Archwilydd Cyffredinol Cymru
Auditor General for Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Structured Assessment 2015

Betsi Cadwaladr University Health Board

Audit year: 2015

Issued: December 2015

Document reference: 687A2015

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The team who delivered the work comprised Matthew Edwards, James Foster, Alan Hughes, Ian Hughes, Charlotte Owen, David Thomas, Mandy Townsend and Mike Usher.

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The Health Board remains in a precarious financial position, and needs to quickly implement a number of actions to strengthen its governance arrangements. Leadership capacity, capability and resilience are key risks and the absence of a clinical strategy and Integrated Medium-Term Plan (IMTP) continue to hinder the Health Board's ability to deliver necessary changes quickly.

Summary

Context

1. Betsi Cadwaladr University Health Board (the Health Board) is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services for a population of around 678,000 people across North Wales and a significant number of visitors and tourists to the area. The Health Board has a budget of around £1.3 billion, employs around 16,700 staff, and has three district general hospitals. It also provides care at 18 other acute and community hospitals and a network of over 90 health centres, clinics, community health team bases and mental health units. North Wales has 114 GP practices, 97 dentists, 74 opticians and 155 pharmacies providing NHS services.

2. In recent years the Health Board has faced a number of specific and well publicised challenges relating to its governance arrangements and aspects of patient care. In June 2015 the Minister for Health and Social Services placed the Health Board into special measures as a result of specific and ongoing concerns about the Health Board's:

- governance;
- mental health services;
- obstetric services;
- GP out-of-hours services; and
- ability to connect and engage with staff, stakeholders and the public.

3. Following the imposition of special measures in June 2015, the then Chief Executive was suspended and the Deputy Chief Executive of NHS Wales took over as interim Chief Executive. As a key initial response to special measures the interim Chief Executive and his leadership team introduced 100-day plans as a mechanism of focusing attention on each of the areas of concern identified by the Minister.

4. In November 2015, the deputy Minister for Health Minister for Health and Social Services announced that the Health Board would remain in special measures for two years, with regular milestone monitoring against an improvement plan. Specific additional support in a number of areas was also identified. It was recently confirmed that the previous Chief Executive will not be returning to his post, and at the time of preparing this report, arrangements to identify his substantive successor were well advanced.

5. Work by ourselves and Healthcare Inspectorate Wales (HIW) informed the decision to keep the Health Board in special measures for two further years. The findings from that work were reported in October 2015[1]. The joint work with HIW has informed, and has been informed by our structured assessment work in 2015. The findings presented in this report draw on that joint work but also set our findings against a broader range of audit inquiries.

[1] Betsi Cadwaladr University Health Board: Letter to Interim Chief Executive

6. As in previous years, our structured assessment work in 2015 has examined the adequacy of Health Board's governance arrangements, the robustness of its financial management arrangements, and the management of key enablers that support effective use of resources. In examining these areas, we have considered the progress made against improvement issues identified last year[2]. The audit work was structured under the following areas:

- **Arrangements for governing the business**, including, strategy, structure, governance arrangements and internal control.
- **Financial planning and management**, including financial health, financial planning and cost improvement.
- **Enablers of effective use of resources**; including, change management, workforce, assets, engagement and technologies.

Main conclusions

7. The Health Board has made some progress, and has started to increase the pace of improvement following the imposition of special measures. However, the overall conclusion from our 2015 structured assessment work echoes that reported in the joint review; which is that despite a positive response to special measures, the Health Board still has a number of fundamental challenges to address. It remains in a precarious financial position, and needs to quickly implement a number of actions to strengthen its governance arrangements. Leadership capacity, capability and resilience are key risks and the absence of a clinical strategy and IMTP continue to hinder the Health Board's ability to deliver necessary changes quickly.

8. The reasons for reaching this conclusion are set out below.

Arrangements for governing the business

9. A lot of work is underway to improve governance, but some fundamental challenges remain and require quick resolution.

10. In reaching this conclusion, we found:

- in the absence of an agreed clinical services strategy, and despite some progress, it remains highly unlikely that the Health Board will be in a position to publish an IMTP in 2016;
- the Health Board remains part way through the implementation of a revised organisational structure with challenges around operational capacity and the ability to grip performance and finances in the interim structures;
- despite progress across a number of areas, most notably management information, the Board is still struggling with some fundamental aspects of effectiveness;

[2] Recommendations made in 2014 together with a summary of progress are set out in Appendix 1.

- there is still work to do to implement and embed sound governance structures and risk management arrangements, most notably in relation to the design and implementation of a Board Assurance Framework, revisiting the structure of the Board's subcommittees and ensuring that those subcommittees are operating effectively;
- internal controls are generally effective in meeting current assurance requirements, with visible improvement in clinical audit, but despite the presence of internal controls they are not always applied consistently;
- operational information governance continues to steadily improve across most areas, but a lack of clarity in Board assurance and reporting lines must be resolved quickly; and
- new, more rigorous performance management arrangements have started to take effect in 2015, but capacity remains a key barrier to sustainable improvement, and performance on key indicators remains variable.

Financial planning and management

11. The absence of clinical, service and workforce plans make it very challenging for the Health Board to deliver sound and sustainable financial management, and the scale of the financial challenge raises significant risks over the financial viability of services.

12. Specifically we found:

- the Health Board's management arrangements were insufficient as it failed to operate with within its 2014-15 revenue resource allocation, reporting a £26 million deficit; and
- the Health Board is yet to establish a sound and sustainable delivery of financial targets in 2015-16 and is at significant risk of not achieving financial balance for the financial year projecting a deficit of £30 million, increasing to a potential £89 million in 2016-17, dependent upon increased resource uplift.

Enablers of effective use of resources

13. Leadership capacity, capability and resilience are key risks and continue to hinder the Health Board's ability to deliver necessary changes quickly.

14. In reaching this conclusion, we found:

- Change management expertise is fragmented across different functions, and there is insufficient internal expertise and capacity to support operational and clinical leaders.
- Progress has been made on nurse and midwifery recruitment and understanding current medical workforce needs, but resolving the long-term workforce challenges in the absence of a clear clinical strategy, and improved management of all staff groups will remain very challenging.

- The Health Board has had governance concerns with some capital projects, and is now in a better position to pursue some longstanding estate development needs alongside its wider strategy development.
- The Health Board is in the process of rebuilding public and stakeholder confidence.
- In comparison with other health boards in Wales, the current level of investment in ICT at the Health Board is the lowest in Wales. Nevertheless, the Informatics team continues to deliver operationally and have well-developed plans.

15. The findings underpinning these conclusions are considered in more detail in the next section of this report, which sets outs the areas where the Health Board is able to demonstrate strengths or tangible developments, as well as the areas which present risks and challenges.

Recommendations

16. Recommendations arising from 2015 structured assessment work are set out below. The Welsh Government's Improvement Plan for the Health Board, published 29 January 2016, contains a number of actions in respect of key issues covered by our structured assessment work, such as strategic direction, planning and wider governance arrangements, we have not sought to duplicate these actions here. The entire Board engaged with us in developing these recommendations at a workshop session on 22 January 2016.

Governing the Business

R1 The Health Board's existing 31-page 'Action Plan' of outstanding recommendations from previous internal and external reviews should be cleansed of:

(i) repeated recommendations;

(ii) completed recommendations; and

(iii) recommendations that are no longer relevant due to changed circumstances.

R2 The remaining recommendations within the 'cleansed' Action Plan should be brigaded against the milestones within the core themes set out in the Welsh Government's BCU Improvement Plan, as a key part of the 'Implementation Plan' that the Board is now required to produce.

R4 The Health Board should progress at pace its development of integrated clinical services, working in genuine partnership with its staff and with external stakeholders.. This work should focus on:

- Both one-year planning and IMTP development; (linking with the Health Board's obligations under the Well-being of Future Generations Act 2015); and
- Financial sustainability
-

R5 The Health Board should strengthen its focus on Informatics to underpin its planning capability, to support better decision-making and to ensure that its informatics service is well placed to support new national IT systems as they become available.

R6 The Health Board should move away from over-reliance on external consultants by creating/identifying dedicated in-house capacity and capability to support:

- change management; and
- service transformation.

Detailed findings

Arrangements for governing the business

A lot of work is underway to improve governance, but some fundamental challenges remain and require quick resolution

17. In reaching this conclusion, we found:

- In the absence of an agreed clinical services strategy, and despite some progress, it remains highly unlikely that the Health Board will be in a position to publish an IMTP in 2016.
- The Health Board remains part way through the implementation of a revised organisational structure with challenges around operational capacity and the ability to grip performance and finances in the interim structures.
- There is still work to do to implement and embed sound governance structures and risk management arrangements. Most notably, this relates to the design and implementation of an agreed Board Assurance Framework, revisiting the structure of the Board's subcommittees and ensuring that those subcommittees are operating effectively, to ensure all risks are captured and managed effectively.
- Internal controls are generally effective in meeting current assurance requirements, with visible improvement in clinical audit, but despite the presence of internal controls they are not always applied consistently.
- Operational Information Governance continues to steadily improve across most areas, but a lack of clarity in Board assurance and reporting lines must be resolved quickly.
- The recent introduction of more rigorous performance management arrangements is to be welcomed has not yet translated into substantial improvement across key performance measures.

18. The findings underpinning these conclusions are summarised in the following sections and tables.

Strategic planning

In the absence of an agreed clinical services strategy, and despite some progress, it remains highly unlikely that the Health Board will be in a position to publish an IMTP in 2016

19. The need to identify clinically and financially sustainable plans for the future shape of health services in North Wales has been a feature of our structured assessment and joint review reports for several years, and the Health Board still does not have a clinical services strategy.

20. The Health Board did not produce an agreed three-year IMTP for 2015 in the required timeframe. Whilst the Health Board did produce a draft IMTP, this was not submitted to Welsh Government following initial discussions, as it did not meet all aspects of the requirements for an IMTP. The absence of a clear and approved overarching medium-term plan is significantly compromising the Health Board's ability to deliver the service improvement and modernisation which is necessary. It is a concern that the Health Board is still in this position.

21. Our joint work with HIW in September, acknowledged the work that was undertaken to develop the Health Board's vision and strategic goals. Whilst these are important steps to take, the Health Board was still far from being able to produce an IMTP for 2016-17 to 2018-19, as required by the Welsh Government's NHS Planning Framework. Clear and detailed strategies and plans were still needed across the various sectors that underpin the IMTP and for the public engagement that will be necessary to accompany it. We concluded that there will need to be an honest appraisal of whether or not the Health Board currently has the necessary skills and capabilities to take forward this work, and any gaps identified will needed to be addressed as a matter of urgency.

22. Our work on strategic planning as part of the structured assessment found signs of progress, which should provide important foundations for the development of the 2016-2019 IMTP. However, the scale of the engagement challenge is significant, meaning there is a high risk that the Health Board will not be able to make sufficient progress to achieve a signed-off plan in line with WG timescales. Nevertheless, it is important that the Health Board produce a public plan for 2016-2019, even if this does not fully articulate all of the requirements for a formal IMTP.

23. The importance of getting the strategic planning work right, taking stakeholders and the public with the Health Board, and not rushing, cannot be overstated. Articulating and agreeing the necessary transformation will take time, and continuous engagement.

24. Some elements of the planning framework are further progressed than others with the most significant challenge being the absence of an agreed Clinical Strategy. There is an acceptance that this will not be in place for the 2016-2019 plan, although the new plan will set out the approach and timeline to develop this strategy. The Health Board is more confident regarding its ability to develop clear plans for health inequalities, primary and community care services, and mental health services.

25. All of this is outlined in the Health Board's high-level planning timetable, which covers the extensive engagement activity as well as the development and sign-off of the plan. However, the scale of the tasks is significant, with little scope for slippage. The capacity of the central planning team is small, with a heavy reliance on the new secondary care and area teams to develop priorities and operational delivery plans. The implementation of new organisational structures will improve the ability of these teams to take this work forward, pending decisions on the affordability of the new structure and clarity over some lines of accountability.

26. The key developments and ongoing risks and challenges in relation to strategic planning are summarised in Table 1.

Table 1: strategic planning

Vision and goals
Strengths and developments • The Health Board recognises the gaps in its previous approach, and has taken some steps towards addressing them, in particular by clearly and consistently stating its purpose – to improve health and provide excellent care. The Board agreed a vision in early 2015, which it included in its draft IMTP 2015-2018, and formally agreed at public Board in October 2015. The Board agreed seven strategic goals in 2015. This is in itself a major step forward, allowing the planning team to start work to align plans with these new goals. This will in turn support the development of detailed plans to deliver the goals. There is a plan to consult on the vision and goals in the near future. • An approach to develop an approvable IMTP, based on successful planning approaches from other parts of Wales, is now in place, with a challenging plan to achieve the IMTP for 2016-2019. The development of a number of fundamental underpinning strategies and plans is now well advanced. In particular: – The Health Board has agreed an ambitious Quality Improvement Strategy setting out its vision for the quality of services in North Wales. But delivering this ambitious strategy will require coordinated effort across the whole Health Board, and until the new structure is in place, and other strategies and plans formally agreed this will remain a challenge. – The Health Board has a good understanding of its population's health needs, and a strong public health team to help it understand what this means for future services. – The Health Board is in the process of developing a Primary and Community Services Strategy, and a Mental Health Strategy. – The Health Board is starting to understand the funding needed to implement planned changes over three years and prioritise investment. • Through the Strategy, Partnerships and Planning subcommittee, the Health Board is starting to explore and understand the impact that the new North Wales prison, the Mid Wales Healthcare collaborative, and Local Service Boards may have on its services and strategies in the future.

Vision and goals

Strengths and developments

- The Primary and Community Services Strategy builds on work already consulted upon in Healthcare in North Wales is Changing, and work with Dr Chris Jones (special measures advisor), and the draft District Nursing strategy. In October, the new area directors and partners were involved in planning workshops to help take this forward, but gaining buy-in from the wide range of stakeholders, including independent primary care practitioners may take some time. In November, the Health Board appointed three Area Medical Directors.

Risks and challenges

- The Health Board has not delivered an IMTP in either of two previous years. The Board agreed a one-year delivery plan for 2015-2016 and Welsh Government is using this plan to track progress in-year. Achieving an agreed IMTP against this background is a highly challenging expectation.
- The strategic goals will need to be underpinned by a detailed vision and delivery plans. These will take time to develop, and will require effective engagement with both internal and external stakeholders. Through this approach the Health Board needs to determine:
  - What its Clinical Services Strategy will be.
  - Clarity about the role of acute hospitals, ie what does one hospital on three sites mean in practical terms?
  - How the new commissioning arrangements will work. Will they be extended to internal commissioning?
- Although the Board has agreed its vision and goals, they have not yet been widely agreed with stakeholders and partners. Consultation within the Health Board has commenced, through the Stakeholder Reference Group, Healthcare Professional Forum and Local Partnership Forum and this will be further developed over the winter period. Furthermore, some aspects of the vision need underpinning by a clinical strategy. The successful handling of this engagement phase is critical to the development of robust plans.
- The timetable is very challenging, as the Board will need to sign-off the draft IMTP in January 2016, or agree to submit an approvable one-year plan before 31 March 2016.
- The Mental Health Services' strategy development is supported by an Interim Director of Primary, Community and Mental Health Strategy, and Peter Meredith-Smith (special measures advisor), but this is from a very low baseline. Considerable work is required to gain a shared vision with stakeholders, partners and service users of what the future model should be, alongside the development of this strategy. Some engagement work with service users, carers and staff has been undertaken and the feedback from this work will help shape the plan in its next phase of development. The strategy then needs translating into detailed implementation plans. This will take some time.
- There remain significant challenges around capital requirements to deliver modern sustainable health services. Finances are likely to affect both the rate of investment in and progression of strategic change programmes and how much funding is available for the IMTP.

Planning capacity

Strengths and developments

- Planning capacity was limited at the beginning of 2015. The Executive Director of Strategy, Director of Secondary Care, the three Area Directors, and Assistant Directors of Finance all bring capability and expertise to the distributed planning model. The central planning team remains small with four Assistant Directors for Capital, Corporate Planning, Strategic and Business Analysis, and Health Strategy, supported by a small team. The additional capacity in the operational management structure, in the form of area and secondary care directors should enable the vision of planning as enabling function for operational management to be finally put in place.
- The corporate planning team have adopted a successful framework, based on a similar distributed planning/partnership model, for use locally. This means that limited central capacity is in theory boosted by dispersed general management capacity in directorates/areas and acute units. This top-down, bottom-up approach has the potential to be successful if correctly implemented.
- The development of a commissioning model, and additional capacity and capability within the finance team to support this model brings extra planning capacity.

Risks and challenges

- despite the additional senior capacity enhancements referred to above, a risk is that directorate, area and acute teams will not have the capacity and the capability at middle-manager level to support the required planning activities in a timely fashion; and
- furthermore, until the organisational structures are in place below director level, directors will continue to be pulled away from strategic developments to deal with day-to-day operational issues.

Organisational structure

The Health Board remains part way through the implementation of a revised organisational structure with challenges around operational capacity and the ability to grip performance and finances in the interim structures

27. Ourselves, and others, had previously identified a number of concerns about the Health Board's original Clinical Programme Group based organisational structure. During 2014 the previous Chief Executive consulted upon plans to implement a significantly revised organisational structure aimed at strengthening the management arrangements in respect of the three acute hospital sites. Work began to implement the new organisational structure in May 2015.

28. However, following the imposition of special measures and the suspension of the previous Chief Executive, the executive team identified a number of concerns around the cost benefits of the new structure and some lines of accountability within it. They instituted a 'pause' whilst further work took place to provide answers and assurances to the concerns raised.

29. At the time of our joint work with HIW in September, we recognised the importance of addressing the issues that had been raised but also highlighted our concern that the Health Board found itself in the invidious position of having to examine fundamental aspects of the new structure, at a time when it needed to be bedding in the new structure and empowering all of those holding new roles within it to secure the necessary pace of change.

30. At the time of drafting this report, recruitment is now underway to posts in the new structure. This means that the Health Board remains part way through a change programme. In the interim, many senior and middle managers are working in temporary roles, with all of the reductions in authority and autonomy that such roles bring. This uncertainty influences the organisation's ability to grip its performance and financial challenges and needs to be resolved quickly.

31. The most obvious gap in the organisation's management structure is the absence of a substantial and permanent Chief Executive following the imposition of special measures in June 2015. The fundamental importance of appointing an individual with the right skill sets and experience is fully recognised by both the Board and Welsh Government. At the time of drafting this report, recruitment plans to identify a new Chief Executive were well advanced.

32. The key developments and ongoing risks and challenges in respect of organisational structures are summarised in Table 2.

Table 2: organisational structure

Organisational Structure
Strengths and developments • the organisation consulted on (2014) and started to implement a new organisational structure in 2015; • appointments both at executive and director level are widely recognised as bringing much needed extra capacity and capability to the Health Board; • the split into an secondary care team, with three senior hospital site teams, and three geographic area teams provides welcome clarity on both accountability and decision making both within the organisation and for external stakeholders; and • the pause instigated by the Interim Chief Executive was an understandable decision pending resolution of a number of queries around lines of accountability and whether costs were adequately budgeted for.

Organisational Structure

Risks and challenges

- The Health Board does not have a permanent Chief Executive.
- Gaps in capacity and capability of middle and lower levels of the management structure are becoming more obvious.
- There remain a number of outstanding queries about the new structure, and these must be resolved rapidly:
  - Cost: the new structure proposes to increase management capacity in a number of key areas, however, more work is needed to clearly demonstrate the benefit associated with the additional cost.
  - Executive responsibilities: the draft structure puts executive accountability for all delivery, including acute, primary and community care, mental health services, and also performance reporting and improvement, under the Chief Operating Officer (COO). Whilst this is not uncommon in Wales, this means that the COO is Executive Director for the majority of the business of the Health Board raising questions about the breadth of the role, and whether there is sufficient separation of executive responsibility for delivery and performance reporting. Other health boards manage some of this tension by splitting performance reporting from operational delivery. Moreover, given the key challenges this Health Board faces in respect of primary and community care, and mental health services, there needs to be assurance the executive focus and 'voice' for these services at the Board is not diminished. Our work in 2016 will keep these potential challenges under review.
  - Support services: key clinical services, such as diagnostics, do not have clearly identified accountability lines in the new organisational structure, and this will need to be resolved. Other enabling functions, such as information technology, service improvement, planning, finance, workforce and governance need to be embedded consistently within the new structures. If not, their ability to influence and support change will continue to vary and may hinder the rapid progress necessary across all of these areas. Until these queries are worked through in the new structure, it remains unclear whether the organisation has sufficient management capacity and capability at these critical senior middle management levels.
- The prolonged pause caused uncertainty, and affected the ability of new directors and teams to plan for the future, and enact their plans quickly. It is also affected the capacity of new area teams, meaning that some of their key new engagement functions are not yet operational.
- There is a high level of pressure on key executives due to the need to tackle multiple challenges at the same time. Such prolonged periods of uncertainty place stress on staff, and increased organisational turmoil can provoke key staff, with desirable transferable skills, to seek opportunities elsewhere.

Board effectiveness and management information

Despite progress across a number of areas, most notably management information, the Board is still struggling with some fundamental aspects of effectiveness

33. The additional support that has been provided from Ann Lloyd has demonstrated that the Health Board still needed help with some fundamental aspects of governance, particularly in respect of Board effectiveness.

34. Whilst securing the right person to fill the Chief Executive role is vital, that post holder will only succeed if they are part of a cohesive Board and executive management team that has the right skill sets and capacity. Our joint work with HIW in September indicated that this remains a highly problematic area for the Health Board. Despite the various Board development activities undertaken in recent years, it was clear from our interviews and observations that more work in this area is needed. The work that Ann Lloyd was leading on, identifying Board member skill sets, will be vital in this regard. This must be a necessarily honest appraisal and used to get to the root of issues that continue to affect Board cohesiveness and effective decision making.

35. The 100-day plan was completed over the summer, and further Board development took place in the autumn of 2015. It is too early to judge the effectiveness of all of this very recent work on Board effectiveness, and we will continue to keep this under review in 2016.

36. As part of our additional structured assessment work, we examined the management information received by the Board in more detail, and in particular information contained in the integrated performance report. Positively, we observed improvement in both coverage of key performance areas, and in presentation and clarity of integrated reporting compared to previous years. Moreover, the style, format and content of integrated performance reporting at the Health Board has substantially improved, and now compares favourably with the rest of Wales.

37. Nevertheless, there remains scope to improve both coverage of key service areas, and some other aspects of integrated reporting. Specific challenges exist in relation to coverage of performance forecasting, and ensuring that the Board receives sufficient information on the performance of important service areas, such as primary care and mental health services, where it is holding specific risks, and where previous deficiencies in performance reporting are likely to have contributed to the Board being unsighted of deteriorating performance.

38. The findings underpinning our structured assessment conclusion are summarised in Table 3.

Table 3: Board effectiveness and management information

Board effectiveness
Strengths and developments • An ongoing programme of Board development work has taken place, which has included work on Board etiquette. • Ann Lloyd plans further work on Board etiquette and behaviours to ensure that the tension, which must necessarily exist between Independent Members and the executive, is healthy and provokes, rather than represses, the necessary discussions and debates. • New Independent Members have brought additional capability and different experience to the Board. • The Committee Advisor role brought additional capacity and experience to committees. The current review of these roles will report shortly, and includes a substantive review of the effectiveness of these roles. • Many aspects of Board administration have been addressed, but are not yet all working effectively. These include agenda management, enforcement of paper deadlines and a revised process to provide quality assurance of Board papers. These standards must be rigorously enforced by all directors and Independent Members.
Risks and challenges • Despite some signs of progress in recent months, our observations throughout 2015, and the Board's own review showed there are still some fundamental issues outstanding: – successful interaction between Board Members requires further development to achieve common goals and harness effective discussion, debate and decision making; – focus on scrutiny rather than collective responsibility of the Board in making decisions – there is a balance to be struck; – evidence of 'camps' within the Board; and – visible impatience between Board members. • The lack of a permanent Chief Executive impacts on the Board's ability to drive and lead organisational change at the necessary pace. • There is also potential for senior managers, other than executive directors, to have more exposure to Independent Members and Board-level discussions. This may help alleviate some of the pressures on the executive team, and raise Independent Members' awareness of the skill sets that exist amongst the wider senior management team.

Management information

Strengths and developments

- The new Integrated Quality and Performance report is still developing, but now provides good coverage of most areas of the business, with a mixture of national and local indicators. Within the detailed report, there is appropriate benchmarking in many areas, not just within Wales but also more widely across the UK. A detailed finance report supplements a high-level summary of financial performance in the Integrated Quality and Performance report, and the Board considers both reports in the same part of the meeting.
- There have noticeable improvements in the quality, legibility and accuracy of the integrated reports. We compared the content of the Health Board's report with other performance reports from other NHS bodies across Wales. Our comparison highlighted a number of positive developments:
  - The Health Board uses monthly reports with more detail in quarterly supplementary reports that include some programme performance on efficiency programmes.
  - Some benchmarking of performance with Wales and English NHS Trusts (via CHKS).
  - Clearly structured performance report is easy to navigate and links to Health Board objectives. Scorecards convey overall performance. Most indicators include targets. Local targets mostly evident.
  - Wide use of colour coding to communicate performance. For all indicators in the suite there is colour coding using the Welsh Government's status scale.
  - Performance report has a good summary of performance including reference to objectives (same as national domains).
  - Finance report uses charts, RAG ratings, forecasts year-end position and includes budget, cash and balance sheet positions.
  - Use of exception reporting helps to minimise the volume of reporting. These use graphics to convey current and trend performance. Exception reports identify corrective action, and sometimes state who is responsible.
- The Integrated Quality and Performance report reflects national targets and some locally agreed areas of focus.
- The introduction of revised Board Paper guidance has helped to improve the quality of Board and Committee reports in some areas.
- The monthly Infection Control report is excellent in terms of its clarity, structure and content.

Management information

Risks and challenges

- Whilst the Integrated Quality and Performance report has good coverage of acute, quality and access indicators, it requires further development of primary, community, mental health, commissioned service indicators, and better alignment with objectives. The Health Board plans to improve reports iteratively, but faster progress especially on primary care and mental health would help the Board track progress in these vital service areas. In addition, more insight is required on how actions will affect across the Health Board, and more forecasting of future performance would help the Board understand the likely impacts of its decisions.
- Performance trajectories indicate planned performance, but key planning milestones are not included in the Integrated Quality and Performance or the Finance report. As the Board approves a plan, either one year or an IMTP, then milestones should be reported as part of these reports.
- Other Board and Committee papers and reports still vary in quality and presentation. It is clear that quality assurance arrangements, particularly at subcommittee level are not working effectively. Summaries should be included in reports, rather than within the cover Board paper to improve integration. Where this happens the papers are more concise, have better focus, and Board or Committee is able to make faster decisions that are more informed, without being side tracked into the detail.

Governance structures and risk management

There is still work to do to implement and embed sound governance structures and risk management arrangements, most notably in relation to the design and implementation of a Board Assurance Framework, revisiting the structure of the Board's subcommittees and ensuring that those subcommittees are operating effectively

39. The Health Board has had a substantial amount of external advice and support in revising its governance structures and risk management arrangements.

40. In September, we identified that work was also underway in other areas relating to Board governance, including a redevelopment of the Board Assurance Framework and the corporate risk register. Given the fundamental importance of these aspects of Board governance, progress to embed these redevelopments needs to be swift. The work on the Board Assurance Framework needs to reflect changes arising from the evaluation of the Board's Committee structure implemented in January 2015, given that our joint review work indicated that the revised structure is not yet working effectively.

41. Our structured assessment work involved ongoing observations at Committee meetings and we are aware that work has been progressed within the Health Board to draw up a draft Board Assurance Framework. The Board approved a revised Risk Management Strategy in July 2015 and work is continuing to map risk throughout the governance structures. Much of the redevelopment is work-in-progress at the time of drafting, and it would be premature to offer formal audit commentary at this stage. We have, however, aimed to acknowledge these developments in the Table 4.

Table 4: governance structures and risk management

Governance structures and risk management
Strengths and developments • New Board Committee and subcommittee structure was implemented in January 2015, with a planned six-month review of the new supporting structure's effectiveness, demonstrating a positive increase in self-awareness. This review suggested amendments to the Committee structure to improve effectiveness. • This wider review of the Committee structure also examined whether there was sufficient prominence to workforce and information governance issues, given that these do not feature as specific committees or subcommittees within the 2015 structure. The lack of a single committee overseeing these issues, and Health and Safety, within the 2015 subcommittee structure means these remain live issues, and need to be resolved quickly. • Revisions have already been made which addressed the scheduling issues, which previously made it more difficult for the Integrated Governance Committee (IGC) to triangulate across subcommittees and draw together finance, performance, quality and planning, and provide an integrated overview to Board. • The 100-day governance plan brought new focus and energy to the governance action plan, ensuring that many of outstanding governance actions were completed. • A new Board Assurance Framework is under development, and the Board has drawn on both internal and external expertise in its preparation. The Board has helpfully shared Board Assurance Framework drafts with both internal and external audit for comment. • The Board held development sessions on its risk appetite, and is in the process of describing it publically as part of the Board Assurance Framework. • Recognising that its risk management arrangements needed improving, the Board approved a revised Risk Management strategy and Framework. A number of levels – Board, Executive, and Operational – will monitor the new single risk repository. The intention being that duplicate review will be eliminated, and that risks will be monitored by those best placed to mitigate or resolve them. • From October 2015, the Quality, Safety and Experience (QSE) subcommittee agenda revised its agenda and the structure of meeting. This revised format provides more focus on key risks and issues, and the agenda is shorter. There are still a lot of papers for 'noting', but the key risks for the Committee to track going forward are very clear with the exception of sustainability of acute services, and primary and community care. These risks are: – infection prevention and control; – nursing homes/continuing health care; – maternity services; – patient experience; – informatics; and – mental health.

Governance structures and risk management

Risks and challenges

- At the time of drafting, the operation of the IGC needs attention. The model relies on the IGC receiving assurances from subcommittees, therefore, subcommittees and IGC must meet on the correct schedule. Furthermore, the chair of the IGC should be independent from those subcommittees to avoid the risk that they are holding themselves to account.
- The QSE subcommittee has a larger agenda than its predecessor committee. We outlined some concerns about its operation in our joint review; however, the issues outlined could be resolved largely by better quality assurance of the papers it receives, and ensuring that areas of potential duplication are received by another subcommittee, such as information or workforce issues.
- Whilst it is positive that work has been undertaken to devise a Board Assurance Framework, it is important that this is now finalised and operationalised as a matter of urgency.
- The current intention to hold all risks within a single repository (DATIX) is positive. Nevertheless, the operation of this new system, will need careful monitoring to ensure that all risks are appropriately scrutinised and managed. The failure to ensure risks are appropriately escalated/de-escalated is a real and active risk, as it has happened in the past in this Health Board with C.difficile in 2013, and GP out-of-hours in 2015.

Internal controls

Internal controls are generally effective in meeting current assurance requirements, with visible improvement in clinical audit, but despite the presence of internal controls they are not always applied consistently

42. The Health Board has internal controls, and these are in the main effective, with positive areas of strength, including Internal Audit, Counter Fraud and policies and procedures based on evidence.

43. Standing Financial Instructions (SFIs) and Standing Orders (SOs) are in place, but our follow-up of procurement issues (reported separately) demonstrates that the presence of internal controls does not always guarantee that Health Board staff will follow due processes. Internal Audit reviews of operational governance compliance also raise concerns that SFIs and SOs are not always fully adhered to by management. This issue does raise wider potential concerns, and as part of the implementation of the new organisational structures, the Health Board will need to assure itself that all staff in post apply internal controls as required by its SFIs and SOs.

44. The findings underpinning our structured assessment conclusion are summarised in Table 5.

Table 5: internal controls

Internal controls
Strengths and developments • The alignment and reporting of clinical audit have improved in 2015, with reporting particularly improved over the summer. There is evidence of clinical audit being driven by key clinical risks, and repeat audit of areas such as the deteriorating patient. There is a Health Board-wide clinical audit plan. • Internal Audit continues to be a strength, meeting the standards set out in its Charter, and providing valuable ad hoc advice and support to management alongside its more formal reporting role. • The Annual Governance Statement process improved this year, and was prepared on time. The final version meets the standard requirements, and both internal and external audit were able to provide comment on the draft. We expect to, and appreciate the opportunity to comment, and the extent of comments provided was much reduced on previous years. • The Annual Quality Statement continues to evolve and improve. A clear and structured process supports its development. • Counter fraud remains an active and strong function, with a balance of proactive and reactive work. The 2015 inspection by NHS Protect found only minor issues, which the department quickly addressed. • Post payment verification extended to dental contractors, as a pilot for the whole of Wales. This is a positive development, which builds upon the work already in place for general medical services and ophthalmic contractors. • SFIs and SOs in place and appropriately updated. • The Health Board has recently introduced a new mechanism to track more robustly the implementation of audit recommendations.
Risks and challenges • Whilst there is now a formal Clinical Audit strategy, it is not linked to the Quality Improvement Strategy, or the Quality Improvement Faculty. Clinical audit could benefit from the rigour applied to the development of the Quality Improvement Strategy, particularly as clinical audit activity is a key component of quality improvement in healthcare settings. • The operation of the new recommendation tracking mechanism will be kept under review, to ensure it operates as intended as an additional check and balance in the system. Its effectiveness will be tested by our 2016 and 2017 follow-up work.

Information governance

Operational Information Governance continues to steadily improve across most areas, but a lack of clarity in Board assurance and reporting lines must be resolved quickly

45. At an operational level the Health Board has clear information governance arrangements, with appropriate accountabilities and reporting lines. However, the Board Committee restructuring removed the Information Governance Committee. Information Governance and informatics more widely is now split across three subcommittees of the IGC. This means that most,
but not all, information governance issues now sit with the QSE subcommittee, with its acknowledged workload challenges. The lack of clarity about where information governance and informatics papers, reports and scrutiny now sit may be resolved with experience as the new Committee structure becomes more established. We will keep this under review in 2016.

46. The findings underpinning our structured assessment conclusion are summarised in Table 6.

Table 6: information governance

Information governance
Strengths and developments • The Health Board has clear and appropriate leadership for information governance: – The Director of Corporate Services has delegated responsibility for ensuring that the Health Board corporately meets its legal responsibilities, and for the adoption of internal and external governance. This director is also the Health Board's nominated Senior Information Risk Owner (SIRO) and the Information Governance function sits within his portfolio. – The Caldicott Guardian (Executive Medical Director) is responsible for the arrangements around the use and sharing of clinical information. This includes all uses of patient identifiable information within the organisation, ensuring its sharing takes place only for legitimate purposes, and only the minimum necessary information is used in each case. – The Assistant Medical Director (Secondary Care East) is the Health Board's nominated Data Protection Officer and has delegated responsibilities from the Caldicott Guardian specifically concerning compliance with the Data Protection Act and uses of person identifiable information within the organisation. – The Assistant Director of Informatics has delegated responsibility for the technical infrastructure to ensure the security; delegated responsibility for the data quality of the information assets held within the Health Board and delegated responsibility for the management of health records. • The Health Board completed a self-assessment against both Caldicott and the NHS Connecting for Health Information Governance Toolkit. This will enable the Health Board to provide a greater level of assurance by measuring its performance against a set of nationally agreed key standards covering the whole information governance arena.

Information governance

Strengths and developments

- Information Governance Group (IGG) –This operational group provides advice on meeting the Health Board's responsibilities for such as Data Protection, Caldicott, security, and providing assurance in relation to, for example; storing, sharing, using and disposing of medical information in accordance with legislation (policies).

Risks and challenges

- Scrutiny arrangements are less clear, and Information Governance is split between the three subcommittees of the IGC. This split between subcommittees could dilute the level of focus provided to Information Governance and Informatics issues. This is further compounded by a lack of operational clarity about which information governance and informatics papers should go to which subcommittee.
- Our high-level review of progress on our clinical coding recommendations demonstrated that progress on resolving medical records storage and volume issues is not fast enough. This is likely connected to the level of investment in informatics more widely by the Health Board (see Appendix 3, Table 13).

Performance management

New more rigorous performance management arrangements have started to take effect in 2015, but capacity remains a key barrier to sustainable improvement, and performance on key indicators remains variable.

47. The Health Board introduced a new performance management strategy from April 2015. The new performance management arrangements are based on successful models used elsewhere in the UK, and rely on regular accountability meetings to tighten grip on operational issues. The accountability meetings held every month, (except in the months with quarterly reviews) are led by COO, Executive Director of Finance and Clinical Executives. These monthly and quarterly accountability meetings are based on a four point agenda, quality and safety, operational delivery, finance, and local issues. The local issue can be anything the operational functional group chooses to highlight, either a positive development to share, or something managers need help and support to improve or deliver. These accountability meetings are reinforced through Quality Assurance Executive oversight on key quality and safety areas, and weekly Corporate Directors' Group meetings.

48. A Programme Management Office (PMO) approach underpins and reinforces the Health Board's revitalised performance management arrangements. From November 2014, an external company was appointed to support a more formal PMO approach, and provide greater impetus and achievement of savings. The focus of the PMO team is primarily to develop and implement a Financial Recovery Plan within the organisation. The size of the PMO function means that it is not intended to deliver the savings itself, instead relying on service areas to deliver savings (under the facilitation of the PMO).

49. The development of the PMO approach is a positive step and it is providing the Health Board with much needed extra capacity and expertise in programme and project management. The organisation does not yet have similar internal capacity or expertise focusing on the larger scale (and longer term) transformation projects. There are risks with this model. Not least the capability and capacity of service areas to:

- deliver the savings on top of their day jobs;
- be sufficiently innovative and challenging in their approaches;
- work in silos rather than as part of a strategic programme; and
- provide capacity until the new organisational structure is fully implemented.

50. The findings underpinning our structured assessment conclusion are summarised in Table 7.

Table 7: performance management

New performance management arrangements
Strengths and developments • The new performance and accountability arrangements are open and transparent and reflect increased grip and rigour in holding people to account. This increased grip and rigour in was needed to balance the improvement support approach long practised within the Health Board. • The new performance management strategy clearly articulates how operational teams, corporate departments or service groups are monitored, supported, and held to account. • Two rounds of quarterly reviews have now been completed for the area, secondary care, and estate and facility management teams. • The management teams received formal feedback both face to face and via letter, which set out clearly the actions required and questions raised for the next review. • A monthly accountability framework is populated and kept up to date on SharePoint for each of the operational functional groups, ie the three area teams, Secondary Care, MHLD division and Estates and Facilities. The framework is based around the seven domains within the national performance framework, and includes an expanded range of indicators to provide greater granularity of performance information. • The same performance information is used by directors, operational staff and feeds the Board and Committee reports, allowing triangulation of performance information at various levels within the Health Board. • Staff training took place to enable the information to be cut in a manner, which reflects the management accountabilities of the operational teams and ensure all staff understood their roles in the process. • New accountability agreements are now in place, and signed by directors and executives. These cover a range of performance and financial metrics. • All budgets have been signed off by the organisation, with subsidiary budget holders held to account through line management routes. • The Quality Assurance Executive continues to hold monthly meetings to track quality and safety challenges and metrics, and address improvement in real-time. • These arrangements are complemented by the new PMO approach: – Additional external expertise, on interim contracts (with two senior, experienced Programme Managers). The Health Board has its own Service Improvement Team with around 20 staff on internal secondment to the PMO.

New performance management arrangements

Strengths and developments

- The external contract is reasonably costly, but this is offset by improved ability to deliver savings across the Health Board. The Health Board allocated £1.5 million in 2015-16 for external support (to cover the PMO and some additional lean transformation expertise).
- Based on underlying principles structured around Prince2 methodologies to put strong project management around all of the projects.
- Mechanisms to allow it to allocate resources, track savings projects and the overall programme. This includes exception reporting, project trackers and escalation procedures. For example, a Project Initiation Document or Project Request flowchart that service areas use to request hands-on support from the PMO/Service Improvement Team. By using this, the process has created decision points/gateways to ensure that service improvement resources are allocated appropriately.
- There are weekly update meetings with each identified lead under the Financial Recovery Plan. This checks progress against target. The process uses AMBER and RED risk ratings if projects are not on track, with escalation processes built in. The delivery of savings and how this is managed by the PMO is discussed under financial management in Section 2, Table 8.
- The longer-term ambition is for the PMO to act as an Internal Consultancy service. This will provide specialist expertise to service areas through a team, which is allocated based on need and potential for improvement.

Risks and challenges

- At present, improvement support expertise is divided across a number of functions in the Health Board (Faculty of Quality Improvement; the Programme Management Office with the quality improvement team on secondment; Clinical Audit; and embedded in operational management). The Health Board needs to consider how it can ensure that it has access to the internal improvement and turnaround expertise that it needs to deliver both national and local targets.
- The Health Board is developing proposals for the future role of the PMO, ie to find a more permanent solution to staffing and running this function. However, this is not yet in place. The Health Board does not have a Transformation Director post though some senior staff understand the benefits of this role. The importance of the Health Board deciding how transformation will be delivered and supported cannot be overstated, and we discuss this further in Section 3, Change Management, Table 9.
- The Service Improvement Team provides additional capacity and skills to support the service areas with their savings programme. However, the staff are not senior and therefore they provide additional capacity rather than decision making/leadership expertise. It is still unclear whether the skills of the Service Improvement Team are a close match to the needs of the organisation and the PMO approach. For example, their ability to deliver cashable savings or major transformation projects, as their experience is in small-scale clinical improvement projects. Over the next few months, the Health Board plans to make a decision about the scale of the restructuring required to the Service Improvement Team.
- The incomplete restructuring means that many senior and middle managers are now in interim posts, and the resulting lack of certainty will not help.
- All directors identify insufficient capacity and capability at middle management level, in particular around change management, programme and project management, and improvement skillsets (see change management Appendix 3, Table 9).

New performance management arrangements

Risks and challenges

- Performance Management needs to be aligned to the organisation's vision, goals and plans, which although the Board agreed these in October, still need to work their way through appraisal and operational planning processes. This leaves a level of uncertainty, which could be used to avoid accountability.
- Performance Management is starting to align with appraisal and performance review systems for individuals and operational units as the new structure is implemented. Nevertheless, as the organisation's appraisal rates are stubbornly low, (see Section 3, Table 10), it is likely to take some time for the changed accountability culture to filter through all layers of the organisation, and be demonstrated in our audit work.

Performance commentary on key example indicators

Improved performance is visible in some areas

- Performance is improving in some areas, but this improvement is not consistent. Without detailed audit work, it remains difficult to state with any certainty whether these performance improvements are due to local improvement projects, or the more effective performance management arrangements. These positive signs of progress need to be recognised. In particular:
  - infection control: C.difficile rates have fallen again in 2015, although rates are still high compared to the rest of Wales;
  - prevention indicators, such as vaccination rates show steady and sustained improvement over 2015, although in many cases they are not reaching Welsh Government target levels;
  - stroke performance is now upper quartile for the UK as a whole;
  - cancer performance is the best in Wales; and
  - some quality and safety metrics, such as fundamentals of care demonstrated improvement in early 2015 as new nurses took up post.
- The impetus provided by special measures, the 100-day plans, and the Interim Chief Executive continue to have a positive impact on the key areas of Ministerial concern. In October 2015:
  - Out-of-hours services: there is good progress across all the actions from the 100-day plan and external report. The main areas where progress has been slower are the ability to recruit sufficient nurse practitioners and GPs (east area) and lower than establishment staffing levels are affecting progress. The key risk areas around sufficient staff to fill rotas, triage and mandatory training are green in the main.
  - Maternity services: monitoring arrangements demonstrate that there are comparable quality outcomes in Quarter 1 of 2015 compared with the same period in 2014. Despite an increase in the reliance on agency staff and overtime payments for existing staff. Recruitment remains problematic, particularly for medical staff, and staffing levels remained precarious and at an unsustainable level at the time of our fieldwork.

New performance management arrangements

Performance against key Welsh Government targets remains static

- Waiting times for diagnostics, referral to treatment (26 weeks and 52 weeks), and the follow-up outpatient backlog remain below Welsh Government and internal targets. These have fluctuated throughout 2015, improving some months and deteriorating in others. The Health Board has recently rejuvenated improvement projects for both scheduled care and outpatients, but it is still early days, and success will depend on both clinical engagement and access to the correct change management skillsets.
- Operational Management are targeting many key efficiency measures, such as use of theatre time, but there is still a way to go before targets are achieved and resources utilised effectively.
- Quality and safety metrics, such as mortality remain static, after showing some improvement in 2014.
- There has been a significant reduction in the backlog of complaints but this has been at the expense of dealing with new complaints in a timely manner. Performance against the Putting Things Right 30-day target needs focused action by corporate and operational teams working closely together.

Deteriorating performance appears to have halted in many other areas

- Deterioration in a wide range of performance indicators was evident in the first quarter of 2015, but this general trend is no longer apparent.
- Whilst across the whole Health Board performance is no longer in general deteriorating, the improvement in some places masks deterioration in others. For example, Accident and Emergency waits (both four and 12 hours) show variation month to month and between the three sites. The Health Board will need to understand the reasons behind this difference in performance, and ensure that learning from improving sites is rapidly transferred across north wales.

Financial management

The absence of clinical, service and workforce plans make it very challenging for the Health Board to deliver sound and sustainable financial management, and the scale of the financial challenge raises significant risks over the financial viability of services

51. The NHS Finance (Wales) Act 2014 (the Act) came into effect on 1 April 2014 giving additional resource flexibilities to health boards to balance their income and expenditure over a three-year rolling period from 2014-15. The Act also required the Health Board to prepare a rolling three-year IMTP, approved by the Welsh Ministers The Health Board should benefit from the additional flexibilities provided by the Act, but failed to meet its second financial duty to have an approved three-year IMTP in place for the period 2014-15 to 2016-17. The Local Health Board instead developed a 'One Year Plan' for 2014-15, which was approved by the Board in May 2014.

52. Our joint work with HIW in September, identified the need for a transformational approach to service planning as demonstrated by the Health Board's challenging financial position, with a likely deficit of £30 million currently being predicted for the 2015-16 financial year. It is encouraging to see developments in the approach that is now
being brought to the management of in-year savings by the introduction of the PMO, although current savings plans are likely to fail to bridge the deficit, which is being forecast, highlighting the need for more transformational, rather than transactional approach.

53. In reaching this conclusion, we found:

- the Health Board's management arrangements were insufficient as it failed to operate with within its 2014-15 revenue resource allocation, reporting a £26 million deficit; and
- the Health Board is yet to establish sound and sustainable delivery of financial targets in 2015-16 and is at significant risk of not achieving financial balance for the financial year projecting a deficit of £30 million, increasing to a potential £89 million in 2016-17, dependent upon increased resource uplift.

54. The findings underpinning these conclusions are summarised in Table 8.

Table 8: financial management

2014-15 financial position
Strengths and developments • the Health Board operated within its annual capital resource allocation reporting an underspend of £34,000 for the year; and • production of timely monthly reports to Welsh Government and the Board throughout the year, highlighting performance against key targets, reasons for significant variances together with proposed actions.
Risks and challenges • the Health Board did not operate within its 2014-15 revenue resource allocation, reporting a deficit of £26 million; • the Health Board failed its Public Sector Payment Policy, paying only 90.2 per cent of non-NHS bills within 30 days (against a target of 95 per cent); and • significant and deteriorating in-year changes to the projected 2014-15 financial forecast position.

2015-16 financial management and performance

Strengths and developments

- The 2015-16 Interim Annual Financial Plan recognised the significant financial challenges it faces – identifying a savings requirement of over £42.8 million and a further financial gap of £14 million between its annual resource allocation and its planned net expenditure for 2015-16.
- The Health Board's savings target is categorised into two main areas, 'Strategically Managed Schemes' and 'Locally Managed Schemes'. The PMO's reporting lines for the 'Strategically Managed Schemes' are through the COO and the Executive Director of Finance.
- Acknowledgment of the deteriorating in-year financial performance from month five, resulting in a revised projected year-end deficit of £30 million.
- Accountability Agreements have been developed as a mechanism to formal sign off of budgets for 2015-16 with progress being made with all registered budget managers across the Health Board to complete and sign the agreements.
- Further actions are being explored to mitigate the financial risks – 'assessing further actions which could be taken to reduce expenditure within the financial year from both top-down and bottom-up initiatives, while obviously ensuring that they do not adversely affect patient care'.
- A new approach is now being brought to the management of in-year savings by the introduction of the PMO approach. This is:
  - Making an impact on the delivery of savings and in 2014-15 delivered around £16.2 million savings from a standing start.
  - Producing monthly progress reports for the Finance team. These are reported to execs and members. Performance as of month 5 2015-16 is shown below.
  - Aiming to become more closely aligned with the transformation programme to better support the achievement of longer-term priorities set out in the IMTP for 2016-17 and beyond.
  - Risks escalate up or down beyond the PMO approach via the weekly escalation meetings with executives. The executives review corporate risks to help shape the PMO programme.
- The Health Board anticipates meeting its £46 million capital resource allocation for the year.

2015-16 financial management and performance

Risks and challenges

- Financial planning and management remain extremely challenging – the Health Board is projecting year-end deficit of £30 million, predicated on:
  - a budget deficit of £14.2 million as a planning assumption; and
  - recognition of £16 million additional in-year cost pressures.
- Significant risk of failing to meet the Public Sector Payment Policy of paying 95 per cent of non-NHS bills within 30 days.
- Insufficient savings plans identified and delivered to date:
  - £34.4 million savings identified at month 5 v savings requirement of £42.9 million (funding gap);
  - £9.434 million savings delivered to month 5 v month 5 saving target of £9.784 million; and
  - additional schemes/CIPs are yet to be identified to fully address the funding gap and the Board recognises that £12million of identified CIPs may not be delivered.
- PMO schemes are strategic schemes focused on the key challenges in each area. West, Central and East are making changes separately rather than in a coordinated manner. The benefits of this approach, in targeting key concerns, carries a risk that learning will not spread between areas.
- There is a risk that the PMO function is spreading itself too thinly and this is reducing its impact, by focusing on Length of Stay, Theatres and Outpatients as well as other areas.
- The savings target does not take into account the £30 million budget deficit nor the recovery of the £26.6 million 2014-15 deficits. Although the Health Board has been informed it will not have to repay the 2014-15 deficit in 2015-16.
- Additional cost pressures, including overspend on monthly medical and nursing agency and NHS provider contracts are undermining progress in addressing the in-year deficit.
- Unprecedented financial challenges remain in the medium-term – Annual 2015-16 Budget Strategy projects increasing financial challenge, based upon an assumed two per cent uplift in resources, projecting a financial gap of £89 million in 2016-17.
- A significant amount of work is needed to identify clinically and financially sustainable plans for the future shape of health services in North Wales.

Enablers of effective use of resources

Leadership capacity, capability and resilience are key risks and continue to hinder the Health Board's ability to deliver necessary changes quickly

55. In reaching this conclusion, we found:

- change management expertise is fragmented across different functions, and there is insufficient internal expertise and capacity to support operational and clinical leaders;
- progress has been made on nurse and midwifery recruitment and understanding current medical workforce needs, but resolving the long-term workforce challenges in the absence of a clear clinical strategy, and improved management of all staff groups will remain very challenging;
- the Health Board has had governance concerns with some capital projects, and is now in a better position to pursue some longstanding estate development needs alongside its wider strategy development;
- the Health Board is in the process of rebuilding public and stakeholder confidence; and
- in comparison with other health boards in Wales, the current level of investment in ICT at the Health Board is the lowest in Wales, nevertheless, the Informatics team continues to deliver operationally and have well-developed plans.

56. The findings underpinning these conclusions are summarised in the following sections and tables.

Change management

Change management expertise is fragmented across different functions, and there is insufficient internal expertise and capacity to support operational and clinical leaders

57. The Health Board recognises at all levels that it needs to change and special measures reinforce this point, and bring with them new opportunities, both in terms of recognition from outside that change needs to happen, and support to deliver the necessary changes.

58. The new executive team brings expertise in turnaround and more widely of different clinical and operational working practices. Nevertheless, to achieve transformation in terms of both efficiency and effectiveness of services, these leaders need clinical buy-in and the capacity to lead change.

59. The findings underpinning our structured assessment conclusion are summarised in Table 9.

Table 9: change management

Change management
Strengths and developments • the Health Board recognises it needs to transform services; • executives and directors with experience of turnaround and different ways of working have brought fresh perspectives and impetus; • the development of the PMO approach demonstrates the Heath Board recognises it needs to invest in change management expertise, but in the absence of sufficient internal capacity and capability, a more permanent solution is required for the medium term; • the functions of a Faculty of Quality Improvement (not including clinical audit) within revised Quality Improvement Strategy could bring together a number of elements of clinical expertise to support change; • change projects led by directors and executives for scheduled and unscheduled care are having an impact on some longstanding performance issues; • there is an organisational development function within Workforce and organisational development central team; • lean methodology and other techniques are being used in outpatients with outside support and expertise; and • local change projects continue to deliver small-scale change in clinical teams and areas, such as enhanced recovery.
Risks and challenges • In the absence of an agreed clinical services strategy, there is a risk that changes may be made which limit possible alternative future solutions. • The Health Board will need a set of strategic change programmes and sub programmes and projects to support delivery of its strategic goals. This creates a challenge for capacity, coordination and prioritisation. • PMO approach focuses on delivering short-term savings, but the staff seconded are junior and lack experience of major strategic change projects. • Faculty of Quality Improvement is clinically led, with a wide range of expertise but this disparate expertise is not coherent or clearly joined up with other projects and programmes. • The use of external expertise provides a quick impetus to the organisation, but leaves risk that such one-off or project-based support will not leave a legacy that the organisation can build on. There is a need to embed skills internally, through training and or recruitment/secondment of individuals with the capabilities necessary. • Executives are frank about the need of the Health Board and its middle managers to 'catch up' with change programme skills and capability developed in England. • The Director of Transformation post is on hold whilst issues of cost of the new management structure are resolved. In the interim, the Health Board appears to lack the necessary programme management skills and capacity to support its organisational change requirements, and is buying-in expertise through the PMO. • Finally, the workforce and organisational development (WOD) corporate department will need to support change programmes with their specific expertise. It is not clear that there is sufficient capacity in WOD to support the level of organisational change that is required.

Workforce

Progress has been made on nurse and midwifery recruitment and understanding current medical workforce needs, but resolving the long-term workforce challenges in the absence of a clear clinical strategy, and improved management of all staff groups will remain very challenging

60. The Health Board now has a reasonable diagnosis of the major workforce issues facing it over the medium term, particularly on medical and nursing elements of the workforce. However, it does not yet know what the solutions are for some of its recruitment issues, and as the wider UK supply of these key staffing groups tightens, it will continue to struggle to recruit enough staff to safely continue with the current service models. This further emphasises the need to think radically about both its medium-term plans and invest in change management expertise to make the most of its current workforce.

61. The findings underpinning our structured assessment conclusion are summarised in Table 10.

Table 10: workforce

Workforce
Strengths and developments • The Health Board now understands its medical workforce needs. The Office of the Medical Director reviewed all clinical specialities with the support of a wide range of colleagues. This assessment of medical workforce need will inform the clinical services strategy, management of risk in the interim, and discussions and relationships with the Wales and North West Deaneries regarding future workforce needs. • Further developing links with North West Deanery in 2015 identified opportunities to include some North Wales GP practices in trainee rotations, and supported filling locum vacancies with North West trainees. • Progress on nursing vacancies, with recruitment from elsewhere in Europe, brought agency nursing costs down rapidly as 2015 progressed. • The Health Board is actively refreshing its approach to hearing and recording staff concerns, including whistleblowing arrangements. It has refreshed its whistleblowing policy in 2015, established Safe Haven and Safe To Speak Up routes to support professional codes relating to duty of candour in 2015. • Midwifery recruitment was particularly successful in 2015.

Workforce

Risks and challenges

- Although medical workforce needs are clearly understood, there remain significant problems finding short-term solutions in the absence of a clinical services strategy. GP recruitment and retention is an issue with the national shortage compounded by early and impending retirements across North Wales. The fill-rates for acute vacancies, especially for trainee posts, remain lower than desirable. The Wales Deanery has further plans to increase rota numbers to ensure all trainees work 1:11, and reduce the number of training sites across Wales. All of these factors combine to increase pressure on staff-in-post and drive the demand for locum doctors, The Health Board continues to have a high demand for locum doctors to keep services running on three sites.
- Sickness rates across the Health Board at 4.85 per cent are stubbornly above the target rate of 4.55 per cent, although this represents an improved position from earlier in 2015 when that rate was above five per cent.
- Poor appraisal rates remain a problem, with only 28 per cent of non-medical staff having a current appraisal. Medical staff appraisal rates are improving rapidly with impending revalidations and now stand at 97 per cent and low non-medical staff appraisal rates not only hinder individual accountability, but also suggest that the Health Board may not be adequately prepared for the introduction of nurse revalidation in 2016.
- The Safe Haven and other new arrangements to support staff in reporting concerns are positive developments. Nevertheless, these are new, and it is too early to judge if they are effective.
- Workforce raised issues and concerns are still not triangulated in Board reports with other information sources such as complaints, and incidents. Until this happens, the Health Board may remain unsighted of emerging safety concerns.
- Recent inspections by HIW raise issues around:
  - Variability between wards, and in some cases very poor compliance rates, for mandatory training. This issue also features in our follow-up of Hospital Catering and Nutrition.
  - On learning from inspection not being shared across the Health Board with the same problems being found in different places. We have raised this challenge in our previous structured assessment work in 2013.

Estates and Assets

The Health Board has had governance problems with capital projects, but is now in better position to resolve some long-standing estate development needs alongside its wider strategy development

62. There have been longstanding issues with the NHS estate in North Wales, not least the necessity to remove asbestos and resolve fire regulation issues in Ysbyty Glan Clwyd. There have been problems with capital projects, which are under investigation, but action has been taken to address the causes which have resulted in a new more robust capital process, supported by a new capital manual.

63. The absence of an estates strategy is understandable in the absence of an agreed integrated or clinical services strategy. Once the Health Board agrees its primary and community strategy and mental health strategy, progress can be made on deciding on many of the future investment requirements for estates.

64. The key findings from our structured assessment work on estates and assets are summarised in Table 11.

Table 11: estates and assets

Estates and assets
Strengths and developments • New capital manual, and revised capital management processes developed with external advice. • Welsh Government has approved some capital Business Cases such as Llangollen and are actively considering others including Blaenau Ffestiniog and Flint. • Ysbyty Glan Clwyd refurbishment is underway to remove asbestos and bring it up to date on fire regulations. The new emergency department is already open along with new operating theatres, critical care area and the first set of refurbished wards, and other new facilities are on target to be delivered on schedule. • The Health Board is starting to understand the funding needed to implement planned changes over three years, and prioritise investment. Capital requirements have been identified for Ysbyty Glan Clwyd, with strategic plans and Business Cases prepared for a number of other schemes such as Flint, Blaenau Ffestiniog and the Sub Regional Neonatal Intensive Care Centre (SuRNICC). • Investment already made in areas supporting quality and safety, eg new operating theatres, critical care area and refurbished wards at Ysbyty Glan Clwyd.
Risks and challenges • There remain significant challenges around estates requirements to deliver modern sustainable health services in North Wales. In particular: – Until the Health Board agrees a wider integrated clinical services strategy, it is not possible to develop a comprehensive estates strategy to support future clinical models. Therefore, detailed scheme costs cannot be built into an IMTP until the clinical strategy is agreed. – Finances are currently tied up in an old and geographically distributed estate. – There is a high level of backlog maintenance which will need to be addressed as part of the estates strategy. In the meantime discretionary capital expenditure is prioritised towards addressing the highest risks. • Ysbyty Glan Clwyd project suffered a number of governance concerns, which are under investigation. • Some capital requirements not yet funded, with Strategic Plans and Business Cases awaiting approval by Welsh Government such as Flint, Blaenau Ffestiniog and the SuRNIC.

Stakeholder engagement and partnership working

The Health Board is in the process of rebuilding public and stakeholder confidence but the scale of the challenge is significant.

65. In placing the Health Board into special measures, the Minister for Health and Social Services identified the need to reconnect to the public and stakeholders.

66. The findings of our joint work with HIW in September acknowledged the increased visibility and engagement of the senior team with both internal and external stakeholders, with encouraging evidence that the Health Board is actively listening to the views and concerns of its staff, its partners and the public. We did not underestimate the challenges this presents in terms of re-energising an organisation that has been the subject of significant external criticism whilst trying to regain public confidence and having to take difficult decisions about the future shape of health services in North Wales. It will of course be necessary to demonstrate that, having listened, the Health Board is taking the appropriate action to respond to issues raised and to embed sustainable approaches to future internal and external engagement.

67. Over the summer of 2015, the Health Board implemented a new engagement strategy with a focus on listening. The 100-day plan for communication and engagement helped focus attention and demonstrate delivery of tangible actions. This work continued into the autumn, with formal publication of the strategic goals and vision.

68. These findings were underpinned by our wider structured assessment work in 2015, and our conclusions are summarised in Table 12.

Table 12: stakeholder engagement and partnership working

Stakeholder engagement and partnership working
Strengths and developments • New strategic goals and vision were agreed through Board development activity throughout 2015. A significant amount of work went into agreeing both the goals and the vision at Board level, and this now needs to be translated into agreement with internal and external stakeholders. • The new approach to public engagement, based on listening, not a formulaic structured question-based approach will bear dividends in time. This approach is essential to rebuilding public trust going forward. • The Health Board has used many different strands to listen to its staff, partners and public, including traditional engagement events, going to the public, using meetings and events such as fairs and shows, and social media. • The new engagement strategy and plans provide a solid basis to hold a wider conversation with both staff, partners and the public about the future shape of services in North Wales. • There is positive feedback from partners on the tone and balance of the new listening approach.

Stakeholder engagement and partnership working
Risks and challenges • to continue rebuilding public trust in the Board will take time, and the listening approach, will need to be extended beyond the initial phase to include equal conversations allowing the Health Board to use co-production and similar partnership-based approaches to developing its clinical services strategy in 2016; and • there remains scope to engage more effectively with politicians both in local and national government, and the Health Board should use partner expertise in local government to help it build relationships in 2016.

ICT and use of technology

In comparison with other health boards in Wales, the current level of investment in ICT at the Health Board is the lowest in Wales, nevertheless, the Informatics team continues to deliver operationally and have well-developed plans

69. The findings underpinning our structured assessment conclusion are summarised in Table 13.

Table 13: ICT and use of technology

ICT and use of technology
Strengths and developments • There is clear leadership and a capable supporting team, ensuring that the Health Board understands what it needs to do to deliver information systems that support healthcare delivery. • The Health Board is now in-year 5 of its five-year informatics plan, and the Health Board reports that a number of projects were postponed due to delays in national projects, or due to other investment priorities. The Informatics department continues to work towards its own annual operational plan, and support operational delivery. There is a clear, phased programme of work, which is broken down into clear sub programmes: Community and Mobile Working; Digital record; ICT Infrastructure; Information; and Transactional, which is now being more fully reflected in the developing IMTP. • Disparate inherited ICT systems are slowly being replaced, and integrated. • A data warehouse is in place, this is used to produce consistent management information, and information analysts work closely with the Chief Operations Officer's team to produce the suite of performance reports for the organisation. This is supported by work on clinical engagement in information flows, and the external consultancy supporting lean pathway development in the Health Board. • There are evidence-based technical project and programme management arrangements in place, and internal projects deliver.

ICT and use of technology

- Business Continuity Plans (departmental) have been developed for critical areas, including:
  - informatics;
  - health records;
  - programmes;
  - ICT; and
  - clinical systems.

The informatics service has recently been awarded a Data Quality award and continues to receive good feedback on the service that they deliver across the Health Board.

Risks and challenges

- Our ICT capacity review, reported separately, highlights that in comparison with other health boards in Wales, the current level of investment in ICT at the Health Board is the lowest in Wales.
- The informatics operational proposals clearly outlined the investment needed to modernise ICT systems across the Health Board. However, this investment has been considered alongside other priorities and risks facing the Board to prioritise capital expenditure. Not all of the £7 million set out in the Plan was approved given capital funding constraints and the Board will need to consider how to address this deficit in funding as a in its future plans.
- A number of operational groups sit beneath the IGC, and its subcommittees to both help co-ordinate operational delivery and support scrutiny. These are the Health Records Group, and the Health Informatics Group (HIG). How well these groups fit, function and add value to the new Board and organisation structures is being addressed as part of the operational governance arrangements.
- Pressures on the Health Records Service due to increasing activity and service needs continue to be identified. Health Records has been included in the corporate risk register. There remain major issues around the storage facilities for current and archive (acute) medical records, with as yet no agreement on the most effective and efficient use of resource in relation to case note storage. In the interim there are yearly action plans that mange case note storage, whilst complying with agreed retention and destruction guidelines.
- Our diagnostic work on ICT capacity and investment is reported separately, but highlighted that the overall level of spend on ICT is the lowest in Wales and well below the recommended level of spend of two per cent of total revenue. It also, highlighted poor perceptions of ICT facilities and limited integration of ICT systems across the Health Board. Current ICT systems do not support the Health Board's ability to move patients and services. This is a key challenge in the current financial climate.

Appendix 1

2014 Structured Assessment Recommendations

The 2014 structured assessment recommendations and a summary of progress made against each are set out below. Despite progress in some areas, significant challenges remain around finances, governance and some aspects of performance:

- part 1: the Health Board is yet to establish a sound and sustainable approach to either in-year or medium-term financial management;
- part 2: the Board has taken steps to strengthen governance arrangements, but the scale of the challenge remains significant and the pace of change needs to further increase; and

  part 3: the Health Board recognises it has had issues with planning, change management and wider stakeholder engagement, although there are indications of positive progress in recent months.

Recommendation		Summary of progress
Financial planning and management		
R1	Develop sustainable plans for financial and clinical service models with greater service integration.	Despite some signs of early progress, referred to in our main report, this recommendation has not been achieved. In the absence of agreed strategic, clinical and workforce plans the development of sustainable financial plans will remain challenging.
Arrangements for governing the business		
R2	Assurance to Board from committees must be strengthened alongside the new Committee structure. For example through the use of assurance reports.	The Board introduced Committee assurance reports in 2015, and they are starting to be used more consistently.
R3	Finalise and implement new organisational structure and ensure alignment of support services.	Implementation of the new organisational structure was further reviewed, due to concerns about its cost and effectiveness. Revised arrangements are now being put in place in accordance with the agreement reached with the Board, to ensure the organisation can work to achieve its objectives.

Recommendation	Summary of progress
Arrangements for governing the business	
R4 Complete the current programme of Board and Corporate Director Team development.	The 2014 to 2015 programme is complete, but it has not fully achieved its objectives. Board development will be ongoing and will be cognisant of anticipated changes to personnel.
R5 Focus on openness and transparency to build public trust. For example publically stating the reasons behind controversial decisions.	The Board has made good progress on increasing transparency, with 100-day plans available on its website, monthly public reporting on performance and quality and a revised tone in its communications. The focus on openness and transparency will need to continue in 2016 to ensure it becomes part of the culture of the organisation and support the long-term goal of rebuilding public trust.
R6 Strengthen and standardise 'raising staff concerns' arrangements to good practice standards.	The Health Board revised its whistleblowing policy and introduced a number of other mechanisms for staff to raise concerns in 2015. This includes the Safe Haven and the Board signing up to the national 'Speak out safely' campaign. Their effectiveness remains to be tested, and triangulation with other early warning mechanisms through Quality Assurance Executive will need to be demonstrated before we can record this action as fully complete.

Recommendation	Summary of progress
Arrangements for governing the business	
R7 Complete the outstanding actions from our HIW/Wales Audit Office overview of governance arrangements.	The Health Board made progress against most of the recommendations. This was then tested by Internal Audit and reported in June 2015. The introduction of the 100-day governance plan provided further impetus and ensured that most of the actions were complete by the end of September 2015. The remaining actions are in progress, and nearing completion, for good reasons, in the main to ensure that the Board and wider organisation had an opportunity to take part in their development, and because some were subject to an effectiveness review of interim arrangements. These are: • Board Assurance Framework; • Risk Management arrangements; and • Board and Committee operation and supporting structures are under review to improve their effectiveness.

Appendix 2

Management response

Report title: Structured Assessment 2015

Issued: January 2016

Document reference: 687A2016

Ref	Recommendation	Accepted	Management response	Completion date	Responsible officer
R1	The Health Board's existing 31-page 'Action Plan' of outstanding recommendations from previous internal and external governance reviews should be cleansed of: (i) repeated recommendations; (ii) completed recommendations; and (iii) recommendations that are no longer relevant due to changed circumstances.	Accepted	The Health Board's consolidated governance action plan has been reviewed. Each recommendation has been assessed in line with the advice received from WAO. This assessment has been tested with Ann Lloyd Independent Adviser and all Board members.	31st March 2016	Board Secretary

Ref	Recommendation	Accepted	Management response	Completion date	Responsible officer
R2	The remaining recommendations within the 'cleansed' Action Plan should be included within the implementation plan that the Board will be required to produce in response to core themes set out in the Welsh Government's BCU Improvement Plan.	Accepted	On the 29th January 2016 the Deputy Minister for Health made a written statement regarding BCU's Special Measures Improvement Framework. This set out the criteria that the Health Board must meet in order for special measures to be considered for de-escalation in the future. The expectations in the improvement framework are aligned to the remaining recommendations from the previous governance action plan. The Board's initial response to phase 1 of the special measures improvement framework was considered at its public meeting on 18th Feb 2016.	31st March 2016	Board Secretary
R3	The Health Board should progress at pace its development of integrated clinical services, working in genuine partnership with its staff and with external stakeholders. This work should focus on: • both one-year planning and IMTP development; (linking with the Health Board's obligations under the Well-being of Future Generations Act 2015); and • financial sustainability.		The Improvement Framework described above sets clear requirements for the Board to agree an Annual Plan by the end of April; work is in hand to achieve this, including engagement with Advisory Groups and stakeholders. The approach to developing the full strategy for clinical services will be set out by the end of April with a detailed timeline set out by October as required in the Special Measures Improvement Framework. Financial sustainability for the medium to long term will be developed alongside the delivery of key clinical, service and workforce plans.	May 2016	Director of Strategy Director of Finance

Ref	Recommendation	Accepted	Management response	Completion date	Responsible officer
R4	The Health Board should strengthen its focus on Informatics to underpin its planning capability, to support better decision-making and to ensure that its informatics service is well placed to support new national IT systems as they become available.		The Assistant Director for Informatics (ADI) joined the Executive Management Group in February 2016. The ADI is also Chair of the National ADI Group and is strengthening engagement and planning of national IT system through membership of Welsh Clinical Informatics Council and the newly formed NHS Informatics Strategic Development Group (which) oversees the implementation of the recently published national Informed Care Strategy). The Health Board's governance arrangements for reporting to the Board have been revised and a paper will be presented to the Executive Management Team to strengthen the capacity of the Informatics service to deliver BCUs operational plans.	May 2016	Chief Executive
R5	The Health Board should move away from over-reliance on external consultants by creating/identifying dedicated in-house capacity and capability to support: change management; and service transformation.		The Board has approved the development of an internal Programme Management Office approach. The Board is clear that these skills do not currently reside within the organisation and following the appointment of the CEO this matter will be subject to detailed discussion to determine the final model and scope.		Chief Operating Officer

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