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Structured Assessment 2017 – **Hywel Dda University Health Board**

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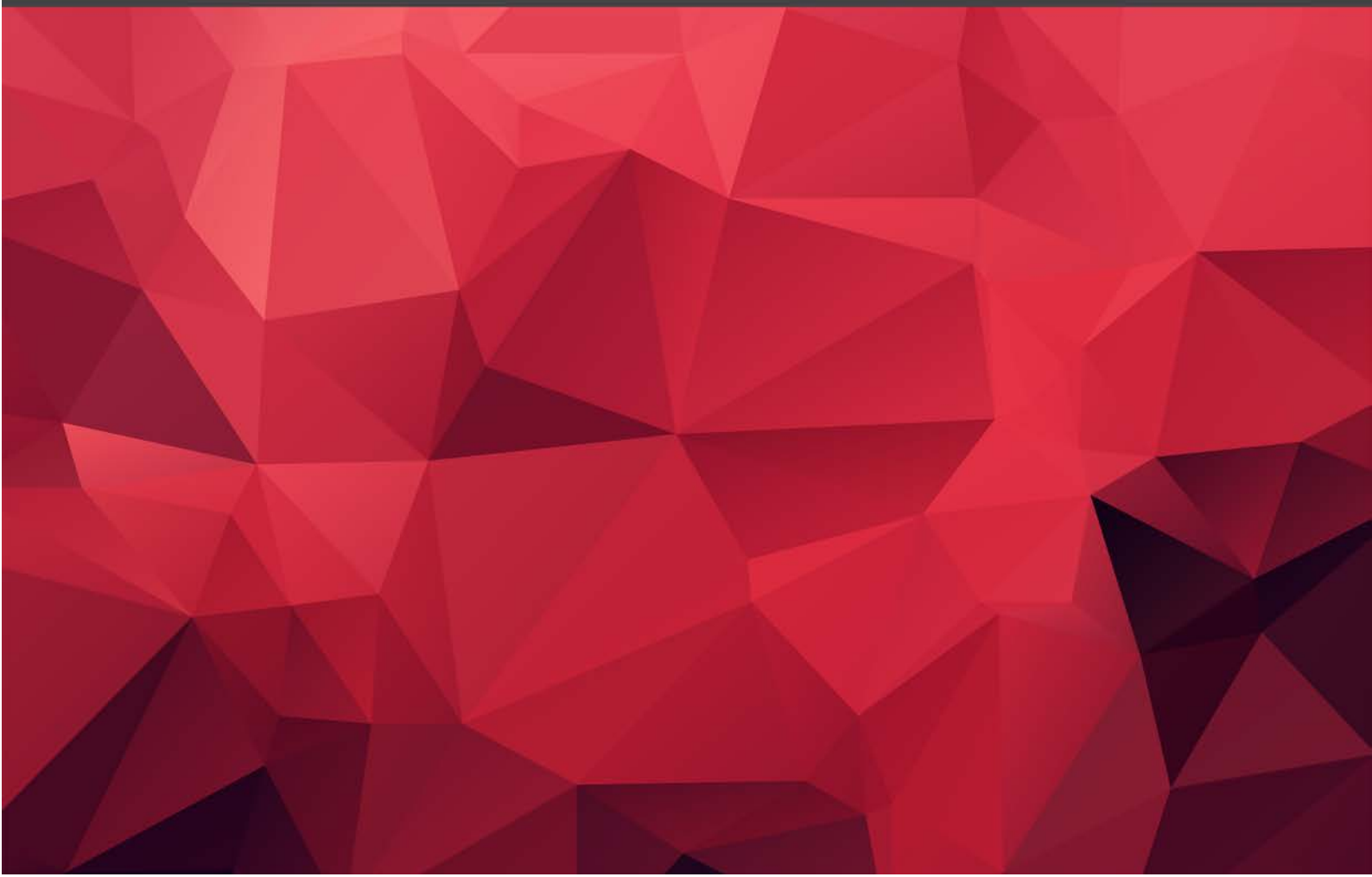

The team who delivered the work comprised Anne Beegan, Jason Blewitt, Jeremy Saunders, Melanie Williams and Phil Jones.

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The Health Board continues to face financial challenges and although there have been a number of improvements in strategic planning, stakeholder engagement and informatics, increasing maturity at an operational level is required to support its governance and performance arrangements.

Summary report

Introduction and background

1 Our structured assessment work helps inform the Auditor General's views on Hywel Dda University Health Board's (the Health Board) arrangements to secure efficient, effective, and economic use of its resources. Our 2016 work found that although the Health Board is laying some sound foundations to secure its future and the pace of change is increasing, it remains in a very challenging financial position and has considerable work to do across a range of important areas.

2 As in previous years, our 2017 structured assessment work has reviewed aspects of the Health Board's corporate governance and financial management arrangements, and, in particular, the progress made in addressing the previous year's recommendations. Recognising the growing financial pressures faced by many NHS bodies and the challenge of meeting the financial breakeven duties set out in the NHS Wales Finance Act (Wales) 2014, we have also reviewed the Health Board's arrangements to plan and deliver financial savings.

3 We have also used this year's structured assessment work to gather evidence to support a pan-Wales commentary. It will set out how relevant public sector bodies are working towards meeting the requirements of the Wellbeing of Future Generations Act (Wales) 2015. That commentary will be reported separately early in 2018.

4 We have based the findings set out in this report on interviews, observations at board, committee and management group meetings, together with reviews of relevant documents and performance and finance data.

5 In September 2016, the Welsh Government, under its Joint Intervention and Escalation Arrangements moved the Health Board's status from 'enhanced monitoring' to 'targeted intervention'. At that time, the Welsh Government communication highlighted the need for improvement of specific issues in the following areas:

- an ongoing inability to secure an approved Integrated Medium Term Plan (IMTP);
- significant overspend in the financial year 2015-16 and financial projections for 2016-17 forecasting a further substantial deficit; and
- the need to build organisational capacity and capability, including reviewing executive portfolios to ensure balance and appropriateness.

6 During 2017, the Health Board has remained at 'targeted intervention' status. The areas of concern broadly remain consistent with those first identified in September 2016, although during the year, the Welsh Government also identified the need for improvement in the following areas:

- a need to build on the clinical services discussions that have taken place through a series of public engagement events to develop an IMTP; and
- the Health Board's ongoing challenges around unscheduled care.

7 In March 2017, the Welsh Government also commissioned an external review of the Health Board's financial governance arrangements. The findings of this review, undertaken by Deloittes, are broadly consistent with and complement our structured assessment work. As part of escalation arrangements, the Welsh Government expects the Health Board to reflect and act on the outcomes of this work.

Key findings

8 Our overall conclusion from 2017 structured assessment work is that **the Health Board continues to face financial challenges and although there have been a number of improvements in strategic planning, stakeholder engagement and informatics, increasing maturity at an operational level is required to support its governance and performance arrangements**. We summarise the reasons for this conclusion below.

Financial planning and management

9 In reviewing the Health Board's financial planning and management arrangements, we found that **the Health Board faces significant financial pressures and the approach to planning and delivering savings, while strengthening, is not yet helping it to recover its deficit financial position.**

Financial performance

10 **Although savings performance in 2017-18 looks more promising, historical overspends against resource limits mean that the Health Board is forecast to have a cumulative increasing deficit of £139.7 million by March 2018**.

11 In recent years, the Health Board has not set a balanced financial plan, has overspent, not delivered on savings plans and the deficit has grown. Over the last six years, whilst it has achieved savings that contribute to closing the funding gap, the Health Board has been reliant on one-off measures, accountancy gains and additional non-recurrent funding.

12 The Health Board did not achieve in-year financial balance during 2013-14 and 2016-17, with a three-year deficit position of £88.3 million for the period 2014-17. It does not expect to achieve in-year financial balance in 2017-18, with a current planned deficit of £58.9 million, although this is an improved position compared to the planned deficit in 2016-17. The Health Board's three-year deficit position for the period 2015-18 has however increased to £139.7 million.

13 The Health Board has had a poor track record of delivering the savings targets it has identified and this record has deteriorated up to March 2017. Over the last five years, the Health Board has set ambitious savings targets. It has been unsuccessful in delivering these targets yet, in most years, it has set targets greater than those achieved in previous years. The shortfall has been more

significant in recent years, and unplanned growth in service costs has added to the financial deficit.

14 There was a high degree of variation in the success of savings plans for 2016-17. The Health Board agreed a savings plan that totalled £29.4 million but achieved £8.9 million. Some schemes over-achieved savings targets and other under-achieved. This indicates that the Health Board could further improve its savings planning and delivery arrangements.

15 The Health Board's savings schemes do not bridge its resource gap and the position for 2017-18 and beyond is looking very challenging. At month six, the Health Board was planning on savings worth £26.4 million, with a further £1.8 million of unidentified savings. The Health Board expects to meet its planned £58.9 million deficit but the run rate at month six would suggest a year-end deficit of £67.7 million. The Health Board is currently processing additional financial recovery measures, and a recent paper to the Board indicated that the projected year-end deficit has reduced to £62 million.

Financial savings planning and delivery

16 **Previous arrangements for planning and delivering savings have been neither effective nor sustainable, but there are signs of improvement since the introduction of the turnaround process with an opportunity to increase the focus on service transformation, improving value, efficiency and reducing waste.**

17 Corporate leadership and management of savings have been ineffective in recent years, with a lack of ownership of savings plans. A more strategic and transformational approach was urgently needed, along with improved accountability, to ensure greater staff buy-in to the financial challenge.

18 The introduction of the Transformation Programme, along with the appointment of the Turnaround Director, has improved the focus on transformational change to place the Health Board on an improved financial footing. The Turnaround capacity however has been limited although the now established programme management office will start to play a more active role in supporting the Turnaround agenda.

19 Arrangements to support budget holders identify savings and manage within their overall budget on a day-to-day basis need to be strengthened to ensure that they are more proactive and challenging. The role of the finance team to support operational staff is historic, not extending beyond providing financial information for budget holders. This approach does not provide the necessary support and challenge to operational teams, although steps are being taken to change this through an organisational change process.

20 The absence of zero-based budgeting has hampered the ability to identify efficient and inefficient areas to ensure that data on opportunities for cost improvements accurately informs the identification and design of savings plans. Although the Health Board has been able to make use of benchmark data to identify technical

efficiencies, such as prescribing costs, and efficiencies have now started to be identified in relation to outpatients and operating theatres.

21 Sharing good practice and shared learning is improving but it needs to be fully embedded and happen with a greater pace. The Health Board's approach to saving and financial planning has broadly remained the same for a number of years. Up until recently, the Welsh Government's 'Invest to Save' schemes have not been used, nor any internal invest to save initiatives or reward schemes. The Health Board has however shown willingness to embrace prudent and value based healthcare principles, but this is not yet embedded into service planning.

Financial savings monitoring

22 **While arrangements to monitor and scrutinise savings are being strengthened, they are not yet sufficiently embedded and there remains more work to do at an operational level.**

23 Along with the Board, the Business Planning and Performance Assurance Committee (BPPAC) has responsibility for the scrutiny of the Health Board's financial position, but the time allowed on the BPPAC agenda has gradually reduced. A new finance sub-committee has recently been established to ensure that the Health Board's financial position is given more focused attention.

24 Since the appointment of the Turnaround Director, fortnightly 'holding to account' meetings are held with the operational directorates and corporate services. This process has added the much needed scrutiny to the saving process at an operational level, but a greater focus on the financial position needs to be embedded within the directorate and service level governance meetings and performance management reviews.

Governance and assurance

25 In reviewing the Health Board's corporate governance and board assurance arrangements, we found that **the Board has continued its work to define its assurance requirements and strategic plans are progressing, but operational structures and performance management arrangements need to be further developed.** We summarise the reasons for reaching this conclusion below.

Strategic planning

26 **The Health Board is starting to develop its long-term strategy but this is not progressed enough to inform the next round of planning, and more work is needed to monitor annual plan delivery at an operational level.**

27 In 2017, the Health Board established its Transformation Programme, which encompasses its programme of work to develop a clinical services strategy for the future. The work is only at the design stage and will not be ready to inform the development of the 2018-2021 Integrated Medium Term Plan. Due to the previous

lack of a clinical services strategy, the Health Board had sought agreement to progress to an Annual Operating Plan (AOP), which the Welsh Government approved in June 2017.

28 The Health Board's 2017-18 AOP consists of a series of action plans, and it is the responsibility of the BPPAC to scrutinise the delivery of these action plans on behalf of the Board. The action plans are comprehensive and identify where delivery is off track, but the development of these plans has been unco-ordinated and there is limited tracking of progress at an operational level. The Health Board has recognised that it needs to strengthen the development of its plan for 2018-19. The Health Board is currently developing its AOP for 2018-19, which it aims to develop in line with Welsh Government timescales.

Organisational structure

29 **The Health Board's revised organisational structure is maturing but could benefit from closer working between corporate and operational services.**

30 The Health Board's executive team is almost at full complement, with the Director of Therapies and Health Sciences appointed and due to take up post in the New Year, and recruitment currently taking place to fill the Director of Primary, Community and Long Term Care post substantively. The new Directors of Public Health and Nursing, Quality and Patient Experience both took up post in the summer, and a new post of Turnaround Director was created and appointed to also in the summer period. The senior management team however is large in comparison and does require directors to be very clear on each other's roles and responsibilities. Directors are still working through their responsible portfolio areas, increasingly identifying opportunities to have a greater impact on the running of the Health Board by collaborative working. There is also scope for some of the executive team to be more visible across the Health Board.

31 At an operational level, the triumvirate teams are now in place at a directorate and service level, although the structure relies on a significant degree of communication to ensure cross-organisational working. The teams are at various levels of maturity and clinicians in post still need to develop their leadership skills. This is placing a considerable amount of pressure on the Director of Operations. In addition, some of the corporate functions need to be more integrated with the directorates to provide the necessary support and challenge to help them manage all of their resources.

Board effectiveness, Board assurance and governance structures

32 **Board assurance arrangements continue to evolve and plans are in place to improve the effectiveness of committees, although overall Board effectiveness is generally sound.**

33 The Health Board recognises that it needs to improve its assurance flows and integrating new board members. There has been some turnover of independent

members (IM), with three new members appointed during the year. The Chair manages this process effectively and the Health Board has not experienced the extent of IM turnover that other NHS bodies have, which is positive. Work is underway to develop the independent members through training and organisational development work, which alongside similar work with the executive team will help shape the Board into a high performing board.

34 The Health Board recognises that its committees need to improve to ensure that the Board receives the necessary assurances. Work is already underway to reconfigure the Quality, Safety and Experience Assurance Committee (QSEAC) and two new sub-committees have been set up to improve the effectiveness of the BPPAC.

Risk management

35 **Risk management arrangements have continued to be strengthened but more needs to be done at an operational level.**

36 The Health Board launched a new risk management framework in September 2017, and a development session with the Board has revisited its appetite for risk and risk tolerance. Improvements have been made to the corporate risk register since our 2016 structured assessment work, and risks are considered at an operational level. However, work is now needed to refine risks at an operational level, and risk review dates in registers are sometimes out of date.

Information governance

37 **Information governance arrangements support compliance with current legislation, but meeting the significant challenges of new General Data Protection Regulations (GDPR) and Cyber Essentials requirements will be challenging within the current resources**.

38 The new information governance team that was put in place in October 2016 is helping to drive through the information governance agenda. A review of current policies is underway and action is being taken to ensure that the Health Board complies with new legislation by May 2018. However, a considerable amount of work is required and the Health Board is having to prioritise how this resource is used between now and next May.

Performance management

39 **The Health Board's performance management arrangements need strengthening at an operational level to enable the necessary assurances to be given to the Board and its committees.**

40 The September Board meeting approved a revised draft performance management, which sets out the role of the BPPAC in seeking assurances. Operational performance rests with the Director of Operations through a scheduled

programme of performance management reviews. These reviews aim to hold directorates to account for delivering safe and effective services, however the time allocated is not sufficient and the metrics used to measure performance need expanding. Performance against national targets remains mixed, although globally the Health Board's performance has improved compared to previous years.

41 Although supported by the Director of Nursing, Quality and Patient Experience, the performance management reviews would benefit from wider involvement and collective ownership from the executive management team to increase the level of scrutiny and challenge of the operational directorates. The directorates' own governance arrangements also need to be improved to ensure consistency in the extent to which performance of their respective departments is considered.

Other enablers of the efficient, effective and economical use of resources

42 In reviewing the Health Board's arrangements to support the efficient, effective and economical use of resources, we found that **the Health Board has taken significant steps to improve stakeholder engagement, and strengthen its informatics arrangements, but is still reliant on external capacity to drive change, and needs to develop its workforce further**. We summarise the reasons for reaching this conclusion below.

Change management

43 **The Health Board's Transformation Programme is its vehicle for service change, supported by its programme management office (PMO) but it is still reliant on the use of external resources.**

44 The Transformation Programme brings together five work-streams covering clinical services, women and children's services, and mental health services. The Service Improvement Team contributes to the programme, along with a range of representatives and clinicians.

45 During 2017, the Health Board commissioned the use of Capita to provide programme management support to the Transformation Programme. The Opinion Research Service was also commissioned to provide independent analysis to the programme. Although the aim is for the PMO to provide support to the Transformation Programme going forward, the Health Board recognises that there is still a need to draw on additional external expertise.

Workforce management

46 **Although there are improvements, the Health Board continues to have a number of staffing challenges and needs to do more to transform its workforce.**

47 Sickness absence has improved across the Health Board to below the Welsh Government target, and the rate of medical staff appraisals is performing well against the target. However, consultant job planning, non-medical staff appraisals and mandatory training need improving.

48 The Health Board has run a number of successful recruitment campaigns and vacancy levels have reduced, along with turnover rates. However, the Health Board remains reliant on bank and agency staff. Work is underway to control the costs associated with using temporary staff, which is a key component to the turnaround process. The Transformation Programme also includes HR representation, although the focus is on managing the implications of service changes as opposed to generating workforce transformation ideas. A workforce plan underpins the 2017-18 AOP, but this has been traditional in nature, recognising the need for the Health Board to get on a stable footing in relation to its workforce. Over time, the Health Board's plan will need to include more actions relating to workforce modernisation.

Partnership and stakeholder engagement

49 **The Health Board is taking an open and proactive approach to stakeholder engagement and is working positively with its partners.**

50 The Health Board's 'Big Conversation Event' engaged stakeholders through a wide variety of mechanisms, and the open and honest approach taken by the Health Board on its sustainability challenges has been welcomed. The Health Board continues to engage with its partners on a range of matters. It has recently developed its partnership governance framework to ensure that partnership risks are managed.

Information management and technology

51 **The Health Board has made concerted efforts over the last year to strengthen its informatics arrangements and pick up the pace in delivering its digital strategy but it is too early to say how effective these steps will be**.

52 A new process using a decision matrix has recently been introduced to prioritise the work of the informatics team. However, balanced against the need to also respond to emerging issues, the team's effectiveness of the process may be restricted due to the overall limited IMT resources.

Recommendations

53 We have detailed the recommendations arising from the 2017 structured assessment work in Exhibit 1. The Health Board will also need to maintain focus on implementing any previous recommendations that are not yet complete.

54 The Health Board's management response detailing how it intends responding to these recommendations will be included in Appendix 1 once complete and considered by the relevant board committee.

Exhibit 1: 2017 recommendations

2017 recommendations
Financial savings
R1 The Health Board needs to improve the identification and design of saving schemes through: a. increasing the use of data and intelligence to identify opportunities for efficiency improvements reflecting them in more meaningful and realistic savings targets for different areas of the business; b. avoiding over-reliance on in-year cost control, accountancy gains and non-recurrent savings; and c. embedding the 60-day cycle process to identify where longer term and sustainable efficiencies can be achieved through service modernisation, and approaches such as value based healthcare and productivity improvements.
R2 The Health Board needs to develop the financial management capabilities within the operational directorates and service departments by progressing with the organisational change process (OCP) for the finance department. The change will see the finance staff align with the operational structure and provide greater opportunity for them to provide support and challenge on a day-to-day basis.
R3 The Health Board needs to adopt a more proactive approach to learning and sharing good practice about savings and wider financial planning. This should include making more use of initiatives such as the Welsh Government's 'Invest to Save' schemes.
Strategic planning
R4 To enable the development of a three-year integrated medium term plan, the Health Board needs to ensure that it has a clear outcome from its Transforming Clinical Services programme to inform the 2019-22 planning round.
Operational structure
R5 The Health Board needs to progress its work to develop its clinical directors at pace, and provide the necessary support to its wider triumvirate teams to develop their management capabilities.
R6 Following the implementation of the proposed planned changes to the finance department, the Health Board needs to ensure that the structures of the other corporate functions appropriately support and challenge the operational directorates.
R7 The Health Board needs to revisit its operational structure, and the position of primary care and community services in particular, to ensure that it fully supports integrated working and effective management of operational issues.

2017 recommendations	
R8	To show leadership, visibility of the executive directors across the Health Board needs to extend to all directors and consideration needs to be made to holding meetings with operational teams away from the headquarters wherever possible.
Risk management	
R9	The Health Board needs to further embed its revised risk management framework and to continue its work with its operational teams to refine the recording of risks.
Performance management	
R10	The Health Board needs to strengthen its performance management framework at an operational level by: • ensuring sufficient time is allowed within the bi-monthly performance management reviews to consider all elements of performance, including finance, workforce and delivery against plan; • ensuring that the process includes wider representation from across the directors; • ensuring that governance approaches at operational and service level are standardised and include a comprehensive review of performance; • expanding the range of performance metrics that are considered at an operational level, particularly in relation to quality and safety; • exposing the operational directorate teams to scrutiny at both BPPAC and QSEAC on areas of underperformance.
R11	The Health Board needs to continue to improve its integrated performance assurance report by drawing the reader's attention to areas of underperformance, expanding the range of local performance metrics that are included within the report to provide a more rounded view of performance, where appropriate.

Detailed report

The Health Board continues to face financial challenges and although there have been a number of improvements in strategic planning, stakeholder engagement and informatics, increasing maturity at an operational level is required to support its governance and performance arrangements

55 The findings underpinning this conclusion are detailed below.

The Health Board faces significant financial pressures and the approach to planning and delivering savings, while strengthening, is not yet helping it to recover its deficit financial position

56 In addition to commenting on the Health Board's overall financial position, our structured assessment work in 2017 has considered the actions that the Health Board is taking to achieve financial balance and create longer-term financial sustainability. We have assessed the corporate arrangements for planning and delivering financial savings in the context of the overall financial position of the organisation.

57 A detailed examination of individual savings plans was beyond the scope of this review. However, we have considered the approach in the area of medicines management and this has informed our overall views on the effectiveness of the organisation's approach to the planning and delivery of savings. We have also reviewed progress made in addressing previous structured assessment recommendations relating to financial management. Our findings are set out below.

Although savings performance in 2017-18 looks more promising, historical overspends against resource limits mean that the Health Board is forecast to have a cumulative increasing deficit of £139.7 million by March 2018

In recent years the Health Board has not set a balanced financial plan, has overspent, not delivered on savings plans and the deficit has grown

58 Each year, the Welsh Government allocates revenue to the Health Board to provide the resources for it to pay for locally provided and contracted healthcare services for its resident population. This allocation is known as the Revenue Resource Limit (RRL). Each year there are increases in the RRL allocated at the beginning of the year by the Welsh Government. These increases in revenue help to address inflationary costs of healthcare, which include growth in pay costs, medication costs, and increasing demand for services.

59 The Health Board has arrangements in place for the setting of its revenue and capital budgets. These have remained largely as in prior years but continuing financial pressures have meant that despite

these arrangements, the Health Board has been unable to agree a balanced financial plan for the last five years and the deficit continues to grow. Exhibit 2 shows the financial performance over the last six financial years. It shows that whilst the achievement of savings has contributed to closing the funding gap, these have not been sufficient or as planned and the Health Board has been reliant on other one-off measures, accountancy gains and significant additional non-recurrent Welsh Government funding. Despite this, these additional measures have also not been sufficient to meet the funding gap. Consequently, the Health Board did not achieve financial balance between 2013-14 and 2016-17. The Health Board is also anticipating not achieving financial balance in 2017-18, although this is an improved position compared to the planned deficit in prior years prior to the additional Welsh Government monies. This is not a sustainable position going forward and recovering the deficit position to achieve financial balance in the near future will prove to be challenging.

Exhibit 2: summary of financial performance for the periods 2012-13 to 2017-18 (forecast to month six)

	Funding Gap	Actual Savings	Unidentified Savings[1]	Additional WG monies	Accountancy Gains/ Reserves	Net income/ Favourable Movements	Additional Cost Pressures	End of Year position
2012-13	£41,630	-£19,807	-£271	-£8.000	-£11,252	-£2,300		
2013-14	£56,790	-£23,531		-£14,443	-£450		£859	£19,225
2014-15	£70,903	-£14,883		-£60,925	-£4,250		£16,630	£7,475
2015-16	£99,087	-£8,571	-£9,198	-£58,257	-£3,900		£12,038	£31,199
2016-17	£106,345	-£8,858		-£40,545	-£6,246	-£8,596	£7,513	£49,613
2017-18	£90,900	-£15,056	-£12,944		-£4,000			£58,900

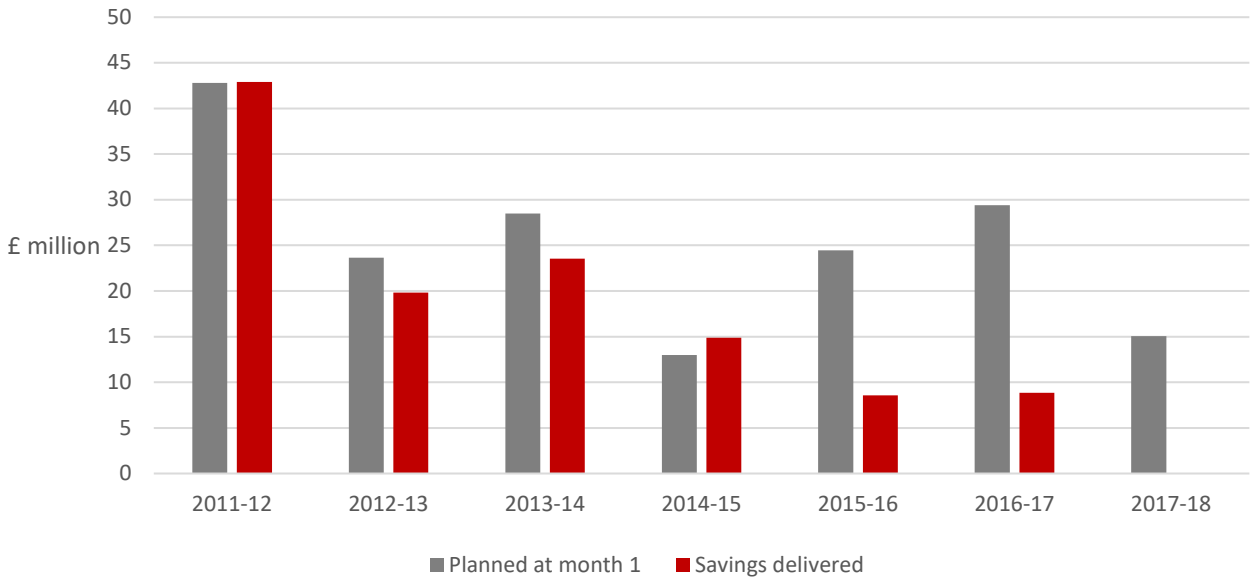
Source: Monitoring Returns to the Welsh Government

The Health Board has had a poor track record of delivering the savings targets it has identified and this record has deteriorated up to March 2017

60 Over the last five years, the Health Board has set ambitious savings targets. The Health Board has been unsuccessful in meeting its targets and has, in most years, set targets greater than that achieved in previous years. Over the period April 2012 and March 2017, the Health Board has set savings plans targets of £119.0 million, and has achieved £75.7 million, a shortfall of £43.3 million (Exhibit 3). This shortfall has been more significant in recent years. In addition to this, the Health Board has incurred additional unplanned growth in service costs, which has added to the underlying financial deficit. This growth in costs can occur for a range of reasons including, for example, winter pressures and flu, or greater need for specialist out of county placements.

[1] Unidentified savings schemes are those that have no identified plans at the start of the year.

Exhibit 3: summary of performance against savings plans



Source: Monitoring Returns to the Welsh Government

There was a high degree of variation in the success of savings plans for 2016-17

61 In 2016-17, the Health Board's total resource gap was £106.3 million. To help address the gap, it agreed a savings plan that totalled £29.4 million at the start of the year, with 305 saving schemes identified to help it meet the annual savings target. Exhibit 4 provides summary analysis prepared by the Health Board on over and under-delivery against its saving schemes.

62 By the end of the 2016-17 financial year, the Health Board under-delivered against its savings plans by achieving just £8.9 million in savings. There was a high degree of variation in the success of savings approaches with over-achievement in a small number of schemes. The scale of over and under-delivery indicates that the Health Board could further improve its savings planning and delivery arrangements. Moreover, because of growth in service costs during the year, the net effect of the performance against savings plans and increase in costs meant that the deficit position grew.

Exhibit 4: summary of 2016-17 saving scheme delivery

Category	Number of identified schemes	Total planned savings	Achieved savings	Variance between planned and achieved savings
Identified savings schemes over-delivering by £50,000 or more	1	£404,826	£1,024,000	£619,174
Identified savings schemes over-delivering by £49,999 or less	0			
Identified savings schemes achieved exactly the planned amount (+/-£10)	241	£7,368,151	£7,368,157	£6
Identified savings schemes under-delivering by £9,999 or less	18	£83,481	£61,869	-£21,612
Identified savings schemes under-delivering by £10,000 to £49,999	7	£282,381	£108,932	-£173,449
Identified savings schemes under-delivering by £50,000 or more	6	£2,242,000	£294,941	-£1,947,059
Identified savings schemes delivering £0 (nil) savings	32	£439,310		-£439,310
TOTAL	**305**	**£10,820,149**	**£8,857,899**	**-£1,962,250**
Unidentified savings schemes	17	£18,579,894		-£18,579,894

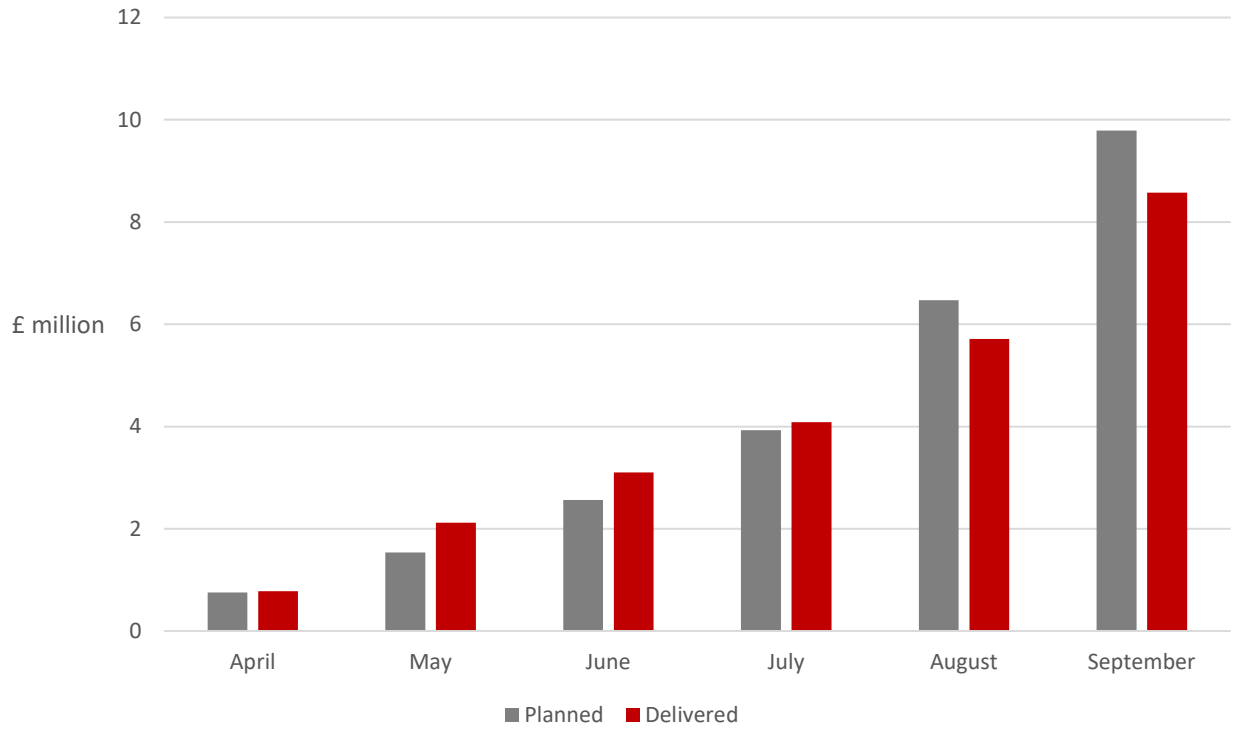
Source: Hywel Dda University Health Board

The Health Board's savings schemes do not bridge the entirety of its resource gap, and the position for 2017-18 and beyond is looking very challenging

63 In 2017-18, the Health Board's total resource gap was £90.9 million. To help address the gap, it agreed identified savings that totalled £15.1 million at the start of the year but also included £12.9 million of unidentified savings and £4 million of accountancy gains/reserves, leaving a planned deficit of £58.9 million.

64 As at month six, the Health Board's identified savings had increased to £26.4 million but actual delivery against this was £1.2 million behind (Exhibit 5). The level of unidentified savings was reduced at £1.8 million.

Exhibit 5: summary of 2017-18 saving scheme delivery performance by month



Source: Monitoring Returns to the Welsh Government

65 As at month six, the Health Board was showing a £33.9 million overspend and was still forecasting meeting its £58.9 million planned deficit. However, this was assuming that the savings plan (for which delivery was already behind) and the unidentified savings were met. Further, of the £26.4 million identified savings, £3.9 million were classified as 'red'[2] and £0.6 million classified as 'to be confirmed'. In addition, based on the run rate[3] for £33.9 million at month six, this would give a year-end deficit of £67.7 million not £58.9 million. A recent paper to the Board at month eight, would suggest that the Health Board's year-end deficit would be nearer £62 million.

[2] Throughout the year, the Health Board uses a RAG rated system to identify the level of confidence that individual savings schemes will deliver, with a rating of 'Red' indicating limited confidence in delivery. Savings schemes identified as 'to be confirmed' require further information before they can be RAG rated.

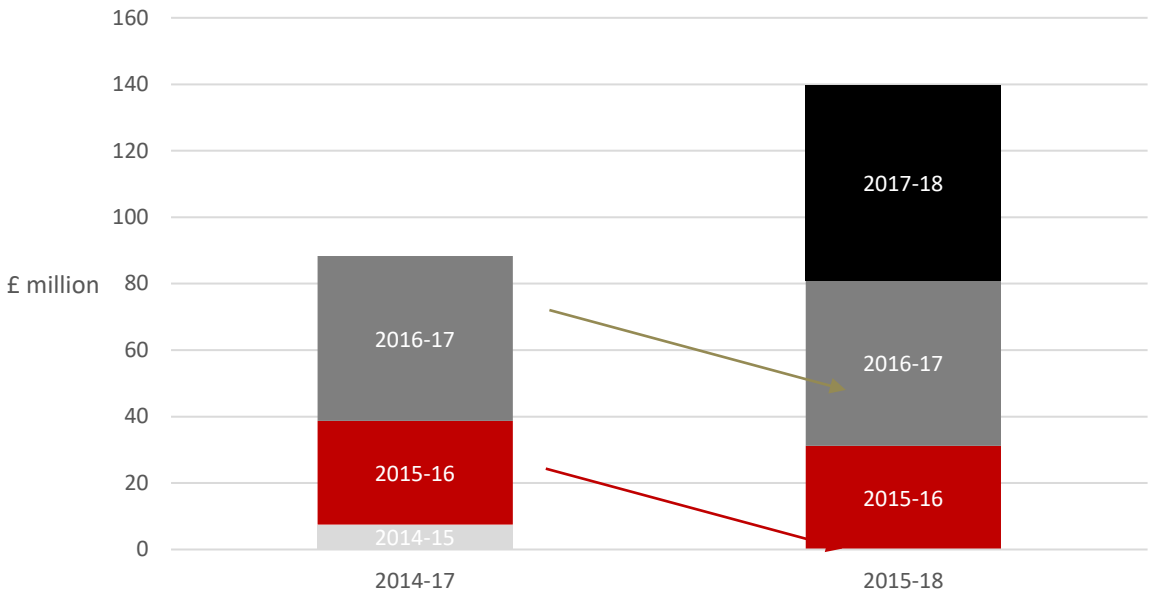
[3] 'Run rate' is the process of extrapolating the current financial position to provide an annual projection.

66 The Health Board is in the process of implementing additional financial recovery measures. It is positive to note that the Health Board is aware of all key areas of concern that we have identified during the course of our work on financial savings, and is putting in processes to strengthen arrangements. The Health Board is putting in place remedial arrangements to help it achieve its planned £58.9 million deficit by the year-end. However, as a result of the recent deterioration in performance, the Health Board will struggle to achieve its:

- agreed deficit plan, ie to achieve an agreed deficit of £58.9 million without effective remedial action or additional financial allocation; and
- target of identified and unidentified savings set at the start of the year.

67 As part of NHS Finance Act (Wales) 2014[4] (the Act) requirements, the Health Board must spend within its financial allocations over a rolling three-year financial period. As identified previously, the Health Board has developed savings approaches but these do not bridge the entirety of the resource gap. While the Health Board's approach to savings planning is helping to contain the overall growth in its expenditure, it is not reducing its planned deficit within a given year or cumulative deficit over a rolling three-year period (Exhibit 6). For example, the Health Board's three-year deficit position for the period 2015-18 is expected to be £139.7 million, rising from £88.3 million for the period 2014-17. The Health Board will therefore not meet its requirement to spend within allocation as set out in the Act for the period 2015-18.

Exhibit 6: Three-year cumulative financial positon (deficit)



Source: Hywel Dda University Health Board

[4] National Health Service Finance (Wales) Act 2014

68 The rolling nature of requirements set out in the Act will mean that the Health Board is highly unlikely to recover its three-year cumulative position, even if in the current year it were to develop and deliver additional savings plans to manage spend within its allocation. Based on the trajectory of financial performance to date, breaking even in the near future will prove extremely challenging. To meet the requirements of the Act without affecting access to services, we believe that the Health Board will need to demonstrate a reduction in planned deficit over a number of years. This will need to be delivered though less reliance on non-recurring cost cutting measures and more emphasis on creation of sustainable service models through:

- linking financial budgets to activity through zero-based budgeting to identified efficient and inefficient areas and to effectively benchmark against good practice;
- value based healthcare[5];
- tackling unwarranted variation in referrals and clinical pathways;
- challenging the fitness for purpose of existing models of care;
- significant and persistent attention on enhancing productivity; and
- focusing on prevention, but ensuring prevention activity is delivering the required financial and quality outcomes.

69 The approaches identified above should help to address the impact of growing population health demands, while also focussing on health outcomes. We do however recognise that there remain transactional savings efficiencies and delivery of these could make a marked difference on the overall financial position of the Health Board.

Previous arrangements for planning and delivering savings have been neither effective nor sustainable, but there are signs of improvement since the introduction of the turnaround process with opportunity to increase the focus on service transformation, improving value, efficiency and reducing waste

70 All Health Boards and Trusts in Wales have to identify savings to be able to aim to spend within their revenue allocation. For many bodies, growing cost pressures make it increasingly difficult to set a balanced budget, even with annual uplifts in funding. Traditional savings approaches across Wales have focussed on cost control measures, procurement savings, recruitment freezes and changes in staff skill mix or grade mix, to name a few.

71 Once these approaches have been exploited, health bodies will be required to think differently, because cost-cutting approaches will have diminishing returns. This section of the report considers the corporate arrangements for planning and delivering savings. We have not reviewed the design, accountability, risks or performance of individual saving schemes.

[5] NHS Confederation – Value Based Healthcare

Corporate leadership and management of savings have been ineffective in recent years and a more strategic and transformational approach is urgently needed going forward to ensure greater staff buy-in to the financial challenge

72 The Health Board has historically rolled forward budgets year on year (uplifting for cost pressures) and has allocated savings targets to directorates on a straight-line basis. In addition, the approach to savings has primarily been top down with a mixture of corporate led savings schemes and targets imposed on directorates for delivery. Both of these have led to disconnect within the Health Board resulting in a lack of ownership for delivery of savings plans and the budget overall. The Health Board believes, in part, this disconnect has led to non-delivery of savings plans and budgets.

73 In addition, there had been a lack of ownership from staff within the Health Board, particularly at ground level, for the financial challenges faced by the organisation, and the specific need to deliver the previously identified savings. The Health Board has recognised this and has taken action. In 2017-18, savings were removed from directorate baseline budgets and budget holders were formally required to sign up to their budgets. This will improve the transparency of directorate budgets and provide clear accountability and ownership for managing financial performance. Run rate relief was given to directorates based on historic cost pressures but there has been mixed usage of this across directorates, an issue that will need to be reviewed particularly as this run rate relief can only be temporary.

74 Interviews with staff also identified that there was a lack of clarity over what directorates felt that they could and could not do both in terms of financial management but more so in terms of changes to approaches to identify efficiencies at a local level. To enable quicker decision-making and implementation of actions to improve efficiencies, there is a need to provide clarification to budget holders of their delegated authorities and to make local decisions.

75 There has also been a disjoint between financial and strategic planning, with these areas operating in silos. There is currently no clinical strategy in place, with the unapproved three year Integrated Medium Term Plan (IMTP) for 2014-19 having previously been used to provide strategic direction. In addition, the development of the IMTP, and subsequent annual operating plans (AOPs), has been done in isolation with a lack of a joined up approach, which draws on all parts of the Health Board. The lack of ownership and joined up working is also reflected in financial management and delivery of savings plans.

76 The Health Board has since embarked on developing its clinical strategy through its Transformation Programme. Although this is only in the very early stages of development, the Health Board has recognised the need to transform its services in order to become financially sustainable. Over the last 12 months, a new Director of Finance has been appointed, and in July, a new Turnaround Director took up post. The new Turnaround Director in particular has started to make some positive changes to the scrutiny and challenge of savings delivery and budgets, with the Director of Finance focusing his attention on the wider financial position.

77 The team in place to support the Turnaround Director however has been limited, particularly given the scale of the challenge, with just the Director and a supporting project manager in post. The Turnaround Director has however developed strong links with the Service Improvement Team, which form part of the Transformation Programme to support the focus on improving efficiencies. This arrangement has provided some additional capacity. A Programme Management Office (PMO) has also now been developed within the planning function, which will start to support the Transformation

Programme, as well as the turnaround agenda. At the time of fieldwork, this team, other than the project manager, had not yet been integrated into the turnaround agenda. This will now start to improve as the PMO becomes more established, which alongside the SIT will help the turnaround process expand to look beyond just savings plans and into underlying cost pressures too.

78 Clear corporate leadership is required to ensure a change in culture regarding financial management including greater staff buy-in, improved ownership and a more joined up approach.

Arrangements to support budget holders identify savings and manage within overall budget need to be strengthened to ensure that this is more proactive and challenging

79 Demand for services has increased in recent years, and this not only has an effect on service costs, but also the capacity of operational management to be able to release the time to effectively plan financial savings and efficiencies. The Health Board has recognised that senior management and service level budget holders do not always have the capacity and capability to plan, develop and deliver saving schemes and staff interviewed often saw the delivery of savings as an additional pressure on top of their day job, particularly with the additional scrutiny that the turnaround process has added.

80 There has historically been a culture within the Health Board where the role of finance has been to provide financial information to budget holders to use in the management of their budget. This approach has not provided the support and challenge needed within the operational directorates to enable them to manage their budgets effectively.

81 The Turnaround Director has now added the necessary scrutiny and challenge at an operational level on an ongoing basis, and the directorate teams have largely welcomed this. However, some of the directorate teams have not yet developed their financial management capabilities. They would benefit from ongoing support and challenge of the centrally based finance team. The new Director of Finance who has instigated a review of the finance structure to ensure that this is fit for purpose and mirrors the operational delivery structure has recognised this. This would go some way to enable a more inclusive form of financial management; however, progress to revise the structure has been slow. Moreover, alongside this change in structure, there remains a need to change the culture within the finance team to ensure that staff responsible for individual directorates are more proactive in providing a more support and challenge role in holding budget holders to account in delivery of their budgets and development of savings plans.

82 In 2016, we made the following recommendation relating to financial management, specifically delivery of savings plans. Exhibit 7 describes the progress made.

Exhibit 7: progress on 2016 financial management recommendation[s]

2016 recommendation		Description of progress
R1	The Health Board should increase the pace of implementation and delivery of its savings plans.	**In progress but not yet complete** Our previous structured assessment work identified the significant financial challenges that the Health Board faces, not helped by increasing slippage in savings plans. Since the appointment of the new Turnaround Director, the pace and delivery of the Health Board's savings plans for 2017-18 have significantly increased. However as reported, the Health Board is behind profile against its savings plan at month six, and recovering the financial deficit position will continue to be challenging for some time.

The absence of zero-based budgeting has hampered the ability to identify efficient and inefficient areas to ensure that data on opportunities for cost improvements accurately informs the identification and design of savings plans

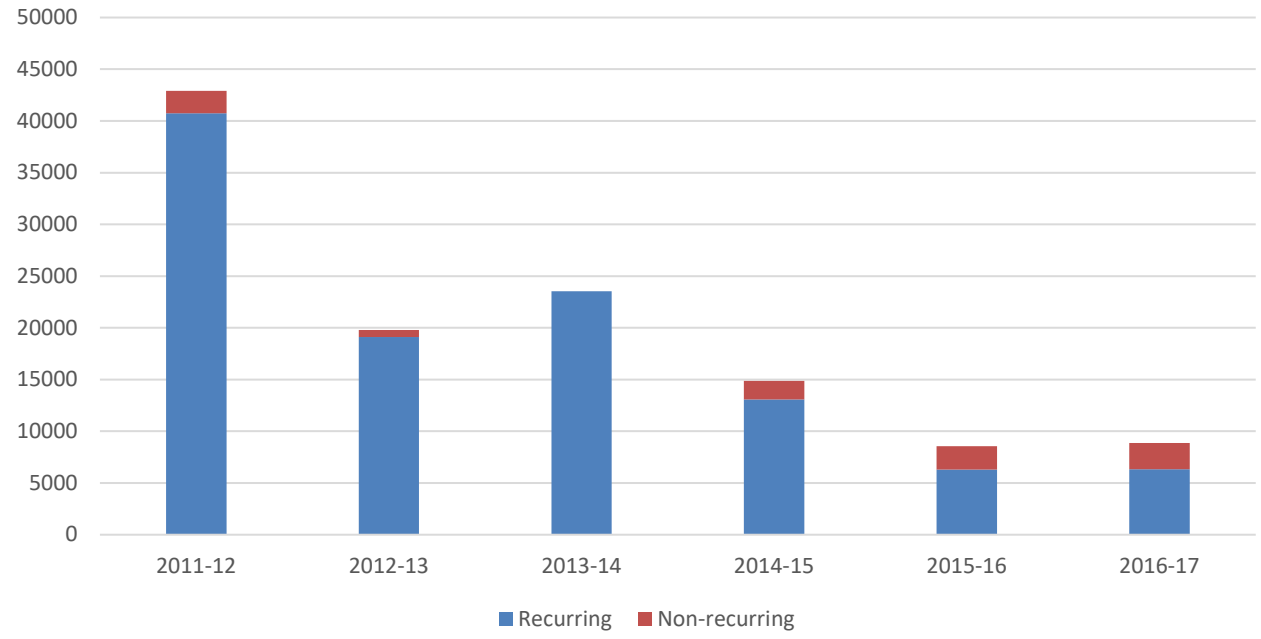
83 The savings planning approaches in 2016-17 and previous years resulted in a large number of savings schemes, which tended to focus on in-year cost control and transactional savings. The volume of schemes in 2016-17, at 305 would have made local and central management of these schemes challenging. There were also a number of low value schemes, and concerns raised during interviews identified that the level of project paperwork required for these was disproportionate to the type of scheme. In some cases, this was putting staff off progressing some ideas, particularly the low value ones.

84 It is important that all health bodies across Wales understand the extent of inefficiency in the organisation. In previous years, we have commented on the extent to which there are links between finances, service and organisation objectives, so that the full impact of decisions is known. In the Health Board, the budget is not zero-based, either in totality or for discrete parts. The links between the budget, objectives and other plans are also unclear. Without these, the ability to identify efficient and inefficient areas and to benchmark against good practice is difficult.

85 The Health Board recognises the need for the budget to be zero-based and clearly linked to activity and plans to start work on this over the next year. Whilst there has been some use of benchmarking to help inform savings and efficiencies, particularly in relation to areas such as prescribing, there is a need for greater use of this alongside the zero-basing of the budget to help drive efficiencies and target them at the right areas. This is particularly important given the poor history of savings planning and budget delivery.

86 When constructing savings plans, it is important to consider the balance between, and effect of, recurring and non-recurring savings schemes. A greater focus on recurring schemes should make the budgetary pressure lower in following years. We found that of the total savings identified in 2016-17, 28% of these were non-recurring. The level of identified recurring savings has gradually deteriorated over the last six years (Exhibit 8).

Exhibit 8: split between recurring and non-recurring savings



Source: Monitoring Returns to the Welsh Government

87 A large element of the Health Board's savings plans relates to pay. In 2016-17, £19.7 million of the £29.4 million savings target related to pay. Against this, the Health Board only achieved £2.7 million, of which £2.3 million was non-recurring. In 2017-18, £13.9 million of the £26.4 million current savings target relates to pay. At month six, the Health Board is already £1 million behind where it planned to be against its pay related savings target. Once short to medium-term workforce efficiencies, such as a reduction in bank and agency costs, are delivered, efficiencies relating to pay can only been achieved from longer term service changes.

88 The Health Board is currently operating to an annual operating plan (AOP), and plans to do the same for 2018-19. This can force the Health Board to develop an annualised approach to savings schemes, without thinking through the potential for savings over the long term. With a reliance on non-recurrent savings schemes, savings planning retains an annualised short-term focus, with little emphasis on planning for future years.

89 The Health Board has acknowledged that savings to date have been largely transactional and that there is a need for more transformational changes in order to achieve greater efficiencies in the future, although this has been harder to define given the lack of a clinical strategy. The Turnaround process along with the Transformation Programme should help focus attention on more transformational changes and efficiencies, with improved efficiencies already identified in relation to outpatients and operating theatres.

Sharing good practice and shared learning is improving but needs to become fully embedded so that this is done at a greater pace

90 As referred to in the paragraphs above, the Health Board's approach to savings and wider financial planning up to 2016-17 has remained broadly the same for a number of years despite the declining trend in financial performance.

91 Changes to the planning process however were made in 2017-18 to ensure that savings targets were removed from baseline directorate budgets. In addition, 'stretch targets' were introduced to push directorates to over-deliver against their required savings targets. The scrutiny and challenge of the budgets have also increased following the appointment of the new Turnaround Director.

92 Many of these changes have been because of the new appointments to the Turnaround Director and Director of Finance posts. However, planning information used to forecast the profile of individual savings schemes information and to monitor delivery against them continues to be inaccurate. There is a need for more work to understand the reasons why forecasts are incorrect and to strengthen these going forward.

93 In developing savings schemes, Welsh Government has had a scheme for a number of years called 'Invest to save'[6]. Up until March 2017, the Health Board had made no use of this scheme. In addition, the Health Board has not used any internal invest to save initiatives. Invest to save could be more widely used to help pump-prime required improvements, such as technology investments that result in cashable efficiency. There is also no use of a reward and recognition scheme within the Health Board to encourage and reward good performance against savings targets.

94 Across Wales, the prudent[7] and value based healthcare agendas offer an opportunity to maximise economy, efficiency and effectiveness through a focus on and alignment of individual patient outcomes, population health improvement, productivity and resources. There is a clear desire in the Health Board to embrace these principles but they are not well embedded into service planning at present.

95 The Health Board however was able to point to a number of examples of shared learning with external bodies and national groups in relation to achieving savings and efficiencies. However, interviews with staff identified that shared learning internally still needs to improve. The Turnaround process has enabled some shared learning but it appears that shared learning within the Health Board is limited to the turnaround process, or via finance staff. There is a need for shared learning to become more embedded in operational management, so that good ideas are shared and rolled out across the organisation on a regular basis. It is also important to share learning, to ensure that an improvement in one area does not create an unplanned cost pressure in another.

[6] Welsh Government Invest to Save

[7] Achieving prudent healthcare in Wales

While arrangements to monitor and scrutinise savings are being strengthened, they are not yet sufficiently embedded and there remains more work to do at an operational level

96 Robust and regular monitoring and scrutiny of saving plans and subsequent delivery ensure slippage, risks and issues are identified early so mitigating action can be put in place. The Board and senior management team need to be assured that savings are being delivered at pace and that the Health Board is on target.

97 In previous years, we have reported weaknesses in the monitoring and reporting of the budget. Steps have been taken to address this. In 2015, the Health Board established its Business Planning and Performance Assurance Committee (BPPAC) to ensure a holistic review of finance, performance and planning. Alongside this, the Integrated Performance Assurance Report (IPAR) was developed which aimed to bring together performance and financial information into one place. However, the BPPAC agenda is large and over time, the scrutiny of the Health Board's financial position reduced, although scrutiny had been provided at Board. Since the introduction of the turnaround process, BPPAC has taken a more proactive approach to scrutinising the financial position but recognised that more needed to be done. A new Finance sub-committee has recently been established to ensure that the financial position, including delivery of savings, is given more focused attention. A newly appointed independent member with a financial background and experience chairs this sub-committee, which met for the first time in November.

98 Finance and performance reports to the Board (and committees) however are still not integrated which makes it difficult to assess the impact of financial decisions on performance and vice versa. Since his appointment, the Turnaround Director has also produced a detailed paper, which sets out savings performance. The paper supports scrutiny of the overall savings position, as well as performance at directorate level and against corporate savings schemes. Since October 2017, steps have been taken to combine the turnaround position within the broader financial report. There remains a need however for greater triangulation of performance, workforce and financial data to provide a rounded view of the impact and risks of decisions, and the actions that need to be taken to deliver on the financial position, whilst not having a negative impact on performance and quality of services.

99 Prior to the turnaround process, the Quality, Innovation, Productivity and Prevention (QIPP) executive steering group signed off savings plans. Since the appointment of the Turnaround Director, fortnightly 'holding to account' meetings have been held with operational directorates and corporate services. Initially focused on scrutinising and monitoring delivering of savings plans, the remit of these meetings has now been extended to include scrutiny of budgets and the management of cost pressures. This process has added much needed scrutiny to the savings process at an operational level, although some directorates are finding the scrutiny challenging. A historical staff culture means that there has been resistance to some of these meetings and ongoing reasons for non-delivery of saving targets.

100 The Turnaround Director scrutinises the development of savings plans through a RAG rated system, which he then reports through to the BPPAC and subsequently to the Board. Through the holding to account meetings, the Turnaround Director is also challenging the operational directorates on the impact on quality of service provision. Clinical representation is part of the turnaround process in providing the quality assessment of savings schemes and the impact on performance. We have seen limited evidence of the consequence of individual saving schemes on performance or quality being effectively reported to BPPAC, QSEAC or Board, although the committees and the Board maintain a

high-level focus on performance and quality, and will refer matters between committees where there are concerns.

101 The role of the finance function within the savings and turnaround process has primarily been the provision of information rather than scrutiny and challenge. Finance representatives now attend the holding to account meetings, but could play a more active role in providing support and challenge to the directorates as discussed earlier in this report. A key part of their role would also be ensuring that better management data is available to ensure that quick decisions can be made.

102 The previous performance management framework exacerbated the cultural and behavioural issues associated with the delivery of savings plans as reported in previous sections. Previously, there has not been buy-in to the financial challenges by operational staff, nor the required financial savings, and they have not been performance managed to deliver against budget. Regular operational performance reviews are now in place through the Director of Operations; however, financial performance has limited coverage, with a broad assumption that the turnaround process is covering this.

103 The operational structure is also relatively new and leadership teams are, in some cases, still in the early stages of development. Directorate governance structures are also evolving and there is a need for a more standardised approach to be adopted so that key governance issues, including financial management and performance, are addressed at all levels. There is a need to change the culture amongst staff to ensure that all staff buy in to the financial position and the change needed. We discuss the Health Board's performance management arrangements later in this report.

104 Overall, the steps being taken to monitor the Health Board's financial position are still relatively new and will take time to embed but they are positive steps.

The Board has continued its work to define its assurance requirements and strategic plans are progressing, but operational structures and performance management arrangements need to be further developed

105 Our structured assessment work in 2017 has examined the Health Board's arrangements for planning, the effectiveness of the governance structures, information governance arrangements and performance management arrangements. We have also assessed progress against recommendations made in 2016. Our findings are set out below.

The Health Board is starting to develop its long-term strategy but this is not progressed enough to inform the next round of planning, and more work is needed to monitor annual plan delivery at an operational level

106 The findings underpinning this conclusion are based on our review of the Health Board's approach to strategic planning, monitoring and reporting on delivery of the Annual Operating Plan (AOP). We have also considered the arrangements, which support delivery of strategic change programmes underpinning the planning and service modernisation process, and the progress made in addressing previous recommendations relating to strategic planning. Our key findings are set out below.

The Health Board's annual planning process lacks collaborative working and ownership at an operational level

107 In 2016, we highlighted the Health Board's continued failure to secure an approved three-year Integrated Medium Term Plan (IMTP). This was in part due to the Health Board's lack of a clear clinical strategy to provide sustainable services and a balanced financial plan. Delays in the IMTP decision and the subsequent need to get agreement on the 2016-17 AOP resulted in the Health Board having limited opportunity to address concerns raised by the Welsh Government prior to producing an IMTP for the period 2017-2020, and the Health Board subsequently agreed with the Welsh Government to produce an AOP for 2017-18.

108 In developing the 2017-18 AOP, the Executive management team considered the draft prior to it being presented in more detail to the Board in January 2017. The Board subsequently approved this plan in March 2017, prior to submission to the Welsh Government, which formally approved it in June 2017. The Board further endorsed a refreshed Executive Summary version of the plan in May 2017, bringing together the updated financial strategy for 2017-18, along with the turnaround plans. It is noted that the plan presented on the Health Board's website however is the unapproved 2016-2019 three-year IMTP, and not the updated 2017-18 plan which is only accessible via Board papers.

109 The Health Board's 2017-18 AOP continues to be aligned with its 10 strategic objectives, which were first developed in 2016-17, the first eight of which focus on population health. Our previous structured assessment work has commended the Health Board on its drive towards becoming a population health focussed organisation, and it is positive to see this reflected in the current AOP. For 2017-18, the Health Board also sought to reflect the impact of new legislation such as the Well-being of Future Generations Act 2015, and the Social Services and Well-being Act 2014, building on its work with its partners through the West Wales Care Partnership.

110 Underpinning the 2017-18 AOP is a series of comprehensive action plans. The directorates developed the action plans, which set out their intentions for the period in question. However, they were inconsistent in their format and developed in isolation from each other, with separate action plans for each of the county directorates for example, as well as for the corporate functions. The planning team supported the directorates to develop their action plans, but there does not appear to have been a mechanism that brought together the action plans to ensure that they were complementary of each other and that opportunities for integration were maximised. Linkages to other existing strategies such as the Mid Wales Health Collaborative (MWHC), A Regional Collaboration for Health (ARCH) and the Swansea City Deal were also patchy, and although the summary plan provides a clear outline of the actions that intend to be taken during the year, not all of these are reflected in the underpinning action plans.

111 The responsibility of monitoring delivery against the AOP rests with the Business Planning and Performance Assurance Committee (BPPAC). Quarterly action plan reports are provided for scrutiny, along with the integrated performance assurance report, and updates on the financial and capital position. A mid-year update on progress is also provided to the Board. The action plans included as part of the annual plan and subsequently used to update the BPPAC clearly identify where delivery is off track, using a RAG rating system. Monitoring of delivery against action plans however does not appear to take place at a directorate level. There is no mention of delivery against plan in the directorate's performance management meetings, the directorate's own governance meetings, with

the exception of those for the Carmarthenshire County directorate nor at the Operational Business meetings chaired by the Director of Operations.

112 In 2016, we made the following recommendations relating to the development and scrutiny of the three-year IMTP. Exhibit 9 describes the progress made.

Exhibit 9: progress on 2016 operational planning recommendations

2016 recommendation		Description of progress
R4	Ensure there is sufficient capacity and infrastructure to facilitate the delivery of the Integrated Medium Term Plan and Service Change Plans.	**In progress but not yet complete** Our previous structured assessment work identified concerns relating to the capacity of the planning team, following staff movement. It also identified the Health Board's ambition to fully implement its revised organisational structure and establish its programme management office to provide the much-needed capacity to support delivery of the IMTP. The Health Board has fully implemented its revised operational structure, and has established its programme management office although this is only a recent development. The organisational structure however is still maturing and planning capacity to support the operational teams remains lean. Service change plans are in place for the finance function, although progress to make the necessary changes has not yet commenced.
R6	The Health Board should review current arrangements for scrutinising the AOP and emerging IMTP to ensure that the NHS Planning Framework 2017-20 requirements can be met.	**Complete** Our previous structured assessment work identified that following the NHS Planning Framework 2017-20, Health Boards were required to ensure that arrangements to monitor quality and delivery against plan were in place, with: • an executive group to oversee plan delivery; • a board sub-committee or group to scrutinise and challenge progress and performance on a regular basis; and • the Board to receive an overall assessment of progress at least bi-annually. The executive management team receive updates on delivery of the plan, and the BPPAC now receives quarterly updates against the plan with a six-monthly update also provided to the Board. The introduction of a new planning sub-committee will provide further opportunity for scrutiny and challenge.

The Health Board has taken proactive steps to develop its strategic vision, although the timeframe for development means that it will not inform the next round of planning

113 In our 2016 structured assessment work, we recognised that the Board had supported the establishment of a Clinical Services Strategy group, to drive and co-ordinate the development of its much-needed clinical strategy. This group was established in December 2016, with the plan to produce a strategy by March 2017, which would inform the 2018-2021 IMTP. Alongside this, the Health Board had developed a transformation group and programme of work, predominantly focusing on transforming out-of-hospital provision as part of a whole system response to managing demand. The Clinical Services Strategy however was overtaken by the development of a Transforming Clinical Services programme. In June 2017, these separate streams of work were combined into a single strategic programme, the Transformation Programme[8], along with the work that was also underway in relation to mental health, and women and children's services. A strategy was not produced for the March deadline, but the work undertaken to develop a Clinical Services Strategy was carried forward into the Transformation Programme.

114 During the summer, the Health Board undertook a 12-week period of engagement to seek views from the public and partner organisations to inform its Transforming Clinical Services (TCS) Programme. This was seen as Phase 1 of a three-phased approach to 'Discover, Design and Deliver', with the first phase focused on the Discover stage. The Health Board's intention was to present emerging solutions to the November Board meeting within its draft 2018-2021 IMTP, seeking agreement to progress to Phase 2, the Design stage during 2018. At the same time, the Health Board also undertook a 12-week period of consultation to seek views from the public on its Transforming Mental Health Services (TMHS) programme, with the intention to also present the final service model at the November Board meeting. This step was part of the agreement to progress to Phase 3, the Deliver stage during 2018.

115 Although the findings from both exercises had been presented to the Board seminar in September, only the findings from the TCS programme were formally presented to the November 2017 Board meeting. However prior to the meeting, the Welsh Government had advised the Health Board to work on an annual plan basis for 2018-19 and not a three-year IMTP, due to it being unlikely to produce a balanced financial plan over the next three-year period. In addition, the Health Board had already recognised that 2018-19 would need to be a bridging period while the potential service models for the Transforming Clinical Services Programme are worked through, recognising that it would be difficult to provide a definitive three-year plan when the longer term vision for services was still undecided. The Health Board is currently working on its draft AOP for 2018-19 in line with the Welsh Government requirement for a plan to be submitted by the end of March 2018. The Health Board has recognised the need for the underpinning action plans to be much more integrated, and is also strengthening its links with the regional strategies and the potential that these bring, including the development of the Llanelli Wellness Village as part of the Swansea City Deal. A draft AOP was due to be considered by the Board in November, but this will now be considered in a separate Board seminar, with the formal draft due to be considered by the Board in January 2018.

[8] The Transformation Programme consists of five work streams – out-of-hospital, urgent and emergency care, planned care, mental health services, and women and children's services.

116 In 2016, we made the following recommendations relating to longer-term strategic planning. Exhibit 10 describes the progress made.

Exhibit 10: progress on 2016 strategic planning recommendations

2016 recommendation		Description of progress
R5	Prioritise developing the Clinical Services Strategy to ensure that it is available in time to support the development of the IMTP and the supporting strategies	**In progress but not yet complete** Our previous structured assessment work identified that the Health Board had focused work on developing its Clinical Services Strategy, which would be needed to secure an approved 2018-2021 IMTP. The Transformation Programme has since superseded the Clinical Services Strategy work. It is the intention of the Health Board to now have potential service models from all of the transformation work streams to inform the development of the 2019-2022 IMTP.

The Health Board's revised organisational structure is maturing but could benefit from closer working between corporate and operational services

The senior management team is still relatively new and developing as a single leadership team

117 The Health Board's executive team is now almost at full complement, with the Director of Therapies and Health Sciences appointed and due to take up post in the New Year, and recruitment currently taking place to fill the Director of Primary, Community and Long Term Care post substantively. The new Directors of Public Health and Nursing, Quality and Patient Experience both took up post in the summer, and a new post of Turnaround Director was created and appointed to also in the summer period. The Health Board's senior management team however is large in comparison with other health boards, with 14 director posts within the structure including the Chief Executive. This compares with 10 director posts in other health boards such as Betsi Cadwaladr University Health Board, and Cardiff and Vale University Health Board. We acknowledge however that two of the director posts are on a fixed term basis to focus specific attention on the transformation and turnaround agendas.

118 The size of the senior management team does require directors to work collaboratively together and to be very clear on each other's roles and responsibilities. The recent Deloitte's review identified that there remained a need for greater integrated working between directors, and as a collective leadership team. Our work also identified that directors are still working through their responsible portfolio areas, and are not yet fully maximising the opportunities of realising greater benefits, if they work more collectively to support each other. A number of areas where we identified that directors could work better together include quality and safety, and turnaround, which up until recently have largely been

led by individual directors, mainly the newly appointed Director of Nursing, Quality and Patient Experience, and the Turnaround Director.

119 The need to be working better together has been recognised, with a recent presentation by the Chief Executive to his senior management team which focused on sharing personal objectives and identifying areas where the directors can maximise opportunities by working collectively. Following the appointment of a new Head of Organisational Development (OD) in the spring, a programme of work is also now in place to further develop collaborative working amongst the directors.

120 In our 2016 structured assessment work, we raised concerns relating to the size of some executive portfolios, with the capability of some supporting structures also a concern. In its September 2016 letter to the Health Board in relation to its escalation status, the Welsh Government recommended that the Health Board should review executive portfolios to ensure balance and appropriateness. While changes have been made to a number of director portfolios over the last 12-18 months, concerns remain in relation to the size of the portfolio for the Director of Operations, largely due to the maturity of the underpinning structure as discussed further in this report.

The revised organisational structure requires a degree of maturity and corporate services need to be more integrated with operational teams

121 The Health Board has now fully implemented its revised organisational structure with triumvirate teams, made up of a clinical director, general manager and lead nurse, in place at both directorate and service level across the organisation. All directorates report to the Director of Operations.

122 Observations at performance management reviews (discussed later in this report) indicate that the directorates, and consequently the Director of Operations, appear to be responsible for all aspects of operational business, including finance and workforce. The corporate functions, such as finance, workforce, planning and IT, however are not yet structured in a way that really enables the directorates to manage the totality of their resources. Instead, these functions act more as central services providing outreach into the directorates to provide traditional advice and support at the back end of an issue. The respective executive directors recognise this. For finance in particular, an Organisational Change Process (OCP) is currently being worked through to transform the finance service into one, which enables the operational service to think differently about how it manages its budget, and to be at the forefront of the operational discussions.

123 In addition, the triumvirate teams are at various levels of maturity, and for some areas, are still on a learning curve to fully grasp what is required of them to manage their respective areas. Although it is positive that each of the directorates are led by a clinical director, the Health Board has recognised that the clinicians in post still need to develop their leadership and management skills, and consequently all clinical directors and general managers at a directorate level are currently line managed by the Director of Operations. As the clinical directors develop their management skills, line management of the general managers should become their responsibility, freeing up capacity of the Director of Operations. This shift is in line with the intentions of the revised operational structure.

124 Although it is recognised that the operational structure has evolved over the last couple of years, the current structure requires a significant degree of communication between the directorates to ensure all relevant matters are considered, and Health Board wide service activities and priorities are met. For example, communication between the four hospital directorates responsible for unscheduled care and

the scheduled care directorate is required to manage winter pressures on beds and minimise the negative impact on planned care within each of the hospital sites. Similarly, the hospital directorates need to maintain regular communication with the county directorates to manage the flow of patients between hospital and the community. The Health Board is currently trialling a joint clinical director post across the county and hospital directorates in Pembrokeshire to see if this arrangement improves the communication flows, and better facilitates more co-ordinated working across the operational structures.

125 While it is positive that the Health Board has a Director of Primary Care, the current operational structure places primary care outside of the three county directorates, who are responsible for community services in their respective areas. This creates a fragmented focus to managing the totality of out-of-hospital services, and adds a further layer of complexity to arrangements. Although the Director of Operations holds monthly operational business meetings to bring collective issues together, because primary care is outside of the operational structure, they do not participate in these meetings and the primary care contribution to potential solutions is therefore missed.

126 The directorate teams can find that a lot of their operational capacity is taken up with meetings, with many meetings that they are required to attend often held in the Health Board's main headquarters in Carmarthen. This can place an additional burden on their time due to the travel involved, and during our fieldwork, it was noted that the Ceredigion based directorate teams in particular were less visible at these meetings. Many of the executive directors are visible across the Health Board, however a greater emphasis on ensuring all directors are visible along with facilitated opportunities for meetings to be held closer to the directorates bases, should help to free up capacity for the directorates to focus their time on managing the business.

Board assurance arrangements continue to evolve and plans are in place to improve the effectiveness of committees, although overall Board effectiveness is generally sound

127 As part of our 2016 structured assessment work, we considered arrangements that health bodies have in place to assess, plan and provide assurances as part of a board assurance approach. The findings underpinning this conclusion are based on our updated review of the effectiveness of the board, its governance structures and assurance arrangements. Our key findings are set out below.

The Board recognises that it needs to develop but overall provides effective scrutiny and challenge

128 The Board's administration and conduct continue to be effective. There are processes in place to review the board and committee effectiveness, with self-assessments undertaken at each committee on an annual basis. Like last year, we continue to observe good levels of scrutiny and challenge with generally good responses from executives at board and committee meetings, although it is recognised that the pace of action to address matters of concern at times is frustrating. Board agendas are long and although the items discussed are all of relevance, Board members however can get lost in the detail.

129 This year the Health Board has experienced turnover of independent members (IMs), although this has not been to the same degree that other NHS bodies have experienced. This is largely as a result of the Chair's effective management of IM appointments and the proactive approach to have a range of one to four year contracts in place, which means that IMs do not all leave at the same time.

130 Only two members of the Board have left this year, which has included the chair of the Quality, Safety and Experience Assurance Committee (QSEAC), and the chair of the Audit and Risk Assurance Committee (ARAC). Recognising the potential loss of individual knowledge and experience, the Health Board has been proactive in ensuring the appointment of new chairs of these committees prior to the outgoing chairs leaving. This has allowed for a period of handover minimising the impact on the quality and effectiveness of these meetings.

131 With new IM additions to the Board, there are a number of new executive directors and a recognition that the Board as a whole is still developing. Some of the IMs, including those new to the Board have substantial experience, whilst others are less familiar with the NHS governance arrangements, and are still developing their knowledge and skills. A number of development sessions are in place to cover the role of an IM, the role of the Board, individual portfolios, and the governance and assurance framework. Academi Wales and the NHS Confederation are delivering some of the sessions. The Head of Organisational Development is also working with all of the IMs to develop them as a team, and in February 2018 will facilitate a joint session with all of the executives to develop a high performing board.

132 As well as development sessions, throughout the year, there are also a number of Board seminars. The seminars allow IMs the time to understand particular issues in more detail than is allowed within the main Board agenda. This includes detailed discussions on such matters as strategic planning.

133 To support triangulation of issues and improve the connection between 'Ward to Board', there is now pairing of IMs and executive directors as part of a programme of Board walkabouts. This will enable IMs to correlate assurances provided, and will provide opportunities for IMs to engage with staff and patients, and gain a greater understanding of service issues. Findings from these walkabouts will be reported back to Board. These have been absent in the Health Board for some time, so it is positive to see that progress has been made to get a formal walkabout process in place, which will commence in January 2018.

134 In November, the Health Board moved to electronic board papers with the ARAC and Primary Care Applications Committee, the first committees to use them. The general view is that the electronic board papers are a positive step forward, freeing up capacity within the governance team, as well as those attending meetings, and facilitating advance upload of papers onto the Health Board's website prior to the meetings taking place. The electronic version of papers however has identified the need for papers to be much shorter and succinct, using hyperlinks to supporting papers where necessary, as opposed to including them in the board pack. Papers observed through Board and committee meetings are generally well structured but do provide a lot of detail.

135 In 2016, we made the following recommendations relating to board effectiveness. Exhibit 11 describes the progress made.

Exhibit 11: progress on 2016 board effectiveness recommendations

2016 recommendation		Description of progress
R7	Make strategic objectives more outcome focussed so that assurances can focus on the 'difference made' by delivering the objective.	**In progress but not yet complete** Our previous structured assessment work identified that the Health Board's measures to supporting the strategic objectives could be more outcome focussed to enable assurances to focus on the impact of the objectives. The Health Board's strategic objectives now have clear aims. Given that the majority of the objectives are population health focused however, it is recognised that more work is needed to clearly articulate the population outcomes that would be expected to be achieved. The recently appointed Director of Public Health will be looking to take this forward.
R10	The Health Board should ensure it complies with all requirements of the Welsh Health Circular WHC/2016/22 on transparent public reporting.	**In progress but not yet complete** Our previous structured assessment work identified that the Health Board did not provide easy access on their website to the Board annual plan, the complaints/concerns raising policy, and the flexible visiting times policy. Although the website does now contain a direct link to the complaints/concerns raising policy, the Board annual plan remains embedded within Board papers and the link to the flexible visiting times policy does not work.

Committee effectiveness needs to improve but this is recognised and actions are already being taken

136 The Board Assurance Framework (BAF) continues to evolve. The Health Board's BAF was first introduced in 2016, and our previous structured assessment work identified that the BAF compared well with other health bodies. The BAF is used to inform the agendas of the Board and its committees. Detailed action plans relating to each of the strategic objectives have started to be produced to provide assurance to committees on a rolling basis that mitigating actions are being taken. The first of which was presented to BPPAC in November 2017

137 The Health Board clearly recognises that there remains a need to improve its governance and assurance arrangements, not least the functioning of some of the committees. Our observations of the QSEAC identified items on the agenda that were more suited to the BPPAC given that the focus was on performance. In addition, there were operational matters presented to the committee, which could have been better dealt with through its sub-committees. Both the committee chair and the Director of Nursing, Quality and Patient Experience have recognised that the functioning of the QSEAC and its

sub-committees needs to change, and work has already taken place to reconfigure the sub-committee structure. The aim of these changes is to improve assurance flows to QSEAC.

138 Similarly, it is recognised that BPPAC meetings have become too long because of the depth of the agenda that the committee needs to cover. There have been proposals to introduce two main sub-committees for the group, one for finance and one for planning. These have both now been established and met for the first time in November. Both sub-committees will ensure focussed scrutiny in their respective remits and provide assurance to BPPAC, enabling a more manageable BPPAC agenda.

139 Interoperability between committees and cross referral of concerns have previously been a concern, however a new decision tracker has been introduced to log any matters than need referring, and the resulting outcomes. Chairs of committees now also meet regularly to plan through the agendas, and all committees, including the Board, now have an annual work plan.

140 The Health Board has developed a governance 'how to' manual, which was presented to Board in September. As part of this, there is work underway to review the effectiveness of all existing groups, sub-committees and behaviours. The intention is to set out clearer processes to ensure that management responsibility is clear, particularly in relation to papers, actions are tracked, and issues are effectively escalated.

141 In 2016, we made the following recommendations relating to committee effectiveness. Exhibit 12 describes the progress made.

Exhibit 12: progress on 2016 committee effectiveness recommendations

2016 recommendation		Description of progress
R9	Improve the clarity of audit recommendation tracking by including information in the summary of how many recommendations are overdue.	**In progress but not yet complete** Our previous structured assessment work identified the need to provide clarity in the summary briefing to ARAC members on the number of recommendations outstanding. The Health Board has since developed a proforma, which will aid the capture of the number of outstanding recommendations on the audit tracker. The proforma however is not yet fully embedded into the committee process.

2016 recommendation	Description of progress
R11 The Health Board should ensure that reports from the Delivery Unit are subject to its governance and assurance arrangements.	**Complete** Our previous structured assessment identified that while internal and external audit reports received the necessary profile, the picture is less consistent in respect of reports produced by the Delivery Unit. The Delivery Unit reports are now included as part of the Health Board's audit and review tracker tool, however, the tracking process is reliant on lead officers informing the governance team that the report has been received.

Risk management arrangements have continued to be strengthened but more needs to be done at an operational level

142 The findings underpinning this conclusion are based on our review of the effectiveness of risk management arrangements and progress in addressing previously identified improvement issues relating to risk management. Our key findings are set out below.

143 The Health Board has recently revisited its risk management arrangements with a new framework launched in September 2017. The framework focuses on clarifying the escalation processes, the responsibility for reporting risk, and the correct controls and actions. Alongside the development of the risk management framework, the Health Board has restructured the risk team with a head of assurance in place, supported by a senior risk officer, an assurance officer and a risk support officer. The role of the team is to support the organisation in identifying and managing risks, including the risk registers.

144 A recent Board development session was used to revisit the Board's appetite for risk and tolerance levels. The session considered all risks set out in the corporate risk register scoring 15 or more. Following the finalisation of the risk management framework, the operational teams will receive a briefing session through the monthly operational business meeting in February 2018.

145 The Health Board has a relatively robust corporate risk register, developing this further since our 2016 work. The corporate risk register is derived from risks arising from the directorates, which could affect the Health Board's day-to-day operations. The risk register now includes the date the risk was identified, the date by which actions need to be taken, and the review date. It also includes a description of the controls and additional required actions, the business domain and the target level of risk. It does not however link the risks to the Health Board's strategic objectives, and therefore it is difficult to see where the operational risks are having a direct impact on the Health Board's ability to deliver against its objectives.

146 The operational performance reviews also reflect on the risks, and attention given to making sure that operational directorates maintain a focus on continuing to reduce the risk through mitigating actions. A new approach to reviewing and monitoring directorates' risks was introduced in the summer, using a radar diagram to present the actual versus target risk score. The review dates for some risks were

however out of date. There is also a need now to build on the work to date with operational directorates to refine the risk being identified locally, whilst not losing sight of the day-to-day operational issues that they are managing.

147 In 2016, we made the following recommendation relating to risk management. Exhibit 13 describes the progress made.

Exhibit 13: progress on 2016 risk management recommendations

2016 recommendation	Description of progress
R8 Strengthen the corporate risk register by adding dates, description of controls, additional required actions, description of residual risk, linking objectives and identification of risk tolerance.	**In progress but not yet complete** Our previous structured assessment work identified that there were a number of areas were the Health Board's corporate risk register could improve. The corporate risk register has since been updated and now includes the date the risk was identified, the date by which actions need to be taken, and the review date. It also includes a description of the controls and additional required actions, the domain and the target level of risk. It does not however link the risks to its objectives.

Information governance arrangements support compliance with current legislation, but meeting the significant challenges of GDPR and Cyber Essentials requirements will be challenging within the current resources

148 The findings underpinning this conclusion are based on our review of the effectiveness of the Health Board's information governance arrangements and progress in addressing previous recommendations relating to information governance. Our key findings are set out below.

149 In our 2016 structured assessment work, we identified that the Health Board had put in place a new Information Governance structure, with a Head of Information Governance appointed in October 2016. The team is responsible for all aspects of information governance supported by, and reporting to, the Director of Planning, Performance and Commissioning. The Information Governance sub-committee (IGSC) receives updates from the team, which in turn, provides assurance to BPPAC.

150 The Health Board is aware of the new General Data Protection Regulations (GDPR), which come into force in May 2018, and have begun a review of its current policies to bring them in line with the new legislation. Policies and procedures are in place to meet current legislation including Data Protection Act, Freedom of Information Act, Wales Accord on the Sharing of Personal Information (WASPI) and Caldicott requirements. The Health Board has had a number of reported data protection breaches, which are reported through the IGSC.

151 To be compliant with GDPR and Cyber Essentials, the Health Board needs to do more than review its Information Governance policies. The Health Board is aware of what is required and has begun work

to ensure compliance. This includes identifying its information assets, appointing information asset owners and instigating a review of all of its WASPI agreements. The Information Governance manager and her team, with support from the IGSC, are carrying out the majority of this work. The limited resources available in this team and the size of the Health Board will make this work challenging in terms of scope and timing. The IGSC has recognised this and has identified the need for an external gap analysis to identify the areas they need to target their limited resources; this is currently awaiting approval by the Executive Team. The Health Board will need to ensure that a decision is made quickly, as non-compliance with the GDPR can result in significant financial fines.

152 In 2016, we made the following recommendation relating to information governance. Exhibit 14 describes the progress made.

Exhibit 14: progress on 2016 information governance recommendation

2016 recommendation	Description of progress
R12 Improve the pace at which outstanding information governance, and information management and technology (IMT) related audit recommendations are addressed.	**In progress but not yet complete** Our previous structured assessment work identified that while progress had been made on addressing data quality arrangements, the pace of addressing some recommendations had been slow. Our recent work has identified that the pace of progress in addressing information governance, and IMT related audit recommendations has improved but a small number remain outstanding. This includes recommendations relating to: • disaster recovery testing, with a test planned for the new year; • physical and environmental controls at the Glangwili and Withybush data centres; and • data cleansing processes between PAS and Radiology systems. A detailed progress update review of information governance and IMT related recommendations will be reported in a separate Wales Audit Office report.

The Health Board's performance management arrangements need strengthening at an operational level to enable the necessary assurances to be given to the Board and its committees

153 Health bodies in Wales are held to account on a range of national measures and targets that are set out in the NHS Wales Delivery Framework 2017-18. In addition to these national targets, health bodies can set local measures and targets to focus on areas particularly pertinent to them. We have reviewed performance management and reporting arrangements, as well as the trend in performance against key measures. Our key findings are set out below.

Operational performance management reviews are not sufficiently focused or co-ordinated

154 The Health Board has recently revised a draft performance management framework, which was approved at its September Board meeting. Day to day performance management rests with the operational teams overseen by the Director of Operations. A scheduled programme of performance management reviews are held with the directorate teams on a bi-monthly basis throughout the year. These reviews cover all directorates that report directly to the Director of Operations, including community and mental health services. The performance management reviews are chaired by the Director of Operations and since her appointment in the summer, the Director of Nursing, Quality and Patient Experience has also attended. There is also representation from the HR and finance teams, and where possible, the Medical Director will attend. However, of the meetings we observed as part of our structured assessment work, neither the HR representative nor the Medical Director were present, and the relevant clinical director was not present in one of the reviews.

155 A set agenda for each of the performance management reviews is used, focusing on workforce, quality and safety, activity, finance and risk. High-level information is available on a range of workforce metrics, and dashboard reporting on high-level performance Tier 1 targets relating to activity is also included. Underpinning the directorate performance management reviews, the directorates have each established their own governance structures through which they should be managing the performance of their respective departments. The extent to which performance is considered within each of the directorates' governance meetings is however mixed.

156 In all of the review meetings we observed, it was evident that the time allocated did not allow sufficient discussion on important areas. In a number of reviews, the majority of time was spent considering workforce, and quality and safety indicators, and even so, the quality and safety aspects were very high-level. Very little attention, if any, was given to performance, finance and risks, and there was no consideration of any medical quality and safety issues. There was also no consideration of how well the directorate was delivering against its requirements of the AOP and financial savings.

157 In each of the meetings, the operational teams raised concerns with the quality of workforce data used to monitor workforce performance, with these issues a repeat of issues raised in the previous meetings. Moreover, although there is a dashboard of activity performance data, the data is aggregated to either Health Board or hospital level, and does not provide the depth of information that you would expect to see at an operational performance management review, for example, by ward or specialty.

158 During the performance management reviews, we observed the finance representatives providing some challenge relating to the bottom-line position; however, it would be more beneficial for these representatives to be enabling and supporting the teams to deliver actions and improvements. Although it is positive to see the Director of Nursing, Quality and Patient Experience now playing an active role in the reviews; however, the Director of Operations is ultimately holding the ring on the performance reviews. The process would benefit from being a more comprehensive review, which brings in other Executive Directors (and/or assistant Directors), including the Turnaround Director, who is currently holding the directorate teams to account for delivery in a separate stream of meetings.

159 Primary care is excluded from the performance management review process and is instead managed through the development of the primary care clusters. These have been established during the year, recognising the sustainability issues that the Health Board is facing in relation to the delivery of its

primary care services. The interim Director of Primary, Community and Long Term Care oversees development of the clusters, and progress is reported to the Board.

160 In addition to the bi-monthly performance reviews, the Chief Executive Officer also holds a rolling programme of monthly performance reviews to hold the operational directorates to account against delivery of the Tier 1 targets. This largely is with the aim of providing assurance to the Chief Executive Officer, and ultimately the Welsh Government through the Joint Executive Team (JET) meetings that the Health Board will deliver against its performance and financial targets.

Scrutiny of performance at committee level lacks focus and attention on areas of underperformance

161 The BPPAC has delegated responsibility to scrutinise performance on behalf of the Board. The Health Board has a detailed Integrated Performance Assurance Report (IPAR), which seeks to provide assurance on delivery against all of its Tier 1 targets. We have previously commented that the Health Board is continually strengthening the IPAR, but exception reporting needed to improve. Our current work has found that the IPAR has now become unwieldy and the committee struggles to focus on the areas that need the most attention. While the BPPAC needs to recognise where the Health Board is achieving good performance, its focus ultimately needs to be on seeking assurance on the actions that the Health Board is taking to deliver on the underperforming areas. A task and finish group, made up of members of BPPAC have recently reviewed the IPAR structure and a revised version is currently being developed.

162 As part of its performance management framework, the Health Board could also benefit from developing a suite of locally based performance targets to underpin the Tier 1 targets. This would help provide BPPAC and the Board, with a more focused picture on areas of underperformance. An example of this would be the Tier 1 target in relation to the 12-month rolling reduction of delayed follow-up appointments. The Health Board is currently meeting this target; however, the Tier 1 target does not provide the context in relation to the totality of patients on the follow-up waiting list, the extent to which patients are delayed, and the number of those delayed who have a booked appointment. All of which are currently problematic.

163 Because of his responsibilities, the Director of Operations is largely the lead officer accountable for performance. Our observations at the BPPAC indicate that, on a number of occasions, it has been unable to take assurance that operational performance is improving. Although the Director of Operations is keen to prevent unnecessary travel and attendance at committee meetings, asking the relevant directorate teams to present progress on particular performance areas where there is continual underperformance would strengthen scrutiny and challenge on operational performance.

Although there have been improvements, performance against national measures is mixed, and the Health Board is failing to meet financial and some workforce targets

164 The Health Board's overall performance against the national delivery framework is mixed. Given our work has taken place part way through the year; we have considered progress made over the previous 12-month period up to October 2017. The Health Board is performing well in relation to stroke management, mental health assessment, delayed transfers of care, diagnostic waits and delayed follow-ups (noting the caveat in paragraph 161 above). The management of cancer referrals is also

improving, although performance is not quite at the target level. This performance is positive given the Health Board's historical performance against all national targets.

165 Performance against the national targets for unscheduled and scheduled care is however less positive, with targets not yet achieved for waits for emergencies and Referral to Treatment (RTT) times. However, performance is improving over time and, compared to other Health Boards particularly in relation to unscheduled care, is some of the better performance across Wales (Exhibit 15).

Exhibit 15: performance against unscheduled and scheduled care targets (October 2016 – October 2017), compared with October 2015

	Oct 15	Oct 16	Jan 17	Apr 17	Jul 17	Oct 17	Current position in Wales
Number of patients waiting more than 1 hour for an ambulance handover	94	58	178	62	37	202	2nd
% of patients spending more than 4 hours in an Emergency department	86.5	85.2	82.8	87.5	89.4	85.4	3rd
Number of patients waiting more than 12 hours in an Emergency department	255	364	547	274	278	580	5th
% of patients waiting less than 26 weeks for treatment	78.8	80.0	81.4	85.2	84.4	83.6	6th
Number of patients waiting more than 36 weeks for treatment	6,202	4,809	4,827	2,965	3,328	3,265	4th

Source: Hywel Dda University Health Board's Integrated Performance Assurance Report

166 As discussed earlier, the Health Board is also failing to meet its financial target and some of its workforce targets, with:

- only 63% of staff having a PADR or medical appraisal in the last 12 months; and
- only 55% of staff completing mandatory training.

167 The Health Board is meeting the Welsh Government sickness absence target of a rolling reduction over a 12-month period.

The Health Board has taken significant steps to improve stakeholder engagement, and strengthen its informatics arrangements, but needs to do more to develop its workforce and is still reliant on external capacity to drive change

The Health Board's transformation programme is its vehicle for service change, supported by its programme management office but it is still reliant on the use of external resources

168 The findings underpinning this conclusion are based on our review of arrangements in place to support the delivery of change and transformation. Our key findings are set out below.

169 The Transformation Programme is the Health Board's main driver for change (as discussed in paragraph 113), supported by the Service Improvement Programme, which focuses more on short to medium changes to improve efficiencies. The Transformation Programme formally commenced in 2017, although two of the five transformation work streams had already commenced prior to the formal establishment of the Programme. These are the Transforming Women and Children's Services programme, and the Transforming Mental Health Services (TMHS) programme. Although the Transformation Director has been involved in the TMHS programme, the capacity to drive through the changes from these two work-streams largely rests with the respective operational directorates.

170 To support the Transforming Clinical Services (TCS) programme, the Health Board has established a further three work streams focused on out-of-hospital care, urgent and emergency care, and planned care. Each of these work streams are led by two clinicians, one from primary care and one from secondary care. The work streams also include representation from relevant professional groups, key partners including the community health councils, and primary care localities, as well as an independent member from the Board.

171 As mentioned in paragraph 114, the Health Board embarked on a 12-week engagement exercise during the summer to inform the 'Discover' stage of the TCS programme, as well as a 12-week consultation exercise to inform the 'Design' stage of the TMHS programme. These two exercises were co-ordinated through the Transformation Director and Director of Governance, Communication and Engagement. Members of the senior management team and lead clinicians jointly ran the respective sessions held across the Health Board's localities. The Health Board commissioned the use of Capita to provide programme management support for the TCS programme. The Health Board also commissioned Opinion Research Services (ORS) to provide analysis of the TCS engagement exercise, the results of which were presented to the Board in November 2017.

172 In our previous structured assessment work, we have made reference to the Health Board's plan to develop its own Programme Management Office (PMO). This has now been established under the leadership of the Director of Planning, Performance and Commissioning, and consists of five programme officers, and five data analysts. The last of the appointments to the PMO were made in

October. Some of the PMO have been working alongside Capita on the 'Discover' stage of the TCS programme. The aim is that the PMO will take over the support needed for the next phase, focusing on the design of the potential options.

173 A Service Improvement Team (SIT) supports the Transformation Director. This team consists of a head, and three service improvement leads. The purpose of the SIT is to provide dedicated resource to help stimulate the transformation discussion at an operational level, focusing on the opportunities to improve service provision. As well as support to the operational directorate teams, the SIT focuses on three specific areas – outpatients, operating theatres and the orthopaedics pathway. Many of the opportunities that are being identified through these three improvement areas are operational efficiencies. The team are now working very closely with the Turnaround Director to improve the Health Board's financial position. The Turnaround Director has introduced a '60 day' process, which aims to identify opportunities for efficiencies through improved working. This includes a process of discussion, working up of ideas and then testing them in practice. If the improvements are found to be beneficial, they are then included within savings plans. Directorates are then held to account to deliver against them. The SIT is a key stakeholder within the '60 day' process.

174 Overall, the Health Board has a number of strands to support the delivery of change. Through the transitional work with Capita, and the full establishment of the PMO, it is slowly building its own capacity and capability to support change going forward. The Health Board however recognises that it still requires external expertise to support the next phase of the TCS programme; however, this will be to specifically provide independent quality assurance and guidance. The challenge for the Health Board will be in making sure that all of the strands align and work together. While this appears to be the case now, as the turnaround agenda needs to push for more transformational change in the short to medium term, this will need to be complementary to the longer term direction of travel emerging from the Transformation Programme. The development and delivery of the 2018-19 AOP and longer-term three-year IMTP need to support the turnaround agenda.

175 In 2016, we made the following recommendations relating to change management. Exhibit 16 describes the progress made.

Exhibit 16: progress on 2016 change management recommendations

2016 recommendation		Description of progress
R2	Take active steps to reduce future reliance on external support for the provision of skills, capacity and capability by working with those external organisations to sustainably build and embed programme and project management along with data analytical skills in Health Board staff.	**In progress but not yet complete** Our previous structured assessment work identified that the Health Board was reliant on procuring an external strategic partner to access skills quickly. The Health Board has now established its programme management office (PMO) with the intention for the PMO to take over the support needed for the next phase of the Transforming Clinical Services programme. The Health Board recognises however that it will still require external resource to support the 'Design' stage of the TCS.

2016 recommendation		Description of progress
R3	Agree and adopt formal change management approaches and data analytic approaches.	**In progress but not yet complete** Our previous structured assessment work identified that the Health Board had not adopted a programme management methodology for managing complex service transformation, and to support successful delivery of projects or programmes. The Health Board has adopted the Discover, Design and Deliver programme approach to transformation, which is being applied to its Transforming Clinical Services programme. However the TSC programme is only at the 'Discover' stage, and it is too early to see whether the three-stage approach will be effective, The Health Board has also now established a team of data analysts within its PMO. Their role will be support the development of the service models as part of the TCS programme, as well as support wider demand and capacity reviews within the operational services.

Although there are improvements, the Health Board continues to have a number of staffing challenges and needs to do more to transform its workforce

176 The findings underpinning this conclusion are based on our review of arrangements to manage the workforce efficiently, effectively and economically. Our key findings are set out below.

177 Workforce performance measures reported through the Integrated Performance Assurance Report indicate that sickness absence is reducing. In October 2017, the level of sickness in-month was below the Welsh Government target at 4.7%. There is a staff member within the workforce function dedicated to the management and support of sickness absence issues, which includes routine audits and the provision of training and advice to operational directorates. This role, along with the focus on sickness absence at the bi-monthly performance management reviews, appears to be having a positive impact on sickness absence.

178 Medical staff appraisals are above target at 93%, which is largely influenced by the medical revalidation requirements. However, the extent to which consultants have up to date job plans (less than 12 months old) is low at just 26%. The extent to which non-medical staff have received a performance appraisal and development review (PADR) is also below target at 63%. Performance for PADR in some of the corporate functions is the lowest. As mentioned earlier in this report, there are concerns with the quality of data contained in the Electronic Staff Record system, as well as the completeness of the data, which can affect the recorded PADR rates.

179 Compliance with mandatory training is also an issue, with performance in October 2017 at 55% compared to the target of 85%. The learning and development team are currently looking at how mandatory training can be delivered differently, as operational directorates, like many others across Wales; struggle to find the capacity to release staff to attend training.

180 Although vacancy levels have reduced, along with turnover rates, recruitment remains a problem for the Health Board. The Health Board has run a number of successful recruitment open days at hospital sites targeting university areas, using social media and advertising as far afield as the London Underground as examples. The Health Board has also travelled abroad to seek international recruits, offering opportunities for new recruits to develop their language skills. Nevertheless, the Health Board currently has a vacancy rate in the region of 370 posts, and is reliant on the use of bank and agency staff. The Health Board spends a greater proportion of its total workforce expenditure on agency and locum staff than all other health bodies in Wales.

181 To support the financial position, work had been underway to strengthen management and control of costs associated with the use of nursing agency staff and locum medical staff. The Health Board is the only one using the agency supplier, Thornbury, an off-contract supplier. The Director of Workforce & Organisational Development (OD) has been leading a substantial piece of work to reduce the use of Thornbury, with a phased implementation from 1 November 2017. In addition, the Health Board has extended opening hours of the Bank Office in order to provide deploy resource more effectively. In parallel, a focused piece of work has also been in place in relation to medical variable pay reduction taking into account such issues as the agency worker pay caps introduced by the Welsh Government.

182 Despite the recruitment challenges, the Health Board has now also set up a weekly workforce control panel to provide a more efficient and timely mechanism to get vacant posts agreed and processed. The control panel includes the Director of Workforce and OD, the Director of Finance and the Turnaround Director.

183 Underpinning the 2017-18 AOP, the Health Board has a detailed workforce plan. This plan is traditional in its nature, focusing on what actions will be taken to address the current core HR issues such as sickness absence, training and recruitment. There is limited reference to what actions the Health Board will take to modernise and transform its workforce. The Health Board has been slow to transform its workforce, and still very much focuses on grade as opposed to the necessary skills and roles required to complete a job, regardless of profession. However, the Health Board recognises that its focus has had to be on getting the organisation stable in relation to its workforce before moving into the transformation agenda.

184 For the Health Board to realise the benefits of its developing work on Transforming Clinical Services, transforming its workforce needs to be central to the discussions. HR representation is included within the Transformation Programme, with the assistant directors supporting the five work streams. However, their involvement is to understand the potential implications on staff of any service changes rather than advising or engaging on future models. The Transformation Programme would benefit from organisational development support, in order to help generate the workforce transformational ideas. The Health Board however lacks organisational development capacity, with just one OD practitioner in post, having joined the Health Board in the spring. Given some of the OD challenges at the senior management and operational level, as well as the Board, her capacity to date has been targeted at these areas.

185 Finally, clinical engagement has been an issue for the Health Board, and it was identified during our fieldwork as an issue that still needed to be addressed, despite some improvements. The 2016 'Patterns of Medical Engagement in Welsh Health Boards' report indicates that the level of medical engagement is generally low in the Health Board. This is particularly the case for consultants and senior medical grades. The report also indicated that medical engagement was more positive in relation to providing patient care, and working in a friendly and supportive environment. Medical staff were least engaged in corporate issues such as understanding the financial consequences, developing the business, and quality, safety and performance. This would reflect the need for the Health Board to develop its lead clinicians into leaders and managers, as discussed in paragraph 50.

The Health Board is taking an open and proactive approach to stakeholder engagement and is working positively with its partners

186 The findings underpinning this conclusion are based on our review of arrangements in place to effectively engage with stakeholders and work with partners. Our key findings are set out below.

187 As previously discussed, the Health Board has recently undergone a substantial period of engagement and consultation over the summer as part of its Transformation Programme. As part of the TCS programme, the Health Board's 'Big Conversation Event' engaged the Health Board's stakeholders through a wide range of opportunities. Information was circulated to approximately 4,000 stakeholders, and opportunities for stakeholders to make their views were available through surveys, attendance at over 80 events and using social media.

188 Through the 'Big Conversation Event', the Health Board took the opportunity to have an open and honest conversation with its stakeholders over the sustainability challenges that it is facing and the need to 'do things differently'. This engagement process was seen to be an overwhelmingly positive approach and a significant change to the way in which the Health Board has historically engaged with the public in recent times.

189 While undertaking the 'Big Conversation Event', the Health Board was also consulting with its stakeholders over the potential models of care for its Transforming Mental Health Services programme. A similar approach was taken to allow stakeholders to make their views on the suggested models being put forward, which has also received a positive response. For all of the Health Board's transforming agenda, all information has been made available on the Health Board's website.

190 Both of the Health Board's engagement/consultation events with its stakeholders have been recognised nationally as outstanding programmes of work, and the Health Board should be commended for the significant positive steps that it has taken to engage particularly with the public.

191 Alongside the Transformation Programme, the Health Board also continues to engage with its key partners for routine business. The Health Board is actively engaged in the West Wales Care Partnership and is working with its local authority partners to work through the implications of pooled budgets, the first of which are required to be in place by April 2018.

192 The Health Board is also playing an active role in a number of the national agendas, with the Chief Executive Officer for example, the lead for critical care, and imaging services across NHS Wales. Through the regional planning committee, the Health Board is also continuing to strengthen its partnership arrangements with Abertawe Bro Morgannwg University Health Board, with regional collaborative arrangements developing, for example, for vascular and ophthalmology services.

Improvements have also been made in the ARCH collaborative, and there is a strong lead into the Mid Wales Health Collaborative, with the Health Board also actively taking a role in a number of other partnership arrangements.

193 The Health Board has however recognised that it is involved in a considerable number of partnership arrangements, not all of which add value. Recent work has been undertaken to review existing partnership arrangements, using a weighting process. This has led to some valuable insights, which have informed decisions about which partnerships to prioritise, including the West Wales Care Partnership Board and its three Public Service Boards.

194 The Health Board has also recognised that some of its statutory partnership arrangements are still relatively new and evolving, but importantly require robust governance arrangements to be put in place to prevent the Health Board being exposed to any risk. In response to this, the Director of Governance, Communication and Engagement has developed a partnership governance framework and underpinning toolkit. This was approved by the Board in September, and a partnership governance officer is also now in place.

The Health Board has made concerted efforts over the last year to strengthen informatics arrangements and pick up the pace in delivering its digital strategy but it is too early to say how effective these arrangements will be

195 The findings underpinning this conclusion are based on our review of the Health Board's use of information technology arrangements. Our key findings are set out below.

196 The Health Board has appropriate information management and technology (IMT) structures, policies and procedures in place including an executive lead, strategic outline programme (SOP) and reporting structures to manage the IMT function. The executive lead maintains a weekly focus on IMT issues through discussions with the Assistant Director of Informatics, and maintains communication with the wider informatics team on a monthly basis to ensure projects are being progressed and to discuss and escalate risks, where relevant. All matters relating to IMT and Information Governance are scrutinised through the BPPAC, and the two IMT related sub-committees – IGSC and the Capital, Estates and IMT sub-committee.

197 In the past, accountability for delivery of IMT projects has not been consistent and some projects ran over budget in terms of time or resources, or were not delivered at all. To address this, the Health Board now has a digital health strategy, with five themes identified from the TCS programme. This strategy recognises the potential that digital can have in improving services and patient experience. The IMT department has an annual plan in place, which draws from the key themes in the digital strategy, as well as areas of risk, statutory requirements, the AOP, and service requirements.

198 To prioritise actions within the plan, a decision matrix process was introduced in 2017. The top priorities were presented to the Board and include projects such as the Welsh Clinical Portal transition, Ward to Board reporting, email upgrade and GDPR. It is the responsibility of the IMT team to deliver the plan. Nevertheless, they also need to respond to emerging issues such as system or server issues, and cyber-attacks that affect the Health Board throughout the year. Given the limited IMT resources available and that the prioritisation process is still in its infancy, it is too early to say how successful this process will be in delivering on the Health Board's digital strategy and other priorities.

199 The IMT team and its executive lead recognise the challenge ahead and have identified particular risk around:

- Cyber and IT security
- Infrastructure support
- Project management and business change support for major projects

200 These are the subject of papers to the senior management team identifying the need for additional IMT resources, but no decision has yet been made on whether the additional resources will be provided.

Appendix 1

The Health Board's management response to the 2017 structured assessment recommendations

Exhibit 17: management response

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R1	**The Health Board needs to improve the identification and design of saving schemes through:** a. **increasing the use of data and intelligence to identify opportunities for efficiency improvements reflecting them in more meaningful and realistic savings targets for different areas of the business;**			
	Greater understanding of the extent of inefficiency in the system to help improve budget management and the targeting of schemes, which will result in recurring savings. A greater focus on recurring schemes will also help reduce budgetary pressures in following years.	The Health Board recognises the issues raised and has established an Efficiency Opportunities Control Group to both review efficiency opportunities identified at a National level (via the NHS Wales Efficiency, Healthcare Value and Improvement Group and the Efficiency Framework) for local application and to highlight other improvements through benchmarking exercises. This will form the basis of savings targets. The Group has met since autumn 2017. The Directors of Finance and Turnaround are currently assessing the membership and role of the Group to ensure it is best placed to undertake these key functions.	March 2019	Director of Finance
R1	**The Health Board needs to improve the identification and design of saving schemes through:** b. **avoiding over-reliance on in-year cost control, accountancy gains and non-recurrent savings; and**			
	Greater understanding of the extent of inefficiency in the system to help improve budget management and the targeting of schemes, which will result in recurring savings. A greater focus on recurring schemes will also help reduce budgetary pressures in following years.	Cost control must be ingrained into the organisation and the Turnaround Programme is trying to engender a culture where every decision to spend is thoroughly scrutinised by budget holders to ensure value for money is delivered. It is also recognised that this by itself is not sufficient and the main savings schemes will look at different ways of working that deliver value services rather than just relying on technical savings opportunities.	March 2019	Director of Finance

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R1 The Health Board needs to improve the identification and design of saving schemes through: c. **embedding the 60-day cycle process to identify where longer-term and sustainable efficiencies can be achieved through service modernisation, and approaches such as value-based healthcare and productivity improvements.**				
	Greater understanding of the extent of inefficiency in the system to help improve budget management and the targeting of schemes, which will result in recurring savings. A greater focus on recurring schemes will also help reduce budgetary pressures in following years.	The initial assessment of opportunities, that suggest the organisation could deliver similar or even enhanced services for less financial cost, has produced a target list of circa £44 million. It builds on the headings from 2017-18 but with an increased focus on efficiency and productivity – Length of Stay bed day reduction, low acuity medically fit model, Outpatients, Theatres. The Health Board is also moving to implementing evidence-based pathways that will offer increased value in Orthopaedics, Ophthalmology etc. In part, this is by pulling forward opportunities identified through the Transforming Clinical Services process as they arise. In order to ensure delivery, the Health board is strengthening further governance structures around delivery. During 2017/18, nine 60-day cycles were run for six themes, which identified a series of actions to support the delivery of the savings plan. This approach will continue. Each theme identified may be subject to more than one 60 day cycle during the course of 2018/19 and this will be dependent upon the number and type of opportunities identified during each initial cycle	March 2019	Director of Finance

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R2	**The Health Board needs to develop the financial management capabilities within the operational directorates and service departments by progressing with the organisational change process for the finance department. The change will see the finance staff align with the operational structure and provide greater opportunity for them to provide support and challenge on a day-to-day basis.**			
	Operational teams at directorate, service and department levels will have the skills to effectively manage their budgets and identify opportunities for financial efficiencies.	The Finance OCP proposal recognises the importance of the following; 1. Investing in Business Partnering with service areas 2. Developing a 'Business Partner' approach which is fundamentally different from Management Accounting 3. Getting out into the service on a more consistent basis to support and challenge 4. Making investments in and full use of systems 5. Establishing 'Centres of Excellence' in key deliverables such as Value Based Healthcare techniques, Benchmarking and Costing, data analysis and financial Reporting. Consultation on the Finance OCP issued before Christmas 2017 and closed on 17 January 2018. The following milestones have been set: • Comments received will be considered and changes agreed by Mid February 2018 • Appointments of staff spring 2018 • Training and development throughout 2018-19 • The new Finance function is expected to be in place and fully operating to expectations by Christmas 2018 (funding permitting)	March 2019	Director of Finance

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R3	**The Health Board needs to adopt a more proactive approach to learning and sharing good practice about savings and wider financial planning. This should include making more use of initiatives such as the Welsh Government's 'Invest to Save' schemes.**			
	Shared learning is embedded across the Health Board so that good ideas are shared and rolled out on a regular basis. Opportunities to make financial efficiencies across directorates are also maximised.	The review of the Efficiency Opportunities Control Group will look at how the organisation can improve sharing good practice. The Health Board has over the years had a number of 'Invest to Save' bids funded. It was also successful in the September 2017 funding round with four bids approved. Internal invest to save projects have also been undertaken over the years and are considered if the options arise.	March 2019	Director of Finance
R4	**To enable the development of a three-year integrated medium term plan, the Health Board needs to ensure that it has a clear outcome from its Transforming Clinical Services programme to inform the 2019-2022 planning round.**			
	A three-year integrated medium term plan that is able to set out the Health Board's longer-term strategic vision, increasing the potential for the IMTP to be approved by the Welsh Government. If approved, the Health Board will meet its statutory requirement to have an approved IMTP.	The Transforming Clinical Services (TCS) programme was launched at Board in June 2017 as a three-phase programme. Phase 1, the Discovery phase concluded in November 2017, an output paper considered by Board in December 2017 and Phase 2, the Design Phase commenced. The Board has agreed a project plan and timeline for Phase 2. Key milestones for Phase 2: • Option development, refinement, testing and shortlisting • Commence formal consultation • Output report following consultation setting out the preferred way forward; • Approval to move to Phase 3 – implementation	September 2018	Medical Director

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R5	**The Health Board needs to progress its work to develop its clinical directors at pace, and provide the necessary support to its wider triumvirate teams to develop their management capabilities.**			
	Stronger leadership and management at an operational level, freeing up the capacity of the Director of Operations.	A number of actions are being taken to support and develop the current cohort of clinical leaders and to develop leaders for the future. • Establishment of a Clinical Executive connecting clinical leaders with Executive Directors • Medical Leadership Forum quarterly • Action Learning Programme for Aspiring Clinical Leaders • Annual Clinical Leaders Conference • Further development of the Medical Peer Mentor Programme • Further development of the New Consultants Programme	March 2019	Medical Director
R6	**Following the implementation of the proposed planned changes to the finance department, the Health Board needs to ensure that the structures of the other corporate functions appropriately support and challenge the operational directorates.**			
	Operational directorates and departments have improved access to the skills of the corporate functions to enable them to manage the totality of the resources more effectively.	The Director of Workforce and OD and the Head of Organisational Development will undertake a review of corporate functions.	March 2019	Chief Executive Officer

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R7	**The Health Board needs to revisit its operational structure and the position of primary care and community services in particular, to ensure that it fully supports integrated working and effective management of operational issues.**			
	Improved communication flows and integrated working to effectively manage issues that cut across a range of services, particularly those based 'out of hospital'.	Community Services are already part of the Operations Integrated Management Team. Each County Director is directly responsible to the Director of Operations. The recent appointment of the Director of Primary Care, Community and Long Term Care (DoPCCLTC) will provide further opportunity to better integrate primary care into the operations management structure. Primary Care was always invited to the monthly Operations Business Meeting, however the appointment of the DoPCCLTC will further progress integrated working between primary and secondary care. Better integration between primary care, community and secondary care will also be improved through the joining of the Acute Services Quality, Safety and Experience Sub Committee and the Community and Primary Care Quality, Safety and Experience Sub Committee. The newly formed sub-committee will report to the Health Board's Quality, Safety and Experience Assurance Committee. The DoPCCLTC will review the operational interface between primary, community and secondary care in 2018-19.	December 2018	Director of Operations/ Director of Primary Care, Community and Long Term Care
R8	**To show leadership, visibility of the executive directors across the Health Board needs to extend to all directors and consideration needs to be made to holding meetings with operational teams away from the headquarters.**			
	Increased capacity for operational teams to focus their time on managing the business and an increased understanding of operational challenges by directors that are not currently as visible as they could be.	The Board QSEAC and Clinical Executive Team meetings are rotated across the three counties and not held in Headquarters. As part of developing the Board Performance Assurance Framework, consideration will be given to holding these meetings on hospital sites. The new Framework should reduce the number of meetings operational management staff are asked to attend.	April 2018	Chief Executive Officer

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R9	**The Health Board needs to further embed its revised risk management framework and to continue its work with its operational teams to refine the recording of risk.**			
	A continued improvement across the Health Board in the recording of risks, clarification of the escalation process, and the relevant controls and actions.	The Health Board's risk management framework will be reviewed in year to enable closer alliance to the strategic objectives following the refresh that is currently underway. The whole risk management framework and supporting infrastructure will be reviewed in year to support delivery of the Strategic Objectives. The risk Datix module will continue to be rolled out within the new financial year, which will improve risk identification, assessment and reporting and will enable these to feed into the decision-making framework.	March 2019	Board Secretary
R10	**The Health Board needs to strengthen its performance management framework at an operational level by:** • **ensuring sufficient time is allowed within the bi-monthly performance management reviews to consider all elements of performance, including finance, workforce and delivery against plan;** • **ensuring that the process includes wider representation from across the directors;** • **ensuring that governance approaches at operational and service level are standardised and include a comprehensive review of performance;** • **expanding the range of performance metrics that are considered at an operational level, particularly in relation to quality and safety; and** • **exposing the operational directorate teams to scrutiny at BPPAC and QSEAC on areas of underperformance.**			
	Performance management reviews are co-ordinated and focus attention on all aspects of performance. A wider range of performance metrics support reviews. These metrics are also monitored through operational governance arrangements. Committees are able to take assurance that performance is improving, and where there is continued underperformance, that appropriate actions are being taken.	The Performance Management Assurance Framework (PMAF) is currently being revised to address these issues. This includes reviewing the current governance arrangements for performance management. Once the revised draft PMAF is complete, it will be submitted to relevant Committees for discussion. A Quality dashboard is being developed to expand the range of quality and safety performance metrics routinely reported. The first iteration of the dashboard will be presented to QSEAC on 20 February and the dashboard will be further developed in the coming months to further expand the range of metrics and to provide a drill down facility to ward where available. Dashboards are also being developed for unscheduled care, referral to treatment, stroke, diagnostics & therapies and cancer. In February 2018, work will begin on developing a primary care dashboard.	September 2018	Director of Performance, Planning and Commissioning

Rec	Intended outcome/benefit	Management response	Completion date	Responsible officer
R11	**The Health Board needs to continue to improve its integrated performance assurance report by drawing the reader's attention to areas of underperformance, expanding the range of local performance metrics that are included within the report to provide a more rounded view of performance, where appropriate.**			
	The integrated performance assurance report (IPAR) enables focused scrutiny and challenge at committee and Board on areas of underperformance.	The IPAR has been reformatted to give greater prominence to areas of under-performance, including an executive summary that highlights particular areas of concern. This will be reported to the Business Planning and Performance Assurance Committee on 27 February 2018. Alongside the report, the dashboards mentioned in R10 above provide a drill down facility for the under-performing metrics so that any areas of concern (eg hospital, ward) can be more easily identified and targeted for improvement.	February 2018	Director of Performance, Planning and Commissioning

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