Pecyn dogfennau cyhoeddus

Y Pwyllgor Cyfrifon Cyhoeddus

Lleoliad:
Ystafell Bwyllgora 3 - y Senedd

Dyddiad:
Dydd Mawrth, 5 Tachwedd 2013

Amser:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Fay Buckle
Clerc y Pwyllgor
029 2089 8041
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Agenda

1 Cyflwyniadau, ymddiheuriadau a dirprwyon

2 Cyllid Iechyd 2012-13 a thu hwnt: Tystiolaeth gan Lywodraeth Cymru (09:00 - 09:45) (Tudalennau 1 - 9)

PAC(4)-28-13 papur 1

David Sissling - Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol/Prif Weithredwr, GIG Cymru
Kevin Flynn - Dirprwy Brif Weithredwr GIG Cymru
Martin Sollis - Cyfarwyddwr Cyllid, Llywodraeth Cymru

3 Cyllid Iechyd 2012-13 a thu hwnt: Tystiolaeth gan Fwrdd Iechyd Prifysgol Caerdydd a'r Fro (09:45 - 10:35) (Tudalennau 10 - 18)

PAC(4)-28-13 papur 2

Adam Cairns, Prif Weithredwr, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

4 Papurau i'w nodi (10:35) (Tudalennau 19 - 20)

Trefniadau Fframwaith Cenedlaethol ar gyfer Gofal Iechyd Parhaus y GIG: Llythyr gan David Sissling (22 Hydref 2013) (Tudalennau 21 - 22)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan Archwilydd Cyffredinol Cymru (31 Hydref 2013) (Tudalennau 23 - 27)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan David Sissling (15 Hydref 2013) (Tudalennau 28 - 36)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan Arolygiaeth Gofal Iechyd Cymru (11 Hydref 2013) (Tudalennau 37 - 38)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan yr Athro Merfyn Jones (4 Hydref2013) (Tudalennau 39 - 40)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan David Sissling (2 Hydref 2013) (Tudalennau 41 - 65)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan Bwrdd Iechyd Prifysgol Betsi Cadwaladr (12 Medi 2013) (Tudalennau 66 - 69)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan Mary Burrows (12 Medi 2013) (Tudalennau 70 - 83)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan David Sissling (2 Awst 2013) (Tudalennau 84 - 88)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan Mary Burrows (18 Gorffennaf 2013) (Tudalennau 89 - 100)

Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr: Llythyr gan Pwyllgor Meddygon Ymgynghorol a Arbennigwyr Gwynedd (5 Gorffennaf 2013) (Tudalen 101)

5 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol: (10:35)

Eitemau 6, 7 ac 8

6 Cyllid Iechyd 2012-13 a thu hwnt: Trafod y dystiolaeth (10:35 - 10:40)

7 Cyflog Uwch-reolwyr (10:40 - 10:45) (Tudalennau 102 - 104)

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8 Trefniadau Llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr (10:45 - 11:00) (Tudalennau 105 - 118)

PAC(4)-28-13 papur 4

Evidence paper from the Director General, Health and Social Services to the Public Accounts Committee in response to the Wales Audit Office Report on Health Finances 2012/13 and beyond.

Introduction

The Welsh Government welcomed the Wales Audit Office report on Health Finances when it was published in July. We generally accept the recommendations and we are already taking the necessary responsive action in each area.

This paper provides commentary and evidence in respect of the areas covered by the report. We also believe it is appropriate to cover some of the issues raised by the draft budget which was laid on 8 October and the recent Written Statement on the additional resources to be allocated to the NHS in 2013/14.

2012/13

The WAO report acknowledges the Department generally managed financial risks well across the year. It recognises the tough decisions taken to enable the provision of additional funding to support financial and service pressures across NHS bodies. As a consequence all NHS organisations met their statutory financial targets at the year end.

In reflecting on 2012/13 it is important to highlight a number of very significant developments. These will have a profound impact on all aspects of planning and delivery in the Welsh NHS.

- The publication of the report into events at Mid Staffordshire by Robert Francis QC. This has placed a greatly increased emphasis on matters of quality and safety.
- The continuation of major programmes of service change. Patterns of delivery are being reconfigured both in hospitals and in primary and community care settings.
- An unprecedented increase in demand for emergency care services. Analysis indicates this is particularly associated with an increasingly elderly population. In appropriately prioritising the care needs of emergency patients there was an impact on planned care. The overall performance picture was therefore mixed in 2012/13. There were improvements in some key priority areas including :

- Stroke services
- Hospital admissions for chronic conditions
- C.Difficile levels
- MRSA levels
- Day care rates
- Length of stay

However performance against access targets for unscheduled and planned care deteriorated. As a final point in this regard it is important to note patient satisfaction levels have remained at a very high level.

2013/14

The current year has been particularly distinguished by a strong emphasis on quality and safety. Relevant developments include:

- The publication of Safe Care, Compassionate Care
- The publication of Annual Quality Statements by all NHS organisations
- Greater transparency, highlighted by the recent launch of My Local Health Service which publicises a range of quality indicators
- The development of more Delivery Plans for major conditions – respiratory, neurological condition, eye care
- Progress reports for established Delivery Plans
- Strengthened Board governance to respond in particular to the WAO/HIW report on Betsi Cadwaladr University Health Board
- Work to strengthen the regulatory and inspection regime
- Focus on quality improvement through the renowned 1000 Lives programme

The year has also been characterised by very focussed work to respond to the necessary pressures in the unscheduled care system. Welsh Government has worked with NHS organisations and action is being progressed in a range of areas. There has been a particular emphasis on leadership, care delivery models, discharge arrangements and Winter planning. Performance has improved over recent months as a consequence. Service Change has continued with a growing recognition of the need to align service, workforce and financial aspects. Welsh Government has led work to significantly strengthen planning processes – for 2013/14 and over a rolling 3 year period.

It was in the context of the developments described above and with the knowledge of increasing financial pressures that the Minister for Health and Social Services announced a review of the budgets to ensure the Welsh NHS could respond to the requirement associated with the Francis Report. The budget announcement on 8 October set out planned increases to the Health and Social Services allocation for

the period from 2013/14 to 2015/16. The budget has been subject to scrutiny at the Children and Young People's Committee and the Health and Social Services Committee. An additional and recurrent allocation of £150m has been announced by the Minister to recognise and support the plans that LHB's had already put in place.

The Minister has announced the detail of the allocation reflecting a distribution that is driven by a population formula. The allocation basis for each orgnaisation is shown below:

	Nurse Staffing	Unscheduled Care (Including Amb. Pressures)	Immunistion programme	Kalydeco drug funding	VER Funding	Total
	£m	£m	£m	£m	£m	£m
ABMU	1.80	21.80	1.30		0.55	25.45
Aneurin Bevan	1.90	23.88	1.14		0.00	26.92
BCU	2.20	26.64	1.56		0.50	30.90
Cardiff and Vale	1.40	17.09	1.03		2.33	21.85
Cwm Taf	1.10	13.42	0.66		1.68	16.86
Hywel Dda	1.30	15.51	0.86		1.30	18.96
Powys	0.40	5.16	0.30		0.05	5.91
WAST					0.97	0.97
NWSSP					0.05	0.05
Central Programme			0.15	2.00		2.15
Total	**10.10**	**123.50**	**7.00**	**2.00**	**7.43**	**150.03**
Note: The Ambulance service pressures are included within the total unscheduled care funding and are allocated.						
by LHB to reflect commissioning responsibilties.						

Whilst the additional monies allocated to the Health in the budget is welcome the Minister has made it clear that it will not remove the need for significant further change in the Welsh NHS nor would it relieve all the pressures facing the service. Rather it will enable and support further transformational change. Welsh Government is currently working with Chairs and Chief Executives to ensure appropriate expectations, plans and work programmes are established for the remainder of 2013/14.

Looking Ahead 2014/15 and Beyond

Health Boards and Trusts are required to produce robust 3 year plans by January 2014. These will be set in the context of the priority given to the maintenance of high quality care. They will recognise the reality and challenges associated with a period of sustained austerity . They will be based on the increased allocation to Health and Social Services announced in the recent budget.

2014/15 £180m

2015/16 £240m

The plans will describe changes to service delivery models with the introduction of new care pathways. The expectation is of significant development in preventative, out of hospital care. There will also be attention given to driving up efficiency and productivity – reducing length of stay, increasing day care and statutory discharge processes. The plans will focus on aligning service, workforce and financial aspects.

The Committee will be aware of the proposed NHS Finance (Wales) Bill which was laid before the Assembly on 30 September. The Bill will provide Local Health Boards with improved flexibility allowing them to balance their books over a three year period. It will encourage longer term planning and decision making. It will however be predicated on a very disciplined financial regime informed by the 3 year plans previously described. Some of the main characteristics of this regime will be:

- enhancing financial reporting systems
- improving the capability of financial teams
- improving financial forecasting abilities
- strengthened monitoring arrangements
- better sharing of best practice

The requirement is for Health Boards to plan to maintain or improve current performance levels. Of particular importance are indicators of quality including mortality, infections, stroke, and immunisation. We will increasingly focus on the outcomes of care as well as time – determined measures of access to care. It is recognised the achievement of these improvements will require adoption of proven best practice, enhanced clinical engagement, improved information systems, innovation and strong national and local leadership.

Wales Audit Office Recommendations

In welcoming the report we generally accept its recommendations, We trust the Committee find Annex 1 – setting out relevant responsive details – helpful.

Conclusion

The Wales Audit Office emphasises the challenges facing the Welsh NHS. It draws attention to many areas of strength and positive progress. We will build on these but accept the need for change in key areas. We will in particular recognise the need for our financial processes to support and enable quality in our clinical delivery systems.

HEALTH FINANCES 2012-13 & BEYOND - Recommendations and Welsh Government responses
ANNEX 1

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
1	**Recommendation 1.** The Department continues to send mixed messages over the availability of additional funding: insisting at the beginning of the financial year that no funding will be provided before later allocating additional funding. We understand the Department's desire to focus NHS bodies on their goal of living within their means. However, the historical provision of providing additional funding has contributed to an unhelpful culture where some NHS bodies are second guessing the position and assuming they will get additional funding. **To help develop a culture of greater financial transparency across NHS Wales, the Department should:** • **develop a shared understanding and ownership by regularly reporting and discussing with NHS bodies the financial position of NHS Wales as a whole, including the central budgets managed by the Department;** • **clearly articulate the position at the beginning of the financial year in respect of what flexibility the Department has to manage financial risks;** • **during the year, keep NHS bodies updated in terms of any flexibility within the central budget and how it intends to use any surpluses; and** • **work with and challenge NHS bodies to improve the consistency and transparency of financial reporting and forecasting particularly for cost**	August 2013 March 2014	**Agreed** The NHS Wales Finance Directors will be provided with a full and complete update of the overall Departments financial position each month at their formal Finance Directors meetings. This will include the potential use of and decisions associated with any contingency funding. The developments and improvements we are making to the planning processes and in particular the focus on the medium term will require formal approval by the Welsh Government of NHS plans.. This will enable us to clearly set out the financial expectations and any flexibility being provided over this period. The improvements to the planning processes will also enable better quality monitoring arrangements and the ability to identify and challenge NHS organisations on inconsistencies and discrepancies in their reporting and forecasting.

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
	improvement programmes.		
2	**Recommendation 2.** Service reconfiguration and change offers the best chance of developing a lower-cost model that puts the Welsh NHS on a more financially sustainable footing. At present, the financial costs and benefits of transformation and reconfiguration are unclear. The Department is in the process of supporting and challenging NHS bodies as they develop integrated three-year workforce, service and financial plans. **In considering NHS bodies' three-year plans, the Department should:** • **robustly challenge NHS bodies to develop an ambitious programme to reform the delivery and configuration of services, to include integrated service plans that set out in detail the costs (both revenue and capital expenditure) and expected financial benefits alongside patient quality and safety impacts; and** • **test the sustainability of NHS bodies' plans for medium to long-term change against the Department's own assumptions for the medium to long-term prospects for NHS finances.**	March 2014	**Agreed** The formal challenge and assessment of both current and future service reconfiguration plans will be addressed as part of the Integrated Planning Framework. In line with the implementation of the Financial Duty change the Integrated Planning Framework, setting out the requirements for sustainable integrated plans, including evaluation of expected financial benefits alongside patient quality and safety impacts, will also include a formal assessment and approval process. The NHS bodies' Integrated Medium Term Plans will be assessed and approved in context of the overall resources available within the Department's Main Expenditure Group. The financial flexibility being provided through the proposed NHS Finance (Wales) Bill will support the Integrated Medium Term Plans. Accordingly there will be a robust evaluation and approval mechanism to ensure that the NHS bodies plans and profiles are aligned to the overall available resources.
3	**Recommendation 3.** In order to manage financial and service pressures, it is clear that many NHS bodies have deprioritised delivery of their targets on waiting times for planned procedures. Given the financial constraints, some form of prioritisation of activity and goals could be seen as	March 2014	**Agreed** Tier 1 targets are used to agree the annual priorities areas of focus for the NHS. This years priorities are based on five quality domains across range of

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
	inevitable. But such prioritisation needs to be well thought through, transparent and the risks need to be managed. The extent to which such prioritisation is documented and publicised varies between NHS bodies. The Department has not deprioritised any areas and has tasked NHS bodies with delivering against an increasing number of Tier 1 priorities. **The Department and NHS bodies should work together to develop a robust framework for reviewing priorities and managing risks in those areas of service delivery that assume a lower priority, in particular to clarify:** • **whether it is realistic to continue to expect NHS Wales to improve performance against an ever-rising set of priorities given a real terms decline in resources;** • **the extent to which NHS bodies are free to determine their own local priorities/risk appetite in relation to deprioritising service delivery; and** • **the extent to which NHS bodies should publicise and engage the public in relation to prioritisations that impact on the level or quality of services.**		targets . The number have been kept to a minimum but are spread across the wide areas of responsibility covered by the HBs. Financial balance remains one of these areas In recognition of the financial environment and the challenges from the previous year, WG are working with HB's to agree realistic plans and improvement trajectories. This approach supports the need and on going work to establish a 3 year financial and delivery planning process in the future. This will allow for more long term sustainable improvements to be developed when timelines are more realistic.
4	**Recommendation 4.** Last year we recommended that the Department challenge NHS bodies to accelerate savings from workforce planning while managing the risks to service levels and quality. We found that there are still significant issues with workforce planning and the robustness of the workforce savings that NHS bodies claim to have delivered.	Dec 2013 to March 2014	**Agreed** The Department has set up a dedicated project team with associated governance arrangements to develop and implement improvements to NHS organisations planning processes. A key component of this work will be to ensure that NHS plans incorporate key linkages between activities and are integrated in terms of finance, workforce and service delivery.

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
	The Department should: • **step up its challenge of NHS bodies' workforce plans, to ensure that they have robust and detailed workforce plans, which link directly to service plans and plans for workforce savings; and** • **provide detailed in-year challenge to test whether the workforce savings that NHS bodies report can be reconciled to the workforce plans and actual staffing levels.**		Better quality planning will enable more robust and clearer evidence to support the on-going monitoring and challenging processes that follow.
5	**Recommendation 5.** Last year we recommended that the Department should support NHS bodies in sharing good practice on savings, but our local work suggests that there is little evidence of learning across NHS Wales either by sharing good practice on savings schemes that have worked well or using available costing data to identify and learn from existing practices. **The Department should support NHS bodies by helping to identify, gather and disseminate good practice, considering the use of case studies, seminars, training and a central access point for this information.**	December 2013	**Agreed** The Department will work with NHS bodies, through the Directors of Finance group, to develop a best practice group and programme of work to disseminate and promote best practice. This will build on the work and recommendations of the Best Practice and Innovations Board – specifically around the opportunities, tools and information to promote best practice.
6	**Recommendation 6.** Last year we recommended that the Department work with NHS bodies to profile technical accounting adjustments and central savings across the year. This year, we found several NHS bodies are still making relatively large adjustments at the end of the year. This situation exposes the Department to significant financial risks at the year end, if those adjustments do not materialise. **We recommend that the Department steps up its challenge on NHS bodies to produce updated**	Actioned	The monitoring return guidance for 2013/14 has been strengthened; requiring organisations to accurately reflect any accountancy gains in their reported positions: o *"Any accountancy gains/balance sheet movements, unallocated reserves and savings items should be appropriately phased to ensure that the year to date position is not distorted"* Specific lines have been included on Table D (Underlying Position) to report any year to date and future month's accountancy gains.

Recs (No. of elements)	Recommendation Summary (number of separate elements listed to meet recommendation in full)	Target date	Progress / Update
	projections, including in-year balance sheet reviews, building on the good practice we found in at least one local health board.		Comments are required in the narrative on any entries made. A new table introduced in 2013/14 (Table A-Movement of Opening Financial Plan to Forecast Outturn" also requires organisations to report any current or forecast accountancy gains which will contribute to the achievement of their forecast outturn position. A monthly reconciliation is undertaken between all entries and any issues raised with the organisation.

Cardiff & Vale University Health Board
Submission to Welsh Government Public Accounts Committee – 28 October 2013

Welsh Audit Office - Health Finances 2012-13 and Beyond

SUMMARY

This report provides an update on the current financial position and three year financial plan of Cardiff & Vale UHB. It sets out the Health Board's response to the Welsh Audit Office *Health Finances 2012-13 and Beyond.*

CARDIFF & VALE UHB CURRENT FINANCIAL POSITION

The UHB is on track to deliver the first year of the three year financial recovery plan which was agreed with Welsh Government in March 2013.

The UHB recognised in summer 2012 that it needed to take a radically different approach to recovering its underlying financial deficit. It therefore invited Ernst & Young to help develop a turnaround programme in early 2013. This resulted in a report in January 2013 which set out clearly that the UHB had a large underlying financial deficit, but also identified a range of opportunities, based on benchmarking, which would move the UHB from deficit into recurring surplus.

As a result of this, by March 2013, the UHB had developed and agreed a three year financial recovery plan with the Welsh Government. This returns the UHB to recurring financial balance in 2014/15 and pays back the deficit from 2013/14 in 2015/16. The agreed profile is as follows:

	2013/14 £m	2014/15 £m	2015/16 £m
Deficit / (Surplus)	**32.5**	**(8.1)**	**(25.1)**

The financial plan set out above anticipated a requirement to deliver savings each year significantly higher than those planned and delivered by Foundation Trusts in England of 4.3% in 2013/14 and 5% in 2014/15. This poses a significant challenge.

In 2013/14, in line with the above plan, the UHB is planning an agreed deficit of £32.5m. This will be achieved through delivering savings equating to £56.7m. In addition to this the UHB is covering the cost of incremental uplifts from national pay contracts of £4.7m ('Agenda for Change' and 'Consultant Contract'). In total therefore the UHB has an agreed plan which delivers savings in 2013/14 of £61.4m (5.3%).

The savings are being delivered through a combination of changes:

- Service change which improves patient care e.g. changes to mental health services which support policy implementation (care moving into community sectors from inpatient)
- Service related efficiency including reductions in length of stay through earlier discharge of patients, earlier rehabilitation of patients leading to lower likelihood of them requiring a continuing health care package, more effective prescribing
- Administrative efficiency e.g. savings on procurement, back office functions
- Workforce changes e.g. skill mix and reductions in variable and temporary pay

At M6, the UHB has a deficit of £7.1m worse than its planned deficit of £16.2m (1.3%). There is a significant risk to achieving the in year financial position of approximately £15m. The UHB believes that its plans are sound, but the UHB entered the year with no headroom or contingency. Further cost pressures have arisen in year e.g. around medicines management and growth in continuing health care and there has in addition been slippage on change programmes. However the UHB continues to forecast that it will be close to delivering the planned and agreed forecast deficit at year end.

45% of the UHB costs relate to pay (61% of influenceable costs). This means that in order to manage in a flat cash environment, with a national pay increase, continuing requirement to fund incremental pay awards and no changes to terms and conditions, either workforce numbers need to reduce or average pay needs to reduce.

As at the end of September 2013, workforce numbers have reduced by 180 compared to the end of March 2013. A further reduction of 380 is expected by the end of March 2014. The UHB issued a section 188 giving notice that significant numbers of jobs would be put at risk in June 2013. The three month consultation period is now complete and workforce change schemes are now being individually delivered by UHB Clinical Boards.

CARDIFF & VALE UHB 2014/15 FINANCIAL PLAN

In 2014/15 the UHB will be in the second year of its financial recovery plan. The UHB has made assumptions about the Welsh Government budget as follows:

- Flat cash settlement
- Impact of changes to Research and Development and Service Increment for Teaching funding are neutral
- No changes to the funding formula or additional allocation for population growth

The UHB is also assuming the following:

- Funding for specialised services will also be at flat cash plus the marginal rate for any additional treatments provided above 2013/14 contract levels. It is essential that patient flows towards the tertiary centre are backed by the appropriate resource flows.
- The UHB is not planning for significant cost pressure from the introduction of new drugs or Welsh Government policies.
- No assumptions have been made around changes to national terms and conditions negotiated for 2014/15 which could impact favourably both on the financial position but also in terms of incentivising changed patterns of working to deliver better patient care (e.g. 7 day working). Terms and conditions, particularly around the consultant contract and GP contract, are significantly more expensive and less flexible than the English contract.
- A small amount of funding has been built in for costs of strategic service change e.g. workforce changes, investment in project managing and non recurring capacity to drive change programmes.
- Capital will be allocated on a similar basis to 2013/14, however any opportunity to increase this would enable faster implementation of new technology and upgrading or vacating poor quality estate. Both these would support financial savings and improvements in quality and safety.

The UHB in making the assumptions above is taking a cautious position and it is hoped that the 2014/15 budget settlement announced will improve the position as the headline is that there will be some growth rather than a flat cash settlement. At the time of writing, we are currently assessing the impact that this settlement will have on our 3 year plan.

The UHB is then expecting cost pressures for 2014/15 as follows:

- Pay award of 1%
- Incremental drift in line with 'Agenda for Change' and 'Consultants Contract'
- Increased costs of PFI contracts for car parking, which cannot be passed on to the public
- Recovering the underlying deficit
- Non recurring costs of achieving Tier 1 targets, particularly Referral to Treatment times
- Demand growth in continuing health care
- Non pay inflation, with particular pressures on energy prices
- Primary and secondary care drugs growth

These assumptions mean that the UHB will need to deliver a savings target of 6.2% to achieve its planned financial surplus for 2014/15. The plan also assumes that the 2013/14 savings targets are achieved recurrently.

This equates to a real-terms reduction in expenditure of 6.2% and will again require workforce reductions to deliver. The UHB continues to use benchmarking of upper quartile performance against its UK peers to identify those areas through which savings schemes can be delivered.

In 2014/15 the UHB is also aiming to move some funding from acute into primary and community care, predominantly by requiring lower savings targets from primary and community care. This will enable the clinical and management teams in these areas to focus on managing demand, changing services and support preventative treatment, however it has the impact of requiring a higher savings target on hospital services which will be challenging to deliver.

At this stage, no change to the financial position has been planned as a result of the South Wales Programme. Modelling on the potential impact of this is being undertaken following the recent public consultation.

RESPONSE TO WELSH AUDIT OFFICE *Health Finances 2012-13 and Beyond*

The Health Board has a positive relationship with Welsh Audit Office and finds its reports helpful in supporting effective service and financial planning and management. The Health Board contributed to and has reviewed in detail the *Health Finances 2012/13 and Beyond* report. The response from the Health Board is set out below:

Number	Recommendation	Response
R1	The Department continues to send mixed messages over the availability of additional funding: insisting at the beginning of the financial year that no funding will be provided before later allocating additional funding. We understand the Department's desire to focus NHS bodies on their goal of living within their means. However, the historical provision of providing additional funding has contributed to an unhelpful culture where some NHS bodies are second guessing the position and assuming they will get additional funding. To help develop a culture of greater financial transparency across NHS Wales, the Department should: • develop a shared understanding and ownership by regularly reporting and discussing with NHS bodies the financial position of NHS Wales as a whole, including the central budgets managed by the Department; • clearly articulate the position at the beginning of the financial year in respect of what flexibility the Department has to manage financial risks; • during the year, keep NHS bodies updated in terms of any flexibility within the central budget and how it intends to use any surpluses; and • work with and challenge NHS bodies to improve the	The Health Board agrees that it would be a helpful approach if a clear allocation was provided at the beginning of each financial year. The Health Board agrees that there is a key role for Welsh Government in sharing the financial position of NHS Wales across NHS organisations, facilitating their working together to plan and deliver cost improvement programmes and challenge delivery. This is currently delivered via the monthly Directors of Finance and Chief Executives meetings, through monthly Quality and Delivery meetings and through the six monthly JET meetings. The Health Board plays an active role in all these fora and will continue to support Welsh Government continuously to improve these processes.

	consistency and transparency of financial reporting and forecasting particularly for cost improvement programmes.	
R2	Service reconfiguration and change offers the best chance of developing a lower-cost model that puts the Welsh NHS on a more financially sustainable footing. At present, the financial costs and benefits of transformation and reconfiguration are unclear. The Department is in the process of supporting and challenging NHS bodies as they develop integrated three-year workforce, service and financial plans. In considering NHS bodies' three-year plans, the Department should: • robustly challenge NHS bodies to develop an ambitious programme to reform the delivery and configuration of services, to include integrated service plans that set out in detail the costs (both revenue and capital expenditure) and expected financial benefits alongside patient quality and safety impacts; and • test the sustainability of NHS bodies' plans for medium to long-term change against the Department's own assumptions for the medium to long-term prospects for NHS finances	The Health Board fully supports the recent Welsh Government requirement to develop integrated three year workforce, service and financial plans. The Health Board anticipated this requirement, submitting its first plan to Welsh Government in June 2013. The Health Board supports the external and peer review process put in place by Welsh Government to review the September 2013 and January 2014 plans. It would be helpful if Welsh Government could provide an update on expected allocations and assumptions for the three year plan prior to the January 2014 submission. It will be particularly important to understand the capital position especially the amounts which are likely to be available for backlog maintenance and core IT and equipment replacement which is a high risk for the UHB.
R3	In order to manage financial and service pressures, it is clear that many NHS bodies have deprioritised delivery of their targets on waiting times for planned procedures. Given the financial constraints, some form of prioritisation of activity and goals could be seen as inevitable. But such prioritisation needs to be well thought through, transparent and the risks need to be managed. The extent to which such prioritisation is documented and	The Health Board did not deprioritise delivery of targets on waiting times in 2012/13 although there were significant levels of elective procedure cancellations due to pressures of unscheduled care. The Health Board has taken a more pro-active approach to winter planning, supported by the Welsh Government assurance process, to ensure that these are minimised in winter 2013/14.

	publicised varies between NHS bodies. The Department has not deprioritised any areas and has tasked NHS bodies with delivering against an increasing number of Tier 1 priorities. The Department and NHS bodies should work together to develop a robust framework for reviewing priorities and managing risks in those areas of service delivery that assume a lower priority, in particular to clarify: • whether it is realistic to continue to expect NHS Wales to improve performance against an ever-rising set of priorities given a real terms decline in resources; • the extent to which NHS bodies are free to determine their own local priorities/risk appetite in relation to deprioritising service delivery; and • the extent to which NHS bodies should publicise and engage the public in relation to prioritisations that impact on the level or quality of services.	The Health Board would agree that it will be essential to have a robust framework for determining policy priorities at Welsh Government level including a clear cost benefit analysis and support in terms of what areas of service will therefore be a lower priority. The Health Board has a prioritisation framework which can support its own local determination of this, but this is relatively underdeveloped at this point. The Health Board plans to develop a 10 year Clinical Services Strategy during 2014/15. This will involve extensive public engagement around both service priorities and deprioritisation to support delivery within the funding available.
R4	Last year we recommended that the Department challenge NHS bodies to accelerate savings from workforce planning while managing the risks to service levels and quality. We found that there are still significant issues with workforce planning and the robustness of the workforce savings that NHS bodies claim to have delivered. The Department should: • step up its challenge of NHS bodies' workforce plans, to ensure that they have robust and detailed workforce plans, which link directly to service plans and plans for workforce savings; and • provide detailed in-year challenge to test whether the	The Health Board agrees that a key component of integrated planning is the alignment of service, financial and workforce plans. The Health Board submitted the first three year integrated plan including workforce plans to WG in June 2013. This set out plans to reduce workforce significantly in 2013/14. At M6 the workforce has reduced by 179 and is 87 wte over plan. The Health Board has an integrated Performance Management Framework in place for all Clinical Boards and Corporate Departments. All these have integrated service, financial and

	workforce savings that NHS bodies report can be reconciled to the workforce plans and actual staffing levels.	workforce plans and delivery against these are tested on a monthly basis at the Executive Performance Review meetings. Workforce indicators form a key component of the monthly performance dashboard produced for each directorate. The Health Board will need to continue to reduce staff numbers over the next three years. It will also be important to agree across NHS Wales the approach to pay terms and conditions in a way which supports service delivery whilst managing within the funding available. Some of the workforce efficiencies would more appropriately be delivered through pay restraint or changes to terms and conditions, eg enabling 7 day working to be the norm or by matching Welsh pay contracts (eg Agenda for Change, consultant contract, GP contract) to the English contract which has significantly better terms for employers.
R5	R5 Last year we recommended that the Department should support NHS bodies in sharing good practice on savings, but our local work suggests that there is little evidence of learning across NHS Wales either by sharing good practice on savings schemes that have worked well or using available costing data to identify and learn from existing practices. The Department should support NHS bodies by helping to identify, gather and disseminate good practice, considering the use of case studies, seminars, training and a central access point for this information.	The Health Board agrees that there could be more sharing of good practice, both across Wales and across the UK. This has been an increasing focus at the Directors of Finance monthly meetings recently, with sessions covering benchmarking, procurement opportunities, Continuing Health Care, prescribing etc. Welsh Government has facilitated this and the Health Board would support them continuing to do this. There are areas across Wales where benchmarking could be significantly improved, through better information systems and standardisation of data definitions. This includes patient activity, prescribing etc.
R6	Last year we recommended that the Department work with NHS	The Health Board supports this recommendation as part of

	bodies to profile technical accounting adjustments and central savings across the year. This year, we found several NHS bodies are still making relatively large adjustments at the end of the year. This situation exposes the Department to significant financial risks at the year end, if those adjustments do not materialise. We recommend that the Department steps up its challenge on NHS bodies to produce updated projections, including in-year balance sheet reviews, building on the good practice we found in at least one local health board.	good practice around financial reporting and is working with the Welsh Audit Office to understand what opportunities it has for improvements in this area.

SUMMARY

In summary, Cardiff & Vale UHB has an agreed three year financial plan to move it from significant underlying deficit into recurring surplus. Despite challenging savings targets, which are slightly behind plan at M6, the UHB is on track to deliver year 1 of the plan. Plans are based on benchmarking and aim to drive improvements in patient care as well as financial savings. The three year plan is based on a flat cash settlement, the potential improvement in this announced recently will enable some headroom to manage in-year risks and pump priming of service change.

The Welsh Audit Office report is helpful in identifying further areas where the Health Board can improve its performance both as an individual organisation and through partnership with other Health Boards and with Welsh Government, to continue to manage to improve services within finite resources.

Eitem 4

Y Pwyllgor Cyfrifon Cyhoeddus

Lleoliad:	Ystafell Bwyllgora 3 – y Senedd
Dyddiad:	Dydd Mawrth, 15 Hydref 2013
Amser:	09:00 – 10:34

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_15_10_2013&t=0&l=en

Cofnodion Cryno:

Aelodau'r Cynulliad:	Darren Millar (Cadeirydd) Mohammad Asghar (Oscar) AC Mike Hedges Julie Morgan Jenny Rathbone Aled Roberts Jocelyn Davies Sandy Mewies
Tystion:	Huw Vaughan Thomas, Archwilydd Cyffredinol Cymru, Swyddfa Archwilio Cymru Stephen Martin, Swyddfa Archwilio Cymru Meilyr Rowlands, Estyn Gillian Body, Archwilydd Cyffredinol Cynorthwyol, Swyddfa Archwilio Cymru Paul Dimblebee, Cyfarwyddwr Grŵp – Archwilio Perfformiad, Swyddfa Archwilio Cymru
Staff y Pwyllgor:	Claire Griffiths (Dirprwy Glerc) Joanest Jackson (Cynghorydd Cyfreithiol)

TRAWSGRIFIAD

Gweld trawsgrifiad o'r cyfarfod.

1 Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Croesawodd y Cadeirydd yr Aelodau a'r cyhoedd i'r cyfarfod.

2 Trefniadau Cyflenwi ar gyfer Absenoldeb Athrawon: sesiwn friffio gan Swyddfa Archwilio Cymru

2.1 Cafodd y Pwyllgor sesiwn friffio gyda Huw Vaughan Thomas, Archwilydd Cyffredinol Cymru, ar adroddiad Swyddfa Archwilio Cymru, 'Trefniadau Cyflenwi ar gyfer Absenoldeb Athrawon'. Roedd Stephen Martin o Swyddfa Archwilio Cymru a Meilyr Rowlands o Estyn yno gyda'r Archwilydd Cyffredinol. Yn ystod y sesiwn friffio, cafodd aelodau'r Pwyllgor gyfle i ofyn cwestiynau.

3 Papurau i'w nodi

3.1 Nodwyd y papurau.

4 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol:

4.1 Derbyniwyd y cynnig.

5 Trefniadau Cyflenwi ar gyfer Absenoldeb Athrawon: Aelodau i drafod y materion a godwyd gan adroddiad Swyddfa Archwilio Cymru

5.1 Cytunodd y Pwyllgor i gynnal ymchwiliad byr i'r 'Trefniadau Cyflenwi ar gyfer Absenoldeb Athrawon'.

6 Rheoli Grantiau yng Nghymru: Trafod y cyngor gan Archwilydd Cyffredinol Cymru

6.1 Nododd y Pwyllgor yr ohebiaeth a chytunodd i adolygu'r sefyllfa ar ôl i adroddiad blynyddol Llywodraeth Cymru ar Reoli Grantiau, a ddisgwylir ym mis Rhagfyr 2013, gael ei gyhoeddi.

7 Argyfyngau Sifil yng Nghymru: Trafod y cyngor gan Archwilydd Cyffredinol Cymru

7.1 Nododd y Pwyllgor yr ohebiaeth a chytunodd y byddai'r Clerc yn ysgrifennu at Lywodraeth Cymru i gael eglurhad o'r materion a godwyd yn ei gyngor.

8 Proses gaffael Llywodraeth Cymru a'r camau a gymerwyd ganddi i waredu hen Westy River Lodge, Llangollen: Trafod y cyngor gan Swyddfa Archwilio Cymru

8.1 Nododd y Pwyllgor yr ohebiaeth a bwriad Swyddfa Archwilio Cymru i fonitro'r modd y mae Llywodraeth Cymru yn diweddaru ac yn egluro cynnydd gyda gweithredu argymhellion y Pwyllgor.

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Darren Millar AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff

Our Ref: DS/LD/TLT

22 October 2013

Dear Darren

PUBLIC ACCOUNTS COMMITTEE – CONTINUING NHS HEALTHCARE

Following the Public Accounts Committee on 8 October, there were two specific actions requiring the provision of information on:

- A detailed breakdown of retrospective cases logged both before and since 2010.
- Cumulative data identifying the number of claims being processed, clearance levels and the number of challenges made to outcomes.

Retrospective claims received prior to/on 15 August 2010

Of the 1,983 claims to be processed, 600 were completed at July 2012, rising to 1,350 at October 2013. The proportion of claims cleared has therefore increased from 30% to 68% between July 2012 and October 2013.

Retrospective claims received post 15 August 2010

At July 2012 1,555 claims had been received, of which 226 claims were completed (a 15% clearance level). At September 2013 a total of 1,572 claims had been received. The total claims completed at end September 2013 were 339 (a 22% clearance level).

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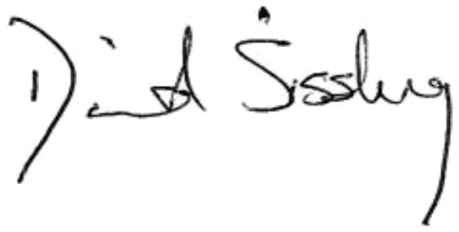
Challenges to outcomes

There have been 12 complaints which were settled by Local Health Boards. These are a mix of voluntary settlements (which were resolved at investigation stage) or resolved without the need for investigation.

There were 4 complaints investigated by the Public Service Ombudsman for Wales in the last financial year. One complaint was not upheld, 2 complaints were upheld and one partly upheld.

Yours sincerely



DAVID SISSLING

cc Mark Drakeford AM, Minister for Health and Social Services
Albert Heaney, Director of Social Services and Integration

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

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Mr Darren Millar AM
Chair of the Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff CF99 1NA

Date: 31 October 2013
Our ref: HVT/1982/fgb
Page: 1 of 2

Dear Darren

PAC Inquiry on Betsi Cadwaladr University Health Board

I wrote to you on 16 September 2013 with some views on the written submission that Mrs Mary Burrows provided in place of her scheduled attendance to give oral evidence at the Committee's meeting of 18 July 2013. In that letter, I indicated that I would write again when colleagues here had considered her evidence more fully.

Having reviewed the written evidence from Mrs Burrows, I can confirm that there is nothing in its content that would cause me to have any concerns about either the fairness or accuracy of the findings presented in the joint report that I published with Healthcare Inspectorate Wales (HIW) in June 2013. The report was, of course, signed off as factually accurate by the Accountable Officer of the Betsi Cadwaladr University Health Board (Mr Geoff Lang), and the report's findings and recommendations have subsequently been accepted in full by the Board itself.

It may, however, be helpful to the Committee for me to confirm the process that we and HIW went through to discuss and agree our findings with the Health Board. On 26 March 2013, Kate Chamberlain and I wrote to Geoff Lang, in his capacity as Acting Chief Executive (as Mary Burrows was at that point on sickness absence), informing him of our intention to conduct the joint Governance Review. Mrs Burrows subsequently returned to work in April 2013, and she was interviewed by the review team during the fieldwork stage of the review.

Immediately upon completion of the fieldwork in the latter part of May, Dave Thomas (WAO) and Mandy Collins (HIW) wrote jointly to Mary Burrows in her capacity as Chief Executive of the Health Board to set out the main findings of the joint review team. I have previously shared a copy of that letter with the Committee, and I enclose a further copy for ease of reference. That letter set out quite starkly the key concerns that the joint review team had uncovered. Mrs Burrows acknowledged receipt of the letter, as did the then Chair of the Board, who was a copy recipient.

Direct Line: 029 2032 **0510** E-mail: huw.vaughan.thomas@wao.gov.uk

Shortly after the issue of the letter Mrs Burrows went on sick leave, and by the time the full draft report was ready for circulation in early June the 'Accountable Officer' designation for the Health Board had been assigned to Geoff Lang, who had been appointed as Acting Chief Executive. In discussing the draft report with Mr Lang in his capacity as the Accountable Officer to confirm its factual accuracy, we made it clear that it was the Health Board's responsibility to decide whether Mrs Burrows should herself be involved in the report clearance process, and if so how that should be done, given that she was on sick leave. This is standard practice, and it would not have been appropriate in those circumstances for staff of either the Wales Audit Office or Healthcare Inspectorate Wales to have sought to liaise directly with Mrs Burrows.

I trust that this is a helpful clarification. If there are any further matters that I can assist the Committee with, then please do not hesitate to let me know.

Yours sincerely

HUW VAUGHAN THOMAS
AUDITOR GENERAL FOR WALES

Enc *WAO & HIW joint letter to Mrs Mary Burrows, 23 May 2013*

cc *Dr Kate Chamberlain, Chief Executive, Healthcare Inspectorate Wales*

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Reference	MB/1/2013
Date	23 May 2013
Pages	**1** of **3**

Mary Burrows
Chief Executive
Betsi Cadwaladr University Health Board
Health Board Headquarters
Ysbyty Gwynedd
Penrhosgarnedd
Bangor LL57 2PW

Dear Mary

Joint HIW & WAO Review of Governance at Betsi Cadwaladr University Health Board

As you'll be aware a joint HIW and WAO review team was on site at the Health Board last week as part of the review of governance arrangements at the Health Board. We are very grateful to yourself and Health Board colleagues for finding the time to meet with reviewers, and for sharing information with us during what is a very challenging time for the organisation. Our particular thanks go to Grace Lewis Parry and her team for their support in helping to arrange the fieldwork week at short notice.

The information we collected last week is now being carefully considered alongside other sources of evidence, and will be used to inform the content of a draft report that we anticipate will be ready for circulation to the Health Board for factual accuracy checking in early June.

Information provided to us by Grace has demonstrated that much work is underway to address many of the concerns that HIW and WAO have previously identified. Within this we note the action that has been taken to strengthen Board meetings through use of minuted in-committee sessions, and a greater focus on patient experience information. We also note that hospital site management arrangements have been introduced, that work is underway to review the executive and clinical programme group organisational (CPG) structures, and that decisions have been taken in relation to community services.

However, information shared with us by Board members, and other senior members of staff has highlighted a number of issues which we consider are undermining the effective governance of the Health Board. Because of the nature of some of the concerns which are emerging, the review team felt it was appropriate for us to write to you now to highlight these matters. We expect these issues to feature prominently in our report, and we thought that early sight of them would allow the Health Board to start to consider its response to what are a number of potentially difficult and challenging issues.

The main concerns which are emerging so far are set out below.

- There would appear to be a potentially irretrievable breakdown in the working relationship between certain senior leaders in the Health Board, which is compromising the effective leadership and governance of the organisation.
- There is a concern about the stability and capacity of the Executive team as a result of sickness absence and staff turnover, and specific concerns about clinical leadership capacity of the Executive team given the acting nature of the executive posts with clinical responsibilities.
- In relation to the Executive team there is a further concern about a lack of cohesion in the way the team works which can mean that there is not a clear consensus amongst executives on important issues that come to the Board.
- Effective scrutiny and discussion at the Board on key issues such as urgent medical recruitment needs and CPG restructuring are being hindered by papers either being circulated late or tabled on the day. This is understandably provoking independent members to request more information in order to get the assurances they are seeking, which has the effect of further delaying key decisions.
- The Board has yet to see proposals for the reconfiguration plans involving acute services despite having commissioned this work last Summer. Notwithstanding the significant challenges associated with such a review, the delay in developing these plans is worrying given their fundamental importance in shaping future health services which are clinically and financially sustainable. Given the concerns expressed above about cohesiveness of executive team working, it will be vital to ensure that any proposals presented to the Board adequately address the inter-related issues of service, financial and workforce planning.
- Concerns that we have previously raised in relation to the governance, accountability and workability of the CPG structure have still to be fully addressed. Getting a clear consensus on the revisions to the CPG structure to address these issues appears to have been problematic, with the Board rejecting proposals that were previously submitted, and reworked partial proposals are now due to be discussed at the Board meeting on 23rd May.
- Linked to the above, accountability and performance management arrangements relating to CPGs need to be strengthened to ensure key aspects of corporate governance such ownership of budgets, responsibility for cost containment, and delivery of improvements are adequately addressed.
- When senior staff such as Assistant Medical Directors, have concerns about aspects of service delivery, we have been told it would not be uncommon for these to be raised only by email rather than through other, more formal and inclusive channels. This may be preventing important quality and safety issues from being fully considered at the appropriate forum, and creates the risk that the Board and its Committees are not fully informed of risks facing the organisation.

In addition to the issues listed above, we are also now aware of the *C. Difficile* outbreak in the Health Board, and a number of patient deaths where *C. Difficile* was the cause of mortality or a contributory factor. It is of very significant concern to us that the Board was not sighted of the magnitude of the issue in a timely manner. Moreover, the Director of Public Health Medicine has subsequently informed us that the actual scale of the problem is significantly worse than originally thought. This raises major concerns about the Health Board's clinical governance arrangements and specifically its reporting processes for something as fundamental as infection control. The exact details of the issues surrounding the outbreak are still unfolding, but the emerging picture is extremely concerning and we will continue to monitor the situation as it develops and reflect the latest position in our draft report. In the meantime, HIW will be writing separately to the Health Board to seek further information on the nature and handling of the outbreak.

Work will now continue with the preparation of a draft report setting out the totality of our findings. However, we'd be happy to receive any observations or queries that you may have on the issues raised here.

We have also given an undertaking to keep senior Welsh Government officials updated on the emerging findings of the review given the fact that they are already in close dialogue with yourself and the Chairman in relation to the challenges the Health Board is currently. It is therefore our intention to share a copy of this letter with David Sissling.

Yours sincerely

David Thomas
Director, Health & Social Care
Wales Audit Office

Mandy Collins
Deputy Chief Executive
Healthcare Inspectorate Wale

cc Professor Merfyn Jones, Chairman, Betsi Cadwaladr University Health Board

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
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Department for Health and Social Services
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Llywodraeth Cymru
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Mr Darren Millar AM
Chair
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Our Ref: DS/RA

15 October 2013

Dear Darren

Public Accounts Committee – Governance Arrangements at Betsi Cadwaladr University Health Board

I wrote to you on 2 October providing comments on correspondence received from Mary Burrows. I have given this matter some further thought. I believe it may be helpful to offer the Committee some additional observations. These relate to the role, responsibilities and accountabilities of Chief Executives appointed to Health Boards in the Welsh NHS.

The Job Description for the role is relevant and helpful in this regard. I attach a copy and would draw the Committees' attention to the sections entitled :

- Job Purpose

- Key Accountabilities
  - Improving Population Health and Patient Services
  - Performance
  - Governance
  - Leadership of Staff

The Job Description is, I believe, quite clear in establishing a wide range of leadership responsibilities. Quite properly the Chief Executive has to ensure the organisation can operate effectively to enable achievement of statutory duties and other priorities as defined by Welsh Government or agreed by the Board. The relationship of the Chief Executive with the Board is critical. The Chief Executive has to formally provide advice, identify risks, propose strategic and operational responses and enact agreed Board decisions.

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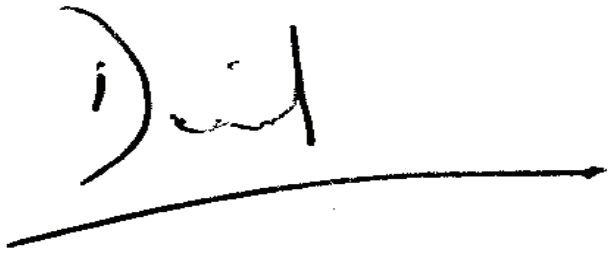
In light of the above the Chief Executive clearly cannot act in a passive observational capacity. He or she must act on any concerns and must take action as the Principal Executive Officer or as the point of primary executive advice to the Board. In certain circumstances, a Chief Executive might properly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

Finally it is important to acknowledge the challenging and demanding nature of the Chief Executive role. There are however many examples in Wales - often associated with determined and self insightful leadership – where individuals are carrying out the role successfully.

I hope the above is helpful.

Yours sincerely



David Sissling

JOB DESCRIPTION

Post Title:	Chief Executive and Accountable Officer for ... LHB
Accountable to:	The LHB Chairman and Board for the management of the LHB's affairs delivery of Welsh Government (WG) Policy and performance requirements and implementation of board policies: The Chief Executive of NHS Wales for the proper stewardship of public funds, the delivery of WG policy and performance requirements.
Key Relationships:	LHB Board Members of the Stakeholders Reference Group Members of the Professional Forum Local Partnership Forum Local Authorities The Third Sector AMs, MP's and Ministers and WG Officials Media CHC's Contractors Universities
Remuneration & Terms and Conditions:	As determined by the LHB Remuneration and Terms of Service Committee within the policy framework set by the Welsh Government.
Location:	

Job Purpose:

The Chief Executive will be the Accountable Officer for the Local Health Board (LHB) with full responsibility for the continued development and management of the LHB. The Chief Executive provides top level leadership, vision and strategic direction and management across all aspects of the LHB's activities and will ensure that all required decision making, control, delivery and development systems are in place. The Chief Executive is accountable for providing advice to the Board on all elements of LHB business and specifically on matters, relating to probity, regularity and administration.

Particular key responsibilities will be to:

- Integrate the planning and delivery of all services within the LHB, including a commitment to working and responding locally and delivering statutory plans with partners.

- Develop an organisational culture that supports clinical engagement in decision making and a drive for continuous service change and improvement.

- Lead and manage the performance and development of the LHB.

- Ensure performance targets are set and achieved and the LHB achieves all of its financial targets and that its financial affairs are conducted legally.

- Effectively lead and manage the integration of the various components of the LHB to develop a unified organisation which delivers a service that:

    - delivers improved population health and well being
    - reduces inequalities
    - improves patient safety

- Provide proper stewardship of public funds and the compliance of the LHB all statutory, legislative and policy requirements. with

- Act as an ambassador for the LHB building the reputation of the services it plans and manages.

Key Accountabilities:

Improving Population Health and Patient Services

- Working with the UPHS (Unified Public Health Service) and other agencies to lead on the improvement of population health and the public health agenda.

- Leading the change in emphasis from in-hospital care to effective prevention, early intervention and long-term community based support.

- To engage effectively with clinical leaders so that the LHB provides safe, high quality, acceptable care for patients in line with NHS standards for services in Wales, within the resources available.

- Initiate and facilitate effective partnerships and alliances between the LHB and other agencies so as to influence the agendas of these bodies and to draw on their experiences and perspectives in creating local NHS and community strategies, policies and actions to deliver long-term health improvements.

- To motivate all clinical staff to benchmark services continuously against best practice evidence, research and audit to ensure high quality standards of patient care.

- To foster a culture which embraces and recognises opportunities for the utilisation of new clinical and service technologies.

Performance

- To achieve the financial and corporate objectives set for the LHB, ensuring the effective, efficient and economical use of resources in achieving planned activity and delivery of all required performance targets.

- Project managing successful delivery of national programmes.

- Meet agreed commitments across the community as set out in the Annual Operating Framework and prepare the LDP response.

- Ensure delivery of the LHB's contribution to performance priorities within local partnership plans.

- Implement an appropriate Performance Management System to ensure performance of the health community is monitored and managed and supports continuous performance improvement.

- Ensure the development of information strategies to assess health needs and to support evidence based decision making.

Strategic Development and Partnership Working:

- To lead the formulation of the LHB's direction in line with the Welsh Government's Strategic Framework for the NHS and the National Plan for the NHS.

- To engage with and promote co-operation and collaboration with other organisations to develop strategic partnerships and alliances to improve the health of local communities and ensure effective partnership working.

- Ensure that strategic partnership arrangements are developed and continuously improved with local authorities and other local voluntary, statutory and private sectors.

- Promote and facilitate effective partnership working with other organisations (including private and voluntary sector service providers) to enable the LHB to function effectively and support the delivery of the range of statutory plans.

- Develop a culture of public involvement that is open and transparent, ensuring that users, carers and the general public's views are effectively represented and appropriately incorporated into decision making across the LHB.

- Develop effective relationships with the CHC's, Professional Forum and Stakeholder Reference Groups to ensure strategic plans are developed with full cognisance of their views.

Governance

- Ensure the corporate business of the LHB is effectively managed and high standards of integrated governance are established including corporate, clinical - and staff governance.

- To oversee the design and implementation of systems of business conduct, public accountability and managerial delegation and control which ensure the resources of the LHB are deployed economically, efficiently and effectively and that the LHB meets its statutory financial duties.

- Ensure a proactive approach to risk management including the systematic, identification, assessment and management of risk.

- To ensure that the LHB acts within its statutory powers and delegated authority, in accordance with statutory, legislative and Welsh Government directives and requirements.

- To develop effective organisational arrangements and capacity that enables the LHB to meet its strategic aims within a framework of strong, effective governance consistent with NHS values in terms of safety, openness, probity, and accountability.

Leadership of Staff:

- Develop processes which ensure full engagement and commitment of all clinicians; to deliver improvements to patient accessibility and clinical outcomes.

- Ensure the development of an organisation which encourages personal development and learning; encourages and supports innovation; team building and creative partnerships and a commitment to patient safety.

- Lead, direct, develop and manage staff and services of the LHB to create an open, supportive and productive culture to ensure efficiency, effectiveness and innovation.

- Lead and manage the Executive Team so that each Director is able to fulfill his/her individual responsibilities, ensuring that Directors work together to achieve the LHB Board's aims and objectives by influencing, managing and monitoring their performance.

- To implement effective performance management that supports personal development of LHB staff and succession planning for the LHB, NHS Wales and the

- Develop the LHB as an exemplar employer and establish effective recognition and partnership arrangements with trade unions and other staff organisations to ensure that through effective communication and consultation the interests of staff are understood and appropriately reflected in the management processes of the LHB.

- To ensure a Human Resource Strategy and Workforce Plan are developed which are fully integrated with planning and financial plans.

- Developing effective working relationships with employed staff, but also with local contractors to harness their support for a service that delivers improved health, reduces inequalities and improves patient safety.

Ambassador for the LHB:

- To develop and implement a communication strategy that is sensitive and responsive and secures the support of all parties within the LHB community.

- The Chief Executive will act as an ambassador for the LHB and NHS Wales.

- As one of the cadre of senior leaders within Wales - to contribute to the wider health and organisational agenda of NHS Wales and WG.

Performance Appraisals:

- Performance will be appraised and objectives agreed on an annual basis with Chair and Chief Executive NHS Wales.

Objectives for 2009/10 will include:

- Achievement of Access 2009 targets etc.

- Develop the culture and behaviours of the LHB, to support partnership working, openness safety, and continuous service improvement.

- Establish the Trust and manage with the Transition Directors the move from `Transition' to full establishment of the LHB by October 2009.

- Meet all the targets/requirements in the Annual Operating Framework.

PERSON SPECIFICATION

Qualifications

- Masters degree or equivalent qualification or level of experience
- Further evidence of management training and commitment to ongoing professional development

Experience and Knowledge

- A very successful track record of leadership and strategic management at Board level, in a complex NHS, public or commercial organisation.
- Experience of running a business with a focus on, productivity efficiency and engagement.
- Experience of effectively managing considerable resources and budgets, with a track record of delivering long term financial sustainability and outstanding value for money.
- Track record of achieving sustained organisational/service change and improvement with evidence of embedding culture and organisational values successfully and achieving workforce engagement delivering improved outcomes in quality, performance and service.
- Experience of undertaking sensitive negotiations and managing contracts to maximise the benefits and outcomes for an organisation.
- High degree of political sensitivity and experience of dealing with a range of complex issues within a political or demanding stakeholder environment.
- Experience of developing and implementing strategy and service development in a large complex organisation, exploring new service opportunities.
- Experience of enhancing the reputation of an organisation.
- Knowledge of issues within the healthcare sector.
- Experience of successful initiation and facilitation of strategic partnership working and alliances with contractors, LAs, voluntary, statutory and private bodies and stakeholders.
- Experience of and insight into, developing an organisational culture that promotes clinical engagement in decision making and leading continuous change and improvement in services, encouraging the use of new clinical and service technologies.

Abilities and Personal Qualities

- Innovative and entrepreneurial with strong service focused approach, exceptional communication, interpersonal, negotiating and influencing skills.

- Ability to think and act strategically and to articulate a clear sense of direction and vision to a wide audience.

- Ability to build effective relationships with a range of internal and external stakeholders including with clinicians.

- Demonstrable leadership and ambassadorial skills with an ability to demonstrate a flexible leadership style - consensual and participative but decisive when warranted.

- Commitment and passion for citizen focused service with the ability to embed such an ethos at all levels of the organisation.

Language

Welsh and English languages have equal status in Wales; this was conferred by the Welsh Language Act. The Act requires public bodies (whether they are based in or outside Wales) which deliver services in Wales to respect the right of people to access and use public services through the medium of Welsh. The new Chief Executives will be expected to ensure that their organisations meet the requirements of the Act. In some parts of Wales, in particular the north and west, Welsh is the first language of a significant proportion of the population.

Though Chief Executives of the new LHBs will not be required either to speak or learn Welsh they wi11 need to display real empathy towards the language and demonstrate leadership on this issue, in order to strengthen bilingual services within the NHS in Wales. This might, of course, include making efforts to learn the language.

Terms & Conditions

Salary: A salary range up to 200K is envisaged, depending on the specific LHB.

Successful candidates will be expected to relocate to a location which will facilitate effective discharging of their responsibilities as Chief Executive and which should preferably be within their Local Health Board area.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Darren Millar AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
CARDIFF
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Eich cyf / Your ref
Ein cyf / Our ref

10 October 2013

Dear Darren

PUBLIC ACCOUNTS COMMITTEE – GOVERNANCE ARRANGEMENTS AT BETSI CADWALADR UNIVERSITY HEALTH BOARD

Thank you for your letter dated 25 September 2013. I am very grateful to you for drawing to Healthcare Inspectorate Wales' (HIW) attention the correspondence that you have recently received from Professors Healy and Merfyn Jones relating to Governance Arrangements at Betsi Cadwaladr University Health Board (BCUHB).

I can confirm that HIW is aware of the concerns raised by Professor Healy, and we have been keeping a 'watching brief' on the actions being taken forward by the Health Board regarding these matters. As you may be aware that the Delivery Unit recently undertook an examination of the arrangements at the Hergest Unit, and in addition the Health Board has asked the Royal College of Psychiatrists to undertake a review of the Unit. The review by the Royal College began in September and once the final report is available I will be meeting with the Health Board to discuss its finding and to assure myself that any necessary action is taken forward at pace.

In respect of your specific question as to whether there would be merit in the Committee holding an additional evidence session on your inquiry into 'Governance Arrangements at Betsi Cadwaladr University Health Board', my view is that there would be very little merit in this. The joint report we produced with the Wales Audit Office, together with the evidence already presented to the PAC illustrated quite clearly the issues in relation to the gap between the Board and ward/service delivery level, therefore I question what the benefit of

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further discussion and debate of an already well explored issue would be. I believe that there now needs to be a focus on assuring ourselves and citizens that the Health Board is adequately addressing such issues and moving them forward. Since the publication of the joint report in June of this year I have regular discussions with the Acting Chief Executive and Nurse Executive to assure myself that progress is being made. I consider there to be clear evidence that there is now a real focus on the quality and safety of patient care and on ensuring that the right governance frameworks are put in place, to address the gap between the Board and those providing patient care.

I am meeting with the new Chairman next week to discuss the findings of the joint review and to get a sense of the next steps that he intends to take. At that meeting I will be raising with Peter the need for us to have continued and regular dialogue with the Health Board and the requirement for a follow-up review in due course.

Please do not hesitate to contact me if you wish to discuss the content of this letter.

Yours sincerely

DR KATE CHAMBERLAIN
Chief Executive

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Mr Darren Millar AM
Chair
Public Accounts Committee
National Assembly
Cardiff Bay

Our Ref: DS/TLT

2 October 2013

Dear Darren

Public Accounts Committee –Governance Arrangements at Betsi Cadwaladr University Health Board

Thank you for your letter of 20 September inviting me to comment on correspondence received from Mary Burrows. I am pleased to respond.

1. You specifically asked me about the date at which Mary made her intention to leave the NHS known. I was asked about this at the PAC meeting on 18 July 2013 and I declined to respond as this is primarily a matter which relates to Mary's relationship with her employer – Betsi Cadwaladr University Health Board.

2. These are a number of references to the emphasis which was placed on the delivery of financial and performance targets. I trust I responded to this matter in my letter to the Committee of 31 July 2013. Welsh Government did indeed press all Health Boards to deliver their statutory financial duties and key performance priorities – many of which relate to quality and safety aspects. The challenges involved in this delivery were recognised. However they were no greater for Betsi Cadwaladr than all other Health Boards. Clearly delivery in such circumstances needs to be underpinned by strong Board level governance – to provide direction, manage risk and ensure resilient internal arrangements. It was shortcomings in some important elements of governance rather than the nature and scale of the delivery challenge, which distinguished the position which developed in Betsi Cadwaladr.

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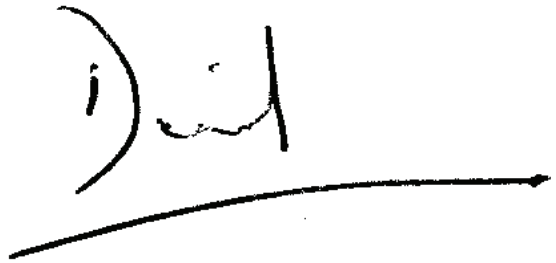
3. I am not sure it is appropriate for me to comment on detailed matters regarding the CPG structure. More generally we sought clarity and action from the Board in respect of its broader managerial arrangements from later 2012. In particular we encourage stronger site management, the introduction of a Chief Operating Officer and clarity on CPG structures.

4. It would be inappropriate for me to comment on other aspects of Mary's submission. Many relate to internal matters. Others have, I think, been covered by the evidence we have previously provided to the Public Accounts Committee.

I trust the above is helpful.

Yours sincerely



David Sissling

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Dyddiad / Date: 4 October 2013

Mr Darren Millar AM
Chair
Public Accounts Committee
Welsh Government

Dear Mr Millar

Public Accounts Committee – Governance Arrangements at Betsi Cadwaladr University Health Board.

Thank you for your letter dated 20th September 2013, addressed to Dr Higson inviting the Health Board to comment on the correspondence received by the Committee from Mrs Burrows, in response to a number of questions raised with her by the Committee, in place of the oral evidence session originally scheduled for the 18th July 2013.

Dr Higson has yet to take up his appointment as Chair of Betsi Cadwaladr University Health Board and your office requested that this matter be dealt with as soon as possible. I therefore attach a document which includes comments on matters of accuracy only arising from Mrs Burrows' submission.

In response to your further enquiry, as an employee of the Health Board, Mrs Burrows is required to work within the existing policies and procedures of the organisation which relate to information governance. I can confirm that the Board has not issued any separate or additional restrictions as to what information Mrs Burrows is able to disclose publically.

Yours sincerely

Merfyn Jones

Professor Merfyn Jones CBE
CHAIR

Cyfeiriad Gohebiaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive:
Swyddfa'r Gweithredwyr / Executives' Office,
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Original text:	BCUHB comments:
Please note that from 27 January to 14 May 2012, I was not the Accountable Officer. **Mr Lang formally assumed this role, as conferred by WG to cover my absence and to make sure he had the required authority to take decisions and lead the Board.**	Formal notification of change of Accountable Officer status was issued on 1st February 2012.
Furthermore I was absent from: **8 March to 4 April 2013** **29 April to 13 May 2013** **From 24 May 2013 onwards**	Accountable Officer status remained with Mrs Burrows during this period up until 6th June 2013 when formal notification of change was issued by Welsh Government.
I can confirm that my intention to leave the NHS started on 8 March 2013 and was not linked to the WAO/HIW report, which was commissioned weeks after my intention was made known.	First indications of exploring possible vacating of post of Chief Executive emerged on the 6th March 2013 and were further reaffirmed on the 8th March 2013. Mrs. Burrows was absent from work for the period 8th March 2013 and returned on the 4th April 2013 to full work duties. Her wish to explore leaving her post became stronger on the 23rd May 2013
Suggested question 1: *The report presents a pretty damning picture of the way in which your Health Board was being run – do you accept the findings and acknowledge that as Chief Executive, much of the accountability for those failings rests with you?* I have provided a statement which adds context to many of the findings. The report, I believe, concludes a number of failings attributable to multiple causes and in so far as a Chief Executive may be held accountable for collective failings extending beyond the Health Board's powers of deliberation and control then I have accepted my responsibilities and made my apologies to all concerned. However, I have also made clear that I do not consider it appropriate that I personally should be made the	

Original text:	BCUHB comments:
accountable scape-goat on the back of this Report (or linked reports mentioned in it) without appropriate wider consideration of, for example, the impact of disinvestment decisions beyond my personal decision and control. Fundamentally, financial constraints were recognised as the root cause of the majority of the management difficulties experienced by the Board. Notably, pre-award of additional funding for NHS Wales in the sum of £10 million, which has since been sanctioned, the external emphasis was one of insistence that the Board achieve financial balance and performance targets. This was in the face of also dealing with remedy of the full scale of management issues requiring address, some inherited and others identified on an on-going basis through service reviews and negative trends noted in assurance information provided to the Board. Inevitably, this had impact on the pace of turnaround not within the power of the Board, or me alone, to deliver corporately.	
Pace of change, and cohesive working amongst the Board members and the Executive Team	
Suggested question 2: *Problems identified in respect of financial management and planning, the organisational structure, executive capacity and the quality governance arrangements have endured for some time, and don't appear to have been adequately gripped, why has the Health Board not been able to adequately address these concerns?* I have to an extent provided a response to this question under 1 above. Issues were being addressed as outlined in my evidence and that of Mr Lang. I would draw attention to the forward to the Report which makes it clear that the amalgamation of 8 organisations was *"never going to be a simple task".* Evidence indicates that organisational	

Original text:	BCUHB comments:
change takes somewhere between 5 to 7 years. I would also draw attention to Don Berwick's review into "Patient Safety in England"1 noting that "*faults are to be expected in any enterprise of such size and complexity*". Much of the track record that is good is, of course, not subject to scrutiny in any review. The focus of the Overview Report is on cause for faults including perceived faults (in the absence of detailed evidence as to context) and to an extent seeking to apportion blame, an approach contrary to that espoused by Berwick in his review. Accepting the complexity of the integration project, the financial constraints the Board was faced with, and then expectations as to the change management completion timetable to secure all round achievement of improvement goals a reality check was required. A risk based determination of priorities to be delivered within required budget agreement and/or sooner flex of the budget to ensure maintained momentum was needed. This considered approach to turnaround and intervention was not initially forthcoming, arguably until the noise in the system as to the complexity of the various workstreams, competing delivery requirements, uncertainty of break even position and lack of capacity to meet all demands within budget had become deafening. Recognising the need for action involving significant expenditure (as had been indicated by a potential budget deficit of £19 million, provision of a £15 million cash injection in 2012 to address demand and then a further predicted deficit & in 2013) additional money directed to address implementation of, for example, needed recruitment was after all a belated start rather than an end point in terms of external input obviously required. You cannot always make an issue go away by playing a game of "Emperor's new clothes" and to try to is as inappropriate a management reaction	

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as it is deluded. The matter of tackling the many bureaucratic obstacles in the path of instantaneous smooth collective corporate implementation of change is a change management project of itself. When dealing with turning around local culture and re-directing local agendas this can, in the best of many hands, take time. Criticism as to pace of integration, noting that the budget allocated was not sufficient to generate the capacity to deliver all objectives simultaneously, has not been fully addressed.	
Suggested supplementary questions: *a) What pressure had you been under from the Welsh Government to address the growing concerns they had about the Health Board?* WG Officials reminded all Health Boards and Trusts of their statutory obligations and an expectation that these would be met. Emphasis was, in particular, placed on the financial obligation to break even (i.e. balance the "books") and in addition make cost efficiencies (i.e. savings) although the need for financial investment had been identified for example, Birth Rate +, and changes resulting from service reconfiguration. Improving A&E performance at Glan Clwyd was continually being pressed for, which required investment and changes in its operational protocols. This double bind position for NHS organisations, and so notably affecting the Health Board, is a matter of public record. *b) How would you characterise your relationship with the Welsh Government?* It was a constructive working relationship noting that the financial constraints result not from the Welsh Government but the fact of operation within a global climate of recession requiring need for savings and	

Original text:	BCUHB comments:
efficiencies. However, it would be naive to consider this relationship was not strained at times by the very natural human and corporate tendency to consider that demanding more for less of one body absolves the other from responsibility. *c) Was it not the case that you were trying to fend off the concerns of the Welsh Government by giving overly positive assurances that progress was being made, when in fact that wasn't the case?* No, not at all. Information was given by me and others based on information provided to the Board and WG as to progress which was believed to be accurate. Assurance information was collated from a number of sources (triangulated). Its worth was evaluated. A 'confirm and challenge' approach was taken by the Board. Being assured of having accurate information upon which to act is a concern all round. Arguably emphasis on more assurance delayed input of needed funding and support. What was required by way of external input and support was delayed pending obvious evidence of issues requiring resolution that could not be hidden altogether behind an argument of the need for greater efforts or efficiencies on the part of Board, those reporting up to the Board and those working directly with patients. I have made it clear that I strove hard to maintain all-round focus on patient safety and to ensure the quality of services was not sacrificed or down-played but placed top of agendas. *d) Would it not have been better to be honest and indicate that there were fundamental problems, and to seek help from the Welsh Government in addressing those problems?* This question implies that I have been	

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

Original text:	BCUHB comments:
Suggested question 3: *The ability to work cohesively, both at the board and executive team level seems to be a significant problem for the Health Board. Why were working relationships so problematic and what were the causes of the tensions that we heard about from your executive team colleagues last week?* Differences in approach to balancing finance, safety and quality of care were the root of the problem as outlined in my statement and evidence given by Mr Lang.	
Management and clinical leadership structures	
Suggested question 4: *Who was the architect of the CPG based organisational structure, and would you accept that, as originally designed, the structure was not fit for purpose?* The previous Medical Director of the North Wales NHS Trust. The structure was deemed fit for purpose as it had been introduced at the Trust, tested and consulted upon as part of the transition to an integrated health board. As it evolved, changes were made within CPGs based on reflective assessment and exchanges that came from working as a collective and	
Suggested supplementary questions: *a) Interim hospital site managers needed to be put in place as an emergency measure in May to address concerns about the lack of interface between CPGs and geographical hospital sites. Doesn't that indicate that there were fundamental flaws in the original design of the organisational structure?* No, as other NHS organisations have experienced the same issue with matrix management. There is an interface between CPGs, as evidenced within the organisation that worked to address this, which was successful in some cases and	

Original text:	BCUHB comments:
not so in others. The issue is one of providing more senior capacity to support clinical site managers and hospital management teams to improve flow through the hospital whilst at the same time making sure clincial services actively operate across the Region to reduce variation, raise standards and improve equity of access to that of the best. *b) Why, after an internal review had recommended a reduction from 11 to 6 CPGs, did you instead take proposals to the Board for a 12 CPG model – and could you not see that such a model would fundamentally fail to address the concerns that had led to the review in the first place?* Please refer to my statement and Mr Lang's statement which explain the rationale. Please note that the CPG element was not presented at the Board, only the recommendations about the Executive structure were presented and discussed as a decision had to be taken in order to progress change mindful of the requirements of the Organisational Change Policy. It is an incorrect assumption that the CPG element was presented for discussion. *c) Is part of the problem that you are too personally attached to the CPG model to the extent that you were not objective about its short comings?* No, this is a very disparaging assertion to make to a professional of my length of service, seniority and reputation within the health service. This structure was developed using evidence from London	At an in committee meeting of the Board on 25th April 2013 draft paper summarising the response to the Consultation Executive and CPG Structures formed part of the agenda. However, prior to the meeting there was agreement between the Vice Chairman and the Chief Executive that "further work was required in relation to the CPG structure"...."detailed discussion on the outcome of the CPG structure was deferred as Independent Members felt the draft paper did not adequately reflect or respond to the principles of the review"

Original text:	BCUHB comments:
and Birmingham NHS organisations and considered in depth. It is not my style to pursue an objectively flawed plan of whatever nature and the same holds true here. The clinical model is similar to other Health Boards, and NHS organisations, that manage complex health care. Please refer to my statement and other responses within this supplementary statement.	
Suggested question 5: *The CPG based structure is designed to help promote clinical leadership, yet members of the consultant body have written to this Committee so say that they think it is not fit for purpose. What work has been done to engage with clinicians to promote the benefits of the structure, and to understand the concerns they have about it?* To put this into context, the consultant body is about 600 in number and as I understand it the letter you refer to represents a small number of consultants and not the whole or anywhere near the whole. I was made aware by some consultants at YG that they did not see or agree with the letter sent and were unhappy about a release to the media. Nonetheless, I accept and indeed champion hearing of a minority of voices. The Chiefs of Staff, and their teams engaged with clinicians to promote the benefits of the structure, to challenge historic ways of working and build teams to improve the health of the population overall rather than staying with geographically defined areas of management structure. This way provided the best means of addressing variation and ensuring equity as commented upon already. The concerns were intently understood given the cultural and behavioural issues that needed confronting (i.e previous organisations that competed with each other now needed to integrate and work cooperatively). Some wished to revert to	

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the old Trust structures (i.e. not working with other teams across the geography). Reversion to old structures, as explained, threatened loss of ability to integrate services across North Wales to best service user advantage. Successful examples exist of combining teams across the region into 'one' service delivered in many sites , including cancer, therapies, rheumatology, pain management, pharmacy, radiology, pathology, anaesthetics, and cardiology to name just a few. Horizontal integration, undertaken in other Health Boards (as well as through their clinical boards or divisions (CPGs)), is expected over time to reduce variation, any inequity of service provision and generally raise standards to the highest level across the 'patch'. Clearly, a theory with some evidence of positive result in practice is to be preferred over a system which is not working to deliver equity for service users; my emphasis being on improving patient access and experience of care.	
Quality and Safety arrangements	
Suggested question 6: *Since the report has been published, senior clinicians have made public their concerns about deteriorations in the quality of care, increased RAMI scores, and a culture whereby they have felt unable to properly raise concerns about patient care. What is your response to these claims?* To reiterate I was very concerned about quality and safety of care and raised this regularly within the organisation and also with WG. My original evidence was clear about this and I refer Members to it. I dispute the foundation of any claim that the LHB culture failed to permit and/or encourage escalation of concerns about patient safety and/or failed to treat any concern seriously. I personally took decisions and instructed others to take	

Original text:	BCUHB comments:
action to address patient care concerns. I was aware of RAMI scores and sought information, action and assurance of address for Ysbyty Gwynedd in particular. This included attention being focused on morbidity and mortality rates and any perceived variation occurring between hospital sites or specialities. Concerns could be and were raised. Openness was promoted as evidenced by the reiteration of policies, meeting groups such as the Senior Medical & Dental Staff Committee as well as enabling direct contact with senior leaders, including myself, within the organisation. Concerns were also raised with Independent Members. There is therefore plenty of evidence of concerns being raised through a number of routes and of issues being addressed. Consultants and other clinical staff were articulate, blunt and emphatic about raising safety issues and seeking assurance as to resolution which they did either in person, via written communication, at LNC, LMC & Partnership Forums or by using intranet forums. Where individuals felt they could not raise concerns, internal investigations, personal discussions and/or formal meetings took place to establish cause. If people were not listening, engaging or if bullying was believed to have occurred, then this was dealt with through a range of measures, as per nationally agreed policies, which included suspension/remediation/dismissal of staff as appropriate. Evidence exists of the Health Board taking appropriate action.	
Suggested question 7: *When did you first become aware of the C Difficile outbreak, and patient deaths, in Ysbyty Glan Clwyd?* About the third week in April (I returned on 4 April), several weeks after the outbreak had been declared. The Acting	On 22nd March 2013 the Acting Director of Nursing notified the Acting Chief Executive that an outbreak of Cdiff had been declared on the YGC site. The Quality and Safety Committee of the Board was informed of the outbreak by the Acting Director of Nursing on the 4th

Original text:	BCUHB comments:
CEO, Director of Public Health & Director of Governance had been dealing with the matter. When I was made aware of the outbreak, recognising immediately the seriousness of it, I asked for a rapid review and explanation as to why matters had not been escalated to senior leaders including the Board.	April 2013. The Acting Director of Nursing was leading the response to this outbreak supported by the Acting Medical Director and the Director of Public Health The acting Director of Nursing has recorded that she and the Chief Executive had a telephone call on the 12th April 2013, for the Acting Director to brief the CEO on key issues at that time. During this call Mrs. Burrows was briefed on the major outbreak and they discussed the challenges of a cohort ward.
Suggested supplementary questions: *a) Why was the Board not properly briefed about the C Difficile issues at its meeting on 20th April, when the situation had been managed as an 'outbreak' since 28 March?* It should have been raised even though internal investigations and discussions with Public Health Wales had then yet to be concluded. The matter was raised publicly at the following Board meeting at my request followed by in Committee discussions with the Board thereafter. As stated in the Overview Report, my position, and expressed intent on the part of the Board, was for there to be prompt upfront sharing of information and transparency about issues. *b) Did you, or other executive or management colleagues, deliberately withhold this information from the Board?* Absolutely not.	The situation had been managed as an outbreak from 22nd March 2013 not 28th March. The Board met on the 25th April not 20th April. The Quality and Safety Committee, which has oversight of these matters on behalf of the Board was advised of this outbreak on April 4th.
Suggested question 8: *What arrangements have been put in place to ensure that quality and safety issues are properly considered and discussed at the CPG level, and how does the Executive oversee these arrangements to ensure they area*	

Original text:	BCUHB comments:
working correctly? Each CPG has a quality & safety group and significant issues are reported directly to the Executive Director responsible, issues raised are escalated, when necessary, to the Executive team for resolution. Performance meetings are held by the Executive Director responsible, issues raised are escalated, when necessary, to the Executive team for resolution. Reports go to the Safety & Quality Committee and significant issues should be raised as well as discussed in detail by the Board as outlined in the WAO/HIW Report	
Suggested supplementary question: a*) Would you accept that organisational structure, and the way it has been implemented, has failed to adequately bridge the gap from the ward to the Board?* A Board would not generally be expected to be sighted on all operational matters involving over 17,000 staff irrespective of the organisational structure in place. The point is to ensure appropriate escalation of issues requiring the involvement of the Board and in reverse Board to Ward dissemination and understanding of strategic corporate objectives with delegation of responsibility for delivery of operational objectives to plan. The desirability of avoiding a so called 'Board to Ward gap' is universal in all large organisations and is about ensuring an open, integrated culture with good informal and formal communication flows. The 'Board to Ward' gap cannot be wholly attributed, as may be implied, to the clinical leadership structure in place. As indicated the issues are wider and not just confined to this Board. A part of the process of integration and 'closing the gap' discussions lie with how	

Original text:	BCUHB comments:
the Committee structures operate and quality of assurance evidence routinely provided, including focus on strengthening the processes of information gathering, presentation and assessment to enhance effective functioning of the Board itself (in terms of the questions it asks and avoidance of dependency on internal Committees as a source of assurance information in isolation). Nationally, boards have been undergoing development to ensure embedding of a culture of "no surprises' and issues drawn out in the Report relate to this universal agenda and need to be understood in this context. Coming through the Quality & Safety Committee, Finance & Performance and other mechanisms (e.g.1000 Lives safety walk-around & associated data) information related to staffing levels, infection trends, as well as themes emerging from patient concerns, required further exploration, discussion and relevant action within the organisational structure as well as at the Board level. A perfect organisational structure and would enable early warning and facilitate prompt resolution of issues requiring action again ideally at operational level. With check and challenge going on within internal governance management structures, boards are then enabled to maintain focus on strategy and quality whilst maintaining on-going awareness of the effectiveness of correcting strategic actions in closing any identified gaps in control/assurance from Board to Ward as identified in the Report. All NHS bodies aspire to achieve this manner of co-operative, effective and efficient working together to achieve strategic goals.	
Financial management and sustainability	
Suggested question 9: *Why, during 2012-13, did your financial forecasting to the Welsh Government suddenly change so drastically, from a*	

Original text:	BCUHB comments:
prediction of year-end breakeven up to Month 5, to a predicted year-end deficit of some £19m at month 6? Please note the Accountable Officer change in status between January to May 2012 and the need to review, and consider, evidence presented by Mr Lang. I am able to state, effective upon my return, that within a matter of 2 to 3 months the advice from the now outgoing Director of Finance to the Finance & Performance Committee was that the Board would not be able to balance "its books" on the plans agreed by the Board by the end of April when the final budget was set. This begs the question as to whether the budget as set at that time was fit for purpose (i.e. whether the financial savings plans were truly evidence-based, realistic and deliverable). I expressed concern about this when I returned and asked for alternative plans as some plans that had been agreed, in my opinion, were not achievable and in some instances were revealing of duplication between corporate and CPG plans (i.e giving rise to double accounting of 'efficiencies). This was identified in the Report. Forecasting was a matter of concern by the WG, which had prompted the review by Mr Chris Hurst, with Mr Lang, in March/April 2012. My understanding now is that Mr Hurst was commissioned by WG to provide support to LHBs and Trusts as he had ended his employment at the end of December 2012. The contract was for about 15 days of management consultancy. My understanding is he was asked by WG to review the Health Board however you will need to confirm this with Mr Hurst as to the facts as well as Mr Lang. I assumed when I returned that WG had commissioned his time, which I am aware they paid for. After the deficit was declared, the WG commissioned the Allegra Report. This	

Original text:	BCUHB comments:
report did not cover CPGs as the WAO were undertaking their own structured assessment which covered this aspect of financial forecasting as well as audits of two CPGs and the overall structure and governance of the organisation. The Allegra consultant did not wish to interview Chiefs of Staff when names were put forward by myself. Given that these clincial leaders were responsible for significant budgets, this was a missed opportunity to understand the relationship with finance, the budget setting process and the levels of autonomy they had including tensions that existed between a system of devolved responsibility and accountability and that of centralised control and mandates. The main focus, as outlined in the terms of reference, was financial. Members should also note the caveats recorded by the author of this report.	
Suggested supplementary questions: *a) Why was there a forecast of break even in the early part of that year, despite there being a significant in year over-spend?* Please also refer to Mr Lang's evidence as the budget was agreed by the Board during my absence. Nonetheless I can say that the Board (in common with others) is required to set a budget that will achieve balance irrespective of the fact that there has been a 'flat cash' settlement every year for four years meaning savings of 6% or more for this Health Board (as for others) year-on-year. The Minister has asked for a change in the financial regime to move to a 3 year budget, which I highly commend. The current financial regime is not fit for purpose in my opinion. Evidence from previous years is that savings plans tend to take hold later in the financial cycle, which is a feature of all Health Boards. How the 'savings' per	

Original text:	BCUHB comments:
month are profiled may skew forecasting, a concern raised with this Health Board by WG as has already been highlighted and discussed. However, as budgets were rolled over and individual deficits accrued some specialties like Medicne and Surgery started the financial year already in an overspend position because of their inability to, within the first few months, save the projected amount per month and reduce the run rate below previous years. In many cases, a virtually impossible financial performance catch-up situation is generated. A quick fix (in most organisations) looks to staff costs to address budget deficit and although not openly stated, rationing through measures that will reduce costs, delayed waiting lists is one example. However, losing significant numbers of predominately nursing staff in circumstances where the CNO has stated more recruitment of nurses is required to meet safe staffing levels is not an option in terms of the high risk of compromising patient safety. Recognising, this position the WG has already released an additional £10 million to address the shortfall in nursing numbers, which was a welcome development. *b) During 2012-13 one of your Executive Directors undertook a Turnaround role for a short period of time. What did that role achieve, and why did it only last a few months?*	
Please refer to my statement. My preference was for external support, which was not backed and this was shared with WG. Accordingly, internal appointment was the only option and one of the Executive Directors took on the role. He identified areas where spend could be further contained, reduced or stopped (i.e. with reference to bank, overtime and agency staff expenditure)	The proposal for an existing Director to undertake the Turnaround role arose at an Executive Team Development session held on the 03/10/12. This proposal was endorsed by Mrs Burrows and she revised Executive roles accordingly. The reason for bringing this arrangement

Original text:	BCUHB comments:
and this level of information continued to be provided. Undertaking two roles proved to be difficult and was not intended to be long term as decisions had been already been taken on turnaround support for the 3 CPGs that were challenged financially. The more efficient proposal was to effect changes to the Executive structure that would build in a more sustainable 'turnaround' approach (e.g. appointing a Chief Operating Officer supported by the three operational turnaround posts.)	to an end related to differences of emphasis in simultaneously addressing patient safety and financial challenges.
Suggested question 10: *In August 2012, your Director of Finance, and two Independent Members felt it necessary to raise concerns about the Health Board's challenges directly with the Wales Audit Office. Why do you think that they felt it necessary to take such action?* Please refer to the statements of those concerned as to their motives and reasons. I can only say that they did not discuss their intentions with me, the Chairman or with the Board. They thought the meeting was confidential (i.e not to be disclosed to the organisation), which was a naive assumption, the Director of Finance then openly advising WG afterwards. This raised concerns with WG that such a meeting was taken outside the governance arrangements of the Health Board prompting a personal communication from WG on the same day (which is how I was first informed) about their serious concern regarding the actions of these individuals. I believe the word 'rogue individuals' was used and quite rightly I was asked to investigate this. When I asked each individual involved about why this meeting was held without the Board's knowledge and outside of governance arrangements, their answers were varied, mixed and inconsistent.	The meeting was between the Director of Finance, Wales Audit Office and two Independent Members who were acting in their capacity as Chairs of Audit Committee and Finance and Performance Committee respectively. As part of these roles the Independent Members have particular responsibility for ensuring sound financial governance.
Suggested supplementary questions:	

Original text:	BCUHB comments:
a) Was it the case that the internal relationships were such that those Board members did not feel the issues would be adequately addressed if they had just raised them internally? The matters should have been raised internally with the Chairman, myself and with the Board. We would have initiated support ourselves from the WG if concerns could not be resolved. Sometimes individuals jump out of following process with good intent and not always appreciating the relevance of process when focused on achievement of a goal. Hindsight sometimes results in different interpretations of actions not perhaps consciously directed at the time. *What actions did you take when you learnt about these disclosures to the WAO – did you attempt to give assurances that you would create a climate whereby such concerns could be discussed openly, or did you try and reinforce strict adherence to governance protocols?* This question implies there was not a climate for open debate and challenge. There is no evidence to suggest this to be the case indeed minutes of various meetings and forums will indicate there was open challenge, debate and discussion at many levels going on at this time. As to the meeting itself after it took place, Executives were reminded that matters should be discussed internally to seek resolution with the Board as would be expected as part of standard governance arrangments. It is fair to say Executive Directors were alarmed with the disclosure to WAO in a situation of the intention for such a meeting not having been discussed with, Executives or indeed the Board or myself. However, perhaps this feeling would not have been experienced had	

Original text:	BCUHB comments:
there not been a sense of shame generated by external concern about breach of standard governance arrangements. *b) How would you describe your relationship with your Director of Finance after she made those disclosures to the Wales Audit Office?* A professional one as would be expected.	
Suggested question 11: *In 2012, two external reviews were undertaken in response to concerns about the Health Board's financial management, one by Chris Hurst and one by Allegra. How widely were the findings of each of these reviews shared within the Health Board, and in particular were they both discussed at the Board? If not, why not?* Please refer to Mr Lang's statement regarding Mr Hurst and his review. As I was not the Accountable Officer at the time I cannot answer about the scope of disclosure or discussion by the Board concerning this review report beyond the information already given. The Allegra Report was shared with individuals involved in the Review, which included Board Members and actions were taken as a result of the Report. It was not widely shared within the Health Board but rather formed part of Board business. Please refer to Mrs Grace Lewis-Parry's evidence.	
Strategic Vision and Service Reconfiguration	
Suggested question 12: *The public consultation exercise undertaken last year explicitly excluded consultation on reconfiguration of the three acute hospital sites in North Wales. What work had been done to lead you to the conclusion that you did not need to develop proposals for acute services reconfiguration at that time?*	

Original text:	BCUHB comments:
Retention of 3 A&E Departments had already been agreed in October 2009. Otherwise elements unfinished from the Secondary Care Review of 2006 suggested changes related to Paediatrics, Neonatal, Emergency Surgery and Obstetrics & Gynaecology were necessary. Medicine, which covers a range of services such as acute medicine, geriatrics, cardiology, internal medicine, is critical to the stability of other services and had not been part of any recent review. Given the interdependencies, the Acute Strategy was initiated. Please refer to the statement provided.	
Suggested supplementary questions: *a) Shouldn't the challenges you had experienced with medical recruitment have led you to realise that sustaining a three site model, which complied with new doctor training requirements, was going to be hugely difficult?* Evidence was indicating that recruitment could be successful provided some services were moved to a consultant delivered model rather than continued reliance being placed on Trust Grade staff or middle grades. The delivery model relying on non-consultant grades is a legacy issue and required address given the risks posed especially with changes to immigration rules. Furthermore the main issue related to on-call not 'normal' in-hours service. Services can operate at sites that are not designated as training sites, provided rotas are staffed differently. Chiefs of Staff, and their clinical directors, had worked through a number of options that would retain core services at all three hospitals each involving investment as the key service delivery issue was about achieving standards not cutting services. Evidence shows that reconfiguration of	

Original text:	BCUHB comments:
services may not save significant amounts of money, but may incur costs. Again, this is a hugely complex area where some schools of thought consider greater efficiency is achievable though increased reliance on more senior level staff whilst others focus on lean pathways. The main issue, I believe, is of ensuring balance to maintain through all best quality services at best realistically achievable price- the Triple Aim (population health gain; improved safety & quality and best use of resource to contain or reduce cost). *Would you agree that the proposal taken to the Board in April 2013 for the recruitment of an additional 72 clinicians by August was in effect "crisis management" that might have been avoided if earlier progress had been made with the acute services strategy? And what involvement did you have in the development of the proposal?* Please refer to my statement as this has been explained. The proposal was not an indication of crisis management rather of a moving target that relied on continued dialogue and decisions with the Deanery, which the Interim Medical Director had led with formidable resolve. Back in November 2012, I supported this work when brought to me as a Board Assurance Framework risk for 2013 knowing that it would later converge with the Acute Strategy work, the former short term, and the latter longer term. The proposal was developed by senior clinicians and the Medical Director. I received draft documents as did Executive Directors who discussed these at regular meetings including a special meeting to reach consensus on the recommended options and cost envelope. *b) The interim Medical Director told us last week that 30 middle grade doctors*	The issue was raised through the Board's Corporate risk register

Original text:	BCUHB comments:
have been recruited. Where has the money come from to fund those posts? The money was provided from within a contingency allocation for clinical services this financial year. c) *North Wales isn't immune from the challenges associated with providing clinically and financially sustainable services, yet it is the only part of Wales not to have consulted on future options for acute services – how would you justify that?* That is incorrect. Consultation had taken place on paediatrics, neonatal, emergency surgery, obstetrics, gynaecology and vascular services in 2012. 3 A&E Departments were agreed by the Board in October 2009. The retention of core services at 3 DGHs was agreed in January 2013. Cancer, clinical haematology and pathology were subject to internal consultation and agreement with the CHC. These all form part of acute services. Please refer to my statement. *d) Were decisions on the future shape of acute services simply put off because of the difficult challenges you anticipated from some clinicians, the public and local politicians?* No not at all.	3 A&E Departments were agreed by the Board in March 2010.
Suggested supplementary question: *a) Does the Health Board have sufficient capacity and capability to come up with the transformational plans that are needed to create safe and sustainable services?* No, there has been a lack of sufficient management capacity, one example being within the planning team, which works with Chiefs of Staff and Clinical Directors. This is being addressed. The Health Board reduced its	

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

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Bwrdd Iechyd Prifysgol
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Dyddiad / Date: 29 July 2013

Dear Mr Collier

Public Accounts Committee 18th July 2013
Requests for further information

Thank you for your email of the 19th July requesting additional information following the Health Board's attendance at the PAC on the 18th July.

Please find below the information requested:-

Further information on the categories and amount of re-charging made to cross-border Health Authorities.

Cross border activity and recharges are governed and regulated by the ***Cross Border Protocol*** agreed between the Welsh Government and the Department of Health.

This Protocol sets out the agreed procedure for:

- Securing NHS healthcare for residents in England who are registered with a GP in Wales.
- Commissioning NHS healthcare for residents in Wales who are registered with a GP in England.

Specific rules apply to the following border counties:

Areas of Wales bordering England	Clinical Commissioning Groups bordering Wales
Flintshire	NHS South Cheshire
Wrexham	NHS West Cheshire
Denbighshire	NHS Wirral
Powys	NHS Herefordshire
Monmouthshire	NHS Shropshire
	NHS Telford and Wrekin
	NHS Gloucestershire
	NHS South Gloucestershire

For these specific border counties, the following rules apply:

Residency	GP Location	Funding Responsibility
Wales	Wales	LHB
England	Wales	LHB
Wales	None / (unknown)	LHB
Wales	England	CCG
England	England	CCG

For patients resident elsewhere in England or Wales who are registered with a GP on the other side of the border, responsibility for commissioning or for planning and securing their healthcare will remain with the PCT or LHB area where the patient ***defines his or her usual place of residence.***

Patients from across the UK are entitled to use the services provided by the Health Board, and the income arising from caring for patients from outside the Health Board's borders is subject to standard processes, including tariffs and contractual arrangements where appropriate.

For areas from which there is a longstanding relationship, such as patients from Western Cheshire, Shropshire and North Powys, formal contracts are held which ensure that the costs of caring for patients are reimbursed in a regular and timely manner. These contracts provide long-term planning stability to both the provider and the commissioner of care.

In addition to the cross border counties, as a result of travel and tourism into North Wales, the Health Board also treats patients from across the wider UK regions. Income is collected for these patients based upon admitted patient care (inpatient or outpatient treatment), and is charged at National Cost Tariffs.

It is important to note however that Cross Border Recharges cannot be made for an ***Attendance at A&E*** as A&E Services are paid for by the local LHB / Trust irrespective of patient residency or GP registration. If a non-BCU resident attends A&E and is then admitted to a ward they then become an A&E Admission in which case the LHB is able to recharge for the cost of their treatment.

There are a number of challenges to collecting the income due to the Health Board for treating non-BCU patients:

- Residency status between Welsh Health Boards is dependent on the patient's postcode, and between English PCTs residency is dependent on the patient's GP. Cross border arrangements determine residency on the patient's GPs but only between certain English PCTs and certain administrative areas with BCUHB, otherwise "local" rules then apply. This can be very complex.

- Charging requires the prompt and accurate coding of activity.

- Overseas Visitors' entitlement to free NHS care is subject to complex rules, and staff do not always feel confident to challenge patients in respect of their residency and entitlements. The Health Board is able to charge the Welsh Government for patients from Countries where the UK has reciprocal agreements, otherwise we will charge individual patients our local "private patient" prices.

- There are approximately 7,000 Residents of Shropshire and Western Cheshire with a registered GP in North Wales, for which the Healthcare responsibility lies with BCUHB.

- There are approximately 8,500 residents of North Wales (Flintshire, Wrexham, Denbighshire) registered with Shropshire, Wirral or Western Cheshire GPs for which the Healthcare responsibility lies with the relevant English CCG.

- For patients registered with a BCUHB GP and resident elsewhere in England, the CCG of "usual residence" is the responsible commissioner, however identifying the "usual residence" can be challenging.

- For patients with no registered GP, the home address as given by the patient determines the responsible LHB / CCG. It is difficult to challenge a patient on their declared home address.

The Health Board has a range of controls and measures in place to ensure that it captures all external income due to it, and regularly uses Internal Audit to test these controls and assurances.

During 2012/13 the Health Board recovered £15.633 million of external healthcare income, which represents 1.3% of its total £1.2 billion resource allocation

Further information on the number of patients affected by the delay in elective procedures caused by the emergency expenditure controls in the final weeks of the 2012-13 financial year.

The number of patients affected by the decisions made December 2012 for the final quarter of 2012/13 was approximately a combined 1250 inpatient and day case and 1600 follow up outpatient reviews.

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University Health Board

A note on when the Board and Quality and Safety Committee first became aware of concerns with the *C Difficile* outbreak.

On the 7th March 2013 the Quality and Safety Committee of the Board met. This Committee received the minutes of the Infection Control meeting held in January 2013 which had been chaired by Mrs J Galvani, the Executive Nurse Director at that time. C Difficile rates were reported to the committee at this meeting, as is routine. What was reported is as follows:-

"December 2012 data indicates a 10% improvement overall with a 30% improvement at Wrexham Maelor Hospital."

On the 22nd March 2013 a C Difficile major outbreak was declared on the Ysbyty Glan Clwyd hospital site and the Acting Chief Executive was notified immediately. Comprehensive arrangements were urgently put in place in line with the Major Infection Outbreak Control Plan.

The Quality and Safety Committee next met on the 4th April 2013 and at this meeting the C Difficile outbreak was discussed.

A copy of the Health Board's risk register.

20130729 BCUHB Corporate Risk Regist

Further information on actions undertaken by the Health Board to address Risk Adjusted Mortality Index (RAMI) figures.

The Health Board has been aware of a month on month increase in RAMI in Ysbyty Gwynedd for the last 7 months of validated data (now up to April 2013). In the last few months, the RAMI in Ysbyty Glan Clwyd has also increased and the RAMI in Wrexham Maelor is higher than that seen in the other two hospitals but has been relatively stable over the same time period. This matter is being thoroughly investigated and regular written updates are being provided directly to the Chief Medical Officer for Wales. Further detailed information in relation to all aspects of the mortality reviews and methodology and further investigations into the RAMI data are detailed in the attached correspondence.

561 Ruth Hussey.doc

589 Ruth Hussey.doc

2013-07-25 MD Letter RH (m).doc

Yours sincerely

Grace Lewis-Parry.

Grace Lewis- Parry
Director of Governance and Communications

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

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

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

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

Suggested question 1:

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

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

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

Suggested question 2:

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

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

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

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

[1] **A promise to learn– a commitment to act-** Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England- August 2013

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

Suggested supplementary questions:

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

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

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

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

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

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

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

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

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

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

Suggested question 3:

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

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

Management and clinical leadership structures

Suggested question 4:

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

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

taking account of feedback from staff and patients.

Suggested supplementary questions:

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

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

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

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

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

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

Suggested question 5:

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

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

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

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

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

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

Quality and Safety arrangements

Suggested question 6:

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

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

I dispute the foundation of any claim that the LHB culture failed to permit and/or encourage escalation of concerns about patient safety and/or failed to treat any concern seriously. I personally took decisions and instructed others to take action to address patient care concerns. I was aware of RAMI scores and sought information, action and assurance of address for Ysbyty Gwynedd in particular. This included attention being focused on morbidity and mortality rates and any perceived variation occurring between hospital sites

or specialities.

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

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

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

Suggested question 7:

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

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

Suggested supplementary questions:

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

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

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

   Absolutely not.

Suggested question 8:

What arrangements have been put in place to ensure that quality and safety issues are properly considered and discussed at the CPG level, and how does the Executive oversee these arrangements to ensure they area working correctly?

Each CPG has a quality & safety group and significant issues are reported directly to the Executive Director responsible, issues raised are escalated, when necessary, to the Executive team for resolution.

Performance meetings are held by the Executive Director responsible, issues raised are escalated, when necessary, to the Executive team for resolution.

Reports go to the Safety & Quality Committee and significant issues should be raised as well as discussed in detail by the Board as outlined in the WAO/HIW Report

Suggested supplementary question:

a) Would you accept that organisational structure, and the way it has been implemented, has failed to adequately bridge the gap from the ward to the Board?
A Board would not generally be expected to be sighted on all operational matters involving over 17,000 staff irrespective of the organisational structure in place. The point is to ensure appropriate escalation of issues requiring the involvement of the Board and in reverse Board to Ward dissemination and understanding of strategic corporate objectives with delegation of responsibility for delivery of operational objectives to plan. The desirability of avoiding a so called 'Board to Ward gap' is universal in all large organisations and is about ensuring an open, integrated culture with good informal and formal communication flows.

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

A part of the process of integration and 'closing the gap' discussions lie with how the Committee structures operate and quality of assurance evidence routinely provided, including focus on strengthening the processes of information gathering, presentation and assessment to enhance effective functioning of the Board itself (in terms of the questions it asks and avoidance of dependency on internal Committees as a source of assurance information in isolation). Nationally, boards have been undergoing development to ensure embedding of a culture of "no surprises' and issues drawn out in the Report relate to this universal agenda and need to be understood in this context.

Coming through the Quality & Safety Committee, Finance & Performance and other mechanisms (e.g.1000 Lives safety walk-around & associated data) information related to staffing levels, infection trends, as well as themes emerging from patient concerns, required further exploration, discussion and relevant action within the organisational structure as well as at the Board level. A perfect organisational

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

Financial management and sustainability

Suggested question 9:

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

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

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

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

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

Suggested supplementary questions:

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

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

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

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

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

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

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

Suggested question 10:

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

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

Suggested supplementary questions:

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

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

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

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

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

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

Suggested question 11:

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

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

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

Strategic Vision and Service Reconfiguration

Suggested question 12:

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

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

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

Suggested supplementary questions:

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

Evidence was indicating that recruitment could be successful provided some services

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

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

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

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

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

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

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

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

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

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

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

Suggested question 13:

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

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

Suggested supplementary question:

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

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

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

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Darren Millar AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff

Our Ref: DS/TLT

2nd August 2013

Dear Darren

GOVERNANCE ARRANGEMENTS AT BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD

During my appearance before the Public Accounts Committee on 18 July. I agreed to send you several pieces of additional information.

Cost of Chris Hurst's Work for the Health Board

Chris Hurst undertook two days work for Betsi Cadwaladr at a total cost, including VAT, of £2,800 plus expenses (paid at Welsh Government rates). I understand that the rate agreed for Mr Hurst's work was recommended by Welsh Government's recruitment consultants Odgers Berndtson.

Date of Chris Hurst's Departure from Welsh Government

Chris Hurst resigned and left his role in Welsh Government as Finance Director for the Department of Health and Social Services on 31 December 2011.

Details of the escalation process for concerns about Local Health board

I attach at Doc 1 a copy of the Escalation Process as set out in the Delivery Framework.

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Terms of Reference for the report prepared by Allegra

The formal Terms of Reference for the Allegra Report are attached at Doc 2.

Expenditure by Betsi Cadwaladr University Health Board on Salary Protection

We are currently seeking the most update information on expenditure on salary protection for the Local Health Board. I will arrange for this to be sent you as soon as possible.

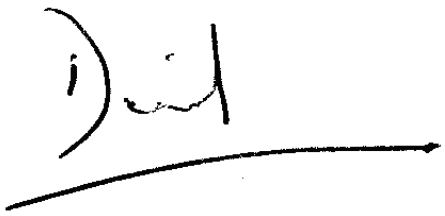
Definition of "Core Capacity" and Impact of unscheduled care on Core Capacity.

I was asked to provide information regarding `core capacity'. In relation to surgical operations this comprises the theatres and beds which are generally designated or assumed to be available for planned activity. Clearly the theatres and beds are supported by budgeted staff and non-pay resources. Health Board will plan activity levels with reference to the capacity and will schedule admissions and operations accordingly. The core capacity will not take account of potential 'additional activity' which is secured either within the organisation through waiting times initiatives or externally by, for example, the use of other NHS providers or the independent sector. Such activity normally incurs additional, premium costs above those included in planned budgets.

I was also asked to clarify the impact of unscheduled care on core capacity. During the Winter and early Spring of 2012/13 there was a high level of demand for unscheduled care. This occurred across the UK. Our Health Boards opened additional beds but also used some of the core elective capacity for patients admitted as emergencies. This led to cancellations of planned activity. Health Boards did reinstate some of the cancelled activity and took decisions in this regard which were guided by clinical priority.

As stated above this additional activity was more costly and required the application of additional funding. The ability of Health Board to fund such activity was determined by the amount of money available to them in the context of their statutory financial duties.

Yours sincerely



David Sissling

2. Escalation within the Delivery Framework

Escalation Level	Performance trigger	Escalation Action	Monitoring	De-escalation
0.	Local delivery of all targets and/ or within trajectory.	None required – earned autonomy (including potential for reducing the frequency of Q&DM) and minimal monitoring beyond that required for national returns. Proactive assurance mechanisms.		
1.	Health Boards/Trusts fail to achieve/ maintain one deliverables.	Health Boards/Trusts are responsible for remedial action in response to areas of failure. WG indicates the additional monitoring requirements. Plans brought forward to redress the position with immediate effect.	WG, in conjunction when necessary with DSU (or other intervention mechanism identified by WG), assures and monitors implementation of plans and effectiveness of solutions. Executive highlight report. Support from other agencies if required.	Immediate removal of escalation action upon achievement of plan and return to improving KPIs.
2.	Continued failure to achieve/ maintain one or more key deliverables.	WG instigates DSU and/or other intervention. WG and DSU (or other intervention mechanism identified by WG) will be actively involved in determining the necessary changes within the HB/Trust to deliver required outcomes through regular meetings/calls.	WG Representatives to join regular meetings/calls and monitor effectiveness of organisational response with DSU and &/or other intervention mechanisms.	Sustained improvement of KPIs causes removal of escalation actions.
3	Continued failure and/or a failure to maintain an agreed improvement trajectory following intervention.	Issues raised with Chief Executive NHS Wales. Meeting required between HB Chief Executive, NHS CEO and/or NHS Deputy Chief Executive to determine future requirements and actions.	Regular reporting established between CEO NHS Wales and HB Chief Executives until improving trajectory established.	Maintenance of agreed improvement trajectories causes return to escalation level 2.
4.	Continued failure to improve performance or failure to engage with the national process despite level 3 escalation.	Actions to be determined by NHS Chief Executive which may include the following: • Meeting required with Chair, Vice Chair, CEO, Board Secretary and relevant Executives. • Introduction of `special measure' arrangements. • Review of executive effectiveness. • Review of Board effectiveness. • Removal of appropriate funding streams.		

DOC 2

Yr Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant
Department for Health, Social Services and Children

Llywodraeth Cymru
Welsh Government

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Our Ref: KF/12/014/A3816983

12 October 2012

Dear Alison

Betsi Cadwaladr University Health Board - External Review

Thank you for a most helpful scoping discussion yesterday. I am writing to set out the Terms of Reference for the Welsh Government's (WG) external review of the relevant financial matters at Betsi Cadwaladr University Health Board (BCUHB), these are as follows:

- Identify the key drivers of financial performance in the financial year 2012/13.
- Identify the key drivers of under performance in the financial year to date (month 6)
- Review the revised plan to the end of the current financial year and comment on the likely achievability.
- Assess progress on the development of the financial plan for 2013/14.
- Comment on the organisational management structure and effectiveness.
- Comment on the governance structure and effectiveness around the development, adoption and review of financial plans.
- Comment on the risk to year end performance on the main Tier 1 targets including RTT, Unscheduled Care of the proposed plans.

Heather Evans will project manage the review and will be your first point of contact. We are agreed that you will provide external leadership to the review, undertaking most of the fieldwork and reporting to me.

We have agreed that the output of the study will be a summary report of findings and recommendations, with supplementary advice as appropriate.

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Heather will be in touch shortly to agree with you background information requirements and to confirm dates/times of interviews and project board meetings etc.

I look forward to hearing from you.

Yours sincerely

Kevin Flynn
Cyfarwyddwr Cyflenwi /Dirprwy Brif Weithredwr, GIG Cymru
Director of Delivery/Deputy Chief Executive, NHS Wales

Cc Heather Evans, Head of NHS Financial Management, DHSSC, WG

Public Accounts Committee: governance arrangements at the Betsi Cadwaladr University Health Board, published on 27 June 2013.

I apologise to the Chairman and Committee Members for not being present to respond to the WAO/HIW Report, but for medical reasons due to ongoing long-term cancer treatment, I am prevented from attending. I therefore wish my statement to be made public in the interests of openness and transparency.

My comments are not directed at Ministers who I have the utmost respect for. My comments are directed at the Health Board, WAO, HIW and government officials (hereby referred to as Officials) where necessary. As I have been absent from the organisation since May 2013 I will not be able to give the Committee information on recent actions and would therefore rely on the evidence that Mr Lang and others have provided. The intent of this statement is to build on evidence already presented, including evidence of the 18th of July, to add more context and explanation and to paint an honest picture of what transpired from my perspective over the last 18 months.

Introduction

I welcome the majority of findings in the WAO/HIW Report (hereby referred to as Report) and will respond in detail for a number of reasons.

First, I was not offered an opportunity by the Health Board to see or comment on the draft report, receiving the Report before the press embargo was lifted. There are matters of fact in the Report that need addressing and conclusions that may be drawn without being set in appropriate and factual context. Please accept my thanks for allowing such an opportunity to comment.

There is a NHS Managers Code of Conduct to act with integrity, openness and honesty for the benefit of the public and the Service. It has been a privilege and honour to serve the staff and patients of North Wales for the past six years and they deserve answers. I trust my evidence and that of others will go some way to provide this.

As the Accountable Officer, I fully accept my share of responsibility as a member of the Health Board. I believe patients, staff and the public deserve an apology and therefore offer my own personal apology to staff, patients and the public as the findings of the Report should not undermine confidence in the NHS. I also offer my personal apologies to patients and families that may have been affected by the outbreak of *Clostridium difficile* and to the staff who have had to manage under significant financial and clinical challenges.

Context

The Committee should be aware that over the last 18 months I was absent for a combined period of six months for medical reasons as outlined in the opening paragraph. I was therefore not present when two critical events took place namely the budget setting for 2012/13 (and the Chris Hurst Report) and also for 2013/14. I was charged with implementing a budget despite concerns about deliverability and the impact it would have on care. These points were raised with the Finance & Performance Committee at various stages.

My observation of the Report is that is it an insight into some issues arising over the last 12 months yet has not fully captured the context of the environment. The comments on Quality and Safety have been my biggest concern, especially staffing levels and I am relieved this has been raised.

In terms of context the Health Board was a merger of 8 organisations with distinct identities, behaviours and culture. There is much to praise about the Health Board that should not be lost in receipt of the Report. Clinicians have made significant improvements in integrating some services, improving outcomes and reduced variation in some specialities. The Health Board has led a major redevelopment of Ysbyty Glan Clwyd that will provide a modern, fit for purpose hospital for North Wales able to provide care for a wide population. These and many other achievements should be remembered. Improvements in care and its governance arrangements will continue to be needed and this has been adequately outlined in the Report.

The Health Board has operated in a flat cash situation for 4 years taking over 6% out each year in savings. Management costs have been reduced by 20% and initially 1000 staff left the organisation. At one point according to BMA figures, 348 beds were removed from the health system. The strategic direction for North Wales was agreed including management arrangements in October 2009. This built on work that started in 2008/9 as a whole system approach to address gaps that arose from the 2005/6 Secondary Care Review, now out of date. The second phase, the Acute Services Strategy will address medical and other surgical specialities through clinical networking based on the success of those currently operating e.g. Renal, Cancer, CAMHs, Cardiac, Critical Care.

In addition the Health Board undertook a number of service reviews and consulted on service change in the face of much opposition. Retirement and illness of some Executives during the last 12 months had an impact on how the Executive team was able to work as a team. In the midst of this, clinical leaders continued to pursue their clinical strategies and deliver against Welsh Government and other requirements to the best of their ability.

There was a breakdown in working relationships amongst Board Members, which includes the Executive team. The Executive Team began to fracture early in 2012 when I was absent and blame was apportioned to clinical leaders for financial deficits and non-delivery of savings plans. Some Executives and Independent Members (IMs) took particular stances about finance as the main priority that created tension and conflict within the team. This could not be reconciled despite best endeavours and as the Report identifies, the Board was not able to operate effectively. Process began to override everything with a delay in decision making as a result.

In my professional opinion, financial balance became the main priority for the Health Board. Documentation from Officials during 2012/13 stated that financial balance must be achieved and there could be consequences if this did not happen. Tensions continued to grow.

The relationship between a Chairman and Chief Executive is important as is the relationship between the Chief Executive and the Chief Executive of NHS Wales. I respect Professor Jones and we were able to work together in a professional manner. Confidence and trust between myself and some Board Members became strained which dates back to a number of positions and actions I took due to my concerns regarding the Board's ability to fully appreciate and comply with its obligation to public & patient safety and prioritise such obligations ahead of financial balance when necessary. It was the role of the Chairman to manage such tensions providing support where necessary and

resolving issues. When this could not be achieved the relationship unfortunately broke down to the dismay of both parties.

My actions, which I believe strained relationships were:

- Support in private and public to retain core services at the 3 District General Hospitals outlining the risk of some services collapsing if core services removed, at times a lone voice in this debate. Whilst it be may be convenient to argue that only two hospitals are needed in North Wales or a downgrade of one is appropriate, the reality on the ground is quite different which illustrated that gap between Board and Ward in such debates. The uncertainty that still exists about core services affects medical recruitment, staff morale and the ability to move forward with service improvement. Mixed messages from Board Members further exacerbated this situation. Clarity must be provided and the Acute Review should assist in this matter;

- Using my executive power, authorisation to recruit consultants and Emergency Nurse practitioners to A&E Departments to improve safety, access and to achieve performance targets, an area of continued if not daily involvement by Officials. The Chairman supported my position whilst there was disagreement amongst some Executives on incurring more cost in a deficit position;

- Using executive power, authorisation to recruit to Birth Rate Plus staffing levels, a situation delayed for over 18 months as a detailed funding stream could not be agreed by the Finance & Performance Committee. The Board had been the subject of criticism in three separate reports, was a significant outlier to other Health Boards, a sickness rate exceeding 5.5%; involvement of the Chief Nursing Officer and the Royal College of Midwives; increased use of bank and overtime and redeployment of community midwives to labour wards to staff them safely. This was a position I was no longer prepared to tolerate and put my actions and reasons in writing to the Chair of the Finance & Performance Committee and the Quality & Safety Committee, copied to the Chairman. None acknowledged my letter or the concerns raised;

- Using executive power, authorisation to recruit to 60 vacancies, mainly nursing that through a Audit process, required my personal authorisation on every vacancy agreed above budget, documentation to an Assistant Finance Director and explanation to the Audit Committee for my actions and those of the Deputy/Acting Chief Executive. This is highly unusual. A Chief Executive would not normally get involved in such level of detail. This created exceptional personal exposure for myself and Mr Lang making it almost impossible to manage. Two Officials from Welsh Government were also concerned about this, exchanged in a series of phone calls and a formal letter seeking assurance that the vacancies were going to be filled. My concern was so great that I wrote to the Chair of the Finance & Performance Committee, the Quality & Safety Committee and the Audit Committee, with a copy to the Chairman about the process and the need to balance the views of the Medical, Nursing & Therapies Directors respectively as well as the Directors of Finance and Workforce & Organisational Development. None acknowledged my letter or the concerns raised;

- Constructive challenge to the Finance & Performance Committee when it was recommended to slip the additional planned activity to meet financial balance. This approach is a 'false economy' as it carries the activity into the following year and costs more. Although the Report states this was clinically led, Chiefs of Staff were instructed to come up with options to save more money as the Board was being required to financially balance. The Board was reporting an end of year deficit, which in the end achieved a small surplus instead. Clinicians did provide options, but one cannot conclude that they condoned it. Surgical staff were not being fully utilised and patients were being disadvantaged. Evidence presented to the Committee showed that there would not be the capacity to accommodate this slippage even if clinical services were operating at 100% efficiency. Waiting List Initiatives or other additional payments would be required in 2013/14. This was not accounted for the in the original 2013/14 budget so I was relieved to learn that the Health Board has now agreed to fund the activity which will require further cost savings to manage it. It is worth noting that this is separate from the backlog waiting list for follow up appointments which has increased from 25,000 to over 42,000 patients waiting, a major concern expressed by the BMA given the clinical risk this poses. Both the Medical Director and I have supported the BMA's view and have raised this issue a number of times within the Board. Not enough funding has been allocated to tackle the backlog of patients. Follow up waiting lists are not tracked by Welsh Government and only a few Health Boards report this;

The role of a Chief Executive is an important one and as such needs to get the best out of the team that he/she has to work with. If the team do not wish to act corporately as is their responsibility, then it becomes difficult for any Chief Executive to fulfil their role with the Board.

I have worked with 4 NHS Boards prior to this Health Board and have found the last 18 months the most challenging and disturbing of my career. When needed support came from other Chief Executive colleagues when I raised financial balance over safety become more prominent. On reflection my main regret is that I should have whistle blown upon my return in mid-May 2012 about the direction the Board was heading in regarding making finance its main priority and its increasing ineffectiveness in managing its overall obligations. In such situations governance becomes fragile, blame is allocated, teams become driven by process and sight is lost on very critical matters, a situation Mid-Staffordshire and subsequently other NHS Trusts have found themselves in.

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

Many of us were aware of the variation in experience and understanding of IMs in running such a complex health organisation. Board Developments sessions were held as given in evidence already. A structured Board Development programme was commissioned earlier this year to try to address further development and understanding. The continual circle of producing more and more detailed

reports especially for Sub-Committees, explaining them and then producing further reports became a source of frustration for all, which the Report identifies. This pattern was allowed to continue despite concerns raised by some Executives on the difficulty this was presenting to allow them to effectively manage the organisation and take key, well informed decisions.

The Cwm Taf Report Governance Report several years ago identified the need for training for IMs, but to my knowledge this was never commissioned by Officials as an All Wales programme, but became a matter for Health Boards. There should be a fundamental review of the process of appointments to make sure that those appointed have experience and a good understanding of the NHS, are tested thoroughly on their abilities to operate as an Independent Member understanding their roles and have external validation and 360 appraisals

The Report highlighted issues of lateness of papers and/or presenting papers to the Board on the day. This was not normal practice and for reasons given already in evidence there were reasons that this occurred. It is not good governance. I was present for the discussion on the contingency plan (72 doctors). Clinical leaders had been working since November 2012 on addressing how services could be provided given changes the Deanery was planning to make. Discussions were ongoing with the Deanery and it is fair to say that up to the submission of the first paper to the Board in April, discussions were still being pursued to make sure that North Wales was not disadvantaged. Executives and the Board were aware of the issues. The Executive had had discussions about the paper and an extraordinary meeting was held amongst Executives to assess, challenge and validate what would be presented. The paper presented had been drafted much earlier, refined and therefore was not simply written the night before and presented to the Board the following day as was referred to in Committee questions. The first presentation of the paper to the Board asked for permission to at least start a process of recruitment by the production of job descriptions at the very least. The second meeting, where the paper was presented again sought agreement to proceed with recruitment and to utilise the money in the budget for such contingency.

The Report highlights two events, submission of the Budget papers on 26 April 2012 by the Director of Finance and the Acting Chief Executive and the contingency plan(see above) for 72 doctors (worst case scenario) in April 2013 by the Medical Director. I wish to correct the Report by stating that the paper was a product of the Medical Director and presented by hi, which had my full support. I insisted it had to be brought to the Board for discussion given the potential risk to services and this was scheduled in the agenda. There was much debate about the recommendations in the paper with many Board Members not wishing to expend resource on such a contingency plan despite the fact allocations had been made in the budget for such events. To reiterate, it should not have been tabled but happened as a consequence of two issues – the first was the continued dialogue with the Deanery resulting in a better clinical proposition as it turns out and the second, a significant disagreement about cost between Finance and the senior clinicians who had developed the proposals.

There is no doubt that agenda management needs improving and clarity of the Board Secretary's role reaffirmed. Discussions had been held between myself and the Director of Communications & Governance and as a consequence the clinical governance portfolio was transferred to the Director of Nursing & Midwifery. As to the Sub-Committees many were concerned with the overlap between

Finance & Performance and the Quality & Safety Committee. The Chairman had indicated his concern on this matter as well.

My professional view is that in the autumn of 2011 with increasing concerns about achieving financial balance for 2011/12, the late budget setting for 2012/13 and further concerns about financial balance, reinforced by Officials, the Board's direction turned to achieving financial balance to the extent that it outweighed the clinical safety, access, quality issue, governance and reconfiguration that were being raised. As the Accountable Officer I accept my duty in achieving finance balance, but I would not do that at all costs to safety and I made that clear. If this meant that my Accountable Officer status would be removed and thus unable to operate as a Chief Executive, then that was the price to pay. I made it clear in March to two Officials that although financial balance was likely to be achieved, I was not prepared to be the scapegoat for every single failure or event within the Health Board as the problems were way beyond one person. They are collective and involve all Board members as the Report outlined and has been shown in evidence to the Committee.

In my view the Finance & Performance Committee (F&P) became quite powerful offsetting the remit of the Quality & Safety Committee (Q&S) at times. Decisions were being taken by the F&P Committee that had consequences for clinical services, RTT an example which the Report has highlighted. In September I requested that Q&S Committee members attend the F&P Committee as I was very concerned about it taking decisions that impacted on the quality and safety of care. The request was granted.

Management and Clinical leadership structures

For ease of reference, clinical programme groups (CPGs) are clinical divisions or directorates in other Health Boards. An analysis was undertaken of other Health Board clinical and management structures that indicated that the number of clinical directorates and their functioning was similar to this Health Board. I undertook this analysis for the Chairman in November 2012 as questions continued to be asked by Independent Members about the CPGS. My assessment was accepted by the Chairman, but I am unaware whether this information and other issues raised were shared with IMs to answer concerns. The Vice-Chairman had signalled his desire to have a review earlier, as indicated in his evidence. I advised that with the consultation on service changes to North Wales, now concluded, reorganisation at that time would present risks to clinical management and leadership. He accepted this and made that point to the Committee which I am grateful for.

As to comments regarding accountability, clarity of accountability and performance, the Health Board's Strategic Direction 2009-2012 set out clearly the Executive and clinical management structures. CPGS Chiefs of Staff (or clinical directors in other health boards) were, and continue to be, accountable to an Executive Director and they in turn are held to account by the Chief Executive. This has always been the case. The Board of Directors is the operational management team consisting of the Executive, Chiefs of Staff and Trade Union Representatives. Issues arising from the management team are taken forward by Directors where necessary and help to advise the Board on key matters. It has proved to be a useful forum to address performance, quality and safety issues. It meets monthly and has also included local government.

Directors set objectives for the CPGs and they were responsible for managing their performance and hold them to account. This they did as I had weekly telephone or face to face meetings with Executives to understand current issues and to advice and direct on some occasions improvements that needed to be made. Performance meetings were held and actions taken. Improvements can always been made and the change to having the responsibility for CPGs to one Director, a Chief Operating Officer (COO) has been approved with support to help address simplify the lines of reporting and accountability. Management capacity was shared equally across the CPGs which in given two very large CPGs out of the 11 in place more management resource was needed, initially provided by senior management in other CPGs supporting their financial planning. The COO and the changes being made to the clinical structure should hopefully address that.

The consultation for changes to the Executive structure and CPGs was produced for the Board six days prior to the meeting. In discussion with the Vice-Chairman, the CPG element was not discussed but the Executive proposals were as there was a need to make a decision to progress with changes and recruitment to begin. The Report refers to the proposal being 'neither financially or operationally viable'. As the author of the paper, I was not asked about the rationale behind recommendations or the context with which it was set in. For the record, the consultation, albeit small indicated serious reservations with organisational change at this time. The fact is 8 of the 11 CPGs were working near or within control budgets, 3 were not. These 3 were 80% of the financial deficit. Smaller CPGs were more successful in achieving financial rigour, building strong clinical teams and driving forward service change. The Finance Director signed off the 8 CPGs as financially mature. The financial figures in the paper referred to hospital site managers if external recruitment were to proceed, which would bring a cost with it. The Board would not support additional revenue for more management posts. The figures were for illustrative purposes. Hospital site managers were temporarily appointed from within the organisation and evidence has been given on the process used at that time by the Acting Chief Executive.

Importantly, given the dysfunctional nature of the Board, one may wish to reflect that the decision and recommendation to reorganise the group of people (the Chiefs of Staff and their teams) who are actually cohesive, have positive working relationships and are able to reach consensus is an organisational risk that will need to be very well managed.

The Committee has asked why, after determining that 11 CPGs should be reduced to 6, the paper to the Board presented the opposite, indeed 11 to 12. On the face of it, it appears does appear contradictory and needs explanation. First, it reflected the feedback albeit small on the risks to reorganisation and concerns that successful CPGs would be subsumed into much larger clinical units. Secondly it addressed Dr Miles request for a Primary & Community CPG separate from acute medicine. Third, it offered the opportunity for an incoming COO, who would be responsible for the CPGS to consider how best he/she should structure it (eg. 6, 8, 12) and to engage with the CPG Chiefs of Staff on how to achieve this effectively.

Reorganisation of CPGs will trigger the Organisational Change Policy. This means that Chiefs of Staff and their clinical management teams will be put at risk, new job descriptions developed, job matching and grading undertaken, jobs advertised, interviews held, appointments made and a new clinical management structure for each new developed, produced and consulted upon. This will take six months or more if everything works smoothly at a time of considerable upheaval in the

organisation itself, a lack of confidence in the Board as it currently exists and a financial challenge that is even more difficult than in previous years. Structural change does not guarantee success and should not be seen as the solution to all problems. CPGs will be small in number but larger in their budgets and scale of responsibility. Dr Miles referred to the fact that it is not the numbers that are necessarily the issue, but their function and its interaction with site based management, an issue other Health Boards have had to consider as well. I agree with this comment.

Reorganisation must be undertaken in a planned way, staff affected fully involved, treated fairly, supported by their Trade Unions including the BMA and are communicated with regularly as they are weary of organisational change and uncertainty.

Site management was suggested by Officials, the CPG Review Panel as well by some senior clinicians, the latter who wished the old Trust operational structures to be reactivated. The three previous NHS Trusts had a Director of Operations for each site as well as Clinical Directorates (CPGs). Therefore the same issues raised by the Report into how there would be interaction between the CPGs and the Hospital Site Managers is similar to issues that previous NHS Trusts faced and overcame. The 3 District General Hospitals have experienced clinical site managers and a hospital management team led by a Deputy Medical Director and Deputy Nursing Director respectively similar to some other Health Boards. The introduction of a hospital site manager will give more seniority in such a system. The points raised about a lack of a job description were well made. The Director of Primary, Community and Mental Health has management responsibility for the Hospital Site Managers and the explanation to take their feedback and modify the role from an initial brief was a reasonable response to questions posed by the Committee. I have no further comments to make on the evidence already given on this.

It will be important that the 8 CPGS referred to earlier, who will be subsumed into new CPGs do not lose their identity or become despondent. Many have expressed that because they were successful they will now be disbanded lowering morale in the process. As the Report highlights the importance of clinical leadership, maintaining clinical leaders and their clinical teams during reorganisation will be extremely important. The Medical Director has expressed his concern to the Board about the potential loss of good clinical leaders and their will to engage on key issues as a result of reorganisation. This will need to be managed so as not to lose such engagement especially with the Acute Services Strategy in production. I am sure under his leadership this can be achieved.

The Report raises concerns of a taking an Executive post and recreating that as a COO post with the duties of the original post. Five other Health Boards have done the same thing. This was discussed with several of them and their example followed. I would therefore assume that the WAO will raise the same concerns with these Health Boards as has been raised in the Report. Additional support for the COO was agreed by the Board in May that would be funded from savings made from combining the Planning and Improvement posts as the Board did not wish to expend additional resource on management (see previous comments).

Combining planning and improvement/performance into one post is not unusual and has been done in other Health Boards and NHS organisations. We took a deliberate decision to separate these, creating the Director of Improvement as an Associate Director under the legislation in 2009 and it is fair to say there have been debates about whether combining posts should proceed. The Board however accepted the recommendation.

I wish to put on record comments about the Medical Director and an inference that there may be a lack of leadership. It is important that the Report does not unwittingly undermine the medical leadership that has been provided albeit in as an interim appointment. The evidence does not support this. Firstly, the Acting Medical Director is the substantive Deputy Medical Director and is therefore experienced in managing the affairs of a Medical Director and his office. He was a previous Medical Director in a LHB. He has given full authority to act and has proven his capability during his tenure in this role, which has now been on two separate occasions. Secondly, the Local Negotiating Committee of the BMA have confidence in the Acting Medical Director and the Chairman of the BMA Council, a consultant employed by the Health Board, has publicly stated local medical colleagues' support of him. Whilst is it always desirable to have a substantive position, the Health Board has an obligation to its employees if they are ill. The situation has been well managed following Workforce and OD policy and advice. The Health Board should not set aside employment law or an individual's rights as an employee and would be heavily criticised if it did.

As to other changes in the Executive, two were off at points of time due to illness (this includes myself) two were retirements and the third a new job after 8 years in North Wales, events that were not within anyone's control. Changes to an Executive should be expected yet it was unfortunate that these happened within the space of a year. What it has done is offered an opportunity to refresh the team, which should be welcomed.

Quality and Safety Arrangements

I welcome and support the comments and recommendations in this section of the Report. I have already stated my concern about quality and safety of care, some of which has been highlighted in a number of external reports as referenced in the Report.

Concerns were repeatedly being made about staffing levels to the Quality & Safety Committee and whilst they agreed that staffing levels should be adequate, the Finance & Performance Committee was not supporting investment to achieve this (refer to Birth Rate Plus and the staff vacancies held). At a Q&S Committee in October 2012, I supported the Director of Nursing's views on staffing levels and drew to their attention the need to address this. The Board although sited on the issues did not act effectively in accordance with its obligations to patient safety, quality and staff welfare in this area in my opinion. Vacancies were held to reduce or contain costs, a point raised by Trade Unions, the BMA and the Royal College of Nursing. Beds were closed to reduce use of bank and Agency and avoid cost and we must be transparent about such decisions. The staff on the ground know this to be the case and it would be disingenuous not to acknowledge it as a governance issue. I believe that no-one will be proud of such actions even though they are a well used method by the NHS across the UK to contain costs. To my knowledge the Board has not identified in its budget for 2013/14 resource to meet the requirements for safe staffing levels as set out by the Chief Nursing Officer earlier this year. The Committee may wish to seek information from the Health Board about whether this has been addressed or not.

The PHW Report on *C Difficile* has highlighted problems with escalation, communication, outbreak management and staffing, both at ward level where the outbreaks occurred and within the Infection Control team itself, reducing its staff from 7 to 3. Whilst the principle was to integrate the infection control teams into one was reasonable and to have an overarching Infection Control Committee, it is evident that in so doing, local clinicians who had been heavily involved in local infection control

issues where no longer sited on issues. This was raised by the Local Negotiating Committee of the BMA. Corporate functions were also expected to meet their savings targets, which could have been an influence on pursing integration and reducing overall staff numbers however I have no evidence to support this and cannot account for the actions of the Infection Control Committee given I have no access to the minutes to review and conclusions to be drawn. What I can disclose is that the lead Microbiologist for Glan Clwyd raised his concerns about infection control staffing and I sought assurance that his concerns were being listened to and actions taken. My understanding was that action was being taken but by that time the outbreak had manifested itself at Glan Clwyd with the subsequent events outlined in the PHW Report.

The functioning of the Q&S Committee remains challenging given the breadth of the agenda and subjects which need to be explored. It is fundamental a system failure not be able to triangulate information presented and then ask the right question. As an example for infection control warning signs such as staffing levels; bed capacity and utilisation; hand hygiene compliance; antimicrobial prescribing compliance, reported events; staff concerns as well as trends in infection rates are a rich source of information that aids a Committee in being able to undertake adequate scrutiny of the safety issues. This applies at a local level as well. Whilst this information was made available, bringing it all together to see the whole picture did not happen, a lesson for all Health Boards and NHS Trusts in Wales. To undertake this takes experience and training including self appraisal and review of how well scrutiny is being applied, in essence asking the question ‘what are we missing here’ and ‘how are we comparing to others inside and outside Wales’.

The Q&S Local Officers Group was established to bring the clinical Executive Directors together as each holds the responsibility for clinical governance in their job descriptions. Its aim is to triangulate information coming from a range of sources, assess and draw conclusions on areas of clinical risk that need addressing. Mrs Lewis-Parry and Mr Lang have given evidence in this regard which I cannot aid much further. It will need to be functioning better as has been stated by others and it will be for the new Director of Nursing & Midwifery to address this.

Financial management and sustainability

The Report highlights a number of issues about financial management and sustainability. The 2012/13 budget setting process caused concern with the Director General and Finance Director at that time, Mr Hurst. The Director General did contact me during my period of absence from February to mid-May 2012 as to the initial shortfall being identified and concerns about financial forecasting and management. I was not in a position to respond, but did disclose the conversation with the Acting Chief Executive at the time. The concern prompted the Chris Hurst Review which the Acting Chief Executive received and acted upon.

The Report mentions signing off budgets with caveats. Each Corporate Director and Chief of Staff accepted their budgets and worked to them to the best of their ability given the constraints placed upon them in a flat cash scenario with increasing drug and therapeutic costs, salaries and patient demand. Their ‘caveats’ are risks that as a clinician and responsible budget holder, they raised in order that it was open and transparent about what they may not be able to achieve from a clinical standard or quality perspective. It is unusual to be reported in this way. It is usually done in another form which is presentation of savings plans with clinical risk assessed. My understanding is that this year, the Medical Director, Acting Chief Executive and the Q&S Committee have been notified by

one senior clinician that under their GMC professional duty, the budget allocated is not sufficient to deliver obligations for health and safety of staff and patients. Clinicians do not do that lightly and could be seen as whistle blowing.

Savings plans and their deliverability were identified by the Report and it is correct to say there was duplication in savings schemes. This was identified and through the Delivery and later the Recovery Board, some withdrawn and other proposals requested to address the financial gap. This happened in some cases, but was not sufficient and hence non-recurrent measures including slipping additional planned activity were enacted.

External support for turnaround was discussed with Officials and previous to that Officials had suggested external financial support. This was not supported some Executives or in some cases IMs due the costs it might incur. For turnaround this meant an existing Director took on this role for a short period of time.

Integration of clinical, workforce and financial plans is important and new arrangements were introduced in 2012 to seek to achieve this for 2013/14. Positive comments were received from Officials on the approach although they raised concerns about the capacity in planning to bring all of this together and advised on external support. To my knowledge this has now being implemented as the team in place is very small and deals with not only strategic planning and commissioning, but also public engagement and consultation, the latter enough for a full time team of its own. The lack of management capacity within the organisation has been a constraint compounded by direction to reduce management costs and a reluctance to overturn this position for financial reasons. I trust that new management will undertake a review of the management capacity and capability in the organisation and advice to Board on what will be required to deliver clinical service and sustainability including finance in the future.

The Report references services that are not clinically or financially stable and implies that reconfiguration and service change can deliver this. That may be the case in some instances however evidence shows that reconfiguration, which is sought to address standards and safety, may incur more cost, which will need to be accounted for.

Strategic Vision and service reconfiguration

The Acute Service Strategy is part of a planned programme of continual service review and potential change. It would be useful to see if other Health Board's have produced a fully comprehensive acute plan covering all medical and surgical specialities, pathways of care and associated outcomes over a period of 10 years or more, levels of activity and predicted demographic changes and demand; workforce requirements; timetable for change; financial requirements and the like. Perhaps this can be shared as examples of good practice. The approach adopted has been drawn from international research, using a similar health pattern and challenges in Australia that mirror many of the issues faced in North Wales such as geography and medical recruitment. Whilst it may be appear to be slow, there are already clinical service strategies in place for many acute services such as cardiology, emergency medicine, vascular, rheumatology, cancer, palliative medicine to name a few. They are not however drawn into one comprehensive plan based on functional clinical networks that will support core services at the 3 District General Hospitals. This is the intended aim of the Strategy and should be completed on time mindful of impending changes to the CPGs which will occur during this

period of development and production of a strategy to take forward service change over coming years.

The Report references again the contingency plan for 72 doctors that were presented to the Board in April and again in May. This was the worst case scenario as outlined by the Medical Director who presented the paper. As indicated by evidence given to the Committee, only 30 doctors were needed and indications are they have been recruited even into difficult specialties such as paediatrics.

Conclusion

The Committee has given me an opportunity to provide a detailed response to the issues raised by WAO and HIW. There is agreement on many of the observations made and recommendations offered yet I hope the Committee can see that these need to be set in a wider context to understand the complexity of the issues, reasoning and rationale behind decisions and importantly the need to make sure that quality and safety is not sacrificed for financial balance. Governance arrangements need to be sufficient and strong and communication improved to help achieve this.

The Minister's recent statements on changing the financial system, the additional £10m recurrent funding to recruit more nurses to meet the Chief Nursing Officer's staffing policy and a review of the allocation for NHS Wales with the Finance Minister are welcome, much needed and timely. My personal view is that more resource is needed for the NHS over and above what efficiencies can be made within the system. Continual savings of 6% or more each year in a flat cash scenario will drive short terms decisions that may have long term impact, force clinicians to fit services to a budget rather than need and potentially led to unsafe care, high mortality rates and a loss of confidence in the NHS overall. This is starting to be seen now with daily reports of NHS failures in England and should not be a feature of NHS Wales. Wales has a unique opportunity, hugely dedicated staff and a system of integration that can drive real improvements.

This Report should, as recommended by the authors of the report, be considered and reviewed by other health boards for there will be similar issues yet may not be as stark as those for this Health Board.

I welcome further questions that may arise from my evidence.

Yours sincerely,

Mary Burrows, Chief Executive

18/07/13

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Mr Darren Millar
Chair of Public Accounts Committee
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Dear Mr Millar

At a meeting of the Consultants based at Ysbyty Gwynedd on the 5th July 2013. The following points were agreed:

1. The Consultant body had lack of confidence in the current Board and Executive to manage with appropriate speed, the changes necessary to sustain good health care in north Wales
2. The Consultant body didn't believe the current internal structures of the Health Board (the Clinical Programme Groups) were fit for purpose.
3. There needs to be a fundamental shift of emphasis to locality based management with locality based clinical input.

Yours sincerely

Tony Roberts

Dr Tony Roberts
Chair, Gwynedd Consultants and Specialists Committee

Cc Mark Drakeford, Minister for Health and Social Services
David Sissling, Director General, Health and Social Services/Chief Executive, NHS Wales

Yn rhinwedd paragraff(au) ix o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

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Mae cyfyngiadau ar y ddogfen hon