Health and Social Services Group
Welsh Government

SPECIAL MEASURES INTERVENTION
Betsi Cadwaladr University Health Board

Llywodraeth Cymru
Welsh Government

INDEPENDENT PLANNING REVIEW – FINAL REPORT

Independent Advisor - Integrated Planning
March 2024

AN INDEPENDENT REVIEW OF INTEGRATED PLANNING IN BETSI CADWALADR UNIVERSITY HEALTH BOARD

INTRODUCTION

1. This is a report of a review of the planning arrangements in Betsi Cadwaladr University Health Board (hereafter, the health board), commissioned in July 2023 by Performance, Escalation and Intervention, Welsh Government. The review was part of the Special Measures escalation which sought:
   - a well-functioning board
   - a clear deliverable plan for 2023-24
   - stronger leadership and engagement
   - improved access, outcomes and experience for citizens
   - a learning and self-improving organisation

METHODOLOGY

2. I was appointed on 17 July 2023. Relevant documents were provided by Welsh Government and also by the health board. Face to face meetings were held in the health board during August and a number of on-line interviews followed in September. At the time of my fieldwork, Independent Members of the board were being recruited and committees were being reconstituted. Therefore, this valuable view of planning was not available, though I was grateful for a detailed interview with the then interim chair of the health board, now the chair.

   While not every individual involved in planning was available, I am confident that the range of interviewees was sufficient to achieve a view of planning across the health board. Details of the interviews held are at Appendix A**.** Concurrent to my review, there were other independent advisors working in the health board, albeit at different stages in their work. My review has benefitted from being connected to them through regular group feedback sessions and several one-to-one discussions.

CONTEXT

3. Familiarity with the health board geography and service profile has been assumed and is not set out here. The significant challenges facing the health board have been publicised widely and there is little value in replicating those contextual aspects in detail here. However, it is noteworthy that in February 2023 Audit Wales produced a report into Board effectiveness. In August 2023 Audit Wales issued the results of a structured assessment into the health board's governance, organisational design, strategic planning and management of financial and other resources.[1] The latter report in particular refers to issues relevant to my review and I have therefore summarised their findings below:

   - the health board's new operating model had the potential to strengthen the organisation but needed to be effectively implemented alongside development of strong and stable leadership. (This model was implemented in 2022 when three integrated health communities (IHC) were set up, combining acute, community and primary care services) alongside a number of pan-North Wales services).

[1] Review of Board Effectiveness 23 February 2023; Structured Assessment 2022 – Betsi Cadwaladr University Health Board www.audit.wales

- improvements in some aspects of strategic planning arrangements, though the health board was still without an approvable Integrated Medium Term Plan (IMTP). Further, the clinical strategy (August 2022) did not have underpinning implementation plans with clear milestones and outcomes.

- planning for the IMTP had improved with clearer programmes of work and some consideration of resource requirements for the plan's first year.

- timeframes for developing plans and strategies were not well aligned – clinical plans needed to set out service models followed by the enabling strategies such as workforce, estate, digital and finance. The health board had adopted the opposite approach.

4. Other points raised by Audit Wales were that engagement with staff on developing the IMTP was limited and there was variability in the extent to which strategies had clear supporting plans and milestones. Various committees of the board had contributed appropriately to the IMTP development (2022-25) and in monitoring its progress. A new format of reporting was being developed though some board members remained frustrated about the clarity of progress reports.

5. In responding to the Audit Wales findings, the health board said that it would be taking stock of its strategic commitments as a part of the revised approach to planning. My review, plus a new internal planning framework, were identified as means for developing the health board's approach further. A review of the vascular service implementation would be used as a tool to support a refined clinical strategy which would become a strategic tool.

DEFINITIONS

6. Early in my fieldwork I learned of the development of *An Integrated Planning Framework* which was agreed by the Board on 28 September 2023. It set out the basis for planning in the health board, including roles, responsibilities and the attributes of good plans. Several key definitions were included:

- Strategic planning – the process of determining an organisation's medium to long term goals and identifying the best approach for achieving them

- Operational Planning – the process of implementing strategic plans including the steps to achievement as well as the resources needed

- Business planning - operates at the service level: reviewing and confirming the activity, capacity and resources for plans that guide day to day delivery. It involves addressing known or emerging trends, plus business continuity planning to maintain critical functions in an emergency or disruption.

SCOPE

7. As noted in the introduction, a clear deliverable plan for 2023-24 is a key focus for the Special Measures process, though planning has an important part to play in achieving the other outcomes. Hence the review has looked at planning as an activity and how it is carried out in the health board. I clarified with interviewees that the context of the review was planning and the implementation of change. The review also looked specifically at how the health board carried out its responsibilities in terms of the IMTP process. This broad scope meant that some specialist areas

were not included at this stage such as civil contingencies, capital planning and commissioning. The review's terms of reference are at Appendix B.

DOCUMENT STRUCTURE

8. The report is presented in sections using a broad governance lens as follows:

Section 1	**Guidance:** summarises relevant planning guidance
Section 2	**Structures:** the entities and devices to support planning
Section 3	**Systems:** organisation-wide arrangements for the IMTP
Section 4	**Processes:** supporting the delivery of planning in general
Section 5	**Performance**: management, risk and accountabilities

Section 6 sets out in a commentary my **findings** under the terms of reference. A set of **recommendations** for future work is included as Section 7. Additional detail is in several appendices, including a glossary at Appendix C.

Section 1 STRATEGIC PLANNING GUIDANCE

National Level Policy and Planning Expectations

9. Policy and planning guidance is published to assist planning. *A Healthier Wales* sets out strategic goals for health and health services and its continued importance has been reaffirmed year on year by the Welsh Government; the latter providing annual guidance on the areas of strategic focus for the IMTP process. There are other national policy frameworks that aim to inform local planning such as the National Clinical Framework. There is also legislation, such as The Well-being of Future Generations (Wales) Act 2015 which places specific requirements for the strategic decisions of public bodies in Wales.

10. The performance management framework for monitoring the progress of plans provides further opportunities to discuss progress. This feedback loop is an important part in guiding and improving strategic planning, for example, the need to ensure that plans are feasible by triangulating proposed activity with financial and workforce resources. IMTPs are expected to have outcome-based plans demonstrating an integration of primary, community and secondary care and also how these connected effectively with social care to achieve improved health and health care at the local level.

11. I interviewed Welsh Government officials who advised that, together with the NHS Executive, they assisted health boards by providing advice and guidance on what is needed to shape plans. I heard about frustrations with the quality and timeliness of the health board's plans, but also a recognition of improvement in the Annual Plan submitted for 2023-24.

Local Strategic Context

12. In 2021 the health board refreshed its ten year strategy*: Living Healthier Staying Well* and it became a "strategic overview". The strategy's key aspects were improving health, care closer to home, serious health needs, mental health, children and young people, health ageing. Underpinning principles going forward were set out, including outcomes for each area and a brief description of the actions needed.

13. All of those interviewed knew of the strategy but questioned its value as a planning aid - it had not been developed further into something more practical that would

guide strategic planning. Most people wanted to see the supporting Clinical Services Strategy developed into an implementable clinical services plan. I was informed that strategic planning also took into account the strategic plans of local authorities and other partners, though some commented that this was under-developed.

Planning and Implementation Approaches and Methodologies

14. Apart from specialist areas such as civil contingency planning and bids for capital, there are no nationally mandated methods for strategic, operational, implementation planning and delivery. However, it was evident from a draft IMTP submission for 2022/23[2], that the health board was committed to a methodological approach and had taken steps to bring together specialist resources to support planning, transformation and improvement. A report to the health board's executive leadership team dated 16 November 2022 provided insights into the rationale for this approach. It referenced recent executive workshops and the learning to date about how projects and programmes were run in the health board.[3] It spoke of consensus around the need to expedite the development of a decision-enabling/delivery support structure to oversee a strategic change portfolio, using an evidence-based approach. A new approach and structure were proposed.

Planning for Improvement

15. Improvement science has been a part of NHS Wales since the turn of the century. It has an evidence base and track record of incremental front line service change using proven tools and techniques. Improvement Cymru is the specialist resource at the national level for improvement and supports organisations in a range of improvement techniques. From experience I was aware that in the past, North Wales health bodies had demonstrated internationally recognised leadership in this field. *The Betsi Way* is a locally produced synopsis of a range of improvement techniques that, together, form the health board's approach to planning for improvement.

Peer Support for Planning

16. Developmental support for strategic planning has been available to health bodies in Wales: planning peer groups meet regularly; there are regular open learning events; and there are opportunities for planners to study at the post-graduate level. It was evident that the health board participated in these arrangements. Several interviewees told me that they had successfully completed the post graduate diploma in strategic planning though this investment had not been evaluated locally.

[2] A 3-year IMTP was submitted but not approved and an annual plan was submitted subsequently.

[3] Application of Axelos Best Management Practice Framework – a paper for information sponsored by the Executive Director of Transformation, Strategic Planning and Commissioning

Section 2: Planning Structures, Roles and Functions

Lead Executive Planning Role

17. Planning is an executive function in health boards in Wales[4] The health board's Integrated Planning Framework summarised the role of the Executive Director of Transformation, Strategic Planning and Commissioning as: the lead for embedding effective integrated planning throughout the organisation, working closely with Board members in respect of the preparation and publication of statutory plans. The role was expected to maintain good relationships with the planning function in Welsh Government and to represent the Board at national level planning networks. Ensuring sufficient capacity, skills and expertise within the Strategic Planning Team was included. (Hereafter, this role is referenced as the Executive Director of Transformation).

18. The Executive Director of Transformation has a clinical background, having taken up a senior health board management role ten years ago. After undertaking a number of senior roles in the health board, he opted to take the current role when the re-organisation was underway in 2022. He did so because he was committed to developing the strategic direction of the health board and implementing it effectively for the benefit of North Wales citizens.
Capital, estates planning, and civil contingencies planning were not in the planning portfolio.

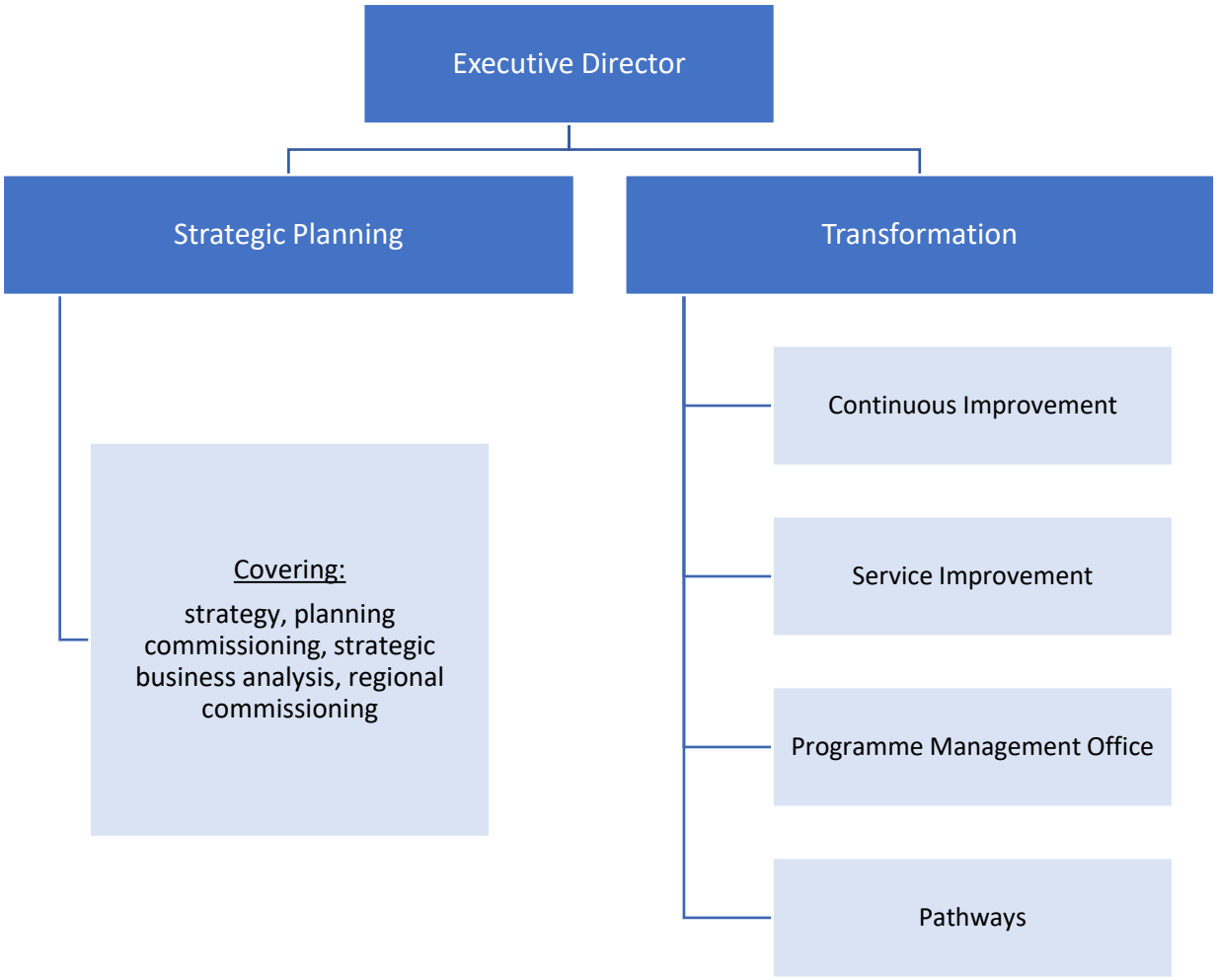
Corporate Level Planning

19. The structure and functions within Transformation, Strategic Planning and Commissioning were formed around 18 months ago. The reason for this approach was to ensure that the organisation had a coherent change portfolio and also to improve programme management using best practice (see paragraph 15).

The functional make-up of the overarching Transformation, Strategic Planning and Commissioning Team is shown overleaf.

[4] Health Board Regulations 2009 include "… [a board] officer responsible for strategic and operational planning". The job description and the summary of executive planning duties (May 2022) was reviewed.

Transformation, Strategic Planning and Commissioning: Teams - July 2023



20. In terms of the staffing, a headcount summary is set out in the following table (with a more detailed table at Appendix D):

Team	Headcount	Notes
Strategic Planning	11	Includes 2 vacancies
Continuous Improvement	14	One post seconded
Service Improvement	6	Includes 3 vacancies
Programme Management Office (PMO)	12	5 vacancies and one secondment
Pathways	18	Includes 4 vacancies, 1 seconded, 3 based elsewhere
Support	5	
TOTAL	**66**	Inc: 14 vacancies, 3 secondments

21. In interviews the members of the **Strategic Planning Team** described their role as being responsible for strategy development, strategic planning and developing the IMTP / Annual Plan. Close support and advice were provided to IHCs, but this was

described as “not being a Planning Business Partner”, though there was an identified experienced senior planner aligned to each IHC. A check and challenge approach was also adopted with planners in IHCs and programmes. The Strategic Planning Team also had experience in business case development either in direct support of, or in quality assurance of others. One member of the team was aligned to partnership working. This was broadly reflected in the role set out in the health board’s developing framework (paragraph 7). It referenced the team as being responsible for the preparation and maintenance of planning resources, training and development opportunities to embed and improve planning skills and competences throughout the organisation.

22. The Strategic Planning Team considered that it could do much more to help all levels of planning but there was insufficient resource. It was reported that there was a need to upskill health board staff on planning. This would improve local plans and also the IMTP process. Other improvements they wanted included: the collective executive ownership of plans; the need to work closely with clinicians; developing a clinical services implementation plan to frame future work; and greater engagement to avoid dislocation from other parts of the health board.

23. Within the transformation arm of the structure, I was informed that the **Improvement Team** focused on:
- continuous improvement - described as enabling the organisation to improve itself through training, coaching and encouragement; and
- service improvement – which was where improvement specialist managers were allocated directly to key initiatives

24. To develop organisational capabilities in improvement, the Improvement Team produced The *Betsi Way* toolkit which aimed to support new and experienced staff in improvement methodologies. The Executive Director of Transformation said that this had been instrumental in increasing the number of staff completing improvement training in the organisation. Training was a growth area; a practitioner course was under development and would add to Improvement Team’s offer.

25. The **PMO** was established in line with best practice and a delivery group had been set up to oversee the programmes within a change portfolio. It was explained that once the strategic direction of the health board was defined fully, this strategy would drive the portfolio. Special Measures had been “a curve ball” into these plans and had subsumed the PMO resources. Even so, delivering the Special Measures programme was seen as a positive test of good programme management because it had high visibility and plenty of opportunities for learning.

26. In terms of **Value Based Healthcare and Pathways**, the team was described as working with priority areas on development of clinical pathways. Pathways practitioners supported the development, improvement, roll out and compliance monitoring of priority end-to end pathways within each network. It was reported as progressing well with some good feedback on the first few finalised. This included supporting the national Value Based Care initiatives, and recently some of that work had been nominated for an award.

Support for Local Planning from the Centre

27. In addition to supporting the development of the IMTP/Annual Plan and other pan-health board activities (paragraph 22), the Strategic Planning Team was expected to support local planning. At the time of my field work, one senior planning post was

vacant which meant that Assistant Director was stepping in to support one of the IHCs. All three individuals supporting the IHCs were experienced planners with extensive knowledge of the health board. At interviews with planners and IHC senior managers, this role was valued and described largely in terms of liaison.

28. In terms of improvement work, the intention was not to lead or support every plan or project, but to provide best practice advice, training, tools and techniques. It was acknowledged that there was still some way to go in terms embedding this. Despite awareness-raising activities among senior leaders, there were still some challenges about how the teams' resources could be accessed. As my fieldwork continued, staff resources from Transformation, Strategic Planning and Commissioning were reallocated to IHCs, networks and specific programmes. This was an action within the Special Measures plan and would result in ten service improvement practitioners (at bands 6 and 7) and seven pathways team members (at band 7) being re-allocated. The Strategic Planning Team was not affected.

29. The arrangements would be governed through a matrix management approach; changes to work allocation being agreed with the Head of Improvement or Head of Pathways who continued to have line management responsibilities. It was evident that there had been significant engagement on this proposition. The Executive Director of Transformation commented that it was important that those who were moving closer to IHCs built up relationships within local leadership teams. Early indications were that this was a positive step and was supported by the staff involved.

30. From documents received which set out the proposals for allocation, the table presented in paragraph 21 would look like this:

Team	Headcount	Re-Assigned	Notes
Continuous Improvement	14	3	One post seconded
Service Improvement	6	6	Includes 3 vacancies
Pathways	18	7	Includes 4 vacancies, 1 seconded, 3 based elsewhere

Challenges for Transformation, Strategic Planning and Commissioning

31. Several key challenges were identified by the teams as:

- members of the Strategic Planning Team commented that they felt strategic planning was not valued in the health board. There were challenges in being able to support strategic plans within limited resources. Clarity on the role and responsibilities of the strategic planners was needed.

- the health board's journey to improve its management of change had led to a lot of initial work to "rip out poor foundations and re-lay them correctly." This type of foundational work had not always been visible and probably had been under-estimated but was drawing to a close. Running the Special Measures programme had helped, in that the whole team was more visible and more learning about managing change would be obtained.

- an organisational culture that expected the improvement teams to "do" transformation even though local ownership was essential. Even so, there were

signs that managers were realising that if the improvements were to stick, staff at the front line had to be empowered to make the changes themselves rather than being “done unto” by another team

- requests for help were often for immediate assistance and it was not always possible to respond at short notice.

32. I was shown communications products about improvement which were of a high standard. It was explained that a lot of time had been spent engaging with people about the work of the teams.

Feedback from others

33. My fieldwork suggested the service valued the Strategic Planning Team which was recognised as being very experienced and helpful. Some senior leaders wanted more of this support outside of the Annual Plan process, valuing the knowledge and challenge that the team brought, especially at critical stages of thinking. They also welcomed the knowledge that this team brought when planning the route through which decisions needed to be made and also in taking responsibility for navigating other corporate functions on their behalf. Building relationships across the IHCs and pan-North Wales services was seen as important going forward, as was the need to have relevant and up to date data from within and outside the health board. These were seen as key aspects of the Strategic Planning Team’s role.

34. Most interviewees associated strategic planning with the IMTP process. It was evident that developing and producing the Annual Plan was perceived as being professionally led and carefully produced, sometimes under difficult circumstances. The use of various templates over the years produced mixed responses. While recognising the need for consistency when gathering information about plans, there had been various formats which had been confusing and difficult to complete. However, one IHC Director reported that the response from the Strategic Planning Team to a request for help with a new template had been timely and very valuable in shaping the local priorities.

35. Feedback on the improvement and pathways arm of the Transformation, Strategic Planning and Commissiong Team was also very positive. The range of specialist skills was appreciated and the helpfulness of staff was commended. People on the receiving end of this help recognised the skillset but also saw the improvement team (with whom they had worked) as quickly getting to grips with the problem; operated with a lot of common sense; and built relationships with front line staff quickly. This resulted in improved groundwork for change within a whole programme even though the improvement input was for a specific period only.

Business Planning at the Service Level

36. In 2022 the health board’s reorganisation led to three IHCs responsible for planning services in an integrated way - across primary, community and secondary care - and with partners. The IHC Directors were accountable to the Chief Operating Officer which is a health board executive position that was filled at the beginning of August 2023.

37. Alongside the IHCs, a number of services were planned and managed on a pan-North Wales basis, for example, mental health services, women and children. Primary care planning was characterised by cluster arrangements and a strategic programme for primary care had been envisaged in the IMTP 2022-23 (and in the

Annual Plan 2022/23). Also, some cross-cutting change initiatives were being managed through strategic programme management.

38. Not every aspect of planning and the supporting structures was looked into as part of this review. Rather, the aim was to understand largely how planning was undertaken and specifically, the 'operational planning entities'. I was able to talk to a representative sample of senior people who were close to these arrangements and who provided their comments. Similarly, I also captured the views of some of those who were involved in these arrangements who were closer to the front line.

Planning Structures – Capacity in IHCs

39. It was reported that there was a huge span of local planning and change work going on at the local level. A business management/support function operated across the IHCs and included day to day business management, performance, accountability processes and planning. The IHCs in the East and West each had a person in this role at a middle management level. It was reported that project co-ordination was limited given the other responsibilities in this business support role. The IHC covering the Central area had benefitted from several years of investment and had a more senior business manager who applied around a third of their time on planning and overseeing projects. There were three other posts in this business function, but it was reported that their capacity to support IHC planning and projects was limited.

40. Notwithstanding these reported constraints, it was evident that some attempts were being made to improve planning and co-ordination. One IHC was undertaking work to understand the capacity required in the business management function which was described as "being at the centre of an ever-expanding universe". A detailed infographic that had been developed for the IHC to illustrate the local change agenda and the way in which this fed into corporate planning processes.

41. Impressively, a stocktake of all the change initiatives had been undertaken and categorised. It was reported that there had been 38 initiatives in urgent and emergency care alone. This validation exercise had been helpful in providing clarity, removing duplication and also identifying where local planning support was needed. Work was in hand locally by this IHC business unit to quantify what was needed. (The author of this work had successfully completed the Post Graduate Planning diploma.) In another IHC, work was underway to bring together several people in project management roles previously in the former acute unit and the former community unit. This would become a dedicated team with planning expertise: one member of the proposed team had undertaken the planning diploma and another was hoping to do so.

42. A senior manager with experience of both the PMO and at programme level considered that the amount of strategic change was so large and important, that the IHCs needed their own PMO-type arrangements. Local senior leaders need to be able "see and feel" the change they were orchestrating; this was a key characteristic of successful change programmes.

Pan-North Wales Planning including Primary Care

43. Pan-north Wales services included women and children, cancer, radiology, pharmacy, dental and mental health. It was reported that in one such service no planning support from the centre had been provided. Another director described the service planning as a three-year rolling plan which was tracked regularly. It had three priorities and essential information was updated on each, such as, what needed to

happen and when, the equipment needed, all costs and workforce forecasts for three financial years. Risks and opportunities were considered, including horizon scanning of longer term impact. There was on-going collaboration on the plan among the team and this was stepped up to align with the IMTP process. Collaboration included linking with local and national stakeholders. Service users were reported as being involved throughout the process.

44. Primary care had a prominent position in the current Annual Plan and was described as a priority. The framing of three strategic objectives was linked to the health board strategy in terms of support and care for people close to the place they call home. A key means for supporting change was described as the cluster arrangements which had benefited in 2022 from development in cluster planning support teams as well as professional collaboration. Going forward, cluster planning would focus on governance models and adopting *The Betsi Way* improvement methodology to support pathway development and service improvement. In terms of addressing the chronic disease backlog, clusters would be supporting a range of programmes and projects.

45. The lead for primary care had joined the health board in early 2023 and said that there was no primary care strategy, but a strategic programme for primary care had been established, though it lacked the components of effective change management. No resources had been available to support a review of the change initiatives underway in primary care or those being planned. This led to external resources carrying out a review. Overall, 200 plans had emerged though few had a definitive plan or were being managed. Around 140 projects were being managed through the cluster arrangements but there was little to suggest they were being evaluated. Helpfully, the Strategic Planning Team had assisted in stripping these back into more feasible plans.

Programme Level Planning

46. It was evident that programmes were used regularly as a means of managing strategic change in the health board. Several interviewees recalled a time relatively recently when a number of strategic programmes were running (this number was described variously as “several”, “a lot”, “10 or 14”). With regard to these programmes a number of themes emerged: unclear governance, lack of accountability and delayed decision-making. Other learning at the time was was that programmes lacked capability in programme management. This had led to the development of the PMO which, it was envisaged, would help to develop and grow programme and project management capacity and capability over time.

47. Nationally mandated programmes for Unscheduled and Emergency Care and also Planned Care were operating. The health board established these programmes and at the time of writing, others were also in existence, such as primary care, CAMHS and mental health. It was reported that the PMO worked with these programmes and carried out a health-check for risk, resource plans, programme boards, the existence of a plan, a benefits plan and to assess if the programme was on track.

Perceptions of Planning from Senior Leaders

48. The work of the Transformation, Strategic Planning and Commissioning Team was recognised as professional, specialist and supportive. People wanted more of it. Other challenges to operational planning were; the lack of an over-arching strategy, in particular a clear plan for the health board’s clinical services; and also an

operating model that did little to break down what was described as “silos within silos”.

49. Specifically about planning in programmes, senior leaders were critical of the lack of demand and capacity modelling. Without this fundamental activity, the solutions being developed might not meet future need and this meant that assurance could not be provided to the Board. Others said it was difficult to obtain basic consistent information to support plans.

50. I heard from interviewees various perceptions on the health board’s approach to programmes along the lines of: lacking a programmatic approach; programmes cutting across service areas without clarity on accountability; and not being “proper programmes”. Also, it was reported that there was no standard documentation and local programmes and projects used different methods. There was a consensus that the two national programmes were now much clearer, with comments such as: the right people were starting to be pulled in and national level programmes were being used for as expert advice. However, it was reported that there was a greater need for empowering those managing change i.e. greater authority to make decisions within programme parameters.

51. Other noteworthy reflections were from several people who said they had previously raised issues about programmes and projects, but the organisation had been critical of what had appeared to be exposing risk and weakness. One person reflected that over recent years the health board had lost a cadre of skilled general managers who were pivotal in planning and leading local change. While they had needed only supplementary help and skills to lead local change, it now appeared that the default position was to recruit a programme or project manager. These were often internal appointments which then had a knock-on effect elsewhere in the organisation.

52. A lot of interviewees talked about planning in the pandemic. The health board’s pandemic response was deemed to have been good with planners being deployed to operational roles. Several people commented that the flexibility and agility during the pandemic was not being taken forward and there was a danger of falling back into more traditional ways of working. One insightful comment was that post-pandemic, it appeared that project management could now be undertaken remotely. I was particularly struck by one interviewee with a planning role at the operational level who said:

> *“Covid had a big impact on our progress, but being part of the vaccination and treatment centres made me feel part of something. Things were done together with a common purpose. I want to ride that wave again.”*

Partnerships

53. It was reported that the importance of partnership working was well understood in the health board, though there was a strong focus on the acute sector. Partnership planning took place at the IHC level. There was a single North Wales Regional Partnership Board, three Public Service Boards and six local authorities. Partnership planning was described as ‘sometimes a bit clunky’ but the need to work with partners as early as possible was recognised.

54. However, there was a lot more needed to improve this and there was a pressing need for the health board to strengthen its governance arrangements in this area. Discussions were expected in the coming weeks. I have seen in revised board committee arrangements were approved on 28 September 2023 and these showed that three advisory groups have been re-established though the Partnership, People and Population Health Committee was yet to be constituted. In light of this, the review did not go into the detail at this stage of how partnership planning was being undertaken.

Support to Planning from Enabling Functions

55. It was reported that shortly IHCs would each have a workforce business partner who would offer advice and feed in relevant workforce planning information. If more specialist workforce planning advice was needed, the workforce business partner would access it from the resources at the centre. It was considered that an important aspect of this business partnering model was the ability to maintain oversight of plans at the local level from a workforce perspective. Applying workforce planning information into plans had been found to make a significant difference in opening up new thinking – especially where planners were looking into historically difficult issues.

56. In the health board's digital function, it was reported that these staff were encouraged to take secondments in order to better understand what the health board needed, thereby improving benefits realisation planning. A Business Relationship Manager role had been adopted and supported IHCs and other structures to work through what they needed and also helped the identify priorities for the digital service. This contrasted with the recent past which was described as lacking collaboration and had a "just do it" approach leading to pet projects being pushed through from leaders on short contracts. Up until recently planning in the health board had been very top-down, but this was perceived as changing - in the last few months there was much more listening and respect. Similar comments about pet projects and 'top-down planning' were made by interviewees from other parts of the health board.

57. From a finance perspective, the *NHS Wales Finance Academi* was cited as an important feature in improving finance skills, including supporting functions to develop sound plans. It had also been useful in developing a talent pipeline and the competences needed to progress in a finance career, particularly in terms of what was expected from a finance business partner role – a role that was reported as being well established in the health board. The *Academi* offered technical skills training but also training in softer skills which were also important when finance business partners were collaborating in multi-disciplinary teams. It was suggested that a similarly supported planning business partner might be useful which would provide synergies with other business partner roles.

58. Public health input into operational planning was valued, particularly in terms of providing localised information on population health. Recently a comprehensive pack of information had been produced to help local planning. An experienced planner who had been seconded from the PMO to public health, said that good feedback had been received on the pack because it provided the rationale for a course of action and "made the story real". The recent transfer of public health staff into the employment of the health board (from Public Health Wales) was seen as a positive step in building capacity to support planning at the local level. It was reported that as a result of individual academic research, comparisons with other

health boards revealed that those with approved IMTPs were enabled to move much more into the population health space; they framed their conversation around their strategy whereas in the health board it seemed always to be about undelivered plans.[5]

Building Planning Capability

59. In the foregoing various capability-building products and actions were mentioned and I have set these out below as a reminder of recent progress to support planning and which had received positive feedback.

The Betsi Way
Prioritisation Process toolkit
Best Practice Workbooks from the PMO
Project management documentation
Reduced bureaucracy for business cases thereby reducing bottlenecks at the executive team level
Access to the Post-graduate Planning Diploma
'Critical friend' help secured via the Special Measures process
A project health check for improvement areas
Improvement Practitioner Training
Business partnering in some areas / Business Relationship Management
More expert resources allocated to the operational and programme level
Successful short interventions and pieces of work to support programmes and preparing frontline staff for change

60. It was interesting to hear of ready suggestions from interviewees on what more would help to build planning capability as follows:

<u>Information for Planning and planners throughout the year</u>

- making data more accessible for problem solving or explaining variance e.g. costing data, waiting list
- demand and capacity modelling information
- providing joined up analysis
- learning and knowledge transfer about what works in planning and delivery
- relevant performance information about plans

<u>Skills for all</u>

- planning and project management basics
- resource allocation in change initiatives
- ensuring quality and safety from a planning perspective
- improvement techniques

<u>Mandated standards and methods ('How we do change round here')</u>

- project management standards / gateways
- a bespoke project management methodology for the health board

[5] The Planning Diploma enables individuals to achieve a Masters qualification – this research was described as an evaluation of the IMTP process in terms of developing and applying effective prevention planning.

- risk management in projects and programme
- how to end projects, planning for evaluation, impact and benefits

Experience and Support

- more support to be available from the Transformation, Strategic Planning and Improvement Team, particularly at the senior IHC level
- forums that supported collaboration
- access to short term help as defined by the plan
- recognition of the value of planning and effective implementation

61. In addition to the practical measures suggested by interviewees in the preceding paragraphs, the following aims were suggested:

- more collaboration on change especially at the Board level thereby ensuring visible collective ownership with a joined up narrative

- to focus on fewer key objectives and to plan and implement these well within a clear strategic direction

- moving away from discussions about the need for programme /project managers to anticipating the skills needed in a process of change

- improving and empowering the governance around programmes and projects such as delegated decision-making in line with the plan

- enabling the Transformation, Strategic Planning and Commissioning Team to build strong relationships across the Health Board

Section 3: IMTP Processes

62. This section is about system-wide planning arrangements and how they operated in the health board. It focusses mainly on the IMTP/Annual Plan which provided the basis for health board planning.

Summary of IMTP Process

63. I learned that IHCs and pan-health board services and others developed plans for inclusion in the IMTP process in line with guidance produced by the Strategic Planning team. The guidance drew together the national priorities and timetable for submitting plans for consideration. Various templates had been used over the years. It was described by many as the route through additional funding was secured. The challenging financial situation had meant that sometimes only a limited amount of investment was possible in the end. Owing to the high number of submissions, it was not always possible for the Strategic Planning Team to provide individual feedback on the plans.

64. From interviews with the Strategic Planning Team, I learned that there had been a lot of changes in recent years with respect to the leadership of the IMTP process. Even so, it was generally thought that the arrangements had been reasonable – guidance was provided each year; support and advice was on hand to help services develop plans which then became the foundation for the IMTP/Annual Plan which the team put together. It was accepted that, like most processes of this nature, there was

room for improvement. The team reported that those services which planned on an ongoing basis did not find the IMTP process difficult.

Current Annual Plan 2023-24

65. Interviewees reported steady improvement in the IMTP process though the 2023-4 planning had been beset by problems at Board level which meant that planned scrutiny by committees did not take place. Also that there had not been substantive executive postholders for workforce or finance. This had made triangulation of the proposed plan very difficult not least because the finance and workforce directorates were facing other significant problems in the directorates. This meant that while the concept of integrated planning was understood, it had proved very difficult to achieve for the current plan. It was also reported that integrated planning for the health board meant the closer integration across primary and secondary care which had been the reason for the reorganisation into IHCs. The protracted roll out of the operating model had impeded progress in this respect.

Developing the Annual Plan for 2024-25

66. The Chief Executive (who at the time of my fieldwork was acting in an interim capacity) told me that having a feasible Annual Plan was very important and she expected that it would be derived from good plans developed at the local level with help and support from specialist teams. (Watching the Board meeting held on 28 September, the timeline for developing the next Annual Plan was discussed and comments made by the Board were agreed to be incorporated into the arrangements going forward – specifically in terms of early engagement with stakeholders.)

67. It was reported by those involved in leading the process that the development of the next Annual Plan was much improved: engagement had started early with IHCs and others; regular meetings were being held. Even so, there was still a long way to go to develop an effective planning system that would feed the IMTP process effectively in the future. The Strategic Planning Team concurred; early engagement with IHCs and other services had taken place and it was evident that IHCs and other services were already thinking through and prioritising what needed to be included. The Strategic Planning Team had also met other health boards with the aim of learning more about their clinical services strategies.

68. While allocated to IHCs, Strategic Planning Team members told me they were not planning business partners. Local plans were being developed at the IHC level and at the centre a prioritisation framework had been developed to help. It was stated that it was important that local plans linked to the priorities rather than simply a means to find new investment which had led to over-promising in the past. Discussions with teams were now about priorities and looking at services differently to see what could be done without additional investment.

69. It was reported that guidance was provided to support local planning (as in previous years) and the Integrated Planning Framework was mentioned as a means of clarifying what local plans needed to include. There had been a session organised on population health from the Public Health Team and included a local profile which had been well received. One IHC Director recounted that support had been provided on developing a plan on a page for services and this was used also to frame on-going discussions with teams in the IHCs and pan-North Wales services.

70. On a fortnightly basis the Strategic Planning Team convened a planning huddle. Attended by a wide range of planners, it had become a forum for open discussion

and information exchange. When feedback on the plan was received from Welsh Government this was included in the huddle, as was general progress on the Annual Plan and any current issues. Also on a fortnightly basis, an oversight group was convened. This was more formal and included the enabling functions where further consideration of financial and workforce aspects were discussed. Risks were also discussed in detail. Terms of reference were being developed for this group, the meetings for which were aligned with regular meetings with Welsh Government on progress.

71. From a finance perspective, it was reported that work was underway to develop early financial assumptions for the 2024/25 Annual Plan and to feed these in to help planning at the local level. Some areas were under review already it was helpful to benchmark assumptions with other health boards in advance of detailed planning. This year there was a much earlier start which was helpful. It was reported that financial templates were ready and finance business partners and others were preparing to work with local teams to assist with savings plans but also for some investment. Although the financial situation was bleak, investment in the right areas was still possible. Senior finance professionals joined the planning huddle and the planning oversight group which were reported as valuable sessions.

72. Those involved in submitting plans provided mixed opinions. Early engagement and regular meetings were acknowledged improvements. However, the consensus was that the whole process felt more like an event rather than part of a continuous, mature planning process. People spoke of “feeding the corporate beast” through a top-down process. The lack of feedback on previous local plans that had been submitted was also noted.

73. There was a perception that the current Annual Plan (2023/4) was focused on outputs rather than on outcomes. Several interviewees said the Annual Plan was not a “reality to staff in the health board”. This contrasted with the plan for Special Measures which was closely monitored and the timescales seemed more realistic. To improve this, it was suggested that more time needed to be spent at the executive level in developing ownership of the plan and communicating this more widely.

Section 4: Planning Processes

74. In this section I have focused on what people found to be a barrier to effective planning and suggestions for improvement i.e. areas to improve capability.

75. There was a theme around fundamentals. People talked about the need for structured collaborative thinking, basic information, standard project planning skills. The Chief Executive talked about staff being curious about how to solve simple problems and being able to produce detailed plans with accurate scheduling and resource allocation. Alongside this, there needed to be effective tracking of changes to plans. The Integrated Planning Framework was considered to be a good start in setting standards for plans.

76. I received feedback across all interviewees that reflected the importance of planning. For some, planning was not the issue, it was delivering plans which was poor. The broad range of reasons was suggestive of different experiences of implementation. Some favoured a structured approach to implementation; others were dismissive of

methodologies such as PRINCE2 citing rigidity and bureaucracy. Flexibility and agility were attributes most cited at interview, together with a plea for reducing the level of reporting on progress.

Strategy into action

77. There was strong consensus on the need for large scale transformation and that this could lead to significant change and disruption. No one I interviewed appeared daunted by this. However, there was a widely held view that strategising in the health board had resulted in only high level overviews and principles. While helpful, they were insufficient to support the next steps required in planning for the future. The consensus was for more detail in either a clinical services strategy or strategic implementation plans which were a priority. Also, most people want to understand 'how it all fitted together' so that they could make sense of it all and could enthuse their teams and colleagues about a realistic future.

Back to Basics

78. A significant number of interviewees offered comments about the need to 'go back to basics'. When probed, these were areas encountered in the early phases of planning, including: problems in obtaining data and information; a lack of understanding of the problem to be solved; and concerns about the level of collective senior commitment to the plan. Some people involved in programmes cited not knowing if a decision had been made or not. There were difficulties in convening the right people from the health board 'in the room' and facilitating good thinking – people were too busy with their day job.

79. One senior leader, new to the health board remarked that the foundations for effective planning and implementation were not there. Frequently in interviews I heard the phrase "planning is everyone's business" yet there was a perceived lack of planning skill across the health board. It was reported several times that despite using the terminology around planning, this often turned out to be at a superficial level of skill and knowledge.

Skills

80. On probing this further, this perceive deficit was described in terms of resource planning, using data, business insights, safety, financial management and improvement techniques. In a discussion within the context of future organisational development within the health board, it was reported that there was a need to ensure that future development programmes equipped senior managers in areas such as planning, programme management and use of data as a core competence. This was being developed but would need investment.

81. Others who commented on this said that operational staff were expected to plan but were very busy and needed time to plan. The improvement approach supported the way that front line staff operated. Having a structured approach to planning was seen by a significant number as helping people to understand quickly what was expected; others thought this could deteriorate into a cut and paste exercise or be a constraint to good thinking. Few were aware of any planning tools in the health board and there were varying views on the effectiveness of prioritisation frameworks, planning templates and completing progress reports. Consensus was largely around planners at the centre being available to help in person at key points in the generation of plans. The postgraduate Planning Diploma was viewed positively as a firm indicator of the value the health board placed on planning.

Outcomes versus Outputs

82. Several interviewees commented that planning in the health board was characterised by outputs when it should be aiming for outcomes. Tangible end products were perceived to be helpful as an indicator of progress, but it was not always clear how or why these products were important enough to be considered milestones. Cynics suggested some gaming of the reporting system was possible by making a straightforward end product into a milestone with a long timescale. Other perspectives were that products were essential building blocks of any change and the health board needed to commission products more clearly. Product-based planning was seen by some as an i Perot ant transferable skill that was an essential part of a quality management process.

Information to support planning

83. I have reported various comments about a lack of data to support planning. I interviewed a former interim Director of Performance who was highly critical of the health board's capability to understand its systems architecture and what it could yield in terms of data for planning and performance. Bringing data together to provide new insights was not seen as a priority and there appeared to be a focus on how the data looked rather than acting on it. Some interviewees commented on a growth in performance measures and dashboards. This gave the impression that data was accessible, but busy managers did not have the time or skill to pull information from these sources.

Costs of Change

84. Programmes and projects did not estimate the effort involved in managing change or collect information on actual effort i.e. as part of resource planning. Very few, if any interviewees talked in these terms despite the availability of staff being cited as one of the chief constraints in developing plans maintaining progress. Processes to help the organisation understand, learn and spread knowledge about the costs of implementing change were not evident.

Valuing Planning and Planners

85. A number of staff considered that planning was not valued in the health board though the support for planning and its contribution to the health board from the Chief Executive was viewed positively. It was suggested by some with longer experience, that hitherto, planning was valued in terms of personalities rather than as a critical function or skillset. This meant that when an individual left, it had a big impact. The visibility of the Strategic Planning Team was mentioned and whether more could be done to raise the profile using the intranet. A member of the Strategic Planning team's support staff explained that this was a planned development.

Section 5: Governance and Oversight

Board Oversight – IMTP and Planning

86. It was reported that up to February 2023, monitoring the health board's plans was by Performance, Finance and Information Governance Committee (hereafter, PFIG) and also the Partnerships, People and Population Health Committee (PPPH). PFIG monitored progress via an integrated performance report which showed progress against outcomes and targets. This report was produced by the Executive Director of Finance and Performance. From documents received, the PPPH took assurance on strategy and planning development from information provided in documents

supported by personal briefings to the committee. The types of plans being considered by the committee also included the work of the enabling functions, such as progress on workforce and digital plans.

87. The events affecting the Board in early 2023 led to very limited oversight by committees owing to a limited number of Independent Members. This position had improved and on 28 September, the Board was advised that five of the seven committees had been re-established. Some changes to committee names and terms of reference were approved. The PFIG Committee had re-started; its planning and performance responsibilities included oversight, delivery and monitoring of financial strategy, planning policies and performance; performance strategies, policies, Welsh Government /local targets and performance reports. This committee was also expected to scrutinise the management of risk.

88. PPPH has become the Planning, Population Health and Partnerships Committee. In terms of planning scrutiny, it was expected to provide advice and assurance on the development of the IMTP/Annual Plan and enabling strategies, including its monitoring and delivery. This committee will also seek assurance on the delivery of enabling strategies, population health improvement, partnership arrangements and risk management. The inaugural meeting of this committee was on 10 January 2024.

89. In June 2023 when the Board was considering the draft plan, it was advised that during 2023-24 the health board's plan would be to seek to stabilise and recover delivery and performance. Performance monitoring and reporting on the progress of the Annual Plan would be developed in light of the Special Measures reporting arrangements. The Transformation, Strategic Planning and Commissioning Team intended to develop a live dashboard view of key information about the Annual Plan. This would provide a single and consistent approach to monitoring and reporting progress on initiatives. The portfolio/PMO would be responsible for this and in an interview, I learned that arrangements were well advanced for transferring this reporting from the Directorate of Finance and Performance. A report to the PFIG Committee on 2 November 2023 stated that: *"…. During the last 6 months the focus in Performance, Planning and Transformation has been upon the monitoring and delivery of our Special Measures agenda. Our reporting tools have been well received and are now being further developed to capture the remaining Annual Plan performance and planning priorities. Collation of Q2 delivery responses is currently being finalised in order to report the Annual Plan Q2 delivery position to the Board in November 2023."*

90. In terms of the current plan, the executives and board monitored this, though the performance reporting had its limits. The Executive Director of Transformation considered that information presented to the Board about the progress of the Annual Plan was reasonable and clear. However, it was noticeable that people engaged well with the information presented on the progress of the Special Measures plans. Greater assurance could be obtained when reports on progress had been reviewed by planning professionals. This was something to be developed going forward, including, for example, being able to provide a three-month forecast, blending progress with risks.

91. An executive told me that they had not been asked to report progress against the plan or any exception reporting, though updates had been provided for the Special Measures Programme. On a day-to-day basis though, the Annual Plan was used to

frame discussions with staff, including the setting of objectives. A senior finance official said that within the context of the performance reporting, monitoring the annual plan had seemed like a bolt-on activity.

Accountability and Performance

92. I was told that a performance and accountability framework was being developed. I was advised that if it was to improve performance, it needed to be implemented properly, have meaningful targets and outcomes and set out accountabilities very clearly. Various interviewees had told me that currently there were numerous leads for services – North Wales leads, IHC leads, pathway leads - it was difficult to know who was accountable.

93. The Integrated Performance Framework was approved by the Board on 28 September. It expected strategic objectives to be cascaded through the Annual Plan thereby informing the objectives for all teams and individuals throughout the organisation. Measurable targets would be set and agreed. In terms of oversight, the framework reflected the board and committees' roles and those of executives. Collectively executive oversight would be through the Executive Delivery Integrated Performance Group.

94. Individually, each executive director was responsible for supporting the development of strategic and organisational plans, including the Annual Plan/IMTP process and in the development and implementation of their own directorate, division and integrated community plan. Directorate performance reviews were key to these arrangements. The Executive Director of Finance and Performance had responsibility to produce the integrated performance report for the Board and for ensuring that plans to address adverse performance were developed and implemented.

95. A key element of the framework was the alignment with the strategic planning cycle. The development of robust plans was affirmed as the vehicle for ensuring a clear focus on delivery and for prioritising resources. Alignment between the Annual Plan and those within directorate teams and individuals demonstrated an integrated approach. A process illustrated how performance issues could be escalated to the board. A staged approach showed the range of increased levels of scrutiny for sub optimal performance. Business intelligence was identified as a key means for developing assurance and provide critical improvement intelligence for leaders. It was stated that this area would be developed as a core organisational functionality. A phased approach was envisaged with the framework being fully operational by April 2024.

Feasibility and Risk

96. It was reported that assessing the feasibility of plans was not embedded in the health board. There were tools available for aligning workforce, activity and finance plans which might be explored. In developing plans for the next IMTP it was suggested that improving the feasibility of plans might be approached by looking at specific issues or themes such as agency costs or productivity. It was suggested that the Transformation, Strategic Planning and Commissioning Team might be well positioned for this type of activity.

97. Risks to the current Annual Plan were reported as: the balance between multiple competing priorities, the ability to deliver against planned financial deficit reduction, recruitment challenges and reputational challenges. In various interviews the

importance and value of risk identification and management in change initiatives (plans) was reaffirmed. Templates to capture plans always included sections on risk and the Planning Oversight Group reviewed these on a regular basis.

98. On 28 September 2023 the Board approved a Risk Management Framework which included how risks should be handled within programmes and projects. Risk registers were expected to be maintained, with escalation into the health board's risk system being at the discretion of the project lead.

Reporting on the Portfolio of Change

99. I was told that the PMO had started by managing and reporting on a small number of projects and programmes. As this portfolio grew, it was overseen collectively by a Portfolio Direction Group of which most executives were members. Just as this group had begun to guide the portfolio, Special Measures had come into play and the group was stood down. The PMO had then taken on the Special Measures Programme and its associated reporting.

100. It was reported that IHCs and clinical networks would continue to report progress on the performance of plans to the existing Performance Delivery Group. Board level oversight of all these arrangements would continue through the relevant board committees. A demonstration of the Special Measures reporting portal was provided. I was told that it was very important to have single version of the truth and the portal supported this. Progress on milestones was reported and tangible evidence of completion was expected such as minutes, letters and plans, which I observed. It was recognised that currently the system focused on outputs, but this would be developed into monitoring outcomes. From its early days, as a support for Special Measures, feedback from the executive had been very positive. Work was in hand to develop it further including pulling in data from other sources in order to provide broader insights.

101. In terms of managing changes and variation, the Chief Executive said that there did not appear to be a change control process for the Annual Plan. I was advised that, where changes to the Special Measures Programme were anticipated, a change control process was overseen by a Special Measures Review Group and I saw examples of this approach in documents.

Section 6: Commentary

102. Planning is about trying to control the future. Implementation is the continuation of planning efforts often within a governed structure that aims to secure the planned benefits. It follows that planning covers a lot of ground: problems to be solved will vary; opportunities may be risky; plans may be strategic and long term or may need an hour-by-hour schedule. Hence, a review such as mine is unlikely to cover all aspects of planning in a large, complex organisation. However, I have concluded that the critical success factors for the health board at this time have been drawn out in the review.

Based on my findings, the health board needs to develop a cohesive and coherent planning system which would need collective planning and ownership at Board level. To assist I have set these out in a table overleaf and the paragraphs thereafter provide further explanation and detail.

103. The key components of the proposed planning system are:

	Key Component	Focus for Planning
A	An **Overarching Strategy** and **Clinical Model**	Sets out the aims and goals of the organisation and the expected outcomes. Drives the planning 'ask' across the organisation. Provides the clinical blueprint for plans to follow.
B	Organisational development that supports and improves the **operating model** in order to meet strategic goals	Characterised by: leadership development programmes that include a focus on managing change effectively; technical upskilling in managing change; governance of change; risk management and planning for quality. Development and promotion of planning as a profession. Facilitation and convening skills essential for engagement with professional groups and multi-disciplinary teams, staff, other stakeholders and partners and the public.
C	Consensus on the **Organisational Approach to planning and delivering change** at corporate and local levels	Standards and approaches, information requirements for tracking and for benefits. Corporate and local planning activity described and supported. Agreed approaches on key inputs such as engagement.
D	Comprehensive **Analyses** and views of the change agenda, including the IMTP	Corporate systems and processes that generate multiple views of the change agenda to provide assurance that strategic benefits will be delivered. Performance views of the change agenda that support effective decision making
E	Support for **change initiatives,** Processes and planning activities at the front line	Standards and levels of detail for projects. Explicit expectations on key dimensions for change such as stakeholder engagement, level of fit with strategic direction. Practical measures to support front line service planning

104. The preceding sections of my report have demonstrated that, despite significant planning activity and good areas of development, key parts of the planning system were under-developed in the health board. There was strong consensus on three contextual deficits that were 'getting in the way' and were essentially barriers to planning activity at all levels, namely the:

- lack of an implementable long-term strategy or a strategic clinical services implementation plan (some called this a clinical model)
- need for some stability, especially in terms of leadership.
- confusing and complex operating model which was difficult to navigate.

105. However, as this commentary section will demonstrate, other aspects of the planning system need improvement. Specific findings associated with the review's Terms of Reference (Appendix A) are addressed in paragraphs 127 to 146 as they relate largely to 'E' in the preceding table.

A - Overarching Strategy / Clinical Model

106. A long term strategy that is owned and understood by staff and stakeholders, is a key building block. It sets the scene for change and provides a common narrative about the future. For planners, it creates the backdrop and mandate for further detailed planning – essentially the blueprint for the future – covering the all important aspects of why things need to change. An agreed strategy drives the planning 'ask'. An organisation undertaking widespread change uses its strategy to deploy its specialist planning and delivery resources to meet its priorities for further detailed planning and implementation.

107. In the health board it was generally accepted that the current strategy/strategic overview lacked sufficient detail to drive effective planning. There were strong support for a strategic clinical services plan or clinical model as an important area for immediate development. Whichever strategic steps are decided upon, strategic planners need to be involved in supporting the Board in the design and development processes. Moreover, this work will provide the guiding principles and direction of travel for planning and benefits realisation. It will need to be planned in detail.

108. Generally, as the longer-term strategy or plan develops, further strategic planning is identified – these may well be pan-organisational programmes about services and/or internal organisational development. Strategic planning at the centre is critical to developing and co-ordinating the sequencing of this work which is likely to require convening and capturing longer-term, high-level thinking from a broad range of contributors including internal and external stakeholders and the public. It often involves the commissioning and consideration of long-term forecasts; the development of options; and significant activity to secure commitment to a new way of working. Strategic planning should be at the heart of synthesising these inputs. At this level, plans are likely to be described in terms of outcomes, expected results and benefits.

109. While the definitions in the health board's integrated planning framework were succinct, a more helpful framing would be that: strategic planning is the on-going organisational process of using available knowledge to document the intended direction. It supports the prioritisation of effort; allocates resources more effectively; aligns staff and stakeholders around the collective goals; and ensures that the goals are underpinned by sound reasoning and good data. These attributes need to form the basis of strategising and strategic planning going forward thereby building trust and confidence in the plans as well as collective ownership.

B - Organisational development that supports and improves the health board's operating model in order to meet strategic goals

110. It was evident from interviewees that the on-going reorganisation lacked the underpinning OD programme to deliver the benefits of the changes. The development of an OD programme will provide a real opportunity to address some of the key areas of skills and competence around planning. It will facilitate and support the organisation's approach to planning, for example, if planning is expected to be everyone's business, it will explain how this will be taken forward on a practical basis. At the leadership level, it will help to develop the roles of senior managers in

planning and delivering change which can be translated into the commissioning of relevant development programmes.

111. A comprehensive OD programme can also support a culture of learning and spread. Planning and implementation activities are valuable case studies, my review found that, with little prompting, those involved in planning were often reflectors and have good ideas about improvements. Good planning practice was apparent in some areas and in a learning environment, can be adapted and/or adopted quickly. An OD programme that focuses on the benefits of learning can expedite improvements in planning and implementation. For example, the reflections of those involved in planning the pandemic would seem to be an important area of learning for the emerging planning communities. Developing a learning culture is an aim of the Special Measures process and capturing the experiences of those involved in managing change and improvement provides a rich source of learning almost immediately.

112. A pre-requisite for effective planning of any kind is that it needs to be able to operate under reasonably 'healthy' conditions. As a concept, organisational health determines an organisation's ability to develop, communicate and follow an agreed strategy by maintaining highly engaged people. Key factors include how teams work towards a common goal, while coping with organisational change. Coincidentally, the health board's Workforce Strategy 2019-22 (on the health board website at the time of my fieldwork) also proposed this model which was defined as an outcome-based approach to defining and measuring the organisation's ability to cope with change and continue to function with a high-performance workplace culture. The outcome areas are illustrated at Appendix E and is included here to show the co-dependency between good planning and organisational strength and energy. It illustrates simply that making planning everyone's business will involve a range of executive inputs.

113. Having an operating model that is clear, efficient and frictionless is a critical success factor in managing change especially on a broad scale and at pace. Using projects and programmes as devices for change has an impact on any operating model in that, to be empowered to make decisions, they become temporary governance structures that cut across existing management accountabilities. Otherwise, they will simply create another level of bureaucracy. This important governance dimension of planning and delivering change needs to be considered alongside the development of the operating model. The feedback from my review was that staff wanted consistency, clarity and empowerment.

114. Planning as an activity connects different parts of an organisation, often requiring a matrix-working approach. It relies on good thinking, critical appraisal skills, specialist expertise and sound knowledge of business processes. Planners and improvement practitioners are sense makers and sense managers who are often dealing with ambiguity. They can be leading or supporting people in and through 'the swirl': those periods in the lifecycle of the change process where there is uncertainty and a need to convene and facilitate good collective thinking to develop a solution or to keep to an agreed path.

115. An OD programme needs to consider these aspects as well as upskilling staff on technical aspects of planning and project management. My review found strong views expressed on a lack of foundational planning and project/programme

management competence. This perceived planning skills gap needs to be examined in detail and training must reflect the standards and organisational approach expected by the board.

C - Organisational Approach to Planning and Delivering Change

116. I heard much about the importance of effective planning, though less about implementation. While the latter may have been implied, it seemed to me that there was a focus on the production of plans with less attention given over to ensuring effective implementation. For some, planning was described as traditional, appearing to operate in a command and control way from the centre, rather than being a creative, exciting and collaborative process.

117. The health board has taken creditable steps in developing its approach to planning and delivering change. Bringing together its specialist practitioners into the Transformation, Strategic Planning and Commissioning teams has shown a strong commitment to effective planning and implementation. My sense is that there is still some way to go for the approach to become 'business as usual'. It appeared to be weighted towards transformation and improvement techniques, though this was probably the result of the timing of my review and the Special Measures process. Nevertheless, it seemed to me that further development was needed in terms of: learning from feedback systematically; securing a clear mandate around the planning approach; and continuing to communicate effectively.

118. The frameworks for planning, performance and risk were under development during my fieldwork and feedback was not available then. However, the Risk Management Framework needs to address change management more clearly. The emerging planning forums might be useful communities to secure feedback to ensure that the intended implementation of the frameworks meet board level expectations.

119. In terms of the contribution of the Transformation, Strategic Planning and Commissioning teams, it was evident that there was still some way to go in embedding the collective 'offer'. In terms of the Strategic Planning Team, there was view that it could do more with more resource. However, the role and purpose of the Team needs to be much clearer. Exploration of the business partnering model might be useful. A strong digital presence and a communications and engagement plan will go a long way in helping people to understand the Team's offer and how to access it, even as it is unfolding.

120. From the interviews I conducted, participants at all levels demonstrated high levels of engagement in strategic planning and implementation. This is an asset going forward and would suggest that people want to be involved further. Interestingly though, areas that were <u>not</u> mentioned by interviewees were: the skills, knowledge, support for partnership working; the centrality of engagement (co-production) and consultation in delivering major change; qualitative/sentiment data and its use in planning; strategy development skills; softer skills training in facilitation and convening; establishing building and leading effecting project and programme teams; and effective project and programme leadership (programme board training). This may be indicative that planners would benefit from greater exposure to a wider range of change management and also that the health board should set out clearly what is expected in change management initiatives. The Integrated Planning Framework was a good first step in laying these foundations.

121. Another observation was that no one mentioned planning tools – the specialist software that underpins scheduling and resource allocation. If there is an expectation that plans have been assessed and modelled e.g. using 'what-if scenarios' staff need the tools to do this. Excel is not suitable for this purpose. Where there is a large change agenda and skills are in short supply, central planning resource such as in Transformation, Strategic Planning and Commissioning, are often a starting place for developing proficiency in this type of software use and knowledge transfer.

D – Comprehensive 'Views' of Plans and their Progress

122. I found a strong consensus about lack of information to support planning. First, the need for relevant data to be available to help solve problems and plan the way forward. Second, the need to be able to track the progress of plans from a range of perspectives, not just whether plans met deadlines.

123. An organisation with a significant change agenda needs to think about the information on which decisions about change will be made and also how it will know that goals are being achieved. Boards need to set out their requirements in this respect and establish the routes through which objective commentary can be secured. The Transformation, Strategic Planning and Commissioning Team has a key role in this respect. An effective planning system has an underpinning information system that provides data on progress and results. This needs to be turned into useful information for guiding individual change initiatives. Where individual plans are consolidated, such as in the Annual Plan, the Board requires assurance and insights into benefits, risks and feasibility of these types of plans.

124. The information and data aspects of a modern planning system not only supports the management of change effectively but provide a solid basis for communication to staff and stakeholders, including the public. This is crucial when the change agenda is likely to require difficult decisions.

E – Supporting change at the front line

125. An effective planning system takes account of the individual building blocks – the activities, products, standards and processes that operate at the frontline. While this is where board expectations are operationalised, it is also where innovation and learning happen. A systematic approach to capturing and spreading these important aspects provides many benefits. They are often the areas that most staff will encounter when they are involved in change. In the following paragraphs, it seemed appropriate to align this part of the proposed planning system with the specific areas in the review's terms of reference.

<u>Mechanisms to support operational planning at the IHC level</u>

126. Arrangements varied for supporting operational planning from the centre. Access to ad hoc advice for IHCs was available through assigned senior planners though one vacant assigned role was being filled by the then Assistant Director who retired during the course of my fieldwork. While this post has been filled on a secondment basis, it was unclear how this important support function to IHCs <u>and</u> pan-North Wales services was being operationalised. More clarity on the role and purpose of these connections is needed. Business partnering or business relationship manager roles have the advantage of clarifying what is being provided; it also establishes parameters for the staff involved and can be a powerful means of creating a development path for less experienced staff.

127. IHCs were in various stages of corralling staff into business support functions of into which planning was included. Their starting points were quite different. The attempt in one IHC to quantify the demand for planning and implementation support was commendable – this is the only way to start to work through capacity requirements i.e. having first audited the existing and planned commitments and estimated the required effort. This needs to become a common practice. In terms of pan-North Wales services and their ability to develop operational plans, further work is needed from the health board. Plans being developed in the current IMTP/Annual Plan process should provide insights into the level of need and could provide the basis for discussion.

128. The regularity of engagement on planning is to be commended – the huddle and the oversight group providing forums for discussion and information exchange. Programmes and projects were used as vehicles for change at the operational level. In terms of the former, there had been action to check their governance and fitness for purpose of some, which was reasonable. *The Betsi Way* provides a helpful way in to understanding what the health board expects in terms of change initiatives though it appears to be aligned more to improvement. Its further development needs to be part of a wider organisational approach to planning and delivery as part of an agreed planning system (as set out in 'C' in the table in paragraph 104).

<u>Corporate functions, partners and IHCs in feeding into planning processes including how these are assessed in the planning framework. Integrated planning in the health board.</u>

129. In terms of the IMTP process which began in 2022, there had been difficulties with the integration of plans. Key directorates lacked executive leadership while also dealing with significant issues. There had been a late start to the financial contribution planning process and the planned scrutiny by the board did not happen. The conditions for good planning did not exist at that time. It was helpful to hear that the learning had been shaped the arrangements for the 2024-25 Annual Plan and that enabling functions, IHCs and pan-North Wales services were involved. There was evidence of an earlier start and a more co-ordinated collaborative process. Workforce and finance professionals were confident that they were aligned and involved appropriately.

130. In terms of assessment, there was evidence that this was happening at the point at which plans were generated. On occasion the Strategic Planning Team was being asked to help shape priorities. A prioritisation toolkit was being used and again, these devices or frameworks need to be tried, reviewed collectively, and refined or adapted. The Planning Oversight group met fortnightly and was valued by the enabling functions. This would be the obvious forum to test any measures for assessing plans or given the importance of overall deliverability, to test alignment/feasibility methods. This would provide an important integrated assurance and advisory mechanism for the Board.

131. Partnership planning did not feature in interviews though partnership working through cluster development and cluster plans seemed to be thriving. The meaningful involvement of partners in planning needs to be included in the development of the planning system, specifically as part of the health board's approach to planning (C – in the table at paragraph 104).

132. In summary, the current Annual Plan (2023-24) for which planning started in 2022 showed signs of being started with the intention of greater collaboration, more

transparency about priorities and financial resources, and triangulation of activity, finance and workforce. The subsequent conditions for developing and agreeing the Annual Plan were difficult and it was not possible to achieve approval. The arrangements for the 2024-25 plan which have been running this year would appear to have a strong collaborative 'no surprises' approach. This should improve the quality of plans which are collated into the Annual Plan and should provide greater assurance to the Board. On the wider and more strategic matter of developing integrated plans across primary and secondary care, it was not surprising to hear little about this given that: there is no clinical model to provide a blueprint for this type of planning; and the underpinning structure to develop plans (IHCs) were still forming. These are key aspects of an effective planning system and need urgent attention.

Current governance arrangements to support integrated planning

133. My comments focus on integrated planning associated with the IMTP process/Annual Plan development. They fall into two parts: first the governing arrangements that shape the plan before review by the board; and second, the formal, committee level and board scrutiny that follows later in the plan development. In light of the problems at board level during 2022/2023, it was difficult to assess the overall governance arrangements. I have therefore focussed on the arrangements for the 2024-25 plan. At the time of my review these were largely in relation to local planning (supported by the centre). The planning oversight group and the planning huddle have been working collaboratively to ensure that plans are fit for purpose for the Annual Plan. Further, the Strategic Planning Team members provide advice and support as required.

134. In line with the Special Measures programme plan, there was work underway to establish the board and its committees together with a Board development programme. Interviews held at the most senior level provided some assurance that, when established fully, there would be significant involvement in setting the strategic direction and standards. The role of the PPHP committee in providing advice and assurance will be pivotal going forward. The board meeting I observed on 28 September 2023, was assuring in that members were engaged in the Annual Plan development process.

135. The IMTP process and Annual Plan have an important strategic and practical purpose. As an assurance device, it seeks to demonstrate to the board and to external stakeholders, the expected delivery of agreed activity, commitments within a financial limit. Not all change undertaken in the health board is included, which is reasonable for the IMTP process but without a comprehensive view of the whole change agenda, the Board does not have its own line of sight on these matters.

136. Why is this important? The Board needs to understand the amount of change that is on-going and planned. It also needs to be satisfied that the amount of change is feasible. The Strategic Planning, Transformation and Commissioning Team should stand ready to provide objective advice on a regular basis in anticipation of these questions. At some point, the Board will want to understand the extent to which the whole change agenda has delivered the outcomes and what learning has been captured and spread. This cannot be achieved through the lens of the areas identified in the Annual Plan.

137. A further reason why it is critical to baseline the change agenda is that it can show more clearly whether there is sufficient capacity in terms of dedicated change

agents. It can also help to identify over-allocation of staff resources. Only a small percentage of the workforce are dedicated change agents, most people who are mobilised into a programme or project have other responsibilities. Over-allocating these people creates risks which can be designed out of plans by effective resource planning around effort and availability. Once the change agenda is captured, thematic views of the can be developed, for example, which aspects of the change portfolio have a digital component or address quality and safety. It can show how different parts of the change agenda connect with others – the joined-up approach that people were asking for.

138. Further, in the context of a health board with serious resource constraints, the Board should be curious about the estimated and actual cost of its proposed change agenda. In understanding a baseline map of change, the Board will be in a better position to govern the future in terms of how change will be supported, commissioned and funded. It should also identify opportunities to achieve economies of scale or for joined up work across supporting functions. These aspects of an effective planning system are covered in C, D and E in the table at paragraph 104.

<u>The capacity and capability for integrated planning capacity for strategic and operational planning</u>

139. Trying to assess whether there is sufficient planning capacity is largely impossible if existing and future plans do not estimate effort. Similarly, where those involved in change initiatives have other commitments, their availability to contribute is critical. Otherwise, plans are built on weak assumptions from which little assurance can be provided. It is also important because it:

- reveals the true level of resource needed for change and avoids the optimism bias.
- improves confidence in delivery at all levels.
- provides transparency and legitimacy to staff and stakeholders for decisions when plans change and resources have to move around to meet new priorities
- demonstrates through data the value of planning and delivery.
- broadens the skill set of planners and implementers – resource planning changes timescales, supports 'what if' modelling, leads to innovative ideas on new ways of working – in my experience it often illustrates that very expensive resources have been factored in to perform basic tasks.
- develops a body of knowledge around programmes and projects and the resources they need to be successful – a key part of a learning culture.

140. During my review, the re-allocation of improvement resources was decided in response to requests for more resource at the operational level to meet the commitments within the Special Measures plan. The responsiveness of the corporate level on this was prompt and demonstrated specialist resource allocation in special circumstances. The development path for a portfolio management approach (November 2022 – see paragraph 15) was reasonable and would serve the requirements of an organisation which seeks transformation while operating in a precarious financial environment. It provides an evidence-based method which is used by organisations that operate a multi-programme/project agenda. It would be reasonable to consider the basis on which specialist resources are governed once the Special Measures process has concluded, for example a network of PMOs linked to the portfolio office might suit the governance arrangements more appropriately.

This would need to be considered in the context of developing the organisational approach to planning.

141. Research is relatively light on the capabilities needed for strategic planning and how to implement it. However, some useful insights were identified and provide valuable perspectives.[6] This research emphasised that strategic planners needed to be positioned to help leaders develop strategies that engaged hearts and minds; that led to energised implementation and sustained results without continual pushing and prodding. Strategic planners were identified as pivotal in supporting leaders and everyone in developing and engaging in the future. Their role was important in demonstrating that strategic planning was not contrived, rather that it was a confident exciting process to help people think well together about the future they want to be part of. My sense is that the health board's strategic planners would want to occupy this space.

142. Returning to the research, strategic planners were described as having a role not only in convening events to capture people's thoughts but in designing and implementing methods to optimise the potential of participants; opening up new possibilities through the effective use of data/intelligence; and using facilitation to bring out new insights. Orthodox strategic planning around productivity, rational approaches, efficiency, stability-seeking and the avoidance of uncertainty were found to send out subtle, conservative messages to do only what appears feasible. Importantly, the research pointed towards high performing organisations having deeply embedded strategic planning competence spread widely across the organisation. This would be a feature of the organisational development aspect of the health board's planning system (B – in the table at paragraph 104).

143. In my report I have drawn out the capability-building products and activities that exist in the health board. They are helpful and valued by the planning and leadership community. I have also included the principal areas suggested in the feedback which could support planning capabilities going forward. They provide a starting point for consideration in developing the planning system going forward. The Executive Director of Transformation has plans for building capabilities centrally and across relevant staff with regard to project, programme management, improvement and pathways. There is a need to pull these together, including the learning from Special Measures, and plan to build planning and implementation capabilities across the health board. Again, this needs to fit within the context of a health board planning system.

Engagement and awareness activities in the planning processes

144. Strong efforts have been made to connect planners and others involved in integrated planning and it is evident that an embryonic planning community has emerged and needs to be developed and supported. However, little was said about engagement with internal and external stakeholders – the people likely to be affected by the change. Planners mentioned some ad hoc activities that would count as engagement, but there was no real evidence of systematic engagement to find new insights that would shape plans on an ongoing basis. Helpfully, the new Integrated Planning Framework alluded to this. Generally, where strategic planning principles require these activities to be included in planning, they generate connections

[6] An appreciative exploration of strategic capacity and the impact of soar in building strategic framework. Malone, Patricia Ritzler 2010

between engagement specialists who can provide planning advice and help/support on approaches. From conversations with the Independent Advisor looking into engagement activity, it was evident that feedback from the health board's engagement teams was that they felt outside of the planning arrangements and wanted to help more.

145. A cross cutting theme of my review has been the need for collaboration and a joined-up approach. This was mentioned by staff who wanted a sense of ownership of plans; the involvement of people, staff and partners in plans that affected them; and also in how the many moving parts of the health board might be connected into a frictionless planning system. The Organisational Health model I referenced in Appendix E might be a useful catalyst for further thinking.

146. In summary, my findings support the need for an effective planning system in the health board (paragraph 104). This needs to cover all aspects of planning, including implementation, benefits realisation and upskilling of the workforce in line with agreed organisational development goals. The underpinning information to support planning and track progress will need to be designed on a collaborative basis. The Board will have a key role in setting the direction on all of these aspects.

147. In terms of the specific terms of reference for my review which I have set out in detail on paragraphs 127 to 146, my findings support the need for planning activity in the health board to be couched within a system, not a linear event to produce the IMTP/Annual Plan (paragraph 104 includes a framework for this). Despite the challenges that existed for planning at the time of my fieldwork, there were some immediate opportunities to influence collective thinking about planning: a new board and a new executive team, learning from Special Measures and the collective independent advisor feedback. The Annual Plan under development provides a further opportunity to learn and understand how plans and planners develop ideas and put them into action.

Section 7: Recommendations

148. The information obtained during the review supported strongly a range of recommended actions that needed urgent attention. These include urgent attention on a clinical services model and ownership by the Board of strategic plans which needed to be joined up. There is a need to focus on improving data and its availability for planning purposes as well as ensuring that systematic engagement with stakeholders is embedded in planning and implementation activity. The need for improvement in communicating plans and learning from change management initiatives will be a key step in developing an effective planning environment. On a practical level, how planning and implementation expertise is organised and deployed to support the health board's endeavours needs to be clarified. These are important areas for the health board to embed if it is to become exceptional at planning and managing change.

149. The areas identified in the previous paragraph are drawn fro m the review and from the commentary in Section 6. They are covered in the following three areas which need immediate action:

a) designing the planning system to support the change agenda.

b) developing an organisational route map showing the key, cross cutting strategic work ahead; and

c) understanding capacity and capability to support the change agenda.

a) An effective planning system

150. I recommend that the health board takes a collaborative approach to designing an effective planning system which is outlined in paragraph 104 and is informed by the commentary in Section 6, the learning from the other independent advisor reports, from the Special Measures process and from engagement with stakeholders. Developing *the Betsi Way* further – taking account of stakeholder views and best practice should result in a strong operating model for planning and implementation which has broad support. This process should lead into the development of standards about how plans are developed. This will build on the planning framework and will underscore the importance of resource planning.

151. Strategic planning at the centre will be pivotal to the strategic and developmental work likely to be needed in the short and medium term. Further clarity on what strategic planning means in the health board and how it expects this activity to be carried out are essential components of an effective planning system. It is unlikely that the level of current resources at the centre will be able to support it. A review will be needed once the route map and planning system design are clearer. The merits of the business partnering might be considered in that work. If *the Betsi Way* is to become business as usual, it needs to embrace wider planning and change management in the round.

b) Organisational route map

152. I recommend that on a collective basis, the health board develops a route map for the next three years showing key organisational milestones, inputs and dependencies. It is likely to be a mix of strategic and tactical plans. The supporting

narrative will focus on why each aspect is needed and will lead to a destination. Network diagrams suit this type of approach. This provides for strategic planners and leaders some of the landscape for the medium term. It will also provide the opportunity to consider the role and purpose of the Strategic Planning Team going forward.

153. The absence of a clinical model was mentioned by those interviewed and it would be reasonable to include this on the route map with a defined date. My sense is that embarking on a new strategy at this stage would be unhelpful and should be included as a milestone, but later. Planning for a new or revised strategy might need to start now and will need to be resourced as there is little capacity at the centre to manage this. The route map should also include the OD programme to underpin the roll out of the operating model.

154. Detailed, resourced plans should be produced to support year 1 milestones. It is important that the route map is a visible artefact among the leadership cadre. The Strategic Planning, Transformation and Commissiong team should be commissioned to convene activities to develop this and to oversee its progress. Its ownership and development could be the subject of regular board development sessions, though its monitoring and implementation needs a focussed and businesslike approach.

c) Understanding capacity and capability to support the change agenda

155. I recommend that the health board takes steps to understand fully the current and future commitments across its entire change agenda and to work through the capacity needed to plan and implement it. This should be in the form of a baseline plan from which the Strategic Planning, Transformation and Commissiong teams can assess feasibility, risk and inter-dependencies. I set out the rationale in paragraphs 136-9.

156. In terms of capability-building I recommend that the health board considers the comments in the review on what planners want for the future and work through how these might be provided (paragraphs 61-62). The planning meetings which the health board is supporting might become valuable communities to generate feedback and co-design some early products.

157. On a broader scale, there is a collective need to improve capabilities around strategic planning and implementation. A proposition should be developed that secures collective agreement on the way forward for strategic planning and implementation in the future and specifically how capability will be developed. The health board is recommended to consider the research included in this review and the Organisational Health Model or similar.

Finally, I should like to extend my thanks to everyone involved in the review: to those who took the time to share their thoughts and ideas with me and to those who made the arrangements for my review. I was particularly impressed by the tenacity and determination to improve the health and health services in North Wales through effective planning and management of change.

Sally Attwood

Appendix A

Interviews and Discussions

Board Level
Chair
Chief Executive
Interim Executive Director of Finance
Executive Director of Transformation, Strategic Planning and Commissioning
Deputy Director, People & OD
Interim Board Secretary
Interim Chief Operating Officer
Transformation, Strategic Planning and Commissioning
Assistant Director, Health Strategy
Director of Transformation
Business analyst - Assistant Director – Strategic and Business Planning Analysis
Head of Strategy and Planning
Head of Strategy and Planning
Planning Manager
Corporate Planning Manager
Planning Support
Programme Manager
Transformation Team
Head of Improvement
Service Level (IHCs and pan-BCU)
Director, IHC West
Director Midwifery and Women's Services
Deputy Director of Integrated Clinical Delivery – Primary Care
Business and Planning Manager
Mental Health Business Manager
Corporate Functional Level Including Programmes
Director of Performance
Assistant Director of Digital Delivery, Strategy and Engagement
Associate Director of Workforce and Operational Planning
Planned Care Programme Director
Director of Finance, Commissioning and Financial Planning
Chief Finance Office & lead on finance for Transformation and Planning
Welsh Government / Other
Planning Programme Director, Health and Social Care, Welsh Government
Director of Finance
Finance Manager, Delivery Unit
Policy Lead, Unscheduled Care
Head of Capital Planning
Independent Advisers
Director of Planning, Public Health Wales

Appendix B

Terms of Reference

INDEPENDENT ASSESSMENT OF INTEGRATED PLANNING APPROACH AND PROCESS - JULY 2023

INTRODUCTION

On the 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board to special measures with immediate effect.

This decision followed the tripartite group of Healthcare Inspectorate Wales, Audit Wales and Welsh Government officials' meetings in November 2022 and January 2023 to specifically discuss concerns about the service delivery, quality and safety of care and organisational effectiveness at Betsi Cadwaladr University Health Board. This decision reflects serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management.

BACKGROUND

Betsi Cadwaladr University Health Board (BCUHB) does not have an approved organisational plan in line with its statutory duty under the Finance (Wales) Act 2014 as the Health Board was not able to submit an Integrated Medium Term Plan (IMTP) for 2023-2026 that could break even over a rolling three-year period. BCUHB has never had an approved IMTP.

The special measures framework for March-December 2023, approved by the BCUHB Board on 25 May, outlines the areas of focus. This includes arranging an independent assessment of its integrated planning arrangements.

AIMS AND OBJECTIVES

The aims are:

- To provide an assessment of integrated planning capacity and capability within BCUHB in terms of strategic, partnership and operational planning.
- To assess the organisation's approach to developing their IMTP and the associated decision-making mechanisms.
- To support the development and implementation of a local, integrated planning framework incorporating strategy and planning (internally across the organisation and externally with partners).

The objectives are to:

- Undertake a rapid assessment of integrated planning.
- Assess capacity and capability within Betsi Cadwaladr UHB in terms of strategic, tactical, and operational planning.

a. What mechanisms are in place to support operational planning at an IHC level?
b. How do the corporate functions, partners and IHC's feed into planning processes?
c. How are all the various functions considered and assessed in the planning framework?

d. Do the current strategic governance arrangements (from ward to Board) support integrated planning?

This will include reviewing the following areas:

- An assessment of whether the health board has access to sufficient integrated planning capacity and capability for strategic and operational planning.
- How does integrated planning in BCUHB operate?
- How aware and engaged are the different functions across the Board in the process?
- How effective are the arrangements in place?

The independent assessment will also:

- Clearly define areas of support and improvement.
- Support the development of a maturity matrix.
- Make recommendations to implement robust processes, structures and reporting arrangements for the development of an integrated planning system and annual plans / IMTPs.

Whilst capital planning and emergency planning are not integral to this review, these functions need to be considered as part of the overall process.

The assessment will carry out, but not be limited to the following actions:

- Review of documentation.
- Review of governance arrangements.
- Interviews with key staff (internal) (to be identified).
- Interviews with key stakeholders, including Welsh Government officials (external)
- Review of current 2023/24 Annual Plan development and implementation process.

In response to the planning interventions, the health board will be expected to:

1. Ensure that Planning and Transformation is embedded within the governance structure for Special Measures.
2. Review and agree a planning maturity matrix through which the organisation can assess themselves against to identify the steps required to develop the planning processes.
3. Implement the recommendations of the assessment exercise, demonstrate the actions being taken and the improvements made.
4. Put steps in place to the support the development of an IMTP/Annual Plan for 2024/25.

The planning interventions should be read in conjunction with Special Measures actions highlighted in the special measures framework for March-December 2023 which is attached in the related documents section.

TIMESCALE FOR COMPLETION

It is anticipated that the assessment will take place over a four-week period, commencing in July 2023.

KEY PERSONNEL

- The review will be led by Sally Attwood, Independent Advisor for Planning and Transformation.
- The nominated health board contact for this review will be Chris Stockport, Executive Director of Transformation and Strategic Planning.
- The Welsh Government nominated contacts will be Olivia Shorrocks, Deputy Director, Performance and Escalation and Samia Edmonds, Planning Programme Director.

Appendix C

GLOSSARY

Agile	A method of project management that used for software development. It is characterised by the division of tasks into short phases of work with frequent reassessment and adaptation of plans.
Betsi Way	An Improvement Methodology Toolkit developed by the Continuous Improvement Team
Business Partner	Work closely with line managers to build their capacity in a specialist area (such as HR), plan and manage talent and develop approaches that achieve shared organisational objectives
Business Relationship Manager	Acts as the liaison between the organisation and a selected internal customer group to understand operational and developmental needs of the business.
Change Control	A means to identify, document and authorise changes to a project.
Continuous Improvement	An on-going effort to improve projects, services or processes – often seeking incremental improvements over time
Finance Academi	A collaborative, support network and skills-enhancing entity aimed at embedding best practice in NHS finance professionals in Wales www.financeacademy.nhs.wales
Generative Governance (Schulz, M)	A mode of board governance (distinct from fiduciary or strategic) where the board applies a robust deliberative process and plays a key role in the framing of issues and the development of strategic options and plan – involvement in strategic planning is sooner rather than later. Requires different thinking, capacity and capability.
Integrated Planning	An approach that is characterised by be effective and timely collaboration in preparing service, workforce and financial plans.
Milestone	A significant stage or event in the development of something. In projects milestones are usually limited to an important point which, when reached, provides a green light to the project sponsor that objectives are being met (or decision can be made)
Operating Model	The structures and processes to organise and manage the business
Portfolio Management	The selection, prioritisation and control of an organisation's programmes and projects in line with strategic objectives and capacity to deliver.
Programme Management	The process of managing several related projects often to improve performance. Programme managers are concerned with the aggregate outcomes of the programme.
Project Management	A process to deliver an end result within an agreed timeframe, cost and quality.
Project Management Office	PMO: A group or department that defines and maintains standards for project management
Project Office	Focuses on a single specific project or group of projects usually starting from the design and implementation phases.

Service Improvement	A framework for developing, testing and implementing changes leading to improvement.
SMART	A mnemonic for shaping performance goals: specific, measurable, achievable, relevant and timely. Largely used for individual performance development
Targeted Intervention	A process to make sustainable changes and improvements underpinned by a maturity matrix
Value Based Health Care	Aims to improve the health outcomes of the people in Wales in a financially sustainable way. www.vbhc.nhs.wales

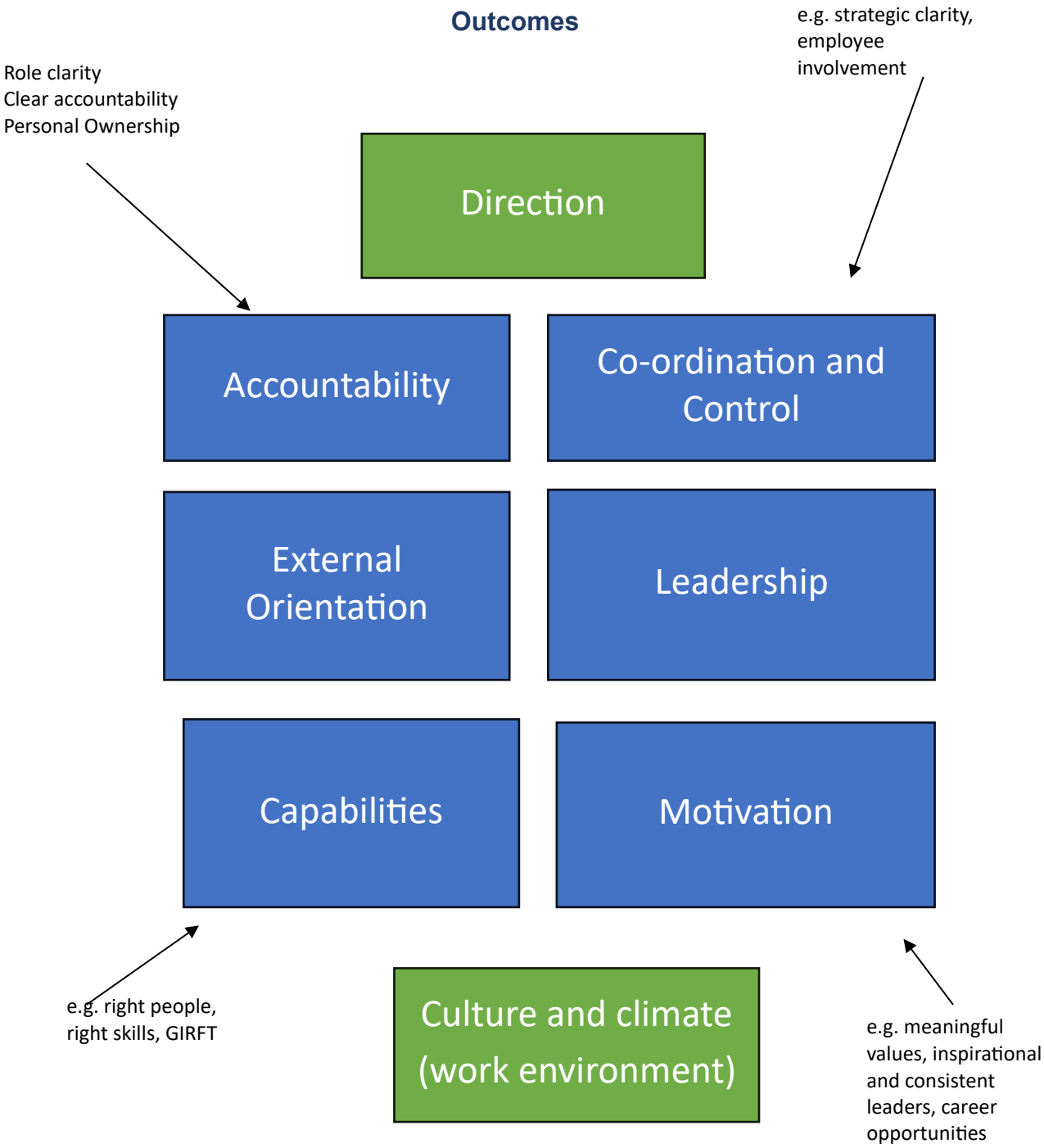
Appendix D

TRANSFORMATION, STRATEGIC PLANNING & COMMISSIONING HEADCOUNT - July 2023

Strategic Planning	Asst Director Strategic Planning	1	
	Asst Director Strategic & Business Analysis	1	
	Head of Strategic Planning	3	one post vacant
	Strategic Planning Manager	1	
	Strategic and Business Analysis	1	vacant
	Planning Manager - Business Cases	1	
	Corporate Planning Manager	1	
	Regional Commissioning	1	Partnership post
	Support	1	
	Sub total	11	includes 2 vacancies
Transformation Improvement (continuous improvement and service improvement)	Director of Transformation & Improvement	1	
	Head of Improvement	1	
	Head of Continuous Improvement	1	
	Service Improvement Lead	1	
	Service Improvement Manager	8	
	Service Improvement Facilitator	2	1 post seconded
PMO	Head	1	Vacant
	Programme Manager	3	All on secondment
	Portfolio Office senior manager	1	
	Portfolio Office Manager	2	
	Centre of Excellence Lead	1	vacant
	Centre of Excellence Managers	3	All vacant
	CAMHS Project Manager	1	
Pathways	Head of VBC & Pathways	1	
	Clinical Editor	2	I vacancy
	Pathways Lead	1	
	Pathways Practitioner	7	1 vacancy, 1 secondment
	Pathways Programme Manager	1	
	Benefits Lead	1	
	VBC Programme Manager	1	vacant
	VBC specialist	1	vacant
Innovation	Head of Innovation and Analytics	1	
	Senior Analysts	2	
	Strategic Analysts	3	all vacant
	Sustainable Transformation Officers	3	See Note B
Support	Business Manager	1	
	Business Support Manager	1	
	Administrator	1	
	PA& Project Support	2	
	Sub total	55	12 vacancies
TRANSFORMATION, STRATEGY & PLANNING TOTAL		**66**	Inc: 14 vacancies, 3 secondments

Organisational Health Model[7]

Outcomes



[7] McKinsey – Beyond Performance – The hidden value of organisational health and how to capture it *Aaron De Smet, Bill Schaninger, Matthew Smith*