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

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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.