospitals. Moving trainees between hospitals and health boards is a challenge, because of a number of issues—in particular, because of the service commitment that they provide. The landscape has changed—it is extremely prescriptive. I will, perhaps, turn to Helen to talk around paediatrics, because it is quite prescriptive.

[188] **Dr Fardy:** As Professor Donnelly has pointed out, for paediatrics the curriculum is set by the Royal College of Paediatrics and Child Health and approved by the General Medical Council. To deliver that curriculum, we need two main things, really, from a training unit. One is that they have a rota with a sufficient number of trainees so that they can be released for educational activities, to make sure that they have out-patient experience and can attend regional teaching, and all of the other things that they need to do to meet the curriculum. The other aspect is that they need to have a sufficient throughput of cases to give the trainees enough experience and opportunity to meet all the various stipulations of the curriculum, in order that they can eventually progress through to getting their certificate of completion of training. At the moment, because of the way that trainees are spread very thinly across a large number of units, they are not on rotas that enable them to get those experiences, and they are not all working in units that have sufficient numbers of patients coming through them.

[189] **David Rees:** Just to clarify, for paediatrics, you have identified the Royal College of

Paediatrics and Child Health and the GMC. Is it the same for all specialities, that the royal colleges and the GMC set and approve the curricula?

[190] **Dr Fardy:** Yes; it is.

[191] **Professor Donnelly:** Yes; the process is that the college devises the curriculum, and then it is signed off and approved by the GMC. Part of the deanery's role is to ensure that the trainees in Wales have access to whatever they need to access in a particular year in that hospital—or in that health environment, because a lot of it is in the community.

[192] **David Rees:** You are effectively the guardian of the standards, is that so?

[193] **Professor Donnelly:** Yes.

[194] **David Rees:** On paediatrics in particular, it has been highlighted to us often that paediatrics is one of the specialities that it is difficult to recruit to at this moment in time across the UK. Are there any issues related to recruitment linked to the curriculum, or is it simply that people are not interested in paediatrics?

[195] **Dr Fardy:** I think that there is an issue of not as many trainees being attracted to paediatrics as a specialty. Part of that is due to the fact that they may be looking at consultants in paediatrics, at their pattern of work and at their work-life balance, which can be quite arduous. They may be deciding that that is not for them. Again, that goes back to making sure that the service models enable a consultant workforce to develop in such a way that we would attract people into the specialty.

[196] However, I think that there is a problem for Wales as well. As we are not meeting all the standards for the curriculum, because of the trainees being spread sometimes across quite small units, our exam pass rate, for example, is quite low compared to most of the other deaneries in the UK. That is something that trainees will look at when they are considering where they are going to apply to join the programme.

[197] **Elin Jones:** In the evidence submitted to the Betsi Cadwaladr and Hywel Dda health board consultations, the national clinical forum and the Wales Deanery were particularly challenging on the number of sites that both health boards considered to be sustainable in the longer term. The preferred option is for a five-site model in south Wales. Can you comment on the sustainability of a five-site model and whether it is achievable? In particular to the Wales Deanery, do you consider that a five-site model is sustainable in terms of five sites providing training on the specialities that are involved in this consultation?

[198] **Professor Harmer:** The formal view was, while five sites is feasible, it may pose problems in the longer term, 10 years down the line. The number of sites is not necessarily linked directly to the number of training sites, because you have various options on how you can run a site. You can decide on a consultant-only service. That again has implications both in cost—it is a very costly way of doing it—and in availability of staff in the long term. That comes to the output of training as well. They are quite complex in that. The forum's view was, while five was possible, it may pose problems in future. Four was much easier to sustain if you want to be absolutely certain, 10 years down the line, that you would be okay. Part of this, as I said earlier, was not directly related to obstetrics or paediatrics, but to a review of all the other services that would be required within those hospitals. However, it did appreciate that four sites would pose geographical problems.

[199] **Professor Donnelly:** I echo Professor Harmer's comments. He made an important distinction between training units and service. We have been very clear about that over the last two to three years with our training reconfiguration. What we need is for trainees to be on

rotas in health environments where they can get their curriculum requirement, get their regional teaching, have high exam pass rates and have a positive experience. That could be different to a service unit where there are perhaps no trainees or there are trainees on a day basis, not 24/7, shoring up the rota. We have been really keen to stress with the south Wales programme board and the other two health boards, including Powys, that we are very keen on a hub and spoke training model. The hubs would be the consolidated hospitals—let us call them hospitals for the sake of argument—and the spokes would be health environments, those community hospitals, where perhaps currently the 24/7 trainees are dispersed and very thin on the ground, propping up the rotas. In a spoke, trainees can attend and be there 9.00 a.m. to 5.00 p.m. daytime or 9.00 a.m. to 9.00 p.m., as long as it meets the curriculum requirement for that specialty. So, a key question for us as a deanery, as this works through, is what service specialties will be in whatever spokes there are and how we can offer the best training opportunities for those spoke models.

[200] **Elin Jones:** So, to follow up on that, on the number of consolidated hubs for training purposes in south Wales, what number will you be recommending to the south Wales programme?

[201] **Professor Donnelly:** Echoing the national clinical forum's comment, from our perspective, five is doable and feasible, but in broad terms the smaller the number the better, because of the pressure on rotas. Consolidation into a smaller number of 24/7 rotas would make it more sustainable and would give the trainees a better work-life balance and exposure to whatever they need to have exposure to.

[202] **Lindsay Whittle:** None of us can foresee the future. I asked the previous witnesses where we will be in 10 years' time. Where do you think we will be in 10 years' time on the reconfiguration plans?

[203] **Professor Donnelly:** It is very difficult to comment on the future, as we all know, but I always say that there is one fixed point in health, if there is a fixed point anywhere, and that is the ageing population. What we need to do in health is ensure that we have clinicians who have the skills and competencies to deal with an increasingly ageing population with multiple comorbidities, at a place that is best suited for both the service to be delivered safely and for the individual. From a training perspective, I guess that it would be remiss of me to not mention the Greenaway review—I am sure that most will have heard of it—which is just about to be published. It is a UK review of postgraduate medical training. Undoubtedly, one of the themes will be broad-based training. In Wales, there are opportunities for us, for training purposes, to use that broad-based training to meet the service needs and the patient needs. So, if that is about looking after older folk—I do not call it geriatrics any more; it is looking after older folk with multiple comorbidities—there is an opportunity for us to use that broad-based training in Wales and be ahead of the game, to make Wales the destination of choice for trainees.

[204] **Lindsay Whittle:** Most of the campaigns that I have become involved in are mainly on neonatal issues and 24/7 A&E services. That is what most people are mainly concerned about. I do not mind—and most people I speak to do not mind—travelling for a really specialist service. We have had evidence from the professionals at Morriston on the burns unit. Everybody in south Wales recognises that if you get badly burned, you go to Morriston. If I get badly burned, I want to go to Morriston. I am happy with that. However, if I have an accident, if I break my arm or if a member of my family is pregnant, we want to go to the nearest hospital. It is as plain and simple as that. How are we going to cope with that in 10 years' time?

[205] **Professor Harmer:** One thing that has to get over to the public is that, if you decide that there will be four or five main centres, it does not mean that there will not be a service in

other hospitals or facilities. It will be different. Some of the changes that have occurred have been usefully illustrative. The opening of Ysbyty Ystrad Fawr in Ystrad Mynach is an example. It was initially viewed as a poor-standard substitute for Caerphilly District Miners Hospital, but as someone who lives in that area and has used it several times, I would say that it is a totally different service and provides a good service to the community. What we have to accept in the future is that the traditional models have to start to change. The traditional model of a hospital that provides everything, with doctors there all the time, has to change. We have to look at the competencies that are required for certain things to be done and who can best provide those.

[206] Coming back to where we will be in 10 years' time, I think that we will have a model of care that will be different to where we are now. We have moved, in the last 20 years, quite dramatically away from saying, 'Doctor does this, nurse does that', into a much more healthcare-based system. I think that the future is quite rosy if we can go down that line and encourage more care to be provided by specialist workers—I say 'specialist workers' because I cannot identify them as nurses or anything. There are huge numbers of people who could be used. It is important for the public to understand that there will not be cardiac surgery or neurosurgery on their doorstep, but if they break their arm, somebody will be there to look at them quite locally. They may not be able to deal with the complete picture that is developing and they may need to be transferred, but 90% of their initial problems will be dealt with locally. That is an integral part of the plan.

[207] **David Rees:** Professor Donnelly, in your paper, you highlight the changes that you recognise, for example the difficulty in recruitment, particularly in A&E, and site numbers. Do you wish to add anything on that point?

[208] **Professor Donnelly:** In terms of recruitment into emergency medicine, it is important to remember that this is a UK phenomenon. It is undoubtedly related to the model of service, both in emergency medicine departments and in medicine as a whole. It is clear, going forward, that having doctors who work solely in emergency medicine is not the solution for the front door of any hospital, and that there has to be a holistic view of this. One has to be very clear about what service is behind that front door and how it links to the more specialist services.

11:30

[209] However, again, there are the challenges that Dr Fardy touched on. On recruitment, the trainees are extremely sophisticated in terms of their career choices. They have access to a huge array of information and intelligence around the quality of training programmes in particular hospitals and the exam pass rates, which we have mentioned. They look at not just the quality of the training, but the perception of the quality of the service and lifestyle. This new generation will look specifically at work-life balance, and in Wales we have to get that whole package correct. So, the challenge around emergency medicine is with us. Changes around the Greenaway review may help us with that, depending on what type of service is, at that point, currently called an A&E. Frequently, in A&E, the first point of contact is, perhaps, a foundation doctor, who is highly trained, but the least experienced clinician in that building. In Wales, we have some superb trainees, but I think that that is an ongoing issue for us, which, with the service reconfiguration plans that you have heard about this morning, will be helped by that direction of travel and by a smaller number of units, because we will be able to consolidate the current posts that we have into a smaller number of units to make them more sustainable.

[210] **Leighton Andrews:** When you talk about a smaller number of units for training purposes, that does not necessarily mean a smaller number of institutions, does it? So, post reconfiguration, you could have a number of different training units in a larger number of

facilities, depending on the discipline.

[211] **Professor Donnelly:** It is about exactly that. We have been clear. Our focus, as I said in my introduction, is on the quality and sustainability of training. The hospitals and the health boards can set up services that are consultant delivered, advanced-practitioner delivered et cetera. We can use the trainees more flexibly and not over rely on them, because there is clearly an over-reliance on trainees to provide the 24/7 middle grade and lower grade rotas.

[212] **Kirsty Williams:** Quite rightly, as you say, it is not your job to provide services; it is your job to provide training opportunities for future doctors, and, therefore, rotas to provide a service is not what you are concerned about. There will be a considerable delay in these plans being implemented, especially in south-east Wales, where we need a whole new hospital to be built. What will your attitude be to maintaining your trainees in hospitals such as Nevill Hall and the Gwent in this interim period? Can you wait until these plans are decided, or will you have to make unilateral decisions about where your trainees are in the intervening period?

[213] **Professor Donnelly:** There is clearly a disjoin in timeline. We have flagged that up from the beginning, and we are very conscious of it. Today is a day of training. A week and a month is a significant period of training. I look at our training reconfiguration at a number of levels, but there clearly is a lower level of reconfiguration of training that always exists, and we are ensuring that that is in the same strategic direction as the higher level that is required. So, we are moving into the community, and we are doing that not ad-hoc, but when the opportunities arise, to minimise the effect on service. However, there is a likelihood that, at some point, with certain specialities, depending on recruitment, retention and quality issues, we will have to, with due notice, relocate trainees to other places. At a lower level, we do that on a month-by-month basis in collaboration with health boards. However, the pressure is especially on those areas that you know, including emergency medicine, paediatrics, psychiatry and core and higher medicine. We have filled the core medicine places this year, but clearly there is a huge issue in terms of the experience of the registrar level, because of this new model of service that exists. The trainees look at those registrars and ask, 'Do I want to be that?', and increasingly, they are saying, 'no'. So, there is a disjoin in timeline. As I mentioned earlier, we have regular meetings with the health boards and I should also have said that the dean and I attend the medical directors' executive group on a monthly basis, where, with the medical directors, we discuss these issues in detail and that very question comes up on a regular basis.

[214] **David Rees:** On that point, you have highlighted in your document this difference in timelines. You actually say that it,

[215] 'is likely to occur ahead of the timescale being set for service reconfiguration'.

[216] When is 'likely' in that case?

[217] **Professor Donnelly:** In terms of our proposals, we are hoping to move some specialties in August 2014. However, this will be on a phased basis and with due notice to those health boards. As we move through in other specialties, emergency medicine and psychiatry—psychiatry is perhaps more longer term, but it will only be longer term if recruitment levels stay as they are—I think that one of the important points is that we do not, and I particularly do not, get fixed on numbers in terms of recruitment. It is about trends and the intelligence under those numbers in terms of the quality of trainee coming through into Wales; because of national recruitment, we have intelligence on the sort of proxy measures around the quality of trainee. So, it is a complex picture, but those timelines are disjointed and will depend on a number of factors in terms of the feedback on the training. A large part of our work is working on a day-to-day basis with health boards, departments, and individual

consultant supervisors to ensure that, even in this pressured environment that we have talked about, the trainees and the training are seen as a priority.

[218] **David Rees:** Okay. Thank you. Darren, you have a question.

[219] **Darren Millar:** Yes. Some of the issues that I want to touch on have already been raised, but, obviously, some of the health boards, Professor Donnelly, have used the deanery almost as a bit of a whipping boy, really, for some of the changes that are being proposed and are suggesting that it is the whole training side of things that is forcing them to deliver some change in terms of service reconfiguration. You have already mentioned the Greenaway review, which is due to report very soon. To what extent will the Greenaway review help you to review the situation in Wales? You alluded to potentially some quite drastic changes in training configuration next year, in August. To what extent will you review those that might currently be in the pipeline? Will you then refresh and update your evidence that you have been providing to the south Wales board, for example, in terms of the advice and information that you have been able to provide to it to help inform its decision making?

[220] **Professor Donnelly:** This clearly is an iterative process and it is very complex. We are constantly refreshing where we are. For certain specialties, we are going into further recruitment now and we will then get further intelligence about where we are likely to be this time next year. It is important, with Greenaway, to understand what I understand about the process that we will need to follow. Greenaway will make a certain number of recommendations. Each Government will have to consider those recommendations and make a judgment about which of those they will want to implement and then have a process whereby they are implemented.

[221] So, that is likely to change if he recommends what we think he will recommend in terms of broad-based training. However, that will shift and it will require us to refresh some of the elements of what we are proposing. For example, what he is likely to say is that that broad-based training should include paediatrics, perhaps community paediatrics and general practice psychiatry. So, in terms of our reconfiguration proposals at this stage, we will have to revisit all of those and, if that recommendation is accepted by the Welsh Government and we move on it, mesh those into our reconfiguration plans.

[222] **Darren Millar:** So, if you have a much broader base to the training, you should have people coming through with a broader range of skills, and therefore that should help to plug some of the gaps going forward in the ultra-specialisms that people tend to pursue these days within clinical circles. Is it fair to say that?

[223] **Professor Donnelly:** Yes. The idea is that, say, after three or four years of broad-based training with a number of specialties, one comes out with a sort of general certificate of competence, with a set of competencies and skills that the health board employer can look at and say, 'We can use this species of doctor here to provide service at this level', and then, after that, the trainee—the doctor—can choose to stay as that broad-based doctor, whatever they will end up being called, or go on to do their 'ology', and do two or three years of super-specialist training. I think that some specialities—obstetrics and gynaecology, I suspect—will need to continue to be run through, but within this there is likely to be, we hope, the flexibility to move. One of the ideas behind 'Modernising Medical Careers' in 2007 was that flexibility. I think that the reality is that there has not been that flexibility. It is extremely inflexible, which I think leads to huge issues for us in Wales in terms of career choice and career change. However, again, it is a UK phenomenon. I think that we are hopeful that that flexibility will be built in, because it is competency-based, which is highly likely to meet the needs of NHS Wales. However, a decision will need to be made on that.

[224] **Darren Millar:** It sounds like, potentially, that there could be some very good news,

then, for Wales as a result of this sort of broader, more generalist approach, if you like, to medicine. However, I would just like to check something. You mentioned that the timeline is that we are expecting the Greenaway report to be published imminently—certainly this autumn. The Welsh Government is signing up to respond to that in some way and then there is a timeline to implement. That will not impact on the August 2014 timeline that you have already mentioned, is it, because it is going to go beyond that, is it not?

[225] **Professor Donnelly:** It will. As soon as we have an indication from the Welsh Government that this is the direction of travel—. It may be on a pilot basis, because that has been some of the discussions. We should not change the entire model. I think that it is a positive opportunity for us. The test will be whether the trainees will want that broad-based model. The feedback that we have all had is that yes, they do. The other barrier or possible constraint is that the health boards—and health organisations across the UK, but particularly in Wales—will have to generate jobs for that species of doctor coming through. So, there are different elements to it. In terms of the timeline, until we are clear about that direction of travel and whether we will implement it in that timeline, I think that our plans will be to reconfigure, because, if we do not, there is a bigger risk for us. The bigger risk is that certain specialties will be hit so hard in terms of retention or recruitment that we possibly will not be training in certain specialties.

[226] **Darren Millar:** So, you must have an indication at the moment as to where those changes will need to be made, which part of the country they might need to be made in, and which specialties those changes will have an impact on. Which parts of the country are they? Are you able to share that information with us?

[227] **Professor Donnelly:** Sorry, in terms of—?

[228] **Darren Millar:** If you are planning some changes that you are potentially going to implement at the end of August 2014 or in August 2014, what are the changes that you have in the pipeline, and where will they impact?

[229] **Professor Donnelly:** Perhaps I could turn to Helen.

[230] **Dr Fardy:** In terms of paediatrics, we have had a draft paper on the reconfiguration of training in the public domain since May 2012. That is the document that we have been using in our discussions with the health boards and with the south Wales programme. The document outlines that there would be changes to paediatrics across all of the Welsh health boards that currently have paediatric in-patient units, but, in terms of actually determining which would be the training units, we are leaving that for the health board to advise us on as long as the unit meets the Royal College of Paediatrics and Child Health curriculum standards in terms of throughput and opportunities for training. So, the changes would be across Wales.

[231] **David Rees:** To clarify, therefore, the south Wales programme board, which we have been hearing from today, was aware of these plans when it was having discussions on its consideration of reconfiguration of services?

11:45

[232] **Dr Fardy:** That is right, and I have been a member of the paediatric clinical reference group for the south Wales programme, working with all the clinical directors and the chair of that group through the paediatric discussions on service reconfiguration.

[233] **David Rees:** Is the same true of others?

[234] **Mr Gasson:** Yes. Similarly, I have been on the clinical reference group for maternity

services, so, probably from the start, it has been fully aware of where we are likely to end up. Obviously, obstetrics is heavily impacted by paediatrics and, in particular, neonatal services. Those two go hand in hand, so there has tended to be a bit of cross-fertilisation between the paediatric group and the maternity group to try to ensure that we are singing off the same hymn sheet.

[235] **David Rees:** Elin, do you want to follow up?

[236] **Elin Jones:** I just wanted to understand a bit better the implementation of the Greenaway proposals, if they do propose change. You said that Welsh Government would be expected to respond to some of those changes. Is it possible that the Welsh Government and we here in Wales could run a different timetable for implementing proposals, or that we could do it differently in any way? I have always understood that training was a kind of cross-UK model, but you seem to be suggesting that we could be running at a different timetable, especially. To just squeeze in one other question that is slightly related, you have spoken about the difficulties of recruiting into training places in Wales, so how successful are we in keeping the potential trainees in the graduates of medical education in Wales? What kind of percentage of those people do we keep in Wales?

[237] **Professor Donnelly:** In terms of the Greenaway review, it is my understanding that there would need to be a judgment as to which recommendations will meet the workforce needs of NHS Wales. I think the opportunity for us in Wales, as I see it, is a slightly different flavour to that broad-based training. It is likely that, within that four-year period, there are opportunities for the training to be themed, perhaps. So, it may be that we combine paediatrics, psychiatry and general practice—a lot of community-based training—so that the trainee comes out with a community-oriented or community-themed general certificate of training. We could then have a more surgical, acute medicine theme as well. That is what I was alluding to: there are opportunities for us to play with that to meet the needs, and for it to look and be different. In England, there have been a number of pilot sites for broad-based training. They are not the full three or four years. They have been seen as quite attractive by trainees, so the initial indications—and I think that is all that I can say—are that that kind of training will be attractive, as long as the employers then have a role, a job, for those doctors. That is a key element.

[238] **Elin Jones:** And our success in retaining medical graduates?

[239] **Professor Donnelly:** In Wales, we are approximately two thirds of the way up the league table in terms of retaining medical students. We retain about two thirds. It is after foundation that we start to lose trainees. Again, I have to say that this is extremely complex. One would expect a medical school like Oxford, one of the highest internationally, to retain all of its medical students locally, but it does not. It is close to the bottom of the league table. So, this is extremely complex in terms of their perception of training, lifestyle and the service that they are working in, and they are a mobile population—they are young, they are in their early 20s, and they do have a different view on work. It is a buyer's market. Within a number of specialties, they can literally decide where they want to work, whereas 10 or 15 years ago, it was highly competitive.

[240] **David Rees:** Leighton, you have a supplementary question.

[241] **Leighton Andrews:** I want to go back to this hub-and-spoke model, just to understand this. If you take the south Wales programme—Elin has explored the difference between the four and the five-hospital model—and you end up with four hospitals designated with the role of providing the functions that are outlined in the south Wales programme, are those four the only ones that can be the hub?

[242] **Professor Donnelly:** Part of the definition of the hub in training terms is trainees being on a 24/7 rota. That is part of the principle of consolidating the training, to put them on a more sustainable training rota. Our view would be ‘yes’ for the 24/7, but it does not exclude the spokes having trainees, whether it is a 12-hour or a 14-hour shift, et cetera, but not on a 24/7 rota.

[243] **Leighton Andrews:** What I was trying to get at really, I suppose, was this: in the south Wales programme, there are certain kinds of disciplines whose distribution between the different hospitals there are particular concerns about. Could a hospital be a hub for the training of other aspects of medical discipline, other than those that are being considered by the south Wales programme?

[244] **Professor Donnelly:** Yes. In the consultation, clearly, it is just looking at a number of fairly fragile services/training, but, yes, we would look at the entire piste. As Professor Harmer commented, the interdependencies between specialties are there, so once you start to look at anaesthetics, it will affect obstetrics, and so on. So, yes.

[245] **Leighton Andrews:** Right. Let us just understand that, then. So, if a particular model is taken for four hospitals—we do not need to worry about which ones they are for now—in the areas of fragile care that, as you say, the south Wales programme is focused on, does that then mean that, incrementally, training in other areas will move away from the hospitals?

[246] **Professor Donnelly:** I think that there will be that knock-on effect in terms of those rotas. As we go through our training reconfiguration work, it is clear that that consolidation is what is required for just about every specialty for making sustainable, high-quality rotas. However, the important distinction is not to rely on trainees to provide the service. You could still provide a 24/7 service with non-training grades, and that is a very important point.

[247] **Kirsty Williams:** But you can only do that if you can recruit qualified doctors to those posts.

[248] **Professor Donnelly:** It is qualified doctors and other staff. We will always talk about advanced nurse practitioners. In my specialty, we have community nurses who are trained up to do initial triage, and, actually, they are better skilled at doing that than are second or third-year trainees. Even though we are focusing on medicine, it is not just about looking at medicine.

[249] **David Rees:** We have a question now from Gwyn, followed by Darren, who has a supplementary question.

[250] **Gwyn R. Price:** It is just a question to NCF, really, on the transport. Have you had discussions with the health boards on transport? It is very important that we link these hospitals up with a creditable transport system. I was wondering what your views are on this.

[251] **Professor Harmer:** Absolutely. It has been one of the points that we have made every time we have spoken to a health board, namely that we have to look at transport, and not only public transport, but emergency transport and retrieval and the transfer of patients. We have brought up the public transport side of it quite often, particularly in the rural areas—although the south Wales programme does not involve that quite so much, it certainly impacts on the bottom end of Powys quite largely. The concern that we have is to seek assurances on an all-Wales basis that we can look at patient transfers, patient transport and patient retrieval, and certainly at an enhancement of the air ambulance service to make it 24/7. At the moment, it can fly only during daylight hours, and in this rain it probably would not be flying. So, we need to move that forward, and we need to have a better system for the Welsh ambulance

service, to be sure that we are getting the right people to the right place. We need to learn lessons about taking trained personnel out to the patients, rather than transferring them in. In other words, trying to hit not just the golden hour, but the platinum 10 minutes, when you can make a difference to people's lives. Those points have been stressed at every meeting that we have had, and that is certainly part of our response back to the south Wales programme: we want to be sure that that is in. However, we believe that it is an all-Wales issue, not just something for each specific health board to deal with.

[252] **Rebecca Evans:** We have heard differing views during the course of reconfiguration—since the start at Hywel Dda—about the golden hour and whether it has a clinical background or it is just a nice sounding phrase.

[253] **Elin Jones:** Like 'the platinum 10'.

[254] **Rebecca Evans:** Yes, 'the platinum 10' is also an interesting sounding phrase.

[255] We have heard that advances in medicine have moved on and that the golden hour is not as important and that what is important is when somebody can arrive to stabilise you. Are we still using the golden hour?

[256] **Professor Harmer:** It is not used as widely now. The lessons that have been learned from some of the helicopter emergency medical service units is that, if you can get a person to a patient and they can perform the tasks that are required to safeguard that patient's life, the outcomes are better. The idea of the golden hour used to be that if you could get someone into hospital within the hour, they would do a lot better. The evidence now is that if you can get a skilled person to that patient in half an hour, they will do even better. So, the golden hour has largely disappeared. The 'platinum 10 minutes' is a term that I used to use in critical care. The idea was that, if you did not protect somebody's airway in the first 10 minutes and it became obstructed, they would be dead. It is not just the skill of getting the person out there; it is also a matter of educating the public and educating other people in health centres and in sports centres on how you deal with emergencies.

[257] **David Rees:** Darren, do you have a question?

[258] **Darren Millar:** Yes, I have two questions that are more for the NCF than the deanery. I asked this question to people from the south Wales programme board earlier: we have seen three very different approaches to stakeholder engagement and public consultation across Wales as part of these service reconfiguration proposals; what is your assessment as to whether the Government guidance on stakeholder engagement and consultation is adequate, or not? Does it need to be more refined or more specific in future?

[259] **Professor Harmer:** My feeling in general is that it has been pretty extensive and thorough. The problem that members of the clinical forum feel is that they have perhaps been limited, to some degree. In other words, we are discussing the south Wales programme as it is put forward in those specific areas, but, as I said at the beginning, it is much more complex than that from the clinicians' point of view because of the impact that it has. Certainly, with regard to my own base specialty of anaesthetics and critical care, every decision made requires an anaesthetist on board and a critical care set-up. Each of the health boards has been different in the emphasis they have placed on particular aspects of that care. That has led to problems for the national clinical forum as to how much advice we can give that is outside the area of consultation and how much more should there be. So, as a general feeling, the genuine engagement with the public has been reasonably good; the engagement with clinicians, particularly in the south Wales programme, has been excellent, and we have been very impressed with that. We need to be certain that we are putting the messages over that, if we are dealing with a south Wales programme that is looking at three specific areas, we also have

to engage with the public on the impact in the other areas. It does not mean the mass closure of hospitals, but it just means perhaps a change in the way in which care is delivered. I am not sure that message is getting over. That is my personal view.

[260] **Darren Millar:** So, perhaps there should be something in the guidance that is issued to health boards around the need to consider the wider implications, rather than just a short, focused piece of work. That is very helpful.

[261] **Professor Harmer:** May I interject? Something that was helpful in the south Wales programme was the use of case studies. The more of those you can have, the better, but they have to be realistic case studies and they probably need to be based on real life. It is not a matter of somebody sitting in a room thinking of little Johnny doing something, but to look at what has happened to a patient in the last year, what was their clinical care pathway and the way in which that will be different with the new plan—whether it will be better, or worse. The public needs to know that. I said to one of the south Wales programme people that, even if they had 1,000 of those scenarios, they probably still would not cover everything, but at least they would have a pretty good idea of what would happen to anybody in the system.

[262] **Darren Millar:** There are some aspects of the south Wales programme board's proposals that are, perhaps, less controversial than others and which seem to have wider public support than others. Do you think that there would be merit in changing the guidance to lower the threshold, perhaps, at which there is a requirement to go through the full stakeholder engagement, through the full formal public consultation process, just to allow people to get on with changes where they have widespread support?

12:00

[263] **Professor Harmer:** Looking back over my career in the last 10 years, it is a shame when you cannot get on with some things because you are waiting for other things to be resolved. Some are obvious, and you get on and do them. We get bogged down in some of the minutiae, whereas other things need to change. I would reiterate Peter Donnelly's view that, for some of the specialties, my clinician colleagues on the NCF say that we are heading for a crisis if we are not careful. If we keep waiting and waiting, we will be in crisis. The crisis means that a hospital shuts and can no longer admit people. So, there are some things that we need to get on with. It is a matter of trying to match them, because if you move down that line, it must be so that you are not prejudging all the other aspects that come with it.

[264] **Darren Millar:** My final question is on the role of the NCF in the future. You have an annual role—your form is renewed, if you like, on annual basis while these current proposals are on the table. However, we know that the NHS is constantly changing and constantly having to adapt to new things. Do you think that you need to be a permanent feature on the health service landscape in the future?

[265] **Professor Harmer:** Some form of independent clinical body would be useful for the future. As it stands, I depend upon my colleagues on the forum giving up their time. They do it of their own free will—at travelling expenses, shall we say—and I bombard them with paperwork and things like that. To expect that to continue would be quite difficult. However, there is a role for an independent grouping that is there to help in the implementation, and to reassure the public that the clinicians understand their concerns and are trying to make sure that, in the end, the care they receive is of a high quality.

[266] **Darren Millar:** Thank you.

[267] **Kirsty Williams:** Professor Harmer, you said that transportation has been at the forefront of a lot of your colleagues' minds in looking at the plans. At each of the consultation

meetings that I went to in my constituency, the ambulance trust had a different answer to the same question that I asked each time; it sent different people. At one meeting, we were told that the Welsh Ambulance Service NHS Trust would have to have significant resources pumped into it for it to deliver against the plan. At another meeting, I was told that there were no resource implications for the ambulance trust. At a third meeting, I was told that this was great news for the ambulance trust as it would allow it to operate much more efficiently, and that it could perhaps do with less. What is your evaluation of the robustness of the ambulance trust's input into these plans, and whether or not they are realistic?

[268] **Professor Harmer:** It would be difficult for me to comment on what exactly was said at each meeting. In the discussions that we had with the representatives of the Welsh Ambulance Services NHS Trust—we dealt with the medical director—we were told that there was some scope for readjusting how it worked within the current budget, and that that would be helped if we were to have reduced numbers of centres. In other words, we knew where a patient needed to go to, and it would mean not sending them to one hospital only to transfer them on to another one—we could make definitive decisions. We had a long discussion about highly trained paramedics or doctors being an integral part of the ambulance service, a bit like the London helicopter emergency medical service. They would be based around Wales to be sent out. I have honestly never heard the trust tell me that it would save it money.

[269] **David Rees:** Thank you very much for coming in this morning. We very much appreciate your contributions in response to the questions today. You will get copies of the transcript for corrections to factual errors. Thank you for your attendance; we appreciate it.

12:04

Papurau i'w Nodi Papers to Note

[270] **David Rees:** We have the minutes of the previous meeting on 25 September. I see that all Members are content to note those. We have a letter from the Deputy Minister for Social Services regarding the committee's Stage 1 report on the Social Services and Well-being (Wales) Bill. She highlights areas that she felt were relevant to our report, and where the Government is looking to put amendments in. She has also provided a table for us to review in relation to some of those points. Is it okay if we note these at this point? I see that Members are agreed.

12:05

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

[271] **David Rees:** I move that

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

[272] Are all Members happy with that? I see that there are no objections.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 12:05.
The public part of the meeting ended at 12:05.*

[1] Requested annotation to transcript
Re paras [92], [93] and [95]

I would be grateful if the committee would consider an annotation to correct an inaccuracy in my response to Mr Whittle's question.

The Royal College of Physicians and the College of Emergency Medicine both have published standards referring to the number of hours a Consultant should be present in the acute hospital every day, seven days a week. The College of Emergency Medicine wishes to see this for at least 16 hours a day, as stated in my evidence, however the Royal College of Physicians position is that this should be for at least twelve hours every day (and not 16 hours as stated in my evidence). Outside these hours a Consultant would be on call and available to return to the hospital if required.

Therefore Mr Whittle was referring to the College of Emergency Medicine's standard in his question. All other aspects of my response stand as given.

Hamish Laing
14.10.13