Board Paper 15.5.15

IN COMMITTEE Item 15/105

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Title:	Betsi Cadwaladr University Health Board Targeted Intervention January / February 2015

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Responsible Director:	Trevor Purt

Summary of Key Issues:	Welsh Government (WG) decided in November 2014 to escalate BCUHB to 'targeted intervention' under the NHS Wales Escalation & Intervention Arrangements Protocol. The report on this targeted intervention, conducted by Ann Lloyd, is attached. The Board is asked to note the report and, taking into account any subsequent feedback received from WG, to confirm the next steps including publication arrangements.

Action Required By Board:	**To:** *(please tick all that apply)*	
	Note	√
	Endorse	
	Ratify	
	Approve	

Key Impacts:	*(Please provide a short summary against all that apply)*	
	Corporate Objective	Good governance
	Finance	
	Quality Impact Assessment	
	Standards for Health Services in Wales	Governance, Leadership & Accountability
	Equalities, Diversity & Human Rights	
	Risk & Assurance	Corporate risk CRR20 – governance arrangements

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

BETSI CADWALADR UNIVERSITY HEALTH BOARD

TARGETED INTERVENTION. JANUARY/FEBRUARY 2015.

FINAL.

1. INTRODUCTION.

The Welsh Government decided in November 2014 to escalate BC UHB to "targeted intervention" under the NHS Wales Escalation and Intervention arrangements protocol, March 2014. This decision was based on a discussion between the Welsh Government, the WAO and HIW. The aim of the protocol is to identify potentially serious issues affecting NHS Wales and to ensure that appropriate action is taken. Targeted intervention is action designed to strengthen the capacity and capability of the NHS body to drive improvements.

The reasons for the increased concerns relating to BC UHB were:

- Significant changes in the financial plan for 2014/15 and concerns about the ability of the organisation to deliver a revised plan.
- Significantconcerns around the delivery, safety and quality of the mental health services
- The management and control of capital schemes, capital planning and capital cash control

In addition, concerns were raised about the performance of the organisation against Welsh Government service performance targets.

The aim of the intervention was to provide support to help the Health Board to succeed by ensuring that there was a clear understanding of the challenges they faced, that plans were developed which addressed those concerns with urgency and that the capacity to deliver the necessary action was put into place urgently.The reviewer was as to look at how the organisation made decisions and the capacity and capability of the organisation to deliver its key priorities.

This report outlines the outcome of the first stage of targeted intervention – namely the diagnostic review. The work was undertaken during December 2014 and January 2015 , led by Ann Lloyd CBE, independent advisor, assisted by Margaret Pratt who undertook the forensic financial and governance review. Lesley Law, Welsh Government and Llinos Roberts BCUHB provided invaluable help in tracking down and analysing the necessary documentation. The leaders of the organisation were interviewed in depth during the course of the review and the intervention team is very grateful for those open, frank and illuminating discussions and the information provided. The intervention lead will report to the Chair, Mr. Peter Higson OBEwhose help in facilitating

access to all material information and individuals has been greatly appreciated.
The review covers the following areas:

- An assessment as to why the Boards plans have not been delivered as intended, why the financial situation has deteriorated and an assessment of the financial and performance prospects for 2015/16.
- An assurance review into the new controls in respect of the management of capital schemes
- Governance and controls with specific reference to those that impact on the quality, performance and financial position of the organisation
- An assurance review of the actions being planned and taken to address quality concerns in the mental health services
- The 3 year plan and the operational plans and strategies
- The functioning, scrutiny and decision making processes of the Board
- An assessment of the capacity and capability of the organisations leadership to deliver.

Criteria for de-escalation will be determined at the end of Stage 1. As the aim of the intervention is to support the organisation the reporting line will be to the BC UHB Chair who will be accountable for taking the appropriate action. The DG/CEO NHS Wales will be copied into all correspondence and reports generated by Stage 1 (diagnostic review).

2. FINANCE and control.

   Analysis.

   The organisation has a history of failure to address an escalating cost base – clearly outlined in the independent review undertaken by Alison Lord of Allegra in 2012.

   The IMs over time became increasingly frustrated about their inability to effectively hold the executives to account to gain the necessary assurance due to the absence of quality information. This culminated in the former Finance Director, the Chair of Audit and the Chair of Finance "whistle blowing" their concerns to the Welsh Audit Office in September 2012.

   There was a change of leadership at Board level in 2013/14.

   2014/15 financial plan.

   An incremental approach was adopted to budget setting by rolling forward the 2013/14 budget allocations adjusted for known cost pressures. The budget was based on there being no change in demand for services during the year.

   The Board adopted an outline plan which defined cost improvement proposals to fit the resource envelope of £1.3 bn.

An underlying deficit of £20.2m was brought forward from 2013/14. Cost pressures of £17.8m were identified. Savings targets of £76.3m were identified which included service disinvestments of £33.7m. (It is disappointing to note that a report commissioned from Deloittes, December 2013 into the efficiency of their services which recommended that the organisation could save approximately £107m was never actioned at the time. It is now being used by the new PMO.)
The annual operational plan was adopted in May 2014 and gave assurance about the risks to the achievement of statutory financial duties.
At that time IMs identified the following risks to delivery – the need for disinvestment and in which areas, savings plans representing 73% of the whole had yet to be identified, additional savings could be required as part of the national pay negotiations, the degree to which the CPGs were committed to make the necessary savings, the accountability mechanisms for delivery, that no payback of the overspend covered by the Welsh Government in 2013/14 would be required. They also identified specifically the risk of weak integration between finance, workforce and service planning and the exercising of accountability generally.

It became clear by July 2014 that, despite the assurances in the operational plan, the savings plans required from the CPGs were not being delivered to full effect and additional expenditure on locum and agency staff was required to maintain safe services. No firm plans for significant service disinvestment to deliver £33m had been agreed. The reported position at the July 2014 Finance committee was that planned savings should have been running at £4.1m per month and were in fact at £3.5m; the adverse variance at the end of June was £15.259m with a monthly run rate over allocation of £5m. The forecast deficit for the year was identified at that time as £35m. Causes for concern were the cost of drugs and agency and locum costs. The IMs asked for the timescale and mechanisms for disinvestment and for assurance that the savings would be made.
However at the same Finance committee, it was recognised that the capacity planning tool used was seriously flawed and that a further £17.236m was required to reach tier 1 RTT targets.

The adverse variances against plan identified in July 2014 have continued and the Board has not been able to realise a balanced plan.

A new FD came into post in August 2014.

In December he presented to the Board a suite of additional costs savingsin order the try to mitigate the increasing escalation of the run rate, with a year

end forecast of £76m – less £37m assistance from Welsh Government – leaving a potential year end deficit of £39m. These costs savings were clearly identified in terms of the potential risk of being achieved. The new FD has clearly risk assessed the proposals and reported to the Board those that are of particularly high risk, which at the February confidential Board session,stood at £5.4m of the agreed additional measures. He does not believe that these can be achieved.

Some improvement has been secured through these measures and the increasing grip being exercised through the FD and the new COO, who came into post at the end of September 2014 and via a new PMO which started operating in November 2014. By the end of Month 10 the run rate has reduced to £4.1m over plan (or £1.2 m with WG assistance) and the cumulative deficit stands at £58.6m(or £29.4m with WG assistance). However this picture is skewed because of an adverse variance caused through a WHSSC in month adverse variance of £1.2m in February 2015. The Health Board does not directly control the WHSSC expenditure. It is therefore vital that there should be an improvement in the communication and forecasting between the Health Boards and WHSSC to ensure that there is absolute control and clarity about the performance and financial management of the specialist contracts and the consequences for the bottom line for the individual Health Boards.

The forecast deficit to the end of the year remains at £27.5m This will be a challenging target to achieve. Much hope is being placed in the effectiveness of the PMO to provide assurance and support to deliver the required savings. The organisation acknowledges that it needs to influence provider behaviour in the areas of CHC, GP prescribing and WHSSC commissioning and control. The organisation is also assuming that it does not have to repay the previous year's brokerage.

Cash.
Of considerable concern is the fact that the organisation will run out of cash in March. The gross year end cash shortfall is £33.0m; they will receive additional working capital cash from WG of £6.3m and there are other net changes to forecast which equate to £0.7m.
To overcome the estimated £26m cash shortfall the Board agreed in February 2015 to delay HMRC payments of £11.5m and to delay paying the NHS pensions agency at £9.1m This still left them with a net cash shortfall of £5.4m for which there are no proposals.However this problem has now been resolved by Welsh Government providing the necessary cover. It is important that steps are taken to ensure that such a cash shortfall does not occur again.

Summary.

The financial situation is very serious this year – and the achievability of breakeven in 2015/16 is even more serious and remote. Indeed the prospects for the coming three years are exceptionally difficult. (See the section on the strategy and the three year plan.) The new FD has exercised a grip on the management of money and reports the issues to the Board and the Finance Committee in a clear and concise way but he cannot achieve success alone. He has indicated to the Board and the corporate directors group the very grave difficulties with which they are faced. It is of concern that within the Board there is a sense of inevitability about the results. A question to the Chair would be whether or not he considers that the current Board is able as constituted to make the radical decisions required to balance safe services and resources effectively. It is also of concern that the Chair could not gain sufficient assurance about the performance of the organisation in his first six months to have enabled him to have instituted a recovery programme at an earlier date. There is also a real need to ensure that the executive team and senior staff are very clear about the priorities they need to pursue, priority setting having been seen to be very variable in the recent past.

Much hope and expectation is being invested in the new management team as it comes into post together with the effectiveness of the PMO – but the management of the resources available remains an issue for the whole of the organisation and a radical change in culture and accountability is needed together with a very clear strategy to deliver safe and sustainable services. To date all the action and responsibility seems to be vested in the FD and the COO; action appears not to be regarded as a responsibility for the whole of the executive team (excluding the MD and ND who are wrestling with the safey and sustainability of services). This is neither a desirable nor sustainable position.

The prevalent culture of "bail out" from the Welsh Government must change. Additional money from the Welsh Government should be used to improve health and care systems, not to cover the "bottom line", especially as the CEO considers that there is sufficient resource within the organisation to run the services required for the population; he considers that much of the resource is currently being wasted through duplication and a lack of efficiency.

A summary of the financial review undertaken by Margaret Pratt is found as Appendix A.

Action required.

- As a matter of urgency the Board needs to agree its clinical and service strategy to ensure that the organisation can deliver safe and sustainable cost effective services from within its resource envelope.
- The strategy needs to be underpinned by a sound three year plan which clearly indicates the accountability for delivery and the steps to be taken in financial and service recovery.
- The CEO should ensure that the financial plans presented to the committees and the Board are fully worked up, owned and risk assessed.
- The Board should be firm in declining to adopt financial plans until it is assured that they are fully aligned with agreed strategies and plans – workforce, estates, services etc., are practical, realistic and achievable, are underpinned by agreed and realistic timescales and action plans and are underpinned by risk and sensitivity analyses.
- It is imperative that the Board sets plans for 2015 – 16 that are practical, realistic and achievable. The CEO and his team need to ensure that the financial plans presented to the Board for approval in March 2015 are owned by the service leaders charged with their delivery, are backed by definitive plans for delivery within timescales and metrics for achievement, are subject to a clear accountability framework and a system of effective incentives and sanctions and have been comprehensively risk assessed. They must be underpinned by action plans to manage and mitigate emerging risks.
- The FD is undertaking zero based budgeting for 2015/16. However this approach can only be effective if supported by clear and accurate clinical service, workforce, performance and estates plans. The Board must assure itself that these are in place and are deliverable.
- The CEO and FD should consider the level of reserves to be held for 2015/16, taking into account experience in 2014/15 and the knock on effect of the additional savings required.

3. CONTROL OF CAPITAL SCHEMES and the management of capital schemes and spend.

   Analysis.
   Considerable control problems have been experienced over the management of capital schemes and until the Welsh Government is satisfied that better controls have been instituted then this area will remain the subject of intervention.

In the light of the criticisms and concerns engendered by the lack of controls the Health Board Commissioned Capita to undertake an independent review. Capita reported their conclusions and recommendations to the Corporate Directors group in December 2014. The report is sound and achievable.

The concerns about control have a knock on effect with the Welsh Government approval of capital schemes; capital resource is granted to the Health Board by Welsh Government on the basis of approved business cases; recent business cases have been rejected on the basis that benefits have not been demonstrated.

Action required.

- An action plan for the implementation of the recommendations contained within the Capita report should be developed by the end of March 2015 and responsibility for its implementation is assigned to a relevant corporate director.
- The action plan should set out clear dates and governance arrangements for ensuring the delivery of specific actions.
- Other Health Boards in Wales should review their arrangements against the Capita recommendations to ensure best practice is implemented throughout Wales.
- Relevant training should be given to those staff charged with the development to ensure that business cases in future meet the requirements of the Welsh Government.
- The capital plan should form an integral part of the service plan – any capital bid should clearly be able to show where and how it fits into the strategic direction for the organisation.

Recommendation.
If assurances can be provided by the organisation that they have a worked up an implementation plan for the Capita recommendations and a competent director has been assigned the responsibility to implement and monitor that plan, then the Welsh Government should allow a further six months review to ensure that the agreed action is being taken before lifting the intervention level on this element.

4. PERFORMANCE AND QUALITY.

Analysis.

The performance of the organisation, excluding financial performance, is measured against the 7 domains of the Welsh national framework. The

quality of the service delivery is overseen by the Quality, Safety and Experience committee and performance is overseen by the newly established Finance and Performance committee. The seven domains are:
Staying healthy
Safe care
Effective care
Dignified care
Individual care
Timely care
Our staff and resources.

The Board is also in the process of developing a suite of local indicators – including measures of Nursing quality, other key performance standards, which include "I want great care", PMO efficiency, C section rates, staff turnover, cancelled procedures, follow up waiting list, OOH data, appraisals for medical staff, hand hygiene rates, and contract performance activity.

Intervention was required as there had been a continued deterioration of performance against a number of key performance measures and resulting safety concerns arising from the inability of the Health Board to provide consistent timely access to clinical care, including unscheduled care and planned care. (Meeting WG, WAO, HIW 31st October 2014)

A number of reviews have been undertaken in the past 18 months which have indicated a lack of grip and accountability to deliver the required improvements. Over the past 12 months, the new Nurse Director and Medical Director have made significant efforts to improve the quality of the service provided and the accountability of the clinical staff for the care delivered. Considerable progress has been made by the Nurse Director in resolving the long delays and very poor handling of complaints and concerns within the Health Board. It is of concern that this function has been moved to the Corporate Services Director who is not clinically qualified and who might not be able to exercise the same influence with clinical staff and complainants that the Nurse Director has clearly demonstrated.
The Medical Director has undertaken the RAG rating of all clinical services – it is important that the results of this assessment are included in the 3 year plan, in order of priority for action, to further improve clinical and patient safety risks.

In terms of service improvement the new CEO has set personal targets for the new COO for 2014/15 covering key tier 1 targets:

- Delivery of the stroke pathway

- Delivery of the cancer minimum 62 day wait target
- Delivery of ambulance category A response times
- Delivery of 8 week maximum diagnostic waits
- No over 52 week RTT waiting times.

The COO considers that these targets will be achieved by the end of March 2015.

At December 2014 the organisation remained at escalation level 4 on a number of high priority delivery areas and was showing "red" i.e. a continued failure to improve performance or failure to engage with the national process in the following areas:

- Staying healthy – smoking cessation
- Safe Care – pressure sores/ C. Difficile/ MRSA/ Serious incidents
- Dignified care – postponed procedures
- Timely care – Referral to treatment/diagnostic waits/ emergency departments/ ambulance/ cancer/ stoke
- Use of staff and resources – sickness rates/ appraisals/ finance.

Safe Care: Pressure sores – the preliminary outcomes for Nov 14 indicate a significant rise in the number of hospital acquired pressure sores – and action is being taken; the progress to date has not been as positive as desired. The Nurse Director is monitoring the implementation and effectiveness of the action rigorously.
Safe Care: C. Diff and MRSA - this still remains very difficult to control especially on the Glan Clwyd site – again the Nurse Director is putting considerable energy into ensuring the action being taken is effective.
Safe Care: Serious Incidents – there has been a significant rise in the reporting of serious incidents in Nov 14 – however this might be due to the fact that additional investigating staff have commenced in the past 2 months to both investigate trends and to help the clinical teams with quality improvement.
Dignified care: the numbers of postponed procedures has increased, which might be expected during the winter months because of other pressures – but this is being monitored and managed rigorously by the COO and her staff. However the concern must be the impact of the growing burdens on the elective service to deliver during 2015/16 in the light of increasing delays and numbers. A sound capacity:demand model will need to be used for 2015/16 to ensure that there is absolute clarity about the workload to be delivered to avoid breaches.
Timely care: breaches – the situation is deteriorating with both the 52 week and 36 week performance being behind plan. However the Health Board maintains that it remains on profile to deliver its yearend target of no-one waiting over 52 weeks with outsourcing being a key part of year end delivery – but this needs to be monitored with rigour to ensure that this is achievable and affordable.

Timely care: 4 hour A & E target – this is declining – action is being taken to increase the management grip on this service and also to introduce Primary Care "in reach" in all DGHs – but there is no clarity about how much this will cost and what alteration in the pattern of service delivery and volume will result. This is being combined with effecting reduce lengths of stay. 12 hours waits in A & E have been very variable and have increased significantly over the past year.
Timely care: Cancer within 31 days – it is good to see that although performance has fluctuated considerably over the past 18 months, the target for non urgent cancers is being maintained. However the target for urgent cancers slipped back in December having improved greatly in November.
Timely care: Stroke – although this remained red for bundle 2 there have been significant improvements in performance largely due to the staff redesigning the care pathway. This improvement should be maintained.
Resources: Staff sickness – this remains high and no definitive action to manage and reduce these levels has been agreed. A meeting is shortly being held with the staff side to discuss management of sickness but this is very late in the day.
Summary.
It will take a mammoth effort on behalf of the whole of the executive team to enable the organisation to improve this performance, especially as this is a period of the year that always experiences real pressure. Every effort is being made by the teams to meet the priorities identified by the CEO but a concern is that the knock on effects for 2015/16 will be very difficult to manage. Failure to achieve these targets will have a demoralising effect on the new team.

Action required.

- The Board must assure itself that it has the appropriate demand and capacity models to formulate a firm and reliable plan to manage performance in 2015/16 and that it allocates resources effectively to meet the needs and demands of its population.
- The quality of the information reported to the Board has improved but the Board must continue to seek regular progress reports from named officers accountable for the delivery of the priorities of the Health Board.
- The Board and its subcommittees must also be very clear about what is required to deliver safe and effective services to its population for the future and must be very thorough in its monitoring to ensure that the recommendations from officers are delivering the required results and can be maintained. They must be clear about the resources required to deliver and ensure that they are sufficient and yet do not increase the financial burdens within the organisation. Priority setting is of paramount importance for the Board if it is going to succeed in its task.

- It is essential to ensure that for the three year plan period a structured programme is developed and implemented at pace and with grip to deliver cost effective and safe services and to use every opportunity to close the financial and safety gaps that exists at present. This means that the three year plan must be very clear about the future shape of services and how the Board will engage with the wider staff and public to deliver the changes necessary.
- Referrals and waiting lists need to be thoroughly scrutinised to ensure that they are valid and a soundly based demand/capacity model must be implemented. Associated with this, job plans must be revised and scrutinised to ensure that they fit the requirements of the capacity model and as a matter of urgency a practical and evidenced based workforce plan must be agreed. Staff appraisal rates, which are currently poor, must improve to ensure that staff are developed effectively. Every resource within this organisation must be used to effect an improvement in the quality and sustainability of the services provided and the Board must be prepared to make difficult decisions. Very effective and early communication and engagement with the communities and key stakeholders will be needed.
- The Board needs to be mindful of the April/May "dip" that can result following significant effort to reach year end targets and ensure that this does not occur.
- The performance indicators against which the organisation is held to account are basic – not world class; the performance of the organisation should not only be compared with other part of Wales (and there is a tendency displayed to be part of the "pack") but should seek out the best providers of services and compare their performance with those.

5. Mental Health Services.

   Analysis.
   A number of reports and incidents within adult and older people's mental health services have been produced over the past 2 years. These collectively and individually give rise to very considerable concerns about the quality and safety of care provided in the units.
   Reports from HIW regarding adult services identified a number of areas for improvement in record keeping, basic quality of care, the environment, training and development for staff, medicines management, the range and mix of patients and the clinical relationships which required concentrated and energetic action to be taken to improve and secure the services. Action has

been taken to close those areas where improvement could not be guaranteed.
The RCP was invited in by the Health Board to review the service – their observations complemented the reports of HIW.

An Interim Director of mental health has been seconded into the Health Board for one year from 1st September 2014 to provide leadership and direction to the service. He has brought focus to the services but it is of concern that the Wrexham adult mental health unit has recently been the subject of concerns relating to its HIW spot check.

There is a great deal of work needed to bring the services up to the standard required. The Interim Director produced a report on the improvements made and needed for the Board in March 2015 but this remains to be quantified in terms of the consequences of the actions necessary. It provides evidence of the changes that have been delivered but it is clear that more time and effort will be required to enable this service to reach its maximum potential and probably a change in the design of the whole service is going to be required.

Of concern is the fact that on the measures of performance used in Wales, these services are "green". The evaluation of the quality and safety of mental health services will need more thought in order to enable any issues of concern to be highlighted at an early stage to Health Boards.

Action required.

- The Interim Director must continue to provide a full report against action required arising from the critical reports to provide assurance and direction to the Board and confidence to patients and carers that the services are improving. This should be presented to the March Board meeting.
- To provide this service with the focus and leadership required to make long term sustainable improvements in the quality and design of the mental health services, a top quality team of Director, Medical Director and Nurse Director dedicated solely to mental health services, which could include CAMHS, should beappointed with a proven track record in the delivery of high quality services and the management of change to lead and drive improvements in this service over the next 3 years. (It is noted that an interim director for Primary, community and mental health services has recently been appointed to replace the previous Director who has been moved to manage strategic planning.) The new Mental Health director should be held personally to account by the CEO

– this responsibility should not be delegated. In discussionsthe Health Board directors are unclear in their views about where mental health might sit within their management structure with some believing that its component parts might be split between various service groups. This would be a very insecure move. It hasalso been envisaged that the COO would assume responsibility for the services – this again would be unwise as it could distract the COO from the not inconsiderable task that she has of turning around the culture and performance of the acute and primary care operational elements of the organisation.

- The Board needs to manage its Board cycle to ensure that the improvement in the quality and sustainability of these services is given top priority.
- Alternative measurements of quality and safety need to be included in the Board papers to allow theBoard to obtain more assurance about their mental health services in general. (Copies of suggested measures can be provided if required.)

6. Strategy and the current 3 year plan.
   Analysis.
   The Health Board failed to produce an acceptable 3 year plan for 2014/15; it has worked hard to produce a sound 3 year plan for 2015/16 – the first draft of which was submitted to the Welsh Government for consideration on 31st January 2015. The Health Board went to some length to ensure that this was a credible plan, employing help from Deloittes. Latterly the Director of Primary care, mental health and community has been moved to take up the post of Director of Strategy to strengthen the planning team.
   The plan has not been accepted by the Welsh Government as the Welsh Government considered it to be incomplete with significant work remaining to address current gaps, service, resource and performance challenges. The Government wishes to understand more fully the Health Boards intentions in respect of national and local priorities. The organisation has been asked to prepare a detailed one year operational plan.(Appendix B)

   The Board faces a significant handicap in the absence of an agreed service strategy. It formulated a strategy for North Wales back in 2011 but little action was taken to implement this, largely due to a major public outcry about the suggested actions to be taken. Little action has been taken subsequently to review the strategy to take account of increasing clinical risk and safety issues and the difficult financial position.

The three year plan that has been produced does not clearly describe the changes to the services that are required and the timescale or the shape of the future community services. It is broad in its description of the direction of strategic travel and the action proposed under the enablers that it has identified but it is very light on the actual change in service delivery that will be needed – in particular the description of the primary and community service that should be available, costed to included workforce consequences and change and a description of what in the next 3 years will and will not be provided on hospital sites in order to achieve their vision of "cash out and shift left" (an unfortunate slogan.) Much thought and effort has gone into this plan in respect of visions and aspirations for the future; this work should not be lost but now the hard task of describing exactly what has to happen needs to be delivered. They need to test their plans against their described key design principles of reinvigorating primary care and partnerships and of delivery closer to home.
A questionmustsurround the detail of who has been engaged in developing the strategy and how they have influenced the design of solutions suggested in this plan. If key staff and stakeholders – including communities – have not been involved then there will remain a considerable danger of more mistrust developing and an overreaction which has caused inaction in the past.

The financial summary for the 3 year plan also raises significant concerns. Without a clear and definitive way forward being described, the FD has had to use his best endeavours to develop this. There is a statutory requirement to deliver financial balance year on year but this currently cannot be achieved by the plan. The cost pressures summarised at the end of February 2015 for each year were –

- £66.4m 2015/16
- £30.3m 2016/17 – thus creating a cost pressure of £96.7m
- £32.1m 2017/18 – thus creating a total cost pressure over the 3 years of £128.8m

The pressures include pay inflation, pension changes, non pay inflation, demand and service growth, and include the underlying deficit for 2014/15 of £62.5m offset by additional WG funding of £42.5m.
Plans are being debated by the Board which outline ways in which these challenges are to be managed and overcome.

Action required.

- As a matter of urgency the Board needs to decide upon a clear strategy and the real action that needs to take place to change services over the next three years. The Medical Director has RAG rated the services and action needs to be taken on these results. A clear

practical plan for designing and delivering the future primary care services needs to be developed without delay so that in 12 months' time the next three year plan iteration can have concrete plans for service provision that is safe, sustainable, affordable and meets the needs of the population and that have been developed with users and the clinical staff and relevant stakeholders. It has to be capable of being implemented fully. This is a formidable task but is essential. The detailed explanations of vision are in this three year plan but they need translation and action to implement.

- The Board has had considerable difficulty in making difficult decisions relating to clinical services, but these now need to be pursued and implemented without delay.
- The immediate strengthening of the strategic planning experience within the organisation is needed – with very senior and experienced staff employed to work with the key stakeholders – clinicians, partners and users and the executive team – to plan in detail the changes needed and to bring about their implementation.
- The organisation needs to redefine its communications and engagement strategy to avoid some of the problems that can be encountered by public resistance to service change.

7. Leadership and governance.
   Analysis.
   a) The Board.
      The Board currently consists of 11 independent members, including the Chair, following the model determined for Wales and up to 9 executive or other directors, all of whom are entitled to speak. This is a very large Board, the size of which will have a consequences for the ways in which it can operate. The Board is polite and supportive but, because of the history of the organisation, consistently probe the detail of the information providedin order to receive assurance. I would recommend that the IMs continue to press the executive on issues of strategy and delivery. Thefull range of skills and competencies that might be expected from non executives on health boards is incomplete at present e.g. there is no one with a legal, estates or financial background and no-one thatcomes from a purely commercial background. However the IMs have a sound range of knowledge and have used their individual skills to undertake their responsibilities. Because of the absence of some specialist skills a suite of Board Advisors has been appointed to strengthen the governance arrangements at subcommittee level – in HR and finance and audit. A number of IMs are coming to the end of their terms of office within the next 3 months.

The Board has previously been described as "adding no value to the organisation" (GGI review April 2014) – this is possibly because they have been seen as being distant from the organisation; their actions have not been communicated well. There is now a far more realistic understanding at Board level of the situation in which the organisation finds itself and the difficult decisions that it will have to make. The Board has not been very successful at making difficult decisions, in part because of a lack of the necessary evidence on which to base a decision. This situation is improving. The Board IMs have taken action in the past to draw attention to the position of the organisation and its services e.g. the Audit chair and the Finance chair "blew the whistle" to HIW and the WAO in September 2012 about the deficiencies they perceived that were notbeing addressed by the management.

Those IMs whose appointment preceded the joint WAO/HIW reviews of the governance of the organisation have been severely shaken by the concerns uncovered. They remain very frustrated that they have been unable to obtain the assurance they required from the executives about key performance measuresin the recent past. They continue to question the detail of the evidence presented in order to restore their confidence that they understand fully the problems presented to them and that effective action is being taken to rectify the situation. The situation is improving with the appointment of the new executives in operational and financial management. Additionally,since their appointment, the new Nurse Director and the new Medical Director have instilled confidence into the IMs about their understanding of quality and safety issues within the organisation and that the necessary action to improve the safety and quality of care action is being taken. However the IMs are very aware that they have no strategy for the future shape of services and that much remains to be achieved in improving the quality of services, in service redesign andin stakeholder management. They are cautious in taking decisions to reform clinical services, having been conditioned by past history and the mistrust expressed by the population and the stakeholders about their previous decisions. The Chair and the new Vice Chair have taken on a role to test the status quo and to challenge the delivery of services.

A governance review was undertaken by GGI in April 2014 at the instigation of the new Chair. The headline findings were as follows:

- There has been a clear lack of strategy and agreed measurable objectives

- The response to reviews has been defensive
- The need to demonstrate reduced risk may have had the damaging effect of preventing certain risk issues from being escalated or discussed at the Board
- There has been considerable work put into the development of the quality improvement plan
- Structural concerns persist around the CPG structure
- There is a need to strengthen the contracting process and its governance
- The nature and scale of support on corporate quality and governance to the front line operations needs to be described and delivered
- Engagement with neighbours, support agencies and WG is critical.

Arising from the lack of a strategic direction and measurable objectives the GGI found that:

- The Board was not seen as adding value to the organisation
- Reports and information to the Board are not prioritised and "work arounds" fill the vacuum e.g. departments setting their own objectives and timescales
- Risk management and governance structures "float" within BCU and are not grounded to achieve common goals
- It is difficult for Board members to be assured on the key priorities in a planned and structured way
- Competing issues cannot be prioritised in respect of their impact on the organisation so Board and Committee papers lack focus and are repeated in a number of places. This leads to lengthy and discursive meetings.
- Without a clear strategy with SMART defined corporate objectives the corporate risk register and the Board assurance framework are unconnected to the corporate strategic view of the organisation, a commitment to delivery and an understanding of risks that could compromise the achievement of objectives.

A number of objectives arose from those observations and the quality of the information to the Board has improved. Steps have also been taken to improve and rationalise the subcommittee structure from a system of committees dealing with:

- Quality and safety
- Audit
- Information governance

- Charitable funds
- Remuneration and terms of service
- Mental health act requirements
- Finance
- Workforce and organisational development

to committees dealing with:

- Integrated governance – with finance and performance, quality safety and patient experience and strategy planning and partnerships reporting to it
- Audit
- Mental health act
- Remuneration and terms of service
- Charitable funds.

This new system came into operation in January; the GGI will return to refresh their previous findings in April 2015 so that progress in improving the governance of the organisation can be tracked.

Summary:IMs

In discussion with the existing IMs it is clear that they all perceive there to be an issue with the business and focus of the Board. The Board is polite and although IMs challenge they do not necessarily receive the assurance that they seek. The Chair is particularly exercised by this feature of executive behaviour and constantly pushes for answers and timescales for action. The IMs have had to push hard for answers in the past and this has meant that they have had little scope to develop their strategy and make decisions about the future shape of services. They appreciate that they do not have a workforce plan which matches the quality requirements of the organisation and are unsighted on the best ways in which to redesign services. They need to press the executives for this information. They believe that past clinical modelling has failed, it being too parochial and they believe that external communication is very poor. They describe the organisation as being "very bad at making things happen" and they believe that the executives are forced into a position of firefighting too often. They are frustrated that little has been actioned from externally commissioned reports and recommendations and that there is a lack of progress and purpose within the organisation. They have been worn down by criticisms.

Their confidence has increased with the appointment of the new MD, ND, COO and FD but they will need to continue to test the information provided to them to ensure that the BAF remains clear and accurate and that the quality of the information continues to improve. They will also have to ensure that the executives deliver on the key priorities for the organisation.

The Board has recently made a decision on a change in the services provided in the light of safety concerns but were very exercised about the ways in which this decision might be made and the consequences. The reaction to the

decision they took – and they individually clearly stated in public their view that change had to occur in the interests of the safety of the patients concerned - was mixed, with someinappropriate behaviour being exhibited by some stakeholders. The Board must change its focus for action to drive forward service change and development and to ensure that they can deliver appropriate high quality and sustainable services for the future. This will require stron leadership with courage and determination, very sound communications, a good early warning system and sound evidence from the executive. They have to start operating as a collective enterprise focussed on change; they need to increase the pace at which decisions about changes in services and the delivery of the future model of care are made and be clear about how implementation has to be handled. They need to engage key stakeholders more effectively.

The Board has undertaken a Board development programme over the past year and has reflected on the position in which it finds itself. The members have agreed a suite of "commitments" as a Board to the population they serve – see appendix 2. The future agenda for Board development should be reviewed to ensure that it reflects the current and strategic challenges facing the Board.

b) Executive management and delivery.

The Executive leadership model and style is in the process of change. The previous Chief Executive exercised control via a system of Clinical Programme Groups with a number of directors taking corporate and service responsibility. This appears to have been flawed in terms of accountability.

This model is being scrapped by the new CEO. He wishes to replace it by a matrix model for operational delivery where "the main axis of accountability for line management, service and budgetary performance will be vertically through area teams and secondary care services with horizontal pan Board responsibilities held by clinical divisions assigned to the various teams for standard setting, quality assurance and ensuring consistency of service." Such matrix management can be complex to administer and can obscure responsibility. The Board has asked for assurance on the effectiveness of accountability within this structure. The rationale behind the decision to move standard setting etc. for the clinical services away from the direct control of the MD and ND is not fully understood and again the Board has asked for assurance on this element of management and control.

The 3 new area teams are accountable for the operational management and commissioning of all community health services, the effective engagement of primary care practitioners and for commissioning secondary care services. This is the former England PCT model – and the Board will have to monitor whether or not variations in commissioning practice arise, particularly as they affect secondary care services, to ensure that there are quality standards of equal value across all communities. However the power of the area teams to

innovate and drive improvements in primary and relevant secondary care to lead to a reduction in inequalities and an improvement in quality and value for money is to be welcomed.

The operational model has been consulted upon within the organisation and has been approved by the Board – but it appears that no costings were available for its implementation at the time of agreement.In a paper dated January 2015, the FD estimated that the new management structure would cost an additional £2.06m but the 3 year plan indicates that an additional £5m will be required.The wiring diagram and the scheme of delegation are not yet available but the GGI has commenced this work. The responsibilities of the COO – who heads this complex organisation – are considerable and care will have to be taken that she has the support required to manage these complexities.

The Executives have not yet agreed on a scheme to manage mental health services – my advice in section 5 should be considered before a final decision is made. CAMHS should ideally not be split away from mental health services, particularly as there are a number of problems arising with this service throughout the UK.

Currently, there is no agreed future corporate executive management structure although the Board has received an update on the possibilities. Specifically in a paper dated December 2014 a Director of Primary, mental health and community services is included whose functions will include the strategic direction for primary care and community services, partnership development and integration. However a Director of Strategy is also included to be responsible for overall strategic planning and commissioning. A revised corporate executive structure has the potential for improving control within the organisation whilst reducing the current number of executive directors. Some changes have however been made, which might need to be revisited e.g. the new Director of corporate affairs has recently picked up the portfolio of concerns and complaints and PPI from the Director of Nursing. The ND had improved performance considerably from the time of her appointment and had taken personal responsibility for the reputation of the organisation in proactively managing concerns and taking on the communications role in respect of SIs, inquests etc. The decision to move the responsibility from the ND should be fully risk assessed.

The executive team: conclusions.
The COO has been appointed to apply grip to the organisations performance and delivery; however much of her success will depend on the quality and

capability of the candidates appointed for the 4 new roles within secondary care and the area teams. It is to be hoped that those clinical leaders who have helped develop the organisation are not disaffected by a more managerially driven structure and that their expertise and influence are retained.
The MD and ND have shown sound leadership qualities in the face of considerable adversity. They will have only a dotted line responsibility for clinical standards etc. in the new structure – this is possibly too tenuous a link and could well blur accountability The wiring diagram that is to be produced will be vital in bringing clarity to the situation.
The FD has brought clarity and openness to the reporting of the financial situation and he needs to be able to continue to work in a constructive relationship with his colleague executives to influence the organisation to deliver value for money from its services.
The Director of Primary, community and mental health services has been moved into the post of Strategy director in order to complete the first cut of the 3 year plan and the post of the Corporate director/Board secretary seems to have been split.
The HR and workforce Director needs to refocus his attention to the consequences of the 3 year plan and the work of the area teams to ensure that the plan and subsequent training and development and relevant HR policies are available to ensure staff remain fit for purpose for the future model.

Currently the Executives and Directors meet collectively weekly as the Corporate Directors Group with an informal session weekly to discuss the politics and other all Wales issues that they need to be aware of. The purpose of this group appears confused in terms of whether or not it is a decision making body. This needs clarifying urgently otherwise the confusion will be perpetuated and will militate against corporate responsibility and will undermine the effective governance of the organisation. And if they do not make decisions who does and how do items for decision get channelled to the Board? The executives wish for more responsibility for decision making to be delegated to them by the Board; the Board will need to assure itself that any increased delegation levels are appropriate.
In order to have any chance of succeeding this team needs to be strong, challenging, focussed, contain the right skills to ensure success, be united and well led. It does not yet give the impression that it is a team with some members appearing to opt out of collective responsibility. The executives must at all times be seen to be adding value to the organisation.
Of concern is the fact that the team appears to have resorted over the past year to "buying its way out of trouble" and bringing in consultancies to fill

gaps in the skills set of the team. With a full team in place it should be unnecessary to continue in this way.

The Chair and the CEO.

Chair. The chair has been in post for 16 months. He recognises the very difficult issues that face the Board over the next 2 years. Hepromoted to the Board development session in January 2015 a very long list of issues that would have to be addressed. See appendix C.
He understands very clearly that the Board needs to demonstrate visible and engaged leadership, to increase the pace of change and set a challenging yet achievable agenda.He recognises that the Board needs to be well led, to be decisive and candid, honest and open, to be cohesive and resilient, to scrutinise and support, to be authoritative and decisive and to enhance the reputation of the organisation and its services. He wants to see very clear and active leadership and for the Board to have a compelling vision for the future of care in North Wales underpinned by a map for achievement and action. He appreciates well that the politics have to be handled and he has spent considerable time in talking to and working with key stakeholders to gain a common understanding of the agenda. He wants grip, pace, visibility, honesty and bravery within the organisation. He is very concerned about the lack of creativity within the organisation and considers that the organisation has a rigid, overly bureaucratic and bullying culture. He appreciates and is frustrated by the fact that the three year plan contains no clear vision for the future and that there is no accompanying OD and workforce plan.
He believes that the organisation has not actioned the decisions of the Board adequately enough. He has changed the governance arrangements with the view to ensuring that the subcommittees are able to scrutinisemore effectively – and for this they will need good information and evidence. He considers that the executives find him dogged and challenging. Indeed, from observation, he has to play a major role in challenging at the Board meetings rather than being able at all times to steer the Board to oversee the setting of strategy and direction.

CEO: The CEO joined the organisation from Hywel Dda UHB in June 2014. He presented his analysis of the problems within the organisationto the Board in September 2014 – see appendix D. He set about changing the management structure to getting a better grip on delivery. Although the operational structure is not yet complete and needs clarity in relation to delegation and accountability, the operational structure should improve the control within the

services. He now needs to be as clear about the corporate services directorate structure – and he certainly must strengthen strategic planning within the organisation and its associated clinical and workforce planning. Of concern is that an immediate grip was not exercised on the problems within the organisation (and the lack of accountability) which were clear in the reports to the Board and might have militated the position in which the organisation finds itself at year end.

The solution to the improvement in the reputation and clinical service quality and sustainability does not rest solely on the management structure – which is an important enabler – but on changing the culture of the organisation to one of delivery to its population. The CEO and Chair must be constantlyavailable and accountable within the organisation and with stakeholders, enunciating and leading change for the future. This needs a leadership that is visible, resilient and makes it clear to staff and the communities that services have to change, resources have to be managed well, performance has to improve and what will need to be done to achieve this. In terms of visibility within the organisation,(rather than with key stakeholders) the CEO seems to be required to be absent in Cardiff and other places exercising his representational responsibilities on a frequent basis. His visibility within the organisation needs to improve; this has started to happen through"100 top leaders" meetings but needs to increase significantly. It is important that an agreement is reached with the Chair about the priorities that he should pursue to ensure that he is unencumbered and is able to devote all his time and energy to directly delivering results for the organisation.

Action required.

- The GGI review of the governance of the organisation need to be refreshed to ensure that the necessary action has been taken – which should include a reformed BAF and a sound programme of Board business.

- The Board as part of its risk management and assurance processes ensure that it understands explicitly the consequences of inaction/and or delays on its financial, workforce and service quality/service sustainability, its workforce plan and financial plan.

- An opportunity should be taken to refresh the skills of the IMs on the Board at the next round of appointment and a good induction should be available to them to prepare them for their role.

- The corporate management structure for the Board needs to be completed and costed and the wiring diagram be completed so that accountabilities and delegations can be clear. The Board will need to assure itself that it is confident that the management structure can be effective and that accountabilities are clear and that it will start to change the culture and focus of the organisation. The CEO needs to assure the Board that he has prioritised strengthening the capacity and capability of the executive to deliver and to ensure that the Health Board is fit to deliver.

- An executive management team should be established without delay with a clear framework of delegation.

- The Board needs to determine the criteria against which the effectiveness of the new structure will be held to account; it must also assure itself that the cost of the structure represents good value for money.

- The Chair, CEO and Board need to move with pace to ensure that the Board is able to rely on executive assurances and the operation of the control systems; allowing the Board to focus on the identification, management and mitigation of strategic risk.

- Communications within the organisation and with stakeholders must improve; communities must be engaged effectively in the development and delivery of services. The Board needs to evidence clear and well-argued cases for change that enables the essential decisions on change to be made. The communications plan will need to promote a wider understanding of the interconnected drivers of service risk and the reasons for change including, service quality, workforce productivity and retention, financial impacts.

- As a matter of urgency the Board needs to revise and refresh its 3 year plan and develop it strategy for the future against which to measure development within the organisation.

Ann Lloyd CBE
March 2015.

Appendix A

BCUHB – financial background and context. 2014 – 15.

In the absence of an agreed three year strategic plan, the Health Board set an annual financial plan based on incremental budgeting in 2014 – 15.

Key component of this approach were:

- An assessment of activity and demand based on the HB capacity planning tool.
- Clinical programme groups and departments budgets that recognised cost pressures in key areas e.g. safe staffing, but assumed that all additional postswould be recruited to. Premium costs of locums and agency staff were not budgeted for
- a workforce plan that did not alert the HB to intelligence about potential difficulties in recruiting to fragile specialties. The financial trajectory of recruitment challenge was not recognised.
- Cost improvement programmes to be developed and owned by clinical programme groups.

The Board received assurance that the budget was "tough but achievable" subject to underpinning cost improvement assumptions including £33m disinvestment.

In summer it became apparent that the finance, workforce and capacity assumptions that underpinned the 2014 – 15 budget were fundamentally flawed:

1. Inability to recruit and retain staff led to high levels of unbudgeted premium costs being incurred
2. CPGs were unable to meet their cost improvement targets and live within their means
3. The Board did not pursue plans to disinvest.
4. Specialist services activity was above plan, leading to unbudgeted pressures on the HB plan
5. Capacity plans had to be revised upwards to achieve RTT. To support the achievement of tier 1 targets the Board invested additional money in RTT targets and maintained local services, despite their recognised clinical fragility, by extensive utilisation of locum medical staff. This increased
6. The HBs overspend and exposed services to greater clinical risk as well as further prejudicing the achievement of statutory financial duties.

Appendix B.

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Prif Weithredwr Dros Dro, GIG Cymru

Department for Health and Social Services
Deputy Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Professor Trevor Purt
Betsi Cadwaladr University Health Board
Health Board Headquarters
Ysbyty Gwynedd
Penrhosgarnedd
Bangor
Gwynedd
LL57 2PW

Our Ref: SD/KH

09 March 2015

Dear Trevor

Integrated Medium Term Plan – Feedback Meeting

Thank you to you and your team for meeting with us on 23rd February to discuss some key points arising from our assessment of your draft Integrated Medium Term Plan (IMTP). The purpose of the meeting was to provide constructive feedback on the plan and help you understand what is needed to develop and strengthen it.

This letter is to provide you with a brief outline of our discussion, follow up discussions, and the agreed next steps.

The January submission of your plan was not complete with the key appendices not being submitted. Significant work is required to address the current gaps, service, performance and resources challenges.

Whilst I understand that work is in progress in some areas, our expectation is for you to provide sufficient detail to fully understand what the Health Board intends to do to achieve local and national priorities. This detail allows a comprehensive assessment and the necessary assurances to ensure proposals are deliverable.

It is clear that a number of the proposals contained within your January submission will require engagement and, where appropriate, consultation with your local population before you can set out a three year plan with sufficient detail. This engagement will take longer than the end of March deadline to complete. As has been discussed more recently with you and your team, you will now provide a detailed operational plan for 2015/16, together with

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milestones for the work you will advance over the coming months to develop a robust medium term plan. I will want to work closely with you in the development of your plan and this process started with my discussions with a number of your team on 5th March.

Your March submission will need to be rooted in a needs assessment of your resident population. There needs to be a clear association between this analysis and how your primary care clusters, community, mental health, integrated services and hospital services are being planned.

In your plan there is significant analysis of current position and an emerging clarity of strategic direction, however you need to ensure that this will be transferred into practical actions, particularly for 2015/16. Across all elements of the plan, in particular your service change priorities, you need to demonstrate a timeline of actions and/or interventions that will take the organisation from the current state to the future state with an understanding of impact of interventions (in terms of quality improvements, efficiencies, activity shifts, workforce shifts) and the required resources to enact the steps. Your plan will require adequate time to be built in to plan and implement meaningful engagement and consultation.

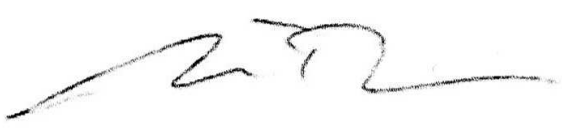
A pathway based approach to planning should be evident and underpinned by robust demand and capacity modelling. I will expect your March submission to demonstrate clear commitment to the delivery of national priority targets such as smoking cessation, HCAIs, unscheduled care targets and RTT.

In addition, I expect to see plans for LHBs, Trusts and support organisations "talking" to each other with alignment demonstrated for example with the WHSCC and WAST plans.

We require your final board approved plan as soon as possible after your March Board meeting but no later than 1 April 2015.

I hope that this accurately captures the key points of our discussion and I am happy to discuss further.

Yours sincerely



Simon Dean

cc.

Martin Sollis, Director of Finance
Dr Ruth Hussey OBE, Chief Medical Officer/Medical Director, NHS Wales
Leighton Phillips, Deputy Director of Strategy and Planning
Andrew Carruthers, Delivery Programme Director

Appendix C

Betsi Cadwaladr University Health Board

In discharging our roles and functions as Board members, we individually and collectively commit to assure ourselves and the population of North Wales that we:-

1. Keep the people of North Wales and their health and wellbeing at the heart of our agenda.
2. Provide a strong vision and clear strategic narrative.
3. Provide and foster a culture of quality improvement and safe, compassionate and confidential person centred care
4. Improve health outcomes, prioritising populations where health is particularly poor.
5. Emphasise the importance of prevention and early intervention in maintaining health, wellbeing and independence.
6. Listen to and learn from the experiences of our patients, their carers and our staff
7. To provide timely access to care throughout the patient journey
8. Act to safeguard the interests, health and wellbeing of the most vulnerable in our society.
9. Use all of our resources effectively to achieve our objectives.
10. Develop our staff to excel by fostering an approach of life-long learning across the Health Board
11. Collaborate and work effectively in partnership with other organisations, individuals and communities
12. Exercise our corporate social responsibilities with due diligence
13. Translate excellence in research and teaching into improvements in population health through innovative and distinctive partnership with academia.
14. Communicate openly and effectively with staff, partner organisations and the public.

Appendix D

List of priorities for BCUHB for 2015/16 devised by the Chair, March 2015

1. Financial management
2. Performance – variability and efficiency
3. Quality, safety and standards
4. 3 year plan – communication plan and briefing – by end of March
   To deliver safe sustainable services that are affordable, to balance, to shift the services to primary care and the community, to tackle health inequalities and improve health
5. Better relationships with other NHS providers and find out where the best value might be for new alliances
6. Dealing with the independent sector and chc
7. Commissioning effectively
8. Joint working with local authorities, police fire and rescue
9. Relationships with the 3rd sector – housing – adding complementary value
10. University links to be developed
11. Engaging effectively with the public and patients
12. "I want great care" roll out – patient feedback and the active management of concerns
13. No more endless action plans – but action instead
14. Demonstrate that this is a learning organisation
15. Demand on unscheduled care – links with ooh and wast
16. Overhaul the mental health services – need a psychosocial model
17. Protect the most vulnerable of the patients
18. Workforce issues and better support for staff – manage agency and locums
19. Ensure that concerns can be raised
20. Dealing with the legacy e.g. Tawel Fan
21. Develop the IT capacity
22. Manage the estates issues
23. Challenge the new management and governance systems.

What the Board needs to do is:-

- Demonstrate visible and engaged leadership
- Increase the pace of change – set a challenging agenda
- Be decisive and determined
- Be candid open and honest – and handle the politics
- Be cohesive and resilient
- Scrutinise and support
- Be authoritative and decisive as a message to the staff and public.

The Board must be active in its leadership. It must develop a compelling vision, underpinned by detail and action.

Appendix E

Points for Anne …. 5 months in!! (from the CEO)

- Change to organisational structure consulted
- Mental health CPG disestablished
- Interim DoMHS appointed
- Board of directors disestablished
- CDG implemented
- New appointments – DOF/COO/DCS/DOS and office manager
- Adverts next week for 3 AD and DOSC
- RDL appointed for team development
- GGI appointed to redesign the wiring diagram of governance and assurance
- Directorate portfolios realigned
- Directors scheme of delegation underway
- New PMO established – weekly performance management meetings with CPGs
- Clarity given on key performance targets
- Clarity on vision and strategy provided
- Deloittes appointed to help the IMTP
- True £ position highlighted to the DG in August 14
- Wider profile with LA/AMs/MPs and staff/partners
- Greater focus on partnership working
- New offices identified for team integration – not a hospital
- 100 feedback given to the Board
- Future hospitals project won
- I want great care rolled out
- Simpler/MBI/ Capita appointed
- Leadership forum established (top 100)

The Past

- No real leadership or clarity in direction
- No vision of how to get there
- Confusion over medical leadership with management
- Competing cultures
- Failed CPG model
- Disempowered executive
- No single medical consultant body for point of contact
- Weak management structure
- Little and variable capacity
- Asset stripped of £6-7m

- No grip
- Confused roles and responsibilities
- Unsupported executive with little power
- Isolationist mentality
- Poor partnership relationships
- Damaged confidence
- Risk averse in taking real issues to decision
- Poor communications and media management

Now

- Can see a step change in Q & S
- Increasing both pace and confidence
- Increasing focus on population growth
- Rolling out locality management with dragonised PBC
- Willing to embrace working differently
- Appetite for change
- Increasingly cohesive board
- In the J curve