Betsi Cadwaladr UHB review on April 4th and 5th 2012

Background

Betsi Cadwaladr UHB was created in October 2009. It is the largest of the Welsh Health Boards (turnover £1.2bn) and is a complex organisation. The Health Board has put in place a progressive clinical leadership model which vests accountability for the delivery of service, quality and financial performance with a small number of clinical Chiefs of Staff (CoS). Each CoS has responsibility for a defined area of clinical services (a Clinical Programme Group). The CoS and corporate executive directors form the Board of Directors.

Over the last 30 months the Board of Directors has overseen the delivery of a number of service changes and improvements for patients in North Wales; but it has also experienced some disappointments and frustrations. Although the Health Board has delivered in-year financial break-even in 2009-10 (6 months), 2010-11 and in 2011-12, it did not deliver the Financial Plan it set for last year and had to use significant non-recurrent measures to compensate for the under-delivery of its savings programme. As a consequence, it assesses that it brings into 2012-13 an underlying deficit of c. £52m from last year. This more than doubles its requirement for savings in the new financial year. This in turn significantly increases the risks to delivery of the 2012-13 Annual Plan.

Purpose of the review and next steps

On April 4th and 5th I visited the Health Board to interview members of the Board to take stock of the financial position and outlook for 2012-13. My objective is to provide an external perspective on the underlying issues which are likely to be constraining delivery and performance. This brief informal note sets out my observations for the Acting Chief Executive but I consider it would be helpful if my observations were shared with the wider Board of Directors. I believe the Board of Directors should make it a priority to make time available to identify the things that can and need to be done to strengthen the current management arrangements and ways working; so that both in-year and longer term delivery is enhanced.

A possible framework for the directors to work through these discussions could be as follows:

1. A brief discussion about a few specific examples of things that have been delivered in line with plans over the last two years; and the factors which appear to have supported successful delivery*
2. A brief discussion about a few specific examples of planned changes/areas of delivery that slipped or not delivered at all; and the factors that may have contributed to this*
3. Identification of refinements to current management arrangements and/or ways working that could help to "level up" success in the future.
4. A brief consideration of the enablers of longer-term term delivery:
    a. Is there clarity across the directors about what services will look like in 5 years time; and
    b. If you were looking back in 5 years time, having successfully delivered the service changes, what is it that has worked well and what risks have you successfully managed/ mitigated?

* This might include the consideration of a small number of key factors such as; leadership (clear, adequate time, right person, etc?), communication (objective clear, key staff kept up to date, etc?), resourcing, and approach taken to holding to account.

Whatever process you decide to adopt, the Health Board's current position and outlook makes it clear that there is a need for urgency. The Board of Directors need to reach a consensus about what

changes would be helpful and then commit individually, and jointly, to put them in place without delay.

It is good governance and common sense for a new organisation to learn and develop as it matures. As a leadership team, you are now in a position to take stock of the relative strengths and weaknesses of the management arrangements and ways of working you have had in place. You have accumulated two years of actual experience of operating under these arrangements and it is important that you learn from this experience.

I would like to record my appreciation for the honesty and openness shown by the Health Board's directors and independent members during the course of my interviews with them.

Chris Hurst

16 April 2012

Observations and suggestions following the review

A number of common themes and questions came out in my discussions with Board colleagues. This is encouraging because it indicates that there is a shared, but currently private, recognition of the need to make some changes to strengthen delivery. Unfortunately I was not able to talk to all Board directors in the time available, so my observations should not be regarded as comprehensive. For example, I did not have the opportunity to meet with any of the Chiefs of Staff. Therefore, it is important that my observations and views are not seen as a substitute for the discussion the directors need to have to test and modify my first impressions, before actions are agreed.

For ease, I have grouped my observations and comments under a small number of thematic headings:

1. Leadership team

- The challenges facing the NHS (across the UK) are significant and the cultural and service changes we need to implement will only be delivered with the support and active engagement of the majority of NHS staff. This creates a significant leadership challenge for NHS top teams.

- The impact of leadership is significantly enhanced when the top team is seen to:
  - have a clear and share definition of what longer term success will look like
  - operate to a single set of priorities
  - give consistent messages (as a team and over time); and
  - operate in support of one another.

- To work in this way, and sustain it, it is essential the leadership team has sufficient time set aside to work through challenges, differences in opinion and to share and test ideas. The benefits of the directors being located across the patch may be lost if there is insufficient time for the top team to work together outside of normal business meetings. Are you making enough time available for this purpose?

2. Culture, priorities and follow through

- The culture within organisations is infectious “from the top”. Some concerns have been expressed about pace and urgency - for both financial delivery and service change.

- Both the tempo and appetite for change, and for in-year delivery, are set by the way the top of the organisation operates – ie. by behaviours and processes , and not by plans or intentions.

- For example, an organisation will never be “light of foot”, dynamic and have pace if decision making is centralised and slow in its execution. Similarly, when we state that X is the organisation’s top priority this year, is this apparent to staff when they look at; our Board papers, departmental agendas, the way scarce staff expertise are being deployed, what the Board is regularly monitoring and reviewing, how often we ask

about progress, etc? Do you believe that there is clarity about relative priorities in the Health Board and are your behaviours, systems and processes reinforcing this clarity?

- Success in organisations is also infectious and this means it is helpful to be seen to focus on a relatively small number of priorities in any period; and to have arrangements in place which can rapidly communicate and celebrate success within and outside of the team, department, and/or organisation.

- Large organisations are faced with delivering many things in any year, but it is helpful if these are synthesised down to a smaller number of coherent and compelling "must dos" for staff, ideally described in terms of patient care. If you asked 20 members of staff about the Health Board's top priorities (for delivery) in 2012-13, would you expect to get some common answers? If you asked the same group what the Health Board's greatest achievements were last year, what would they say?

- I do not underestimate the challenge you have faced in successfully integrating 8 former provider organisations. However, until there is seen to be "one way of doing things in Betsi Cadwaldr", the risks of variable standards of patient care/ experience and of variable delivery will remain.
- As importantly, the perceived longer-term "tolerance" of divergence in practice (eg. the multiple SUI processes still in use was quoted as an example) will undermine the work of the directors to align staff to a common purpose (to delivery consistent and effective health care). Are the directors fully sighted on the areas where there is still variation of practice/ procedures; and have you agree a target date for standardising practice in each of these areas?

3. Management and clinical leadership structure

- It is clear that experience has raised some questions about the overall effectiveness of the current arrangements – these concerns appear to be focused on two important considerations:
  - The differential size and scale of the challenge faced by individual CPGs; and
  - The adequacy of the managerial resources which are available to work alongside and support the CoS.

- There would be little to gain and everything to lose by "throwing the current structure into the air" but there are signs that some strengthening of the current arrangements would be beneficial. What do you consider to be the minimum number of changes that would strengthen the current CPG delivery model?

4. Financial delivery

- It is clear that the Health Board is facing another challenging year in 2012-13, in financial terms, but its challenge has been significantly exacerbated by the under-delivery of 2011-12 savings plans, which it now carries into 2012-13 as an additional pressure.

- From my interviews I perceived that the robustness of the original savings ideas and plans are not at question, per se. It is the delivery arrangements that have not worked as well as expected.

- This is an area that must be reviewed and gripped by the directors, as any perceived tolerance of under-delivery over a period of time will be accepted by staff as a reduced expectation for future delivery in that area (eg. the need for budgets to be managed alongside services).

- Pending the completion of work to identify further savings, the Board has yet to be able to agree a balance financial plan for 2012-13. However, you expect to be in a position to do this at the April Board meeting.

- In light of your experience in 2011-12, it will be essential that the accountability, monitoring and follow through arrangement for savings delivery are both visible and effective from the outset of the year. You shared with me your plans to put a place a new Delivery Board – this appears to be a helpful strengthening of the current accountability arrangements, but it will need to be aligned carefully with the work of the Finance & Performance Committee.

- The Health Board's dependency on non-recurrent savings measures and balance sheet flexibilities in 2011-12 is not sustainable. This means that the effectiveness of new arrangements for holding managers and other staff to account for delivering the plans and actions they have signed up to will be critical to your success.

- The financial results of any organisation largely "lag" behind and reflect operational activity and performance. This means it is usually impossible for financial variation/ overspends to be addressed by adopting solely financial responses and strategies. Performance and practice at the "front of the business" has to be reviewed and improved to deliver financial improvement. Are you clear about what these changes need to be?

- To do this, it is more effective if we can identify and be seen to monitor the "front end" changes we expect to see, rather than solely focus on monitoring the expected financial impact. The latter metrics are important but are usually 6 weeks out of date. This needs to be borne in mind when the Delivery Board is considering what measures it will be using to hold others to account.

- You estimate that c. 40% of all in-year cost increases will be attributable to the need to invest in meeting mandated access targets. Clearly, this assessment creates a number of additional challenges for the Board of Directors, which include:

  - The consequential need to increase in-year cash savings across the Health Board

  - A difficult message to handle with staff who work in the clinical areas that are not receiving investment, but which may consider themselves to face equivalent service access challenges

  - A difficult message to handle with staff who work in the clinical areas receiving the additional investment – ie. this investment cannot substitute for the requirement to deliver ongoing productivity improvements in each year.

- In light of these factors, it may be helpful to consider linking the release of the investment to the delivery of other key improvements in these areas – for example, a move to team based consultant job planning, theatre efficiency gains etc.

5. Strategic delivery

- The arrangements for the Health Board to deliver its longer term plans will not be wholly met by its arrangements for overseeing in-year delivery.

- From my conversations with Board colleagues, I believe it would be helpful for the broad indicators of strategic progress to be fleshed out by the Board of Directors, if they are not already clear and visible. These indicators could then be used by the directors and by the full Board to look (say, twice a year) for assurance that progress is being made towards the Board's agreed strategy.

- A small number of such "signpost indicators" might usefully include things such as:

  - Trend of size and composition of the workforce over time compared to the target size and shape for the future

  - Proportion of patients being cared for outside of hospital compared to those being referred to secondary care (for certain key groups or clinical conditions)

  - Pie chart of programmed (budget) spend, year on year

  - Percentage of non-recurrent savings to total savings

  - Etc.