National Assembly for Wales
Public Accounts Committee

Governance Arrangements at Betsi Cadwaladr University Health Board

December 2013

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Public Accounts Committee
The Public Accounts Committee was established on 22 June 2011.

Powers
The Committee's powers are set out in the National Assembly for Wales' Standing Orders, with its specific functions of the Committee are set out in Standing Order 18 (available at **www.assemblywales.org)**. In particular, the Committee may consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

The Committee also has specific statutory powers under the Government of Wales Act 2006 relating to the appointment of the Auditor General, his or her budget and the auditors of that office.

Current Committee membership

Darren Millar (Chair)
Welsh Conservatives
Clwyd West

Mohammad Asghar (Oscar)
Welsh Conservatives
South Wales East

Jocelyn Davies
Plaid Cymru
South Wales East

Mike Hedges
Welsh Labour
Swansea East

Sandy Mewies
Welsh Labour
Delyn

Julie Morgan
Welsh Labour
Cardiff North

Jenny Rathbone
Welsh Labour
Cardiff Central

Aled Roberts
Welsh Liberal Democrats
North Wales

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Foreword

On 27 June 2013 the Healthcare Inspectorate Wales and the Wales Audit Office published a joint report, which expressed grave concerns about governance arrangements at Betsi Cadwaladr University Health Board. The findings of this report were made only more troubling by the fact that they come at a time when the entire health sector in Wales is undergoing seismic changes in both its funding and structure.

We are very grateful to both the Healthcare Inspectorate Wales and the Wales Audit Office for bringing the matters set out in the report to the forefront of public attention.

The report's conclusion, that an apparent breakdown in working relationships between some of the Health Board's senior leaders had compromised its governance arrangements making it more difficult to properly identify issues concerning the quality and safety of patient care, was particularly disturbing.

We considered it appropriate to conduct an investigation into the issues raised by the joint report, to assist both the Welsh Government and the Health Board in addressing issues around the governance of the Health Board. In particular, it is vital that the Health Board's new leaders, when in place, take action to address the apparent communication gap between frontline staff on hospital wards and the Board.

Glossary

An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office (June 2013) - referred to as the 'Joint Report' for the purposes of this report.

Personnel referred to in the Report

Betsi Cadwaladr University Health Board

Chief Executive – Mary Burrows
Out-going Chief Executive – Mary Burrows (from 23 May 2013)
Acting Chief Executive – Geoff Lang
Former Chair of the Board – Professor Merfyn Jones
Former Vice-Chair of the Board/ Chair of the Quality and Safety Committee – Dr Lyndon Miles
Acting Medical Director – Dr Martin Duerden
Secretary to the Board/Director of Governance and Communications – Grace Lewis-Parry
Chair of the Finance and Performance Committee – Keith McDonogh

Welsh Government

Director General for Health & Social Services/Chief Executive, NHS Wales – David Sissling - referred as 'Director General' for the purposes of this report.
Chief Medical Officer – Dr Ruth Hussey

Healthcare Inspectorate Wales

Chief Executive – Dr Kate Chamberlain

The Committee's Recommendations

The Committee's recommendations to the Welsh Government are listed below, in the order that they appear in this Report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions:

Recommendation 1. We recommend that to ensure senior leaders are held to account, the Welsh Government reviews and where necessary strengthens the performance management and appraisal process arrangements for Chief Executives and Chairs of NHS organisations to ensure that they are appropriately robust, clearly understood and implemented. (Page 17)

Recommendation 2. We recommend the Welsh Government undertakes an urgent review of the training available to board members across all Welsh NHS bodies. The outcome of this review should inform the development and delivery of a national training programme for board members, participation in which should be a condition of board membership. The programme should develop core competencies, clarify requirements and include training specifically developed for newly appointed board members to attend as part of their induction into board membership. (Page 24)

Recommendation 3. We recommend that directive guidance should be issued to all boards on the importance of both individual and collective board development and any such guidance should be reviewed regularly to ensure it is fit for purpose. (Page 24)

Recommendation 4. We recommend that the time commitment required for Independent Members be reviewed to ensure that it is adequate to allow them to fully discharge the functions expected of them. (Page 24)

Recommendation 5. We recommend that the Welsh Government takes action to enable a more robust and consistent system of appraisal for Independent Members of Welsh Health Boards, including the identification of personal training and development needs, and that a peer mentoring scheme for independent members be developed. (Page 24)

Recommendation 6. We recommend the Welsh Government ensures that the importance of the separation and accountability of the Board Secretary role is clearly understood by all NHS organisations. (Page 27)

Recommendation 7. We recommend that Welsh Government consider providing statutory protection for the role of Board Secretary. (Page 27)

Recommendation 8. We recommend that the Welsh Government ensures that all Health Boards review their meeting procedures, to ensure that Board members are presented with all papers in a timely manner and that non-restricted papers are published in the public domain in the same timescales. (Page 29)

Recommendation 9. Having considered the evidence, the Committee welcomes the action being taken by the North Wales Community Health Council to monitor compliance with infection control procedures in hospitals across North Wales. We recommend that the Welsh Government reviews its processes for validating quality and safety, and other critical data from NHS organisations. It is vital that such data is reported accurately if meaningful action is to be taken. (Page 36)

Recommendation 10. We recommend that the Welsh Government finalise, introduce and implement a common set of key performance indicators of quality and safety for use by Health Boards. This would assist in improving performance and identifying risks so that swift action can be taken to address them. (Page 39)

Recommendation 11. We recommend that the Health Board makes the results of its investigations into the high RAMI scores across hospitals in North Wales publically available, together with information on the actions that are being taken to address any patient care issues that are identified. (Page 40)

Recommendation 12. We recommend that the Welsh Government makes information on RAMI scores across all hospital sites in Wales more accessible to the general public, ideally by placing all the data on a single web page, with clear explanations of what the data means. (Page 40)

Recommendation 13. The failure to adhere to accepted budget processes is an issue of particular concern. We do not believe that budgets should be signed off with caveats and recommend that assurances should be provided to us that this practice has now been discontinued within the Health Board. (Page 42)

Recommendation 14. We also recommend that the Welsh Government seeks information from directors of finance at all health boards to ensure that the failures evident within the budget planning processes at the Betsi Cadwaladr University Health Board are not being replicated elsewhere. (Page 42)

Recommendation 15. We recommend that the Welsh Government emphasises to health boards that they should wherever possible avoid utilising unsustainable solutions to financial pressures, such as cancelling or postponing operations, which simply defers costs to the next accounting period. (Page 46)

Recommendation 16. We recommend that the Welsh Government ensures that all health boards minimise the inconvenience and distress caused to patients and their families by requiring that Boards communicate with patients as soon as possible following a decision to cancel or postpone elective operations. (Page 46)

Recommendation 17. We recommend that the Welsh Government takes greater care when commissioning taxpayer funded external advice and that, without exception, the output of such advice is received, reviewed and retained by appropriate Welsh Government departments. (Page 49)

Recommendation 18. In relation to the sharing of the findings of external reviews the Committee believes that it is vitally important, that safeguards are in place to ensure that such findings are widely utilised to learn lessons and improve processes within health boards. We recommend that Welsh Government takes this forward. (Page 50)

Recommendation 19. The Committee believes it is vital that senior leaders set a clear vision for their organisations to respond to the three challenges of developing service, workforce and financial plans. Given the issues around governance arrangements at Betsi Cadwaladr University Health Board, it is imperative that the new senior management of the Board renew and reunite the Executive and non-

Executive leadership team, and close the gap between the Board and Wards. (Page 52)

Recommendation 20. We recommend that Welsh Government work with the Wales Audit Office and Healthcare Inspectorate Wales to develop a clearer set of scales of escalation. This should include a detailed criteria upon which intervention is triggered, the rationale for the type of intervention, and clarity on who should be notified when intervention commences and ceases. We believe that this information should be made accessible to the public. (Page 56)

Recommendation 21. We recommend that the Welsh Government gives urgent consideration to the creation of a pool of additional short term leadership capacity, for NHS Wales, that can be drawn upon at short notice and does not impact on other NHS Wales Health organisations. (Page 57)

Introduction

Background

1. The Public Accounts Committee is a cross party committee of the National Assembly for Wales, comprising of eight Members from all four political parties represented at the Assembly. The Public Accounts Committee is not part of the Welsh Government. The role of the Public Accounts Committee is to ensure that proper and thorough scrutiny is given to the Welsh Government's expenditure.

2. In particular, we can consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

An overview of Governance Arrangements – Betsi Cadwaladr University Health Board

3. On the 27 June 2013, the Healthcare Inspectorate Wales (HIW) and the Wales Audit Office (WAO) published a joint report 'An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board'. The joint report found that:

- the Health Board's governance arrangements and procedures did not adequately address the gap between the ward and the Board;
- routine governance arrangements within the Health Board had not paid sufficient attention to infection control;
- the effectiveness of the Board had been significantly compromised by a breakdown in working relationships between some senior leaders in the organisation; and
- the Board collectively lacked the capacity and capability to provide appropriate levels of scrutiny in relation to service delivery.

4. The joint report also expressed wider concerns about the stability and capacity of the Executive team as a result of staff turnover and sickness absence.[1]

[1] HIW/WAO Joint Report (June 2013), paragraph 19

5. Furthermore, the joint report highlighted problems with the Health Board's organisational structure, based around Clinical Programme Groups (CPGs). CPGs had been created to support the aim of being a clinically-led organisation; however the joint report's findings indicated that problems had been evident for some time as a result of the imbalance between the size of different CPGs and the shortcomings in connectivity between CPGs, geographical hospital sites and the Executive team.[2]

6. Finally, the joint report noted that action had been taken to address these concerns through revisions to the CPG and Executive structures, and through the appointment of Hospital Site Managers at each of the Health Board's main acute hospital sites.[3] It concluded that, while the Health Board had initiated actions to address some of the concerns outlined in the report, fundamental challenges still remained.[4]

7. The Committee notes the resignation of the Chair and Vice-Chair of the Board following publication of the joint report.

8. Given the seriousness of the joint report's findings, we considered it appropriate to conduct a short inquiry into issues raised by the report. During our inquiry we took evidence from a number of witnesses who are listed in this report.

9. Our consideration of this evidence is detailed in the following report which also sets out a number of conclusions and recommendations. We are grateful to all of our witnesses for providing evidence to us, and look forward to the Welsh Government's response to the recommendations set out in this report.

[2] HIW/WAO Joint Report (June 2013), paragraph 16
[3] HIW/WAO Joint Report (June 2013), paragraph 17
[4] HIW/WAO Joint Report (June 2013), paragraph 13

1. The Effectiveness of the Board and its sub-committees

Background

10. The joint report detailed a range of concerns regarding the effectiveness of the Board and its sub-committees. These include:

- A breakdown in working relationships between senior leaders in the Health Board;
- Lack of cohesion and consensus amongst Executive Members of the Board;
- Concerns over the way information is presented to the Board.
- A need for a greater mutual appreciation of the respective roles of executive and independent board members;
- A need for better planning of the agenda for Board meetings.[5]

The historical context of the Board

11. On the effectiveness of the Board and its sub committees, some witnesses emphasised the importance of considering the Board in a historical context, particularly the creation in 2009 of one health board from eight predecessor bodies.

12. The Acting Chief Executive informed us that:

> "…the size and scale of the board, in terms of bringing together eight organisations into one, and then creating a new structure with an agenda that was clearly designed to set about achieving service change, bringing together services across the whole of North Wales to serve its population, and, within, that challenging some quite fundamental historic patterns of loyalties, associations and service delivery. That is a huge challenge for the Board. So, contextually, it is a difficult environment."[6]

[5] HIW/WAO Joint Report (June 2013), paragraph 26
[6] RoP, Public Accounts Committee, 9 July 2013, paragraph 8

13. These challenges were further detailed in evidence from the former Chair of the Board who explained that:

> "…many of the problems were structural in terms of the internal organisation of the whole health board. The problem in creating one organisation out of eight—one should not underestimate the scale of the challenge in doing that, particularly over a very wide geographical area, with a population of almost 700,000 people, and three major hospitals, all with their own cultures and ways of doing things."[7]

14. The Committee notes the challenges associated with merging a number of predecessor bodies into a single new organisation in 2009, but we do not consider that this diminishes from the seriousness of the joint report's findings. We acknowledge that many public sector organisations undergo restructuring and meet the subsequent challenges arising from this. We do not feel that restructuring should lead to poor governance arrangements and through good planning and management restructuring issues should have been anticipated, avoided or addressed.

15. Furthermore, we note that there are other Health Boards within the UK of similar size or larger than Betsi Cadawaladr University Health Board (BCUHB), both geographically and demographically. For example, the 2012-13 revenue budget of the Greater Glasgow and Clyde NHS Board was £2.26 billion, compared with £1.26 billion for BCUHB. As such we do not believe that size should be viewed as a contributory factor to the problems at the Health Board.

16. In the course of our inquiry, we considered whether changing the name of the Health Board could assist it in creating a 'North Wales wide' identity. Although there may be merit in this suggestion, our overwhelming concern is that the Health Board takes action to address the range of concerns identified in both the joint report and our own investigation.

17. The Committee believes it will take significantly more than a name change for the Health Board to recover its damaged reputation.

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[7] RoP, Public Accounts Committee, 18 July 2013, paragraph 38

Senior Leadership

18. The Committee were concerned that the joint report found a breakdown in working relationships between senior leaders in the Health Board.[8] The joint report states that:

> "The current working relationship between the Chair of the Health Board and its Chief Executive present real challenges for the Board. A positive and effective working relationship between the two most senior leaders in the organisation is a vital part of the organisation's governance arrangements and sets the tone of the Board. When the relationship breaks down, as it has in the Health Board, the leadership of the organisation is fundamentally compromised, and the Board finds itself in an extremely difficult position."[9]

19. In reference to the reasons for this breakdown in relationships the former Chair of the Board informed us that:

> "There was absolutely no personality clash between any of the people on the executive or the board; I think there were clear differences of opinion as to policy."[10]

20. Evidence from the outgoing Chief Executive supports that a breakdown in relationships was not a matter of personality clashes. She explained that:

> "I respect Professor Jones [the former Chair] 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."[11]

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[8] HIW/WAO Joint Report (June 2013), paragraph 26 (a)
[9] HIW/WAO Joint Report (June 2013), paragraph 26 (a)
[10] RoP, Public Accounts Committee, 18 July 2013, paragraph 12
[11] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013

21. It is clear to us, from the evidence, that there was a breakdown in working relationships and we believe that this should have been prevented through better management, professionalism and leadership at Board level.

22. This view is consolidated in further evidence provided to the Committee by the outgoing Chief Executive in which she stated regret that she did not 'whistle blow' on the direction of the Board.

23. In written evidence the outgoing Chief Executive stated:

> "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."[12]

24. Furthermore, she informed us that:

> "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."[13]

25. The Committee notes the passive context within which the outgoing Chief Executive has presented her evidence. Given that she apparently had increasing concerns from autumn 2011, we believe that she should have accurately conveyed this to the Welsh Government, or influenced the direction of the Board, as this is clearly the role of a Chief Executive and Accountable Officer. We believe it is

[12] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[13] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013

unacceptable for a Chief Executive to have concerns and not take appropriate action in her capacity as an Accountable Officer. The Committee notes that the Director General had similar concerns in informing us that:

> "…the Chief Executive clearly cannot act in a passive observational capacity. He or she must act on any concerns and must take action as the Principal Executive Officer or as the point of primary executive advice to the Board. In certain circumstances, a Chief Executive might properly raise matters of concern with me. My initial response would be to ask the Chief Executive to clarify the responsive actions they were intending to take and enquire if the matters in question had been formally raised with their Board."[14]

26. Whilst the Committee fully endorses the Director General's statement on this matter, we are also of the opinion that the Welsh Government's oversight of NHS bodies should have enabled earlier identification of problems at the Health Board.

27. Given the issues identified around poor leadership and performance at a senior level, this raises concerns about the quality and rigour of performance management and appraisal processes at the Health Board, and the oversight of the Health Board by the Welsh Government. We question why the problems of leadership of the Board were not identified and addressed sooner and are keen to ensure that these problems do not manifest at other NHS organisations.

28. It is clear to the Committee that there were failings in the holding to account of senior leaders at the Health Board. Specifically the performance management and appraisal process did not identify performance issues and were proven ineffective. In terms of the future, the Committee seeks assurances that such processes are consistent across NHS organisations to prevent similar problems occurring again, either at BCUHB or elsewhere.

We recommend that to ensure senior leaders are held to account, the Welsh Government reviews and where necessary strengthens the performance management and appraisal process arrangements for Chief Executives and Chairs of NHS

[14] Letter from Director General, 15 October 2013

organisations to ensure that they are appropriately robust, clearly understood and implemented.

29. On a different matter relating to senior leadership the Committee notes the various changes to the Accountable Officer during the period January 2012 to the present day. We believe these changes are relevant given that this was during the period when the WAO and HIW were undertaking their review at the Health Board.

30. We note that between 27 January 2012 and 14 May 2012, the outgoing Chief Executive was not the Accountable Officer.[15] We also note that the outgoing Chief Executive was absent on sick leave between 8 March 2013 and 4 April 2013[16], and although an Acting Chief Executive was appointed, the Accountable Officer designation remained with the outgoing Chief Executive.[17] We are also aware that it was during this period, on the 22 March 2013, that the *C Diffile* outbreak emerged.

31. The Committee acknowledges that the outgoing Chief Executive returned to work on the 4 April 2013 until 29 April 2013 and resumed her role as Chief Executive. It was during this period that she was made aware of the *C Difficile* outbreak and this was reported to the Board at its meeting on 20 April 2013.

32. We note that there was a further period of time, 29 April 2013 to 13 May 2013, when the outgoing Chief Executive was absent and once again although an Acting Chief Executive was appointed, the Accountable Officer designation remained with the outgoing Chief Executive.[18]

33. Following the outgoing Chief Executive's departure on sick leave on 23 May 2013 and her subsequent intention to stand down, an Acting Chief Executive was appointed and designated as Accountable Officer.

34. In terms of the future, the Committee questioned the Acting Chief Executive on the steps being taken to create more stability and collegiate working amongst Board members.[19] We were informed that:

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[15] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[16] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[17] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[18] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[19] RoP, Public Accounts Committee, 9 July 2013, paragraph 52

> "In terms of the current executive group, we are quite clear about our role and that our role is a collective one. There have been difficulties in the past 12 to 18 months and my perspective on that is that it is very much as a result of the pressure that the board has been under and the pressure to deliver on a range of fronts."[20]

35. Since the joint report's publication and during the course of our inquiry, both the Chair and Chief Executive have indicated their intention to step down.[21] The former Vice-Chair [who was also Chair of the Quality and Safety Committee] has also subsequently stepped down.[22]

36. We note however, that the Chair of the Finance and Performance Committee remains in place in spite of the issues identified in the joint report.

37. We have considered carefully the evidence presented to this Committee on the reasons for the outgoing Chief Executives decision to depart. In her written evidence to this Committee, the outgoing Chief Executive stated that she first indicated her intention to leave the Health Board on 8 March 2013, but that this intention was not linked to the joint report.[23]

38. Subsequently, the then Chair of the Board, stated that the Chief Executive's intention to leave the Health Board first emerged on the 6 March 2013 and was reaffirmed on the 8 March 2013.[24] However, the then Chair of the Board added that her "wish to explore leaving her post became stronger on 23 May 2013."[25]

39. 23 May 2013 is the date on which HIW and the WAO jointly wrote to the Chief Executive, setting out their emerging findings from their review fieldwork.[26]

40. Of further concern to the Committee is the significant delay in reaching a financial settlement between the outgoing Chief Executive and the Health Board. We believe that this delay of over six months

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[20] RoP, Public Accounts Committee, 9 July 2013, paragraph 54
[21] http://www.bbc.co.uk/news/uk-wales-23073768, [accessed 27 June 2013]
[22] http://www.bbc.co.uk/news/uk-wales-23153307, [accessed 2 July 2013]
[23] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[24] Written Evidence, former Chair - BCUHB, 04 October 2013
[25] Written Evidence, former Chair - BCUHB, 04 October 2013
[26] Letter, HIW/WAO to Chief Executive – BCUHB, 23 May 2013

has significantly impeded the Health Board's ability to progress forward, as it has been unable to commence the recruitment of a new Chief Executive. It is imperative that this process is concluded as soon as possible.

41. However, we are pleased to note that on 6 September 2013, the Minister for Health and Social Services announced the appointment of Dr Peter Higson as Chair of BCUHB. We note that Dr Higson commenced his role on 7 October 2013.

42. Clearly, going forward, we believe it will be vital for the new Chair and Chief Executive, once appointed, to build an effective working relationship, learning from the historic issues that have arisen within the Health Board. The Committee believes that it is vital that a new leadership team is in place, as soon as reasonably practicable, to deliver the culture change that is required.

Working relationships among Members of the Health Board

43. The joint report highlights a lack of cohesion and consensus amongst the Executive Directors of the Health Board stating that:

> "The information presented to us clearly demonstrated that the Executive Directors of the Health Board did not work cohesively as a team, with roles compartmentalised. In particular, Independent Members (IMs) expressed concerns to the joint report's authors about a lack of consensus amongst Executive Officers on important issues that are brought to the Board."[27]

44. The joint report also stated that frustration was evident on the part of both Independent Members and Executive Officers in relation to the way the Board operated. The joint report noted that some Independent Members indicated that they felt they were being 'managed', not being given information about the whole picture, and that the Board was seen by some of the Executive as a forum to just 'rubber stamp' decisions.[28]

45. As a result of these concerns the joint report found that:

> "The additional challenge and request for information that this provokes from IMs was causing frustration to some Executive

[27] HIW/WAO Joint Report (June 2013), paragraph 20
[28] HIW/WAO Joint Report (June 2013), paragraph 26 (d)

> Officers who, conversely, felt that IMs were asking for too much information and that this was slowing down decision-making and preventing the agile management of the organisation."[29]

46. The acting Chief Executive acknowledged that although there were some positive relationships between Executive and Independent members of the Board, stating:

> "There is positive working at a committee level within the board. When you get to the overall board level, there are tensions, and, from my perspective, those tensions are more born of frustration regarding the delivery of the board and having clear plans as to how we address our financial problems, service challenges and governance issues that the whole board is signed up to and aligned with."[30]

47. However, he did not consider there to be a simplistic division between Independent Members and Executive Officers. Similarly, the former Chair did not consider there to have been tensions between "independent members as a block and executives as a block"[31], but rather:

> "…there were tensions about how you balance the financial constraints against performance and against service review. Clearly, there were professional views also being expressed by executive members. I think that there were times when independent members found it frustrating that, occasionally, issues that they felt should have been sorted out at executive level were coming to board sub-committees to be sorted out."[32]

48. The outgoing Chief Executive described in her written evidence to this Committee that:

> "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

[29] HIW/WAO Joint Report (June 2013), paragraph 26
[30] RoP, Public Accounts Committee, 9 July 2013, paragraph 28
[31] RoP, Public Accounts Committee, 18 July 2013, paragraph 18
[32] RoP, Public Accounts Committee, 18 July 2013, paragraph 18

began to override everything with a delay in decision making as a result."[33]

49. She also commented that:

> "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."[34]

50. The Committee notes that the challenges faced by the Health Board in managing financial, performance and service review issues was a contributory factor in the breakdown in working relationships amongst Board Members.

51. Furthermore, having considered the evidence, we are deeply concerned that both the outgoing Chief Executive and former Chair failed to adequately tackle the dysfunctional working relationship issues amongst the Board. As with other evidence presented, by the outgoing Chief Executive, to this Committee, she appeared to adopt an external perspective on the problems at the Board and thereby attempting to distance herself from those problems. We strongly believe that a Chief Executive should be proactive in dealing with such problems and question why she did not choose to intervene in addressing various problems described in her own evidence.

Training for Board Members

52. The Committee has considered what action might be taken in the future to improve working relationships among Members of the Health

[33] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[34] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013

Board and believe that appropriate training offers a valuable opportunity both to improve relationships and understanding amongst board members. The joint report states that:

> "Attention needs to be given to further training for IMs, given that some of the current cadre took up post after the initial induction training had taken place."[35]

53. We received clear evidence of the effectiveness of initial training provided for Independent Members of the Health Board, and for the Board. However, we also received evidence to suggest that over a period of time, arrangements for providing training to new appointments became less thorough, and much less effective.[36]

54. The Committee is concerned that this may be indicative of a wider problem amongst other NHS bodies. Evidence to this Committee suggests that there is little consistency between Health Boards' approach to collective Board training.[37] We also note that HIW published a Governance Report at Cwm Taf Health Board in March 2012[38], which identified the need for training for Independent Members. When we questioned him on this, the Director General stated:

> "At the moment, different boards are implementing different development arrangements, including Betsi—they had a development session earlier this week. I do think that it is an area where, as Welsh Government, we could make sure that there was some core, appropriate and consistent development for boards as they are now, and certainly for new members. It is available now, but we could make sure that it is more consistently applied."[39]

55. The Committee believes that there would be considerable merit in the Welsh Government developing a national training programme, consisting of structured inductions, board development opportunities and refresher updates, with a requirement for board members to attend individually or collectively as appropriate.

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[35] HIW/WAO Joint Report (June 2013), paragraph 28
[36] RoP, Public Accounts Committee, 9 July 2013, paragraph 46
[37] RoP, Public Accounts Committee, 18 July 2013, paragraph 231
[38] A Review of Governance Arrangements at Cwm Taf Health Board, March 2012
[39] RoP, Public Accounts Committee, 18 July 2013, paragraph 793

56. In considering the training requirements for IMs, the Committee believes that it is important to consider the current time commitment identified for IM roles to ensure that it is sufficient to allow IMs to discharge all of the duties expected of them.

We recommend the Welsh Government undertakes an urgent review of the training available to board members across all Welsh NHS bodies. The outcome of this review should inform the development and delivery of a national training programme for board members, participation in which should be a condition of board membership. The programme should develop core competencies, clarify requirements and include training specifically developed for newly appointed board members to attend as part of their induction into board membership.

We recommend that directive guidance should be issued to all boards on the importance of both individual and collective board development and any such guidance should be reviewed regularly to ensure it is fit for purpose.

We recommend that the time commitment required for Independent Members be reviewed to ensure that it is adequate to allow them to fully discharge the functions expected of them.

We recommend that the Welsh Government takes action to enable a more robust and consistent system of appraisal for Independent Members of Welsh Health Boards, including the identification of personal training and development needs, and that a peer mentoring scheme for independent members be developed.

Management of staff turnover and long-term sickness absences

57. The joint report identified concerns about the capacity and stability of the Executive Team and that staff turnover and long term sickness absences, had resulted in the Board having to make a number of interim arrangements at Executive level.[40] In particular, the Medical Director role was seen as a key post in providing the clinical leadership necessary to drive service modernisation, and the uncertainty created

[40] HIW/WAO Joint Report (June 2013), paragraph 42

by the interim arrangements for this post was seen as a real impediment to progress.[41]

58. The Committee questioned the acting Medical Director on whether he considered the interim nature of his position to have made any difference. He informed us that:

> "…the uncertainty made it difficult, and I accept that maybe the strength behind that has been less than it might have been, because of that difficulty. I think that that is acceptable in those circumstances. It is a very unusual set of circumstances that have come together to make that difficult, and we have to work through that."[42]

59. In response to this the Committee raised concerns around the difficulties that can arise when a key person takes long-term sick leave during a crucial time. We sought clarity on why it appeared that long-term sickness had been unattended and not actively tackled for so long at an important time.

60. The acting Chief Executive explained that:

> "It is really important to say that it has not been unattended; it has been carefully managed in accordance with our sickness policies and procedures as a health board. As you will appreciate, it is about the health of an individual, which would be inappropriate to talk about. It has been properly and actively managed in line with our policies as a health board."[43]

61. Similarly, the outgoing Chief Executive informed us that:

> "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

[41] HIW/WAO Joint Report (June 2013), paragraph 42
[42] RoP, Public Accounts Committee, 9 July 2013, paragraph 137
[43] RoP, Public Accounts Committee, 9 July 2013, paragraph 139

has proven his capability during his tenure in this role, which has now been on two separate occasions."[44]

62. Managing sickness absences in accordance with an organisation's stated sickness absence policy is important. We believe that it is vital that an organisation's stated approach to managing sickness absence is fair and consistent. However, it is also imperative that an organisation's approach is robust and timely.

The role of the Board's Secretary

63. The joint report describes the role of the Board Secretary as being critical in ensuring that the Health Board is properly equipped to fulfil its responsibilities.[45] The outgoing Chief Executive told us that:

> "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."[46]

64. In evidence to this Committee, it became clear that having one person holding a combined role of Secretary to the Board, and Director of Communications and Governance, which included responsibility for both clinical governance and complaints/concerns, was unsustainable in terms of workload. We found considerable potential for a conflict of priorities between these different roles. The Secretary to the Board concurred with this assessment stating:

> "It was unique to BCU. There are a number of roles and functions within one post and within one team. I think that there were issues in terms of challenges and tensions, but it was seen to be a reasonable fit at the time when the organisation was set up."[47]

65. She added that:

> "When that was tested out over the years, through the Wales Audit Office structured assessment, and other reviews, it was

[44] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[45] HIW/WAO Joint Report (June 2013), paragraph 81
[46] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[47] RoP, Public Accounts Committee, 18 July 2013, paragraph 222

> seen to be acceptable, until really the last 12 months, when the Chief Executive and I, together with the auditors, were saying that we needed a better separation of these duties."[48]

66. We note that at the time the Committee was taking evidence there remained a conflict of interest in the Board Secretary holding multiple roles, including some important executive responsibilities. However, since that time we understand that the Health Board has largely addressed this.

67. The Committee notes that the conflict of interest between the various roles held by the Board Secretary had significantly contributed to the dysfunctionality of the Board.

We recommend the Welsh Government ensures that the importance of the separation and accountability of the Board Secretary role is clearly understood by all NHS organisations.

We recommend that Welsh Government consider providing statutory protection for the role of Board Secretary.

The provision of information to the Board

68. The joint report raises concerns regarding the way information was presented to the Board particularly with regard to the circulation of papers dealing with key issues, which were found to be circulated late or tabled on the day of meetings and often without the assurance that they represented the consolidated view of the whole Executive.[49]

69. The joint report concluded that the provision of accurate, timely information to Board Members was also likely to contribute to ineffective working relationships amongst them, stating that:

> "We identified several instances when papers dealing with key issues are either circulated late, or tabled on the day, and (as indicated above) often without the assurance that they represent the consolidated view of the whole Executive."[50]

70. Both the former Chair of the Board and the Board Secretary stressed that the provision of late papers was rare, but acknowledged

[48] RoP, Public Accounts Committee, 18 July 2013, paragraph 222
[49] HIW/WAO Joint Report (June 2013), paragraph 26 (c)
[50] HIW/WAO Joint Report (June 2013), paragraph 26

this had occurred.[51] The former Chair of the Board raised concerns with us that there were occasions when more time was needed to consider important papers, particularly when important decisions had to be made. He informed us that:

> "To take the most recent case about the budget paper and the request for 72 or 74 new medical appointments, we have a finance and performance committee that meets just before the board. The Executive and the Finance and Performance Committee had scrutinised that paper thoroughly and it came, naturally, to the Board. It would have been better if it had come earlier, but that was in the nature of the routine of the business.
>
> […]
>
> "The other paper, on recruiting all these medics, was being presented because it was argued that, if we did not take a decision, we might not have enough doctors this coming August. So, it was a sort of emergency. I think that a chair should be able to agree to receive an emergency paper. However, on that occasion, I allowed discussion on that paper but I refused to allow the Board to make a decision and to commit large amounts of money in response to a paper that I had not even been able to read, as I was chairing the meeting. I refused to allow the Board to come to a decision on that."[52]

71. The Committee was informed that while the former Chief Executive and the Secretary of the Board were aware of the possibility of an emergency paper coming to the Board on the day of the meeting, the Chair was not informed in advance. When asked if the Secretary of the Board could give us a reason as to why she had not informed the former Chair in advance of the meeting, she told us, "I cannot. I should have done."[53]

72. The Secretary to the Board further conceded that:

> "…discussion can take place… it is not appropriate, if an important paper is tabled, that people do not have proper time to consider the issues in it. That is not good governance. You

[51] RoP, Public Accounts Committee, 9 July 2013, paragraphs 56 and 64
[52] RoP, Public Accounts Committee, 18 July 2013, paragraph 119
[53] RoP, Public Accounts Committee, 18 July 2013, paragraph 181

> cannot expect board members to make reasonable or rational decisions if they have not had time to properly consider the information."[54]

73. We asked the former Chair of the Board whether the collective Board had been forced into making particular decisions, by Executive Officials, as a result of not having sufficient information or time to consider such decisions.[55] He informed us that:

> "I did not allow the Board to be bounced into making a number of decisions. However, on the budget, I was reassured that the Finance and Performance Committee, on which a considerable number of Board Members sit, had scrutinised the budget and the planning to a suitable level. I take the point about the timing, and I think that we need to reconcile those things."[56]

74. The Committee believes that it is unacceptable that neither the former Chair, nor the Board, were not given advance copies of important papers. We note from the former Chair of the Boards' evidence that he did not have access to these papers on more than one occasion. However, we were surprised that the former Chair and other Board Members did not challenge the problem as it was clearly their responsibility to do so.

We recommend that the Welsh Government ensures that all Health Boards review their meeting procedures, to ensure that Board members are presented with all papers in a timely manner and that non-restricted papers are published in the public domain in the same timescales.

[54] RoP, Public Accounts Committee, 18 July 2013, paragraph 127
[55] RoP, Public Accounts Committee, 18 July 2013, paragraph 200
[56] RoP, Public Accounts Committee, 18 July 2013, paragraph 201

3. Quality and safety arrangements

75. The joint report found that the routine governance and reporting arrangements within the Health Board had not paid sufficient attention to infection control, and that management action should have taken place earlier in response to the pattern that was emerging on *C Difficile* prevalence in 2012.[57]

76. The joint report also raised a number of concerns about the way in which the Board's Quality and Safety Committee operated. In particular, the report referred to the size of Committee agendas and the subsequent risk that important issues would not receive sufficient attention or possibly be overlooked altogether.[58]

77. The joint report emphasised the importance of ensuring that there are lines of communication and accountability between CPGs and hospital management teams so that issues and concerns which potentially jeopardise the quality and safety of patient care are identified and addressed.[59]

Quality and Safety Committee

78. The joint report outlined concerns held by Quality and Safety Committee members regarding the crowded meeting agendas for their meetings, which limited its ability to thoroughly scrutinise and challenge the information presented to it.[60]

79. Regarding the operation of the Quality and Safety Committee, the outgoing Chief Executive considered there to have been a fundamental system failure stating that:

> "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

[57] HIW/WAO Joint Report (June 2013), paragraph 45
[58] HIW/WAO Joint Report (June 2013), paragraph 52
[59] HIW/WAO Joint Report (June 2013), paragraph 56
[60] HIW/WAO Joint Report (June 2013), paragraph 18

> rates are a rich source of information that aids a Committee in being able to undertake adequate scrutiny of the safety issues."[61]

80. The Committee has serious concerns regarding the operation of the Quality and Safety Committee. We believe that agendas for such committee meetings should be better planned and adequate time should be given to cover all business.

Escalation of Concerns

81. The joint report concluded that new arrangements must improve the processes by which concerns are escalated within the Health Board, as they are currently not well understood by staff.[62] This will help ensure that a more bottom-up approach to quality and safety is adopted, with timely escalation via CPGs and Executive Leads to the Quality and Safety Committee, and if appropriate, to the Board.[63]

82. With regards to the process by which concerns are escalated, the Committee heard evidence from some staff at BCUHB to suggest that the culture of the organisation had not encouraged staff to escalate their concerns.

83. However, the outgoing Chief Executive informed us that:

> "I dispute the foundation of any claim that the LHB culture failed to permit and/or encourage escalation of concerns about patient safety and/or failed to treat any concern seriously. I personally took decisions and instructed others to take action to address patient care concerns."[64]

84. She added that:

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

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[61] Written Evidence, outgoing Chief Executive - BCUHB, 18 July 2013
[62] HIW/WAO Joint Report (June 2013), paragraph18
[63] HIW/WAO Joint Report (June 2013), paragraph 18
[64] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013

dismissal of staff as appropriate. Evidence exists of the Health Board taking appropriate action."[65]

85. In commenting on the role of the North Wales Community Health Council (CHC) in identifying and escalating issues at BCUHB, the Director General informed us that:

> "Whether it should have had a role in identifying some of these issues is an interesting question. I had not really thought that through. The CHC would not, I think, have been aware of financial problems, and not to the extent that we should be and were. In terms of the other issues, I am not sure that its members would necessarily be aware."[66]

86. In commenting further on the escalation of issues by CHCs the Director General stated that:

> "Should a CHC that is alert have been signalling some concerns to the board or, alternatively, to a national arrangement or through us? Possibly, but I think that there is a bit of food for reflection on that."[67]

87. Written evidence received by this Committee, from the North Wales CHC, suggests that the CHC had been aware of problems at BCUHB for some time and did not appear to escalate these problems.

88. The Committee notes the issues around the escalation of concerns. We believe that staff across all health boards should actively be encouraged to raise concerns regarding risks to patient safety, rather than fear they will be reprimanded for doing so. We also believe that CHCs have a role in identifying and escalating concerns raised with them.

89. Since the Committee's oral evidence sessions, we also note the intention of the UK Government to create a new criminal offence in England and Wales whereby individuals are 'guilty of wilful or reckless neglect or mistreatment' of patients should they fail to report

[65] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[66] RoP, Public Accounts Committee, 18 July 2013, paragraph 819
[67] RoP, Public Accounts Committee, 18 July 2013, paragraph 819

concerns. The proposed legislation is based on the recommendation made in a report published by Professor Don Berwick in August 2013.[68]

Under reporting of Serious Incidents

90. The joint report raises concerns about the under reporting of serious incidents involving *C Difficile* specifically stating that:

> "There appears to have been significant under-reporting of serious incidents involving *C Difficile*, both internally within the Health Board, and also to the Welsh Government in accordance with published guidance. This contributed to both the Board and the Welsh Government receiving unduly positive assurance as a result of being unsighted on the totality of information regarding *C Difficile.*"[69]

91. In commenting on these concerns, the acting Chief Executive of the Board informed the Committee that:

> "…we did not have a robust system. We accept that and that needs to change. We were reporting infection control data and it was linked to the priorities and the targets that are set at a national level. One of the things that that did not adequately bring to focus for us is the absolute level of infection that was going on and the board's focus on a number of cases, as opposed to whether we were reducing or increasing. So, there is a real issue about refining those indicators and being clear about what they were. Some of that infection control information has been reported. There were weaknesses and they have been identified, and we would not pretend to suggest they were not there."[70]

92. Concerns regarding the underreporting of serious incidents were further exacerbated in evidence to the Committee from the former Chair of the Board who informed us that he was:

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[68] A promise to learn – a commitment to act - Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England [accessed 19 November 2013]
[69] HIW/WAO Joint Report (June 2013), paragraphs 48 and 53
[70] RoP, Public Accounts Committee, 9 July 2013, paragraph 182

> "…shocked to hear of the outbreak of *C Difficile* at Glan Clwyd at a later stage than I believe I should have been told."[71]

93. Furthermore, the North Wales CHC advised us that it also no longer had confidence in information supplied by the Health Board, stating that:

> "In light of the joint HIW/WAO report, the CHC has recently agreed a robust Action Plan to deal with the issues raised and in particular is considering how the CHC monitors the quality of infection control practice in North Wales' hospitals. Further I have, through my Chief Officer advised the Health Board that the CHC can no longer have confidence that the information supplied to us by the Health Board is a fair and accurate representation of what is happening at either Board or ward level. With this in mind, the CHC has withdrawn from the Health Board's Annual Quality Statement process for 2012-2013."[72]

94. The evidence received by this Committee in relation to the under reporting of serious incidents involving *C Difficile* links to other evidence provided to us, to demonstrate that inadequate and inaccurate information was being provided to the Board and its sub-committees. As a Committee we find it extremely concerning that the Board was not properly sighted on vital issues around infection control. Given this, we question whether there can be confidence in the wider quality and safety information that is presented to the Board.

95. More recently, in August 2013, Professor Brian Duerden[73], Emeritus Professor of Medical Microbiology at Cardiff University, published an independent report on BCUHB's infection control arrangements.[74] In particular, his report concluded that the Health Board must strengthen its clinical leadership of infection control at the highest levels, and make sure that it had very clear arrangements for monitoring and managing infection control issues at a local level. Professor Duerden's report also highlighted that a consistent approach to reporting cases across the Health Board was required, so that any

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[71] RoP, Public Accounts Committee, 18 July 2013, paragraph 422
[72] Written Evidence, North Wales Community Health Council, 12 July 2013
[73] For clarity: there is no familial relationship between Dr Martin Duerden, the Health Board's Acting Medical Director, and Professor Brian Duerden.
[74] Professor Brian I. Duerden, 'Review of Governance Arrangements, Structures and Systems for the Prevention and Control of Healthcare Associated Infections in the Betsi Cadwaladr University Health Board', 13 August 2013

signs of an outbreak were identified quickly and appropriate action taken.

96. We understand that in response to Professor Duerden's report, the newly appointed executive director of nursing, midwifery and patient services at BCUHB stated that:

> "We have made it clear that we have an attitude of 'zero-tolerance' to preventable infection across the organisation. As an immediate step I have brought in a leading expert in infection prevention to work with us in north Wales as we improve our wider infection control services. We have also put in place a weekly monitoring system at board level and we now have infection control groups led by senior clinical staff in each acute hospital to make sure there are clear lines of reporting and accountability at a local level. We are also in the process of recruiting additional nurses to our infection control teams."[75]

97. While we welcome the approach being taken by the Health Board, we remain deeply concerned that if inadequate or inaccurate information had been provided to the Board at BCUHB, it would also have been inaccurately provided to the Welsh Government. The joint report notably stated that:

> "…there appears to have been significant under-reporting of serious incidents involving *C Difficile*, both internally within the Health Board, and also to the Welsh Government in accordance with published guidance. This contributed to both the Board and the Welsh Government receiving unduly positive assurance as a result of being unsighted on the totality of information regarding *C Difficile.*"[76]

98. We are concerned that if BCUHB had provided inaccurate information to the Welsh Government, the same could also be true of other Health Boards. The Welsh Government's Chief Medical Officer considered that Health Boards did generally report serious incidents accurately, but stated that:

> "…as soon as I started to question the fact that we had a number of notifications of deaths in relation to C. difficile, I did

[75] http://www.bbc.co.uk/news/uk-wales-23678685, [accessed 13 August 2013].
[76] HIW/WAO Joint Report (June 2013), paragraph 48

> ask for a review of other health boards across Wales to make sure that we were getting the notifications in line with expectations on this particular issue, and I wrote out to health boards."[77]

99. She added that:

> "The issue about serious incident reporting is about this question of, if someone has Clostridium difficile on part 1 or part 2 of the death certificate, whether that is being flagged regularly and systematically to Welsh Government as a serious incident. Having seen what happened with the cases that we were coming in from Betsi Cadwaladr, I went back and double-checked that with the health boards. What is evident was that it was inconsistent, and I have taken steps to try to close that."[78]

Having considered the evidence, the Committee welcomes the action being taken by the North Wales Community Health Council to monitor compliance with infection control procedures in hospitals across North Wales. We recommend that the Welsh Government reviews its processes for validating quality and safety, and other critical data from NHS organisations. It is vital that such data is reported accurately if meaningful action is to be taken.

Communications between the Ward and the Board

100. The joint report identified a communications 'gap' between people working in the organisation's various wards, and it's overarching Board.[79] This was acknowledged by the former Vice-Chair of the Board, who informed this Committee that:

> "…there has been some tension and, perhaps, a gap between the management structure and the front line."[80]

101. Evidence from the Chair of the North West Wales Consultant Group and Director of Psychiatry at BCUHB described a major communications gap between staff on the Health Board's Wards and its senior management. The evidence also alluded to a lack of confidence in the senior leadership of the Board. He stated that:

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[77] RoP, Public Accounts Committee 18 July 2013, paragraph 845
[78] RoP, Public Accounts Committee, 18 July 2013, paragraph 852
[79] HIW/WAO Joint Report (June 2013), paragraph 42
[80] RoP, Public Accounts Committee, 18 July 2013, paragraph 385

> "There are a growing number of Serious Untoward Incidents linked we believe to mismanagement. Our concerns are that there will be even more such incidents in the near future as medical and nursing staff have left the service and the gaps in cover are growing ever more alarming with management seemingly incapable of resolving the issues."[81]

102. While the Committee notes this evidence is from one discipline in one geographical area, we acknowledge that it may represent the view of other clinical groups.

103. The Committee questioned the outgoing Chief Executive on whether the Board's organisational structure, and its implementation, had contributed to a communications gap between Wards and the Board. In response, she stated that:

> "A Board would not generally be expected to be sighted on all operational matters involving over 17,000 staff irrespective of the organisational structure in place. The point is to ensure appropriate escalation of issues requiring the involvement of the Board and in reverse Board to Ward dissemination and understanding of strategic corporate objectives with delegation of responsibility for delivery of operational objectives to plan."[82]

104. She added that:

> "The 'Board to Ward' gap cannot be wholly attributed, as may be implied, to the clinical leadership structure in place. As indicated the issues are wider and not just confined to this Board."[83]

105. Given the significance of adequate infection controls, and their potential contribution to the C *Difficile* outbreak, we asked the Chair of the Quality and Safety Committee why a decision was taken to reduce the number of infection control nurses, and to disband and disestablish the clinical groups that had been set up. However, he

[81] Written Evidence, Chair of North West Wales Consultant Group, 11 August 2013.
[82] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013
[83] Written Evidence, outgoing Chief Executive - BCUHB, 12 September 2013

advised us that "It was not a board decision."[84] He added that "I was not aware that the numbers had been reduced."[85]

106. On this issue, the Secretary to the Health Board said that:

> "The sub-committee on improving infection prevention and control was a formal sub-committee of the quality and safety committee, and its full minutes came up to the quality and safety committee, month by month, together with issues of significance. That gave the executive nurse at the time the opportunity to raise issues of concern, bringing them formally to the attention of the full committee. If you go back through the notes, it is clear that we were concerned about infection control. However, it is absolutely clear that the committee and the board did not understand, until April, the full extent and impact of the *C Difficile* outbreak at Glan Clwyd Hospital."[86]

107. The Committee is very concerned that both the system of raising matters to the Quality and Safety Committee's attention, and of the Committee then identifying matters of concern, were structurally flawed. We note that the joint report recommended a closer examination of the way in which the Quality and Safety Committee works, as the report raised concerns about the way in which the Quality and Safety Committee operates.[87] We concur with this recommendation.

108. The Committee has received sufficient evidence to support the findings of the joint report and we believe that there was a gap in communications between the Ward and the Board. However, we have also received evidence to suggest that improvements are now starting to be made to address this problem.

109. In correspondence to this Committee, the Chief Executive of Healthcare Inspectorate Wales, stated that:

> "Since the publication of the joint report in June of this year I have regular discussions with the Acting Chief Executive and Nurse Executive to assure myself that progress is being made. I consider there to be clear evidence that there is now a real

[84] RoP, Public Accounts Committee, 18 July 2013, paragraph 396
[85] RoP, Public Accounts Committee, 18 July 2013, paragraph 398
[86] RoP, Public Accounts Committee, 18 July 2013, paragraph 406
[87] HIW/WAO Joint Report (June 2013), paragraph 52

> focus on the quality and safety of patient care and on ensuring that the right governance frameworks are put in place, to address the gap between the Board and those providing patient care."[88]

110. The Committee welcomes the focus on the quality and safety of patient care and the new governance frameworks now in place. However, we are keen to emphasise the importance of ensuring these changes are fully implemented as these are issues of direct concern to patients and their families.

We recommend that the Welsh Government finalise, introduce and implement a common set of key performance indicators of quality and safety for use by Health Boards. This would assist in improving performance and identifying risks so that swift action can be taken to address them.

A Rise in Risk Adjusted Mortality Index (RAMI) rates

111. Following publication of the joint report, this Committee received correspondence from consultants based at Ysbyty Gwynedd, which expressed a "lack of confidence in the current Board and Executive to manage with appropriate speed, the changes necessary to sustain good health care in North Wales."[89]

112. The Committee notes that a consultant histopathologist at Ysbyty Gwynedd, was quoted in the media insisting that concerns raised in the report came as no surprise to senior clinicians. He said that "Myself and my colleagues are very upset" adding that:

> "They're very worried that the management of the health board isn't sufficiently strong enough to give them a safe place to treat their patients.
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> "In addition there's been an increase in RAMI (risk adjusted mortality index) - an indicator of excess or unexpected deaths. Until last year RAMI at Ysbyty Gwynedd had shown a steady progressive decline.

[88] Written Evidence, Chief Executive Healthcare Inspectorate Wales, 10 October 2013
[89] Written Evidence, Chair of Gwynedd Consultants and Specialists Committee, 5 July 2013

> "But over the past few months it's started to increase and that the last count was 122 which is quite significant."[90]

113. As a Committee we consider a RAMI rate of 122 to be a worrying death rate for a major hospital site. Moreover, written evidence from BCUHB set out that RAMI rates in other hospitals within the Health Board were of concern:

> "The Health Board has been aware of a month on month increase in RAMI in Ysbyty Gwynedd for the last 7 months of validated data (now up to April 2013). In the last few months, the RAMI in Ysbyty Glan Clwyd has also increased and the RAMI in Wrexham Maelor is higher than that seen in the other two hospitals but has been relatively stable over the same time period. This matter is being thoroughly investigated and regular written updates are being provided directly to the Chief Medical Officer for Wales."[91]

114. We are pleased to see that the Health Board is undertaking a thorough investigation of the reasons behind the high RAMI scores. The investigations should result in a clear and transparent articulation of the issues that are contributing to the high mortality indices that are being reported, and urgent and decisive action to address any patient care issues which become evident.

115. More widely, we believe that more should be done to provide the public with transparent, understandable and easily accessible information on mortality statistics for hospitals in Wales.

We recommend that the Health Board makes the results of its investigations into the high RAMI scores across hospitals in North Wales publically available, together with information on the actions that are being taken to address any patient care issues that are identified.

We recommend that the Welsh Government makes information on RAMI scores across all hospital sites in Wales more accessible to the general public, ideally by placing all the data on a single web page, with clear explanations of what the data means.

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[90] http://www.bbc.co.uk/news/uk-wales-23235262, [accessed 9 July 2013]
[91] Written Evidence, Director of Communications and Governance, 18 July 2013

4. Financial Management and sustainability

Budget processes

116. The joint report raised a number of concerns regarding budget processes specifically stating that a number of budget holders only signed off their budgets for 2012/13 'with caveats'[92]. On this matter, the Health Board's former Director of Finance told us that:

> "In the last financial year, we decided as a health board to put in place an interim budget for one month only, and that was to take account of… issues... We put the annual budget in at the April board for the remainder of that year. In previous financial years, and in this financial year, the board has been fully signed up in advance of the financial year, but we fully recognise that it was important that there was a robust budget set by the health board, rather than one that was just, if you like, a budget in name only."[93]

117. Furthermore, the outgoing Chief Executive informed the Committee that:

> "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."[94]

118. Moreover, we are concerned to hear that the signing up to a budget with caveats had occurred again in relation to the 2013/14 financial year. The Chair of the Finance and Performance Committee told us that:

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[92] HIW/WAO Joint Report (June 2013), paragraph 60
[93] RoP, Public Accounts Committee, 9 July 2013, paragraph 228
[94] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013

> "the position that we are in in July, after the June finance and performance meeting, is that a small number of the CPGs are not able to sign up to their budgets without adding notes about caveats, in terms, for example, of the recruitment of locums, and so on. Clearly the expectation in a delegated situation is: the budget is the budget; that is something that I am used to operating in local government, with whatever constraints that may apply in terms of the planning arrangements."[95]

119. The Committee believes that this unacceptable and that a budget should not be signed off with caveats. Senior leaders must ensure that this is communicated to all members of staff, and that the final budget is not a matter for further negotiation, unless circumstances change significantly. We believe that it is reasonable for debate and discussion to take place before the budget is set, but before the beginning of a financial year a final decision should be taken to set that budget.

120. The Committee fully accepts that there may then be in-year virements between budgets, as unanticipated issues can arise. We believe that failure to do this inherently risks compromising savings plans and budget management processes in the early months of a financial year.

121. In conclusion, the Committee is of the view that the use of caveats could be perceived as a reflection of internal divisions between budget holders in the organisation.

The failure to adhere to accepted budget processes is an issue of particular concern. We do not believe that budgets should be signed off with caveats and recommend that assurances should be provided to us that this practice has now been discontinued within the Health Board.

We also recommend that the Welsh Government seeks information from directors of finance at all health boards to ensure that the failures evident within the budget planning processes at the Betsi Cadwaladr University Health Board are not being replicated elsewhere.

[95] RoP, Public Accounts Committee, 18 July 2013, paragraph 474

Achieving financial break-even in 2012/13

122. BCUHB has historically had a strong track record in delivering its statutory financial targets. However in September 2012, the Health Boards year-end forecast for 2012-13 notably went "from break even to a projected deficit of £19 million."[96]

123. In exploring the reasons for this, the joint report found that:

> "It's [the Boards] dependency on non-recurrent savings is unsustainable. The process for identifying savings schemes needs to be more transparent and robust and future savings plans will need to focus increasingly on the more difficult areas for recurring savings: reducing costs by reforming and reshaping services."[97]

124. The joint report also found that the Health Board had adopted a range of measures to avoid a breach of its statutory 2012-13 Resource Limit:

> "In addition, the Health Board recognised the use of 'strategic reserves', the proactive management of contracts, one-off favourable variances and savings achieved from the implementation of additional expenditure controls in the final weeks of the financial year. These emergency measures included 'a reduction in the additional work to meet access targets and in particular a cessation of waiting list initiatives, except as specifically approved by the Finance and Performance Committee to address safety issues."[98]

125. The Acting Chief Executive told us that the Welsh Government was aware of these plans:

> "I think that it would be wrong to say that it gave permission or consent for us to do it. That was a decision that the Board took, balancing its financial duties and its service duties. However, the Welsh Government was aware of our trajectory."[99]

126. In this Committee's report on Health Finances, published in February 2013, we commented that it was imperative that accurate

[96] RoP, Public Accounts Committee, 18 July 2013, paragraph 510
[97] HIW/WAO Joint Report (June 2013), paragraph 72
[98] HIW/WAO Joint Report (June 2013), paragraph 63
[99] RoP, Public Accounts Committee, 9 July 2013, paragraph 243

information was provided to the Welsh Government on health boards' financial forecasts. The Committee believes that it is the role of a Chief Executive, in their capacity as Accounting Officer, to communicate this information in a timely manner to the Welsh Government.

127. We remain convinced that in the current financial climate it is vital that health boards provide accurate, up-to-date information on their financial forecasts- and the consequences of such- to the Welsh Government. We believe such information will enable the Welsh Government to more effectively support health boards.

128. However, the outgoing Chief Executive also stated that prior to an award of additional funding during the 2012/13 financial year:

> "…the external emphasis was one of insistence that the Board achieve financial balance and performance targets. This was in the face of also dealing with remedy of the full scale of management issues requiring address… Inevitably this had impact on the pace of turnaround not within the power of the Board, or me alone, to deliver corporately."[100]

129. We were alarmed by these comments, because we do not consider service delivery and management issues to be isolated and separate from financial breakeven and performance targets. We believe the health board could have justifiably focussed some of its 2012/13 expenditure on reviewing and improving management issues, on the basis that this would have improved both its capacity to achieve financial break-even and to achieve its key performance targets.

130. We note that the actions of the Board, coupled with additional Welsh Government in-year resource funding, did enable the Health Board to achieve break even in 2012-13. A number of witnesses advised the Committee that the position regarding cancellation of elective operations is more complex than it might initially appear, and that emergency winter pressures meant beds normally used for patients expecting elective operations were unavailable. The Welsh Government stated that:

> "Looking at the number of cancellations across Wales, which is a significant number, the cancellations were made due to a lack

[100] Written Evidence, outgoing Chief Executive – BCUHB, 12 September 2013

> of beds, and the evidence that we have is of health boards having to open additional beds—and spend money on additional beds—to accommodate non-elective demand. At times, they had to send patients out from medical areas into surgical areas. So, our analysis, the emerging analysis, is that that is the main driver, but, clearly, finance influenced decisions in terms of their ability to secure, possibly in the independent sector, possibly in other ways, activity that would compensate for that loss."[101]

131. Similarly, the Chair of the Board's Finance and Performance Committee stated that the reason for cancelled appointments was:

> "…in the main, the impact and consequences of winter pressures on the emergency department, which are common across Wales. So, if there were cancellations there, it was because of increased bed pressure at that time, the presence of outliers in surgical beds and so on. It was not a direct consequence of the decision in respect of the additional investment."[102]

132. As a Committee we believe that this reasoning will be of little consolation to patients and their families. Many patients in North Wales had operations postponed at short notice during the final quarter of 2012-13, and Committee Members representing North Wales have received correspondence from members of the public raising concerns regarding this.

133. In written correspondence, BCUHB advised us that the number of patients affected by the decisions made in December 2012 for the final quarter of 2012/13 was approximately a combined 1250 inpatient and day case and 1600 follow up outpatient reviews.[103]

134. The joint report also comments that this action had a detrimental impact on patient waiting times. It is also clearly not a sustainable approach to meet financial targets, as any elective activity deferred from 2012-13 would need to be carried forward into 2013-14, putting further pressure on resources in the current year.[104] The outgoing

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[101] RoP, Public Accounts Committee, 18 July 2013, Para 754
[102] RoP, Public Accounts Committee, 9 July 2013, Para 357
[103] Written Evidence, Director of Communications and Governance, 18 July 2013
[104] HIW/WAO Joint Report (June 2013), paragraph 63

Chief Executive acknowledged that the decision to cancel appointments was:

> "…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."[105]

135. On 30 September 2013 the Welsh Government introduced the National Health Service Finance (Wales) Bill. The aim of the Bill is to give NHS bodies greater financial flexibility and remove the need to break even on an annual basis.

136. However, we believe the introduction of this Bill emphasises the need for health boards to focus on long-term transformational savings, as opposed to short-term arrangements. This will require both effective financial planning from month one and accountable, robust direction from health boards' senior managers.

We recommend that the Welsh Government emphasises to health boards that they should wherever possible avoid utilising unsustainable solutions to financial pressures, such as cancelling or postponing operations, which simply defers costs to the next accounting period.

We recommend that the Welsh Government ensures that all health boards minimise the inconvenience and distress caused to patients and their families by requiring that Boards communicate with patients as soon as possible following a decision to cancel or postpone elective operations.

137. The Committee has subsequently undertaken inquiries into Health Finances 2012-13 and beyond and Unscheduled Care and will be publishing reports with specific recommendations in these areas in due course.

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[105] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013

External Reviews of Financial Management

138. The Committee noted that two reviews were commissioned looking at financial management issues at the Board.

139. The Hurst review was conducted by the Welsh Government Health Department's former Director of Finance [Mr Hurst] and was published in April 2012. The acting Chief Executive told us that:

> "The [first] report from Mr Hurst, which came in April, discussed the need to sharpen our focus on the delivery of savings, to bring our financial and service planning together, and to be clear about our clinical leaders owning some of the financial issues. Out of that, we established a delivery board and changed some of the ways that we were working within the board."[106]

140. The Committee was concerned to hear from Welsh Government officials that although the Welsh Government had funded the £2800 Hurst review, until recently they had not seen a copy of the report.[107] Welsh Government officials explained that Mr Hurst was available to undertake work across health boards on a call-off basis.

141. The Committee believes that this raises an issue of transparency as the Welsh Government funded the cost of the review, and did not receive a copy of its findings. This would be surprising in any set of circumstances, but especially so given the Welsh Government's role of strategically leading health boards across Wales. This is further exacerbated by the fact that the outgoing Chief Executive stated that the Hurst review was initiated by concerns expressed by the then Welsh Government Health Department's Director of Finance [Mr Hurst] during the 2012/13 budget setting process. In evidence from the outgoing Chief Executive the Committee were told:

> "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

[106] RoP, Public Accounts Committee, 9 July 2013, Para 247
[107] Written Evidence, Director General for Health and Social Services, 2 August

> 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."[108]

142. The Committee questioned the Welsh Government on how it planned to test whether the work it had commissioned was delivering value for money, particularly given they did not know what the outcome was. In response the Director General stated:

> "There are two parts to it. One is who paid for it, and then there is what work was involved, which is part of commissioning. The fact that we paid for it, yes, I accept that. The actual nature of it was specified between Chris Hurst and Betsi Cadwaladr, and the work was presented to Betsi Cadwaladr. You are right—we did not have sight of the finished product."[109]

143. It is also unclear from the evidence received by the Committee how widely the Hurst report was shared within the Board itself. We firmly believe that a report addressing such important issues should have been shared with the full Board. The Director General also told us that:

> "My expectation was that they would have shared those with the board as a matter of good practice. As I said, it is difficult to talk about the Hurst review. That was not shared with HIW and the WAO. I think that we discussed the Allegra review at one of the meetings that we had, but I do not think that it was shared with HIW and the WAO."[110]

144. We understand that this did not happen in this instance and instead, the Hurst report was only presented to a sub-committee. The acting Chief Executive explained to us that:

> "The Hurst report came in at a time when I was covering the chief executive role, and I discussed with the chairman how we would respond to that role and to that report, and develop the plans. That was not taken to the Board as a paper, but the

[108] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013
[109] RoP, Public Accounts Committee, 18 July 2013, paragraph 593
[110] RoP, Public Accounts Committee, 18 July 2013, paragraph 671

proposals that came out of it went to the Finance and Performance Committee."[111]

We recommend that the Welsh Government takes greater care when commissioning taxpayer funded external advice and that, without exception, the output of such advice is received, reviewed and retained by appropriate Welsh Government departments.

145. The Allegra report, published in December 2012, is a more detailed document. The Director General described that in response to escalating concerns around the Health Board (particularly the deterioration in its financial forecast), Allegra Ltd was commissioned by the Welsh Government to provide an external perspective.[112] He said that:

> "…the report was commissioned particularly in the context of financial problems, so its focus necessarily would have been on financial issues. That was the main thrust. That is really what it was there for. There was a request within it to comment on one or two other issues, but this was not a report on the broad range of challenges facing the health board. It was a very short, sharp report that we felt was necessary just to confirm some of the issues that we were concerned about."[113]

146. The Director General also emphasised that:

> "The Allegra report did not just drop on their desks and then we said, 'That's it. Thank you very much'. There was follow-up action. We asked for assurance in terms of the various recommendations and worked closely with the board to make sure that it was giving attention to the various recommendations within that report."[114]

147. The acting Chief Executive told us that the Allegra report:

> "…discussed turnaround a great deal, and it also discussed changing the structure and implementing the chief operating officer role. Furthermore, it discussed linking the acute services review with finance and accelerating movements on that. I think

[111] RoP, Public Accounts Committee, 09 July 2013, paragraph 249
[112] RoP, Public Accounts Committee, 18 July 2013, paragraph 627
[113] RoP, Public Accounts Committee, 18 July 2013, paragraph 655
[114] RoP, Public Accounts Committee, 18 July 2013, paragraph 718

> that, in some of our responses and in some of the comments in the Auditor General report, you can connect those themes and see that there are significant actions on-going now that were referenced in that report."[115]

148. However, written evidence from the outgoing Chief Executive questioned how robustly the recommendations of the Allegra report had been implemented. She said that the Allegra report offered an external view of the organisation:

> "External support for turnaround was discussed with Officials and previous to that Officials had suggested external financial support. This was not supported [by] some Executives or in some cases IMs due to the costs it might incur. For turnaround this meant an existing Director took on this role for a short period of time… 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."[116]

149. We note the outgoing Chief Executive's acknowledgement of a lack of management capacity within the organisation and her view that while management expenditure must be scrutinised robustly to ensure it delivers sufficient value for public money, no organisation can function effectively on a long-term basis if it has insufficient management capacity.[117] However, we question why she did not deal with this issue in her position as Chief Executive.

150. We consider that the commissioning of two Welsh Government funded reviews into financial management at the Health Board may have contributed to the perception that financial balance was a greater priority for the Welsh Government than other aspects of Health Board performance.

In relation to the sharing of the findings of external reviews the Committee believes that it is vitally important, that safeguards are in place to ensure that such findings are widely utilised to learn lessons and improve processes within health boards. We recommend that Welsh Government takes this forward.

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[115] RoP, Public Accounts Committee, 9 July 2013, paragraph 247
[116] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013
[117] Written Evidence, outgoing Chief Executive – BCUHB, 12 September 2013

5. Strategic Vision and Service Reconfiguration

151. The NHS in Wales is facing up to the key strategic challenge of: the need to sustain quality standards within tightening finances, and to reconfiguring and transforming services to respond to these challenges and the evolving needs of the population.

152. Within this context, the joint report found that the Health Board underwent a challenging public consultation exercise during the latter part of 2012, and had started to implement changes to locality and community-based services as a result.

153. However, the joint report also found that there had been a piecemeal approach in taking forward service redesign that makes it more difficult to design and plan the whole system changes that are necessary to create clinically and financially sustainable services.

154. On this matter, the outgoing Chief Executive explained the approach taken by the Board:

> "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."[118]

155. Linked to the strategic vision and service reconfiguration the joint report concluded that given the challenges that are known to exist with medical recruitment, and with the affordability of current service models in North Wales, the need to develop a clear strategic appraisal of options for the future shape of acute services is pressing.

156. The joint report also identified that the Deanery in Wales has raised concerns in relation to the viability of medical rotas to support junior doctor training:

[118] Written Evidence, outgoing Chief Executive – BCUHB, 18 July 2013

> "the Interim Medical Director and Chief Executive took a proposal to the Board in April 2013 to recruit an additional 72 clinicians in time for the August 2013 junior doctor rotation. The feasibility of achieving this is highly questionable and in our view is indicative of a reactive approach to a problem that requires more fundamental action. At the time of our review further discussions were being held between the Health Board and the Deanery on this issue."[119]

157. Whilst we note the written evidence provided by the outgoing Chief Executive on the service plans which have already been developed, it is clear that the Health Board is lacking an overarching strategic plan that sets out clinically and financially sustainable proposals for the totality of healthcare provision in North Wales.

158. Urgent action is needed to address this deficit in strategic planning, given that it is going to take a significant amount of time to work up these proposals and consult on them with the public and other key stakeholders.

159. Development of the required service, workforce and financial plans will require strong senior leadership from within the Health Board, alongside supportive scrutiny from the Welsh Government.

The Committee believes it is vital that senior leaders set a clear vision for their organisations to respond to the three challenges of developing service, workforce and financial plans. Given the issues around governance arrangements at Betsi Cadwaladr University Health Board, it is imperative that the new senior management of the Board renew and reunite the Executive and non-Executive leadership team, and close the gap between the Board and Wards.

[119] HIW/WAO Joint Report (June 2013), paragraph 78

6. The role of the Welsh Government

160. The Welsh Government plays a crucial role in the NHS in Wales. It is the main source of funding for Health Boards, sets strategic direction and provides democratic oversight and accountability. The Director General told us that it had expressed concerns to BCUHB throughout 2012-13:

> "about unscheduled care, and the concerns about finance developed later in September and October. However, unscheduled care continued to be a matter of concern. We also raised issues about the capacity of the health board at the executive level."[120]

161. We heard that as a general rule, correspondence from the Director General was addressed to the Chief Executive or acting Chief Executive.[121] The acting Chief Executive concurred that the Welsh Government had had an on-going dialogue with the Health Board:

> "That occurs at chief executive level, chair level and at individual professional level, so my finance director colleague would have a close relationship with the finance officer, and discussions have been ongoing and the challenges have been recognised… Some of the initiatives were on reviewing the structure, focusing on planning for the year ahead and getting a more structured approach to what we were doing, as a part of that conversation. Those conversations have continued since the publication of the report, in terms of how we work with Welsh Government and how Welsh Government can support us to deliver what we need to do—putting right some of the issues in this report and putting the board on a firmer footing."[122]

162. Similarly, the former Chair of the Board described that:

> "I believe that the Welsh Government did remind the board of its responsibilities, financially and in terms of performance. It was supportive of me as chair, and of others, as we attempted to change the system."[123]

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[120] RoP, Public Accounts Committee, 18 July 2013, paragraph 536
[121] RoP, Public Accounts Committee, 18 July 2013, paragraph 560
[122] RoP, Public Accounts Committee, 9 July 2013, paragraph 25
[123] RoP, Public Accounts Committee, 18 July 2013, paragraph 60

163. The Director General stated that:

> "The general pattern that emerged was of me asking for reassurance and receiving it very promptly. There was no problem; we did not have to particularly chase it up. At times, there was not quite the pace in the consequential delivery, which became a matter of concern and a matter of inquiry for me, I suppose. To an extent, it seemed to be that the executive team was stretched, which is why my attention was then drawn to the capacity of the organisation, and particularly what seemed to be a need to resolve this issue between the clinical leadership structure and the executive leadership structure. The model that a number of health boards have successfully employed—and you need it, I think, in big organisations—is to have a chief operating officer who can appropriately manage the clinical leaders and provide a pan-health-board view of operational matters. That was one of the outcomes of that. Generally, we were getting reassurances of action, but quite often, it was not quite delivered with the pace and to the time frames that we would have wished for."[124]

164. In taking evidence we examined whether the Welsh Government could have done more to intervene more directly, as it has in education and local government, taking over direct responsibility from authorities deemed to be failing. However, the Director General considered that direct action had been undertaken, commenting that:

> "The Delivery and Support Unit is a resource that we, as the Welsh Government, can deploy to organisations when they are in difficulty in terms of areas of performance. We deployed the unit to Betsi Cadwaladr University Local Health Board. At any point in the last 12 months, it has been working on unscheduled care, elective care, stroke, cancer and mental health. It has provided diagnostic support, clinical insight and facilitation to allow the Health Board to develop plans. It has not done it for the Board; we have sent in a team of people that can support the Board to do so."[125]

[124] RoP, Public Accounts Committee, 18 July 2013, paragraph 564
[125] RoP, Public Accounts Committee, 18 July 2013, paragraph 520

165. In response to our questions as to whether the Welsh Government identified problems on a timely basis, and acted promptly, the Director General told us:

> "…were we aware that unscheduled care problems were developing? Yes. Did we act? Yes. Were we aware that the finance problem was developing in a not particularly good position? Yes. Did we take action? Yes. Did we encourage action about the executive team? We did. Did we seek to force things through in a very complicated situation? The answer is 'yes'."[126]

166. The Director General also told us that the Welsh Government's delivery framework has an escalation of action and interaction according to the concerns raised. He noted that in this case issues around Betsi Cadwaladr had escalated from level 0 to level 4 from September 2012 through to February 2013:

> "The health board in our delivery framework was escalated to level 4 in February. So, action was taken when there was a failure to deliver. During the period from September onwards, we also had meetings with HIW and WAO about the way in which the system in a general way could respond to the position."[127]

167. The Committee notes that the National Health Services (Wales) Act 2006[128] confers on Welsh Ministers a discretionary power to intervene by way of an intervention order, if it is satisfied that a health body is not performing one or more of its functions adequately or at all, or that there are significant failings in the way the body is being run. We also note that an intervention order may include removal from office of a member (or members) of a Local Health Board and their replacement with individuals specified or determined in accordance with the order.

168. However, the Committee remains unclear on the criteria upon which intervention is triggered and the scales upon which the type of intervention is based. The Committee believes that prompt intervention can prevent problems escalating, and that further developmental work on this is urgently required.

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[126] RoP, Public Accounts Committee, 18 July 2013, paragraph 813
[127] RoP, Public Accounts Committee, 18 July 2013, paragraph 625
[128] National Health Service (Wales) Act 2006

169. The Committee notes the role that Community Health Councils (CHCs) may have in monitoring escalation issues and believe that it is important for CHCs to be made aware of the intervention process and any Health Boards that become subject to intervention.

We recommend that Welsh Government work with the Wales Audit Office and Healthcare Inspectorate Wales to develop a clearer set of scales of escalation. This should include a detailed criteria upon which intervention is triggered, the rationale for the type of intervention, and clarity on who should be notified when intervention commences and ceases. We believe that this information should be made accessible to the public.

Additional Management Capacity

170. The joint report notably considered that additional capacity for the Health Board was needed in the short term, stating that:

> "In our view additional capacity, ideally from sources external to the Health Board, is needed in the short term to provide the leadership, impetus and fresh perspectives that are necessary. We understand that the Health Board has already made proposals to the Welsh Government in respect of the need for additional capacity, which have been agreed."[129]

171. In response, the Minister for Health and Social Services announced on 27 June 2013 that interim support for the Health Board would be put in place.[130]

172. The Committee welcomes the addition of interim expertise from other Local Health Boards across Wales. However, we are not convinced by the assurances provided by the Director General that this would not detract from the capacity at those organisations lending their senior leaders' time.[131] The Committee notes the Director General's view on the importance of drawing on short term support from within Wales. In evidence, he informed us that:

> "I felt that it was important that NHS Wales, as well as asking Betsi to bring in some internal people, needed to show that

[129] HIW/WAO Joint Report (June 2013), paragraph 43
[130] http://www.walesonline.co.uk/news/health/betsi-cadwaladr-university-health-board-4723226, [accessed 27 June 2013]
[131] RoP, Public Accounts Committee, 18 July 2013, paragraph 856

some of our internal leadership capacity could support an organisation when it needed it."[132]

173. As a Committee, while we appreciate some of the benefits internal NHS Wales capacity can bring, we believe that it is more important that health boards have access to a credible pool of short term additional leadership capacity, rather than relying on internal NHS Wales capacity which can in turn create further challenges for the organisation from which that capacity is drawn.

We recommend that the Welsh Government gives urgent consideration to the creation of a pool of additional short term leadership capacity, for NHS Wales, that can be drawn upon at short notice and does not impact on other NHS Wales Health organisations.

[132] RoP, Public Accounts Committee, 18 July 2013, paragraph 856

Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=7185

9 July 2013	
Geoff Lang	Acting Chief Executive, Betsi Cadwaladr University Health Board
Dr Martin Duerden	Acting Medical Director, Betsi Cadwaladr University Health Board
Angela Hopkins	Director of Nursing, Midwifery and Patient Services, Betsi Cadwaladr University Health Board
Helen Simpson,	Director of Finance, Betsi Cadwaladr University Health Board
18 July 2013	
Merfyn Jones	Outgoing Chairman, Betsi Cadwaladr University Health Board
Dr Lyndon Miles	Outgoing Vice-Chair, Betsi Cadwaladr University Health Board
Grace Lewis-Parry	Director of Governance and Communications and Secretary to the Board, Betsi Cadwaladr University Health Board
Keith McDonogh	Chair of Finance and Performance Committee, Betsi Cadwaladr University Health Board
David Sissling	Director General, Health and Social Services, Welsh Government
Dr Ruth Hussey	Chief Medical Officer, Welsh Government

Martin Sollis	Director of Finance, Welsh Government

List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=7185&Opt=3

Organisation

Joint Letter from Healthcare Inspectorate Wales and the Wales Audit Office to the Chief Executive, BCUHB, 23 May 2013

Written Evidence, Chair Gwynedd Consultants and Specialists Committee, 5 July 2013

Written Evidence, Outgoing Chief Executive, BCUHB, 18 July 2013

Written Evidence, Director of Governance and Communications, BCUHB, 29 July 2013

Written Evidence, Director General Health and Social Services, Welsh Government, 2 August 2013

Written Evidence, Chair of the North West Wales Consultant Group, 11 August 2013

Written Evidence, Director General Health and Social Services, Welsh Government, 2 August 2013

Written Evidence, Outgoing Chief Executive, BCUHB, 12 September 2013

Written Evidence, former Chair, BCUHB, 4 October 2013

Written Evidence, Healthcare Inspectorate Wales, 10 October 2013

Written Evidence, Director General Health and Social Services, Welsh Government, 15 October 2013

Written Evidence, Auditor General for Wales, 31 October 2013