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Ms Sarita Marshall
Deputy Committee Clerk
Health, Wellbeing and Local Government Committee
European and External Affairs Committee
Committee Service
National Assembly for Wales
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Dear Ms Marshall

Please find enclosed the North Wales Local Medical Committee submission for the enquiry.

I shall be attending on 1 December. I look forward to seeing you.

If you have any further queries, please do not hesitate to contact me.

Yours sincerely

Dr E D Jessup
Vice Chairman – North Wales LMC

Enc

NORTH WALES LMC SUBMISSION TO INQUIRY

This submission is in response to the committee's inquiry into how NHS reviews are conducted in Wales. The terms of reference for which are as follows:

To consider the way in which NHS reviews are conducted in Wales, including

- *Whether the Welsh Assembly Government guidance on conducting reviews is appropriate*
- *Whether the Welsh Assembly Government guidance is being followed by local health boards*
- *The Committee will pay particular attention to the reviews currently being undertaken by Betsi Cadwaladr University Health Board, but will concentrate only on the process and not on possible outcomes of the reviews.*

The North Wales Local Medical Committee (LMC) is the statutory body that represents the voice of General Practice across North Wales. Whilst many LMC members may belong to trade unions, the LMC is neither directly affiliated to any individual trade union nor is it a negotiating forum for any trade union; indeed many members are not union members at all.

The LMC meets every two months. Consequently, if correspondence requiring the committee's attention arrives shortly after a meeting, it may take up to two months for the committee to produce a full response. LMC officers are permitted to give advice, prior to ratification by the full committee but it is obviously preferable, if not essential, that the full committee considers and ratifies the LMC's responses, especially for issues deemed particularly important or substantive.

The LMC's role in supplying representatives for committee work is well established and as such it should be the primary point of contact for the Health Board when approaching General Practice The LMC will then appoint a Primary Care Representative (PCR) with suitable experience to deal with the demands of the task concerned, thus simplifying the process by which Health Board management can involve relevant health professionals in their planning and development processes.

The LMC will often nominate individuals for appointment as PCRs because they have a relevant special interest or detailed knowledge, which makes them particularly suitable for the task, even though they may not be members of the LMC and may belong to the allied professions, rather than being GPs.

The other roles of the LMC are concerned with the Terms and Conditions of employment for General Practitioners and their implementation in North Wales. This work includes assistance to the Health Board and to individual practitioners and practices, when performance is called into question.

Over time, the LMC and the Health Board have developed a close and mutually beneficial working relationship, despite numerous and protracted NHS reorganisations.

General Practitioners are the lynchpin of the National Health Service. Under the terms of their contract, they are central in providing patients with long-term continuity of frontline health care from at least 8am to 6:30pm during the working week. General Practitioners are often able to develop a long-term, consistent

rapport with patients in an ever changing health service. They are highly

regarded, trusted and taken seriously by the public at large. Their views on health issues are particularly cogent.

The role of GPs in contributing to the design and planning of services is secondary to this and so largely has to occur outside of working hours. A further difficulty for Health Board management in North Wales is that many daytime GPs contribute to the out of hours service provision, leading to a very high standard of care, but increasing time pressures on GPs in the area to be able to contribute to service development.

Any time taken out by General Practitioners to be involved in health planning within "office" hours often has to rely on the good grace and favour of the individual's colleagues within their practice. Finding locum cover for time taken out of surgery is especially hard in much of North Wales due to its rural nature. This needs to be understood when looking at the difficulties in gaining *"engagement"* with Primary Care practitioners.

The committee's particular focus of attention relates to the questionable nature of the review process as it is currently taking place in North Wales. The evidence for this statement will be explored later in this submission. In the LMC's view, it is impossible to investigate the review process in isolation; it is part of what would appear to be a systematic failure of proactive health care planning to meet the needs of the people of North Wales.

The current reviews are in many ways revisiting old ground that was explored with years of previous background reviews and strategic documents, giving advice to the Planning Directorate of the Health Board. This occurs as the preceding comment infers, against a background of great upheaval in the administration of the Health Board with the amalgamation of six former Local Health Boards and three Trusts into one large, currently immature organisation. Within such a young and developing organisation it is problematic to review strategically health care provision or to implement new organisational structures simultaneously, yet current reviews are attempting to do this.

The locality concept being adopted in North Wales is currently at an early stage of development and is to be welcomed, but concerns exist over how much autonomy the locality management will actually possess; where this has been piloted, there clearly appears to have been a wish to impose top down control. Merged organisations often have great difficulties delivering services. Planning, both immediately after their inception and on an ongoing basis, does not adequately address the health inequality issues that arise in different localities. There is now a financial imperative to assess many aspects of health care provision across North Wales, with a view to rationalising structures where possible. General Practitioners have a good level of overall business acumen and clearly recognise the appropriateness of reviewing services, but find the reasons often given for the need to change ill defined, poorly explained and lacking in research evidence.

The four proposals within the Maternity & Paediatric Review, some of which were clearly going to be dangerous to implement, aroused the alarm felt by General Practitioners over current health care planning across North Wales. At the second stakeholder meeting of this review, it was the intention to determine

which two of these proposals would go forward to the review project board for discussion. They would be the final determinants as to which proposal would go forward to the health board directorate from whom final approval would be sought prior to consultation.

Stakeholders' meetings are said to be only for engagement, not consultation; however once a stand-alone proposal is agreed by the Health Board through engagement, the point of holding a consultation on that proposal becomes unclear, except with respect to the implementation of the same pre-approved proposal. The language used by health planners is often confusing, taking a lot of time to digest and understand. Whilst appreciating that their role is difficult, it seems unwise to leave their advice open to wide interpretation by, for example, patients, carers and others not directly involved in the health service.

Clarity is needed, both from the point of view of the legal framework and to avoid confusion over its implementation.

The term *"engagement"* as used by BCULHB in the review process is causing particular confusion. The Oxford English Dictionary suggests the following definition:

- Engagement – an agreement to do something or be somewhere at a fixed time.

Thus, in everyday English usage, an engagement process always leads to a fixed outcome, not one open to consultation. Perhaps this goes someway to explain the difficulties that are apparent in understanding the use and relevance of this term in health planning.

The LMC has researched the basis for "engagement" as it is being used and adapted in the current review process. Two documents should serve as a good foundation for this:

- Clinical Engagement:

  http://www.wales.nhs.uk/sitesplus/documents/829/ClinicalEngagementPrimaryCareLeadingByDesign.pdf.

- Community Engagement:

  http://www.dumgal.gov.uk/CHttpHandler.ashx?id=1901&p=0

The LMC wishes to bring these papers to the Inquiry as evidence that the struggle that we all have with the term "engagement" is not unique. It is shared by many disparate groups and the answers to this conundrum are not clear. The first of these is an NLIAH document that looks at the process of engagement as it relates to Primary Care Practitioners. It is a recent document (2008), and we quote from its findings:

"The main findings... demonstrate the lack of clarity surrounding clinical engagement within Wales..... particularly in relation to what it is and what it is supposed to achieve and how best to proceed in developing it.

There are three different perceptions of what clinical engagement should be - that of the policy maker, the LHB and the GP - leading to confusion and in some cases barriers to developing services further".

The second document looks at the Scottish Office's attempt to improve community engagement and the salient point is as follows:

"Research evidence and the testimony of community representatives indicate that the realities have not matched the rhetoric; reports have variously described community engagements as:

- *Having "modest impact"*
- *Being "tokenistic"*
- *Prioritising "official views"*
- *Focusing on "peripheral decisions".....*

The creation of National Standards for Community Engagement is designed to tackle these concerns".

These two documents look at engagement within specific targeted areas and groups of people. The Stakeholder meetings in the current review have a large and varied group of people in attendance and thus, we would suggest the problems regarding clarity of agenda and purpose are magnified, in regards to how this critical aspect of the review process is carried out.

These documents provide clear tangible proof for the case to overhaul the engagement concept, the need to define clearly the purposes and needs for engagement within any review carried out in future.

The other reason for bringing these papers to the inquiry's attention is to help guide the policy makers towards research that has already been carried out and avoid unnecessary duplication of work to assess the impact and use of the engagement process and avoid the expense of such an undertaking.

The LMC believe that, the planning process to date is failing in its aims and we outline the failures as we see them. The main issues, set out in detail below are:

- lack of engagement of primary care stakeholders
- lack of balance in Stakeholders' Groups
- confusion in the interpretation of the terminology used to distinguish various stages in the planning process
- lack of adequate research and consultation of appropriate specialists to inform the planning process
- blocking by management of requests for essential information sharing activities between consultants

1: Failure of appropriate engagement of Primary Care:

Formal invitations for primary care representatives to participate in Stakeholder meetings for the current reviews have been few and far between, and in the case of the Maternity Review, invitations were more or less non-existent for General Practitioners individually, and none was received by the LMC.

Although the Surgical and Orthopaedic Review managers sent invitations to the LMC they arrived late in the day, or meetings were at inconvenient times for General Practitioner attendance. Review managers must surely be well aware that Mondays and Fridays are by far the worst days for GPs to be able to leave surgery. Invitations seem to have been sent out haphazardly and not to the corporate LMC, who are the body from whom appropriate representation should have been sought.

The fact there has not been a rush of General Practitioners seeking to sit on planning committees is also due to a number of factors relating to a distrust of the Health Planners at Betsi Cadwaladr.

LMC members who have taken time out from surgery to attend planning meetings over the last few years, have found their voices are increasingly diluted and that the papers reflecting the discussions that have occurred, are often not circulated, or appear to be drafted in such a way as to fit in with a predetermined agenda.

There has been no communication from the BCUHB to the Independent Medical Advisory Committees either at local District General Hospital or Regional level to invite them to become involved or be represented in the review processes.

The Chairman of the Regional Medical Committee has written to the Chief Executive on a number of occasions striving to raise the profile of the Medical Advisory Committees. He has sought to develop stronger links with the Board. Unfortunately there has been no reciprocal response.

These committees have a statutory basis for their foundation and are specifically designed to provide independent medical advice. They have representation from senior members of both primary and secondary care and would have been able to give valuable advice to the Reviews. The unwillingness of the Board to seek their participation is deeply regrettable.

It has become clear since the inception of the ”Clinical Programme Group” concept, that the Medical Advisory Groups would not be the primary route the Health Board would use to acquire medical advice. Independent medical advice, such as that provided by the Medical Advisory Groups, appears to have been sidelined as an irrelevancy.

2: Unbalanced representation at Stakeholders Groups:

On looking at the list of invited representatives, the LMC strongly believe that there is insufficient representation on the Stakeholder Groups from front line and junior ranks of NHS workers. We recognise that all interested parties would seek to gain more representation for their particular interest group but the lack of primary care and junior staff representation stands out and is probably the result of the meetings being in working hours, as much as the lack of invitations and ‘engagement’.

The exclusion of politicians from the Stakeholder Meetings seems misguided as they are clearly stakeholders, elected representatives and community leaders. It must surely be more sensible to involve politicians at an early stage of the engagement process. The LMC’s request for an explanation of the mechanism

by which people have been selected to attend these meetings has yet to be answered.

3: Planning Confusion:

Over the past few years several strategies, service remodelling, reports and reviews have been produced, some with external consultants being brought in to facilitate, at significant costs to the taxpayer. Many of these reports have conclusions that contradict each other: thus planners can choose the findings that best fit their preferred solutions for individual planning issues.

Against this background of planning inertia, it was therefore surprising to see the hasty introduction of three, evidence based, 90 day cycles of review brought in to bring about Health Service reform. Within the Surgical Review this was foreshortened to two 45 day review cycles, only to have it extended with no definite time limit envisaged.

The principle of "stakeholder engagement" has been upheld as a critically important part of this process. As it is described by BCUHB, this is a process where opinions are allowed expression, but without the ability for participants to give advice or formally influence the Project Board on proposals put forward to the health board. This would appear to be seeking opinion for its own sake or a box-ticking exercise that has to be completed to satisfy a political necessity. Neither is consistent with the dictionary definition of engagement.

It is claimed that the engagement process is an iterative one which later leads to a consultation stage. However in the Maternity Review process it was true to the Oxford English Dictionary definition of the words, in that it was to lead to one definitive proposal for the board to approve.

It seems paradoxical that a Stakeholder meeting held to share opinions should be expected to narrow down the lists of options available. This type of meeting, because it should be gathering a range of opinions and ideas fits uncomfortably as part of an iterative process; iteration surely belongs to later stages of the planning process. A meeting, at which ideas are initially shared, if carried out correctly, is more likely to increase the options under consideration.

This underlies the illogical thinking that besets health planning at BCUHB more generally.

The conclusion of recent, major and externally facilitated, reviews which incorporated public engagement on a large scale was that three acute DGHs had to be maintained providing a full range of acute services. These services MUST PROVIDE emergency care as a baseline, everything else is extra. The series of rushed reviews now happening seem intent on overturning this fundamental and critical conclusion.

Is this reflection or chaos?

4: The weak evidence base for information sharing:

Taking into consideration the lack of in-depth medical knowledge of many of the participants within the Stakeholder Groups, the presentations are crucial to the

participants' full engagement. Within these presentations, it appears that highly complex issues such as medical manpower, training and impact assessment have been 'dumbed down' and are presented in a simplistic 'black and white' manner.

Sadly the evidence for the impact of service changes, on the scale proposed has been completely lacking in these presentations. Within all the current reviews, but especially the Maternity Review, there seems to have been no impact assessment of the proposals being put forward on building infrastructure, costs, transport, equality or the bare practicalities of the proposals. This seems elementary but has apparently largely been ignored, to date.

A good example would be the statement that "Maternity and Paediatrics are not core services within a DGH model". This statement is quoted from various Royal College documents and might well be justifiably the case in inner cities where large Maternity or Children Hospitals are located nearby. This is however plainly inapplicable when looking at the core services needed for more rural populations where there are no such specialist hospitals in their localities; indeed the National Service framework document for Paediatrics takes it for granted that District General Hospitals will have a full Paediatric Department.

It seems illogical to ignore the impact of this until the consultation phase of the reviews. If the chosen proposal is later deemed unsuitable because of these practicalities, there will be no "Plan B" and valuable time and resources will have been wasted, something the NHS cannot afford to do. It is difficult to see the point in discussion of proposals that are clearly impractical yet this seems to be the case with the Maternity Review, leaving aside all the safety considerations.

5: Censoring of relevant presentations:

We have been alerted to consultants being refused time to share highly relevant presentations with the Stakeholders' Meetings within the Maternity Review.

Stakeholders need to be made aware of this unorthodox censorship to realise that the information they receive is selected for presentation by the Chiefs of Staff. This incident unfortunately gives weight to the suggestion that the Health Board already have a pre-determined agenda.

In conclusion:

As an LMC we seek to foster good working relationships with the Health Board and to be properly involved with planning for the health care of the North Wales population.

It is crucial that 'management speak' is avoided as much as possible when seeking General Practitioner involvement. GPs often do not understand such terminology and are suspicious that complex language is used to cover problems or areas of concern. The need for the use of plain English in Health Planning has never been greater than it is now – this obviously applies to doctors as well.

The LMC will continue to provide representation for committees as and when requested, but if the current disengagement of Primary Care from Health

Planning continues, then it will become increasingly difficult to find individual General Practitioners who will wish to become involved in Health Planning.

The current lack of any General Practitioner representation for Primary Care as a speciality in its own right within the higher tiers of the Betsi Cadwaladr organisation is deeply regrettable, but again seems to reflect the continuing detachment from management that is felt by Primary Care.