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