Betsi Cadwaladr University Health Board

External review in accordance with terms of reference dated 12 October 2012

This report has been produced in accordance with the terms of reference issued by Department for Health, Social Service and Children, Welsh Government, dated 12 October 2012.

Objectives of review

The objectives of the review were to:

1. Identify the key drivers of financial performance in the financial year 2011/2012
2. Identify the key drivers of underperformance in the financial year to date (Month 6)
3. Review the revised plan to the end of the current financial year and comment on the likely achievability
4. Assess progress on development of the financial plan for 2013/14
5. Comment on the organisational management structure and effectiveness (which has been limited in discussion with CEO)
6. Comment on the governance structure and effectiveness around the development, adoption and review of financial plans
7. Comment on the risk to year end performance on the main Tier 1 targets (including RTT and Unscheduled Care) of the proposed plans

Limitation of scope

This review is based on information provided by Betsi Cadwaladr University Health Board and interviews with key staff which took place on 22 and 23 October 2012, supported by financial analysis undertaken by DfHSSC staff. I would like to record my formal appreciation of the support given by DfHSSC staff in this regard.

Because these observations are based on a high level review of limited information carried out within a limited timescale, they may contain errors or be incomplete and therefore cannot be relied on. They are provided for your information only and should not be copied, quoted or referred to without prior written consent.

If you require any further information, please contact me.

Alison Lord
Director, Allegra Limited
3 December 2012

Summary of findings

1 - Key drivers of financial performance in the financial year 2011/2012			
Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Achieved financial balance in 2011/12 after £17m structural support	• Initial forecast of £71m savings requirement increased to £79m after in year cost pressures. • £58m of savings schemes identified, £45m achieved by year-end. • Escalation measures in last 3 months of year were mainly technical adjustments and the use of reserves and ring fenced allocations. • With the exception of New Outpatients (which was 9% lower than planned), activity levels did not substantially vary from plan, suggesting a savings shortfall rather than an unexpected increase in activity caused overspending, (although this does not take account of possible changes in case mix).	• Under-estimation of in-year cost pressures added to savings requirement. • Insufficient savings were identified to meet the shortfall (initial or revised) • Only 77% of identified savings were achieved - poorest performers were Medicine, Surgery, MH/LD and Corporate schemes which collectively accounted for £11m of the £13m underperformance. • RTT target performance achieved at year-end after significant investment. • High dependence on temporary medical and nursing staff in some clinical areas. Locum spend forecast to reduce by £2m during the year but actually increased by £2m.	N/A

2 - Key drivers of underperformance in the financial year to date (Month 6)			
Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Shortfall of £14.8m at M6	• Initial assessment of £90m financial gap for year, reduced to £64m on review (both after £17m structural support from WG), comprising £41m underlying deficit, £25m inflationary/service growth pressures, £12m RTT requirement and £3m other. • Planning process initially failed to identify sufficient savings to forecast financial balance - £21m savings identified by directorates plus £23m of central "themes" leaving £20m shortfall. Board unable to adopt balanced financial plan at start of year and temporary control measures were introduced pending further assessment. Delivery Board established under control of MD to drive savings delivery • When balanced plan adopted in May following return of substantive CEO, significant level of savings themes still lacked detail • By M6, savings of £15.6m achieved against a plan of £27.4m leading to deficit of £14.8m YTD. Main areas of overspend are: o Pay £11.8m (including agency/ locum spend running at c£1m/ month), esp Medicine and Surgery o Non pay £12.4m (including drugs and	• See 1 above.	N/A

	equipment £3m and power £2m) o Primary Care £3.7m o Commissioning £2.4m o CHC £1.9m • Overspend balanced by release of £19m central contingencies • Analysis suggests improvement in run rate in M6 may not be sustainable as primarily driven by a variety of one-offs and M7 figures will be a key indicator		

3 – Revised plan to the end of the current financial year and likely achievability			
Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Revised plan now forecasting year end deficit of £19m	• Recent reallocation of executive responsibilities to refocus on remedial activities (see 5 below) • YTD run rate trend and directorate bottom up forecast both support deficit of £26m. Additional £7m central reserves (£2m release of funding previously earmarked for RTT, £2.8m technical improvement re prescribing, and £2.3m targeted reduction in commissioning costs) held by DoF means she is confident £19m is achievable, providing support in place to deliver plans. • Revised plan (October 2012) reduces saving target from £74m in year (incl £10m FYE of savings b/f from 2011/12) to £48m, of which £19m achieved YTD, leaving £29m outstanding. Average monthly savings need to increase from £3.2m YTD to £4.8m from Oct onwards to achieve £19m outturn, reinforcing the importance of M7 return. • Directorates now being managed against centrally set control totals • Service changes currently under consultation are not expected to impact in current year and no significant back end loaded schemes are evident so savings to	• Scale of challenge and speed of change required is huge and would stretch any management team. • Diversion of key executives into remedial areas risks loss of focus on their primary areas of responsibility and over stretching of limited resource. • Substantial increase needed in identification and pace of delivery, of savings. Many savings need more detailed plans, measures, milestones, etc. • Forecast deficit will only be achieved if plans and spending restrictions are adhered to at all levels. • A third of revised savings total still rated high (£2m) or medium (£14m) risk. £1.5m of low risk schemes already identified as unachievable. • Additional savings focus to year-end predominantly transactional rather than transformational, achieved through holding vacancies, reducing locum spend, delaying	• Supplement executive resource through appointment of external interim Turnaround Director mandated by Board, and adoption of full Project Management Office approach to accelerate speed of identification and delivery of savings schemes whilst ensuring current clinical input to proposed changes is not lost. • Clinical services should be reviewed for sustainability and emergency temporary closure measures considered where required • Begin implementing working capital management

	year-end will only be achieved through operational grind.	reinvestment, slowing down activity etc.
		• Little evidence of successful workforce modernisation and pay cost management schemes to date
		  o Net leavers of only 570 WTE since Oct 09, including c 400 VERS
		  o Sickness absence running at 5.18% (August 2012)
		  o High variable pay bill
		  o Consultant job planning not progressing
		• An extreme winter could result in additional upward cost pressures
		• Commissioning savings may not be supported by external partners
		• £19m year end deficit, if achieved, would result in negative cash of £22m at March 13 (assuming continued compliance with supplier payment requirements)
			measures to reduce potential cash shortfall

4 - Progress on development of the financial plan for 2013/14			
Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Little evidence of progress on development of 2013/14 plan to date	• Although Health Board wishes to move from annual cycle to 3 year or continuous planning, there was no evidence of any large scale service redesign plans currently sufficiently developed to impact in 2013/14 (or future years). • Medium Term Financial Plan 2013/14 to 2015/16 outlines direction of travel but is not a financial plan. • Timetable in place to receive revised clinical service options in November 2012, with worked up financial plans by January 2013 for adoption into 2013/14 plan. • CEO view is that significant redesign is 3-5 years away and would involve significant capital cost.	• On the basis of performance to date, the current timetable may not be sufficient to consider options, review inter-dependencies, prepare adequate business cases, comply with governance processes, develop fully worked plans etc to enable implementation early enough in 2013/14 to maximise impact on financial performance. • The current service reviews and consultations do not appear to have identified the level of savings required to achieve sustainability in the longer term. • Planning needs strengthening to achieve the current timetable • The reviews of services need to be progressed with greater urgency. • Service review boards currently focus on clinical issues and do not sufficiently consider financial implications. • Balancing longer term change activities with achieving current year outturn will stretch resource in	As 3 above. Also, • Consider appointing an external clinician to lead a systemwide service redesign review • Balance clinical and commercial representation within service review teams to ensure early identification of viability of options presented • Strengthen planning function and prioritisation (possibly through combination with PMO)

		key leadership areas. • Much can be achieved without the need to consult but at present there is no evidence that plans are sufficiently developed for quick implementation. • There is a danger that, without major service redesign plans, savings will be achieved through short term measures.	

5 - Effectiveness of organisational management structure			
Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Confused accountability around the clinically led structure means Health Board appear to lack commercial grip **NOTE: LIMITED REVIEW OF THIS OBJECTIVE AT REQUEST OF CEO**	• Historically there seems to have been a lack of accountability of clinical leads resulting in lack of financial rigour at directorate level, leaving executives having to fall back on Standing Financial Instructions and Schemes of Delegation to change behaviour. No evidence found of top to bottom line of sight supported by clear view of job roles, responsibilities and accountabilities at all levels. • Disconnect between functions and sites, with no Chief Operating Officer to provide cross function/cross site overview and no hospital managers to maximise site efficiency • Recent changes made to executive roles in response to increased distress include DoW&OD appointed Turnaround Director, DoN taking executive lead for Emergency Care, CEO chairing Delivery Board (now Financial Turnaround Board) and reallocation of executive responsibility for directorates away from MD. • Planning responsibility recently split between DoP (strategic) & DoF (operational)	• Clinically focussed directorate leads means operations can lose sight of commercial reality. If clinical dominance is not balanced with commercial input, Health Board will risk financial and performance failure. • Lack of joined up functional and geographic management may limit effectiveness and speed of systemwide redesign. • Split of planning responsibility risks disconnect between strategic and operational activities. • Risk that clinical leadership is not effectively managed when MD absent. • Increased responsibility of some executives risks overload. • Poor performance of key senior staff does not appear to have been addressed through line management processes.	• Consider redesign of organisational structure to create a Chief Operating Officer and site management posts, and enfranchise senior commercial managers to work hand in hand with clinical leads • Strengthen job planning, role clarity and performance management framework • Roles and responsibilities of existing MD and DoP need review • See also 3 and 4 above

6 - Governance structure and effectiveness around the development, adoption and review of financial plans			
Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Strong clinical input and informal reporting networks means formal governance processes may not be fully effective **NOTE: LIMITED REVIEW OF THIS OBJECTIVE AS EXPECTED TO BE PART OF WIDER REVIEW BY HIW**	• Board initially refused to adopt 2012/13 financial plan because it felt the savings plans were not achievable. • Board appears to receive full and appropriate monthly reports on financial and clinical performance. • Some recent confidential Board sessions seem to have no formal papers making an effective review of governance difficult. • Process for clinical input should be robust as savings plans and service reviews are being led by clinicians but unable to interview MD due to illness so limited visibility of clinical governance process adopted in savings plans to date.	• Emphasis on clinical leadership means limited financial input to plans at early stages. • Risk of agreed financial plans being undermined by perceived clinical needs and/or informal networks overriding formal controls. • Determination to achieve financial balance could prevent acknowledgement of under-performance and lead to the adoption of inappropriate plans.	• Findings and risks identified within this review should be shared with HIW and WAO • Confirmation of processes for confidential board sessions is required • Service reviews should be prioritised on clinical areas considered potentially unsafe

7 - Risk to year end performance on the main Tier 1 targets (including RTT & Unscheduled Care) of the proposed plans

Observation	*Evidence/assurance received*	*Risks identified*	*Recommended action*
Current savings plan assumes no deterioration in performance against targets, but increasing financial distress means some performance deterioration is likely unless the savings management process is significantly and quickly strengthened	• Historic and current poor performance against A&E 4 hour and ambulance handover, Cancer 62 days and 26 week RTT targets • Improvement action likely to have a negative cost impact and will need balancing with savings elsewhere. • A&E performance has begun to improve in October (though still below target) following redeployment of DoN to manage Emergency departments, and the recruitment of 2 additional consultants, 15 nursing/support staff and the establishment of an additional GP minor injuries unit at the worst performing site. The cost of this intervention has yet to be assessed. • £12.4m initially put aside to deal with RTT pressures, now reduced to £10.4m • Additional funding of £1.5m from WG to support winter pressures	• As transactional savings activity increases, combined with potential emergency closures on safety grounds, performance against targets is likely to fall unless carefully managed and remedial action taken. • RTT contingency has been identified as potential saving opportunity with the view that RTT will need to be managed without additional resources. Achieving this will be dependent on changing current clinician working practices	• Establishment of an effective PMO would help identify priority savings areas to minimise performance impact, drive changes in working practice and allowing earlier flagging of performance going off track

Summary of conclusions and recommendations:

- The scale of the challenge facing the organisation, and the speed of change required, will place enormous strain on existing executive resources and the Health Board would benefit from seeking temporary resource and expertise to supplement existing capability at senior levels.
- Key drivers of underperformance in FY 2011/12 and FY 2012/13 YTD appear to have been a lack of sufficient savings plans identified at the start of year and a subsequent inability to achieve targeted savings, particularly through service redesign and workforce modernisation.
- The revised plan for FY 2012/13 (showing a deficit of £19m) is achievable but will require strengthened savings activity management and the Health Board should consider the appointment of an external interim Turnaround Director and the establishment of a full Programme Management Office to support its Executive in maximising savings and minimising performance impact. Without careful management, there is a risk that increasing financial distress will lead to deteriorating performance against targets as well as raising potential quality and safety concerns.
- The Health Board is unlikely be able to achieve sustainable financial balance without systemwide service redesign and it is recommended that temporary external clinical support is sought to drive this process. There is also an urgent need to address clinically unsustainable services.
- Whilst the clinically-led management structure provides strength in some areas, there appears to be a lack of commercial and financial rigour at operational levels and this imbalance should be addressed. The functional structure also means there is limited cross functional/cross geographical inter-operation. These issues have been exacerbated by an apparent historic lack of accountability and effective line management at senior levels. Consideration should be given to changing the organisational management structure to address these concerns, including the appointment of a Chief Operating Officer.
- Whilst governance has not been a key focus of this review, it is recommended that findings are shared with HIW.

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