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Canolfan Polisi Cyhoeddus Cymru

Supporting improvement in health boards

Report

Craig Johnson

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- Some local health boards in Wales have struggled over several years to deliver satisfactory health services within their existing resources, with one health board in special measures and others receiving additional funding from Welsh Government.
- This report synthesises expert academic and practitioner knowledge about what is effective in supporting improvement in health boards.
- There are many drivers of performance in health boards: (lack of) funding; organisational size; geography; legacy costs from previous projects; or issues relating to the local health economy.
- Leadership is vital to an organisation's success. However, if an organisation is struggling, just replacing the leader is unlikely to be an effective solution. Only by understanding the full nature of the problem is a proposed solution likely to be successful.
- Organisations that are open to criticism and peer challenge may be more successful. This does not necessarily require an external investigator, but a change in general culture can foster improvement.
- Empowering the whole system is important to improve a health board. Without a successful middle management structure, any efforts at improvement may get 'stuck'.
- Evidence also suggests that increasing the number and quality of staff involved in service delivery can improve an organisation's performance. Structures should also strengthen connections between them and the leadership.
- The role of Welsh Government will differ depending on each individual context, but they have had success previously in pursuing more direct and substantial interventions, and this should remain an option. Where this intervention is adopted, there should be a whole system approach, explicit objectives and timescales, clarity about accountability, and a clear exit strategy.
- As part of this project we sought to capture and reflect the views of Welsh Government It would be valuable to extend this to include the perspectives of those leading local health boards in order to take account of their concerns relating to performance, its root causes, and how interventions can best support them.

Introduction

A King's Fund report (Appleby and Thompson, 2014) found that the NHS across Wales 'faces a very difficult time not just at present but over the next half decade. In the absence of a significant financial boost over the next few years, improving productivity and the value that every health care pound can buy has to be the main policy response'. Modelling by the Health Foundation (Watt and Roberts, 2016) suggests that achieving long term fiscal sustainability in the NHS is realistic, so long as steps are taken by NHS leaders and Welsh Government to address key risks and pressures. This is not a specifically Welsh problem: a recent National Audit Office (2019) report suggested that the announced £20.5 billion funding boost for the NHS in England might not be enough to meet the needs of the changing population.

In this context, some local health boards in Wales have struggled over several years to deliver satisfactory health services within their existing resources, with one health board in special measures and others receiving additional funding from Welsh Government. The former First Minister and the Cabinet Secretary for Health and Social Services asked the Wales Centre for Public Policy to examine the evidence about how governments can support improvement in health organisations, with a particular focus on what can done beyond merely providing additional resources or replacing the leadership of organisations. Understanding how to intervene effectively is salient to the practices of both policymakers and health service leaders, and of wider interest to the communities that health organisations serve.

In October 2018, we hosted a roundtable with senior Welsh Government officials, the then special adviser for health and five experts in health and social services from England and Wales. The event explored the causes of underperformance in health organisations and the role that the Welsh Government can play in supporting improvement. This report brings together the key messages from the event and a review of the academic research and evidence. To facilitate open and honest discussion, the roundtable was conducted under the Chatham House rule. Contributions by participants are presented in this report in a non-attributable fashion.

Local health board performance

There are three broad ways to understand underperformance. The first is in terms of health service delivery, focusing on issues such as waiting times, quality of care and

patient outcomes. Analysis by Triggle and Jeavans (2018) suggests that five out of seven local health boards in Wales did not meet a single target for accident and emergency, cancer, and routine operations in 2017-2018.[1] This, perhaps, as much reflects systemic underperformance as it does relative underperformance by organisations.

Table 1: Local health board financial performance, 2015-2018

Local health board	Deficit
Abertawe Bro Morgannwg	£71.7m
Aneurin Bevan	- £0.5m
Betsi Cadwaladr	£88.2m
Cardiff and Vale	£56.0m
Cwm Taf	- £0.1m
Hywel Dda	£150.2m
Powys	- £0.2m
Total	£365.3m
Source: McCarthy (2018).	

The second is financial underperformance, focusing on issues such as overspending and poor financial planning. Local health boards are required to operate within spending limits set by Ministers. Under the provisions of the National Health Service Finance (Wales) Act 2014, they are required to manage their financial resources within approved limits over rolling three-year periods, as well as having their spending plans approved by the Welsh Government (Worthington and McCarthy, 2014). However, four of the seven local health boards (Abertawe Bro Morgannwg, Betsi Cadwaladr, Cardiff and Vale, and Hywel Dda) reported large deficits for 2017-2018 (Table 1), and some have been overspending for a number of years.

The Welsh Government has provided the additional financial support to those that are in deficit so that they can meet their ongoing commitments, with a clear message

[1] Official figures provide greater detail. For accident and emergency, only Powys met the targets. For referral to treatment times, only Powys and Cwm Taf met their targets. And for cancer targets, no local health board met their targets (Welsh Government 2018a, 2018b and 2018c).

from the then Cabinet Secretary for Health and Social Services that maintaining and improving service is the priority. Alongside this support, there is a real terms increase of 5.2 per cent for health and social services in the draft 2019-20 budget. It is also worth highlighting that the Health, Social Care and Sport Committee's response to the budget notes that the four health boards in deficit are not in a position to repay the deficits they have built up (National Assembly for Wales, 2018).

The third way of understanding underperformance is in terms of organisational structures and governance, which include issues such as understaffing, inefficient practices, and weak governance. The expert roundtable highlighted a number of issues within organisations in Wales, including a surplus of vacancies, pointing blame elsewhere, and a lack of strategy, all of which are discussed in this report.

It is crucial to define exactly what is meant by underperformance within an organisation. For example, the underperformance by Betsi Cadwaladr that led to the Welsh Government putting it in special measures is markedly difference from the underperformance by the Mid Staffordshire foundation trust in England. So it is important to have clear measures by which an organisation's performance can be judged consistently over time. It is somewhat an obvious point, but changes to measures and understandings of performance can mean that yesterday's strong performers become poor performers very quickly.

It is also clear that underperformance is likely to be a longstanding problem, rooted in a series of decisions and past events. Palmer (2005) outlines several potential reasons for underperformance. He argues that historic over-spending cannot be reversed speedily, and that there are high legacy costs. He also suggests that current funding may simply not be sufficient to meet the growing demands placed on the health and social care system and the particular challenges posed by population sparsity in some rural areas. Reflecting this, Hywel Dda, for example, received £24m of additional revenue funding from Welsh Government (2018) on the basis that there were 'excess [demographic and scale] costs that were unavoidable to the Board'.

Murray (2014) echoes many of Palmer's conclusions, and stresses that underperformance is not necessarily the same as failure. Many organisations' difficulties reflect systemic financial and structural challenges facing the NHS, and the external challenges of population health need. Table 2 summarises some of these issues.

Table 2: Potential drivers of NHS underperformance

Issue	Comment
Relative underfunding due to inaccuracies in funding allocation	There may be an underestimation of need or local costs in an organisation, and the data and formula that decided the funding allocation needs to be robust in response.
Size of organisation	This can work both ways. On the one hand, a larger organisation may be able to achieve savings through economies of scale, but they may also struggle with the sheer vastness of service delivery (or diseconomies of scale).
Geography	Rural or 'isolated' areas may suffer from greater challenges, not just in service delivery but in recruiting staff.
Excess legacy costs	There may be legacy costs from previous estate purchases or building, which need to be factored into current performance.
Local health economy issues	Where there is an issue with one part of the health and social care system, this may have knock-on effects for other performance.
Source: Adapted from research by the King's Fund (Ham, 2014 and Murray, 2014) and conversations with experts.	

The nature of underperformance may change over time, and underperformance in one area may affect another. For example, an organisation that is not delivering effective services may need to spend more money to compensate, and as such underperform financially. It is also the case that the reasons for underperformance and the most suitable interventions will vary from organisation to organisation. However, our review of the available evidence and the expert roundtable highlighted a number of key themes, which are explored in the following sections.

Leadership

A recurring theme, both within the academic literature on organisational performance and at our expert roundtable, was leadership. Poor leadership might be a result of an incohesive board, being distracted by other issues (such as organisational change or building projects) or simply executive mismanagement and underperformance (Audit Commission, 2006).

Each of our experts felt that leadership at the local level was crucial to an organisation's success. One explained that in their experience:

> **It's unbelievably clear that even if the local context is very good, if the leadership isn't right then the organisation won't work well. It's absolutely fundamental**.

A study of NHS hospitals in England suggests different leadership structures can be found in high-performing compared to underperforming organisations (Mannion et al., 2005). High performing trusts had a strong direction provided by the leadership, with clear and explicit objectives. Middle management was given the responsibility to carry out the objectives, with robust internal monitoring arrangements also put in place to make sure that objectives were carried out. They also had the flexibility to allow modifications to structures, such as devolution of leadership.

Mannion et al. (2005) found the opposite to be true in underperforming organisations. Their management direction was more geared towards loyalty and personalities. Employees complained of inner circles and cliques. This had practical consequences, as sometimes decisions were taken 'without establishing a strong business case and working through the financial repercussions for other services and departments' (Mannion et al., 2005: 436). More broadly, there was very low accountability, firstly within the organisation but more broadly a lack of willingness to open the organisation to external challenges.

The willingness to open an organisation to challenge is crucial, and experts suggested that this attitude needs to come from the leadership. Challenge does not necessarily mean external inspection, such as that provided by NHS Improvement or the Care Quality Commission in England. It can include the willingness to be reviewed and challenged by external peers. Even in an organisation that is performing well, peer challenge can be useful and permits improvement in an

environment that is supportive rather than combative. One expert talked about how an organisation changed its attitudes to external challenge in line with improvements in its performance and of the value of peer support.

> **[One organisation] talked over a few years about how they used to fear the inspectors coming. Then they were ready for them and then couldn't wait for the next one because they wanted to show off what they'd done**.

> **The ideal system is where you don't need Ofsted or anyone else to come along and tell you where your organisation is. In my own view, the best way to do that is peer-to-peer intervention**.

Another expert spoke of the need to develop the next generation of leaders. There are proactive measures that can be taken, whether that is through developing staff within organisations, or having external programmes that prepare people for future leadership roles. Alongside this, it is also very helpful to have an interim leadership community that is ready to step in if and when there is a sudden change in leadership in a health board (for whatever reason). They can provide a period of stability and without a good pool of interims there is a danger that new leaders are recruited in haste, resulting in some poor appointments.

The research evidence on the merits of replacing leaders is mixed. Boyne (2006) suggests that new leaders can improve the performance of public sector organisations because they are more open to change than incumbents. Barker and Duhaime (1997) support, this concluding that new chief executives are more likely to implement strategic change, and some studies find that replacing whole leadership teams can help turnaround organisations (see Mueller and Barker, 1997 and Pearce and Robbins, 1994). However, others conclude that it makes little difference (see Bruton et al., 2003 and Sudarsanam and Lai, 2001) and some of the experts at our roundtable highlighted negative impacts which rapid turnover of health trusts leaders has had in England.

> **Don't get caught just sacking the leadership. This is what England has done: we're very, very good at removing leaders in England. It's become very toxic. You can't get good leadership in bad organisations because they're in full knowledge that six months down the line they could be moved back on again**.

The evidence from the literature and from our experts suggests replacing leadership which exhibits the characteristics highlighted earlier – an emphasis on loyalty and personality instead of performance, and low accountability – may have a positive impact. However, it is crucial that a suitable replacement is available. Replacing one ineffective leader or leadership team with another is unlikely to help. So it is important to build the capacity of future leaders. Equally, if leaders are changed without addressing root causes of the underperformance which lie outside the organisation's control the new leader is unlikely to succeed.

Some turnaround teams in the NHS in England have had positive initial results, but the organisations they supported have since run into further financial difficulty (Murray, 2014). It is important that interventions address underlying issues, such as strained relationships, confused accountabilities, funding, or models of delivery, and it is clear that while changing leadership may be desirable in some circumstances it is may not be on its own be sufficient to lead to improvement. Ham (2014) argues that transforming the NHS depends on engaging core staff in improvement programmes. In particular, he argues that leadership 'needs to be collective and distributed, with skilled clinical leaders working alongside experienced managers' (Ham, 2014: 4). This does not necessarily need leadership changes but could be achieved through training and internal restructuring. Work by the King's Fund (2017) to support Cambridge University Hospital's NHS Foundation Trust demonstrates this. Previously rated 'inadequate' by the Care Quality Commission, the Trust went through a long-term improvement programme, and is currently rated 'good' by the Care Quality Commission. More recent evidence from the University of Manchester and the King's Fund (Smithson et al., 2018) also suggests that having access to development support throughout the system can improve services.

Empowering the system

Another of the key messages from our expert roundtable is that while leaders are very important, the whole system needs to be considered in its entirety. High performing organisations have good leaders who empower everybody else to perform their role. The experts noted that 'you have to incentivise the whole system to require the place and people to thrive' and:

The well-run organisations have middle managers who are well-trained, well-developed, know where they stand, appraisals that are value adding rather than tick box… It is produced by good governance… It's actually having this whole cluster and there's evidence now from the World Management Survey, which is a huge survey that's been going on for quite a long time, about the importance of the cluster of management practices. One of them is the middle management cadre because that's where things can get stuck.

Empower your middle management cadre and make sure your board is… a diligent and restless board. By that it means taking up all the different roles of a board, not just one or two. It would be making sure there's a sense of purpose. It would be making clear the strategy… Also, the board has to be the sensor taking lots of information, hard and soft, within the organisation, but comparing. What's really going on here? Acting as a diplomat and that's working with partners locally and nationally, so you're managing reputation.

You can have your lovely bouncy bright-eyed and bushy tailed frontline doctors wanting to change things. You can have this wonderful new board, but if you've got in the middle these suppressed middle managers, some of whom want to do good things, but others are superannuated. Others are there because they've just kept their heads down. They're not entrepreneurial… [and] they're just hoping nobody will notice. Frankly, that needs to be tackled.

Empowering staff throughout the organisation is not merely a procedural task, but can also boost morale and create the climate that encourages problem-solving and innovation. Experts talked about the need to motivate staff and generate an environment in which staff can not only do their job, but also be given the space to be ambitious and energised, and present new ideas.

The general sense of an endemic sense of powerlessness pervades failing organisations at every level. Nothing can change, nothing can be done. Actually, the powerlessness pervades the supervising or regulatory organisations as well. In the organisations themselves that conceals a huge sense of frustration, anger, all the things we've heard a lot about. When you go into these situations, for whatever reason.

Once board governance is chaotic, it's lost focus, there's no strategic vision or strategic agenda. There's no sense of story or narrative for the people you're leading. You'll feel a victim in the circumstance, it's all the system's fault. There's not enough money, all the things you can blame on others. Actually, also there's a huge amount of talent in the organisation desperate to have an opportunity to actually contribute. Like others, most of the things I've done in organisations to change have been promoting and bringing people through and giving them room to breathe and operate and start taking some chances.

Experts and Welsh Government officials agreed that the capability and capacity of middle management is really important and that it is here that things can 'get stuck'. As well as empowering middle management to perform their roles, it is important not to ignore the important role of medical staff (doctors, nurses and therapists). Boyne and Meier (2009: 857) find that increasing the number and quality of staff involved in service delivery has positive effects, to the extent that they argue that it 'may be an effective turnaround strategy for all organisations that are highly professionalised, whether in the public or private sector'. This is supported by studies that show that recruiting employees with expertise that fits an organisation's strategic purposes is associated with better performance (Skaggs and Youndt, 2004), and reducing 'frontline' staff more quickly than those in support roles is associated with declining performance (Freeman and Hannan, 1975). Kirkpatrick et al. (2018) also find a positive relationship between hiring management consultants and organisational inefficiency, in a study of the NHS in England.

Together, these arguments highlight the importance of systems leadership when considering means of tackling underperformance. Is productivity, talent and creativity being suppressed in an organisation? What could the workforce do and what is

stopping them? These questions apply not only within health boards but across organisations in Wales. Discussion at the round table suggested there may be a value in looking beyond leadership of the individual health organisation and towards a broader concept of systems or more place-focused leadership. This would require organisations and stakeholders serving the same population to see it as in their interests and be part of the solution, working more closely with the troubled organisation, sharing best practice and helping to enable change. This may also assist Welsh Government when it comes to intervening in organisations, as fruitful relationships may already be in place. However, the available evidence on this was limited and is potentially an area for further analysis.

The role of the Welsh Government

While less interventionist than the UK Government in England, the Welsh Government has formally intervened in a range of local authorities and health boards. Analysing the ultimately successful intervention in the Isle of Anglesey County Council, Grace et al. (2014) highlight lessons for future interventions. They argue that we need:

1. A 'whole system' approach which provides a clear statement of the standards required that the organisation needs to achieve and mechanisms that allow early detection where these standards are not being met and diagnosis of the causes of the failure.
2. An explicit theory of how improvement is to be achieved.
3. Clarity about governance and accountability and experienced leaders to lead the intervention who have the personal qualities, capabilities and capacities to deliver the equation of change.
4. Clear timescales, performance/progress measures, and milestones which are not defined by the organisation but are agreed with it.
5. An explicit escalation strategy, and appropriate exit arrangements.

The experience in Anglesey shows that central government intervention can be effective, so long as the problems and appropriate responses are identified and justified. This is supported by international evidence: Beeri (2013) shows how an

intervention approach by the Israeli government significantly improved the performance of local authorities.

Our experts argued that the Welsh Government, and the relevant Minister in particular, can play a significant role in shaping an intervention and helping to ensure its success. This may either be through the public message they send and/or through procedural steps they take to support those working within the organisation.

> **[In my experience of interventions], there was a very strong ministerial leadership… Don't underestimate the extent to which minsters can support this process…The minster took ownership of this problem. It was very clear that they owned it, they supported the intervention team. That they were willing, when it was appropriate to do so… to take very difficult political decisions that were subject to challenge and scrutiny**.
>
> **In [one example]… [the Minister] changed the system when the organisation was not hitting the targets in the original system. It took huge courage to do that, particularly at a particular time in the political cycle. It paid off, it was the right thing to do and he did it. Others may not have had that political courage to do that**.
>
> **I think minsters have a hugely significant part to play both in setting the context, in supporting the intervention, both pragmatically and in terms of moral support. The most powerful thing ministers did in both cases was to say, "This is the last chance saloon. If this does not work, we will find another way of providing this service." That was very powerful in being able to put some of that stuff in place**.

Experts said that significant Welsh Government intervention should be seen, if not as a last resort, then an intervention once other options have been tried. The intervention in Anglesey was instigated only after a range of other less intrusive attempts had been tried and failed. It was only at this point that an intervention was imposed, and control temporarily taken away from locally elected leaders. Experts noted that the intervention was structured, and supported by a legislative framework. The terms of reference and reporting mechanisms were clear, as were the conditions that would need to be met in order to restore democratic control.

The issue of local democracy is not an issue to the same extent when intervening in health boards. Nonetheless, it is still important that Ministers use external intervention as a (near) last resort.

It is also important to stress that the Welsh Government's role is not that of an unpopular and distant critic. Experts involved in previous interventions by Welsh Ministers spoke positively of the support provided by the Welsh Government to the organisation and the people it trusted to turnaround the organisation.

> **[In my experience]… there was a coaching and mentoring style of leadership right from the top of the NHS within Wales… for the chair, for the chief exec, for people in key positions, for the unions, there was help and support from government… that sense of we're in this together, this is a partnership approach, albeit with consequences, was really important. Practical support, like investing in innovative solutions. Encouraging quality people to come and join the organisation, sometimes with their arm up their back, but always with a sense of, "This will be good for you." That really helped the organisation… facilitating some of those wider changes, about having a champion within the NHS leadership who can make things happen that really ought to happen, but are not happening… you need an enforcer sometimes who can encourage, cajole, persuade, force, reluctant partners to do what's right. Real strong issues and peer and stakeholder support**.

Our experts noted that the Welsh Government will still likely need to have a firm approach, and the powerful threat of potentially withdrawing additional funding or grants in future (the threat of removing core funding is unlikely) can still help to encourage or force decisions. But it is one tool alongside many more supportive and soft power actions.

It may be that there is a need for stronger regulatory organisation in NHS Wales, with a balance to be struck between enabling and directing, and addressing behaviours which do not conform to Ministerial direction. Giving a direction to a health board might not necessarily be an unwelcome order: it could provide the political backing for a difficult or unpopular decision. A strong regulator can also help to create the conditions for which people and boards feel obligated to sort issues out. They can

provide a frankness that other bodies might not be able to – holding up a mirror and calling out underperformance. A regulator might also help to clarify when organisations are actually underperforming, and when there are systemic issues that even the best organisations could not properly solve.

Betsi Cadwaladr

The performance of Betsi Cadwaladr local health board has attracted significant media attention and political debate. It has been in special measures since June 2015 after underperforming in a series of areas. They remain in place at the time of writing (although interventions in some specific areas have been deescalated). Reports have highlighted problems relating to:

- A lack of shared purpose across the organisation
- Leadership
- Poor relationships between the leadership and staff
- Middle management capacity
- Gaps in capability, service and planning capacity.

There have been concerns about mental health services and financial performance. Two reviews, the Ockenden Review and the Health and Social Care Advisory Service report, found significant issues relating to staff levels and training, safeguarding, and service delivery. There is now in place an agreed action plan to which the board is being monitored against.

In November 2018, the then Cabinet Secretary for Health and Social Services (now Minister) made a statement in the Senedd, highlighting a strong focus on improving board capability, as well as introducing more robust appraisal and reporting systems. Together, these measures have been designed to improve governance across the organisation.

Betsi Cadwaladr covers a vast area across North Wales, spanning six local authority boundaries, which do not have identical ways of running services relevant to health and social services. It employs approximately 16,000 staff and serves over 600,000 people. It can be more difficult to recruit and retain staff in rural areas, often resulting in expensive locums, and older patients in rural areas of Wales will need greater

support. Another big problem is that there are issues, such as housing and employment, that directly influence health and wellbeing but sit outside of the Board's control. This highlights the need for a cross-government approach by the Welsh Government and effective partnership at local level between health and social services. Instilling a shared sense of purpose across a large geographic area, within which many different organisations operate, is also a significant challenge.

Therefore, many of the findings raised in this report have direct relevance for Betsi Cadwaladr, particularly relating to empowering the organisation to fulfil its functions, and for the leadership to instil a sense of shared purpose and openness to criticism. However, while Betsi Cadwaladr is in special measures and an obvious topic of discussion relating to underperformance, it should not detract from the challenges facing a number of health organisations in Wales. One expert noted that a focus on organisations already in difficulty in England arguably led the system to ignore the emerging signs of distress in others, and there was a need to ensure that while eyes might be fixed on Betsi Cadwaladr, there is not another organisation beginning to lose its way. This is highly relevant given the recent change in status of Cwm Taf health board (Welsh Government, 2019).

Conclusion

This report has analysed the ways in which the Welsh Government can effectively oversee and support improvement in the NHS. Evidence both from the academic and grey literatures, as well as from previous Welsh Government experience, suggests that they have an important role to play in effectively monitoring performance, and that in the right environment more direct and substantial government intervention can have a positive effect on an underperforming organisation. It is important that such interventions are timely, carefully targeted, and led by teams with experience, credibility and determination. The organisations they intervene in need to be self-aware, willing to be open about the difficulties they face and prepared to move on from the past. Effective interventions must accurately identify the causes of failure, take account of the options that are available, and adopt a whole system approach rather than focusing on issues in isolation.

However, not surprisingly, the evidence shows that what works depends on a range of factors including the external context that an organisation is operating in and its internal capacity to change. That the capacity and quality of leadership within an organisation is crucial does not mean that sacking and replacing leader is the correct

response to organisational underperformance. Each organisation will have specific problems that can only be remedied with a thorough understanding of its operations.

As part of this project we sought to capture and reflect the views of Welsh Government. It would be valuable to extend this to include the perspectives of those leading local health boards, as well as other organisations involved in the NHS, in order to take account of their concerns relating to performance, its root causes, and how interventions can best support them.

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Author Details

Dr Craig Johnson is a Research Associate with the Wales Centre for Public Policy.

For further information please contact:
Dr Craig Johnson
Wales Centre for Public Policy
+44 (0) 29 2087 9640
craig.johnson@wcpp.org.uk

Wales Centre
for Public Policy
Canolfan Polisi
Cyhoeddus Cymru