An Overview of Governance Arrangements

Betsi Cadwaladr University Health Board

A summary of progress against recommendations made in June 2013

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Archwilydd Cyffredinol Cymru
Auditor General for Wales

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SWYDDFA ARCHWILIO CYMRU

Arolygiaeth Gofal Iechyd Cymru
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This report has been prepared jointly by the Auditor General for Wales and the Healthcare Inspectorate Wales (HIW) and is presented to the National Assembly under the Government of Wales Act 1998.

Foreword

Last year Healthcare Inspectorate Wales and the Wales Audit Office reported jointly on the governance arrangements at Betsi Cadwaladr University Health Board (the Health Board). Our report made 24 recommendations aimed at addressing a number of fundamental concerns around:

- the effectiveness of the Board;
- the organisation's management and clinical leadership structures;
- quality and safety governance arrangements;
- the Health Board's ability to manage its finances and secure financial sustainability; and
- the development of strategic plans for the modernisation and reconfiguration of clinical services across North Wales.

Twelve months have passed since the publication of that review, and our organisations have recently completed a high-level review of the progress that has been made by the Health Board in addressing the substantive areas of concern we identified. The findings from our follow-up work are presented in this document in the form of a commentary against each of the 24 recommendations we previously made.

Our overall view is that whilst there is evidence of progress, some of it significant, a number of the fundamental challenges that we identified last year still exist and the Health Board still has considerable work to do before its governance and management arrangements can be regarded to be fully fit for purpose.

In the wake of last year's report, and the consequent announcement that the Chair, Vice Chair and Chief Executive would all be stepping down, there has been a need to stabilise the organisation. This has been largely achieved and progress has been made in some important areas. We are pleased that there have been improvements in the way Board meetings operate and how Board members are supported, although we note the important work that is still underway in relation to board development to clarify roles, foster cohesive working and establish sound working practices in terms of governance.

There has also been an enhanced and ongoing executive focus on quality and safety arrangements with particular improvements in the management of infection prevention and control, especially in relation to the information that the Board now receives on this important matter. However, the Board is still needing to manage substantial longstanding risks in a number of other areas.

There have been significant changes in senior personnel at the Board with a new Chair, Vice Chair, Medical Director and Executive Nurse Director. These new appointments have brought a fresh dynamic to a number of the leadership challenges faced by the Health Board. Disappointingly however, it has taken the best part of a year to secure the services of a new Chief Executive, with the chosen candidate taking up post on 16 June 2014. The time taken to secure this appointment has significantly hampered the progress that the Health Board has needed to make in addressing the problems we identified with the organisational structure, and in particular the difficulty in ensuring connectivity and clear lines of accountability between clinical programme groups and geographical hospital sites.

Now that a new Chief Executive is in place, we would expect to see urgent and rapid progress to address this issue and also to finalise the make-up of the Executive Team, where a number of posts have been held on an interim basis for some time.

It is of especial concern that the Health Board has failed to develop an integrated three-year plan in line with the requirements of the Welsh Government's new statutory planning framework. Before this can be delivered there needs to be clarity over the future shape of clinical services across North Wales, something which is yet to be achieved. The importance of making urgent progress in this area cannot be underestimated given that it is a fundamental step in securing a model of services which is clinically and financially sustainable. The Health Board's financial position in particular remains precarious, and a significant deficit is already being forecast for the end of the current financial year. In developing and finalising its plans, the Health Board will need to meet the challenge of ensuring clinical staff are properly consulted and engaged in this process.

Operationally, there are some important areas of business that need to be strengthened as a matter of urgency. The Health Board must ensure that it improves its approach to the management of risk. Work is ongoing in this area but we remain concerned that the corporate risk register does not have a sufficiently clear articulation of the key risks facing the organisation, with the result that Board members may not be fully sighted on the severity or detail of issues of concern.

Whilst the renewed focus on quality and safety arrangements is to be welcomed, there is still much more that needs to be done to strengthen arrangements and improve the timeliness of responses to complaints and serious incidents. It will be particularly important to ensure there is ownership of these issues within the organisation, along with a stronger approach to organisational learning to prevent problems re-occurring.

In conclusion, we acknowledge the hard work that has been done by the Health Board to address the issues we raised last year, in the context of an extended period of change and uncertainty over senior leadership structures. Progress has been made but significant challenges remain, and will need to be addressed with some urgency if the Health Board is to rebuild the confidence in its abilities amongst its staff, key stakeholders and the people it serves. We will continue to monitor the Health Board's actions against the issues identified in this report and undertake a further review of progress in 12 months time.

Huw Vaughan Thomas
Auditor General for Wales

Kate Chamberlain
Chief Executive, Healthcare Inspectorate Wales

Effectiveness of the board and its subcommittees

Recommendations made in June 2013		Summary of progress made by June 2014
R1	The board needs to develop a common understanding of the respective roles of executive and independent board members, and specifically develop cohesive working relationships that are based on trust.	**Action to develop cohesive working relationships between board members is still ongoing and it is too early to judge the effectiveness of these initiatives.** The board developed and approved standards of behaviour and etiquette in September 2013. Since then, board development work has been undertaken with external support. Initial work with Chris Hannah came to an end in late autumn 2013. In early 2014, further board development work was commissioned from two additional agencies. The Good Governance Institute is currently carrying out work to help strengthen existing governance and board assurance arrangements, whilst Wallace Walker has been engaged to work with the board on the development of the necessary behaviours and relationships required for effective board working. Our interviews have indicated that not all board members have been able to attend some of the sessions run by Wallace Walker. It will be important to ensure that there is full attendance at these sessions if they are to achieve the intended benefits. It is also noted that the Executive Team has undertaken specific team development work supported by Aston Organisational Development and Academi Wales. Collectively, this represents an important programme of work to help address the challenges that have existed in relation to the way the board has previously worked. These challenges include identifying where tensions may exist between board members in terms of clarity of roles and views on capability, and seeking to resolve these constructively in order to achieve collective cohesion.

Recommendations made in June 2013		Summary of progress made by June 2014
R2	In the short-term, additional external senior leadership support and capacity must be brought in to provide impetus and fresh perspectives.	**Additional short-term capacity was secured and has provided some impetus and fresh perspectives although the challenge for Betsi Cadwaladr University Health Board (the Health Board) has been to maintain the momentum that was generated by this additional support.** Immediately following the publication of last year's report, the Welsh Government arranged for short-term additional capacity to be provided by the Chief Executive from Abertawe Bro Morgannwg University Health Board (ABM UHB), and the Chairman and Director of Planning from Aneurin Bevan University Health Board. Under the guidance of the ABM UHB Chief Executive, a Governance and Leadership Delivery Team was established to take forward the following workstreams: • Board development • Strategy and planning • Management and leadership • Governance of quality and safety • Communication This short-term support came to end when the new Chairman took up post in October 2013 although the Governance and Leadership Delivery Team continued its work until the early part of 2014. This group was stood down in March 2014 and workstream activity is being dealt with via the Health Board's ongoing organisational development work. We note that a number of important actions from these workstreams remain ongoing and are reflected in operational plans for 2014-15. The Minister appointed the new Chair and he started on 7 October 2013. The new Vice-Chair started on 6 January 2014. The new Executive Director of Nursing and Midwifery started in June 2013 and a permanent full-time Medical Director started on 2 January 2014. In addition, the following officers were recruited on an interim basis: • Assistant Director of Infection Prevention and Control (IPC), later appointed permanently following an open competitive recruitment, from a foundation trust in England; • Chief Operating Officer for 12 months, on secondment from a foundation trust in England; • Interim Director of Quality Assurance, on secondment from an NHS trust in England; • Assistant Director of Corporate Communications, appointed permanently; and • interim turnaround support (on six-month contracts) for scheduled and unscheduled care. The Health Board has indicated that it is in the process of establishing a Programme Management Office to co-ordinate the various initiatives that are underway to support its organisational development. This is positive, however it is clear to us that additional programme management expertise and capacity will be required for this initiative.

Recommendations made in June 2013		Summary of progress made by June 2014
R3	Corporate risks must be better identified and aligned to corporate objectives. There is a need to move to a proactive approach to the management of risk with the mapping and monitoring of key performance indicators relevant to the effective management of risk at both Executive Team and board level.	**Despite increased prominence at the board, there is still a need for improvement in the Health Board's approach to risk management, and we remain concerned that board members are not fully sighted of the totality and severity of the risks faced by the organisation.** The corporate risk register is now received as the first general item on the agenda at board meetings. The board recognises that the format of the register needs further work, and is receiving external advice to help improve its understanding and management of risk. Improvements are needed to ensure that risks are more explicitly linked to the corporate objectives of the Health Board. A key weakness at present is that important risks are not always clearly articulated or added to the risk register in a timely way. This has the consequence that board members may not obtain a full appreciation of the severity and impact of the most significant risks facing the organisation. Whilst the corporate risk register does reference a number of themes from last year's joint review, we are surprised that the challenges associated with wider corporate governance and assurance arrangements are not explicitly identified, given their fundamental importance to the running of the organisation. It was clear from interviews with some staff in the Health Board that there is a perception that it can be difficult to get important issues on to the corporate risk register. The Health Board needs to explore this issue more fully as part of its work with the Good Governance Institute to generate an appropriate 'appetite' for capturing risk, and to ensure that the board is fully sighted of key risks facing the organisation. A Delivery Unit[1] report in December 2013 noted that not all risks appeared on risk registers and used the high reliance on the use of locums as an example. This risk is amalgamated into a wider staffing risk and is not clearly articulated. The Delivery Unit report also found that risk management processes were not integrated with processes associated with patient and staff safety, complaints and clinical negligence, financial and environmental risk; and do not facilitate rapid learning across the organisation. We note that clinical and non-clinical risk matters are now being managed under the Executive Director of Nursing, in line with recommendations by both the Delivery Unit and the Welsh Risk Pool. We further note that the Health Board has begun work to develop a refreshed Risk Management strategy, and associated policy and procedures. However, implementation of these has been delayed pending further advice from the Good Governance Institute.

1 Delivery Unit: Management of Concerns – Learning Lessons Assurance Review. Finalised December 2013.

Recommendations made in June 2013		Summary of progress made by June 2014
R4	Data presented to the board's various subcommittees must equip the board and its independent members with information that enables them to gain the assurances needed regarding patient safety, risk management and service delivery.	See summary of progress against Recommendation 12.
R5	The current breadth of the Director of Governance and Communications role should be critically appraised to ensure that there is sufficient capacity to fulfil the Board Secretary role, and to avoid any inappropriate overlap with executive responsibilities.	**Whilst there have been changes to the breadth of the Director of Governance and Communications role, there remains scope to further rationalise the role to ensure appropriate separation of Board Secretary and Executive Director functions.** Immediately after our work last year the health board transferred the corporate team delivering Putting Thing Right (concerns, complaints and incident reporting) and the core clinical and non-clinical risk management teams from the Director of Governance and Communications to the Executive Director of Nursing and Midwifery. In addition, we have been advised that the Health Board has also agreed to move responsibility for Health and Safety away from the Director of Governance and Communications post. However, it was decided that this would occur as part of the recruitment to substantive posts within a revised executive team structure. At present therefore, the Director of Governance and Communications role remains broad, retaining responsibility for Health and Safety, and communications, alongside the core Board Secretary role. The Health Board therefore needs to revisit, at the earliest opportunity, the scope of the role to ensure that there is suitable separation of Board Secretary and Executive delivery functions.
R6	The Board Secretary, on behalf of the Chair, must produce an Annual Plan of board business that sets out for all board members the matters that will come before them throughout the year. This should enable board members to satisfy themselves that matters are brought to the board at the earliest opportunity to enable members sufficient opportunity to influence matters.	**The board now has a clear Annual Plan of business and arrangements in place to allow members to contribute to agenda setting.** The Director of Governance and Communications produced a revised Annual Plan in the autumn of 2013, and refreshed it in May 2014 with the input of the Chair. The chairs of committees now meet with the Chair and Board Secretary to agree forward agenda items. These arrangements allow the board to have a clearer idea of its forward programme of work.

Recommendations made in June 2013		Summary of progress made by June 2014
R7	Board members should be sent an agenda and a complete set of supporting papers at least seven calendar days before a formal board meeting. Additional papers should only be accepted in exceptional cases, and only if the Chair is satisfied that the board's ability to consider the issues contained within the paper would not be impaired.	**There have been improvements in the timeliness of circulation of board papers.** Board members now receive an agenda and full set of papers seven days before a board or committee meeting. The board approved business standards in September 2013 which were re-issued in June 2014 to help reinforce expectations in relation to submission of papers. The Chair retains the discretion to allow receipt of papers in less than seven days, providing he is satisfied that this does not impair the appropriate consideration of the content of such papers.
R8	Board agendas should be set to allow sufficient time within meetings to properly consider and debate all matters put before the board.	**The organisation of board agendas has been improved in order to allow all matters to be properly considered.** Board and committee agendas now have anticipated times on them, and it is clear that considerable thought goes into ordering and times. Our observations of both board and committees indicate that there is sufficient time within meetings to properly consider and debate all matters put before them. Positively, we noted that all board and committee meetings are now held face to face and videoconferencing has ceased. This is having a positive effect on the quality of the debate and interaction, but does impact on travelling time for board members. Whilst it is encouraging that board meetings permit adequate consideration of all agenda items, meetings can be excessively long and there is an opportunity for the board to use its work with the Good Governance Institute to further explore good practice lessons in this area.
R9	No papers should be included for consideration and decision by the board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the board to take a reasoned decision.	**More work is needed to improve the quality and content of papers submitted to the board.** Board business standards were adopted by the Health Board in September 2013 and include reference to quality requirements for papers. The detailed guidance to underpin these requirements was developed in spring 2014, but remains in draft form pending completion of the work being done with the Good Governance Institute. There is a general need to further improve the quality of papers that are submitted to the board, and in particular to be clear on why the paper is being presented and what action is required of the board. Where papers identify issues of concern, there is a need for more explicit identification of proposed solutions and actions so that the board can focus on decision making and approval.

Recommendations made in June 2013		Summary of progress made by June 2014
R10	As the Health Board moves forward, it must ensure that sufficient time is given to independent members to enable them to thoroughly assimilate the information they need in order to inform their decision making and scrutiny role.	**Independent Members now have more timely access to board papers.** Following the enforcement of the seven-day deadline, independent Members now have time between receipt of papers and board or committee meetings to read and assimilate information to inform their roles. This has been further assisted by providing independent members with secure electronic access to board papers.
R11	Independent Members must be properly supported to meet their responsibilities through the provision of induction and ongoing development.	**Whilst the Health Board has taken action to improve support to Independent Members, this needs to be evaluated at the individual level to ensure that each Independent Member is able to discharge their role effectively.** Support for Independent Members has taken the form of: • an induction programme and pack which has elements of specific induction for board members and generic corporate inductions the same as other health board staff; • an ongoing board development work programme; • appraisal meetings for all independent members with the Chair; and • access to administrative support. Our interviews identified varying views on the effectiveness of some of these arrangements which would indicate the need for an ongoing evaluation of what is needed by independent members in respect of support and their learning and development. Appraisal meetings can be used to help achieve this, as can the monthly meetings that are now held between the Chairman and Independent Members.
R12	An issue underlying many of the findings is the availability and use of information, with there being particular concerns about the information available to independent members. Board members must have access to meaningful performance data to inform their decision making as well as satisfying themselves that staff across the organisation are using this information to monitor and manage their performance on a day-to-day basis.	**Whilst there have been improvements in the information that is presented to the board, there is still a concern that the board is not always provided with the right breadth, depth and balance of information to fully exercise its functions.** There is now a monthly Quality report, which is iteratively improving, and contains sufficient depth of data to scrutinise trends, for example in hospital-acquired infection rates. There are also separate reports on infection prevention and control, concerns and workforce which provide more detailed information. Alongside this, wider performance reporting now relies on a dashboard; the first iteration of the dashboard went to the May 2014 Board. However, this dashboard almost exclusively focuses on the Welsh Government's Tier 1 Targets, which introduces the risk that the board is not fully sighted of performance across all its service areas and functions. Future iterations of the dashboard plan to include a wider range of information on community, primary care and commissioned services.

Management and clinical leadership structures

Recommendations made in June 2013		Summary of progress made by June 2014
R13	The board must take forward its new Clinical Programme Group (CPG) model as a matter of priority. In so doing, it must ensure that performance management is strengthened and that there is clarity in relation to reporting and accountability arrangements.	**Revisions to the organisational structure have been put on hold, pending a new Chief Executive taking up post; however, some action has been taken to strengthen accountability arrangements within the current structure.** The Health Board's basic organisational structure remains the same as it was at the time of last year's report. The board had taken the decision that there should not be any substantive change to the organisational structure until a new Chief Executive was in post. However, the process to replace the Chief Executive has been a protracted one with the result that little substantive progress has been made against this key recommendation. In the interim, there has been a formal consultation exercise with staff and stakeholders on both the merits and difficulties associated with the current CPG-based model. The views collected as part of this consultation exercise confirm many of the concerns identified in last year's report and reinforce the urgent need to revise the organisational structure. The new Chief Executive does have the benefit of being able to immediately draw upon a significant amount of diagnostic material in determining what changes are needed to the organisational structures. The extent of the problems that are still evident in the current structure points towards the need for those changes to be fundamental, although care will need to be taken to ensure any positive aspects of the CPG-based model are not lost given that some services lend themselves to provision at a North Wales level. Some actions have been taken to strengthen accountability arrangements within the existing structure. Seven CPGs now report directly to the interim Chief Operating Officer, with the remaining ones reporting to either the interim Chief Executive or Executive Nurse Director. This rationalisation of Executive accountabilities for CPGs is an improvement on previous arrangements, and has been accompanied by regular performance review meetings. An accountability framework has been developed but has only recently (June 2014) been received and approved by the board. Whilst we understand that the new accountability framework reflects interim arrangements that have been in place since late 2013/early 2014, we were concerned that it has taken 12 months for the framework to be formally approved by the Board. Given the extent of the concerns previously raised about lines of accountability within the CPG model, and their fundamental impact on the operation of the Health Board, we would have expected the Board to have received and approved a tightened framework much sooner. The accountability framework will need to be reviewed once the extent of the changes to the organisational structure is known.

Recommendations made in June 2013		Summary of progress made by June 2014
R14	The board must implement the additional operational turnaround support for CPGs that it agreed was needed in March 2013.	**Additional capacity to support turnaround has been secured and whilst improvements to infection control arrangements are evident, significant challenges remain elsewhere.** Additional senior management capacity has come in the form of: • An interim Chief Operating Officer • An interim Director of Quality Assurance • A senior Infection Control Nurse There have also been two short-term senior interim posts for scheduled and unscheduled care, and work is underway to expand senior medical leadership capacity within the Office of the Medical Director. Collectively, the above has assisted in directing additional senior capacity to areas where it was needed. There is evidence of impact in terms of strengthened infection control arrangements, and improved performance on Tier 1 performance targets associated with stroke and cancer care. The Health Board has also engaged the services of Professor Duerden to review Infection Prevention and Control (IPC) issues, and Deloitte to identify opportunities for efficiency savings. However, significant operational challenges persist in terms of scheduled and unscheduled care, financial sustainability, and short and medium-term planning. More broadly we remain concerned that management capacity within the CPGs remains stretched. The two most challenged (Community, Primary Care and Specialist Medicine, and Surgical and Dental) had interim managers appointed to provide additional capacity. These managers undertook time-limited projects to support improvement in key service areas with variable effectiveness. One interim role ran for the full six months, but the other interim left after three months. No other additional middle or junior management capacity is in place, and we note that there has been a 20 percent reduction in management and administration across the health board since 2009. Given the scale of the challenges faced by the Health Board it needs to ensure it has sufficient capacity at this level to make change actually happen.
R15	The board must ensure that the new model will provide the necessary connectivity between CPGs, the executive and geographical site management.	**Problems with connectivity between CPGs and geographical site management persist whilst the current organisational structure remains in place.** In the absence of any revisions to the organisational structure, connectivity between the CPGs and geographical hospital sites remains a key challenge for the Health Board. The staff we spoke to indicated that they will use their operational working relationships with colleagues to work around the difficulties presented by the current structure. However, this is far from an ideal position and such informality is no substitute for having clearly set out arrangements that define accountabilities and authorities in relation to hospital site specific issues. Hospital site manager posts will remain in place pending any decisions about revisions to the organisational structure. In the interim, these posts provide one mechanism for harnessing action by CPGs in response to site-specific issues. However, there are some ongoing concerns about clarifying the responsibilities and authorities associated with these roles (see progress against Recommendation 17).

Recommendations made in June 2013		Summary of progress made by June 2014
R16	The board must re-affirm line management structures for medical and nursing staff and their interrelationship with professional accountability arrangements.	**Whilst formal line management structures have not changed, the new Medical and Nurse Directors have taken active steps to engage with clinical colleagues and clarify professional accountabilities.** The Health Board has indicated that 'clinical and professional responsibilities have been reinforced via the Medical and Nurse Directors'. We note that upon taking up post in January 2014, the Medical Director wrote to staff to setting out his responsibility for Leading and Developing the Medical and Dental Profession, although we are not aware that anything similar has been set out formally for nursing staff. More generally it is encouraging to note that both the Medical and Nurse Directors have taken active steps to engage with their respective clinical colleagues in order to positively influence behaviours and practices. Affirmations of clinical and professional responsibilities are to be welcomed and they will need to be embedded into clear operational working arrangements, within a revised organisational structure. The accountability framework supports this aim by outlining the leadership role provided by clinical executives and highlights the importance of the new Quality Assurance Executive (QAE) in supporting the delivery of quality and safety across the organisation.
R17	The board must ensure that it provides clarity in relation to the roles and responsibilities of the hospital site managers.	**Whilst there is clarity about the objectives of the hospital site manager roles, these have not been reinforced through agreed job descriptions setting out responsibilities and authorities.** The Health Board has indicated that personal objectives for hospital site managers have been agreed and issued and that job descriptions for these posts have also been prepared and issued to post holders. We note that there have been several iterations of the job descriptions and they will be reviewed further in line with the Health Board's revised structure. These roles were created to strengthen the focus on geographical site management that is missing from the CPG-based structure and it is clear that the role will need to evolve as the Health Board transitions to a new structure. In interviews with a number of different staff, including hospital management teams and CPG staff, we were made aware of ongoing concerns that delivery of the role can at times be challenging due to a lack of formal authority. Under the current arrangements the role has been predicated upon the use of influencing skills. However the responsibilities and authorities associated with the job do need to be clearly defined and communicated; and role holders must have the necessary authority to address problems that may occur within their sphere of responsibility.

Recommendations made in June 2013		Summary of progress made by June 2014
R18	The board must ensure that there is sufficient stability, and collective capacity and capability in its Executive Team. In so doing, it must ensure that the introduction of new executive roles such as the Chief Operating Officer is not just a re-badging of current executive roles.	**Capacity within the Executive Team has been strengthened but there will be an ongoing need to ensure that there is adequate depth of support for the clinical leadership functions given the scale of responsibilities associated with these pivotal roles.** Capacity in the Executive Team has been strengthened through the appointments of an interim Chief Operating Officer, a new Director of Nursing and Midwifery, and a new Medical Director. However, the posts of Chief Executive, Chief Operating Officer, Director of Finance and Director of Therapies and Health Sciences were all held on an interim basis at the time of our follow-up work pending the arrival of a new Chief Executive on 16 June 2014, and a new Director of Finance in August 2014. The Health Board has yet to fill the vacant role for Executive Director of Therapies and Health Sciences. The new Chief Executive has confirmed his intention to retain the Chief Operating Officer post within the organisational structure. Whilst there has been an element of stability and business continuity as a result of the interim posts being held for some time, there is inevitably a sense that these are 'holding arrangements'. The consequence is that meaningful progress on the more challenging changes associated with service redesign, financial sustainability and organisational structure will only be made when these posts are filled substantively. Importantly, the appointments of a new Director of Nursing and Midwifery Services and a new Medical Director have brought stability and capacity to key clinical leadership roles within the Executive Team. These staff took up post in June 2013 and January 2014 respectively. However, the scope of responsibilities for these two posts is extremely wide given both the size of the Health Board and the fact that they hold the executive and leadership responsibility for tackling some of the Health Board's most pressing challenges in areas such as quality and safety and clinical engagement. There is work underway to increase medical leadership capacity through the appointment of a number of assistant and associate medical directors as part of the Office of the Medical Director, and we understand that the Health Board has recently appointed to the post of deputy Medical Director on an interim basis. Since our original review the Executive Nurse Director has received additional support from the Interim Director of Quality Assurance and the Assistant Director of Infection Prevention and Control. It is important that the board obtains assurance that the clinical leaders in the Executive Team have sufficient capacity and support to drive the improvements that are needed with the appropriate pace.

Quality and safety arrangements

Recommendations made in June 2013	Summary of progress made by June 2014
R19 The board must commission an urgent review of its arrangements for the monitoring and reporting of quality and safety issues to ensure that they are robust. This should include a detailed review of the way in which the Quality and Safety Committee works and its interface with the Quality and Safety Lead Officers Group and arrangements in place at CPG level.	**The Health Board has conducted an urgent review of its arrangements for the monitoring and reporting of quality and safety issues. Revised arrangements have been put in place, leading to an increased focus on quality and safety. More work is required to ensure that there is effective and timely ward to board reporting on issues of quality and safety.** Having previously been shared across three clinical executive posts, lead executive responsibility for quality and safety transferred to the Executive Nurse Director in August 2013. Following an internal review of existing arrangements, additional posts were created to strengthen quality assurance and infection control. Further intervention support was commissioned to help strengthen serious incident reporting and the management of concerns and complaints. Interim quality and safety objectives have been considered by the Board but have not yet been agreed. Work has commenced to develop a Quality and Safety Strategy and quality and safety risks have started to be openly reflected in the corporate risk register. The board commissioned Professor Duerden to review the governance of IPC in the summer of 2013. Since then, there has been a greater focus on IPC at hospital site level and much better reporting of information on healthcare acquired infections to the Board. Performance in this area has improved, albeit the Health Board still compares poorly to other health boards in Wales. Although a structure for IPC has been agreed, progress in recruiting to this structure has been limited to the recruitment of the Assistant Director of IPC. Despite significant effort, there have been difficulties in appointing a lead infection control clinician. However, in order to fill this gap, the Health Board has recently secured three sessions a week from an external clinician who is a recognised expert in this area. This is a positive development and we note that the Health Board is taking advice from Public Health Wales on how best to successfully recruit to the post on a permanent basis. The Board will need to continue to evaluate whether the current arrangement in place is providing the capacity to lead the required changes in this area and at a sufficient pace. More generally the Quality and Safety Committee terms of reference and forward work plan were refreshed in early 2014. Observations indicate that scrutiny of CPGs at the Quality and Safety Committee has improved, although it has been beyond the scope of this follow-up review to review the effectiveness of quality and safety groups at CPG level. The Quality and Safety Lead Officer Group has been replaced by a QAE but this arrangement is still relatively new and requires further development, given that: • the terms of reference for the QAE has not yet been finalised; and • timings of QAE meetings do not align with those of Quality and Safety Committee, and updates/assurances from QAE to the committee are still largely verbal. Whilst there are examples of significant quality and safety issues being recorded on the risk register, it is important that this happens consistently and in a timely way.

Recommendations made in June 2013		Summary of progress made by June 2014
R20	The board must put in place robust arrangements for the reporting, escalation and investigation of concerns.	**The Health Board has made a number of changes aimed at strengthening the arrangements for reporting, escalating and investigating concerns. The number of unresolved concerns, complaints and Serious Untoward Incidents (SUIs) has fallen, but continues to be substantial.** Responsibility for complaints, concerns and serious incidents was transferred to the Executive Nurse Director during summer 2013. The scale of the backlog of complaints and serious incidents was of concern and led the Executive Nurse Director to request further review by the Delivery Unit and Welsh Risk Pool. This work identified a number of fundamental issues, including: • a failure on the part of the Health Board to appreciate the implications of Putting Things Right in terms of the changes it introduced; • no organisational learning strategy/process in place; • a lack of quality assurance of the data which requires impartial/clinical input; • unclear process for the management and ownership of incidents that have occurred between two or more CPGs; • lack of timely implementation and completion of investigations; • lack of timely identification of lessons learned and actions taken following SUIs (including never events); and • an incomplete population of the fields in the local risk management system ie, lessons learnt and actions taken to manage future risk. As a result of these findings, the Executive Nurse Director changed the focus of the Interim Director of Quality Assurance role, placing more emphasis on the Putting Things Right agenda. Weekly meetings were instigated, to hold CPGs to account, and to provide support and coaching. Internal resources were re-prioritised as a means of clearing the backlog of SUIs and complaints. The Executive Nurse Director provides monthly progress reports to the Quality and Safety Committee on progress in resolving the backlog. The backlog of unclosed serious incidents within the Health Board has reduced but remains substantial. A critical internal audit report, issued in draft in January 2014, on SUIs was only finalised in June 2014 due to delays in the provision of agreed management response. This has therefore not yet been received by the Quality and Safety or Audit Committees. Given the seriousness of the concerns and the overall rating of 'no assurance', the delay in finalising this report is not acceptable. To date, we have observed the board receiving information on complaints and SUIs in the context of performance reporting and there have been limited examples of this information being used to support learning.

Financial management and sustainability

Recommendations made in June 2013		Summary of progress made by June 2014
R21	The board should reconsider the issues and recommendations set out in the separate reviews of Chris Hurst and Allegra.	**Little progress has been made in addressing the financial management challenges and implementing the recommendations contained in the separate reviews of Chris Hurst and Allegra.** As a consequence of concerns over the Health Board's financial sustainability, two separate external reviews were commissioned during 2012. Both reviews highlighted that the Health Board's financial challenges were being significantly exacerbated by insufficient savings plans being identified at the start of the year and the subsequent under-delivery against savings targets. The reviews also highlighted the challenges associated with the fitness of purpose of the Health Board's organisational structure, and the need to develop more robust approaches to accountability and line management of senior staff. The Health Board has been unable to demonstrate that it has made progress in addressing the challenges and implementing the recommendations contained in the separate reviews. Whilst the Health Board updated the Welsh Government on 4 December 2013 of progress against the seven themes identified by the Allegra review, the extent to which progress had been achieved against each of the recommendations was not clear. During autumn 2013, the Health Board appointed Deloitte to undertake a further external review to assist its planning and to identify additional potential savings opportunities. The review identified that efficiency gains were capable of delivering substantial savings, when benchmarking against best quartile in the UK, and that improving patient pathways will deliver both quality and efficiency gains. The themes identified are currently being assessed by the Health Board to fully understand what improvements can realistically be achieved. Whilst the Board has not received specific updates on progress towards dealing with the issues and recommendations identified in Chris Hurst and Allegra reviews, work undertaken by Deloitte has taken account of these issues.

Recommendations made in June 2013		Summary of progress made by June 2014
R22	The board must take action to fully integrate and deliver service, workforce and financial plans.	**The Health Board is yet to fully develop and deliver integrated service, workforce and financial plans, and further work is urgently required to strengthen the links between budget setting and operational and workforce planning.** The new NHS Finance (Wales) Act 2014 places a statutory duty on health boards to compile a rolling three-year integrated medium-term plan, starting from 2014-15. This new duty is an essential foundation to the delivery of sustainable quality health services in Wales. The Health Board breached this duty as it was not able to submit a final three-year integrated plan to the Welsh Government for approval in March 2014. The Welsh Government had indicated that significant further development of the plan was necessary in order to meet its expectations. Welsh Government and the Minister for Health and Social Care wrote to the Acting Chief Executive and Chair respectively to outline performance management arrangements pending the development of a three year plan. The Health Board developed a one-year operational plan for 2014-15 that was presented to the board on 6 May 2014. Board members raised a number of concerns on the content of the one-year plan, in particular its deliverability, the failure to identify disinvestment opportunities, and poor linkages between the Annual Budget Strategy and the release of savings for investment in community services. The plan also fails to address the recommendation to develop integrated service, workforce and financial plans. It is of concern that the development of the annual budget and operational plan was not a fully integrated process, with the 2014-15 budgets being set before the one-year operation plan for 2014-15 was developed.

Recommendations made in June 2013		Summary of progress made by June 2014
R23	The board must prepare and approve sustainable service and financial plans before the start of the 2014-15 financial year that clearly demonstrate how financial pressures will be managed and addressed.	**The Health Board failed to prepare sustainable service and financial plans before the start of the 2014-15 financial year and it is yet to fully demonstrate how financial pressures will be managed and addressed.** The Health Board's underlying financial position remains precarious. It only achieved its 2013-14 revenue resource limit of £1.197 billion as a result of additional financial support from the Welsh Government. This included the allocation of repayable brokerage of £2.25 million after the year-end. The magnitude of the financial challenge faced by the Health Board is set out in its Annual Budget Strategy for 2014-15. The strategy identified a savings requirement of over £75 million for 2014-15, including the repayment of the £2.25 million brokered from the Welsh Government in 2013-14. The Health Board's Standing Financial Instruction (SFI's) requires budget holders to 'sign up to their allocated budgets at the commencement of the financial year'. This is intended to promote the full engagement of budget holders with their financial allocations and financial management responsibilities. However, we reported last year that several CPG budget-holders had only agreed to their 2013-14 budgets with various caveats. This practice only undermines the effective operation of the Health Board's budget allocation, financial monitoring and internal accountability processes. It is therefore pleasing to note that the budget setting process for 2014-15 has been more inclusive, with CPGs commenting on a more transparent and engaging approach than in previous years. The Health Board's view is that positive engagement by budget holders can be encouraged and achieved through sign up to a wider performance management framework, as set out in the Accountability Framework (recommendation 13 commentary). Budget holders will be held to account through the Health Board's Performance Development Review system. However, the Health Board has not yet reviewed the extant SFI requirement to 'sign up to budgets' and needs urgently to confirm that its revised approach is consistent with its own rules and regulations. As at 31 May 2014, only £21.4 million of cash-releasing savings schemes had been identified across CPGs and corporate departments. This is significantly less than the total saving requirement of over £75 million for the financial year. The Health Board also reported an overspend position of £10.2 million for the first two months of the financial year (compared with a £5.1 million overspend at the same stage in the previous year). This includes slippage of £0.5 million in the delivery of identified cash-releasing savings to date (against planned savings of £1.964 million). As a consequence, the Health Board is currently forecasting a £35.0 million deficit for 2014-15. Looking ahead, the Health Board continues to face unprecedented challenges in order to deliver a balanced budget in the future. Its Annual Budget Strategy for 2014-15 sets out a projected increasing financial challenge from 2014-15, growing to £186 million over a three-year period to 2016-17 (equating to over 13.8 per cent of annual operation budget). The Health Board's medium-term financial outlook remains very challenging and highlights the need to urgently progress plans that identify financially and clinically sustainable service models.

Strategic vision and service reconfiguration

Recommendations made in June 2013		Summary of progress made by June 2014
R24	The board must progress its strategic plans for acute clinical services as a matter of urgency.	**There is still no clarity on the preferred shape of acute clinical services in North Wales.** Last year's report highlighted the urgent need for the Health Board to progress its strategic plans for acute clinical services, as part of a wider vision of the overall shape of health services in North Wales. Proposals were due to be taken to the board in the autumn of 2013 for implementation in 2014. Although this did not happen, we note that the Governance and Leadership Delivery Team had agreed a revised scope and timetable which was considered at the board meeting in September 2013. A number of workshops have been run in the latter part of 2013 and the first half of 2014. Options are now due to be presented to the board in July 2014. The inability to make more substantial progress on the plans for acute clinical services is a significant concern given the challenges that exist in relation to the clinical and financial sustainability of services in North Wales. It is inevitable that difficult decisions will need to be made on where certain services will be provided and the Health Board must avoid further delay in making these decisions. Proposals need to be put forward which are both clinically and financially viable, and effective clinical engagement will be needed to build consensus and support for these proposals across the organisation. The First Minister's decision to site the neonatal intensive care facility in Glan Clwyd provides the Health Board with a fixed point to plan around. During the course of our follow-up review, HIW was contacted by a group of Health Board staff who were concerned about the Health Board's reconfiguration plans. HIW will be engaging with the Health Board on the nature of the disclosure, allowing it an opportunity to respond to the issues raised. However, the fact that this was raised with HIW indicates further work may be necessary within the Health Board in relation to clinical engagement. Last year, we identified the need for the Health Board to develop a stronger relationship with the Wales Deanery. We are pleased to note that the working relationship has strengthened since the appointment of the new Medical Director; however, concerns about the viability of medical rotas and the quality of training to support junior doctors at Glan Clwyd have persisted and have led to the Deanery moving training posts in Obstetrics and Gynaecology and Surgery to Wrexham Maelor and Bangor. The absence of clarity on the overall shape of services across North Wales has also been a significant factor in the Health Board's inability to submit an integrated medium-term plan to the Welsh Government for approval. Capacity constraints in relation to planning throughout the organisation have also been put forward as one of the main reasons why a medium-term plan could not be produced. Given that planning is such an integral part of the Health Board's business, this is something that needs to be given urgent attention by the Executive Team and the board. This must consider extent to which there are deficits in skill sets and capabilities in relation to strategic and operational planning throughout the organisational structure, and how these can be rectified.