Inquiry into Governance Arrangements at Betsi Cadwaladr University Health Board
Responses to questions raised in earlier evidence from Mary Burrows, Chief Executive, Betsi Cadwaladr University Health - 12 Sept 2013

Part 3: Outgoing Chief Executive, Betsi Cadwaladr University Health Board

Please note that from 27 January to 14 May 2012, I was not the Accountable Officer.
Mr Lang formally assumed this role, as conferred by WG to cover my absence and
to make sure he had the required authority to take decisions and lead the Board.

Furthermore I was absent from:
8 March to 4 April 2013
29 April to 13 May 2013
From 24 May 2013 onwards

I can confirm that my intention to leave the NHS started on 8 March 2013 and
was not linked to the WAO/HIW report, which was commissioned weeks after
my intention was made known.

Suggested question 1:

The report presents a pretty damning picture of the way in which your Health Board was being run – do you accept the findings and acknowledge that as Chief Executive, much of the accountability for those failings rests with you?

I have provided a statement which adds context to many of the findings. The report, I believe, concludes a number of failings attributable to multiple causes and in so far as a Chief Executive may be held accountable for collective failings extending beyond the Health Board's powers of deliberation and control then I have accepted my responsibilities and made my apologies to all concerned. However, I have also made clear that I do not consider it appropriate that I personally should be made the accountable scape-goat on the back of this Report (or linked reports mentioned in it) without appropriate wider consideration of, for example, the impact of disinvestment decisions beyond my personal decision and control . Fundamentally, financial constraints were recognised as the root cause of the majority of the management difficulties experienced by the Board. Notably, pre-award of additional funding for NHS Wales in the sum of £10 million, which has since been sanctioned, 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, some inherited and others identified on an on-going basis through service reviews and negative trends noted in assurance information provided to the Board. Inevitably, this had impact on the pace of turnaround not within the power of the Board, or me alone, to deliver corporately.

Pace of change, and cohesive working amongst the Board members and the Executive Team

Suggested question 2:

Problems identified in respect of financial management and planning, the organisational structure, executive capacity and the quality governance arrangements have endured for some time, and don't appear to have been adequately gripped, why has the Health Board not been able to adequately address these concerns?

I have to an extent provided a response to this question under 1 above. Issues were being addressed as outlined in my evidence and that of Mr Lang. I would draw attention to the forward to the Report which makes it clear that the amalgamation of 8 organisations was *"never going to be a simple task".* Evidence indicates that organisational change takes somewhere between 5 to 7 years. I would also draw attention to Don Berwick's review into "Patient Safety in England"[1] noting that "*faults are to be expected in any enterprise of such size and complexity".* Much of the track record that is good is, of course, not subject to scrutiny in any review. The focus of the Overview Report is on cause for faults including perceived faults (in the absence of detailed evidence as to context) and to an extent seeking to apportion blame, an approach contrary to that espoused by Berwick in his review.

Accepting the complexity of the integration project, the financial constraints the Board was faced with, and then expectations as to the change management completion timetable to secure all round achievement of improvement goals a reality check was required. A risk based determination of priorities to be delivered within required budget agreement and/or sooner flex of the budget to ensure maintained momentum was needed. This considered approach to turnaround and intervention was not initially forthcoming, arguably until the noise in the system as to the complexity of the various workstreams, competing delivery requirements, uncertainty of break even position and lack of capacity to meet all demands within budget had become deafening. Recognising the need for action involving significant expenditure (as had been indicated by a potential budget deficit of £19 million, provision of a £15 million cash injection in 2012 to address demand and then a further predicted deficit & in 2013) additional money directed to address implementation of, for example, needed recruitment was after all a belated start rather than an end point in terms of external input obviously required. You cannot always make an issue go away by playing a game of "Emperor's new clothes" and to try to is as inappropriate a management reaction as it is deluded.

The matter of tackling the many bureaucratic obstacles in the path of instantaneous smooth collective corporate implementation of change is a change management project of itself. When dealing with turning around local culture and re-directing local agendas this can, in the best of many hands, take time. Criticism as to pace of integration, noting that the

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[1] **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- August 2013

budget allocated was not sufficient to generate the capacity to deliver all objectives simultaneously, has not been fully addressed.

Suggested supplementary questions:

a) What pressure had you been under from the Welsh Government to address the growing concerns they had about the Health Board?

WG Officials reminded all Health Boards and Trusts of their statutory obligations and an expectation that these would be met. Emphasis was, in particular, placed on the financial obligation to break even (i.e. balance the "books") and in addition make cost efficiencies (i.e. savings) although the need for financial investment had been identified for example, Birth Rate +, and changes resulting from service reconfiguration. Improving A&E performance at Glan Clwyd was continually being pressed for, which required investment and changes in its operational protocols. This double bind position for NHS organisations, and so notably affecting the Health Board, is a matter of public record.

b) How would you characterise your relationship with the Welsh Government?

It was a constructive working relationship noting that the financial constraints result not from the Welsh Government but the fact of operation within a global climate of recession requiring need for savings and efficiencies.

However, it would be naive to consider this relationship was not strained at times by the very natural human and corporate tendency to consider that demanding more for less of one body absolves the other from responsibility.

c) Was it not the case that you were trying to fend off the concerns of the Welsh Government by giving overly positive assurances that progress was being made, when in fact that wasn't the case?

No, not at all. Information was given by me and others based on information provided to the Board and WG as to progress which was believed to be accurate. Assurance information was collated from a number of sources (triangulated). Its worth was evaluated. A 'confirm and challenge' approach was taken by the Board. Being assured of having accurate information upon which to act is a concern all round. Arguably emphasis on more assurance delayed input of needed funding and support. What was required by way of external input and support was delayed pending obvious evidence of issues requiring resolution that could not be hidden altogether behind an argument of the need for greater efforts or efficiencies on the part of Board, those reporting up to the Board and those working directly with patients. I have made it clear that I strove hard to maintain all-round focus on patient safety and to ensure the quality of services was not sacrificed or down-played but placed top of agendas.

d) Would it not have been better to be honest and indicate that there were fundamental problems, and to seek help from the Welsh Government in addressing those problems?

This question implies that I have been dishonest which I deny was or is the case. Help

was sought and advice given. As to whether the advice was adequate, timely or relevant to the problems being discussed is a different question with hindsight often casting a different light on matters. I have said, with hindsight, that I feel I should have blown the whistle upon my return in mid May 2012 about the direction the Board was heading with regard the external push driving internally the meeting of financial targets as the critical priority. The number of performance management demands having patient safety implications had a detrimental impact on capacity to maintain momentum with this transformation project. It is not possible to snap fingers and generate change over-night if there are consultations to be undertaken, paperwork to be completed and committees to be involved in decision-making. The mantra *"no decision about you without you"* applied to reassure patients of their respectful involvement in treatment decisions affecting them also applies to NHS staff who need to be involved, and crucially, be instrumental in effecting service delivery transformation. Many of the issues are not about top down management but about effecting change across 3 hospitals and a wide geographical area through bottom up change. I have said that I have worked with 4 NHS boards prior to the Health Board. My trouble- shooting experience, if you want to call it that, combined with that of my co-workers on the Board was extensive but I have said the extent of the issues to be dealt with often under spotlight of media attention, and in a situation of public criticism, stretched the capacity of capable staff and their resilience to a degree not previously encountered in my considerable experience of healthcare in Wales and other countries.

Suggested question 3:

The ability to work cohesively, both at the board and executive team level seems to be a significant problem for the Health Board. Why were working relationships so problematic and what were the causes of the tensions that we heard about from your executive team colleagues last week?

Differences in approach to balancing finance, safety and quality of care were the root of the problem as outlined in my statement and evidence given by Mr Lang.

Management and clinical leadership structures

Suggested question 4:

Who was the architect of the CPG based organisational structure, and would you accept that, as originally designed, the structure was not fit for purpose?

The previous Medical Director of the North Wales NHS Trust.The structure was deemed fit for purpose as it had been introduced at the Trust, tested and consulted upon as part of the transition to an integrated health board. As it evolved, changes were made within CPGs based on reflective assessment and exchanges that came from working as a collective and

taking account of feedback from staff and patients.

Suggested supplementary questions:

a) Interim hospital site managers needed to be put in place as an emergency measure in May to address concerns about the lack of interface between CPGs and geographical hospital sites. Doesn't that indicate that there were fundamental flaws in the original design of the organisational structure?

   No, as other NHS organisations have experienced the same issue with matrix management. There is an interface between CPGs, as evidenced within the organisation that worked to address this, which was successful in some cases and not so in others. The issue is one of providing more senior capacity to support clinical site managers and hospital management teams to improve flow through the hospital whilst at the same time making sure clincial services actively operate across the Region to reduce variation, raise standards and improve equity of access to that of the best.

b) Why, after an internal review had recommended a reduction from 11 to 6 CPGs, did you instead take proposals to the Board for a 12 CPG model – and could you not see that such a model would fundamentally fail to address the concerns that had led to the review in the first place?

   Please refer to my statement and Mr Lang's statement which explain the rationale.

   Please note that the CPG element was not presented at the Board, only the recommendations about the Executive structure were presented and discussed as a decision had to be taken in order to progress change mindful of the requirements of the Organisational Change Policy. It is an incorrect assumption that the CPG element was presented for discussion.

c) Is part of the problem that you are too personally attached to the CPG model to the extent that you were not objective about its short comings?
   No, this is a very disparaging assertion to make to a professional of my length of service, seniority and reputation within the health service. This structure was developed using evidence from London and Birmingham NHS organisations and considered in depth. It is not my style to pursue an objectively flawed plan of whatever nature and the same holds true here. The clinical model is similar to other Health Boards, and NHS organisations, that manage complex health care. Please refer to my statement and other responses within this supplementary statement.

Suggested question 5:

The CPG based structure is designed to help promote clinical leadership, yet members of the consultant body have written to this Committee so say that they think it is not fit for purpose. What work has been done to engage with clinicians to promote the benefits of the structure, and to understand the concerns they have about it?

To put this into context, the consultant body is about 600 in number and as I understand it

the letter you refer to represents a small number of consultants and not the whole or anywhere near the whole. I was made aware by some consultants at YG that they did not see or agree with the letter sent and were unhappy about a release to the media. Nonetheless, I accept and indeed champion hearing of a minority of voices.

The Chiefs of Staff, and their teams engaged with clinicians to promote the benefits of the structure, to challenge historic ways of working and build teams to improve the health of the population overall rather than staying with geographically defined areas of management structure. This way provided the best means of addressing variation and ensuring equity as commented upon already.

The concerns were intently understood given the cultural and behavioural issues that needed confronting (i.e previous organisations that competed with each other now needed to integrate and work cooperatively). Some wished to revert to the old Trust structures (i.e. not working with other teams across the geography). Reversion to old structures, as explained, threatened loss of ability to integrate services across North Wales to best service user advantage.

Successful examples exist of combining teams across the region into 'one' service delivered in many sites , including cancer, therapies, rheumatology, pain management, pharmacy, radiology, pathology, anaesthetics, and cardiology to name just a few. Horizontal integration, undertaken in other Health Boards (as well as through their clinical boards or divisions (CPGs)), is expected over time to reduce variation, any inequity of service provision and generally raise standards to the highest level across the ‘patch’. Clearly, a theory with some evidence of positive result in practice is to be preferred over a system which is not working to deliver equity for service users; my emphasis being on improving patient access and experience of care.

Quality and Safety arrangements

Suggested question 6:

Since the report has been published, senior clinicians have made public their concerns about deteriorations in the quality of care, increased RAMI scores, and a culture whereby they have felt unable to properly raise concerns about patient care. What is your response to these claims?

To reiterate I was very concerned about quality and safety of care and raised this regularly within the organisation and also with WG. My original evidence was clear about this and I refer Members to it.

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. I was aware of RAMI scores and sought information, action and assurance of address for Ysbyty Gwynedd in particular. This included attention being focused on morbidity and mortality rates and any perceived variation occurring between hospital sites

or specialities.

Concerns could be and were raised. Openness was promoted as evidenced by the reiteration of policies, meeting groups such as the Senior Medical & Dental Staff Committee as well as enabling direct contact with senior leaders, including myself, within the organisation. Concerns were also raised with Independent Members. There is therefore plenty of evidence of concerns being raised through a number of routes and of issues being addressed.

Consultants and other clinical staff were articulate, blunt and emphatic about raising safety issues and seeking assurance as to resolution which they did either in person, via written communication, at LNC, LMC & Partnership Forums or by using intranet forums.

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/dismissal of staff as appropriate. Evidence exists of the Health Board taking appropriate action.

Suggested question 7:

When did you first become aware of the *C Difficile* outbreak, and patient deaths, in Ysbyty Glan Clwyd?

About the third week in April (I returned on 4 April), several weeks after the outbreak had been declared. The Acting CEO, Director of Public Health & Director of Governance had been dealing with the matter. When I was made aware of the outbreak, recognising immediately the seriousness of it, I asked for a rapid review and explanation as to why matters had not been escalated to senior leaders including the Board.

Suggested supplementary questions:

a) Why was the Board not properly briefed about the *C Difficile* issues at its meeting on 20th April, when the situation had been managed as an 'outbreak' since 28 March?

It should have been raised even though internal investigations and discussions with Public Health Wales had then yet to be concluded. The matter was raised publicly at the following Board meeting at my request followed by in Committee discussions with the Board thereafter. As stated in the Overview Report, my position, and expressed intent on the part of the Board, was for there to be prompt upfront sharing of information and transparency about issues.

b) Did you, or other executive or management colleagues, deliberately withhold this information from the Board?

Absolutely not.

Suggested question 8: What arrangements have been put in place to ensure that quality and safety issues are properly considered and discussed at the CPG level, and how does the Executive oversee these arrangements to ensure they area working correctly? Each CPG has a quality & safety group and significant issues are reported directly to the Executive Director responsible, issues raised are escalated, when necessary, to the Executive team for resolution. Performance meetings are held by the Executive Director responsible, issues raised are escalated, when necessary, to the Executive team for resolution. Reports go to the Safety & Quality Committee and significant issues should be raised as well as discussed in detail by the Board as outlined in the WAO/HIW Report
Suggested supplementary question: a) Would you accept that organisational structure, and the way it has been implemented, has failed to adequately bridge the gap from the ward to the Board? 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. The desirability of avoiding a so called 'Board to Ward gap' is universal in all large organisations and is about ensuring an open, integrated culture with good informal and formal communication flows. 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. A part of the process of integration and 'closing the gap' discussions lie with how the Committee structures operate and quality of assurance evidence routinely provided, including focus on strengthening the processes of information gathering, presentation and assessment to enhance effective functioning of the Board itself (in terms of the questions it asks and avoidance of dependency on internal Committees as a source of assurance information in isolation). Nationally, boards have been undergoing development to ensure embedding of a culture of "no surprises' and issues drawn out in the Report relate to this universal agenda and need to be understood in this context. Coming through the Quality & Safety Committee, Finance & Performance and other mechanisms (e.g.1000 Lives safety walk-around & associated data) information related to staffing levels, infection trends, as well as themes emerging from patient concerns, required further exploration, discussion and relevant action within the organisational structure as well as at the Board level. A perfect organisational

structure and would enable early warning and facilitate prompt resolution of issues requiring action again ideally at operational level. With check and challenge going on within internal governance management structures, boards are then enabled to maintain focus on strategy and quality whilst maintaining on-going awareness of the effectiveness of correcting strategic actions in closing any identified gaps in control/assurance from Board to Ward as identified in the Report. All NHS bodies aspire to achieve this manner of co-operative, effective and efficient working together to achieve strategic goals.

Financial management and sustainability

Suggested question 9:

Why, during 2012-13, did your financial forecasting to the Welsh Government suddenly change so drastically, from a prediction of year-end breakeven up to Month 5, to a predicted year-end deficit of some £19m at month 6?

Please note the Accountable Officer change in status between January to May 2012 and the need to review, and consider, evidence presented by Mr Lang. I am able to state, effective upon my return, that within a matter of 2 to 3 months the advice from the now outgoing Director of Finance to the Finance & Performance Committee was that the Board would not be able to balance "its books" on the plans agreed by the Board by the end of April when the final budget was set. This begs the question as to whether the budget as set at that time was fit for purpose (i.e. whether the financial savings plans were truly evidence-based, realistic and deliverable). I expressed concern about this when I returned and asked for alternative plans as some plans that had been agreed, in my opinion, were not achievable and in some instances were revealing of duplication between corporate and CPG plans (i.e giving rise to double accounting of 'efficiencies). This was identified in the Report.

Forecasting was a matter of concern by the WG, which had prompted the review by Mr Chris Hurst, with Mr Lang, in March/April 2012. My understanding now is that Mr Hurst was commissioned by WG to provide support to LHBs and Trusts as he had ended his employment at the end of December 2012. The contract was for about 15 days of management consultancy. My understanding is he was asked by WG to review the Health Board however you will need to confirm this with Mr Hurst as to the facts as well as Mr Lang. I assumed when I returned that WG had commissioned his time, which I am aware they paid for.

After the deficit was declared, the WG commissioned the Allegra Report. This report did not cover CPGs as the WAO were undertaking their own structured assessment which covered this aspect of financial forecasting as well as audits of two CPGs and the overall structure and governance of the organisation. The Allegra consultant did not wish to interview Chiefs of Staff when names were put forward by myself. Given that these clincial leaders were responsible for significant budgets, this was a missed opportunity to understand the relationship with finance, the budget setting process and the levels of autonomy they had

including tensions that existed between a system of devolved responsibility and accountability and that of centralised control and mandates. The main focus, as outlined in the terms of reference, was financial. Members should also note the caveats recorded by the author of this report.

Suggested supplementary questions:

a) Why was there a forecast of break even in the early part of that year, despite there being a significant in year over-spend?

Please also refer to Mr Lang's evidence as the budget was agreed by the Board during my absence. Nonetheless I can say that the Board (in common with others) is required to set a budget that will achieve balance irrespective of the fact that there has been a 'flat cash' settlement every year for four years meaning savings of 6% or more for this Health Board (as for others) year-on-year. The Minister has asked for a change in the financial regime to move to a 3 year budget, which I highly commend. The current financial regime is not fit for purpose in my opinion.

Evidence from previous years is that savings plans tend to take hold later in the financial cycle, which is a feature of all Health Boards. How the 'savings' per month are profiled may skew forecasting, a concern raised with this Health Board by WG as has already been highlighted and discussed.

However, as budgets were rolled over and individual deficits accrued some specialties like Medicne and Surgery started the financial year already in an overspend position because of their inability to, within the first few months, save the projected amount per month and reduce the run rate below previous years. In many cases, a virtually impossible financial performance catch-up situation is generated. A quick fix (in most organisations) looks to staff costs to address budget deficit and although not openly stated, rationing through measures that will reduce costs, delayed waiting lists is one example. However, losing significant numbers of predominately nursing staff in circumstances where the CNO has stated more recruitment of nurses is required to meet safe staffing levels is not an option in terms of the high risk of compromising patient safety. Recognising, this position the WG has already released an additional £10 million to address the shortfall in nursing numbers, which was a welcome development.

b) During 2012-13 one of your Executive Directors undertook a Turnaround role for a short period of time. What did that role achieve, and why did it only last a few months?

Please refer to my statement. My preference was for external support, which was not backed and this was shared with WG. Accordingly, internal appointment was the only option and one of the Executive Directors took on the role. He identified areas where spend could be further contained, reduced or stopped (i.e. with reference to bank, overtime and agency staff expenditure) and this level of information continued to be provided. Undertaking two roles proved to be difficult and was not intended to be long term as decisions had been already been taken on turnaround support for the 3 CPGs that were challenged financially. The more efficient proposal was to effect changes to the Executive structure that would build in a more sustainable

'turnaround' approach (e.g. appointing a Chief Operating Officer supported by the three operational turnaround posts.)

Suggested question 10:

In August 2012, your Director of Finance, and two Independent Members felt it necessary to raise concerns about the Health Board's challenges directly with the Wales Audit Office. Why do you think that they felt it necessary to take such action?

Please refer to the statements of those concerned as to their motives and reasons. I can only say that they did not discuss their intentions with me, the Chairman or with the Board. They thought the meeting was confidential (i.e not to be disclosed to the organisation), which was a naive assumption, the Director of Finance then openly advising WG afterwards. This raised concerns with WG that such a meeting was taken outside the governance arrangements of the Health Board prompting a personal communication from WG on the same day (which is how I was first informed) about their serious concern regarding the actions of these individuals. I believe the word 'rogue individuals' was used and quite rightly I was asked to investigate this. When I asked each individual involved about why this meeting was held without the Board's knowledge and outside of governance arrangements, their answers were varied, mixed and inconsistent.

Suggested supplementary questions:

a) Was it the case that the internal relationships were such that those Board members did not feel the issues would be adequately addressed if they had just raised them internally?

The matters should have been raised internally with the Chairman, myself and with the Board. We would have initiated support ourselves from the WG if concerns could not be resolved. Sometimes individuals jump out of following process with good intent and not always appreciating the relevance of process when focused on achievement of a goal. Hindsight sometimes results in different interpretations of actions not perhaps consciously directed at the time.

What actions did you take when you learnt about these disclosures to the WAO – did you attempt to give assurances that you would create a climate whereby such concerns could be discussed openly, or did you try and reinforce strict adherence to governance protocols?

This question implies there was not a climate for open debate and challenge. There is no evidence to suggest this to be the case indeed minutes of various meetings and forums will indicate there was open challenge, debate and discussion at many levels going on at this time. As to the meeting itself after it took place, Executives were reminded that matters should be discussed internally to seek resolution with the Board as would be expected as part of standard governance arrangments. It is fair to say Executive Directors were alarmed with the disclosure to WAO in a situation of the intention for such a meeting not having been discussed with, Executives or indeed the Board or myself. However, perhaps this feeling would not have been experienced

had there not been a sense of shame generated by external concern about breach of standard governance arrangements.

b) How would you describe your relationship with your Director of Finance after she made those disclosures to the Wales Audit Office?
A professional one as would be expected.

Suggested question 11:

In 2012, two external reviews were undertaken in response to concerns about the Health Board's financial management, one by Chris Hurst and one by Allegra. How widely were the findings of each of these reviews shared within the Health Board, and in particular were they both discussed at the Board? If not, why not?

Please refer to Mr Lang's statement regarding Mr Hurst and his review. As I was not the Accountable Officer at the time I cannot answer about the scope of disclosure or discussion by the Board concerning this review report beyond the information already given.

The Allegra Report was shared with individuals involved in the Review, which included Board Members and actions were taken as a result of the Report. It was not widely shared within the Health Board but rather formed part of Board business. Please refer to Mrs Grace Lewis-Parry's evidence.

Strategic Vision and Service Reconfiguration

Suggested question 12:

The public consultation exercise undertaken last year explicitly excluded consultation on reconfiguration of the three acute hospital sites in North Wales. What work had been done to lead you to the conclusion that you did not need to develop proposals for acute services reconfiguration at that time?

Retention of 3 A&E Departments had already been agreed in October 2009. Otherwise elements unfinished from the Secondary Care Review of 2006 suggested changes related to Paediatrics, Neonatal, Emergency Surgery and Obstetrics & Gynaecology were necessary.

Medicine, which covers a range of services such as acute medicine, geriatrics, cardiology, internal medicine, is critical to the stability of other services and had not been part of any recent review. Given the interdependencies, the Acute Strategy was initiated. Please refer to the statement provided.

Suggested supplementary questions:

a) Shouldn't the challenges you had experienced with medical recruitment have led you to realise that sustaining a three site model, which complied with new doctor training requirements, was going to be hugely difficult?

Evidence was indicating that recruitment could be successful provided some services

were moved to a consultant delivered model rather than continued reliance being placed on Trust Grade staff or middle grades. The delivery model relying on non-consultant grades is a legacy issue and required address given the risks posed especially with changes to immigration rules. Furthermore the main issue related to on-call not 'normal' in-hours service. Services can operate at sites that are not designated as training sites, provided rotas are staffed differently. Chiefs of Staff, and their clincial directors, had worked through a number of options that would retain core services at all three hospitals each involving investment as the key service delivery issue was about achieving standards not cutting services.

Evidence shows that reconfiguration of services may not save significant amounts of money, but may incur costs. Again, this is a hugely complex area where some schools of thought consider greater efficiency is achievable though increased reliance on more senior level staff whilst others focus on lean pathways. The main issue, I believe, is of ensuring balance to maintain through all best quality services at best realistically achievable price- the Triple Aim (population health gain; improved safety & quality and best use of resource to contain or reduce cost).

Would you agree that the proposal taken to the Board in April 2013 for the recruitment of an additional 72 clinicians by August was in effect “crisis management” that might have been avoided if earlier progress had been made with the acute services strategy? And what involvement did you have in the development of the proposal?

Please refer to my statement as this has been explained. The proposal was not an indication of crisis management rather of a moving target that relied on continued dialogue and decisions with the Deanery, which the Interim Medical Director had led with formidable resolve. Back in November 2012, I supported this work when brought to me as a Board Assurance Framework risk for 2013 knowing that it would later converge with the Acute Strategy work, the former short term, and the latter longer term.

The proposal was developed by senior clinicians and the Medical Director. I received draft documents as did Executive Directors who discussed these at regular meetings including a special meeting to reach consensus on the recommended options and cost envelope.

b) The interim Medical Director told us last week that 30 middle grade doctors have been recruited. Where has the money come from to fund those posts?

The money was provided from within a contingency allocation for clincial services this financial year

c) North Wales isn’t immune from the challenges associated with providing clinically and financially sustainable services, yet it is the only part of Wales not to have consulted on future options for acute services – how would you justify that?

That is incorrect. Consultation had taken place on paediatrics, neonatal, emergency surgery, obstetrics, gynaecology and vascular services in 2012. 3 A&E Departments were agreed by the Board in October 2009. The retention of core services at 3 DGHs was agreed in January 2013. Cancer, clinical haematology and pathology were subject

to internal consultation and agreement with the CHC. These all form part of acute services.Please refer to my statement.

d) Were decisions on the future shape of acute services simply put off because of the difficult challenges you anticipated from some clinicians, the public and local politicians?
No not at all.

Suggested question 13:

What process is being used to develop the acute services strategy, who is leading it, and how are you going to get support from the clinician body within the Health Board?

A project structure is in place, the Medical Director is the Executive lead and Dr David Counsell, Chief of Staff Anaesthetics & Critical Care, is the clinical lead. There is a stakeholder reference group which includes the CHC. Evidence seen shows that the strategy is being supported by the clinical body. I would refer you to the Interim Medical Director for his confirmation of this.

Suggested supplementary question:

a) Does the Health Board have sufficient capacity and capability to come up with the transformational plans that are needed to create safe and sustainable services?

No, there has been a lack of sufficient management capacity, one example being within the planning team, which works with Chiefs of Staff and Clinical Directors. This is being addressed.

The Health Board reduced its management costs by 20% and the impact of this has been exposed. I believe overall management costs are below 4%, which compared to other public and private sector organisations is low. Irrespective of what public or even political views of management are, organisations of this size, magnitude and responsibility need sufficient and experienced managers both clinical and professional to successfully drive the business of health care as articulated by the Kings Fund two years ago. It is fashionable presently to suggest that reducing the number and cost of managers within the NHS will be a cure for all ills and this seems to rule out of play need for leadership and steerage within an organisation. An ability to spend on patient safety when at risk of breaking rules still would seem a situation best managed corporately and collectively by a senior management team in possession of the transformational travel plan and intent on creating safe and sustainable and accessible services for all.