Public Accounts Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
8 July 2014

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda - Supplementary Documents

Supplementary Pack

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

5 Governance Arrangements at Betsi Cadwaladr University Health Board: Updates on reports (09:15-10:50) (Pages 1 - 107)

PAC(4)-20-14(paper 2)
PAC(4)-20-14(paper 3)
PAC(4)-20-14(paper 4)
PAC(4)-20-14(paper 5)
PAC(4)-20-14(paper 6)
Research Brief

Dr Peter Higson - Chair, Betsi Cadwaladr University Health Board
Professor Trevor Purt - Chief Executive, Betsi Cadwaladr University Health Board
Geoff Lang - Executive Director Primary, Community and Mental Health Services, Betsi Cadwaladr University Health Board

Grace Lewis-Parry - Director of Governance & Communications, Betsi Cadwaladr University Health Board

National Assembly for Wales
Public Accounts Committee

Governance Arrangements at Betsi Cadwaladr University Health Board

December 2013

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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National Assembly for Wales
Public Accounts Committee

Governance Arrangements at Betsi Cadwaladr University Health Board

December 2013

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Public Accounts Committee
The Public Accounts Committee was established on 22 June 2011.

Powers
The Committee's powers are set out in the National Assembly for Wales' Standing Orders, with its specific functions of the Committee are set out in Standing Order 18 (available at **www.assemblywales.org)**. In particular, the Committee may consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

The Committee also has specific statutory powers under the Government of Wales Act 2006 relating to the appointment of the Auditor General, his or her budget and the auditors of that office.

Current Committee membership

Darren Millar (Chair)
Welsh Conservatives
Clwyd West

Mohammad Asghar (Oscar)
Welsh Conservatives
South Wales East

Jocelyn Davies
Plaid Cymru
South Wales East

Mike Hedges
Welsh Labour
Swansea East

Sandy Mewies
Welsh Labour
Delyn

Julie Morgan
Welsh Labour
Cardiff North

Jenny Rathbone
Welsh Labour
Cardiff Central

Aled Roberts
Welsh Liberal Democrats
North Wales

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Foreword

On 27 June 2013 the Healthcare Inspectorate Wales and the Wales Audit Office published a joint report, which expressed grave concerns about governance arrangements at Betsi Cadwaladr University Health Board. The findings of this report were made only more troubling by the fact that they come at a time when the entire health sector in Wales is undergoing seismic changes in both its funding and structure.

We are very grateful to both the Healthcare Inspectorate Wales and the Wales Audit Office for bringing the matters set out in the report to the forefront of public attention.

The report's conclusion, that an apparent breakdown in working relationships between some of the Health Board's senior leaders had compromised its governance arrangements making it more difficult to properly identify issues concerning the quality and safety of patient care, was particularly disturbing.

We considered it appropriate to conduct an investigation into the issues raised by the joint report, to assist both the Welsh Government and the Health Board in addressing issues around the governance of the Health Board. In particular, it is vital that the Health Board's new leaders, when in place, take action to address the apparent communication gap between frontline staff on hospital wards and the Board.

Glossary

An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office (June 2013) - referred to as the 'Joint Report' for the purposes of this report.

Personnel referred to in the Report

Betsi Cadwaladr University Health Board

Chief Executive – Mary Burrows
Out-going Chief Executive – Mary Burrows (from 23 May 2013)
Acting Chief Executive – Geoff Lang
Former Chair of the Board – Professor Merfyn Jones
Former Vice-Chair of the Board/ Chair of the Quality and Safety Committee – Dr Lyndon Miles
Acting Medical Director – Dr Martin Duerden
Secretary to the Board/Director of Governance and Communications – Grace Lewis-Parry
Chair of the Finance and Performance Committee – Keith McDonogh

Welsh Government

Director General for Health & Social Services/Chief Executive, NHS Wales – David Sissling - referred as 'Director General' for the purposes of this report.
Chief Medical Officer – Dr Ruth Hussey

Healthcare Inspectorate Wales

Chief Executive – Dr Kate Chamberlain

The Committee's Recommendations

The Committee's recommendations to the Welsh Government are listed below, in the order that they appear in this Report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions:

Recommendation 1. We recommend that to ensure senior leaders are held to account, the Welsh Government reviews and where necessary strengthens the performance management and appraisal process arrangements for Chief Executives and Chairs of NHS organisations to ensure that they are appropriately robust, clearly understood and implemented. (Page 17)

Recommendation 2. We recommend the Welsh Government undertakes an urgent review of the training available to board members across all Welsh NHS bodies. The outcome of this review should inform the development and delivery of a national training programme for board members, participation in which should be a condition of board membership. The programme should develop core competencies, clarify requirements and include training specifically developed for newly appointed board members to attend as part of their induction into board membership. (Page 24)

Recommendation 3. We recommend that directive guidance should be issued to all boards on the importance of both individual and collective board development and any such guidance should be reviewed regularly to ensure it is fit for purpose. (Page 24)

Recommendation 4. We recommend that the time commitment required for Independent Members be reviewed to ensure that it is adequate to allow them to fully discharge the functions expected of them. (Page 24)

Recommendation 5. We recommend that the Welsh Government takes action to enable a more robust and consistent system of appraisal for Independent Members of Welsh Health Boards, including the identification of personal training and development needs, and that a peer mentoring scheme for independent members be developed. (Page 24)

Recommendation 6. We recommend the Welsh Government ensures that the importance of the separation and accountability of the Board Secretary role is clearly understood by all NHS organisations. (Page 27)

Recommendation 7. We recommend that Welsh Government consider providing statutory protection for the role of Board Secretary. (Page 27)

Recommendation 8. We recommend that the Welsh Government ensures that all Health Boards review their meeting procedures, to ensure that Board members are presented with all papers in a timely manner and that non-restricted papers are published in the public domain in the same timescales. (Page 29)

Recommendation 9. Having considered the evidence, the Committee welcomes the action being taken by the North Wales Community Health Council to monitor compliance with infection control procedures in hospitals across North Wales. We recommend that the Welsh Government reviews its processes for validating quality and safety, and other critical data from NHS organisations. It is vital that such data is reported accurately if meaningful action is to be taken. (Page 36)

Recommendation 10. We recommend that the Welsh Government finalise, introduce and implement a common set of key performance indicators of quality and safety for use by Health Boards. This would assist in improving performance and identifying risks so that swift action can be taken to address them. (Page 39)

Recommendation 11. We recommend that the Health Board makes the results of its investigations into the high RAMI scores across hospitals in North Wales publically available, together with information on the actions that are being taken to address any patient care issues that are identified. (Page 40)

Recommendation 12. We recommend that the Welsh Government makes information on RAMI scores across all hospital sites in Wales more accessible to the general public, ideally by placing all the data on a single web page, with clear explanations of what the data means. (Page 40)

Recommendation 13. The failure to adhere to accepted budget processes is an issue of particular concern. We do not believe that budgets should be signed off with caveats and recommend that assurances should be provided to us that this practice has now been discontinued within the Health Board. (Page 42)

Recommendation 14. We also recommend that the Welsh Government seeks information from directors of finance at all health boards to ensure that the failures evident within the budget planning processes at the Betsi Cadwaladr University Health Board are not being replicated elsewhere. (Page 42)

Recommendation 15. We recommend that the Welsh Government emphasises to health boards that they should wherever possible avoid utilising unsustainable solutions to financial pressures, such as cancelling or postponing operations, which simply defers costs to the next accounting period. (Page 46)

Recommendation 16. We recommend that the Welsh Government ensures that all health boards minimise the inconvenience and distress caused to patients and their families by requiring that Boards communicate with patients as soon as possible following a decision to cancel or postpone elective operations. (Page 46)

Recommendation 17. We recommend that the Welsh Government takes greater care when commissioning taxpayer funded external advice and that, without exception, the output of such advice is received, reviewed and retained by appropriate Welsh Government departments. (Page 49)

Recommendation 18. In relation to the sharing of the findings of external reviews the Committee believes that it is vitally important, that safeguards are in place to ensure that such findings are widely utilised to learn lessons and improve processes within health boards. We recommend that Welsh Government takes this forward. (Page 50)

Recommendation 19. The Committee believes it is vital that senior leaders set a clear vision for their organisations to respond to the three challenges of developing service, workforce and financial plans. Given the issues around governance arrangements at Betsi Cadwaladr University Health Board, it is imperative that the new senior management of the Board renew and reunite the Executive and non-

Executive leadership team, and close the gap between the Board and Wards. (Page 52)

Recommendation 20. We recommend that Welsh Government work with the Wales Audit Office and Healthcare Inspectorate Wales to develop a clearer set of scales of escalation. This should include a detailed criteria upon which intervention is triggered, the rationale for the type of intervention, and clarity on who should be notified when intervention commences and ceases. We believe that this information should be made accessible to the public. (Page 56)

Recommendation 21. We recommend that the Welsh Government gives urgent consideration to the creation of a pool of additional short term leadership capacity, for NHS Wales, that can be drawn upon at short notice and does not impact on other NHS Wales Health organisations. (Page 57)

Introduction

Background

1. The Public Accounts Committee is a cross party committee of the National Assembly for Wales, comprising of eight Members from all four political parties represented at the Assembly. The Public Accounts Committee is not part of the Welsh Government. The role of the Public Accounts Committee is to ensure that proper and thorough scrutiny is given to the Welsh Government's expenditure.

2. In particular, we can consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

An overview of Governance Arrangements – Betsi Cadwaladr University Health Board

3. On the 27 June 2013, the Healthcare Inspectorate Wales (HIW) and the Wales Audit Office (WAO) published a joint report 'An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board'. The joint report found that:

- the Health Board's governance arrangements and procedures did not adequately address the gap between the ward and the Board;
- routine governance arrangements within the Health Board had not paid sufficient attention to infection control;
- the effectiveness of the Board had been significantly compromised by a breakdown in working relationships between some senior leaders in the organisation; and
- the Board collectively lacked the capacity and capability to provide appropriate levels of scrutiny in relation to service delivery.

4. The joint report also expressed wider concerns about the stability and capacity of the Executive team as a result of staff turnover and sickness absence.[1]

[1] HIW/WAO Joint Report (June 2013), paragraph 19

5. Furthermore, the joint report highlighted problems with the Health Board's organisational structure, based around Clinical Programme Groups (CPGs). CPGs had been created to support the aim of being a clinically-led organisation; however the joint report's findings indicated that problems had been evident for some time as a result of the imbalance between the size of different CPGs and the shortcomings in connectivity between CPGs, geographical hospital sites and the Executive team.[2]

6. Finally, the joint report noted that action had been taken to address these concerns through revisions to the CPG and Executive structures, and through the appointment of Hospital Site Managers at each of the Health Board's main acute hospital sites.[3] It concluded that, while the Health Board had initiated actions to address some of the concerns outlined in the report, fundamental challenges still remained.[4]

7. The Committee notes the resignation of the Chair and Vice-Chair of the Board following publication of the joint report.

8. Given the seriousness of the joint report's findings, we considered it appropriate to conduct a short inquiry into issues raised by the report. During our inquiry we took evidence from a number of witnesses who are listed in this report.

9. Our consideration of this evidence is detailed in the following report which also sets out a number of conclusions and recommendations. We are grateful to all of our witnesses for providing evidence to us, and look forward to the Welsh Government's response to the recommendations set out in this report.

[2] HIW/WAO Joint Report (June 2013), paragraph 16
[3] HIW/WAO Joint Report (June 2013), paragraph 17
[4] HIW/WAO Joint Report (June 2013), paragraph 13

1. The Effectiveness of the Board and its sub-committees

Background

10. The joint report detailed a range of concerns regarding the effectiveness of the Board and its sub-committees. These include:

- A breakdown in working relationships between senior leaders in the Health Board;
- Lack of cohesion and consensus amongst Executive Members of the Board;
- Concerns over the way information is presented to the Board.
- A need for a greater mutual appreciation of the respective roles of executive and independent board members;
- A need for better planning of the agenda for Board meetings.[5]

The historical context of the Board

11. On the effectiveness of the Board and its sub committees, some witnesses emphasised the importance of considering the Board in a historical context, particularly the creation in 2009 of one health board from eight predecessor bodies.

12. The Acting Chief Executive informed us that:

> "…the size and scale of the board, in terms of bringing together eight organisations into one, and then creating a new structure with an agenda that was clearly designed to set about achieving service change, bringing together services across the whole of North Wales to serve its population, and, within, that challenging some quite fundamental historic patterns of loyalties, associations and service delivery. That is a huge challenge for the Board. So, contextually, it is a difficult environment."[6]

[5] HIW/WAO Joint Report (June 2013), paragraph 26
[6] RoP, Public Accounts Committee, 9 July 2013, paragraph 8

13. These challenges were further detailed in evidence from the former Chair of the Board who explained that:

> "…many of the problems were structural in terms of the internal organisation of the whole health board. The problem in creating one organisation out of eight—one should not underestimate the scale of the challenge in doing that, particularly over a very wide geographical area, with a population of almost 700,000 people, and three major hospitals, all with their own cultures and ways of doing things."[7]

14. The Committee notes the challenges associated with merging a number of predecessor bodies into a single new organisation in 2009, but we do not consider that this diminishes from the seriousness of the joint report's findings. We acknowledge that many public sector organisations undergo restructuring and meet the subsequent challenges arising from this. We do not feel that restructuring should lead to poor governance arrangements and through good planning and management restructuring issues should have been anticipated, avoided or addressed.

15. Furthermore, we note that there are other Health Boards within the UK of similar size or larger than Betsi Cadawaladr University Health Board (BCUHB), both geographically and demographically. For example, the 2012-13 revenue budget of the Greater Glasgow and Clyde NHS Board was £2.26 billion, compared with £1.26 billion for BCUHB. As such we do not believe that size should be viewed as a contributory factor to the problems at the Health Board.

16. In the course of our inquiry, we considered whether changing the name of the Health Board could assist it in creating a 'North Wales wide' identity. Although there may be merit in this suggestion, our overwhelming concern is that the Health Board takes action to address the range of concerns identified in both the joint report and our own investigation.

17. The Committee believes it will take significantly more than a name change for the Health Board to recover its damaged reputation.

[7] RoP, Public Accounts Committee, 18 July 2013, paragraph 38

Senior Leadership

18. The Committee were concerned that the joint report found a breakdown in working relationships between senior leaders in the Health Board.[8] The joint report states that:

> "The current working relationship between the Chair of the Health Board and its Chief Executive present real challenges for the Board. A positive and effective working relationship between the two most senior leaders in the organisation is a vital part of the organisation's governance arrangements and sets the tone of the Board. When the relationship breaks down, as it has in the Health Board, the leadership of the organisation is fundamentally compromised, and the Board finds itself in an extremely difficult position."[9]

19. In reference to the reasons for this breakdown in relationships the former Chair of the Board informed us that:

> "There was absolutely no personality clash between any of the people on the executive or the board; I think there were clear differences of opinion as to policy."[10]

20. Evidence from the outgoing Chief Executive supports that a breakdown in relationships was not a matter of personality clashes. She explained that:

> "I respect Professor Jones [the former Chair] and we were able to work together in a professional manner. Confidence and trust between myself and some Board Members became strained which dates back to a number of positions and actions I took due to my concerns regarding the Board's ability to fully appreciate and comply with its obligation to public & patient safety and prioritise such obligations ahead of financial balance when necessary. It was the role of the Chairman to manage such tensions providing support where necessary and resolving issues. When this could not be achieved the relationship unfortunately broke down to the dismay of both parties."[11]

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[8] HIW/WAO Joint Report (June 2013), paragraph 26 (a)
[9] HIW/WAO Joint Report (June 2013), paragraph 26 (a)
[10] RoP, Public Accounts Committee, 18 July 2013, paragraph 12
[11] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013

21. It is clear to us, from the evidence, that there was a breakdown in working relationships and we believe that this should have been prevented through better management, professionalism and leadership at Board level.

22. This view is consolidated in further evidence provided to the Committee by the outgoing Chief Executive in which she stated regret that she did not 'whistle blow' on the direction of the Board.

23. In written evidence the outgoing Chief Executive stated:

> "On reflection my main regret is that I should have whistle blown upon my return in mid-May 2012 about the direction the Board was heading in regarding making finance its main priority and its increasing ineffectiveness in managing its overall obligations. In such situations governance becomes fragile, blame is allocated, teams become driven by process and sight is lost on very critical matters."[12]

24. Furthermore, she informed us that:

> "My professional view is that in the autumn of 2011 with increasing concerns about achieving financial balance for 2011/12, the late budget setting for 2012/13 and further concerns about financial balance, reinforced by Officials, the Board's direction turned to achieving financial balance to the extent that it outweighed the clinical safety, access, quality issue, governance and reconfiguration that were being raised. As the Accountable Officer I accept my duty in achieving finance balance, but I would not do that at all costs to safety and I made that clear. If this meant that my Accountable Officer status would be removed and thus unable to operate as a Chief Executive, then that was the price to pay."[13]

25. The Committee notes the passive context within which the outgoing Chief Executive has presented her evidence. Given that she apparently had increasing concerns from autumn 2011, we believe that she should have accurately conveyed this to the Welsh Government, or influenced the direction of the Board, as this is clearly the role of a Chief Executive and Accountable Officer. We believe it is

[12] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[13] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013

unacceptable for a Chief Executive to have concerns and not take appropriate action in her capacity as an Accountable Officer. The Committee notes that the Director General had similar concerns in informing us that:

> "…the Chief Executive clearly cannot act in a passive observational capacity. He or she must act on any concerns and must take action as the Principal Executive Officer or as the point of primary executive advice to the Board. In certain circumstances, a Chief Executive might properly raise matters of concern with me. My initial response would be to ask the Chief Executive to clarify the responsive actions they were intending to take and enquire if the matters in question had been formally raised with their Board."[14]

26. Whilst the Committee fully endorses the Director General's statement on this matter, we are also of the opinion that the Welsh Government's oversight of NHS bodies should have enabled earlier identification of problems at the Health Board.

27. Given the issues identified around poor leadership and performance at a senior level, this raises concerns about the quality and rigour of performance management and appraisal processes at the Health Board, and the oversight of the Health Board by the Welsh Government. We question why the problems of leadership of the Board were not identified and addressed sooner and are keen to ensure that these problems do not manifest at other NHS organisations.

28. It is clear to the Committee that there were failings in the holding to account of senior leaders at the Health Board. Specifically the performance management and appraisal process did not identify performance issues and were proven ineffective. In terms of the future, the Committee seeks assurances that such processes are consistent across NHS organisations to prevent similar problems occurring again, either at BCUHB or elsewhere.

We recommend that to ensure senior leaders are held to account, the Welsh Government reviews and where necessary strengthens the performance management and appraisal process arrangements for Chief Executives and Chairs of NHS

[14] Letter from Director General, 15 October 2013

organisations to ensure that they are appropriately robust, clearly understood and implemented.

29. On a different matter relating to senior leadership the Committee notes the various changes to the Accountable Officer during the period January 2012 to the present day. We believe these changes are relevant given that this was during the period when the WAO and HIW were undertaking their review at the Health Board.

30. We note that between 27 January 2012 and 14 May 2012, the outgoing Chief Executive was not the Accountable Officer.[15] We also note that the outgoing Chief Executive was absent on sick leave between 8 March 2013 and 4 April 2013[16], and although an Acting Chief Executive was appointed, the Accountable Officer designation remained with the outgoing Chief Executive.[17] We are also aware that it was during this period, on the 22 March 2013, that the *C Diffile* outbreak emerged.

31. The Committee acknowledges that the outgoing Chief Executive returned to work on the 4 April 2013 until 29 April 2013 and resumed her role as Chief Executive. It was during this period that she was made aware of the *C Difficile* outbreak and this was reported to the Board at its meeting on 20 April 2013.

32. We note that there was a further period of time, 29 April 2013 to 13 May 2013, when the outgoing Chief Executive was absent and once again although an Acting Chief Executive was appointed, the Accountable Officer designation remained with the outgoing Chief Executive.[18]

33. Following the outgoing Chief Executive's departure on sick leave on 23 May 2013 and her subsequent intention to stand down, an Acting Chief Executive was appointed and designated as Accountable Officer.

34. In terms of the future, the Committee questioned the Acting Chief Executive on the steps being taken to create more stability and collegiate working amongst Board members.[19] We were informed that:

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[15] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[16] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[17] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[18] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[19] RoP, Public Accounts Committee, 9 July 2013, paragraph 52

> "In terms of the current executive group, we are quite clear about our role and that our role is a collective one. There have been difficulties in the past 12 to 18 months and my perspective on that is that it is very much as a result of the pressure that the board has been under and the pressure to deliver on a range of fronts."[20]

35. Since the joint report's publication and during the course of our inquiry, both the Chair and Chief Executive have indicated their intention to step down.[21] The former Vice-Chair [who was also Chair of the Quality and Safety Committee] has also subsequently stepped down.[22]

36. We note however, that the Chair of the Finance and Performance Committee remains in place in spite of the issues identified in the joint report.

37. We have considered carefully the evidence presented to this Committee on the reasons for the outgoing Chief Executives decision to depart. In her written evidence to this Committee, the outgoing Chief Executive stated that she first indicated her intention to leave the Health Board on 8 March 2013, but that this intention was not linked to the joint report.[23]

38. Subsequently, the then Chair of the Board, stated that the Chief Executive's intention to leave the Health Board first emerged on the 6 March 2013 and was reaffirmed on the 8 March 2013.[24] However, the then Chair of the Board added that her "wish to explore leaving her post became stronger on 23 May 2013."[25]

39. 23 May 2013 is the date on which HIW and the WAO jointly wrote to the Chief Executive, setting out their emerging findings from their review fieldwork.[26]

40. Of further concern to the Committee is the significant delay in reaching a financial settlement between the outgoing Chief Executive and the Health Board. We believe that this delay of over six months

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[20] RoP, Public Accounts Committee, 9 July 2013, paragraph 54
[21] http://www.bbc.co.uk/news/uk-wales-23073768, [accessed 27 June 2013]
[22] http://www.bbc.co.uk/news/uk-wales-23153307, [accessed 2 July 2013]
[23] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[24] Written Evidence, former Chair - BCUHB, 04 October 2013
[25] Written Evidence, former Chair - BCUHB, 04 October 2013
[26] Letter, HIW/WAO to Chief Executive – BCUHB, 23 May 2013

has significantly impeded the Health Board's ability to progress forward, as it has been unable to commence the recruitment of a new Chief Executive. It is imperative that this process is concluded as soon as possible.

41. However, we are pleased to note that on 6 September 2013, the Minister for Health and Social Services announced the appointment of Dr Peter Higson as Chair of BCUHB. We note that Dr Higson commenced his role on 7 October 2013.

42. Clearly, going forward, we believe it will be vital for the new Chair and Chief Executive, once appointed, to build an effective working relationship, learning from the historic issues that have arisen within the Health Board. The Committee believes that it is vital that a new leadership team is in place, as soon as reasonably practicable, to deliver the culture change that is required.

Working relationships among Members of the Health Board

43. The joint report highlights a lack of cohesion and consensus amongst the Executive Directors of the Health Board stating that:

> "The information presented to us clearly demonstrated that the Executive Directors of the Health Board did not work cohesively as a team, with roles compartmentalised. In particular, Independent Members (IMs) expressed concerns to the joint report's authors about a lack of consensus amongst Executive Officers on important issues that are brought to the Board."[27]

44. The joint report also stated that frustration was evident on the part of both Independent Members and Executive Officers in relation to the way the Board operated. The joint report noted that some Independent Members indicated that they felt they were being 'managed', not being given information about the whole picture, and that the Board was seen by some of the Executive as a forum to just 'rubber stamp' decisions.[28]

45. As a result of these concerns the joint report found that:

> "The additional challenge and request for information that this provokes from IMs was causing frustration to some Executive

[27] HIW/WAO Joint Report (June 2013), paragraph 20
[28] HIW/WAO Joint Report (June 2013), paragraph 26 (d)

> Officers who, conversely, felt that IMs were asking for too much information and that this was slowing down decision-making and preventing the agile management of the organisation."[29]

46. The acting Chief Executive acknowledged that although there were some positive relationships between Executive and Independent members of the Board, stating:

> "There is positive working at a committee level within the board. When you get to the overall board level, there are tensions, and, from my perspective, those tensions are more born of frustration regarding the delivery of the board and having clear plans as to how we address our financial problems, service challenges and governance issues that the whole board is signed up to and aligned with."[30]

47. However, he did not consider there to be a simplistic division between Independent Members and Executive Officers. Similarly, the former Chair did not consider there to have been tensions between "independent members as a block and executives as a block"[31], but rather:

> "…there were tensions about how you balance the financial constraints against performance and against service review. Clearly, there were professional views also being expressed by executive members. I think that there were times when independent members found it frustrating that, occasionally, issues that they felt should have been sorted out at executive level were coming to board sub-committees to be sorted out."[32]

48. The outgoing Chief Executive described in her written evidence to this Committee that:

> "Some Executives and Independent Members (IMs) took particular stances about finance as the main priority that created tension and conflict within the team. This could not be reconciled despite best endeavours and as the Report identifies, the Board was not able to operate effectively. Process

[29] HIW/WAO Joint Report (June 2013), paragraph 26
[30] RoP, Public Accounts Committee, 9 July 2013, paragraph 28
[31] RoP, Public Accounts Committee, 18 July 2013, paragraph 18
[32] RoP, Public Accounts Committee, 18 July 2013, paragraph 18

began to override everything with a delay in decision making as a result."[33]

49. She also commented that:

> "There was at times a lack of understanding about the role of Independent Members and the role of Executives making sure there was a clear line between the responsibility for scrutiny and holding to account as opposed to becoming involved in the operational management of the business including being protective of certain geographical areas. IMs did not meet as a group therefore there was not an opportunity to discuss critical matters often of a confidential nature with them. Despite requests for meetings, these were not arranged and therefore key clinical and managerial information had to be relayed in a weekly email update so IMs could be aware of key issues. This in effect was how 'no surprises' were relayed. IMs were always encouraged to ask for more information or explanation, but the opportunities were not taken."[34]

50. The Committee notes that the challenges faced by the Health Board in managing financial, performance and service review issues was a contributory factor in the breakdown in working relationships amongst Board Members.

51. Furthermore, having considered the evidence, we are deeply concerned that both the outgoing Chief Executive and former Chair failed to adequately tackle the dysfunctional working relationship issues amongst the Board. As with other evidence presented, by the outgoing Chief Executive, to this Committee, she appeared to adopt an external perspective on the problems at the Board and thereby attempting to distance herself from those problems. We strongly believe that a Chief Executive should be proactive in dealing with such problems and question why she did not choose to intervene in addressing various problems described in her own evidence.

Training for Board Members

52. The Committee has considered what action might be taken in the future to improve working relationships among Members of the Health

[33] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[34] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013

Board and believe that appropriate training offers a valuable opportunity both to improve relationships and understanding amongst board members. The joint report states that:

> "Attention needs to be given to further training for IMs, given that some of the current cadre took up post after the initial induction training had taken place."[35]

53. We received clear evidence of the effectiveness of initial training provided for Independent Members of the Health Board, and for the Board. However, we also received evidence to suggest that over a period of time, arrangements for providing training to new appointments became less thorough, and much less effective.[36]

54. The Committee is concerned that this may be indicative of a wider problem amongst other NHS bodies. Evidence to this Committee suggests that there is little consistency between Health Boards' approach to collective Board training.[37] We also note that HIW published a Governance Report at Cwm Taf Health Board in March 2012[38], which identified the need for training for Independent Members. When we questioned him on this, the Director General stated:

> "At the moment, different boards are implementing different development arrangements, including Betsi—they had a development session earlier this week. I do think that it is an area where, as Welsh Government, we could make sure that there was some core, appropriate and consistent development for boards as they are now, and certainly for new members. It is available now, but we could make sure that it is more consistently applied."[39]

55. The Committee believes that there would be considerable merit in the Welsh Government developing a national training programme, consisting of structured inductions, board development opportunities and refresher updates, with a requirement for board members to attend individually or collectively as appropriate.

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[35] HIW/WAO Joint Report (June 2013), paragraph 28
[36] RoP, Public Accounts Committee, 9 July 2013, paragraph 46
[37] RoP, Public Accounts Committee, 18 July 2013, paragraph 231
[38] A Review of Governance Arrangements at Cwm Taf Health Board, March 2012
[39] RoP, Public Accounts Committee, 18 July 2013, paragraph 793

56. In considering the training requirements for IMs, the Committee believes that it is important to consider the current time commitment identified for IM roles to ensure that it is sufficient to allow IMs to discharge all of the duties expected of them.

We recommend the Welsh Government undertakes an urgent review of the training available to board members across all Welsh NHS bodies. The outcome of this review should inform the development and delivery of a national training programme for board members, participation in which should be a condition of board membership. The programme should develop core competencies, clarify requirements and include training specifically developed for newly appointed board members to attend as part of their induction into board membership.

We recommend that directive guidance should be issued to all boards on the importance of both individual and collective board development and any such guidance should be reviewed regularly to ensure it is fit for purpose.

We recommend that the time commitment required for Independent Members be reviewed to ensure that it is adequate to allow them to fully discharge the functions expected of them.

We recommend that the Welsh Government takes action to enable a more robust and consistent system of appraisal for Independent Members of Welsh Health Boards, including the identification of personal training and development needs, and that a peer mentoring scheme for independent members be developed.

Management of staff turnover and long-term sickness absences

57. The joint report identified concerns about the capacity and stability of the Executive Team and that staff turnover and long term sickness absences, had resulted in the Board having to make a number of interim arrangements at Executive level.[40] In particular, the Medical Director role was seen as a key post in providing the clinical leadership necessary to drive service modernisation, and the uncertainty created

[40] HIW/WAO Joint Report (June 2013), paragraph 42

by the interim arrangements for this post was seen as a real impediment to progress.[41]

58. The Committee questioned the acting Medical Director on whether he considered the interim nature of his position to have made any difference. He informed us that:

> "…the uncertainty made it difficult, and I accept that maybe the strength behind that has been less than it might have been, because of that difficulty. I think that that is acceptable in those circumstances. It is a very unusual set of circumstances that have come together to make that difficult, and we have to work through that."[42]

59. In response to this the Committee raised concerns around the difficulties that can arise when a key person takes long-term sick leave during a crucial time. We sought clarity on why it appeared that long-term sickness had been unattended and not actively tackled for so long at an important time.

60. The acting Chief Executive explained that:

> "It is really important to say that it has not been unattended; it has been carefully managed in accordance with our sickness policies and procedures as a health board. As you will appreciate, it is about the health of an individual, which would be inappropriate to talk about. It has been properly and actively managed in line with our policies as a health board."[43]

61. Similarly, the outgoing Chief Executive informed us that:

> "It is important that the Report does not unwittingly undermine the medical leadership that has been provided albeit in as an interim appointment. The evidence does not support this. Firstly, the Acting Medical Director is the substantive Deputy Medical Director and is therefore experienced in managing the affairs of a Medical Director and his office. He was a previous Medical Director in a LHB. He has given full authority to act and

[41] HIW/WAO Joint Report (June 2013), paragraph 42
[42] RoP, Public Accounts Committee, 9 July 2013, paragraph 137
[43] RoP, Public Accounts Committee, 9 July 2013, paragraph 139

has proven his capability during his tenure in this role, which has now been on two separate occasions."[44]

62. Managing sickness absences in accordance with an organisation's stated sickness absence policy is important. We believe that it is vital that an organisation's stated approach to managing sickness absence is fair and consistent. However, it is also imperative that an organisation's approach is robust and timely.

The role of the Board's Secretary

63. The joint report describes the role of the Board Secretary as being critical in ensuring that the Health Board is properly equipped to fulfil its responsibilities.[45] The outgoing Chief Executive told us that:

> "There is no doubt that agenda management needs improving and clarity of the Board Secretary's role reaffirmed. Discussions had been held between myself and the Director of Communications & Governance and as a consequence the clinical governance portfolio was transferred to the Director of Nursing & Midwifery."[46]

64. In evidence to this Committee, it became clear that having one person holding a combined role of Secretary to the Board, and Director of Communications and Governance, which included responsibility for both clinical governance and complaints/concerns, was unsustainable in terms of workload. We found considerable potential for a conflict of priorities between these different roles. The Secretary to the Board concurred with this assessment stating:

> "It was unique to BCU. There are a number of roles and functions within one post and within one team. I think that there were issues in terms of challenges and tensions, but it was seen to be a reasonable fit at the time when the organisation was set up."[47]

65. She added that:

> "When that was tested out over the years, through the Wales Audit Office structured assessment, and other reviews, it was

[44] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[45] HIW/WAO Joint Report (June 2013), paragraph 81
[46] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[47] RoP, Public Accounts Committee, 18 July 2013, paragraph 222

> seen to be acceptable, until really the last 12 months, when the Chief Executive and I, together with the auditors, were saying that we needed a better separation of these duties."[48]

66. We note that at the time the Committee was taking evidence there remained a conflict of interest in the Board Secretary holding multiple roles, including some important executive responsibilities. However, since that time we understand that the Health Board has largely addressed this.

67. The Committee notes that the conflict of interest between the various roles held by the Board Secretary had significantly contributed to the dysfunctionality of the Board.

We recommend the Welsh Government ensures that the importance of the separation and accountability of the Board Secretary role is clearly understood by all NHS organisations.

We recommend that Welsh Government consider providing statutory protection for the role of Board Secretary.

The provision of information to the Board

68. The joint report raises concerns regarding the way information was presented to the Board particularly with regard to the circulation of papers dealing with key issues, which were found to be circulated late or tabled on the day of meetings and often without the assurance that they represented the consolidated view of the whole Executive.[49]

69. The joint report concluded that the provision of accurate, timely information to Board Members was also likely to contribute to ineffective working relationships amongst them, stating that:

> "We identified several instances when papers dealing with key issues are either circulated late, or tabled on the day, and (as indicated above) often without the assurance that they represent the consolidated view of the whole Executive."[50]

70. Both the former Chair of the Board and the Board Secretary stressed that the provision of late papers was rare, but acknowledged

[48] RoP, Public Accounts Committee, 18 July 2013, paragraph 222
[49] HIW/WAO Joint Report (June 2013), paragraph 26 (c)
[50] HIW/WAO Joint Report (June 2013), paragraph 26

this had occurred.[51] The former Chair of the Board raised concerns with us that there were occasions when more time was needed to consider important papers, particularly when important decisions had to be made. He informed us that:

> "To take the most recent case about the budget paper and the request for 72 or 74 new medical appointments, we have a finance and performance committee that meets just before the board. The Executive and the Finance and Performance Committee had scrutinised that paper thoroughly and it came, naturally, to the Board. It would have been better if it had come earlier, but that was in the nature of the routine of the business.
>
> […]
>
> "The other paper, on recruiting all these medics, was being presented because it was argued that, if we did not take a decision, we might not have enough doctors this coming August. So, it was a sort of emergency. I think that a chair should be able to agree to receive an emergency paper. However, on that occasion, I allowed discussion on that paper but I refused to allow the Board to make a decision and to commit large amounts of money in response to a paper that I had not even been able to read, as I was chairing the meeting. I refused to allow the Board to come to a decision on that."[52]

71. The Committee was informed that while the former Chief Executive and the Secretary of the Board were aware of the possibility of an emergency paper coming to the Board on the day of the meeting, the Chair was not informed in advance. When asked if the Secretary of the Board could give us a reason as to why she had not informed the former Chair in advance of the meeting, she told us, "I cannot. I should have done."[53]

72. The Secretary to the Board further conceded that:

> "…discussion can take place… it is not appropriate, if an important paper is tabled, that people do not have proper time to consider the issues in it. That is not good governance. You

[51] RoP, Public Accounts Committee, 9 July 2013, paragraphs 56 and 64
[52] RoP, Public Accounts Committee, 18 July 2013, paragraph 119
[53] RoP, Public Accounts Committee, 18 July 2013, paragraph 181

> cannot expect board members to make reasonable or rational decisions if they have not had time to properly consider the information."[54]

73. We asked the former Chair of the Board whether the collective Board had been forced into making particular decisions, by Executive Officials, as a result of not having sufficient information or time to consider such decisions.[55] He informed us that:

> "I did not allow the Board to be bounced into making a number of decisions. However, on the budget, I was reassured that the Finance and Performance Committee, on which a considerable number of Board Members sit, had scrutinised the budget and the planning to a suitable level. I take the point about the timing, and I think that we need to reconcile those things."[56]

74. The Committee believes that it is unacceptable that neither the former Chair, nor the Board, were not given advance copies of important papers. We note from the former Chair of the Boards' evidence that he did not have access to these papers on more than one occasion. However, we were surprised that the former Chair and other Board Members did not challenge the problem as it was clearly their responsibility to do so.

We recommend that the Welsh Government ensures that all Health Boards review their meeting procedures, to ensure that Board members are presented with all papers in a timely manner and that non-restricted papers are published in the public domain in the same timescales.

[54] RoP, Public Accounts Committee, 18 July 2013, paragraph 127
[55] RoP, Public Accounts Committee, 18 July 2013, paragraph 200
[56] RoP, Public Accounts Committee, 18 July 2013, paragraph 201

3. Quality and safety arrangements

75. The joint report found that the routine governance and reporting arrangements within the Health Board had not paid sufficient attention to infection control, and that management action should have taken place earlier in response to the pattern that was emerging on *C Difficile* prevalence in 2012.[57]

76. The joint report also raised a number of concerns about the way in which the Board's Quality and Safety Committee operated. In particular, the report referred to the size of Committee agendas and the subsequent risk that important issues would not receive sufficient attention or possibly be overlooked altogether.[58]

77. The joint report emphasised the importance of ensuring that there are lines of communication and accountability between CPGs and hospital management teams so that issues and concerns which potentially jeopardise the quality and safety of patient care are identified and addressed.[59]

Quality and Safety Committee

78. The joint report outlined concerns held by Quality and Safety Committee members regarding the crowded meeting agendas for their meetings, which limited its ability to thoroughly scrutinise and challenge the information presented to it.[60]

79. Regarding the operation of the Quality and Safety Committee, the outgoing Chief Executive considered there to have been a fundamental system failure stating that:

> "The functioning of the Q&S Committee remains challenging given the breadth of the agenda and subjects which need to be explored. It is fundamental a system failure not be able to triangulate information presented and then ask the right question. As an example for infection control warning signs such as staffing levels; bed capacity and utilisation; hand hygiene compliance; antimicrobial prescribing compliance, reported events; staff concerns as well as trends in infection

[57] HIW/WAO Joint Report (June 2013), paragraph 45
[58] HIW/WAO Joint Report (June 2013), paragraph 52
[59] HIW/WAO Joint Report (June 2013), paragraph 56
[60] HIW/WAO Joint Report (June 2013), paragraph 18

rates are a rich source of information that aids a Committee in being able to undertake adequate scrutiny of the safety issues."[61]

80. The Committee has serious concerns regarding the operation of the Quality and Safety Committee. We believe that agendas for such committee meetings should be better planned and adequate time should be given to cover all business.

Escalation of Concerns

81. The joint report concluded that new arrangements must improve the processes by which concerns are escalated within the Health Board, as they are currently not well understood by staff.[62] This will help ensure that a more bottom-up approach to quality and safety is adopted, with timely escalation via CPGs and Executive Leads to the Quality and Safety Committee, and if appropriate, to the Board.[63]

82. With regards to the process by which concerns are escalated, the Committee heard evidence from some staff at BCUHB to suggest that the culture of the organisation had not encouraged staff to escalate their concerns.

83. However, the outgoing Chief Executive informed us that:

> "I dispute the foundation of any claim that the LHB culture failed to permit and/or encourage escalation of concerns about patient safety and/or failed to treat any concern seriously. I personally took decisions and instructed others to take action to address patient care concerns."[64]

84. She added that:

> "Where individuals felt they could not raise concerns, internal investigations, personal discussions and/or formal meetings took place to establish cause. If people were not listening, engaging or if bullying was believed to have occurred, then this was dealt with through a range of measures, as per nationally agreed policies, which included suspension/remediation/

[61] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[62] HIW/WAO Joint Report (June 2013), paragraph18
[63] HIW/WAO Joint Report (June 2013), paragraph 18
[64] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013

dismissal of staff as appropriate. Evidence exists of the Health Board taking appropriate action."[65]

85. In commenting on the role of the North Wales Community Health Council (CHC) in identifying and escalating issues at BCUHB, the Director General informed us that:

> "Whether it should have had a role in identifying some of these issues is an interesting question. I had not really thought that through. The CHC would not, I think, have been aware of financial problems, and not to the extent that we should be and were. In terms of the other issues, I am not sure that its members would necessarily be aware."[66]

86. In commenting further on the escalation of issues by CHCs the Director General stated that:

> "Should a CHC that is alert have been signalling some concerns to the board or, alternatively, to a national arrangement or through us? Possibly, but I think that there is a bit of food for reflection on that."[67]

87. Written evidence received by this Committee, from the North Wales CHC, suggests that the CHC had been aware of problems at BCUHB for some time and did not appear to escalate these problems.

88. The Committee notes the issues around the escalation of concerns. We believe that staff across all health boards should actively be encouraged to raise concerns regarding risks to patient safety, rather than fear they will be reprimanded for doing so. We also believe that CHCs have a role in identifying and escalating concerns raised with them.

89. Since the Committee's oral evidence sessions, we also note the intention of the UK Government to create a new criminal offence in England and Wales whereby individuals are 'guilty of wilful or reckless neglect or mistreatment' of patients should they fail to report

[65] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[66] RoP, Public Accounts Committee, 18 July 2013, paragraph 819
[67] RoP, Public Accounts Committee, 18 July 2013, paragraph 819

concerns. The proposed legislation is based on the recommendation made in a report published by Professor Don Berwick in August 2013.[68]

Under reporting of Serious Incidents

90. The joint report raises concerns about the under reporting of serious incidents involving *C Difficile* specifically stating that:

> "There appears to have been significant under-reporting of serious incidents involving *C Difficile*, both internally within the Health Board, and also to the Welsh Government in accordance with published guidance. This contributed to both the Board and the Welsh Government receiving unduly positive assurance as a result of being unsighted on the totality of information regarding *C Difficile.*"[69]

91. In commenting on these concerns, the acting Chief Executive of the Board informed the Committee that:

> "…we did not have a robust system. We accept that and that needs to change. We were reporting infection control data and it was linked to the priorities and the targets that are set at a national level. One of the things that that did not adequately bring to focus for us is the absolute level of infection that was going on and the board's focus on a number of cases, as opposed to whether we were reducing or increasing. So, there is a real issue about refining those indicators and being clear about what they were. Some of that infection control information has been reported. There were weaknesses and they have been identified, and we would not pretend to suggest they were not there."[70]

92. Concerns regarding the underreporting of serious incidents were further exacerbated in evidence to the Committee from the former Chair of the Board who informed us that he was:

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[68] A promise to learn – a commitment to act - Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England [accessed 19 November 2013]
[69] HIW/WAO Joint Report (June 2013), paragraphs 48 and 53
[70] RoP, Public Accounts Committee, 9 July 2013, paragraph 182

> "…shocked to hear of the outbreak of *C Difficile* at Glan Clwyd at a later stage than I believe I should have been told."[71]

93. Furthermore, the North Wales CHC advised us that it also no longer had confidence in information supplied by the Health Board, stating that:

> "In light of the joint HIW/WAO report, the CHC has recently agreed a robust Action Plan to deal with the issues raised and in particular is considering how the CHC monitors the quality of infection control practice in North Wales' hospitals. Further I have, through my Chief Officer advised the Health Board that the CHC can no longer have confidence that the information supplied to us by the Health Board is a fair and accurate representation of what is happening at either Board or ward level. With this in mind, the CHC has withdrawn from the Health Board's Annual Quality Statement process for 2012-2013."[72]

94. The evidence received by this Committee in relation to the under reporting of serious incidents involving *C Difficile* links to other evidence provided to us, to demonstrate that inadequate and inaccurate information was being provided to the Board and its sub-committees. As a Committee we find it extremely concerning that the Board was not properly sighted on vital issues around infection control. Given this, we question whether there can be confidence in the wider quality and safety information that is presented to the Board.

95. More recently, in August 2013, Professor Brian Duerden[73], Emeritus Professor of Medical Microbiology at Cardiff University, published an independent report on BCUHB's infection control arrangements.[74] In particular, his report concluded that the Health Board must strengthen its clinical leadership of infection control at the highest levels, and make sure that it had very clear arrangements for monitoring and managing infection control issues at a local level. Professor Duerden's report also highlighted that a consistent approach to reporting cases across the Health Board was required, so that any

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[71] RoP, Public Accounts Committee, 18 July 2013, paragraph 422
[72] Written Evidence, North Wales Community Health Council, 12 July 2013
[73] For clarity: there is no familial relationship between Dr Martin Duerden, the Health Board's Acting Medical Director, and Professor Brian Duerden.
[74] Professor Brian I. Duerden, 'Review of Governance Arrangements, Structures and Systems for the Prevention and Control of Healthcare Associated Infections in the Betsi Cadwaladr University Health Board', 13 August 2013

signs of an outbreak were identified quickly and appropriate action taken.

96. We understand that in response to Professor Duerden's report, the newly appointed executive director of nursing, midwifery and patient services at BCUHB stated that:

> "We have made it clear that we have an attitude of 'zero-tolerance' to preventable infection across the organisation. As an immediate step I have brought in a leading expert in infection prevention to work with us in north Wales as we improve our wider infection control services. We have also put in place a weekly monitoring system at board level and we now have infection control groups led by senior clinical staff in each acute hospital to make sure there are clear lines of reporting and accountability at a local level. We are also in the process of recruiting additional nurses to our infection control teams."[75]

97. While we welcome the approach being taken by the Health Board, we remain deeply concerned that if inadequate or inaccurate information had been provided to the Board at BCUHB, it would also have been inaccurately provided to the Welsh Government. The joint report notably stated that:

> "…there appears to have been significant under-reporting of serious incidents involving *C Difficile*, both internally within the Health Board, and also to the Welsh Government in accordance with published guidance. This contributed to both the Board and the Welsh Government receiving unduly positive assurance as a result of being unsighted on the totality of information regarding *C Difficile.*"[76]

98. We are concerned that if BCUHB had provided inaccurate information to the Welsh Government, the same could also be true of other Health Boards. The Welsh Government's Chief Medical Officer considered that Health Boards did generally report serious incidents accurately, but stated that:

> "…as soon as I started to question the fact that we had a number of notifications of deaths in relation to C. difficile, I did

[75] http://www.bbc.co.uk/news/uk-wales-23678685, [accessed 13 August 2013].
[76] HIW/WAO Joint Report (June 2013), paragraph 48

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ask for a review of other health boards across Wales to make sure that we were getting the notifications in line with expectations on this particular issue, and I wrote out to health boards."[77]

99. She added that:

> "The issue about serious incident reporting is about this question of, if someone has Clostridium difficile on part 1 or part 2 of the death certificate, whether that is being flagged regularly and systematically to Welsh Government as a serious incident. Having seen what happened with the cases that we were coming in from Betsi Cadwaladr, I went back and double-checked that with the health boards. What is evident was that it was inconsistent, and I have taken steps to try to close that."[78]

Having considered the evidence, the Committee welcomes the action being taken by the North Wales Community Health Council to monitor compliance with infection control procedures in hospitals across North Wales. We recommend that the Welsh Government reviews its processes for validating quality and safety, and other critical data from NHS organisations. It is vital that such data is reported accurately if meaningful action is to be taken.

Communications between the Ward and the Board

100. The joint report identified a communications 'gap' between people working in the organisation's various wards, and it's overarching Board.[79] This was acknowledged by the former Vice-Chair of the Board, who informed this Committee that:

> "…there has been some tension and, perhaps, a gap between the management structure and the front line."[80]

101. Evidence from the Chair of the North West Wales Consultant Group and Director of Psychiatry at BCUHB described a major communications gap between staff on the Health Board's Wards and its senior management. The evidence also alluded to a lack of confidence in the senior leadership of the Board. He stated that:

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[77] RoP, Public Accounts Committee 18 July 2013, paragraph 845
[78] RoP, Public Accounts Committee, 18 July 2013, paragraph 852
[79] HIW/WAO Joint Report (June 2013), paragraph 42
[80] RoP, Public Accounts Committee, 18 July 2013, paragraph 385

> "There are a growing number of Serious Untoward Incidents linked we believe to mismanagement. Our concerns are that there will be even more such incidents in the near future as medical and nursing staff have left the service and the gaps in cover are growing ever more alarming with management seemingly incapable of resolving the issues."[81]

102. While the Committee notes this evidence is from one discipline in one geographical area, we acknowledge that it may represent the view of other clinical groups.

103. The Committee questioned the outgoing Chief Executive on whether the Board's organisational structure, and its implementation, had contributed to a communications gap between Wards and the Board. In response, she stated that:

> "A Board would not generally be expected to be sighted on all operational matters involving over 17,000 staff irrespective of the organisational structure in place. The point is to ensure appropriate escalation of issues requiring the involvement of the Board and in reverse Board to Ward dissemination and understanding of strategic corporate objectives with delegation of responsibility for delivery of operational objectives to plan."[82]

104. She added that:

> "The 'Board to Ward' gap cannot be wholly attributed, as may be implied, to the clinical leadership structure in place. As indicated the issues are wider and not just confined to this Board."[83]

105. Given the significance of adequate infection controls, and their potential contribution to the C *Difficile* outbreak, we asked the Chair of the Quality and Safety Committee why a decision was taken to reduce the number of infection control nurses, and to disband and disestablish the clinical groups that had been set up. However, he

[81] Written Evidence, Chair of North West Wales Consultant Group, 11 August 2013.
[82] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[83] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013

advised us that "It was not a board decision."[84] He added that "I was not aware that the numbers had been reduced."[85]

106. On this issue, the Secretary to the Health Board said that:

> "The sub-committee on improving infection prevention and control was a formal sub-committee of the quality and safety committee, and its full minutes came up to the quality and safety committee, month by month, together with issues of significance. That gave the executive nurse at the time the opportunity to raise issues of concern, bringing them formally to the attention of the full committee. If you go back through the notes, it is clear that we were concerned about infection control. However, it is absolutely clear that the committee and the board did not understand, until April, the full extent and impact of the *C Difficile* outbreak at Glan Clwyd Hospital."[86]

107. The Committee is very concerned that both the system of raising matters to the Quality and Safety Committee's attention, and of the Committee then identifying matters of concern, were structurally flawed. We note that the joint report recommended a closer examination of the way in which the Quality and Safety Committee works, as the report raised concerns about the way in which the Quality and Safety Committee operates.[87] We concur with this recommendation.

108. The Committee has received sufficient evidence to support the findings of the joint report and we believe that there was a gap in communications between the Ward and the Board. However, we have also received evidence to suggest that improvements are now starting to be made to address this problem.

109. In correspondence to this Committee, the Chief Executive of Healthcare Inspectorate Wales, stated that:

> "Since the publication of the joint report in June of this year I have regular discussions with the Acting Chief Executive and Nurse Executive to assure myself that progress is being made. I consider there to be clear evidence that there is now a real

[84] RoP, Public Accounts Committee, 18 July 2013, paragraph 396
[85] RoP, Public Accounts Committee, 18 July 2013, paragraph 398
[86] RoP, Public Accounts Committee, 18 July 2013, paragraph 406
[87] HIW/WAO Joint Report (June 2013), paragraph 52

> focus on the quality and safety of patient care and on ensuring that the right governance frameworks are put in place, to address the gap between the Board and those providing patient care."[88]

110. The Committee welcomes the focus on the quality and safety of patient care and the new governance frameworks now in place. However, we are keen to emphasise the importance of ensuring these changes are fully implemented as these are issues of direct concern to patients and their families.

We recommend that the Welsh Government finalise, introduce and implement a common set of key performance indicators of quality and safety for use by Health Boards. This would assist in improving performance and identifying risks so that swift action can be taken to address them.

A Rise in Risk Adjusted Mortality Index (RAMI) rates

111. Following publication of the joint report, this Committee received correspondence from consultants based at Ysbyty Gwynedd, which expressed a "lack of confidence in the current Board and Executive to manage with appropriate speed, the changes necessary to sustain good health care in North Wales."[89]

112. The Committee notes that a consultant histopathologist at Ysbyty Gwynedd, was quoted in the media insisting that concerns raised in the report came as no surprise to senior clinicians. He said that "Myself and my colleagues are very upset" adding that:

> "They're very worried that the management of the health board isn't sufficiently strong enough to give them a safe place to treat their patients.
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> "In addition there's been an increase in RAMI (risk adjusted mortality index) - an indicator of excess or unexpected deaths. Until last year RAMI at Ysbyty Gwynedd had shown a steady progressive decline.

[88] Written Evidence, Chief Executive Healthcare Inspectorate Wales, 10 October 2013
[89] Written Evidence, Chair of Gwynedd Consultants and Specialists Committee, 5 July 2013

> "But over the past few months it's started to increase and that the last count was 122 which is quite significant."[90]

113. As a Committee we consider a RAMI rate of 122 to be a worrying death rate for a major hospital site. Moreover, written evidence from BCUHB set out that RAMI rates in other hospitals within the Health Board were of concern:

> "The Health Board has been aware of a month on month increase in RAMI in Ysbyty Gwynedd for the last 7 months of validated data (now up to April 2013). In the last few months, the RAMI in Ysbyty Glan Clwyd has also increased and the RAMI in Wrexham Maelor is higher than that seen in the other two hospitals but has been relatively stable over the same time period. This matter is being thoroughly investigated and regular written updates are being provided directly to the Chief Medical Officer for Wales."[91]

114. We are pleased to see that the Health Board is undertaking a thorough investigation of the reasons behind the high RAMI scores. The investigations should result in a clear and transparent articulation of the issues that are contributing to the high mortality indices that are being reported, and urgent and decisive action to address any patient care issues which become evident.

115. More widely, we believe that more should be done to provide the public with transparent, understandable and easily accessible information on mortality statistics for hospitals in Wales.

We recommend that the Health Board makes the results of its investigations into the high RAMI scores across hospitals in North Wales publically available, together with information on the actions that are being taken to address any patient care issues that are identified.

We recommend that the Welsh Government makes information on RAMI scores across all hospital sites in Wales more accessible to the general public, ideally by placing all the data on a single web page, with clear explanations of what the data means.

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[90] http://www.bbc.co.uk/news/uk-wales-23235262, [accessed 9 July 2013]
[91] Written Evidence, Director of Communications and Governance, 18 July 2013

4. Financial Management and sustainability

Budget processes

116. The joint report raised a number of concerns regarding budget processes specifically stating that a number of budget holders only signed off their budgets for 2012/13 'with caveats'[92]. On this matter, the Health Board's former Director of Finance told us that:

> "In the last financial year, we decided as a health board to put in place an interim budget for one month only, and that was to take account of… issues... We put the annual budget in at the April board for the remainder of that year. In previous financial years, and in this financial year, the board has been fully signed up in advance of the financial year, but we fully recognise that it was important that there was a robust budget set by the health board, rather than one that was just, if you like, a budget in name only."[93]

117. Furthermore, the outgoing Chief Executive informed the Committee that:

> "Each Corporate Director and Chief of Staff accepted their budgets and worked to them to the best of their ability given the constraints placed upon them in a flat cash scenario with increasing drug and therapeutic costs, salaries and patient demand. Their 'caveats' are risks that as a clinician and responsible budget holder, they raised in order that it was open and transparent about what they may not be able to achieve from a clinical standard or quality perspective. It is unusual to be reported in this way. It is usually done in another form which is presentation of savings plans with clinical risk assessed."[94]

118. Moreover, we are concerned to hear that the signing up to a budget with caveats had occurred again in relation to the 2013/14 financial year. The Chair of the Finance and Performance Committee told us that:

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[92] HIW/WAO Joint Report (June 2013), paragraph 60
[93] RoP, Public Accounts Committee, 9 July 2013, paragraph 228
[94] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013

> "the position that we are in in July, after the June finance and performance meeting, is that a small number of the CPGs are not able to sign up to their budgets without adding notes about caveats, in terms, for example, of the recruitment of locums, and so on. Clearly the expectation in a delegated situation is: the budget is the budget; that is something that I am used to operating in local government, with whatever constraints that may apply in terms of the planning arrangements."[95]

119. The Committee believes that this unacceptable and that a budget should not be signed off with caveats. Senior leaders must ensure that this is communicated to all members of staff, and that the final budget is not a matter for further negotiation, unless circumstances change significantly. We believe that it is reasonable for debate and discussion to take place before the budget is set, but before the beginning of a financial year a final decision should be taken to set that budget.

120. The Committee fully accepts that there may then be in-year virements between budgets, as unanticipated issues can arise. We believe that failure to do this inherently risks compromising savings plans and budget management processes in the early months of a financial year.

121. In conclusion, the Committee is of the view that the use of caveats could be perceived as a reflection of internal divisions between budget holders in the organisation.

The failure to adhere to accepted budget processes is an issue of particular concern. We do not believe that budgets should be signed off with caveats and recommend that assurances should be provided to us that this practice has now been discontinued within the Health Board.

We also recommend that the Welsh Government seeks information from directors of finance at all health boards to ensure that the failures evident within the budget planning processes at the Betsi Cadwaladr University Health Board are not being replicated elsewhere.

[95] RoP, Public Accounts Committee, 18 July 2013, paragraph 474

Achieving financial break-even in 2012/13

122. BCUHB has historically had a strong track record in delivering its statutory financial targets. However in September 2012, the Health Boards year-end forecast for 2012-13 notably went "from break even to a projected deficit of £19 million."[96]

123. In exploring the reasons for this, the joint report found that:

> "It's [the Boards] dependency on non-recurrent savings is unsustainable. The process for identifying savings schemes needs to be more transparent and robust and future savings plans will need to focus increasingly on the more difficult areas for recurring savings: reducing costs by reforming and reshaping services."[97]

124. The joint report also found that the Health Board had adopted a range of measures to avoid a breach of its statutory 2012-13 Resource Limit:

> "In addition, the Health Board recognised the use of 'strategic reserves', the proactive management of contracts, one-off favourable variances and savings achieved from the implementation of additional expenditure controls in the final weeks of the financial year. These emergency measures included 'a reduction in the additional work to meet access targets and in particular a cessation of waiting list initiatives, except as specifically approved by the Finance and Performance Committee to address safety issues."[98]

125. The Acting Chief Executive told us that the Welsh Government was aware of these plans:

> "I think that it would be wrong to say that it gave permission or consent for us to do it. That was a decision that the Board took, balancing its financial duties and its service duties. However, the Welsh Government was aware of our trajectory."[99]

126. In this Committee's report on Health Finances, published in February 2013, we commented that it was imperative that accurate

[96] RoP, Public Accounts Committee, 18 July 2013, paragraph 510
[97] HIW/WAO Joint Report (June 2013), paragraph 72
[98] HIW/WAO Joint Report (June 2013), paragraph 63
[99] RoP, Public Accounts Committee, 9 July 2013, paragraph 243

information was provided to the Welsh Government on health boards' financial forecasts. The Committee believes that it is the role of a Chief Executive, in their capacity as Accounting Officer, to communicate this information in a timely manner to the Welsh Government.

127. We remain convinced that in the current financial climate it is vital that health boards provide accurate, up-to-date information on their financial forecasts- and the consequences of such- to the Welsh Government. We believe such information will enable the Welsh Government to more effectively support health boards.

128. However, the outgoing Chief Executive also stated that prior to an award of additional funding during the 2012/13 financial year:

> "…the external emphasis was one of insistence that the Board achieve financial balance and performance targets. This was in the face of also dealing with remedy of the full scale of management issues requiring address… Inevitably this had impact on the pace of turnaround not within the power of the Board, or me alone, to deliver corporately."[100]

129. We were alarmed by these comments, because we do not consider service delivery and management issues to be isolated and separate from financial breakeven and performance targets. We believe the health board could have justifiably focussed some of its 2012/13 expenditure on reviewing and improving management issues, on the basis that this would have improved both its capacity to achieve financial break-even and to achieve its key performance targets.

130. We note that the actions of the Board, coupled with additional Welsh Government in-year resource funding, did enable the Health Board to achieve break even in 2012-13. A number of witnesses advised the Committee that the position regarding cancellation of elective operations is more complex than it might initially appear, and that emergency winter pressures meant beds normally used for patients expecting elective operations were unavailable. The Welsh Government stated that:

> "Looking at the number of cancellations across Wales, which is a significant number, the cancellations were made due to a lack

[100] Written Evidence, outgoing Chief Executive – BCUHB, 12 September 2013

> of beds, and the evidence that we have is of health boards having to open additional beds—and spend money on additional beds—to accommodate non-elective demand. At times, they had to send patients out from medical areas into surgical areas. So, our analysis, the emerging analysis, is that that is the main driver, but, clearly, finance influenced decisions in terms of their ability to secure, possibly in the independent sector, possibly in other ways, activity that would compensate for that loss."[101]

131. Similarly, the Chair of the Board's Finance and Performance Committee stated that the reason for cancelled appointments was:

> "…in the main, the impact and consequences of winter pressures on the emergency department, which are common across Wales. So, if there were cancellations there, it was because of increased bed pressure at that time, the presence of outliers in surgical beds and so on. It was not a direct consequence of the decision in respect of the additional investment."[102]

132. As a Committee we believe that this reasoning will be of little consolation to patients and their families. Many patients in North Wales had operations postponed at short notice during the final quarter of 2012-13, and Committee Members representing North Wales have received correspondence from members of the public raising concerns regarding this.

133. In written correspondence, BCUHB advised us that the number of patients affected by the decisions made in December 2012 for the final quarter of 2012/13 was approximately a combined 1250 inpatient and day case and 1600 follow up outpatient reviews.[103]

134. The joint report also comments that this action had a detrimental impact on patient waiting times. It is also clearly not a sustainable approach to meet financial targets, as any elective activity deferred from 2012-13 would need to be carried forward into 2013-14, putting further pressure on resources in the current year.[104] The outgoing

[101] RoP, Public Accounts Committee, 18 July 2013, Para 754
[102] RoP, Public Accounts Committee, 9 July 2013, Para 357
[103] Written Evidence, Director of Communications and Governance, 18 July 2013
[104] HIW/WAO Joint Report (June 2013), paragraph 63

Chief Executive acknowledged that the decision to cancel appointments was:

> "…a 'false economy' as it carries the activity into the following year and costs more. Although the Report states this was clinically led, Chiefs of Staff were instructed to come up with options to save more money as the Board was being required to financially balance. The Board was reporting an end of year deficit, which in the end achieved a small surplus instead. Clinicians did provide options, but one cannot conclude that they condoned it. Surgical staff were not being fully utilised and patients were being disadvantaged."[105]

135. On 30 September 2013 the Welsh Government introduced the National Health Service Finance (Wales) Bill. The aim of the Bill is to give NHS bodies greater financial flexibility and remove the need to break even on an annual basis.

136. However, we believe the introduction of this Bill emphasises the need for health boards to focus on long-term transformational savings, as opposed to short-term arrangements. This will require both effective financial planning from month one and accountable, robust direction from health boards' senior managers.

We recommend that the Welsh Government emphasises to health boards that they should wherever possible avoid utilising unsustainable solutions to financial pressures, such as cancelling or postponing operations, which simply defers costs to the next accounting period.

We recommend that the Welsh Government ensures that all health boards minimise the inconvenience and distress caused to patients and their families by requiring that Boards communicate with patients as soon as possible following a decision to cancel or postpone elective operations.

137. The Committee has subsequently undertaken inquiries into Health Finances 2012-13 and beyond and Unscheduled Care and will be publishing reports with specific recommendations in these areas in due course.

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[105] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013

External Reviews of Financial Management

138. The Committee noted that two reviews were commissioned looking at financial management issues at the Board.

139. The Hurst review was conducted by the Welsh Government Health Department's former Director of Finance [Mr Hurst] and was published in April 2012. The acting Chief Executive told us that:

> "The [first] report from Mr Hurst, which came in April, discussed the need to sharpen our focus on the delivery of savings, to bring our financial and service planning together, and to be clear about our clinical leaders owning some of the financial issues. Out of that, we established a delivery board and changed some of the ways that we were working within the board."[106]

140. The Committee was concerned to hear from Welsh Government officials that although the Welsh Government had funded the £2800 Hurst review, until recently they had not seen a copy of the report.[107] Welsh Government officials explained that Mr Hurst was available to undertake work across health boards on a call-off basis.

141. The Committee believes that this raises an issue of transparency as the Welsh Government funded the cost of the review, and did not receive a copy of its findings. This would be surprising in any set of circumstances, but especially so given the Welsh Government's role of strategically leading health boards across Wales. This is further exacerbated by the fact that the outgoing Chief Executive stated that the Hurst review was initiated by concerns expressed by the then Welsh Government Health Department's Director of Finance [Mr Hurst] during the 2012/13 budget setting process. In evidence from the outgoing Chief Executive the Committee were told:

> "The 2012/13 budget setting process caused concern with the Director General and Finance Director at that time, Mr Hurst. The Director General did contact me during my period of absence from February to mid-May 2012 as to the initial shortfall being identified and concerns about financial forecasting and management. I was not in a position to

[106] RoP, Public Accounts Committee, 9 July 2013, Para 247
[107] Written Evidence, Director General for Health and Social Services, 2 August

> respond, but did disclose the conversation with the Acting Chief Executive at the time. The concern prompted the Chris Hurst Review which the Acting Chief Executive received and acted upon."[108]

142. The Committee questioned the Welsh Government on how it planned to test whether the work it had commissioned was delivering value for money, particularly given they did not know what the outcome was. In response the Director General stated:

> "There are two parts to it. One is who paid for it, and then there is what work was involved, which is part of commissioning. The fact that we paid for it, yes, I accept that. The actual nature of it was specified between Chris Hurst and Betsi Cadwaladr, and the work was presented to Betsi Cadwaladr. You are right—we did not have sight of the finished product."[109]

143. It is also unclear from the evidence received by the Committee how widely the Hurst report was shared within the Board itself. We firmly believe that a report addressing such important issues should have been shared with the full Board. The Director General also told us that:

> "My expectation was that they would have shared those with the board as a matter of good practice. As I said, it is difficult to talk about the Hurst review. That was not shared with HIW and the WAO. I think that we discussed the Allegra review at one of the meetings that we had, but I do not think that it was shared with HIW and the WAO."[110]

144. We understand that this did not happen in this instance and instead, the Hurst report was only presented to a sub-committee. The acting Chief Executive explained to us that:

> "The Hurst report came in at a time when I was covering the chief executive role, and I discussed with the chairman how we would respond to that role and to that report, and develop the plans. That was not taken to the Board as a paper, but the

[108] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013
[109] RoP, Public Accounts Committee, 18 July 2013, paragraph 593
[110] RoP, Public Accounts Committee, 18 July 2013, paragraph 671

proposals that came out of it went to the Finance and Performance Committee."[111]

We recommend that the Welsh Government takes greater care when commissioning taxpayer funded external advice and that, without exception, the output of such advice is received, reviewed and retained by appropriate Welsh Government departments.

145. The Allegra report, published in December 2012, is a more detailed document. The Director General described that in response to escalating concerns around the Health Board (particularly the deterioration in its financial forecast), Allegra Ltd was commissioned by the Welsh Government to provide an external perspective.[112] He said that:

> "…the report was commissioned particularly in the context of financial problems, so its focus necessarily would have been on financial issues. That was the main thrust. That is really what it was there for. There was a request within it to comment on one or two other issues, but this was not a report on the broad range of challenges facing the health board. It was a very short, sharp report that we felt was necessary just to confirm some of the issues that we were concerned about."[113]

146. The Director General also emphasised that:

> "The Allegra report did not just drop on their desks and then we said, 'That's it. Thank you very much'. There was follow-up action. We asked for assurance in terms of the various recommendations and worked closely with the board to make sure that it was giving attention to the various recommendations within that report."[114]

147. The acting Chief Executive told us that the Allegra report:

> "…discussed turnaround a great deal, and it also discussed changing the structure and implementing the chief operating officer role. Furthermore, it discussed linking the acute services review with finance and accelerating movements on that. I think

[111] RoP, Public Accounts Committee, 09 July 2013, paragraph 249
[112] RoP, Public Accounts Committee, 18 July 2013, paragraph 627
[113] RoP, Public Accounts Committee, 18 July 2013, paragraph 655
[114] RoP, Public Accounts Committee, 18 July 2013, paragraph 718

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> that, in some of our responses and in some of the comments in the Auditor General report, you can connect those themes and see that there are significant actions on-going now that were referenced in that report."[115]

148. However, written evidence from the outgoing Chief Executive questioned how robustly the recommendations of the Allegra report had been implemented. She said that the Allegra report offered an external view of the organisation:

> "External support for turnaround was discussed with Officials and previous to that Officials had suggested external financial support. This was not supported [by] some Executives or in some cases IMs due to the costs it might incur. For turnaround this meant an existing Director took on this role for a short period of time… The lack of management capacity within the organisation has been a constraint compounded by direction to reduce management costs and a reluctance to overturn this position for financial reasons."[116]

149. We note the outgoing Chief Executive's acknowledgement of a lack of management capacity within the organisation and her view that while management expenditure must be scrutinised robustly to ensure it delivers sufficient value for public money, no organisation can function effectively on a long-term basis if it has insufficient management capacity.[117] However, we question why she did not deal with this issue in her position as Chief Executive.

150. We consider that the commissioning of two Welsh Government funded reviews into financial management at the Health Board may have contributed to the perception that financial balance was a greater priority for the Welsh Government than other aspects of Health Board performance.

In relation to the sharing of the findings of external reviews the Committee believes that it is vitally important, that safeguards are in place to ensure that such findings are widely utilised to learn lessons and improve processes within health boards. We recommend that Welsh Government takes this forward.

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[115] RoP, Public Accounts Committee, 9 July 2013, paragraph 247
[116] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013
[117] Written Evidence, outgoing Chief Executive – BCUHB, 12 September 2013

5. Strategic Vision and Service Reconfiguration

151. The NHS in Wales is facing up to the key strategic challenge of: the need to sustain quality standards within tightening finances, and to reconfiguring and transforming services to respond to these challenges and the evolving needs of the population.

152. Within this context, the joint report found that the Health Board underwent a challenging public consultation exercise during the latter part of 2012, and had started to implement changes to locality and community-based services as a result.

153. However, the joint report also found that there had been a piecemeal approach in taking forward service redesign that makes it more difficult to design and plan the whole system changes that are necessary to create clinically and financially sustainable services.

154. On this matter, the outgoing Chief Executive explained the approach taken by the Board:

> "The approach adopted has been drawn from international research, using a similar health pattern and challenges in Australia that mirror many of the issues faced in North Wales such as geography and medical recruitment. Whilst it may be appear to be slow, there are already clinical service strategies in place for many acute services such as cardiology, emergency medicine, vascular, rheumatology, cancer, palliative medicine to name a few."[118]

155. Linked to the strategic vision and service reconfiguration the joint report concluded that given the challenges that are known to exist with medical recruitment, and with the affordability of current service models in North Wales, the need to develop a clear strategic appraisal of options for the future shape of acute services is pressing.

156. The joint report also identified that the Deanery in Wales has raised concerns in relation to the viability of medical rotas to support junior doctor training:

[118] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013

> "the Interim Medical Director and Chief Executive took a proposal to the Board in April 2013 to recruit an additional 72 clinicians in time for the August 2013 junior doctor rotation. The feasibility of achieving this is highly questionable and in our view is indicative of a reactive approach to a problem that requires more fundamental action. At the time of our review further discussions were being held between the Health Board and the Deanery on this issue."[119]

157. Whilst we note the written evidence provided by the outgoing Chief Executive on the service plans which have already been developed, it is clear that the Health Board is lacking an overarching strategic plan that sets out clinically and financially sustainable proposals for the totality of healthcare provision in North Wales.

158. Urgent action is needed to address this deficit in strategic planning, given that it is going to take a significant amount of time to work up these proposals and consult on them with the public and other key stakeholders.

159. Development of the required service, workforce and financial plans will require strong senior leadership from within the Health Board, alongside supportive scrutiny from the Welsh Government.

The Committee believes it is vital that senior leaders set a clear vision for their organisations to respond to the three challenges of developing service, workforce and financial plans. Given the issues around governance arrangements at Betsi Cadwaladr University Health Board, it is imperative that the new senior management of the Board renew and reunite the Executive and non-Executive leadership team, and close the gap between the Board and Wards.

[119] HIW/WAO Joint Report (June 2013), paragraph 78

6. The role of the Welsh Government

160. The Welsh Government plays a crucial role in the NHS in Wales. It is the main source of funding for Health Boards, sets strategic direction and provides democratic oversight and accountability. The Director General told us that it had expressed concerns to BCUHB throughout 2012-13:

> "about unscheduled care, and the concerns about finance developed later in September and October. However, unscheduled care continued to be a matter of concern. We also raised issues about the capacity of the health board at the executive level."[120]

161. We heard that as a general rule, correspondence from the Director General was addressed to the Chief Executive or acting Chief Executive.[121] The acting Chief Executive concurred that the Welsh Government had had an on-going dialogue with the Health Board:

> "That occurs at chief executive level, chair level and at individual professional level, so my finance director colleague would have a close relationship with the finance officer, and discussions have been ongoing and the challenges have been recognised… Some of the initiatives were on reviewing the structure, focusing on planning for the year ahead and getting a more structured approach to what we were doing, as a part of that conversation. Those conversations have continued since the publication of the report, in terms of how we work with Welsh Government and how Welsh Government can support us to deliver what we need to do—putting right some of the issues in this report and putting the board on a firmer footing."[122]

162. Similarly, the former Chair of the Board described that:

> "I believe that the Welsh Government did remind the board of its responsibilities, financially and in terms of performance. It was supportive of me as chair, and of others, as we attempted to change the system."[123]

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[120] RoP, Public Accounts Committee, 18 July 2013, paragraph 536
[121] RoP, Public Accounts Committee, 18 July 2013, paragraph 560
[122] RoP, Public Accounts Committee, 9 July 2013, paragraph 25
[123] RoP, Public Accounts Committee, 18 July 2013, paragraph 60

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163. The Director General stated that:

> "The general pattern that emerged was of me asking for reassurance and receiving it very promptly. There was no problem; we did not have to particularly chase it up. At times, there was not quite the pace in the consequential delivery, which became a matter of concern and a matter of inquiry for me, I suppose. To an extent, it seemed to be that the executive team was stretched, which is why my attention was then drawn to the capacity of the organisation, and particularly what seemed to be a need to resolve this issue between the clinical leadership structure and the executive leadership structure. The model that a number of health boards have successfully employed—and you need it, I think, in big organisations—is to have a chief operating officer who can appropriately manage the clinical leaders and provide a pan-health-board view of operational matters. That was one of the outcomes of that. Generally, we were getting reassurances of action, but quite often, it was not quite delivered with the pace and to the time frames that we would have wished for."[124]

164. In taking evidence we examined whether the Welsh Government could have done more to intervene more directly, as it has in education and local government, taking over direct responsibility from authorities deemed to be failing. However, the Director General considered that direct action had been undertaken, commenting that:

> "The Delivery and Support Unit is a resource that we, as the Welsh Government, can deploy to organisations when they are in difficulty in terms of areas of performance. We deployed the unit to Betsi Cadwaladr University Local Health Board. At any point in the last 12 months, it has been working on unscheduled care, elective care, stroke, cancer and mental health. It has provided diagnostic support, clinical insight and facilitation to allow the Health Board to develop plans. It has not done it for the Board; we have sent in a team of people that can support the Board to do so."[125]

[124] RoP, Public Accounts Committee, 18 July 2013, paragraph 564
[125] RoP, Public Accounts Committee, 18 July 2013, paragraph 520

165. In response to our questions as to whether the Welsh Government identified problems on a timely basis, and acted promptly, the Director General told us:

> "…were we aware that unscheduled care problems were developing? Yes. Did we act? Yes. Were we aware that the finance problem was developing in a not particularly good position? Yes. Did we take action? Yes. Did we encourage action about the executive team? We did. Did we seek to force things through in a very complicated situation? The answer is 'yes'."[126]

166. The Director General also told us that the Welsh Government's delivery framework has an escalation of action and interaction according to the concerns raised. He noted that in this case issues around Betsi Cadwaladr had escalated from level 0 to level 4 from September 2012 through to February 2013:

> "The health board in our delivery framework was escalated to level 4 in February. So, action was taken when there was a failure to deliver. During the period from September onwards, we also had meetings with HIW and WAO about the way in which the system in a general way could respond to the position."[127]

167. The Committee notes that the National Health Services (Wales) Act 2006[128] confers on Welsh Ministers a discretionary power to intervene by way of an intervention order, if it is satisfied that a health body is not performing one or more of its functions adequately or at all, or that there are significant failings in the way the body is being run. We also note that an intervention order may include removal from office of a member (or members) of a Local Health Board and their replacement with individuals specified or determined in accordance with the order.

168. However, the Committee remains unclear on the criteria upon which intervention is triggered and the scales upon which the type of intervention is based. The Committee believes that prompt intervention can prevent problems escalating, and that further developmental work on this is urgently required.

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[126] RoP, Public Accounts Committee, 18 July 2013, paragraph 813
[127] RoP, Public Accounts Committee, 18 July 2013, paragraph 625
[128] National Health Service (Wales) Act 2006

169. The Committee notes the role that Community Health Councils (CHCs) may have in monitoring escalation issues and believe that it is important for CHCs to be made aware of the intervention process and any Health Boards that become subject to intervention.

We recommend that Welsh Government work with the Wales Audit Office and Healthcare Inspectorate Wales to develop a clearer set of scales of escalation. This should include a detailed criteria upon which intervention is triggered, the rationale for the type of intervention, and clarity on who should be notified when intervention commences and ceases. We believe that this information should be made accessible to the public.

Additional Management Capacity

170. The joint report notably considered that additional capacity for the Health Board was needed in the short term, stating that:

> "In our view additional capacity, ideally from sources external to the Health Board, is needed in the short term to provide the leadership, impetus and fresh perspectives that are necessary. We understand that the Health Board has already made proposals to the Welsh Government in respect of the need for additional capacity, which have been agreed."[129]

171. In response, the Minister for Health and Social Services announced on 27 June 2013 that interim support for the Health Board would be put in place.[130]

172. The Committee welcomes the addition of interim expertise from other Local Health Boards across Wales. However, we are not convinced by the assurances provided by the Director General that this would not detract from the capacity at those organisations lending their senior leaders' time.[131] The Committee notes the Director General's view on the importance of drawing on short term support from within Wales. In evidence, he informed us that:

> "I felt that it was important that NHS Wales, as well as asking Betsi to bring in some internal people, needed to show that

[129] HIW/WAO Joint Report (June 2013), paragraph 43
[130] http://www.walesonline.co.uk/news/health/betsi-cadwaladr-university-health-board-4723226, [accessed 27 June 2013]
[131] RoP, Public Accounts Committee, 18 July 2013, paragraph 856

some of our internal leadership capacity could support an organisation when it needed it."[132]

173. As a Committee, while we appreciate some of the benefits internal NHS Wales capacity can bring, we believe that it is more important that health boards have access to a credible pool of short term additional leadership capacity, rather than relying on internal NHS Wales capacity which can in turn create further challenges for the organisation from which that capacity is drawn.

We recommend that the Welsh Government gives urgent consideration to the creation of a pool of additional short term leadership capacity, for NHS Wales, that can be drawn upon at short notice and does not impact on other NHS Wales Health organisations.

[132] RoP, Public Accounts Committee, 18 July 2013, paragraph 856

Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=7185

9 July 2013

Geoff Lang	Acting Chief Executive, Betsi Cadwaladr University Health Board
Dr Martin Duerden	Acting Medical Director, Betsi Cadwaladr University Health Board
Angela Hopkins	Director of Nursing, Midwifery and Patient Services, Betsi Cadwaladr University Health Board
Helen Simpson,	Director of Finance, Betsi Cadwaladr University Health Board

18 July 2013

Merfyn Jones	Outgoing Chairman, Betsi Cadwaladr University Health Board
Dr Lyndon Miles	Outgoing Vice-Chair, Betsi Cadwaladr University Health Board
Grace Lewis-Parry	Director of Governance and Communications and Secretary to the Board, Betsi Cadwaladr University Health Board
Keith McDonogh	Chair of Finance and Performance Committee, Betsi Cadwaladr University Health Board
David Sissling	Director General, Health and Social Services, Welsh Government
Dr Ruth Hussey	Chief Medical Officer, Welsh Government

Martin Sollis Director of Finance, Welsh Government

List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=7185&Opt=3

Organisation

Joint Letter from Healthcare Inspectorate Wales and the Wales Audit Office to the Chief Executive, BCUHB, 23 May 2013

Written Evidence, Chair Gwynedd Consultants and Specialists Committee, 5 July 2013

Written Evidence, Outgoing Chief Executive, BCUHB, 18 July 2013

Written Evidence, Director of Governance and Communications, BCUHB, 29 July 2013

Written Evidence, Director General Health and Social Services, Welsh Government, 2 August 2013

Written Evidence, Chair of the North West Wales Consultant Group, 11 August 2013

Written Evidence, Director General Health and Social Services, Welsh Government, 2 August 2013

Written Evidence, Outgoing Chief Executive, BCUHB, 12 September 2013

Written Evidence, former Chair, BCUHB, 4 October 2013

Written Evidence, Healthcare Inspectorate Wales, 10 October 2013

Written Evidence, Director General Health and Social Services, Welsh Government, 15 October 2013

Written Evidence, Auditor General for Wales, 31 October 2013

An Overview of Governance Arrangements

Betsi Cadwaladr University Health Board

Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office

June 2013

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Healthcare Inspectorate Wales
Arolygiaeth Gofal Iechyd Cymru

This report has been prepared jointly by the Wales Audit Office and the Healthcare Inspectorate Wales (HIW) and is presented to the National Assembly under the Government of Wales Act 1998.

Contents

Foreword

The reorganisation of the Welsh NHS in 2009 led to the development of larger and more complex integrated Health Boards. Betsi Cadwaladr University Health Board (the Health Board) is the largest of these, providing a full range of primary, community, mental health and acute hospital services across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham) as well as some parts of mid Wales, Cheshire and Shropshire.

The Health Board came into being following the amalgamation of two[1] former trusts and six local health boards. The bringing together of different organisations with their own cultures and different ways of working is never a simple task, and significant investments of time and energy are needed to ensure a culture and structure that is fit for the new organisation. Over the last twelve months, Healthcare Inspectorate Wales and Wales Audit Office have shared growing concerns that the leadership arrangements at the Health Board are not driving organisational integration at a sufficient pace.

In recent months, the pace of change has been further impeded by challenges associated with the Health Board's financial position; the need to reconfigure services and on-going instability at senior leadership levels.

Further, work undertaken by Healthcare Inspectorate Wales and the Wales Audit Office towards the end of 2012 identified a range of challenges in relation to the Health Board's governance arrangements. These included inconsistent understanding of lines of accountability and deepening concerns that the Board collectively lacked the capacity and capability to provide appropriate levels of scrutiny in relation to service delivery.

1 The Betsi Cadwaladr University Health Board combines the North Wales NHS Trust (previously North East Wales NHS Trust and Conwy & Denbighshire NHS Trust), the North West Wales NHS Trust, and the six Local Health Boards of Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham.

The extent of the concerns that we have at Betsi Cadwaladr University Health Board are significant, and at the time of writing we are not aware that they are replicated in other health boards in Wales. We therefore agreed to work together to undertake a focused piece of review work designed to support the Board through this challenging period and, most importantly, to ensure that the safety and quality of patient care remains at the forefront of the Health Board's agenda.

Whilst this report focuses on the particular circumstances faced by Betsi Cadwaladr University Health Board, we hope that other health boards will themselves reflect on the findings and seek to assure themselves that any relevant issues are being addressed appropriately and in a timely manner within their own organisations.

Huw Vaughan Thomas
Auditor General for Wales

Kate Chamberlain
Chief Executive
Healthcare Inspectorate Wales

Introduction and background

1 The Betsi Cadwaladr University Health Board (the Health Board) has been through a particularly testing time recently with a number of challenges associated with its financial position and its plans for service reconfiguration, which have been a regular topic for intense media scrutiny. Concerns over the Health Board's financial pressures have resulted in independent reviews being conducted in April 2012[2] and in December 2012[3].

2 These reviews raised question marks over the Health Board's organisational structure, its ability to achieve savings targets and the financial and clinical sustainability of current service models. Both reviews highlighted the need for strengthened accountability and line management arrangements at a senior level.

3 Work undertaken by the Wales Audit Office and Healthcare Inspectorate Wales (HIW) at the end of 2012 highlighted a number of challenges around governance, accountability and service delivery. These were reported to the Health Board in the Wales Audit Office's 2012 Structured Assessment[4] findings and Annual Audit Report[5] and in HIW's report of a review of patient care at Ysbyty Glan Clwyd (YGC)[6]. They were further reflected in a quality and safety review that HIW began in late 2012. The preliminary findings of that review were reported to the Health Board in March 2013 and have been incorporated into this report.

4 Taken together, these reports served to underline growing concerns about the effectiveness of the Board's collective leadership and its ability to address the challenges it faces. The Board's capacity to address and manage its challenging agenda is made more difficult by the continuing state of flux caused by sickness absence and recent turnover at the Executive Director level.

2 Stock take of financial position and outlook for 2012-13, Chris Hurst, April 2012

3 External review by Allegra Ltd, commissioned by Welsh Government, December 2012

4 An annual assessment of governance, financial management and use of resources arrangements, reported formally in the Annual Audit Report.

5 http://www.wao.gov.uk/assets/englishdocuments/Betsi_Cadwaladr_LHB_2011-12_Annual__Audit_Report_2012_English.pdf

6 http://www.hiw.org.uk/Documents/477/Betsi%20Cadwaladr%20-%20Report%20-%20Glan%20Clwyd%20Report%20-%20English%20-%20PDF.pdf

About this review

5 Collectively, the issues set out above led both HIW and the Wales Audit Office to the conclusion that it was appropriate, necessary and timely for us to undertake an urgent piece of joint review work aimed at supporting the Board through this challenging period.

6 The overarching objective of this review was to provide a single, consolidated overview of the corporate, clinical and financial governance challenges facing the Health Board and the potential impact of these on patients and citizens.

7 The review work was designed to:

- a provide the Health Board with key information to support it through its current changes;
- b provide clarity on the issues to be addressed, against which the Health Board can demonstrate it is taking the necessary actions and making the necessary improvements;
- c provide a common basis on which the Health Board and the Welsh Government can work together to ensure that the interests of citizens and patients are protected; and
- d fulfil our responsibilities as external review bodies to collectively examine emerging concerns and to report them clearly, openly and in a way which supports improvement and informs any 'turnaround' activities which are necessary.

8 This review drew upon work recently completed by HIW and the Wales Audit Office on areas relating to financial, corporate and clinical governance. Additional fieldwork, undertaken during May 2013, was used to update our findings and to obtain perspectives from individual Board members and other senior staff on the challenges that the Health Board faces. The review team also undertook observation at both the public and the in-committee Board meetings held on 23 May 2013, and examined a range of supporting documentary evidence. Further information on the review approach is provided in Appendix 1.

9 During the review, the Health Board became aware of a *C Difficile* outbreak at YGC, and associated problems with infection control management and reporting. The results of the urgent investigations held following the *C Difficile* outbreak have been referenced in this report, where appropriate, to help illustrate some of the wider challenges that the Health Board faces.

10 This report focuses on the key challenges that the Health Board needs to overcome if it is to strengthen its governance arrangements. Our findings have been grouped together under the following themes:

- a Effectiveness of the Board and its sub-committees
- b Management and clinical leadership structures
- c Quality and safety arrangements
- d Financial management and sustainability
- e Strategic vision and service reconfiguration
- f The way forward: recommendations for driving improvement

11 The preliminary findings of the review were provided to the Health Board immediately following the fieldwork in the form of a letter to its Chief Executive on 23 May 2013, which was copied to the Chairman of the Health Board and also shared with the Chief Executive of NHS Wales within the Welsh Government.

Acknowledgements

12 We are grateful to the Health Board for supporting the review. Particular thanks are due to Grace Lewis-Parry and her team for their support in helping to arrange the fieldwork week, and to Board members and other senior members of staff who made themselves available for interview at short notice.

Summary of the main conclusions

13 In the last 12 months, work undertaken by HIW and the Wales Audit Office, together with that of other independent reviewers, has raised a number of significant concerns about the Health Board's governance arrangements and its management and clinical leadership structures. The Health Board has instigated actions that begin to address some of the concerns raised but fundamental challenges still remain.

14 Most significantly we have concerns that the Health Board's governance arrangements and organisational structure are compromising its ability to adequately identify problems that may arise with the quality and safety of patient care.

15 The current governance arrangements and procedures do not adequately address 'the gap between the ward and the Board', and may even be contributing to it, as has been demonstrated by the recent investigations into the *C Difficile* outbreak at YGC. These investigations have highlighted inconsistencies across the Health Board in the procedures for recording, identifying and reporting deaths where *C Difficile* is an underlying or contributory factor. Moreover, in recent years, systems for reporting *C Difficile* outbreaks and related deaths have been neither consistent nor robust. As a result, these have not routinely been brought to the attention of the Board or the Welsh Government which has created unduly positive assurances at both levels. This is of very significant concern and the further independent external review which is underway must thoroughly investigate the reasons behind this.

16 The Health Board's organisational structure, based around Clinical Programme Groups (CPGs), is designed to support the aim of being a clinically led organisation. However, problems have been evident for some time as a result of the imbalance in size of different CPGs and the shortcomings in connectivity between CPGs, geographical hospital sites and the Executive team. These have been exacerbated by weaknesses in the arrangements to hold CPGs to account on key aspects of financial and clinical governance.

17 It is noted that action has recently been taken to address these concerns via revision to the CPG and Executive structures, and through the appointment of Hospital Site Managers at each of the Health Board's main acute hospital sites. These are positive developments, although some of the details of how the new arrangements will operate still need to be worked through.

18 The new arrangements must improve the processes by which concerns are escalated within the Health Board, as they are currently not well understood by staff. This will help ensure that a more bottom up approach to quality and safety is adopted, with timely escalation via CPGs and Executive Leads to the Quality and Safety Committee, and if appropriate, to the Board. For these arrangements to work properly, the Health Board will need to address the concerns held by many Committee members about the crowded meeting agendas for the Quality and Safety Committee which are limiting the Committee's ability to thoroughly scrutinise and challenge the information presented to it. The Health Board will also need to strengthen the mechanisms it currently adopts for holding the CPGs to account.

19 The Board has a pivotal role to play in driving the work that is needed to strengthen the Health Board's governance arrangements. However, the effectiveness of the Board has been significantly compromised by a breakdown in working relationships between some senior leaders in the organisation. There has been a lack of cohesion in the way the Executive Directors work together, and we have wider concerns about the stability and capacity of the Executive team as a result of staff turnover and sickness absence. The instability created by the long term interim arrangements for the Medical Director post is a particular concern, at a time when the Health Board needs strong clinical leadership.

20 Crucially, the way in which the Board operates needs to be improved in order to support more effective scrutiny and decision-making. In particular, the issuing of papers on strategically important issues late, or on the day of the Board meeting should not be allowed to continue. More generally, there is significant benefit to be gained from a programme of Board development work that helps members work together effectively and cohesively as a Board.

21 A pressing challenge for the Board will be to oversee the development of future models of service delivery which are clinically and financially sustainable. The consultation document *Healthcare in North Wales is Changing*[7] contained some proposals for changes to acute clinical services but work has only recently begun on the development of a wider acute clinical services strategy, with proposals not due to be put to the Board until October 2013.

22 In the absence of clear proposals for the future shape of acute services, the Health Board is having to deal with immediate concerns about the viability of medical rotas across its three sites, and the very real concern that the Health Board's current service model is neither clinically nor financially sustainable. The Health Board met its statutory duty of achieving financial balance in 2012-13, taking into account additional funding received from the Welsh Government, and through the adoption of cost savings which are in part unsustainable. These included a reduction in planned elective services in the final quarter of the year, with a consequent impact on patient waiting times.

7 Public consultation on changes in north Wales health services: http://www.wales.nhs.uk/sites3/Documents/836/HINWIC%20Consultation%20Document%20vv.pdf

23 The Health Board needs additional turnaround capacity to help it address the challenges set out above. We understand that discussions with the Welsh Government are progressing in that respect. The scale of the challenge is significant but, importantly, it is recognised by the Board members. Strong leadership, particularly from the Chair, Independent Members and the Health Board's clinical leaders will be needed, assisted by an Executive that is working in support of each other and to a common set of aims. The pace at which problems are addressed will need to be quickened and difficult issues will need to be tackled - most notably the loyalty that exists to previous organisational structures and a performance management culture that has hitherto been insufficiently robust. The existing acceptance of variations in practice across the Health Board must change.

24 The issues set out above are explored in more detail in the following sections of this report, together with our recommendations for the Health Board.

Detailed findings

Effectiveness of the Board and its sub-committees

25 Work by HIW and Wales Audit Office over the past 12 months has highlighted concerns over the effectiveness of the Board. The Health Board has provided us with evidence of how it has sought to address the concerns we have previously raised. This shows that progress has been made in relation to the way in which the Board operates, with the in-committee sessions of the Board now being minuted, a greater focus on the patient experience, and clarification of the scope and purpose of Board development sessions.

26 However, we have significant concerns that over the last 12 months, a number of factors have combined to compromise the effectiveness of the Board. Our concerns centre around the issues set out below.

a **A breakdown in working relationships between senior leaders in the Health Board.** The current working relationship between the Chair of the Health Board and its Chief Executive presents real challenges for the Board. A positive and effective working relationship between the two most senior leaders in the organisation is a vital part of the organisation's governance arrangements and sets the tone for the Board. When the relationship breaks down, as it has in the Health Board, the leadership of the organisation is fundamentally compromised, and the Board finds itself in an extremely difficult position.

b **Lack of cohesion and consensus amongst the Executive.** The information presented to us clearly demonstrates that Executive Directors of the Health Board do not work cohesively as a team. Roles within the Executive team seem to be compartmentalised and relationships between some members of the team are not positive. The Chairman and the Independent Members (IMs) were concerned about a lack of consensus amongst executives on important issues that are brought to the Board.

c **Concerns over the way information is presented to the Board.** We identified several instances when papers dealing with key issues are either circulated late, or tabled on the day, and (as indicated above) often without the assurance that they

represent the consolidated view of the whole Executive. This compromises effective scrutiny and debate at the Board, and understandably provokes IMs to request more information in order to obtain the assurance they are seeking, further delaying key decisions. An example of this is the tabling of a paper at the April 2013 in committee Board meeting setting out the need for the recruitment of 72 additional clinicians by August 2013 to meet the requirements identified by the Deanery[8] in relation to junior doctor training. Albeit the Chair advised the Board that a decision on this matter should not be reached as there had been insufficient time to consider the issues. Similarly, although considered by the Finance and Performance Committee, the Annual Income and Expenditure Budget for 2012-13 was only circulated to the full Board the evening before the 26 April 2012 Board meeting, with copies tabled at the meeting.

d **A need for a greater mutual appreciation of the respective roles of executive and independent board members.** Frustration was evident on the part of both IMs and Executive Officers in relation to the way the Board operated. Some IMs indicated that they felt they were being 'managed' and were not being given the whole picture, and they were concerned that the Board was seen by some of the Executive as a forum to just 'rubber stamp' decisions. The additional challenge and request for information that this provokes from IMs was causing frustration to some Executive Officers who, conversely, felt that IMs were asking for too much information and that this was slowing down decision-making and preventing the agile management of the organisation.

e **A need for better planning of the agenda for Board meetings.** The scale and complexity of the Health Board's business inevitably means that Board agendas will be full. Whilst the meeting of Committee Chairs in advance of Board meetings to help prioritise agenda items is a positive move, numerous concerns were relayed to us about the size of the Board agendas and availability of time to adequately cover all the business. It is important that the information provided to the Board at a strategic level also contains a level of detail which identifies key concerns.

27 These concerns indicate that urgent action is needed to ensure the Board operates in an effective way. Specifically, there is a need to:

a build trust between the IMs and the Executive, and ensure that there is mutual understanding of the responsibilities and behaviours necessary for the efficient and transparent operation of the Board;

b establish a more disciplined approach to agenda management and the timely submission of papers to the Board to ensure that agendas are manageable and prioritised and that Board members have sufficient time and information to fully consider issues; and

c ensure that issues that are brought to the Board are the product of inclusive discussions and validations by the Executive team.

In respect of tackling some of these challenges, we note the developments outlined in the paper *Strengthening Governance: Update and Next Steps* that was presented to the Board on 23 May 2013.

28 The Chair of the Health Board will need to play a key role in establishing the way in which the Board needs to operate, and in doing so will need to be supported by the Board Secretary. Board development programmes will need to form a crucial part of the process, and particular attention needs to be given to further training for IMs, given that some of the current cadre took up post after the initial induction training had taken place.

8 Wales Deanery (School of postgraduate medical and dental education): http://www.walesdeanery.org/

29 The Health Board should also re-examine the way in which the Board Secretary function is delivered. During the review, some concerns were raised that the scope of the Director of Governance and Communication role is too broad. Given the governance challenges that the Health Board faces, it will be important to ensure that there is sufficient Board Secretary capacity to facilitate the development of the required governance arrangements.

30 The effectiveness of the Board's sub-committees was considered as part of Wales Audit Office's 2012 Structured Assessment work. That found evidence of increasing maturity and challenge within the Board's sub-committees. However, scope for better co-ordination of work programmes across the committees was noted, particularly to ensure that overlap between the work of the Finance and Performance, and Quality and Safety Committees was avoided.

31 Work by both HIW and Wales Audit Office has highlighted specific challenges in relation to the effective operation of the Quality and Safety Committee. These are considered further in the section of this report on Quality and Safety arrangements.

32 The Board must strengthen the way it works to ensure it sets the right culture for the organisation. It has to tackle deep-seated issues such as:

- a insufficient pace of change;
- b a loyalty to historical structures and an associated tolerance of inconsistent practices across the Health Board; and
- c insufficiently robust accountability and line management arrangements for senior staff.

In conclusion:

Urgent work is required to improve the effectiveness of the Board and the processes supporting its work. Strong leadership from the Chair will be needed, assisted by the Board Secretary and by an Executive team working in support of one another to deliver a clear and shared set of aims.

Board development work must be undertaken as a matter of priority to ensure members work effectively as a Board, and to openly discuss and resolve existing frustrations on the part of Independent Members and the Executive.

A more focussed approach to the development of Board agendas is required along with the timely circulation of complete information to support proper debate and scrutiny.

Management and clinical leadership structures

33 To help give effect to the Health Board's stated aim of being a clinically-led organisation, its management structure is based around Clinical Programme Groups (CPGs), each led by a clinical Chief of Staff. The Health Board has an executive management structure with accountabilities allocated across a team of Executive Directors. Collectively the Executive Directors and the Chiefs of Staff form a Board of Directors.

Clinical Programme Group issues

34 Work previously undertaken by HIW and the Wales Audit Office identified problems in respect of the original CPG structure, specifically:

- a significant differences in the size and complexity of individual CPGs, and hence the scale of the challenges they faced;
- b a need to strengthen accountability and performance management arrangements relating to CPGs;

c insufficient management capacity to support Chiefs of Staff in some CPGs; it was noted that in some CPGs, management and support posts were not fully recruited to despite the structure having been in place for the best part of three years; and

d a disconnect between the clinical functions led through the CPGs and the management of service delivery at individual hospital sites, which was causing particular concerns in relation to the reporting or escalating of site-specific issues or concerns.

35 Action has been taken to address these concerns in the form of proposed revisions to the CPG and Executive structuresand through the creation of Hospital Site Manager posts for each of the Health Board's main acute hospital sites.

36 The Hospital Site Manager posts were introduced as an urgent measure in May 2013 as three month secondments and the Health Board staff we spoke to during the review typically saw this development as an important and necessary move. However, some concerns were expressed to us about the process by which the site managers were appointed. No job descriptions for the roles have been devised, resulting in uncertainty over the level of authority the post holders possess, and how they are expected to interact with other parts of the organisational structure.

37 The Health Board's review of its CPG structures and governance arrangements, which commenced in December 2012, has resulted in proposals for a reduction in the number of CPGs from 11 to six. Initially, Chiefs of Staff set up their own review. Recognising the need for wider input and independent scrutiny, a panel chaired by the Vice Chairman was subsequently convened. This resulted in a proposal to the Chief Executive to reduce the number of CPGs to six, together with recommendations to strengthen governance arrangements, although no clear process was identified for how this was to be achieved. The Chief Executive produced a proposal for consultation, which included the proposed changes to CPGs alongside changes to the executive structure. Following consultation within the organisation, the Chief Executive took a proposal for 12 CPGs to the Board. This proposal was not considered by the Board on the basis that it did not adequately address the concerns that initially prompted the review, and that the proposal was neither financially nor operationally viable. In May 2013 a preferred model based on six CPGs was taken to the Board. It is understood that this is the model that the Health Board will now work towards, although the specific process and timescales for moving to the revised model remain unclear at the time of writing this report.

38 The Health Board established a Delivery Programme Board in 2012 to strengthen performance management and accountability arrangements for CPGs. However, during our most recent work, it became evident that concerns remain within the organisation about the robustness of performance management arrangements relating to CPGs, the support structure and capacity within individual CPGs, and the clarity of reporting lines of the Chiefs of Staff.

39 The Health Board's Month 1 Finance report presented to the Board on 23 May 2013 recognised that there were on-going challenges within certain CPGs. That report also noted that 'focused action was needed in a number of areas to drive rapid change in operational performance to deliver safe and financially sustainable services within the financial envelope. As part of the measures agreed by the Board, this will also include additional operational turnaround support for three of the most challenged areas [CPGs] of the Health Board'. In addition, we note that the Health Board has introduced a Budget Managers Handbook and has also commenced work on the development of a written accountability agreement for CPGs.

40 Whilst the CPG-based structure provides a model for delivering the clinical leadership that the Health Board desires, it is clear to us that more work is needed to make it fit for purpose. In particular, the connectivity between the CPGs, the executive and geographical site management must be made more effective. A key part of this challenge will be to clarify the medical line management structures so that accountabilities, delegated authorities and lines of reporting between Chiefs of Staff and Assistant Medical Directors with hospital site responsibilities are understood and work when problems arise. The appointment of a new Director of Nursing also provides an opportunity for similar consideration to be given to the accountabilities and influence of that post in respect of nursing staff. Above all, the model must put service quality and patient safety at the heart of the Board's business and ensure that any concerns are properly identified, considered and dealt with, and do not fall between gaps in the structure.

Executive management team issues

41 Alongside the review of its CPG structure, the Health Board has recently identified the need to make a number of revisions to its Executive management structure with the introduction of Chief Operating Officer and Director of Strategic Development posts. These changes are positive, and provide an opportunity to create specific capacity in areas that would be beneficial to the Health Board. However, we note that these new roles incorporate previous Executive Director responsibilities - the Chief Operating Officer role incorporates the role of Director of Primary, Community and Mental Health Services, whilst the Director of Strategic Development incorporates the roles of the Director of Planning and Director of Improvement and Business Support. In developing the remit of the new roles, the Health Board will therefore need to ensure that the respective portfolios of each role are manageable and realistic. We are particularly concerned that it will not be sustainable to combine the Chief Operating Officer role with that of the Director of Primary, Community and Mental Health Services unless appropriate operational support arrangements are put in place.

42 Concerns about the capacity and stability of the Executive team emerged as a common theme in the fieldwork for this review. Staff turnover and long term sickness absences, which have resulted in the Board having to make a number of interim arrangements at Executive level, are a significant factor in this. In particular, the Medical Director role was seen as a key post in providing the clinical leadership necessary to drive service modernisation, and the uncertainty created by the interim arrangements for this post was seen as a real impediment to progress.

43 The issues described above, when coupled with the concerns raised in the previous section about the lack of cohesive team working amongst the Executive team, point to real challenges for the Health Board's top team in taking the organisation forward. In our view additional capacity, ideally from sources external to the Health Board, is needed in the short term to provide the leadership, impetus and fresh perspectives that are necessary. We understand that the Health Board has already made proposals to the Welsh Government in respect of the need for additional capacity, which have been agreed.

In conclusion:

The Health Board has designed a management structure that is intended to help achieve the aim of being a clinically led organisation. However, both the structure, and its implementation have created a number of fundamental challenges for the Health Board. These have been highlighted by a number of external reviews, yet progress to address these challenges has been slow.

In taking forward any revisions to CPG and Executive structures, connectivity and clear lines of accountability between CPGs, the Executive and geographical site management must be ensured.

In addressing capacity and stability problems within the Executive team, care must be taken to ensure that the allocation of new responsibilities to existing Executives does not exacerbate these problems. In addition, there is an urgent need to strengthen clinical leadership, which has been constrained by the extended interim arrangements for the Medical Director's post.

Quality and safety arrangements

44 Just prior to the commencement of our May 2013 fieldwork, the Health Board had become aware of a *C Difficile* outbreak at YGC. The facts around the outbreak and how it was managed and reported by the Health Board have been the subject of an external review by Public Health Wales (PHW)[9].

45 It is noted from the work done by PHW that the actions in response to the outbreak were robust and proportionate. However, the PHW report noted that the management of the outbreak itself did not conform to best practice. Specifically, it found that the routine governance and reporting arrangements within the Health Board had not paid sufficient attention to infection control, and that management action should have taken place earlier in response to the picture which was emerging on *C Difficile* prevalence in 2012. It is very concerning that the PHW report concludes that there has been 'a failure to provide a safe environment for patients in respect of infection prevention and control at Ysbyty Glan Clwyd'.

46 The PHW report also highlighted a number of pre-existing practices which give rise to serious concerns about the wider infection control arrangements in the Health Board and which need urgent attention.

47 The arrangements for the recording and reporting of deaths where *C Difficile* was an underlying or contributory factor have been the subject of a separate rapid review by the Health Board's Director of Public Health (DPH). That rapid review identified that there were systems and processes in place across the Health Board to record, collate, report, act upon and learn from information arising from such deaths. Similarly there are processes for reporting serious incidents. However, a number of inconsistencies were found across the Health Board's sites in respect of identifying, recording and reporting of information on deaths where *C Difficile* is implicated.

48 From the initial work undertaken by the Health Board, there appears to have been significant under-reporting of serious incidents involving *C Difficile*, both internally within the Health Board, and also to the Welsh Government in accordance with published guidance[10]. This contributed to both the Board and the Welsh Government receiving unduly positive assurance as a result of being unsighted on the totality of information regarding *C Difficile*.

49 Collectively the issues described above demonstrate that the Health Board's governance arrangements surrounding infection control have been inadequate.

50 The data and information from the rapid review will need to be further verified through external review and further epidemiological analysis of *C Difficile* infection across the Health Board to inform an improvement plan. The Health Board has now commissioned an external expert to

9 *Clostridium difficile infection at Ysbyty Glan Clwyd: Final report to the Chief Medical Officer for Wales,* Director of Public Health Services, Public Health Wales, May 2013

10 Putting Things Right – Dealing with concerns: guidance on the reporting and handling of serious incidents and other patient related concerns / no surprises: http://www.nhswalesgovernance.com/Uploads/Resources/AFdiXsBdX.pdf

review its infection control arrangements. It will be important that the Health Board ensures that the review is appropriately wide ranging and that the Board then deals with the findings in an urgent and transparent manner. We have been assured by the Accountable Officer of the Health Board that the findings of the review will be placed in the public domain.

51 In light of these failures the Health Board also needs to seek urgent assurance that its wider arrangements for the monitoring and reporting of quality and safety issues are robust. This will be the subject of further, separate discussions with HIW.

52 That review should include a closer examination of the way in which the Quality and Safety Committee works as we have a number of concerns about the way in which the Committee operates. In particular, the size of Committee agendas creates risks that important issues will not receive sufficient attention or indeed be missed altogether. We note that a Quality and Safety Lead Officers Group (QSLOG) has been created to support and help manage the Quality and Safety Committee's business. However, several interviewees expressed concern to us that the QSLOG was not operating effectively and that its remit, role and membership could usefully be re-examined.

53 The PHW report on the *C Difficile* outbreak in YGC and our work have separately identified concerns over the lack of clarity over the mechanisms in the Health Board for escalating concerns amongst staff. The PHW report makes reference to clinical staff in infection control teams being unsure of how to escalate concerns to the Executive lead. There are systems in place for reporting incidents and escalating concerns within the Health Board, supported by a number of policies. However, our fieldwork has indicated that when concerns about key issues such as staffing capacity become apparent at the hospital site level, there is not a clear understanding of the processes for these to be escalated. Typically they will be raised in email form, for example from the Assistant Medical Directors to the Executive team. This may or may not result in action to resolve the concern but the informality of the mechanism introduces a significant risk that important issues are not formally captured and followed through. We note that the Quality and Safety Committee was not fully sighted on the *C Difficile* issue.

54 Based on the information available to us, it is not possible to obtain assurance that the Board has adequate mechanisms in place for reviewing quality and safety issues associated with staffing numbers and capacity. The PHW report highlighted the reduction in the infection prevention and control nurse staff complement at YGC, with funding for posts being withdrawn when they became vacant, and a reduction to match the lowest staffing levels elsewhere in the Health Board. The reported result was an infection prevention service that had a limited capacity to work proactively.

55 The Board places a strong degree of reliance on the quality and safety mechanisms within CPGs each of which are scrutinised by the Quality and Safety Committee. However, each CPG only reports to the Committee annually and our observation of that process found the quality of the information presented by CPGs to be variable. Participants also told us that the process lacked rigour.

56 Moreover, when we observed the Primary Care and Specialist Medicine CPG's own quality and safety meeting in January 2013, we were concerned that this appeared to be operating as a forum for simply noting issues, rather than actively addressing them. The large size of some CPGs was highlighted as a factor that made it more difficult to adequately consider the quality and safety agenda. Previous work by HIW[11] has also highlighted concerns over CPGs ability to manage and respond to complaints and concerns in a timely manner.

11 http://www.hiw.org.uk/Documents/477/Betsi%20Cadwaladr%20-%20Report%20-%20Glan%20Clwyd%20Report%20-%20English%20-%20PDF.pdf

In conclusion:

The Health Board's organisational structure is contributing to significant risks in the way that the quality and safety agenda is being managed and scrutinised. The Health Board is not adequately addressing 'the gap between the ward and the Board' as shown by its handling of *C Difficile* infection control matters.

The commitment of staff working in the Health Board to providing safe and effective services is not doubted. However, there are fundamental issues to address around the mechanisms for holding CPGs to account for quality and safety issues, the information which gets considered at the Quality and Safety Committee, and the processes for escalating concerns to the Board.

It will be particularly important to ensure that there are lines of communication and accountability between CPGs and hospital management teams so that issues and concerns which potentially jeopardise the quality and safety of patient care are identified and addressed.

Financial management and sustainability

57 The Health Board has a track record of delivering its statutory financial targets, and since it was established in 2009 it has not required additional year-end funding or brokerage to meet its duty to break even, unlike a number of other NHS Wales health bodies. However, in common with other NHS Wales bodies, the Health Board faced a significant financial challenge in 2012-13. Having forecast a multi-million pound deficit throughout the year to February 2013, the Health Board actually under-spent by £5,000 against its 2012-13 resource limit of £1.257 billion, meeting its statutory duty to break even.

58 The Health Board's 2012-13 draft budget identified an initial financial shortfall of £90.3 million (7.2 per cent of gross turnover) (having already taken account of £17 million additional recurrent funding from the Welsh Government). This projected shortfall was subsequently revised down to £64.6 million (5.1 per cent of gross turnover), but the in-year financial challenge was further compounded by:

a delays in developing the service and delivery plan; and

b a failure to identify sufficient and timely savings plans.

59 These problems, together with delays in finalising the Health Board's Operational Service Plan for 2012 13 led to the preparation of an interim 2012-13 budget in March 2012

60 The subsequent 2012-13 draft financial plan was approved by the Board on 26 April 2012, after the start of the financial year. There then followed further significant delays (until September in some cases) in obtaining budget-holder agreements as to their actual 2012-13 budgets. Whilst all Executive Team members agreed their budgets, several CPG budget-holders only agreed to their budgets subject to various caveats. This is extremely rare, and undermined the effective operation of the Health Board's budget allocation, financial monitoring and internal accountability processes.

61 In addition we have established that the Health Board's Standing Financial Instructions (SFIs) were breached on a number of occasions during the year when procuring goods and services. Failures to adhere to SFIs serve to undermine the effectiveness of the Health Board's financial governance arrangements, although we acknowledge that these breaches were detected by the Health Board's procurement controls.

62 The Health Board managed to contain its 2012-13 expenditure within its annual resource limit after receiving its £15 million share of an additional £83 million in-year resource funding provided to NHS Wales by the Welsh Government to 'allow the NHS to manage current pressures and maintain quality of care'. The Health Board also monitored and reassessed its financial position and forecasts on a timely basis throughout the year, and it achieved savings of £49.1 million in 2012-13 (against a target of £74.5 million). The delivery of these savings represents a significant achievement, and was the highest level of savings achieved by any Welsh health board in 2012-13. However, only £35.0 million of the achieved savings were recurrent and some £25.4 million of targeted savings were not actually delivered. The Health Board reported that it had an agreed financial strategy to mitigate the financial risks, including oversight by the Finance and Performance Committee.

63 In addition, the Health Board recognised the use of 'strategic reserves', the proactive management of contracts, one-off favourable variances and savings achieved from the implementation of additional expenditure controls in the final weeks of the financial year. These emergency measures included 'a reduction in the additional work to meet access targets and in particular a cessation of waiting list initiatives, except as specifically approved by the Finance and Performance Committee to address safety issues'.[12] This had a detrimental impact on patient waiting times and is clearly not a sustainable approach to meet the financial targets, as any elective activity deferred from 2012-13 will need to be carried forward into 2013-14, putting further pressure on resources in the current year.

64 In response to the financial challenge, the Health Board used benchmarking and other sources of information as part of its budget setting and risk assessment processes. The Executive Director of Finance introduced the use of a Financial Conformance report to assist the Board and Executuve Team in holding CPGs to account. The Health Board implemented a number of other initiatives during the year including establishing the Delivery Programme Board, mentioned earlier, and the Recovery Board to performance manage the savings targets in addition to identifying executive savings schemes. The Board viewed the executive savings schemes as important because they encompassed inter-CPG areas and were therefore comprehensive. However, Internal Audit[13] highlighted that the 'executive savings schemes posed a risk to the overall delivery of savings targets as in some cases they duplicated Clinical Programme Groups (CPGs)/Corporate Support Function (CSF) [schemes]'.

65 Because of concerns regarding the Health Board's accountability arrangements and the ability of its management and governance arrangements to address this effectively, two separate external reviews were commissioned during in 2012[14, 15]. Both reviews highlighted that the Health Board's financial challenges were being significantly exacerbated by insufficient savings plans being identified at the start of the year and subsequent under-delivery against savings targets. Amongst other things, the reviews also identified challenges associated with the fitness of purpose of the Health Board's organisational structure, and the need to develop more robust approaches to accountability and line management of senior staff.

12 Summary Finance Report (Subject to External Audit) Month 12, 2013, presented to the Finance and Performance Committee on 22 April 2013.

13 Internal Audit Report *Financial Management at CPG/CSF*

14 Stock take of financial position and outlook for 2012-13, Chris Hurst, April 2012

15 External review by Allegra Ltd, commissioned by Welsh Government, December 2012

66 The work undertaken by Allegra, which was reported to the Welsh Government in December 2012, included specific recommendations to appoint an external interim Turnaround Director and the establishment of a full Programme Management Office to support the Executive to maximise savings and to minimise any adverse impact on the Health Board's clinical performance. It also recommended that temporary external clinical support should be sought to drive service reconfiguration and redesign. These recommendations were not immediately acted upon, although an internal part-time Turnaround Director role had already been created for a short period in 2012-13. The Health Board's *Annual Financial Plan (Budget) and Budget Strategy 2013-14* highlighted 'the importance of the using external turnaround and delivery support' to enhance delivery of savings and service transformation. There was also a recommendation to appoint a Chief Operating Officer, and this has subsequently been taken forward as part of the Health Board's recent executive re-structuring.

67 It is not clear on the extent to which the findings from these reviews have been shared amongst Board members, although we are led to believe that they have not been widely circulated or discussed.

68 Looking ahead, the Health Board's financial outlook into 2013-14 and beyond highlights unprecedented challenges in order to deliver a balanced budget in the future. The Health Board's Annual Financial Plan for 2013-14, reported to the Board in March 2013, identified a savings requirement of £78.05 million (6.5 per cent of the 2013-14 budget[16]) in order to achieve its 2013-14 annual resource limit, against which potential savings of only £38.9 million had been identified. Whilst the plan to achieve financial balance in 2013-14 has continued to develop, dependency on non-recurrent savings is not sustainable and the Health Board needs urgently to develop further Cost Improvement Plans to bridge the remaining savings gap. At 31 May 2013, the Health Board reported an over-spend of £5.1 million[17] for just the first two months of the financial year, together with recommended action to address this. At the time of drafting, the Health Board reported an anticipated year-end deficit of £29 million (2.3 per cent of gross turnover).

69 The Health Board's Medium-Term Financial Plan to 2015-16 sets out a projected increasing financial gap from 2013-14, growing to £176.4 million (which equates to over 15 per cent of annual operational expenditure) by 2015-16. These figures quite starkly illustrate that the Health Board's current service model is not financially sustainable within the flat cash funding environment that exists within NHS Wales, and that urgent action is needed to move the organisation to a more financially sustainable and stable position. Further and more radical service change is required to ensure services are clinically sustainable. A key risk is the medical workforce and the ability to attract training posts for some specialties, particularly in the more rural parts of North Wales.

70 As an immediate challenge, further work is required by the Health Board to fully integrate and deliver service, workforce and financial plans. Whilst the Operational Plan refers to an integrated approach, in reality individual plans are not always fully integrated or affordable. Furthermore, the financial implications of service changes and priorities need to be considered and built into the Operational Plan at an early stage, with a clear assessment that the proposed plans are affordable.

16 Annual Financial Plan (Budget) Budget Strategy 2013-14, approved by the Board on 27 March 2013.

17 BCULHB Finance Report Month 2, May 2013.

71 The Health Board has recognised the need for change, and is developing transformational change actions but the timescales are ambitious, given the current financial pressures facing the Health Board. If the Health Board is to be successful, and to avoid a repeat of the significant financial pressures faced in 2012-13, it will need to provide a clear steer on service priorities, recognising that there will need to be disinvestment in some areas and improved efficiency in others.

72 The Health Board will also need to prepare and approve sustainable service and financial plans before the start of the 2014-15 financial year. The plans will also need to clearly demonstrate how financial pressures will be managed and addressed in advance of the financial year.

In conclusion:

The Health Board has a track record of delivering its statutory financial targets, and its actions, coupled with additional Welsh Government in-year resource funding, enabled it to achieve its duty to break even in 2012-13. However, its dependency on non-recurrent savings is unsustainable. The process for identifying savings schemes needs to be more transparent and robust and future savings plans will need to focus increasingly on the more difficult areas for recurring savings: reducing costs by reforming and reshaping services.

The medium-term financial position is very difficult indeed and the Health Board's current service model is not clinically or financially sustainable, meaning that urgent action is needed to move the organisation to a more financially sustainable and stable position.

Strategic vision and service reconfiguration

73 The Health Board undertook a three-month public consultation on its paper *Healthcare in North Wales is Changing*, which closed at the end of October 2012. That consultation focused predominantly on the changes to locality and community services, as the Health Board indicated that significant changes were not yet proposed to acute hospital services. However, it acknowledged that this would need to be kept under review given the on-going challenges with medical recruitment.

74 Following the consultation, the Health Board has developed an implementation programme to take forward a number of the proposed changes, and progress has already been made in a number of areas. There are, however, a small number of areas where the Community Health Council (CHC) is unwilling to support the Health Board's proposals. The CHC forwarded its concerns to the Minister for Health and Social Services, who has asked the Health Board to work with the CHC to find a way forward. Both parties have given their commitment to this action.

75 The Health Board's plans for neonatal intensive care services have been the subject of much public discussion, with significant dissent being expressed from a number of quarters to the Health Board's plans to have these services provided across the border by Arrowe Park Hospital on the Wirral peninsula. The First Minister announced in April 2013 that the Health Board should proceed with its plans and that the Royal College of Paediatrics and Child Health will undertake an independent four month review to see if these specialised services are able to be provided in North Wales in the future.

76 Given the challenges that are known to exist with medical recruitment, and with the affordability of current service models in North Wales, the need to develop a clear strategic appraisal of options for future shape of acute services is pressing. However, work to produce an Acute Clinical Services Strategy has only recently begun, and recommendations to the Board for the future shape of acute clinical services are not expected before October 2013. The extent to which this work will involve formal consultation is not yet clear.

77 A number of interviewees expressed frustration and concern over the slow progress in developing a clear plan for the Health Board's acute services. Factors such as a lack of executive consensus, patchy clinical engagement, and concerns over having to make decisions which may be politically difficult were all cited as reasons why more progress has not yet been made.

78 The need to develop a more strategic and proactive approach to the challenges that exist with the recruitment of medical staff also came through as a key issue during the review. The Health Board's relationship with the Deanery in Wales is vital in this regard. More work is needed in this area given that the Deanery has raised concerns in relation to the viability of some medical rotas to support junior doctor training across the Health Board. Based on these concerns, the Interim Medical Director and Chief Executive took a proposal to the Board in April 2013 to recruit an additional 72 clinicians in time for the August 2013 junior doctor rotation. The feasibility of achieving this is highly questionable and in our view is indicative of a reactive approach to a problem that requires more fundamental action. At the time of our review further discussions were being held between the Health Board and the Deanery on this issue.

In conclusion

The Health Board underwent a challenging public consultation exercise during the latter part of 2012, and has started to implement changes to locality and community-based services as a result. However, progress in developing strategic plans for acute clinical services has been slow, with proposals not expected to be presented to the Board until October 2013, for implementation in 2014.

The delays in taking forward these plans are worrying, given the challenges that exist with medical recruitment and the financial sustainability of current services. Taking forward service redesign in a piecemeal fashion will make it more difficult to design and plan the whole system changes that are necessary to create clinically and financially sustainable services.

The way forward: recommendations for driving improvement

Issues for the Health Board

79 The issues raised throughout this report reaffirm the importance of the Board's role across three key areas; setting the Health Board's strategic vision and direction; establishing and upholding the organisation's overall governance framework and supporting culture; and scrutinising the Executive's performance in delivering safe, high quality services day to day.

80 The Board also has a key role to play in setting the right culture for the organisation. Challenges associated with pace and urgency of change, and ensuring more robust approaches to accountability and line management of senior staff must be addressed. Crucially there must be a continued focus on getting staff to move beyond the loyalties they have to predecessor organisations, so that there is a consistent approach to delivering care across the Health Board and an intolerance to unacceptable variations in practices and procedures.

81 As the Board looks to address these issues, the Chair and Chief Executive must together develop a culture that is open, transparent and willing to be challenged, at all levels of the organisation. The role of the Board Secretary in supporting the Chair and Chief Executive to achieve this is critical in ensuring that the Board is properly equipped to fulfil its responsibilities.

82 The relationship between the Chair and the Board Secretary is a fundamental one. This was recognised when the role of the Board Secretary was first introduced in 2009, and established within the Health Board's own Standing Orders. The relationship should be protected by a clear and direct line of accountability from the Board Secretary to the Chair.

83 The Chair must set the Board's agenda in conjunction with the Chief Executive, and manage its business appropriately, in accordance with its own Standing Orders. In doing so, account must be taken of the priorities facing the Health Board and the planned annual cycle of Board business. The Chair should encourage individual board members to influence the Board's agenda and submit specific requests for matters to be placed on the Agenda sufficiently in advance of Board meetings.

84 To facilitate proper scrutiny by the Board, members must be properly informed and equipped, both individually and collectively to play their full part in board business.

85 This report highlights a number of key areas to which the Board must now give priority, for ease of reference these are reiterated below in the form of recommendations which must be taken forward.

Recommendations to improve the effectiveness of the Board and its sub-committees

Achieving cohesion and consensus

1 The Board needs to develop a common understanding of the respective roles of Executive and Independent Board Members, and specifically develop cohesive working relationships that are based on trust.

2 In the short-term, additional external senior leadership support and capacity must be brought in to provide impetus and fresh perspectives.

Planning and Risk Management

3 Corporate risks must be better identified and aligned to corporate objectives. There is a need to move to a proactive approach to the management of risk with the mapping and monitoring of key performance indicators relevant to the effective management of risk at both Executive team and Board level.

4 Data presented to the Board's various sub-committees must equip the Board and its Independent Members with information that enables them to gain the assurances needed regarding patient safety, risk management and service delivery.

Board Meetings

5 The current breadth of the Director of Governance and Communications role should be critically appraised to ensure that there is sufficient capacity to fulfil the Board Secretary role, and to avoid any inappropriate overlap with executive responsibilities.

6 The Board Secretary, on behalf of the Chair, must produce an Annual Plan of Board business that sets out for all Board members the matters that will come before them throughout the year. This should enable Board members to satisfy themselves that matters are brought to the Board at the earliest opportunity to enable members sufficient opportunity to influence matters

7 Board members should be sent an Agenda and a complete set of supporting papers at least seven calendar days before a formal Board meeting. Additional papers should be only be accepted in exceptional cases, and only if the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

8 Board Agendas should be set to allow sufficient time within meetings to properly consider and debate all matters put before the Board.

9 No papers should be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasoned decision.

Capacity of Independent Members

10 As the Health Board moves forward it must ensure that sufficient time is given to Independent Members to enable them to thoroughly assimilate the information they need in order to inform their decision making and scrutiny role.

11 Independent Members must be properly supported to meet their responsibilities through the provision of induction and ongoing development.

Use of information

12 An issue underlying many of the findings is the availability and use of information, with there being particular concerns about the information available to Independent Members. Board members must have access to meaningful performance data to inform their decision making as well as satisfying themselves that staff across the organisation are using this information to monitor and manage their performance on a day to day basis.

Recommendation for strengthening management and clinical leadership structures

13 The Board must take forward its new CPG model as a matter of priority. In so doing it must ensure that performance management is strengthened and that there is clarity in relation to reporting and accountability arrangements.

14 The Board must implement the additional operational turnaround support for CPGs that it agreed was needed in March 2013.

15 The Board must ensure that the new model will provide the necessary connectivity between CPGs, the executive and geographical site management.

16 The Board must re-affirm line management structures for medical and nursing staff and their inter-relationship with professional accountability arrangements.

17 The Board must ensure that it provides clarity in relation to the roles and responsibilities of the Hospital Site Managers.

18 The Board must ensure that there is sufficient stability, and collective capacity and capability in its Executive team. In so doing it must ensure that the introduction of new executive roles such as the Chief Operating Officer is not just a re-badging of current executive roles.

Recommendations for strengthening Quality and Safety arrangements

19 The Board must commission an urgent review of its arrangements for the monitoring and reporting of quality and safety issues to ensure that they are robust. This should include a detailed review of the way in which the Quality and Safety Committee works and its interface with the Quality and Safety Lead Officers Group and arrangements in place at CPG level.

20 The Board must put in place robust arrangements for the reporting, escalation and investigation of concerns.

Recommendations for strengthening financial management and stability

21 The Board should reconsider the issues and recommendations set out in the separate reviews of Chris Hurst and Allegra.

22 The Board must take action to fully integrate and deliver service, workforce and financial plans.

23 The Board must prepare and approve sustainable service and financial plans before the start of the 2014-15 financial year that clearly demonstrate how financial pressures will be managed and addressed.

Recommendations relating to strategic vision and service reconfiguration

24 The Board must progress its strategic plans for acute clinical services as a matter of urgency.

Wider issues for NHS Wales

86 Those with responsibility for management and oversight of the NHS in Wales should reflect and learn from the issues raised in this report. In our view, greater clarity is needed over the respective roles and responsibilities of NHS Boards, the Welsh Government and External Review bodies, specifically in relation to escalation and intervention arrangements.

87 Over the coming months the Wales Audit Office and HIW will be working with the Welsh Government to review and, where necessary, strengthen arrangements for handling significant risks to service delivery or organisational effectiveness of NHS bodies in Wales.

Appendix 1 - Review Approach

This review has drawn upon the following recent HIW and Wales Audit Office work at the Health Board:

- **a** HIW's Review of Ysbyty Glan Clwyd, December 2012
- **b** HIW's Review of Quality and Safety Arrangements, December 2012 - present
- **c** Wales Audit Office's 2012 Structured Assessment
- **d** Wales Audit Office's Audit of the Health Board's 2012-13 Accounts
- **e** Wales Audit Office's 2013 Structured Assessment (Financial Management module)

The findings from the above reviews were brought together under the following themes*:

- **a** The effectiveness of the Board and its sub-committees
- **b** Organisational structure and lines of accountability
- **c** Strategic vision service reconfiguration
- **d** Stakeholder engagement
- **e** Organisational culture
- **f** Performance management
- **g** Financial management and sustainability

During May 2013 additional fieldwork was undertaken by a combined HIW and Wales Audit Office review team. The fieldwork comprised:

- **a** Interviews with Executive Directors, Independent Members, Chiefs of Staff and Hospital Management Team members
- **b** Document review, including review of *Clostridium difficile infection at Ysbyty Glan Clwyd: Final Report to the Chief Medical Officer for Wales* prepared by the Director of Public Health Services, Public Health Wales
- **c** Observation at the May 2013 public and in-committee Board meetings

* These were themes set out in the Terms of Reference for the review; some have been conflated / combined with other sections in the final report.

Interim findings were shared with the Health Board in the form of a letter to the Chief Executive on 23 May 2013, copied to the Chairman, and shared with the Chief Executive of NHS Wales.

Appendix 2 - Review Team

The Review team comprised:

Paul Barnett (peer reviewer)
Rhys Jones
Mandy Townsend
Sara Utley
Andrew Doughton
Matthew Edwards
Ron Parker
Helen Howard
Christopher Bristow
Leigh Dyas

The team worked under the direction of Mandy Collins and Dave Thomas, with reference peer input from Mike Usher.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

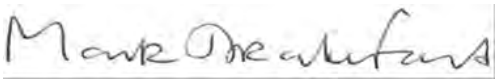
Darren Millar AM
Chair
Public Accounts Committee

5 February 2014

Dear Darren

PUBLIC ACCOUNTS COMMITTEE REPORT INTO GOVERNANCE ARRANGEMENTS AT BETSI CADWALADR UNIVERSITY HEALTH BOARD

I am attaching the Welsh Government's response to the Public Accounts Committee report into the Governance Arrangements at Betsi Cadwaladr UHB which was published in December 2013.



Mark Drakeford AC / AM
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Response to the PAC Report on the Governance Arrangements at Betsi Cadwaladr University Health Board

We welcome the findings of the report and offer the following response to the twenty one recommendations contained within it that fall to the Welsh Government.

Recommendation 1:
We recommend that to ensure senior leaders are held to account, the Welsh Government reviews and where necessary strengthens the performance management and appraisal process arrangements for Chief Executives and Chairs of NHS organisations to ensure that they are appropriately robust, clearly understood and implemented.

Response: Accepted

Performance review processes are already in place for both Chairs and Chief Executives of NHS Organisations in Wales. However we are taking action to ensure that these processes are robust and clearly understood. Welsh Government and Academi Wales published "Doing it right, doing it better" the Good Governance Guide for NHS Wales Boards in January 2014. This document underlines the importance of the performance appraisal process and, in particular, the appraisal of the Chief Executive by the Chair.

The Minister for Health and Social Services conducts a biannual review of the Chair of each LHB and Trust in Wales. These meetings agree objectives for the coming period as well as reviewing performance over the previous period. Self- assessment evidence is provided by Chairs in advance of the review meeting and the Minister provides feedback in written form following the review. This process identifies issues to be addressed and any development needs. In addition to the formal process, the Minister meets the Chairs as a group on a quarterly basis and informally with individuals as issues arise.

All Chief Executives in Wales have objectives in place which have been agreed with their respective Chair and the Chief Executive of NHS Wales. A review of their performance is conducted formally twice a year. The mid year review is undertaken by the Chair of the LHB and the Chief Executive of NHS Wales receives a copy of the review. The end year review is conducted jointly by the Chair and Chief Executive of NHS Wales.

The Minister also conducts a quarterly meeting with the Chairs and Chief Executives as a single group.

Recommendation 2:
We recommend the Welsh Government undertakes an urgent review of the training available to board members across all Welsh NHS bodies. The outcome of this

review should inform the development and delivery of a national training programme for board members, participation in which should be a condition of board membership. The programme should develop core competencies, clarify requirements and include training specifically developed for newly appointed board members to attend as part of their induction into board membership.

Response: Accepted

Welsh Government considers effective Board development to be of critical importance. We believe that there is a need to ensure that we have the right blend of consistent national activity and bespoke local arrangements to ensure non-executive Board members full understand their roles and responsibilities and Board functions.

The Chief Executive of the NHS has already written to Chairs of NHS Organisations in Wales restating that effective Board development is of critical importance and reemphasising the need to ensure there is the right blend of consistent national activity and bespoke local arrangements to support non-executive Board members. The letter makes clear that the bespoke local arrangements are for LHBs to define and secure.

David Sissling's letter also advised Chairs of the national support which is available through Academi Wales – which includes:

- Two at the Top – New Chief Executive and Chair pairings to use this support in their first year, existing Chief Executives and Chairs to access when needs arise;

- Board Development Series – all Health Boards and Trusts should undertake the two parts of the programme over the next 2 years;

- The Good Governance Guide for NHS Wales Boards – to be used by all Board Members on an on-going basis;

- Governance Master class Series – Chairs to identify appropriate Board members to attend the series, learning to be shared with Boards on return to organisation;

- Bespoke Development – all Health Boards and Trusts were asked to discuss other development support with Academi Wales as needs arise.

In response to the Chief Executive's letter all NHS bodies were asked to provide a summary of planned Board development activity for 2014. This information was

received in December and has been assessed. Academi Wales are now working with NHS Organisations to fill any potential gaps in the programme.

Furthermore, the recently published Good Governance Guide for NHS Wales Boards – "Doing it right, doing it better" sets out a framework for Board learning and development. The guidance reminds Boards that the strategic challenges facing Boards give rise to the need for specific skills, and this requirement must be kept under review in a systematic way. In order to ensure an effective balance of knowledge, skills and background, the guidance advocates that Boards should undertake regular skills audits of current Board members.

We have also noted the comments by the Commission on Public Service Governance and Delivery on the training of Boards of Public Services and we will be considering what further action is necessary in the light of the Commission's findings.

Recommendation 3:
We recommend that directive guidance should be issued to all boards on the importance of both individual and collective board development and any such guidance should be reviewed regularly to ensure it is fit for purpose.

Response: Accepted

The letter sent from the Chief Executive of NHS Wales to the Chairs of NHS bodies was unequivocal on the importance Welsh Government place on ensuring the there is effective Board development. This message has already been reinforced in *The Good Governance Guide for NHS Wales Boards "Doing it right, doing it better*" which was issued in January 2014.

As we have outlined in response to recommendation 2, we are considering the need for further national support or guidance in the light of the responses from NHS bodies and the findings of the Commission on Public Service Governance and Delivery.

Recommendation 4:
We recommend that the time commitment required for Independent Members be reviewed to ensure that it is adequate to allow them to fully discharge the functions expected of them.

Response: Accepted

As the *Good Governance Guide for NHS Wales Boards* states – Board Chairs have a key responsibility to plan and manage the time commitment required of Independent Members. Therefore, in the first instance we are writing to the Chairs of NHS bodies in Wales to ask them to review the time available from Independent

Members against the requirements of the role. External support will be provided to them in undertaking the review if they require it.

We will consider this matter further following the review by the Chairs and in the light of the findings of the Commission on Public Services Governance and Delivery and provide an update to the PAC on this in 6 months time.

Recommendation 5:
We recommend that the Welsh Government takes action to enable a more robust and consistent system of appraisal for Independent Members of Welsh Health Boards, including the identification of personal training and development needs, and that a peer mentoring scheme for independent members be developed.

Response: Accepted

Arrangements are in place to ensure Independent Members receive annual appraisals which should identify personal training and development needs Welsh Government. Furthermore, to reinforce this system, *The Good Governance Guidance Guide for NHS Wales Boards* includes a section on Building Board Capacity and Capability which covers Independent Board Member performance appraisals and provides a framework for learning and development of Board members.

Welsh Government already ensures that the information from the performance reviews of independent members is fed into the reappointments process.

We will work with Academi Wales and Chairs of NHS organisations to develop a framework for appraisals and put in place a peer mentoring scheme for independent members. We will ensure that Chairs are held to account for their part in ensuring the appraisal of independent members is robust and considers training and development needs.

We will provide an update to the PAC on this work in 6 months time.

Recommendation 6:
We recommend the Welsh Government ensures that the importance of the separation and accountability of the Board Secretary role is clearly understood by all NHS organisations.

Response: Accepted

The LHBs' Standing Orders already emphasise the role of Board Secretaries as the guardians of good governance within the LHBs and also their independence of the Boards. The Standing Orders also specify that the accountability of the Board Secretary is directly to the Chair and chief executive of the LHBs.

Furthermore, the pivotal nature of their role as principal advisor to the Board and the organisation as a whole on all aspects of governance is explained and reemphasised in *The Good Governance Guide for NHS Wales Boards*.

More widely we have ensured that the all the findings of the joint WAO/HIW report have been considered by all NHS bodies in Wales. The Chief Executive of the NHS wrote to all NHS Chairs and Chief Executives asking them consider the report's findings and provide him with appropriate assurance of their governance arrangements. Their responses included any action they were taking as a result of the report's findings and example of good practice. These individual responses were discussed at a meeting of all the Chief Executives and were shared amongst all NHS bodies.

Recommendation 7:
We recommend that Welsh Government consider providing statutory protection for the role of Board Secretary.

Response: Accepted

Statutory protection for the role of Board Secretary will be looked at alongside the recommendations flowing from the findings of the Commission on Public Service Governance and Delivery.

Recommendation 8:
We recommend that the Welsh Government ensures that all Health Boards review their meeting procedures, to ensure that Board members are presented with all papers in a timely manner and that non-restricted papers are published in the public domain in the same timescales.

Response: Accepted

LHBs' meeting procedures have already been reviewed following the WAO/HIW report findings. The model standing orders which LHBs have adopted require LHBs to ensure that Board agendas and complete sets of papers shall be sent out 10 days before formal Board meetings. In terms of public access the Standing Orders also require that the agendas and related papers should be published at least 10 days before Board meetings. Some LHBs have adopted a 7 day time frame for the issue of agendas and papers to Board members and the public. The Standing Orders specify that supporting papers may exceptionally, be provided after 10 days provided that the chair is satisfied that the Board's ability to consider the issues in the papers would not be impaired. Adherence to the Standing Orders is considered as part of the annual structural assessment undertaken by the Wales Audit Office.

More broadly, the Good Governance Guide for NHS Wales Boards also provides a description of the effective processes that are necessary for the effective operation of Boards.

Recommendation 9:
Having considered the evidence, the Committee welcomes the action being taken by the North Wales Community Health Council to monitor compliance with infection control procedures in hospitals across North Wales. We recommend that the Welsh Government reviews its processes for validating quality and safety, and other critical data from NHS organisations. It is vital that such data is reported accurately if meaningful action is to be taken.

Response: Accepted

We have already strengthened the quality and safety management systems within Welsh Government. We have put in place a group chaired by the Deputy Chief Medical Officer which meets regularly to oversee regularly updated quality and performance information and intelligence about NHS organisations. This enables interaction and, if necessary, escalation with Health Boards and Trusts within the overall delivery framework.

Work is in hand to strengthen data quality and data completeness is already a Tier 1 Measure. We are also ensuring that we triangulate the information from various data sets, including serious incidents, and routinely reported information sources. An example is work in hand in respect of data and reporting of clostridium difficile incidence and associated deaths.

Recommendation 10:
We recommend that the Welsh Government finalise, introduce and implement a common set of key performance indicators of quality and safety for use by Health Boards. This would assist in improving performance and identifying risks so that swift action can be taken to address them.

Response: Accepted

The existing delivery framework already includes a range of Tier 1 quality and safety indicators such as mortality, infections and pressure ulcers which are monitored at a national level. These are published by Welsh Government on the My Local Health Service website. Performance indicators which relate to timely access are also an important measure of quality and safety

In addition, NHS organisations depending on the make up of their services, are agreeing a set of indicators to track performance across all their services as part of their overall assurance framework. To assist with this, the National Quality and Safety Forum has previously agreed a set of quality trigger questions and associated

indicators for use at local level. The 1000 Lives Improvement programme within Public Health Wales is leading work during 2014 on behalf of all NHS organisations to further develop a measurement framework to assist Boards in seeking assurance on quality. The quality improvement work is ongoing.

Recommendation 11:
We recommend that the Health Board makes the results of its investigations into the high RAMI scores across hospitals in North Wales publically available, together with information on the actions that are being taken to address any patient care issues that are identified.

Response: Accepted

This is a recommendation for BCU Health Board. However we would expect them to do this, subject to any necessary caveats to protect any potentially identifiable patient information.

Recommendation 12:
We recommend that the Welsh Government makes information on RAMI scores across all hospital sites in Wales more accessible to the general public, ideally by placing all the data on a single web page, with clear explanations of what the data means.

Response: Accepted

The Welsh Government is now making these data available, together with contextual narrative, through My Local Health Service website.(*DN need to add in the link)* Work will continue to develop a range of mortality measures which better reflect the Welsh NHS and to make those easily accessible to the Welsh public. The proposals will shortly be set out in a statement from the Mortality and Transparency Taskforce which is expected in the Spring. A copy of the statement will be sent to PAC members.

Recommendation 13:
The failure to adhere to accepted budget processes is an issue of particular concern. We do not believe that budgets should be signed off with caveats and recommend that assurances should be provided to us that this practice has now been discontinued within the Health Board.

Response: Accepted

The Welsh Government agrees that budgets should be signed off and owned by budget holders at the start of the year, including agreeing and signing off any variations that may be agreed by the Board during the year. All Health Boards should be adopting this practice which is clearly stipulated within the Health Boards Standing Financial Instructions. The Welsh Government is reinforcing this message

through the Directors of Finance forum. We will also ensure that evidence is provided through the submission of the Health Boards 3 year plans that all individual Divisions and budget holders have been fully engaged and involved in agreeing relevant savings plans and cost reduction programmes.

Recommendation 14:
We also recommend that the Welsh Government seeks information from directors of finance at all health boards to ensure that the failures evident within the budget planning processes at the Betsi Cadwaladr University Health Board are not being replicated elsewhere.

Response: Accepted

The action being taken in relation to recommendation 13 will apply to all Health Boards. We have also ensured that all NHS Bodies have carefully considered the HIW/WAO report and taken any action necessary in their own organisation (See response to recommendation 6).

Recommendation 15:
We recommend that the Welsh Government emphasises to health boards that they should wherever possible avoid utilising unsustainable solutions to financial pressures, such as cancelling or postponing operations, which simply defers costs to the next accounting period.

Response: Accepted

LHBs already take action to avoid using unsustainable solutions to financial pressures. Decisions are taken by LHBs to postpone operations for a variety of reasons that are not linked to financial pressures. This includes the LHB taking appropriate action to cope with surges in demand for surgical beds as a result of emergency admissions, unexpected absences of key staff and the need to take infection control measures.

Last autumn all NHS organisations in Wales put in place comprehensive winter plans. These plans are helping to ensure the disruption to services from surges in demand for unscheduled care is reduced wherever possible. These plans are wide ranging and include:

- Capacity – with up to 490 additional beds (or equivalents) in the plans
- Enhanced staffing and working arrangements
- Reducing delays in discharge - with enhanced partnership working between the NHS and Social Services Departments
- Improved monitoring and intervention arrangements.

We will reemphasise the need for effective communication with public about the reason for the need to postpone operations at the next meetings of the Chief Executives and Chairs.

Recommendation 16:
We recommend that the Welsh Government ensures that all health boards minimise the inconvenience and distress caused to patients and their families by requiring that Boards communicate with patients as soon as possible following a decision to cancel or postpone elective operations.

Response: Accepted

We will reemphasise the need for LHBs to minimise the inconvenience and distress caused to patients and their families by ensuring more effective and timely communication about cancelled or postponed elective operations. This matter will feature on the agenda for the next meetings of the Chief Executives and Chairs.

Recommendation 17:
We recommend that the Welsh Government takes greater care when commissioning taxpayer funded external advice and that, without exception, the output of such advice is received, reviewed and retained by appropriate Welsh Government departments.

Response: Accepted

This is normal practice. There were unique circumstances around the commissioning of the report for Chris Hurst as it was intended to provide advice specially to support the Chief Executive of Betsi Cadwaladr UHB. However, we will ensure all advice directly commissioned by Welsh Government is received, reviewed and retained by the appropriate Department

Recommendation 18:
In relation to the sharing of the findings of external reviews the Committee believes that it is vitally important, that safeguards are in place to ensure that such findings are widely utilised to learn lessons and improve processes within health boards. We recommend that Welsh Government takes this forward.

Response: Accepted

The CMO has already written to all Medical Directors asking them to share the outcomes from any externally commissioned clinical reviews.

The National Quality and Safety Forum also agreed at its last meeting that a key priority of its work and terms of reference going forward in 2014 should be to develop effective mechanisms to share and disseminate wider learning across NHS Wales and with its key partners. A recent Team Wales event, which brings together executives from all organisations and Welsh Government considered the all Wales learning from the Duerden review of infection control arrangements in Betsi Cadwaladr UHB.As part of the work we are undertaking with WAO and HIW (set out

against recommendation 20) we will also be sharing and discussing findings from reports and reviews with the WAO and HIW on a biannual basis.
(See also response to recommendation 6 in respect of the sharing of WAO report on Betsi Cadwaladr UHB).

Recommendation 19:
The Committee believes it is vital that senior leaders set a clear vision for their organisations to respond to the three challenges of developing service, workforce and financial plans. Given the issues around governance arrangements at Betsi Cadwaladr University Health Board, it is imperative that the new senior management of the Board renew and reunite the Executive and non-Executive leadership team, and close the gap between the Board and Wards.

Response: Accepted

All NHS organisations in Wales are well advanced in developing 3-year plans which bring together the key elements of service provision, workforce and finance in one document. The statutory requirement for these Integrated Medium Term Plans is now set out and National Health Service Finance (Wales) Act 2014 and detailed requirements and expectations for Boards specified in the Planning Framework issued in November 2013, These plans, will form the basis of a clear vision for each organisation.

A new Chair and Vice Chair are already in post in Betsi Cadwaladr UHB. The recruitment process for a new Chief Executive is underway. Once the full team is in place we will be setting specific objectives for both the Chief Executive and the Chairs to ensure the Board and the non-executive leadership team operate effectively.

The effectiveness of the new team will also be tested as part of:

- The biannual meetings between the senior executive team in Welsh Government and individual LHBs (ie Joint Executive Team (JET) meetings)
- The regular meeting between the Minister and the Chair.
- The annual WAO Structural Assessment.

Recommendation 20:
We recommend that Welsh Government work with the Wales Audit Office and Healthcare Inspectorate Wales to develop a clearer set of scales of escalation. This should include a detailed criteria upon which intervention is triggered, the rationale for the type of intervention, and clarity on who should be notified when intervention commences and ceases. We believe that this information should be made accessible to the public.

Response: Accepted

The Welsh Government, Healthcare Inspectorate Wales (HIW) and Wales Audit Office (WAO) have been working together to review and where appropriate enhance the collective arrangements for identifying and handling risks to NHS service delivery or organisational effectiveness.

Work has been undertaken to identify the key sources of information and intelligence on NHS bodies that are held by respective parties, and how these can be shared to ensure that emerging concerns are identified and addressed swiftly and effectively.
Arrangements are being developed in which this information can be exchanged in a timely manner, and to identify triggers and prompts for escalation and intervention, and who should undertake those actions. Transparency of the process and the communication requirements arising from it are being considered as part of this.
The Welsh Government, HIW and WAO will be engaging with NHS Wales and other interested parties over the next few weeks whilst finalising the arrangements.

The NHS Escalation and Intervention Arrangements will be launched in time for the new Financial Year and will be published.

Recommendation 21:
We recommend that the Welsh Government gives urgent consideration to the creation of a pool of additional short term leadership capacity, for NHS Wales, that can be drawn upon at short notice and does not impact on other NHS Wales Health organisations.

Response: Accepted

We are already considering this and are at the stage of looking at how to overcome the practical constraints of there being people available with appropriate background and skills at the time needed. This means considering also using the wider UK interim market and putting in place framework arrangements that enable these to be accessed within EU procurement rules in a timely manner when needed.

However, the new escalation arrangements we are putting in place with WAO and HIW are aimed to reduce the risk of us needing to deploy additional support at short notice.

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Mr Darren Millar AM
Chair of the Public Accounts Committee
National Assembly for Wales
Cardiff Bay
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Date: 24 February 2014
Our ref: HVT/2090/fgb

Dear Darren

WELSH GOVERNMENT RESPONSE TO PAC REPORT ON GOVERNANCE ARRANGEMENTS AT BETSI CADWALADR UNIVERSITY HEALTH BOARD

Following a request by the Committee Clerk in her letter of 7 February 2014, I have reviewed the Welsh Government's response to the Committee's report on Governance Arrangements at Betsi Cadwaladr University Health Board.

The Committee will no doubt be pleased to note that that the Welsh Government has accepted all of the recommendations that are addressed to it (recommendation 11 is addressed to the Health Board). I also welcome the publication in January 2014 of the *'Good Governance Guide for NHS Wales Boards – Doing it right, doing it better'*, which is referenced frequently within the response.

However, I consider that the individual responses provided to several of the recommendations are unlikely to provide the Committee with sufficient assurance that the necessary actions are being taken to address the substantive concerns which sit behind the recommendations.

I have listed below the recommendations where I think the Welsh Government response needs to go further.

Recommendation 1: *The response does not set out what the Welsh Government has done to determine whether or not current performance management and appraisal arrangements for NHS Chief Executives and Chairs are robust, and are being properly implemented. I am aware that some specific developmental work is taking place within the Welsh Government to strengthen the existing arrangements, it is therefore perhaps surprising that no direct reference is made to this.*

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Recommendation 2: *Whilst the response points to the availability of reference material and the ability to access national support, the Committee may feel that it does not adequately address the specific issue of ensuring that new board members routinely have access to right training material as part of their induction, or how this is being monitored.*

Recommendation 6: *The Welsh Government's response could have usefully gone further by providing the Committee with information on the breadth of the role of the Board Secretary in other NHS bodies in Wales. It is presumed that this information would have been available from the responses the Welsh Government received when it requested assurances from NHS bodies that they had considered the issues identified in the BCU report.*

Recommendation 7: *The response provides no indication of the anticipated timescale for the implementation of this recommendation, other than to note that it will be looked at alongside the recommendations of the Williams Commission.*

Recommendation 10: *Reference is made to a set of quality trigger questions that have been agreed by the National Quality and Safety Forum. A copy of these could have usefully been included in the Welsh Government's response, and the Committee may therefore wish to request that this information be forwarded.*

Recommendation 13: *The Welsh Government has indicated what it has done to reinforce the message on the agreement of budgets, but has failed to provide the Committee with any assurance that the practice of "caveated sign up" to budgets has been discontinued by Betsi Cadwaladr UHB in the current financial year.*

Recommendation 15*: The response to this recommendation makes minimal reference to the Committee's substantive point of cutting back on elective activity as a result of financial pressures, or to describe what the Welsh Government itself is doing to ensure that this practice does not routinely occur.*

Recommendation 18*: The Welsh Government has perhaps responded to this recommendation too narrowly by referring only to clinical reviews, when the Committee probably were looking for arrangements to be place to promote the sharing of findings from all external reviews.*

Recommendation 19*: The Welsh Government will have been applying scrutiny in recent weeks to the three-year integrated plan that Betsi Cadwaladr UHB has been working on. The Committee may therefore wish to obtain the Welsh Government's view on the quality of that plan, and indeed the quality of three-year planning in other NHS bodies in Wales.*

I note that the Committee is yet to receive a substantive response to recommendation 11, which was addressed to Betsi Cadwaladr University Health Board. If it has not already done so the Committee may wish to contact the Health Board to remind it of this.

Given the above comments, the Committee may well feel that it is appropriate to seek further oral evidence from the Welsh Government on the actions it is taking in response to the Committee's report. If possible, this could be done as part of a wider-ranging session with the Director General for the Department of Health and Social Services, before he departs his job at the end of March.

Finally, in relation to Recommendation 20, the Committee may wish to note that I am pleased with the progress that is being made on developing clearer arrangements for escalation and intervention when problems arise at NHS bodies in Wales. The arrangements described will provide a good basis for the collective sharing of information between Welsh Government, Healthcare Inspectorate Wales and ourselves. This should help identify concerns at an early stage, discuss what action is necessary and ensure that any resulting interventions are proportionate and co-ordinated.

I trust this information is helpful.

Yours sincerely

HUW VAUGHAN THOMAS
AUDITOR GENERAL FOR WALES