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Structured Assessment 2017 – **Abertawe Bro Morgannwg University Health Board**

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The team who delivered the work comprised Jason Blewitt, Katrina Febry, Melanie Williams, Carol Moseley, Geraint Norman and David Thomas

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Introduction and background

1 Our structured assessment work helps inform the Auditor General's views on Abertawe Bro Morgannwg University Health Board's (the Health Board's) arrangements to secure efficient, effective and economic use of its resources. Our 2016 work found 'arrangements that support good governance are largely in place and continue to be strengthened, but the financial position is not sustainable and organisational capacity, connections between programmes and maintaining pace of change present challenges'.

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

5 In terms of context, Welsh Government escalated the Health Board to targeted intervention status in September 2016 due to the Health Board's financial and performance position. During 2017, the Health Board established a Recovery and Sustainability Programme to focus on improving the financial position, alongside maintaining quality and safety and improving organisational performance. The Health Board also commissioned PwC to undertake a high-level review to identify cost efficiency opportunities and has also been responding to the findings of Deloitte's financial governance review commissioned by Welsh Government.

6 The Health Board has faced major Board Member turnover with a number of interim executives and transitional arrangements in place during 2017 and will have a largely new Board for 2018. During this period, the Health Board has also initiated a fundamental change to its commissioning and delivery frameworks and set out a new revised structure for Board committees to be embedded in 2018.

7 The Health Board's planning capacity is limited and in addition to developing its Annual Operating Plan for 2018-19 and developing an up to date clinical strategy, the Health Board needs to take account of a number of significant regional

partnerships including ARCH[1], the City Deal and regional planning with Hywel Dda University Health Board. It is also involved in consultations on other regional service changes including the major trauma network, thoracic surgery, and potential service transfers for the population of Bridgend. In recognition of the scale of challenge facing the Health Board's planning function, the Welsh Government has agreed to support additional planning capacity.

8 Some issues identified in previous structured assessments remain, for example, the pace of change being affected by capacity, reorganisations, and the complexity of programmes as identified in 2014. Other risks and challenges consistent with our previous work include:

- Delivering against plans with a focus on outcome not process and actions;
- Co-ordination and prioritisation of programmes and initiatives;
- Delivering a reasonable and sustained pace of change;
- Workforce planning;
- Living within the resource limit; and
- Frontline culture and capacity, accountability & leadership and ownership of change.

Key findings

9 This year has been an exceptionally difficult year for the Health Board given the fragility of the Board, alongside the need to respond to the issues giving rise to targeted intervention. At the point of producing this structured assessment report, the Health Board continues to find itself in a challenging position, both in terms of its finances, and performance against a number of key national targets. However, the appointment of a new substantive Chief Executive and the introduction of new independent members provide some much needed stability and capacity at Board level to help achieve the turnaround that is required.

10 Our structured assessment work has found that whilst the Health Board has continued to evolve its corporate arrangements for governance, financial management, strategy development and workforce planning, these have not yet been effective at getting the Health Board to where it needs to be with its finances and performance.

11 Whilst the approach to financial savings is strengthening, it is not yet sufficient to recover its cumulative deficit and achieve financial balance. A more focussed asset management is also needed to better prioritise within limited capital funds. Further priorities for 2018 are the need to embed new Board Committee and Delivery Board structures, strengthen aspects of governance and performance management, and build operational management accountability and capacity.

[1] A Regional Collaboration for Health (ARCH) – a health care model for south west Wales

12 The findings underpinning the above key messages are summarised further below.

Financial planning and management

13 The Health Board continues to find itself in a very challenging financial situation although the actions needed to address the problems are recognised and there is evidence that improvements are being made.

Financial performance

The Health Board continues to experience significant financial challenges and whilst savings are helping to close the resource gap, they are insufficient to achieve financial balance.

14 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 three years and the cumulative deficit has continued to grow.

15 In 2016-17, the Health Board ended the year with a £39.3 million deficit. The position looks similar for 2017-18 - the Health Board was forecasting a deficit of £36 million at the time of our fieldwork. 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 very challenging.

16 The Health Board does not have a track record of delivering planned financial savings targets and the success of individual savings schemes is variable. Over the last five years, the Health Board has set ambitious savings targets which it has failed to achieve and has in most years, set targets greater than that it achieved in the previous year. In addition, the Health Board has incurred additional unplanned growth in service costs, which have added to the underlying financial deficit and in turn, influences the level of savings requirement.

17 As part of NHS Finance Act (Wales) 2014 (the Act) requirements, the Health Board must spend within its financial allocations over a rolling three-year financial period. The Health Board's three-year deficit position for the period 2015-18 is expected to be some £75.2 million.

Financial savings planning and delivery

Arrangements for planning and delivering savings have not been effective or sustainable but the Health Board is strengthening its approach and recognises the need to increase focus on service transformation and efficiency.

18 The Health Board's approach to savings and wider financial planning has remained broadly the same for a number of years despite the declining trend in financial performance. There has been a lack of buy in and ownership from budget holders

as the Health Board has historically rolled forward previous annual budgets year on year.

19 As we have commented in previous years, financial, service and organisation objectives need to be better linked. Similarly, the Health Board's budget is not zero based either in totality or for discrete parts, and that the links between the budget, objectives and other plans is unclear. Without this, the ability to identify efficient and inefficient areas and to benchmark against good practice is difficult.

20 It is positive that for 2018-19, the Health Board is planning to include savings plans in the 'bottom line' position of budgets rather than managing savings plans in isolation. The establishment of a Recovery and Sustainability Programme in January 2017 is also a positive step although the scale of the challenge is significant and the Health Board recognises that there is a need to rely less on non-recurrent savings and more on service transformation and efficiency.

Financial savings monitoring

The Health Board has improved its arrangements for monitoring, reporting and scrutiny of savings.

21 In previous years, the Board has not received sufficiently detailed information to support effective scrutiny and challenge of financial savings, although more recently there have been improvements in the information provided and improved scrutiny.

22 Scrutiny and monitoring of the delivery of savings plans at the operational level has been weak in previous years, but steps are being taken to strengthen the arrangements. The key issue for the Health Board is to establish a more integrated approach to the reporting of the finances alongside service performance.

Governance and assurance

23 In reviewing the Health Board's corporate governance and board assurance arrangements we found that there have been significant challenges because of transitional leadership arrangements and board member turnover over the last year. However, the Board now finds itself in a more stable position to take forward key actions such as developing a longer-term strategy, embedding new governance arrangements and strengthening aspects of performance management.

Board effectiveness, Board assurance and governance structures

Following a period of unstable Board membership, the Board is aware that it needs to develop its new Board, revise its committee structures and strengthen overall governance arrangements with pace

24 Independent member and executive turnover have created instability during 2017 but the risks and opportunities for developing the new Board and strengthening

governance are recognised. The Board is aware that the number of new Independent Members and Executive Directors in interim positions continues to present a risk and this has been added to the corporate risk register.

25 The Health Board has commissioned a Board development programme for the new Board, to focus on Board behaviours, corporate leadership, a cohesive team and ensuring effective challenge. The Health Board will also need to consolidate actions on governance improvement issues identified in previous reviews.

26 Quorate committee meetings have been sustained despite Board membership fragility and the introduction of a Performance and Finance Committee has been a positive step. However, some committees have not been wholly effective, in particular the Workforce and OD Committee, and the Health Board is currently considering proposals for revisions to its existing committee structure and memberships. .

27 An executive led Quality and Safety Forum reporting to the Quality and Safety Committee has been established and work undertaken to map and streamline the management groups providing assurances on Quality and Safety.. This has simplified reporting lines although further work is needed.

28 Development of a Board Assurance Framework (BAF) has been slow but with new Board membership and proposed governance structures changes, it is now being progressed as a priority. The Health Board recognises the benefits of risk and assurance mapping and is keen to progress the work alongside the wider development of its new Board. In the meantime, the existing system of assurance continues to operate.

Strategic planning

Whilst working to an Annual Operating Plan (AOP), the Health Board is redeveloping its clinical strategy to inform its longer-term, more transformational planning although planning capacity is limited

29 The Health Board does not have an approved Integrated Medium Term Plan (IMTP) and is working to an Annual Operating Plan. Development of the 2018-19 plan has been informed by key planning principles, with an earlier focus on activity, finance and performance requirements for 2018, and a more thorough engagement of the Board. The Health Board will need to consider how committee level reporting and scrutiny aligns across the new Performance and Finance Committee and the proposed reinstatment of the Strategy Committee.

30 There has been a necessary focus of responding to targeted intervention, although this has led to a short-term approach to strategy and planning. The clinical strategy, developed in 2013 is out of date and there is current uncertainty about the funding of the ARCH programme. The Health Board is aware that it needs to set the direction and longer-term vision for the organisation and is currently developing a new clinical strategy.

31 The Health Board is operating in a complex strategic environment with a number of major strategic programmes and service change consultations to both manage and account for. The Health Board's planning capacity is limited and it is looking to commission help to support demand and capacity planning and build operational planning skills and expertise.

Organisational structure

The Health Board has managed the impact of major executive changes in 2017 and recognises that developing the new executive team, building leadership and capacity, and embedding new programme board arrangements are priorities for 2018

32 Executive officers have shown commitment to maintainingleadership during a period of major executive changes, and the Health Board recognises establishing its new leadership team as a priority for 2018. The revised executive membership provides an opportunity to develop closer collaborative working as a single leadership team, and for ensuring balance across executive portfolios.

33 The Delivery Unit Structure is now fully established and there are some examples of good collaborative working between units. However, there is also evidence that indicates cross-system working between unit management teams is not wholly embedded or consistent. The Health Board has been taking steps to build a senior leadership team approach between unit management teams and the Executive, to develop a collective and corporate view of Health Board wide service delivery and unit management responsibilities.

34 The Health Board has recently stood down its Commissioning and Delivery Boards and three new Programme Boards that incorporate both planning and improvement are being established. Commissioning and value based principles are to be intrinsic to the planning work of the new Programme Boards. It is too early to assess the effectiveness of the new Programme Boards and mapping of the strategic change programmes previously managed by the Commissioning Boards has yet to be completed.

Risk and performance management

Risk management is maturing but performance management would benefit from more integrated reporting and a stronger focus on accountability and outcomes

35 The Health Board is updating its risk management strategy and taking steps to further mature its approach. A workshop for Board members has recently been held to consider its current risk management approach. The Health Board intends to introduce Executive portfolio risk registers and improve the corporate risk register template, with clearer assignment and scrutiny of specified risks by individual committees. The work will be proceeding alongside development of the Health Board's Board Assurance Framework.

36 The Health Board has focused on performance issues that contributed to its escalation to “targeted intervention” and while a Recovery and Sustainability Programme has led important work, greater Delivery Unit ownership is needed. Performance management arrangements are in place but the documented framework is out of date, the number of performance related meetings may not be sustainable and there needs to be a stronger outcomes focus. The introduction of a new Performance and Finance Committee is strengthening scrutiny but aspects of reporting could be improved and more integrated reporting could better meet Health Board needs.

Information governance

Information governance arrangements support compliance with current legislation but meeting the new General Data Protection regulations will be challenging within current resources

37 An Information Governance Board is responsible for all Health Board information and provides assurance to the Audit Committee on the effectiveness of information governance arrangements. An audit by the Information Commissioners Office (ICO) in 2016 identified a number of improvement areas, many of which having relevance to the Health Board’s ability to comply with the new General Data Protection (GDPR) regulations coming into effect in May 2018.

38 The Health Board has been making good progress in addressing the issues identified by the ICO. However, there is a significant amount of work remaining to be compliant with GDPR requirements, including completion of the Health Board’s Information Asset Register and making significant further progress in ensuring all staff have received information governance training. The risk that the Health Board will not be compliant by May 2018 has recently been added to the Corporate Risk Register; not least due to the significant financial penalties should a breach occur. It is unlikely that the Health Board will be able to achieve and subsequently maintain compliance within current resources, and additional capacity is being sought.

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

39 In reviewing the Health Board’s arrangements for managing programmes of change, workforce and assets, and stakeholder engagement, we found that the Health Board has maintained positive stakeholder engagement but faces a number of challenges in respect of workforce, asset management and ICT and programme management.

Strategic change management

A Programme Management Office has been set up and significant organisational development work is progressing, but programme management capacity is limited and strategic change programmes need review

40 The Health Board has established a Programme Management Office to support its Recovery and Sustainability Programme. However, within its limited capacity, its future role for supporting wider strategic change programmes is not clear. There are a number of major regional changes currently being consulted upon which are likely to need programme management support. In addition, the Health Board will need to review the portfolio of *Changing for the Better* strategic change programmes, previously overseen by Commissioning Boards, and remap them to the new Delivery Boards.

41 Workforce and organisational development is recognised by the Health Board as being essential to sustainable service improvement. A number of programmes are running to support leadership and service improvement. They are currently managed separately and the Health Board is working to bring them together and refine the scope of the organisational development programme.

Workforce management

The Health Board continues to face a number of workforce challenges and needs to strengthen its workforce planning and scrutiny arrangements

42 The Health Board is aware that workforce planning is a weakness, hampered by the lack of a current clinical strategy. It is also managing some significant workforce challenges, in terms of recruitment and staff turnover, although it has some success in reducing the costs associated with agency use.

43 The Recovery and Sustainability Programme includes a number of workforce related work streams, which affect finance and performance including sickness absence reduction and improved rostering, and the Medical Director has added a programme to take forward actions on the Medical Staff Survey results. The Health Board's appraisal and statutory/mandated training compliance remain low.

Asset management

The Health Board has yet to define its asset management strategies and faces difficult resource prioritisation decisions with limited ICT capacity to support modernisation

44 The Health Board controls some £600 million of assets including land and buildings, plant and equipment, vehicles, ICT equipment and fleet. However, at the end of 2016-17, the Health Board faced £60 million of backlog maintenance and £75 million of plant and equipment beyond their economic life. The Health Board

does not have an asset management strategy to help it prioritise within the very limited capital resources.

45 The Health Board has developed an approved capital programme for 2017-18 and improved arrangements for its management, with a new Investment Benefits Group set up to review both capital and revenue bids. However, the quality of business cases is variable and the Health Board needs to improve prioritisation at a time of limited funding and move to a less annualised approach.

46 ICT strategy is well developed and the Health Board has good awareness of the efficiencies that can be delivered through the use technology. However, the pace of implementing the digital strategy is dependent on capital funding and internal ICT capacity means that projects are having to be prioritised within available resources. This presents longer term challenges for ICT supporting modernisation

Stakeholder engagement

The Health Board continues to positively engage with stakeholders, although the complexity of partnership working and service change puts significant demand on organisational capacity

47 There is a good track record of positive Health Board engagement with stakeholders and regular reporting to Board form the Partnership Forum and Stakeholder Reference Group. The Health Board has engaged with population and service groups to develop: a Children's and Young People's Charter; an Older Peoples Charter; and a Strategic Framework for Adult Mental Health.

48 To support engagement on service changes requiring consultation with the Community Health Council (CHC) or wider public, the Health Board has agreed a Consultation and Engagement Framework with the CHC. The framework has recently been applied to service changes arising from both the Health Board's annual planning and the Recovery and Sustainability Programme.

49 However, these activities are taking place alongside some complex partnership working arrangements and regional consultations on major change proposals, which is placing significant demand on organisational capacity.

Recommendations

50 Recommendations arising from the 2017 structured assessment work are detailed in Exhibit 1. The Health Board will also need to maintain focus on implementing any previous recommendations that are not yet fully complete[2].

51 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.

[2] The progress made addressing previous recommendations and their current-status is described in Exhibits 7 to13, included in the 'detailed findings' section of this report.

Exhibit 1: 2017 recommendations

2017 recommendations
Financial savings planning and delivery R1 We found the Health Board's approach to savings and wider financial planning has remained broadly the same for a number of years despite the declining trend in financial performance. To foster a more sustainable approach to managing savings, the Health Board should: a. set realistic savings targets. b. Make better use of benchmarking data and internal performance intelligence to better identify inefficiencies (and efficiencies) to feed into savings planning. c. Link financial budgets to activity through zero based budgeting to identify efficient and inefficient areas and to effectively benchmark against good practice. d. Ensure savings schemes are not planned in isolation but are linked to wider programmes of work or changes in activity. e. Adequately profile savings over the course of the year so that delivery is not concentrated in the last six months of the year. f. Reduce reliance on short-term transactional savings in favour of long-term and transformational savings which aim to reduce pressure on future budgets. For example by ensuring savings related to pay are linked to long-term service change.
Financial savings monitoring R2 We found the Health Board's has improved its arrangements for monitoring, reporting and scrutiny of saving. However, to further strengthen arrangements, the Health Board should: a. Improve the ownership of budgets and savings plans by budget holders through strengthened corporate leadership and improving the relationship between delivery units and the corporate centre. b. Ensure that Financial Recovery meetings within Delivery Units have a more explicit focus on the actions needed and are sufficiently long enough to allow good coverage of issues. c. Improve operational scrutiny of savings by encouraging senior finance business partners to be more proactive in holding Delivery Units to account in respect of managing budgets, and both the development of, and delivery against savings plans. d. Standardise the monitoring of financial performance of Delivery Units both in terms of the approach and reporting. the monitoring of financial performance of Delivery Units both in terms of the approach and reporting which is currently inconsistent.

2017 recommendations
Reviewing and strengthening governance arrangements R3 There have been a number of reviews and reports on governance related issues in recent years (Health Board specific and wider), that offer learning and have resulted in many action plans. Welsh Government has proposed that the Health Board undertake a more general governance review. In preparation, the Health Board should draw together the messages from all recent governance reviews and develop a consolidated action plan to address the issues raised by the reviews, and to help identify whether any further governance review would be of value. Consolidation of action plans should include the findings and recommendations from this structured assessment, the current Welsh Government Delivery Unit review of serious incidents management, and those of the Deloitte's financial governance review.
Scheme of Delegation R4 The Health Board should further develop its scheme of delegation arrangements by agreeing a scheme of delegation for capital project approvals.
Governance Structures R5 With full board membership in place for 2018, the Health Board is revising its committee structure and memberships. In doing this the Health Board should: a. Ensure clarity and organisational understanding of the new structure and specifically, about what is a management group, partnership forum or scrutiny function as the current mapping groups them collectively. b. Reassess any gaps or duplication in the operation of the new arrangements once introduced. c. As part of the development of the Board Assurance Framework, determine whether further simplification of governance structures and reporting lines is required.
Quality and Safety governance arrangements R6 The Executive-led Quality and Safety Forum, which was formed in January 2017 has focussed its attention on strengthening quality assurances arrangements. As part of this important work, the Health Board needs to ensure that: a. All management groups, which are required to report into the Forum, do so on as regular basis to avoid gaps in assurance. b. Assurance reports from the Forum to the Quality and Safety Committee meet the committee's requirements in terms of discharging its scrutiny role c. It keeps the quality and safety sub-structures under review to determine whether further simplification of current structures would be desirable. d. There is clarity on the relationship between the Quality and Safety Forum and other groups, particularly the Assurance and Learning Group and the Clinical Outcomes Steering Group.

2017 recommendations
Workforce and Organisational Development Committee R7 Workforce issues are a top corporate risk; the Health Board should strengthen the Workforce and Organisational Development Committee and Board assurance by: a. ensuring committee meetings are held as planned b. making sure there is a greater focus on strategic risks, as opposed to operation matters c. Improve the timeliness of data reported to the committee, ensuring the Board is also appropriately sighted of performance information. d. Improve administration and reporting by ensuring completion dates and responsibilities for actions are provided and reports highlight risks more effectively.
Clinical strategy R8 Work to revise the Health Board's clinical strategy is underway, recognising the changes to the landscape within and outside of the Health Board since the Changing for the Better strategy was developed in 2013. The Health Board now needs to: a. Produce a clear timetable for completing the development of its revised clinical strategy. b. Ensure the emerging clinical strategy aligns to other strategic plans and change programmes within the Health Board. c. Ensure that the clinical strategy is underpinned by supporting strategies and plans in key areas such as workforce, estates and asset management.
New Programme Boards R9 New Programme Board arrangements are being implemented within the Health. As part of this organisational change the Health Board needs to: a. ensure that the new Programme Boards do not focus solely on areas of targeted intervention in secondary care, and that insufficient attention paid to other service areas and improvements b. Re-map the Changing for the Better strategic change programmes formerly overseen by the Commissioning Boards and determine how they align to the new Programme Boards; c. Ensure the new arrangements and interfaces between the Programme Boards and the delivery unit structures are clear and better understood than the previous arrangements; d. Clarify reporting lines for the new Programme Boards and the relationship to the Strategy and Planning, and Performance and Finance Committees

2017 recommendations
Risk management R10 In taking forward its plans to improve risk management, the Health Board needs to ensure that: a. It more clearly identifies risks to the achievement of objectives on the corporate risk register, rather than just listing issues such as “unscheduled care” and “public health”. b. It critically reviews the number of risks on the corporate risk register, as there are too many for proper collective scrutiny. c. It re-maps risks to committees to reflect the new committee structure d. All committees provide oversight and scrutiny for the risks assigned to them.
Performance management R11 In taking forward its Recovery and Sustainability Programme, the Health Board needs to ensure that it facilitates greater ownership of performance improvement actions by the Delivery Units. R12 The establishment of a Performance and Finance Committee has been a positive development. Whilst the Committee’s work to date has necessarily focused on the specific challenges related to the Health Board’s targeted intervention status, the Committee needs to ensure that this approach does not result in insufficient scrutiny of the Health Board’s wider performance. R13 As part of the Performance Management Framework update the Health Board should review its performance dashboard, so that there is a greater focus on focus on targets, trajectories, and outcomes. R14 Generally, the performance report to Board receives sufficient information to support scrutiny. However, the current format could be further strengthened by: a. Making it easier to determine performance against target, b. Providing more clarity on the trend period being considered, c. Better linkage between reported actions, outcomes and timescales for improvement, and d. More performance reporting on commissioned, primary care and partner provided services. R15 In progressing the planned work to develop a more integrated approach to the provision of management information, the Health Board needs to clarify: a. executive accountabilities for performance information and management, b. where business intelligence sits and how it relates to informatics.
Information governance R16 The Health Board has taken steps to increase information governance training for staff and independent members alike, but compliance as at December 2017 was 52%. The Health Board therefore needs to take action to increase information governance training compliance rates.

2017 recommendations
Strategic change management and Programme Management Office
R17 Acknowledging that the Programme Management Office (PMO) is currently focused on supporting the Recovery and Sustainability Programme, the Health Board should prospectively consider programme management arrangements and the future role of the PMO in supporting wider strategic plans and change programmes.
Learning and development
R18 Mandatory training rates are low and not meeting the Health Board's target of 85%. The Health Board should therefore : a. Take steps to increase mandatory training rates to meet the Health Board target of 85%. b. Address access issues with the Electronic Staff Record to allow accurate recording of compliance. c. Ensure the Mandatory Training Governance Committee meets. The committee was established in October 2016 to monitor the mandatory training framework, but to date has not met.

Detailed report

Financial planning and management – The Health Board continues to find itself in a very challenging financial situation although the actions needed to address the problems are recognised and there is evidence that improvements are being made

52 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. We have not considered detailed approaches for individual saving scheme planning and delivery. However, we have considered the approach in the area of medicines management to inform 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.

Financial performance – The Health Board continues to experience significant financial challenges and whilst savings are helping to close the resource gap, they are insufficient to achieve financial balance

In recent years the Health Board has not set balanced financial plans and in 2016-17, it failed to breakeven

53 Each year, the Health Board is allocated revenue funding by Welsh Government to provide the resources for the Health Board to pay for healthcare services for its resident population. This allocation is known as the Revenue Resource Limit (RRL). The RRL allocation increases annually help to address inflationary costs of healthcare, including growth in pay and medication costs, and rising demand for services. As part of NHS Finance Act (Wales) 2014 requirements, the Health Board has a duty to breakeven over a rolling three-year financial period, i.e. spend within its financial allocations. The Health Board forecasts its planned expenditure, which it sets against the financial allocation and other income streams. Where there is a resource gap between the financial allocation and the planned expenditure, the Health Board must address the gap by identifying savings and cost control measures.

54 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 three years and the cumulative deficit has continued to grow.

55 Exhibit 2 shows the financial performance over the last six financial years. Whilst the achievement of savings has contributed to closing the funding gap, these savings have not been sufficient, or as planned, and the Health Board has been reliant on one-off measures, in-year accountancy gains and significant additional non-recurrent Welsh Government funding. The additional measures enabled the Health Board to achieve financial balance in 2014-15 and 2015-16, but they were not sufficient in

2016-17 and the Health Board ended the year with a deficit of £39.3 million. The position looks similar for 2017-18 and the Health Board is forecasting of deficit of £36 million. 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 very challenging.

Exhibit 2: summary of financial performance for the periods 2012-13 to 2017-2018 (forecast to month six)

	Funding Gap £million	Actual savings £million	Unidentified Savings[3] £million	Additional monies £million	Accountancy Gains/ Reserves £million	Net income Favourable Movements £million	Additional Cost Pressures £million	End of Year position £million
2012-13	38.6	-21.4		-11.5	-5.7			
2013-14	56.5	-26.8		-22.4	-6.0	-8.3	6.9	-0.9
2014-15	59.5	-18.7		-26.1	-6.5	-10.0	1.7	-0.1
2015-16	66.7	-16.1	-2.5	-43.0	-40.7		35.4	-0.9
2016-17	101.6	-25.0		-33.0		-5.7	1.5	39.3
2017-18	81.9	-19.9	-4.9	-20.9		-0.2		36.3

Source: Health Board Monitoring Returns to Welsh Government

56 As part of NHS Finance Act (Wales) 2014 requirements, the Health Board must spend within its financial allocations over a rolling three-year financial period. As the Health Board did not break even in 2016-17, and failed its statutory financial duty to achieve financial balance over a rolling three year period (commencing 1 April 2014 and ending 31 March 2017), a substantive report was placed on the accounts by the Auditor General for Wales.

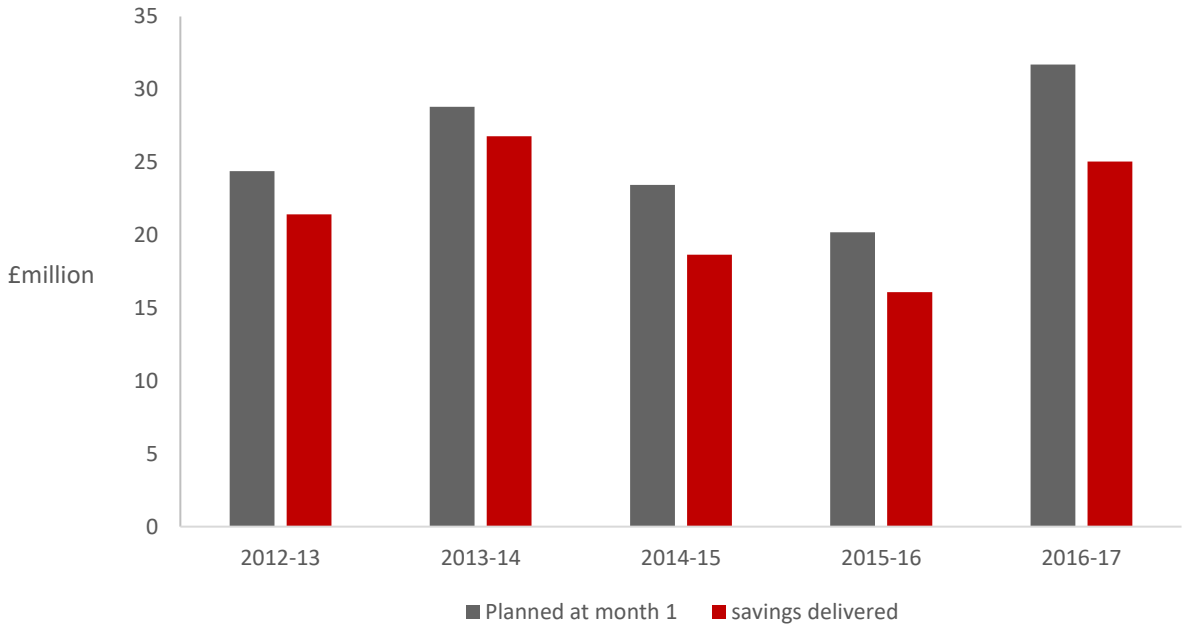
The Health Board does not have a track record of fully delivering its identified financial savings targets and the success of individual savings schemes in 2016-17 was variable

57 Over the last five years, the Health Board has set ambitious savings targets but has not fully met any of its annual savings targets and has in most years, set targets greater than that it achieved in the previous year. Over the period April 2012 and March 2017, the Health Board has delivered some £108 million of savings against a total target of £128.6 million, a shortfall of £20.6 million (Exhibit 3). In addition to this, the Health Board has incurred additional unplanned growth in service costs, which have added to the underlying financial deficit and in turn, influences the level of savings requirement.

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

Exhibit 3: summary of performance against savings plans 2012-13 to 2016-17

The chart shows the performance against annual planned savings targets for 2012-13 to 2016-17



Source: Health Board Monitoring Returns to the Welsh Government

58 At the outset of 2016-17, the Health Board's total resource gap was £101.6 million. To help address the funding gap, the Health Board increased its initial savings plan of £22.6 million to £31.7 million in-year, almost twice that of the savings achieved in 2015-16. The Health Board delivered £25 million of savings, 79 per cent of its £31.7 million target. This level of savings delivery (i.e. approximately 80 per cent of target) reflects savings performance since 2014-15, although prior years' performance had been higher at 90 per cent.

59 To deliver the 2016-17 savings plan, the Health Board identified 238 expenditure savings schemes. Exhibit 4 summarises the performance of these schemes, grouped by scheme type or category of saving, and with over and under delivery shown as the percentage variance between planned and actual savings delivered. There was a high degree of variation in the success of delivering savings schemes in 2016-17, across scheme categories and the individual savings plans. The level 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 underlying financial deficit position grew.

Exhibit 4: summary of performance against 2016-17 saving schemes, grouped by scheme type

	Planned savings £	Actual savings £	Difference between planned and actual £	Difference as % of plan
CHC and Funded Nursing Care	3,578,000	4,059,000	481,000	13%
Commissioned Services	1,191,000	945,000	-246,000	-21%
Medicines Management	1,875,000	18,695,000	-6,000	-3%
Non Pay	5,360,000	4,425,000	-935,000	-17%
Pay	18,020,000	12,460,000	-5,559,000	-31%
Primary Care	1,682,000	1,281,000	-401,000	-24%
Total	**31,706,000**	**25,040,000**	**-6,666,000**	**-21%**

Source: Health Board Monitoring Returns to Welsh Government

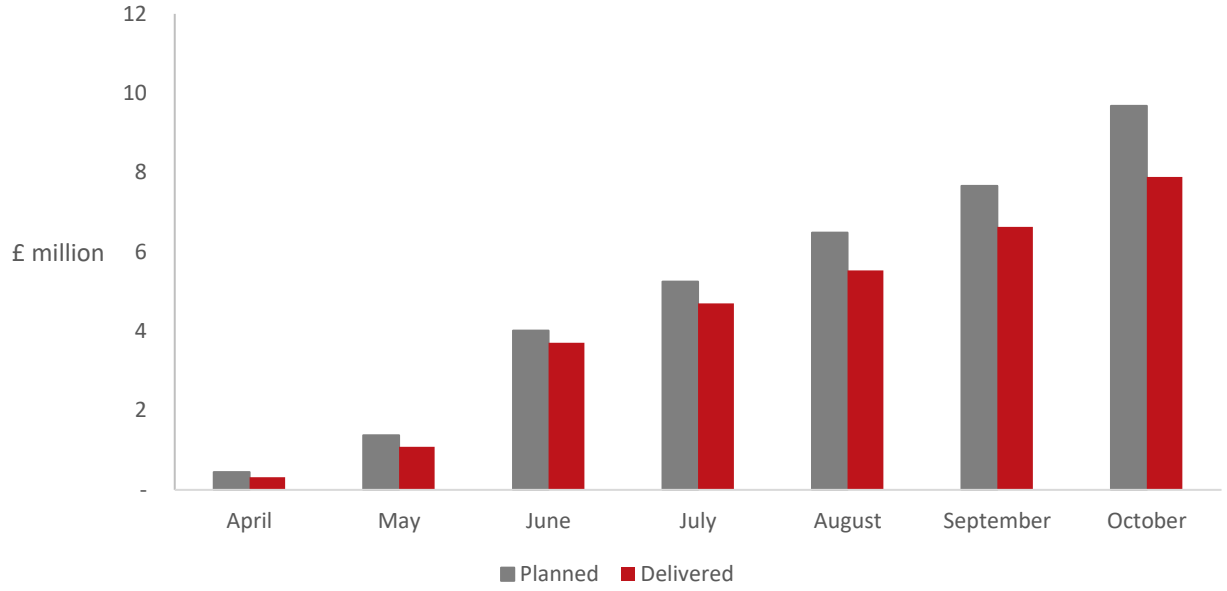
The Health Board's savings schemes for 2017-18 do not bridge the entirety of its resource gap and while the Health Board is implementing additional financial recovery measures, the position is very challenging

60 In 2017-18, the Health Board's total resource gap was £81.9 million. To help address the gap, it agreed identified some 300 savings schemes totalling £19.9 million at the start of the year, a further £5 million of unidentified savings and £20.9 million of additional Welsh Government funding, leaving a planned deficit of £36 million.

61 As at the end of October (month seven), the Health Board's identified savings had increased to £25 million but actual delivery against this was £1.7 million behind planned (Exhibit 5). The level of unidentified savings had increased by £2.4 million during the year to £7.4 million, but the Health Board has now identified schemes to address this savings requirement.

Exhibit 5: summary of 2017-18 savings delivery against the planned target by month

The chart shows the amount of 2017-18 savings delivered against the planned target by month



Source: Health Board Monitoring Returns to Welsh Government

62 As at the end of October 2017, the Health Board has £17.7 million of its savings schemes rated as Green and Amber[4]. This was reduced from the previous month, due to lower confidence in savings from sickness absence reductions. Red schemes increased to £7.4 million, as the Health Board is now converting its financial recovery action plan and previously unidentified savings into tracked savings, although the delivery plans are not yet fully developed. The recovery actions have increased the level of savings to be delivered through workforce and capacity redesign work streams, although fully delivering these in the remaining five months of the financial year will likely be difficult to achieve.

63 The in-month overspend at the end of October 2017, was £2.6 million, with a cumulative overspend of £22.4 million. This was £1.4 million above the anticipated £21 million for the year-to-date. The Health Board is in the process of implementing additional financial recovery measures. It is positive that the Health Board is aware of the key areas of concern that we have identified in the course of our financial savings work, and is putting in processes to strengthen arrangements to help achieve its planned £36 million deficit by the year-end. However, the Health Board's revenue forecast is for a deficit of £41.8 million. Any further expenditure overspend in excess of the monthly £3 million monthly run-rate[5] and / or slippage in savings delivery will create a significant risk to the Health Board delivering its forecast deficit to be no greater than £36 million for 2017-18.

[4] The Health Board uses a traffic light RAG rating system (Red, Amber and Green) to assess the level of risk associated with delivery of its savings schemes.

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

64 As part of NHS Finance Act (Wales) 2014 (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

65 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. The Health Board's three-year deficit position for the period 2015-18 is expected to be some £75.2 million.

66 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 cost cutting measures and more emphasis on creation of sustainable service models through a number of areas including:

- linking financial budgets to activity through zero based budgeting to identify efficient and inefficient areas and to effectively benchmark against good practice;
- value based healthcare[6];
- 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
- focussing on prevention, but ensuring that prevention activity is delivering the required financial and quality outcomes.

67 The approaches identified above should help to address the impact of growing demand, 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.

Financial savings planning and delivery - Arrangements for planning and delivering savings have not been effective or sustainable but the Health Board is strengthening its approach and recognises the need to increase focus on service transformation and efficiency

68 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. 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.

[6] NHS Confederation – **Value Based Healthcare**

Corporate leadership and the approach to identifying savings has been ineffective in recent years and a more strategic and transformational approach is urgently needed going forward to identify and design saving plans to address the financial challenge

69 The Health Board's approach to savings and wider financial planning has remained broadly the same for a number of years despite the declining trend in financial performance. As stated previously, often savings plans have exceeded the savings delivered in previous years, and have not delivered the planned savings.

70 The Health Board has historically rolled forward previous annual budgets year on year (uplifting for cost pressures). The corporate finance team then determines an over-arching savings target percentage. The savings requirement is then devolved to the Health Board's operational Delivery Units on a blanket basis, with no consideration of previous delivery against savings are not specifically linked to programmes of work and changes in activity. The Delivery Units are required to identify, design and deliver specific schemes to achieve the savings target. This approach has led to divisions between the corporate finance team and the Delivery Units, and has led to an absence of ownership for delivery of savings plans. This has meant that there has been an absence of buy-in from all staff, particularly at ground level, for the financial challenges faced by the organisation.

71 The Health Board is currently operating to an Annual Operating Plan (AOP) and the Health Board is working to a clinical strategy developed in 2013 which is out of date (as discussed later in this report). As a result, there is a clear focus by the Health Board on development of annual approaches to development of saving schemes, but a lack of savings planning over the longer term. Our review also indicates that the burden of savings delivery is weighted toward the last six months of the financial year. We believe these approaches are resulting in:

- the absence of the adoption of schemes that will deliver efficiencies in the long term;
- an absence of emphasis on sustainable efficiencies through service modernisation;
- the adoption of schemes which are considered undeliverable in-year and thus written-off; and
- a lost opportunity to identify recurring savings.

72 Therefore, the savings planning approach in 2017-18, and previous years, resulted in a large number of saving schemes which tended to focus on in-year cost control and transactional savings. The number of schemes has increased from 237 in 2016-17 to 283 in 2017-18. The large number of schemes makes local and central management challenging. Our review identified a number of low value schemes, and concerns were raised during interviews that the level of project paperwork required for these was disproportionate to the type of scheme and in some cases, the level of paperwork was putting some staff off progressing some ideas particularly the low value ones.

73 It is important that the extent of inefficiency within the organisation is known. In previous years we have commented on extent to which finances, service and organisation objectives are linked, so that the full impact of decisions is known. We have also reported that the Health Board's budget is not zero based, either in totality or for discrete parts and that the links between the budget, objectives and other plans is unclear. Without this, the ability to identify efficient and inefficient areas and to benchmark against good practice is difficult.

74 The Health Board has undertaken some analysis using benchmarking to inform the finance team and budget holders on savings and efficiencies potential to help focus savings planning. However, it is not clear whether this intelligence or any review of past performance against the savings budgets has

been used to inform allocation of savings targets at an operational level, due to the Health Board approach of applying straight line savings targets to Delivery Units in recent years.

75 When constructing savings plans, it is important to consider the balance between, and effect of, recurring and non-recurring saving 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, 20% were non-recurring (Exhibit 6). This raises concerns that savings are not sufficiently built into service re-design to make them financially sustainable in the future.

Exhibit 6: Percentage of savings realised that are non-recurrent

Year	Recurrent savings (£'m)	Non-recurrent savings (£'m)	Total savings (£'m)	Percentage of savings which are non-recurrent
2012-13	20.054	1.378	21.432	6.4
2013-14	16.007	10.775	26.782	40.4
2014-15	14.882	3.832	18.654	20.5
2015-16	11.945	4.143	16.088	25.7
2016-17	20.013	5.026	25.039	20.1

Source: Health Board Monitoring Returns to Welsh Government

76 A large element of savings plans in 2016-17 and 2017-18 relate to pay. In 2016-17, of the £31.7 million savings required, £18 million related to pay with £12.4 million achieved. In 2017-18, £8.3 million of the £17.7 million savings required relates to pay. As at September 2017, the Health Board was £1 million behind its overall savings target. Efficiencies relating to pay need to be linked to longer term service changes. 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. 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.

Whilst there are signs that the Health Board is beginning to strengthen its approach to planning and delivery of savings, schemes are not yet integrated into operational plans

77 In January 2017, the Health Board agreed that a major change programme, called the Recovery and Sustainability Programme, would be established to drive the planning, implementation and monitoring of actions needed to address the financial and performance issues that led to targeted intervention. In February 2017, a Director of Recovery and Sustainability was appointed. In May 2017, a new Director of Finance was appointed. Changes to the savings planning process are planned for 2018-19, because of the appointment of the new appointments.

78 Under the Recovery and Sustainability Programme, various work streams have been established, each with an executive lead responsible for the delivery. Each work stream is required to identify and implement opportunities to make better use of resources, by considering areas of waste, duplication,

delay, inefficiency and harm to patients. Savings plans are now signed off by Delivery Units and then by the Recovery and Sustainability Director. However, the team in place to support the Director of Recovery and Sustainability is limited given the scale of the challenge and the pace of implementation of the set-up of the new Programme Management Office appears to be an issue. This could play a more proactive role in supporting delivery units when fully set up.

79 For 2018-19, in recognition of the issues regarding the previous approach to budget setting, the new Director of Finance is implementing changes to remove savings requirements from the unit's baseline budgets so that they manage the 'bottom line' position of their budget rather than Delivery Unit budgets and savings being managed in isolation.

80 For a number of years, the Welsh Government has had a scheme for Invest to Save[7]. In recent years, the Health Board has made minimal use of Welsh Government's invest to save funding (for example it received £255,000 for a Sickness Absence Scheme in 2017-18. In addition, the Health Board has not used any internal Invest to Save initiatives. Invest to Save schemes could be used more widely to help pump-prime required improvements, such as technology investments that result in cashable efficiency. However, the Health Board has set up an Investments and Benefits Group in 2017-18 with the intention of taking this forward.

81 The Health Board was able to highlight a number of examples of shared learning with external bodies and national groups. However, our interviews with staff identified that shared learning internally needs to improve. The Sustainability and Recovery Programme has enabled some shared learning but it appears that sharing learning within the organisation is led either by this Programme or by corporate finance staff rather than being an embedded process. Worryingly there is a reluctance between some Delivery Units to work together to share ideas, learning and working practices. This means that good ideas are not shared and rolled out across the organisation.

Financial savings monitoring – The Health Board has improved its arrangements for monitoring, reporting and scrutiny of savings

In previous years, the Board has not received sufficiently detailed information to support effective scrutiny and challenge of financial savings, although there have been improvements in the information provided to improve scrutiny

82 The Health Board has arrangements for financial monitoring and reporting with regular reports to the Board for performance, although we previously highlighted weaknesses in financial reports to the Board in our Structured Assessment 2016. Financial Board reports lacked openness and transparency, and as a result, scrutiny at Board level was limited.

83 In 2016-17, Health Board's monitoring of performance against savings position was inconsistent; whilst the funding gap remained constant, the savings targets changed part way through the year. The change meant that there was not a consistent figure reported against which performance can be tracked. This makes it extremely difficult to monitor and challenge the position against what was initially set and approved as part of the budget at the start of the year.

[7] **Welsh Government Invest to Save**

84 A new Performance and Finance Committee was established in June 2017 and is now meeting at least bi-monthly which will enable further more detailed scrutiny of the finances and savings plans. Following the appointment of the Director of Recovery and Sustainability, a new Recovery and Sustainability Board is now in place. These steps should help strengthen the scrutiny of financial and savings plans that has previously been missing.

85 Following the appointment of the new Director of Finance, financial reports to the Board were improved in July 2017 and now include more far more detail and clarity to enable effective scrutiny. However, financial and performance reports to the Board (and committees) are still not integrated which makes it difficult to assess the impact of financial decisions on performance and vice versa. There is a need for greater triangulation of performance, workforce and financial data to provide a rounded view of the impact and risks of decisions.

86 We have also considered the risk assessment approaches used by the Health Board to determine the degree of risk for savings schemes and likelihood of delivery. Until recently, the Health Board's approach has been variable, with risk assessments not providing a robust view on where the risks lie on saving schemes. From the beginning of 2017, the Health Board has developed a stronger approach for risk assessment, which is in the process of being adopted but will take time to embed across the Health Board.

87 Given the balance between cost, timeliness and quality of services, it is also important that the Health Board understands any risks that savings schemes may have on service performance or the quality. We have seen very little evidence of the consequence of saving schemes on performance or quality being effectively reported to committee or Board. However, we are aware that quality impact analysis has not previously been undertaken as part of the savings planning approach.

Operational scrutiny and monitoring of savings plans and delivery has been weak in previous years, but steps are being taken to strengthen the arrangements

88 Currently savings targets are imposed on a straight-line basis to the Delivery Units who then develop savings plans to try and meet these required targets. Often the aggregated total of the savings plans developed by the Delivery Units are less than the required savings target, and delivery against savings plans are not achieved. Savings plans are now signed off by Delivery Units and then by the Recovery and Sustainability Director. In 2017, the scrutiny of savings plans has increased and this has been a positive step. However, there is a need for a role of the new Performance and Finance Committee and the Board in ensuring that savings plans are realistic and scrutinising potential adverse impacts.

89 In previous years, the cultural and behavioural issues associated with the delivery against savings plans have been exacerbated by the absence of a robust performance management framework. However, in 2017, arrangements to scrutinise and monitor financial performance of the Delivery Units have improved, with the introduction of fortnightly Financial Recovery meetings with the Delivery Units. The meetings are used to hold the Delivery Units to account for financial performance and progress against savings plans. In October 2017, the Health Board introduced an internal escalation process for Delivery Units, which are not performing to the required standard and as a result, require additional scrutiny – in these circumstances the Financial Recovery meetings are held weekly.

90 The Financial Recovery meetings are still relatively new but they have already introduced additional challenge into the system. However, there is still a lot of 'information sharing' and a need for greater

focus on the key issues and actions needed. In addition, most of the meetings run for approximately an hour which, given the scale of the issues to be covered, means that the agenda is squeezed.

91 Over recent months, the Health Board has made positive steps in establishing tighter controls over expenditure. This includes the Investments and Benefits Group, the Administration and Clerical Vacancy Panel and also the Quality, Value, Control (QVC) Panel. These groups are now bedding in but they have already established that the quality and consistency of businesses cases across the Health Board needs to improve.

92 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 challenge needed to ensure that expenditure is managed. Each Delivery Unit has a Senior Finance Business Partner who supports the delivery of savings in collaboration with the Delivery Unit Service Directors. The culture needs to change to ensure that the Senior Finance Business Partners are more proactive in holding the Delivery Units to account in respect of managing budgets, and both the development of, and delivery against savings plans. In addition, there is a need for monitoring of financial performance of Delivery Units to be standardised in terms of the approach and reporting which at present is inconsistent.

Progress in addressing previous financial planning and management recommendations – The Health Board has made progress in addressing previous recommendations on financial management and is taking steps to address outstanding issues

93 In 2016, we made the following recommendations relating to financial management. Exhibit 7 describes the progress made.

Exhibit 7: progress on 2016 financial management recommendations

2016 recommendation	Description of progress
2016 R1a Ensure the outstanding 2015 Structured Assessment recommendation is addressed: 2015 R1 Clarify the financial planning assumptions underpinning the IMTP, given increasing cost pressures, growing funding gaps and overall risk that the IMTP will not be financially balanced.	**Work in progress – more to do** • Financial planning for the 2017-18 IMTP was largely the same as in previous years. • Work is now in progress. For 2018-19, budget planning will be amended to remove the CIP model to ensure all departments and delivery units focus delivery within their overall budgets and they monitor their performance against the bottom line budget.

2016 recommendation	Description of progress
2016 R1b Ensure the outstanding 2015 Structured Assessment recommendation is addressed: 2015 R2 Improve financial reporting to the Board, to provide clearer explanation for any changes to financial position, performance on saving schemes and the corrective action to address any slippage	**Action complete – but subject to ongoing improvements** • In July 2017, the financial reports to the Board were improved, providing far more detail and transparency regarding the financial position and progress against savings plans.
2016 R2 Develop a capital programme for 2017-18 which is formally approved by Board and supported by regular reporting on financial and non-financial performance, risks and overall delivery of the capital programme	**Action in progress** • A capital programme has been approved and the Director of Finance has implemented improved financial reporting to the Board. • The capital plan remains an annual plan, but there is no Health Board wide asset management or estates strategy. Also, the absence of a current clinical strategy is hampering the development of a robust asset management plan.
2016 R3a Financial scrutiny: Consider how financial information can be better scrutinised alongside performance information and greater assurance provided to Board on financial position, impact of financial decisions and that financial controls are being robustly applied.	**Action in progress** • In July 2017, the financial reports to the Board were improved, but financial and performance data are still reported in isolation. There is a need for integration of financial and performance data to inform the assessment of risks and impacts associated with decisions. • The Director of Finance recognises the need to triangulate performance and financial information and is preparing to address this going forward.

Governance and assurance – There have been significant challenges because of transitional leadership arrangements and board member turnover over the last year. However, the Board now finds itself in a more stable position to take forward key actions such as developing a longer term strategy, embedding new governance arrangements and strengthening aspects of performance management

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

Board and committee effectiveness – The Board is aware that it needs to develop its new Board, revise its committee structures and strengthen overall governance arrangements with pace

95 The findings underpinning this conclusion are based on our review of the effectiveness of the board, its governance structures and system of assurance. Our key findings are set out below.

Board Effectiveness - Independent member and executive turnover have created instability during 2017 but the risks and opportunites for developing the new Board and strengthening governance are recognised

96 The Board has experienced major changes to its Board membership in 2017. Seven Independent Board Members (IMs), including the vice-chair, reached the end of their tenure. Three new executives took up post in-year and a number of interim arrangements have also operated to cover other executive roles, including Chief Executive, Chief Operating Officer, HR Director and from December, the Director of Nursing Services and Patient Experience. This level of Board member turnover in a single year is unprecedented and the resulting instability of membership has created difficult leadership challenges. However, the Board has managed these challenges well overall, alongside maintaining focus on financial recovery and performance improvement given the Health Board's 'targeted intervention' status.

97 By December 2017, six new Independent Members were in post with the one remaining vacancy requiring Third Sector expertise subject to re-advertisement. However, the timing of departures and Welsh Government approval of new appointments meant that the opportunity to facilitate a handover period was lost for a number of posts. A new Chief Executive and Director of Governance take up post in early 2018, alongside recruitment for substantive appointments to the HR Director and Director of Nursing Services and Patient Experience posts. This will bring the Board to full complement, although another independent member is due to leave the organisation later in 2018. Executive team changes and capacity are discussed further in paragraph 144

98 Having managed the fragility of Board membership over the course of the year, the Board is aware that the number of new Independent Members and Executive Directors in interim positions continues to present a risk to Board governance and effective committee working and this has been added to the corporate risk register. An induction and planned Board development programme will help mitigate the risk and the Health Board recognises that fully establishing its new Board is a priority for 2018. The Health Board has commissioned the Kings Fund to support this work, focussing on effective Board behaviours, corporate leadership, building cohesion and ensuring effective challenge. The programme will extend to the Executive Team and the Delivery Unit triumvirate management teams, in addition to the Board itself.

99 There have been a number of reviews and reports on governance in recent years, both Health Board specific and in other organisations that offer wider learning; and these have resulted in many action plans. At its September meeting, the Board considered the management response[8] to the 2017 Deloitte's financial governance review, commissioned by Welsh Government. The supporting Board paper sets out a potential scope for further external governance review, noting that as part of the

[8] **Health Board paper 28 September 2017: Financial Governance Review**

Health Boards' targeted intervention status, Welsh Government has proposed that the Health Board undertake a more general governance review.

100 Whilst the new Board may find further governance review helpful, there is a clear opportunity for the Health Board to map all recent governance 'diagnoses', to establish a consolidated view of improvement priorities, develop a coordinated action plan to address them and identify if, and where, any further governance review should be targeted. Consolidation of action plans should include the findings and recommendations from this structured assessment, the current Delivery Unit (Welsh Government) review of serious incidents management and those of the Deloitte's financial governance review.

101 The Health Board is taking actions towards addressing the recommendations from the Deloitte's review. The timescales for completing some actions have been dependent on board member recruitment and this has slowed the pace in some instances. Actions taken include progressing the scoping of the Board development programme with the external agency, exploring an individual feedback/coaching service with Academi Wales and developing a programme for all Board members to visit a high performing board (public or private sector) and share lessons learned.

102 Despite the challenges of Board member turnover as described above, the Board has met its statutory reporting duties and has continued its commitment to the transparent conduct of business. The Deloitte's report, completed in late spring, did highlight weaknesses in Board scrutiny with a heavy reliance on a small number of Independent Members and the need for more collective executive contribution beyond individual portfolio responsibilities. These findings perhaps reflect the state of flux in the Board at the time. Our observations of the September Board meeting found there to be reasonable scrutiny, discussion and debate. We did however note the following:

- Differing levels of scrutiny focus and challenge across board members, with the meeting being either the last or first board meeting for a number of departing or new Independent Members.
- An ambitious agenda, and whilst most items received adequate attention, some were a little rushed and the last two items were not covered.
- Variable quality of assurance reports, despite the Board agreeing a set of 'Board and Committee Report guiding principles' in July 2017. Many reports placed a greater focus on the background and management actions, with limited detail on the objectives, outcomes and risks.
- The opportunity to establish clearer links between the separate financial performance, operational performance, workforce and quality reports through a more integrated approach to Board performance reporting, to better inform the assessment of risks and impacts associated with decisions.

103 It will be important for the Health Board to address these scrutiny and assurance improvement opportunities as part of the broader development of the new Board, and alongside development of its Board Assurance Framework and revisions to governance structures as discussed in the following sections of this report. The Health Board demonstrates good awareness of these issues and the opportunities for improvement.

104 The scheme of delegation outlining the responsibilities of the Board and those that are delegated to its officers has recently been revised to account for transfers of executive duties in 2017 and update the document in-line with current structures. Some of the changes relate a rebalancing of executive portfolios due to interim posts, for example, the transfer of Infection Control to the Director of Public

Health from the Director of Nursing and Patient Experience and interim Chief Operating Officer. Other changes avoid a conflict in roles, for example providing separation for the roles of Caldicott Guardian and Senior Information Responsible Officer (SIRO). The standing orders and scheme of delegation will need to be reviewed again in 2018 to account for any further rebalancing of executive portfolios by the new Chief Executive. A scheme of delegation for capital scheme approvals should also be developed.

105 In 2016, we made the following recommendation relating to board effectiveness. Exhibit 8 describes the progress made.

Exhibit 8: progress on 2016 board effectiveness recommendation

2016 recommendation	Description of progress
2016 R6 Review the website to ensure accessibility, easy navigation and that web content (including published policies and documents) are up to date	**Action in progress** • The Board is committed to the transparent conduct of its business and public reporting and is largely compliant with the new Welsh Government requirements for publishing prescribed information. • There has been a review of the website and its accessibility in the last 12 months but there is still a need to improve the navigation and ensure that the web content is up to date to comply fully with WHC/2016/033 - Publication of information on Local Health Board and NHS Trust websites. • For example: – the new Consultation and Engagement Framework and the final Annual Operating Plan for 2017-18 are not available on the website; and – some policies and plans on the web need updating, for example, the 2012-2016 Equality, Diversity and Human Rights Policy.

Governance Structures - Quorate committee meetings have been sustained despite Board membership fragility and the introduction of a Performance and Finance Committee has been a positive step, but some committees have not been wholly effective and revisions to the committee structure are planned

106 Changes to board membership and loss of independent member experience and expertise during 2017 has placed reliance on a small number of Independent Members. It has also presented difficult challenges for continuity of committee chairs, membership and maintaining quorate meetings. The Health Board has been pragmatic in managing this situation, with quorate committee meetings maintained by remaining executives and independent members sitting on multiple committee meetings. Whilst necessary, this has not always been conducive to effective meetings. There have also been some gaps in meetings and attendance during 2017 and to establish the new Performance and Finance Committee, the Chairman has needed to take up the Chair of this committee alongside his being the Chair for Strategy Group and the Recovery & Sustainability Programme Board.

107 The Chairs Advisory Group has maintained oversight of Board Committee arrangements during 2017, with some in-year changes to some committees and supporting groups. However, Chair's Advisory Group discussions have also highlighted areas of potential overlap between committees and potential gaps in committee working. With full board membership in place for 2018, the Health Board is revising its committee structure and memberships, with proposals presented to Board in December 2017. The proposals set out the remapping of committees, the groups reporting to them, and their alignment to three core organisational themes:

- **Setting strategic direction**: includes partnership working aligned to the Future Generations and Wellbeing Act, and the establishment of a Joint Committee for regional planning with Hywel Dda Health Board.
- **Performance improvement and management**: includes the recently established Performance and Finance Committee, the Workforce and OD (WFOD) Committee and the Recovery and Sustainability Board.
- **Culture and Governance**: this includes the Audit and Quality and Safety (Q&S) Committees. It is proposed that a Board Committee for health & safety (H&S) is established for committee level consideration of environment of care issues, and replacing the current executive committee, which reports to the Q&S Committee.

108 In progressing the proposals for revised committee arrangements, it will be important for the Health Board to ensure the intra-operability of the WFOD and P&F Committees in particular, alongside finalising the terms of reference and committee membership across the revised governance structure. Full Board membership also affords an opportunity for the Chairman to assign new Independent Member Chairs to the P&F and Strategy Committees, releasing him from these roles and avoiding any potential conflict of interest.

109 More broadly, the Health Board will need to ensure clarity and organisational understanding of the new structure and specifically, about what is a management group, partnership forum or scrutiny function as the current mapping groups them collectively. It will also be important to reassess any gaps or duplication in the operation of the new arrangements once introduced, and to consider as part of development of the Board Assurance Framework, whether further simplification of governance structures and reporting lines is required.

110 Within the existing committee structure during 2017, the key committees of Audit and Quality & Safety have generally continued to operate effectively, within the membership challenges described above. Our findings in relation to these committees and others that we observed as part of our fieldwork are set out below.

Audit Committee

111 The Audit Committee has been a well-established and an effective committee in recent years. However, during the early part of 2017, ensuring effective scrutiny and pace of management actions largely rested on the shoulders of the Committee Chair, which was not a sustainable position. However, following Independent Member departures and new appointments, the Audit Committee now has a new Chair and refreshed membership. The Committee Chair, and new Director of Corporate Governance, are currently reviewing the operation of the committee, with self-assessment of its effectiveness planned for 2018. Recognised improvement opportunities being addressed include:

- Focussing on the Committee's role for overseeing the effectiveness of the assurance system;
- Rebalancing the work plan and improving agenda management, with clarity of the purpose of items presented and a stronger risk based approach to scrutiny of issues and progress;
- Ensuring the format and content of papers presented provides clearer identification of assurances and risks; and
- Strengthening aspects of internal controls such as the strengthening the mechanisms for ensuring robust monthly declarations of interest, and gifts and hospitality.

112 The Health Board has a good Internal Audit service and its risk-based plan provides a flow of assurances to support and inform the work of the Committee. Arrangements to monitor management responses to both internal and external (WAO) audit recommendations are in place, with the Committee receiving an Audit Register and Action Plan Report highlighting the number of recommendations complete, in progress or overdue. As at end December 2017, some 32 (11%) external audit and 103 (18%) internal audit recommendations were overdue. Given the number of overdue actions and some signs of slippage in the pace of addressing recommendations, the Committee report has been improved. The longest number of overdue days for outstanding recommendations from each audit are now included and whether these relate to high-risk issues is being added to future reports. This will better inform and help the Committee to target its scrutiny and holding to account where progress, particularly in areas of limited assurance and high risk, is slow.

Quality and Safety Committee

113 The Quality and Safety (Q&S) Committee is also a well-established Committee, but as for the Audit Committee, has had a new Chair since the autumn and is re-establishing its work programme within a refreshed membership. The established arrangements for service delivery units (units) to present annually on their quality governance have continued although the Committee has been proactive in re-shaping the style and focus of these presentations to derive greater assurance on unit risks. There has also been work to improve the flow of assurance to the Committee from Health Board wide management sub-groups / committees.

114 An executive led Quality and Safety Forum (the Forum) met for the time in January 2017, with the purpose of receiving and providing assurance, and escalating quality and safety risks to the Executive Team and the Q&S Committee. The Director of Therapies and Health Science is the chair and the Medical Director the co-chair. The Director of Nursing is a member and chair of the Assurance and Learning Group.

115 On establishment, some 23 management led groups were identified as reporting directly to the Forum, in addition to the six service delivery units providing assurance on their progress against the three year

Quality Strategy. Another seven groups report to other management committees/ groups such as the Infection Prevention & Control Committee, which report directly to the Q&S Committee. A further 12 groups, including the Safeguarding and Radiation Protection Committees; provide assurance to Q&S Committee via their executive leads.

116 The early work of the Forum focussed on validating the groups identified as reporting to it and reviewing their terms of reference and role, for example whether strategic, task and finish, or an assurance group. It also highlighted groups that were not identified or were no longer standing. This work has been essential although the Q&S Committee has been frustrated by the pace for establishing the Forums' work programme and regular assurance reporting from all groups reporting to it. The work to date has rightly focussed on establishing and streamlining the 'landscape' of Health Board wide groups reporting to the Forum, developing operational engagement in the work of the Forum, and building some consistency in the assurances it receives. There is now the need to ensure that:

- all management groups required to report to the Forum do so regularly as this has not consistently been the case creating gaps in assurance to and from the Forum;
- the assurance reports from the Forum are fully meeting the requirements of the Q&S Committee, as these were still evolving during 2017;
- the mapping of unit specific groups initiated by the Forum in 2017 is fully complete, and that these groups are providing assurance via unit quality governance structures, and where relevant, are appropriately connected to the Health Board wide groups; and
- the total number of management groups and complexity of reporting lines (via the Forum, 'other' groups' and executive leads) does not compromise effective assurance flow to, and work planning for, the Q&S Committee.

117 During our observations at the Q&S Committee, we noted assurance reporting from the Forum, and in the areas covered by the other groups reporting directly to the Q&S Committee or via the executive leads. However, in conjunction with development of the Health Board's Board Assurance Framework in 2018, there is an opportunity to consider further simplification of the quality and safety sub-structures; and achieve greater clarity on the relationship between the Forum and other groups, particularly the Assurance and Learning Group and the Clinical Outcomes Steering Group.

Performance and Finance Committee

118 The new Performance and Finance Committee, chaired by the Chairman, has been in operation since June 2017. It was created to fill a gap in the scrutiny of performance and finance, with the former Performance Committee having been suspended in May 2016. It had met five times up to December 2017. We observed the third meeting of the Committee in October and found transparent financial reporting, open discussion and consideration of risks, and overall good scrutiny of issues. Some revisions to the Committee's Terms of Reference were proposed at this meeting but finalising these and the Committee's work plan been deferred pending completion of the wider review of committee arrangements. However, this Committee will address the previous gap in committee level scrutiny of against the Annual Operating Plan (AOP) delivery, or when approved, the Integrated Medium Term Plan (IMTP).

119 To address potential overlaps in the workings of the Performance and Finance Committee and the Recovery and Sustainability Board, it is proposed that the Recovery and Sustainability Board should become an Executive-led Programme Board, overseeing the executive work streams and reporting to the Performance and Finance Committee.

120 In 2016, we made the following recommendations relating to committees and specifically, the scrutiny of performance and IMTP / AOP delivery. The establishment of the Performance and Finance Committee addresses the issue as summarised in Exhibit 9.

Exhibit 9: progress on 2016 committee effectiveness recommendation

2016 recommendation	Description of progress
2016 R3a Following suspension of the Performance Committee and in the context of independent member changes in 2017, reassess performance scrutiny arrangements and whether scrutiny is to remain a function of Board or supported by committee arrangements. 2016 R3b IMTP scrutiny: review current arrangements to ensure the NHS Planning Framework 2017-20 requirement for board sub-committee scrutiny of IMTP progress and performance can be fully met.	**Action complete** The Performance and Finance Committee was established in June 2017. Its remit includes scrutiny of performance, finance and AOP/IMTP delivery.

121 Committee scrutiny of performance has so far focussed on the six targeted intervention areas, which whilst understandable is too narrowly focussed. The Committee has recently agreed to broaden the areas reviewed to gain a more rounded view of Health Board performance, whilst maintaining its focus on the six targeted intervention areas. Following an extremely focussed review of cancer performance in October, the Committee has introduced a 'deep dive' into one of the six areas at each meeting, starting with planned care in December 2017.

122 The Committee is demonstrating good scrutiny of financial performance and associated risks, alongside the oversight and scrutiny of the Recovery and Sustainability (R&S) Programme. The R&S Programme Board has evolved from an Independent Member led to an Executive led Board, which reports to the P&F Committee.

123 Whilst still a relatively new, the P&F Committee it is establishing itself well, with a good level of discussion, challenge and scrutiny evident at the meeting we observed. The Committee is taking an integrated view of performance and in addition to performance and finance data; it considers key workforce metrics and risks. It is proposed to retain the WFOD Committee to ensure sufficient scrutiny of broader workforce and organisational development, although it will be important to ensure clarity in the remits of the two committees in finalising revised committee arrangements and terms of reference.

Workforce and OD Committee

124 In 2016 we noted some improvements in the operation of the WFOD Committee although these were not embedded and workforce information, assurance reporting and overall scrutiny needed further strengthening. In 2017, the Committee has only met three times despite a bi-monthly meeting schedule and we found there to be a poor balance between discussion of operational matters and scrutiny and assurance. Given the importance of workforce issues, which represent the top corporate risk, reshaping this Committee to provide an effective scrutiny and assurance function is essential.

Strategy Committee

125 The Strategy Committee, chaired by the Chairman, last met in March 2017. Earlier discussions at the Strategy Committee and the Chairs Advisory Group had led to a decision that the Committee (a strategic forward thinking forum and not an assurance committee) would better operate as a time limited Task and Finish Group reporting directly to the Board. To some extent, this also freed some capacity for the Recovery & Sustainability Programme. The Board was informed of this change through the Chairman and Chief Executive's Report and Committee update in January 2017.

126 The Strategy Group has since been used to provide space for wider debate on strategy development and play a more central role in considering strategic issues prior to Board consideration. In this context, it may be more appropriate for the Group to be re-established as a Board Committee. The proposals for revised committee structures presented to Board in December 2017 recommended reinstatement of a Strategy Committee and the amended terms of reference drafted indicate that the new Committee will oversee strategy and AOP/IMTP development and the progress of strategic change programmes.

Development of a Board Assurance Framework has been slow but with new Board membership and proposed governance structures changes, it is now recognised and being progressed as a priority

127 The Health Board has an established system of assurance with arrangements for seeking and gaining assurances, but changes to governance structures as described above will necessitate the review of the current system. The Health Board recognises that this should take place in the context of developing its Board Assurance Framework (BAF), alongside its broader Board development work.

128 The significant Board membership issues experienced in 2017 has created a hiatus in taking forward BAF development, following the early 'conversation' on risk and assurance mapping at a Board development event in January 2017. However, the Health Board is now intending to progress BAF development as a priority, with a BAF framework expected to be in place by April 2018. Board involvement in the understanding and design of the BAF and its underpinning governance arrangements will be vital, not least given the number of new board members.

129 In developing the Board Assurance Framework (BAF), it will be important for the Health Board to better account for strategic objectives and risks and use risk and assurance mapping as tools to help build its BAF. Consistent with our findings from 2016 structured assessment, key considerations are:

- Incorporating new and future threats to strategic objectives, including legislative requirements.
- More specifically defining the risks to objectives.

- Building a stronger focus on public health, community, primary care, mental health and partnerships.
- More specifically defining the assurances required beyond general 'three lines of defence' categorisation, and ensuring that sources of assurances are used to best effect, for example:
  - Clinical audit: beyond the clear commitment to national clinical audit programmes which provides benchmarking opportunity; it is not clear how local audit is matched to strategic priorities / objectives; and
  - Regulatory and other external reports: apart from internal and external (WAO) audit reports which are presented to and tracked by Audit Committee, it is not clear where other important reports setting out improvements and recommendations are received and considered, for example the Delivery Unit. The Quality and Safety Committee receives Healthcare Inspectorate Wales, Community Health Council and Public Sector Ombudsman reports, but recommendations tracking is not in place for these.
- Advancing the work on the Board behaviours framework developed in July 2017, to strengthen the quality assurance reporting, ensuring consistency from ward to Board and what assurances are reported and received at each level.

130 Robust corporate risk and performance management arrangements are also necessary to underpin effective assurance systems. These are discussed later in this report.

Strategic planning – Whilst working to an Annual Operating Plan (AOP), the Health Board is redeveloping its clinical strategy to inform its longer-term, more transformational planning although planning capacity is limited

131 The findings underpinning this conclusion are based on our review of the Health Board's approach to strategic planning and the arrangements, which support delivery of strategic change programmes underpinning the Annual Operating Plan 2017-18. We have also considered the progress made in addressing previous recommendations relating to strategic planning. Our key findings are set out below.

IMTP/AOP - The Health Board does not have an approved Integrated Medium Term Plan (IMTP) and is working to an Annual Operating Plan

132 All Welsh health bodies are expected to develop a three year integrated medium-term plan (IMTP), but the Health Board has not had an approved IMTP[9] for two years and has worked to an Annual Operating Plan (AOP) for 2016-17 and 2017-18. At the time of our fieldwork, the Health Board was developing its AOP for 2018-19, with Board agreement that it would not produce an IMTP due to the current recovery and sustainability position of the Health Board. The development process has been informed by a set of key planning principles agreed at a Board development session in August 2017. There has been an earlier focus on activity, financial and service frameworks for 2018, and a more thorough engagement of the Board during the development process.

[9] Structured assessment work focusses on the process and arrangements for strategic planning. It does not assess the quality and robustness of IMTPs, which is carried out by Welsh Government.

133 The development timetable to submit a Board approved AOP to Welsh Government by 31 January has been tight in previous years, creating a challenge for ensuring enough time for Board scrutiny prior to submission. In 2017, this scrutiny did not take place until 30 January and aspects of the plan were not complete. For 2018-19, the development process started a little earlier. The Executive Team reviewed the draft AOP prior to Strategy and Planning Committee receiving presentation of the final draft at its January meeting, ahead of Board consideration in private session 25 January 2018.

134 The Director of Strategy is the executive lead for IMTP development supported by an Assistant Director of Strategy, and a Head of IMTP Development and Implementation. Planning workshops for operational units in October 2017 set out the key principles, the requirement for local plans to meet the objectives of the Recovery and Sustainability Programme and the Health Board's budget setting approach. The framework for Units to develop their local plans was more prescriptive this year, focussing on value and efficiency, and being clear about what can be delivered within an agreed financial envelope.

135 Scrutiny of 2017-18 AOP delivery has continued to rest with the Board, with progress reported to Board quarterly. A detailed Tracker is used to monitor progress against the AOP actions and the 15 Welsh Government Delivery Plans, with each action or Delivery Plan having a nominated lead who assesses progress on a self-scoring basis using the RAG-rating methodology. The Tracker needs to be read in conjunction with the Health Board's performance report, which is complementary to the broader assessments on service change made in the Tracker.

136 Going forward, and subject to agreement of proposed committee changes and finalisation of draft terms of reference, it is proposed that the new Performance and Finance (P&F) Committee will provide sub-committee oversight of AOP/IMTP delivery and performance, while a reinstated S&P Committee will oversee development of the plan and the underpinning strategic change programmes. It will be important for the Health Board to consider how committee level reporting and scrutiny aligns across the remits of the two committees, particularly in respect of joined up monitoring of strategic change implementation (S&P) and overall performance and AOP/IMTP delivery (P&F).

137 In 2016 we made the following recommendations relating to strategic planning. Exhibit 10 describes the progress made.

Exhibit 10: progress on 2016 strategic planning recommendations

2016 recommendation	Description of progress
2016 R3b IMTP scrutiny: review current arrangements to ensure the NHS Planning Framework 2017-20 requirement for board sub-committee scrutiny of IMTP progress and performance can be fully met.	**Action complete, subject to finalisation of draft terms of reference.** • The Board has retained responsibility for scrutinising AOP / IMTP development and delivery during 2017, receiving quarterly Board reports on progress. • A new Performance and Finance Committee established in 2017 will provide board sub-committee scrutiny of AOP/IMTP progress and performance going forward. • Arrangements due to be in place for 2018, although some further actions are required to ensure alignment with scrutiny of strategic change. Further detail is set out in paragraph 126.

2016 recommendation	Description of progress
2016 R5 Update the engagement and communication framework in addition to completing development of a structured engagement plan for IMTP development.	**Action complete** • Service delivery units are required to engage with staff and stakeholders in the development of their plans • The Health Board has developed and agreed an engagement and communication framework with the Community Health Council (CHC). • The engagement and communication framework covers service changes, which require engagement with the CHC or wider public. • The framework is being applied to service changes identified by Service Delivery Units with submissions to the CHC centrally coordinated. • However, it is too early to assess the effectiveness of the engagement and communication framework.

Organisational Strategy – the Health Board is aware that it needs to set the direction and longer term vision for the organisation and is currently developing a new clinical strategy

138 There has been a necessary focus on responding to targeted intervention and addressing organisational recovery and sustainability. However, without a clear vision and overarching strategy, financial and performance pressures has led to a short-term approach to planning and strategy, with limited or no time for longer-term transformational planning. While ARCH provides an extant umbrella framework for taking forward strategy, the ARCH programme office has been hollowed-out since the Welsh Government funding for the programme office ended. There has been no decision as yet on the Portfolio Development Plan (PDP) submitted to Welsh Government in February 2017, creating uncertainty on the future of the ARCH programme and its long-term funding. The Health Board is aware that it needs to develop a long-term strategy to set the direction and vision for the Health Board, informed by an up to date clinical strategy and with active Board engagement.

139 The Health Board's current clinical strategy, *Changing for the Better* (C4B), was developed in 2013. As the landscape within and outside the Health Board has since changed it is appropriate for the Health Board to recast its clinical strategy. Development of a revised clinical strategy is in progress, alongside work to align regional strategies and plans with Hywel Dda University Health Board through the Joint Regional Planning Committee and concurrent with development of the 2018-19 AOP.

140 The new Clinical Strategy should underpin the subsequent development of a ten-year strategy and future IMTP, although the timescales for completing clinical strategy development are not yet confirmed. The Health Board is intending to undertake stakeholder engagement, with a focus on pathways and ensuring an integrated approach to delivery across the Health Board, both between Delivery Units and between primary and secondary care.

141 In terms of the Health Board's clinical and longer term strategy development, there is a need to:

- map and realign previous 'Changing for the Better' (C4B) strategic change programmes no longer overseen by the former Commissioning Boards stood down in September 2017;
- account for other Health Board strategies recently developed, including Children and Young People, Older People, Mental Health, Quality, and Digital; and

- develop supporting strategies, such as estates, workforce and financial strategies, to ensure delivery of the clinical strategy and the longer term vision.

Planning – Health Board planning capacity is limited and it is looking to commission help to support demand and capacity planning and build operational planning skills and expertise

142 The Director of Strategy portfolio covers a diverse set of strategic and operational responsibilities, including strategy development, planning, WFG, engagement and the management of estates. Given the current strategy and planning priorities, it is important for the Health Board to ensure there is sufficient corporate infrastructure and planning capacity to support this portfolio and take forward planning and strategy development with sufficient pace.

143 Additional planning capacity has been agreed with Welsh Government as part of targeted intervention support, and arrangements were being finalised at the time of concluding our fieldwork. While the details and scope of the additional support were not confirmed , the Health Board was anticipating being able to commission external consultancy to help build capacity early in 2018, specifically:

- for demand and capacity analysis and planning, as more detailed forecasting for longer-term service reconfiguration to meet demand is needed; and
- to improve planning skills and expertise in service delivery units, to ensure more robust operational planning and a reduced reliance on the small corporate planning team.

144 The Health Board is operating in a complex strategic environment with a number of major strategic programmes and service change consultations to both manage and account for. These include regional working with Hywel Dda Health Board, ARCH, City Deal, WFG and the partnership working with three Public Services Boards and the Regional Partnership Board. It also includes consultations on the transfer of services for the Bridgend population, the major trauma network and potential changes for thoracic surgery. This adds complexity to the development of the Health Board's own strategic plans and inevitably has an implication for the planning resource. The Health Board should take this into consideration alongside any wider reviews of corporate infrastructure and executive portfolios once a full executive team is in place.

Organisational structure – The Health Board has managed the impact of major executive changes in 2017 and recognises that developing the new executive team, building leadership and capacity, and embedding new programme board arrangements are priorities for 2018

Executive leadership – The committment of individual executives has maintained leadership during a period of major executive changes, and the Health Board recognises establishing its new leadership team as a priority for 2018

145 There have been major changes to the executive team in 2017, which have created a significant leadership challenge, alongside the necessary focus on addressing Targeted Intervention conditions, recovery and sustainability. The changes have led to a number of interim and acting arrangements to cover vacant posts during the year. The key changes have been:

- An interim Chief Executive Officer since January 2017 (previously the Chief Operating Officer).

- An interim Chief Operating Officer since January 2017, covered by the Director of Nursing Services and Patient Experience in addition to their existing role.
- The departure of the Director of Finance in December 2016, covered by an Acting Director until the substantive appointment of a new Director of Finance in May 2017.
- Substantive appointment of a Director Therapies and Health Science in February 2017 previously covered on an interim basis.
- The departure of the Director of HR in early 2017, covered by an Acting Director of HR.
- The departure of the Director of Nursing Services and Patient Experience in December 2017, currently covered immediately by:
  - an interim Director of Nursing Services and Patient Experience since December; and
  - an acting Chief Operating Officer, seconded to the Health Board for 12 months.
- Appointment of a new Director of Public Health in 2017 and a new Director of Corporate Governance in January 2018, on the retirement of the previous post holders.

146 New appointments made during 2017 have had positive impact, particularly in respect of finance and the Recovery and Sustainability programme, but two key posts are still being filled on an interim basis. The new Chief Executive has been appointed and will be taking up post in February 2018, following which, recruitment for a substantive HR Director and Director of Nursing Services and Patient Experience will proceed.

147 The level of executive change this year has relied on the commitment and resilience of a smaller number of executives to lead the focus on delivery and performance to address the recovery and sustainability challenges faced. Going forward, the Board as a whole would benefit from wider executive engagement in financial and delivery performance, reflecting broader corporate responsibilities and not just those of their specific portfolio. Some executives interviewed as part of our work also questioned the balance across executive portfolios in terms of the span of responsibilities. The revised executive membership offers opportunity to develop the new team in 2018, for closer collaborative working as a single leadership team, and for ensuring balance across executive roles and portfolios.

Operational structure - The Health Board's Delivery Unit Structure is now embedded but work to ensure effective cross-system working is needed

148 The Health Board's 2014-15 restructure led to the creation of the six service delivery units[10]. A core 'triumvirate' leads each service delivery unit (unit), consisting of a Service Director, Medical Director and a Nurse Director. The Health Board had intended to carry out a post implementation review of the revised structures and their governance arrangements, once population of unit sub-structures was completed early in 2017. However, the review has not been undertaken due to capacity, the need to respond to targeted intervention and the interim and transitional arrangements across the executive team during 2017.

[10] The six units are: Morriston Hospital, Princess of Wales Hospital, Singleton Hospital; Neath Port Talbot Hospital, Mental Health and Learning Disability Services, and Primary Care and Community Services.

149 Our structured assessment work in 2017 found that the maturity of individual units is still variable. The Health Board has been building a senior leadership team (SLT) approach, with unit management teams now attending a fortnightly SLT meeting with executive colleagues. The aim is to develop stronger collective leadership across and within the unit management teams and to embed a collective and corporate view of service delivery and management responsibilities.

150 During the course of our work however, we have observed silo based unit management responses to cross-unit issues impacting on Health Board performance, with responsibility for resolution passed to the executive director. Although there are examples of good collaborative work, these behaviours indicate that cross-system working between unit management teams is not wholly embedded or consistent. Building collective responsibility and leadership for effective cross-system working between units is an important issue for the Health Board to address. The Health Board has commissioned the Kings Fund to deliver a leadership programme for Delivery Unit management teams in 2018.

151 We have previously recommended that the Health Board review the corporate structures following the 2015 operational restructure, so that the role and capacity of corporate directorates are clearly understood in relation to unit roles, responsibilities and resources. The Health Board determined that for the reasons set out in paragraph 147 the time for completing such as review in 2017 was not appropriate. Ensuring the right balance between Delivery Unit autonomy and accountability with that of the corporate centre has been difficult to achieve in 2017, not least due to the strong corporate oversight needed to respond to targeted intervention, recovery and sustainability. Going forward, the corporate centre needs to become more the enabler, setting the clinical and long term organisational strategy, and supporting unit delivery by ensuring units have the necessary tools and resources.

152 Following the new Chief Executive taking up post in February 2018, the Health Board will need to take stock and clarify the role and capacity of corporate directorates in relation to unit roles, responsibilities and resources.

Commissioning and delivery frameworks - The Health Board has made recent changes to commissioning and delivery arrangements and it is too early to assess the effectiveness of new Programme Boards

153 In our 2016 structured assessment we highlighted that whilst the Health Board's commissioning framework had rightly focussed on long-term population health, it was unclear how commissioning decisions supported and addressed current delivery and performance priorities. We also noted disconnects between the separate commissioning and delivery frameworks.

154 The Health Board established its commissioning approach to deliver the priorities of the 'Changing for the Better' Programme and while some Commissioning Boards had made significant progress, others were less mature with fewer achievements. In addition, the focus and resources to support commissioning and service planning were not well balanced. In considering these issues, the Health Board took the decision to stand down five out of the six Commissioning Boards in September 2017; the exception being the Mental Health and Learning Disability Commissioning Board linked into the Western Bay Partnership. All former Delivery Boards were also stood down, with Commissioning and Delivery Boards to be replaced with three new Programmes Boards – Unscheduled Care, Planned Care and Cancer.

155 The new Programme Board arrangements are in their early infancy but they are intended to promote a value based and whole pathway focus across the Health Board, and 'one ABMU way' of doing things.

Each Programme Board is to be headed by an executive lead with representation from delivery units. The Programme Boards will provide a focus for:

- Planning – commissioning, strategic change, and values based healthcare; and
- Improvement – delivery and performance, and service change.

156 However, the Health Board needs to ensure that the new programme boards do not focus solely on areas of targeted intervention in secondary care, with insufficient attention paid to other service areas and improvements, particularly in the absence of a current clinical strategy. The Health Board will also need to:

- Re-map the Changing for the Better strategic change programmes formerly overseen by the Commissioning Boards and determine how they align to the new Programme Boards;
- Ensure the new arrangements and interfaces between the programme boards and the delivery unit structures are clear and better understood than the previous arrangements; and
- Clarify reporting lines for the new Programme Boards and the relationship to the Strategy and Planning, and Performance and Finance Committees in finalising the revised governance structures and terms of reference.

157 In 2016, we made the following recommendations relating to organisational structure, in respect of the connections between commissioning and delivery programmes. Exhibit 11 summarises the progress made.

Exhibit 11: progress on 2016 recommendations relating to organisational structure

2016 recommendation	Description of progress
2016 R4a Ensure sufficient challenge via the Strategy, Planning and Commissioning Committee on how commissioning decisions are reached and balanced against current delivery priorities.	**Action in progress** • All Commissioning Boards (with the exception of Mental Health), and all Delivery Boards stood down in September 2017, replaced with three new Programme Boards. • New Programme Boards are being established. They are simplified and bring together planning and commissioning, delivery and improvement. • It is too soon to tell if the new programme arrangements will prove effective and the reporting lines for the new Programme Boards and the future role of the Strategy & Planning Committee unclear at the time of fieldwork

2016 recommendation	Description of progress
2016 R4b Improve the clarity and understanding of decisions about re-commissioning and decommissioning within planning cycles and the role of the executive strategy group.	**Action in progress** • See new Programme Board arrangements above • Lack of a current clinical strategy to set the direction and decisions need to be underpinned values based healthcare and the clinical direction • Should have impact next year, but too late to have an impact for the 2018-19 AOP. • It is too soon to tell if revised arrangements will prove effective • It is unclear where the Recovery and Sustainability programme and executive strategy group will fit with these arrangements
2016 R4d Ensure the architecture, interfaces and relative priorities across strategy, commissioning, change and delivery programmes are better understood, with sufficient organisational capacity to service the management arrangements. This should include reviewing current meeting requirements	**Action in progress** • Commissioning and Delivery Boards stood down and new Programme Boards being set up • Development of updated Clinical Strategy in progress • It is too soon to tell if revised arrangements will prove effective • Changing for the Better change programmes need to be re-mapped after Commissioning Boards stood down

Risk and performance management - Risk management is maturing but performance management would benefit from more integrated reporting and a stronger focus on accountability and outcomes

158 The findings underpinning this conclusion are based on our review of risk and performance management arrangements. Our key findings are set out below.

Risk management - The Health Board is updating its risk management strategy and taking steps to further mature its approach

159 The Health Board has a Risk Management Strategy, updated in 2016 to take account of the changes to the organisational structure, and supported by an implementation plan for the period September 2016 to October 2017. Risks are set out in the corporate risk register (CRR) and are managed through the risk management framework. Risks are aligned to objectives in the CRR and broadly mapped to specific Board committees for scrutiny purposes. The Audit Committee maintains oversight of risk management arrangements and the CRR as a whole. Operational risk registers are also in place with risks escalated to the CRR based on the assessed risk score. A task & finish approach has been taken to focus on Datix risk module implementation and support delivery units embed risk management.

160 In November 2017, Internal Audit reported its review of current risk management arrangements to Audit Committee. A 'reasonable assurance' rating was given although the audit highlighted that:

- Arrangements for committees to oversee, challenge and scrutinising their assigned risks was not yet in place for all committees.
- The Health Board had not been routinely receiving the CRR, or a summary of risks over the last year. Whilst not a strategy and policy requirement, the practice would ensure that members are aware of all risks and the mitigating actions being taken. Management has since confirmed that:
  - a Strategic Risk Dashboard will be provided for Board;
  - the Audit Committee will receive the CRR and a strategic risk report at each meeting; and
  - the Assurance & Learning Group and Executive Team will receive a bi-monthly risk management report.

161 A Board workshop on risk management was held in December 2017. It provided members the opportunity to reflect on the CRR, requirements for updating the risks to corporate objectives and consider the current risk management processes and the changes required. Following this, the Health Board has moved to develop a revised risk management work programme and is updating its risk management strategy and policy. This work is expected to run alongside the development of the Board Assurance Framework (BAF), but includes the following:

- Introduction of executive portfolio risk and revisions to the CRR template;
- Realignment of risk management 'teams' to maximise available central staff resource; and
- Improvements to the quality of information in the Datix system and more efficient extraction of information to support reporting and thematic analysis, within the current system constraints. The Head of Patient Experience, Risk and Legal Services is engaging with other NHS Datix users to learn from their experience but is also part of a Once for Wales national group looking at other risk management system providers.

162 Our structured assessment work also identifies a number of additional issues that the Health Board should address in taking forward its planned developments. These are:

- Clearer identification of risks to objectives, informed by risk mapping as part of BAF development, as many 'items' on the CRR are issues rather than risks e.g. USC, public health;
- Assessing the number of risks on the CRR as they are too many for proper collective scrutiny;
- Remapping risks to committees to reflect the new committee structure once finalised; and
- Ensuring that all committees provide oversight and scrutiny for the risks assigned to them.

Performance management arrangements – Performance management and scrutiny arrangements are in place although the Health Board has yet to update its framework and needs to strengthen integrated reporting and its focus on operational accountability and outcomes

163 Health bodies in Wales are set and held to account on a range of measures and targets that are set out in the NHS Wales Delivery Framework. In September 2016, Welsh Government placed the Health Board into targeted intervention, due to the financial position and performance in relation to cancer, waiting times, unscheduled care (USC), stroke and infection control. The Health Board has concentrated on the performance issues that contributed to its targeted intervention status, and while

there are signs of some improvement there is much more to do, and greater traction is needed. We have reviewed performance management and corporate performance monitoring and reporting arrangements. Our key findings are set out below.

The Health Board has focused on performance issues that contributed to targeted intervention and while a Recoverey and Sustainability Programme has led important work, greater Delivery Unit ownership is needed

164 In responding to targeted intervention, the Health Board established a Recovery and Sustainability (R&S) Programme in February 2017, supported by an R&S Director and newly formed Programme Management Office. The aim of the R&S Programme is to steer the delivery of better value, efficiency and sustainability of services, for Health Board 'recovery'. For the Health Board to improve performance and meet the target of achieving financial balance, the Recovery and Sustainability Programme has needed to identify cost savings measures and efficiencies whilst also seeking to improve performance in some key areas. There are eight corporate work streams which, in addition to helping deliver no more than a £36m deficit for 2017-18, relate to workforce and capacity redesign.

165 It has been necessary for the Programme to embed quickly and gain grip throughout the organisation. A range of meetings to agree actions and ensure frequent monitoring of performance have helped drive this, alongside wider performance management arrangements discussed below. Regular Chief Executive briefings have also been provided for all staff, to promote behaviours and mind-set, and monthly executive meetings with Delivery Units are merging with bi-weekly SLT meetings. However, the number and frequency of meetings and the complexity of reporting lines could be simplified, to ensure enough management time and capacity to action the necessary improvements. The Health Board is taking steps towards this, in addition to reviewing the R&S Programme architecture with, for example, the R&S Board becoming executive led.

166 The R&S Director holds the reigns centrally and takes much personal responsibility for actions, holding fortnightly finance and performance reviews with Delivery Units (Units). This has caused some frustration with Units but as referred to in paragraph 150 greater ownership is needed. Programme Management Office (PMO) capacity is also constrained, having been resourced by drawing in resources from other areas. It is unlikely that with its current capacity, the PMO would be able to support wider strategic change programmes linked to C4B and the new Clinical Strategy.

Performance management arrangements are in place but the documented framework is out of date, the number of meetings may not be sustainable and there needs to be a stronger outcomes focus

167 The Health Board's current Performance Management framework (PMF) is out of date, being written in 2015 and pre-dating the current operational structures. The Health Board is preparing to rewrite it, following recent Executive Team agreement of an escalation scheme. Updating the PMF needs to be completed without delay, factoring in the role of the R&S Programme and how it relates to performance management arrangements. Current performance management is based on quarterly Unit reviews. Additional bi-weekly Executive Team and R&S meetings support targeted intervention, although as noted above, may not be sustainable long term.

168 Key areas covered during the quarterly performance review meetings include the Annual Operating Plan actions, which have been added to the Delivery Unit Performance Scorecards. The Deloittes review of Financial Governance observed good practice during the quarterly unit performance review

meetings, but noted that challenge across the performance information was limited and there was a lack of focus on actions. Our review of the performance dashboard found that information on key areas was included although the focus on targets, trajectories, and outcomes was limited.

The introduction of a new Performance and Finance Committee is strengthening scrutiny but aspects of reporting could be improved

169 Establishment of the Performance & Finance Committee in June 2017 has strengthened scrutiny arrangements. The Committee has to date focussed on finance and targeted intervention areas and does not currently receive a full scorecard of all performance indicators. It has recently introduced a programme of 'deep dive' reviews to provide focussed scrutiny in key areas and also receives summary reports of the quarterly Delivery Unit performance reviews. These reports provide assurance that performance reviews are taking place as planned and give an overview of the issues and actions. They do not however give the Committee strong assurance on actual performance across all areas or the trajectory for achieving targets and outcomes. Going forward, the Health Board will need to determine whether the present span of the Committees performance scrutiny should be broader, balanced against the clear need to maintain focus on targeted intervention areas and the Boards oversight and scrutiny of performance.

170 The Board receives a report on the measures outlined in the National Delivery Framework grouped by corporate objective at each of its meetings. The performance report, based on scorecard reporting, includes a high-level overview of performance, a summary of individual target performance, and detailed sections with individual report cards on targeted intervention priorities and other measures. Overall, there is sufficient information to support scrutiny but aspects of the report could be improved, for example, easier assimilation of performance against target, more clarity on the trend period considered, and better linkage between reported actions, outcomes and timescales for improvement. There is little performance reporting on commissioned, primary care or partner provided services, which also needs to be addressed.

Management information and integrated reporting could better meet Health Board needs

171 The Health Board is aware that it could do more to use its available data and management information to better support decision-making and Board assurance. Currently, reports on finance, performance and workforce are presented separately to Board, making it difficult for members to triangulate between issues or drill down beyond the aggregated level of information provided.

172 A task and finish group is to consider a more integrated approach to performance management, management information and future service planning and prioritisation. The focus is on providing integration and insight through its reporting, with work planned to develop a balanced scorecard for use throughout the Health Board. Proposed quadrants for the scorecard include: People; Operations; Finance and Governance; and Customers and Stakeholders (including quality). The opportunity to develop links to the data held in the Datix system are also recognised, although as noted in paragraph 160 there are some systems issues which make this difficult at present. In addition, while the Health Board is developing primary care quality and outcomes data, it is early days and there is currently limited community information.

173 In progressing the work to develop more integrated information, the Health Board will also need to clarify executive accountabilities for performance information and management, where business intelligence sits and how it relates to informatics.

Information governance – Information governance arrangements support compliance with current legislation but meeting the new General Data Protection regulations will be challenging within current resources

174 All Health Bodies need to ensure that they maintain the security, confidentiality and accessibility of patient records and other sensitive information. This requirement is enforced through the Freedom of Information Act (2000), NHS Caldicott requirements, and present Data Protection Act 1998 legislation that is soon to be replaced by the new General Data Protection regulation[11].

175 The introduction of the General Data Protection Regulation (GDPR) comes into force on 25 May 2018 and introduces some significant changes to data protection requirements and principles. GDPR introduces changes to the rights and freedoms of the data subject and these include the following:

- Mandatory reporting to the Information Commissioner's Office within 72 hours of all data breaches where there is a risk to the rights of the data subject;
- Reduction in the timescales allowed for responding to subject access requests to 30 days;
- Changes in right to access, right to be forgotten and erasure; and improving clarity of consent;
- Scope of the Act now extends beyond the boundary of Europe, for data processing of European data subjects, which might affect health bodies that participate in global research studies; and
- Penalties for breach of policy can extend to an upper limit of 4 per cent of turnover, or €20 Million (whichever is the greater);

176 The findings underpinning our conclusion are based on our review of information governance arrangements and the steps the Health Board has taken to be compliant with GDPR requirements. Our key findings are set out below.

177 The Health Board's current information governance arrangements were introduced in 2016. The Information Governance Board (IGB) supports and drives the Health Board's information governance agenda. The IGB is responsible for information governance for all of the Health Board's information not just that held by the informatics department, and provides assurance on the effectiveness of information governance arrangements to the Audit Committee.

178 The Health Board has undertaken work to address issues identified by the Information Commissioners Office (ICO) audit in September 2016, including data quality, data back-up and information security, and developing an Information Asset Register (IAR). Since the audit, the Health Board has set up an IAR, necessary to be able to comply with GDPR, although it is not yet complete in its coverage. However, the Health Board has assigned asset owners for all significant clinical systems and information assets, and is obtaining the necessary information to complete the IAR. Other issues identified by the audit include the absence of a register of Information Sharing Protocols (ISP's) and no update log in place. In November 2017, the ICO reported that the Health Board was making good progress towards addressing its 2016 audit recommendations. There has been a strong drive to

[11] Website for the EU Data Protection Regulation http://www.eugdpr.org/eugdpr.org.html

increase information governance training and information governance is now included as part of induction for staff and independent members alike. However, as at December 2017, training compliance was at 52 per cent.

179 The Health Board is making progress towards meeting the requirements of the General Data Protection Regulation (GDPR), although a significant amount of work to meet the requirements in full remains. Completing the required work to achieve, and subsequently maintain, GDPR compliance will be very challenging with the resources currently allocated to information governance. Additional resources are being sought although there is a real risk that full compliance will not be achieved by May 2018. This risk is significant given the potential penalties for a GDPR breach.

180 The IGB has reported throughout the year on: progress against various aspects of information governance necessary to comply with GDPR; and identified challenges for meeting the requirements, particularly in relation to information governance resources and training compliance. In January 2018 the IGB reported to Audit Committee on a recent assessment of Health Board preparedness for GDPR which concluded that the Health Board would not achieve GDPR compliance by May 2018. Committee members expressed some concern that the likelihood of legislative non-compliance had not been explicitly raised sooner.

Other enablers of the efficient, effective and economical use of resources – The Health Board has maintained positive stakeholder engagement but faces a number of challenges in respect of workforce, asset management and ICT and programme management capacity

181 Our structured assessment work in 2017 has examined the Health Board's arrangements for managing programmes of change, the workforce and assets (including ICT), in addition to stakeholder and partnership working. We have also assessed progress against related recommendations made in 2016. Our findings are set out below.

Strategic change management – A Programme Management Office has been set up and significant organisational development work is progressing, but programme management capacity is limited and strategic change programmes need review

182 The findings underpinning this conclusion are based on our review of strategic change management arrangements. Our key findings are set out below.

183 The Health Board has set up a Programme Management Office (PMO), but as discussed earlier in this report, its primary focus has been to support the Recovery and Sustainability Programme. The PMO in its current form is not integrated to support wider service change and has limited capacity. Its future role for supporting wider strategic change programmes (C4B) is not clear. There are also a number of major regional change proposals which affect the Health Board currently being consulted on, which are likely to require additional programme management capacity if they are to progress.

184 Commissioning Boards, now stood down, were previously responsible for the Health Board's strategic change programmes (C4B), but the portfolio and reporting lines of these programmes have not yet been re-mapped. Clarity is needed regarding where C4B change programmes sit within the new Delivery Board arrangements and in the context of a new clinical strategy.

185 The Health Board recognises that workforce and organisational development (OD) is key to recovery, sustainability and sustainable service improvement. A number of programmes are running to support leadership, OD, service improvement and organisational values and behaviours, with a small improvement hub rolling out training to develop improvement capability and capacity. Currently these elements are managed separately although work is in progress to bring them together and refine the scope of the OD programme. The Health Board is forward looking with lots of ideas, but greater prioritisation and coordination is required to focus effort and resource to best effect.

186 In 2016, we made the following recommendation relating to change management capacity. Exhibit 12 describes the progress made.

Exhibit 12: progress on 2016 change management recommendation

2016 recommendation	Description of progress
2016 R4c Strengthen change management capacity to ensure any requirements flowing from targeted intervention are addressed.	**Action completed:** • PMO established to support the Recovery and Sustainability programme **But:** • Capacity is constrained and is unlikely to meet the demand of strategic change programmes no longer supported through Commissioning Boards

Workforce management – The Health Board continues to face a number of workforce challenges and needs to strengthen its workforce planning and scrutiny arrangements

187 The findings underpinning this conclusion are based on our review of arrangements to manage the workforce. Our key findings are set out below.

188 The Health Board recognises that workforce planning is a weakness, hampered by the lack of a current clinical strategy. With a new clinical strategy due to be in place in 2018, the Health Board will have a clearer direction and platform for developing the workforce plans to support its future service models.

189 Significant workforce management challenges have continued in 2017, creating increasing cost pressure and service risks. The most significant challenge is recruitment. The Health Board reported that as at 30 November 2017, there were 835.57 whole time equivalent (WTE) vacancies, of which 373.44 WTE relate to registered nursing and midwifery and 183.38 WTE to medical and dental. There is continuing fragility of some medical rotas and nursing recruitment has become increasingly difficult due to national shortages.

190 The Health Board is undertaking a number of initiatives to recruit staff including targeted overseas recruitment; promoting the Health Board as an employer, use of social media and working to shorten

the time taken to recruit. The Health Board has also over-recruited Health Care Support Workers (HCSWs) to help close the nurse establishment gap in some areas. This is most notable in the Morriston Delivery Unit where the HCSW over-establishment is 19.88 per cent.

191 The Health Board has had to use agency staff to fill gaps although it has worked hard to reduce reliance on temporary staffing and contain the associated variable pay costs. The Health Board variable pay spend for the first eight months of 2017-18 was £27.0 million, a £3.9 million reduction on spend for the same period of the previous financial year. This included a £2.3 million reduction on non-medical agency and a £0.4 million reduction on medical agency. Welsh Government have introduced an agency rate cap and changes to IR35 taxation requirements, and increased internal controls may also help to contain costs in the short term. However, the Health Board will need to account for the Nurse Staffing Levels Act (Wales) 2016[12] requirements, which come into force in April 2018, through its management of nurse vacancies and future workforce planning.

192 The rate of staff turnover has been increasing and as at 30 November 2017, it was 10 per cent for nursing, nine per cent for allied health professionals and eight per cent for medical and dental staff. The Health Board is collating leaver numbers on a monthly basis to identify hotspots, and exit interviews were introduced in January 2017. These actions aim to identify the reasons why staff are leaving the Health Board, particularly within the first 12 months of employment. Delivery Unit management teams have been tasked with developing plans to address any issues.

193 The Health Board has implemented a number of initiatives to help understand, manage and reduce absence levels, including a focus on well-being and audits to identify hotspot areas. The rolling 12-month sickness rate for the period November 2016 to October 2017 was 5.6 per cent and the in-month October position was not significantly improved on the 2015-16 rate.

194 The Recovery and Sustainability Programme includes work streams in a number of key workforce management areas, which affect the Health Boards performance and financial position. These include:

- Sickness absence reduction;
- Improving staff rostering;
- Reduced recruitment time;
- Incentivised bank nurse take up; and
- Vacancy controls and grade drift.

195 In addition, the Health Board is working to address and improve a number of other workforce management issues. These are summarised below.

- **Non-medical staff appraisal** – the Health Board has a Personal Appraisal Development Review (PADR) Policy and continues to promote appraisal completion. However, at 62 per cent in November 2017, completion rates fell short of the Health Board's 85 per cent target. A recent limited assurance Internal Audit report identified that the quality of appraisals undertaken needed to be improved. The Learning & Development Team is providing PADR training for appraisal reviewers to address this. Rollout of Employee Self-Service and Supervisor Self-Service to enable staff to record PADR data in the Electronic Staff Record (ESR) is not complete. Learning Administrators are able to update staff PADR records in areas without the

[12] The Nurse Staffing Levels Act (Wales) places a duty on health boards and NHS Trusts to calculate and maintain nurse staffing levels in adult acute medical and surgical inpatient wards.

Self-Service function, but some have not received training. This may affect the accuracy of recorded PADR information in ESR.

- **Medical appraisal and revalidation** - Appraisal rates have improved from 30 per cent to 90 per cent over the last 5 years but work is needed to improve the quality of appraisals. Appraisal leads are being appointed in each Delivery Unit to focus on the quality assurance of appraisals in line with Wales Deanery standards.
- **Statutory and mandated training** - compliance remains low, with 56 per cent for fire safety training being the highest compliance across all 13 training modules at 30 November 2017. Moving and Handling (Level 1) was 32.58% and Resuscitation (Level 1) was just 26.43%. An Internal Audit in 2017 provided limited assurance identifying issues for the access of e-learning and mandated recording of training in the Electronic Staff Record (ESR). A Mandatory Training Governance Committee was established to monitor the Mandatory Training Framework on a quarterly basis in October 2016 but at the time of Internal Audits work, it had not met.
- **Medical engagement** – an all Wales medical engagement survey of Consultants and Specialist Associate Specialist Doctors (SAS) was completed in July 2016. The Health Board's response rate was almost 50 per cent. Overall, the results were average to low for the Health Board, with the Morriston Delivery Unit scoring lower than others. Delivery Unit Medical Directors have been acting on the results, with for example, a Clinical Leadership Cabinet being set up in the Morriston Delivery Unit. The Health Board has identified the need for further work under the following themes: purpose and direction; feeling valued and empowered; interpersonal relationships; and development orientation. The Executive Medical Director has established a Recovery and Sustainability project to take forward actions arising from the 2016 medical engagement survey, which is due to be repeated across NHS Wales in 2019.

196 The workforce and organisational development (WF&OD) Committee is responsible for providing a scrutiny and assurance function. As noted earlier however, the Committee's focus has been too operational with insufficient focus on strategic risks. Workforce metrics are presented to the Committee but they are limited and some data could be timelier. Completion dates and responsibilities for actions are not consistently provided and reports need to highlight risks more effectively. There have also been gaps in the Committee's meetings during the year with three of the six planned meetings cancelled. Consequently, the flow of assurance and reporting of key issues from Committee to Board was also disrupted. The Board routinely receives finance and performance reports, but in addition to gaps in reporting from the WFOD Committee, it did not received a workforce performance report at a number of its meetings. The Health Board will need to address the current gap in the scrutiny of workforce and OD issues.

Asset management – The Health Board has yet to define its asset management strategies and faces difficult resource prioritisation decisions with limited ICT capacity to support modernisation

197 The findings underpinning this conclusion are based on our review of arrangements in place to support estate and asset management, and informatics services. Our key findings are set out below.

The Health Board needs to define its asset management strategy to underpin its longer term strategic plans and help prioritise within very limited resources

198 The Health Board controls some £600 million of assets including land & buildings, plant & equipment, vehicles, ICT equipment and fleet. The Health Board does not have an overarching asset management strategy, which will be needed to underpin the organisation's clinical strategy and longer-term plans currently being developed. It is instead managing its assets on a day-to-day basis.

199 For land & buildings, the Health Board faces a significant level of buildings backlog maintenance. As at the end of 2016-17, the Health Board's assets required some £60 million of 'backlog maintenance' – of which some £17 million was high or significant risk. Further, the need for environmental upgrades in clinical areas is compounded by a lack of decant facilities. While there is no documented estates strategy, our review of papers presented to the Board and its committees, along with the interviews we undertook suggest that there is a good level of understanding of estates matters amongst Board members and executive leads. A bid for Welsh Government funding to complete a six-facet review of the estate was unsuccessful and the Health Board now needs to determine how it will prioritise and progress the estates issues it faces.

200 Similarly, for plant and equipment, some £75 million of assets are operating at beyond their economic life and a significant proportion of these require replacement. The Health Board has highlighted that without further investment, it is forecast that this will increase to just under £150 million by 2021-22. The quality of assets places additional strain and risks on the Health Board and this is against a backdrop of limited revenue and capital funding.

The Health Board has improved arrangements for managing the capital programme but it needs to move from an annualised approach and improve prioritisation at a time of limited funding

201 The Health Board has put in new arrangements to strengthen the approach for considering and prioritising capital bids and business cases; although a scheme of delegation for capital scheme approvals should be developed. A new Investment Benefits Group was set up in September 2017 to review potential investment bids (revenue and capital), with the Capital Management Group considering submitted business cases and bids for discretionary funding. The Health Board recognises that the quality of businesses cases for both capital and revenue funding are variable, and attendance at some meetings is low.

202 The Annual Operational Plan (AOP) for 2017/18 included a Five Year Framework for service change which incorporated capital plans. These are being updated and will continue to be used for the AOP going forward. However, capital plans for strategic change are a component of the wider Capital Programme which remains an annual programme with a longer term approach for capital planning needed. This should be linked to clinical and asset management strategies, including digital/ICT, estates, and equipment to help prioritise and target limited capital funds. A scheme of delegation for capital scheme approvals also needs to be developed.

ICT strategy is well developed but internal capacity and resource presents longer term challenges for supporting modernisation

203 The Health Board has an approved digital strategy and has submitted its Strategic Outline Plan in line with Welsh Government requirements. The Health Board has a history of successful business cases and good awareness of potential efficiencies through the use of technology, although the availability of capital funding will influence the pace of digital strategy implementation.

204 The Health Board has a good record on updating its systems and the ICT team engagement with users and overall user satisfaction with the ICT department remains good. However, ICT staffing and funding levels have historically been amongst the lowest in Wales and further funding reductions and savings plans have increased pressure in this area. This is now having an effect on the type and number of ICT projects the department undertakes with project proposals being scored to identify the highest priority projects. This has potential implications for the extent to which ICT can support wider Health Board modernisation plans.

Stakeholder engagement - The Health Board continues to positively engage with stakeholders, although the complexity of partnership working and service change puts significant demand on organisational capacity

205 The findings underpinning this conclusion are based on our review of stakeholder engagement arrangements. Our key findings are set out below.

206 The Health Board is operating in a complex environment. Regional changes and working with multiple partners present opportunities, but also places significant demand on the organisational capacity available to support partnership working and engagement, planning and programme management. The Health Board has a good track record for engagement on service change, and it will be seeking to engage stakeholders and partners in developing its updated clinical strategy and subsequent longer term plans. The Health Board is also currently engaging in consultations on a number of regional change proposals, including the transfer of services for the Bridgend population, the major trauma network and thoracic surgery proposals.

207 There is regular reporting to Board from the Partnership Forum and Stakeholder Reference Group and the Health Board has recently developed a staff engagement policy. The Health Board has engaged very positively with specific population and service user groups, with the results of this year's work including: establishing an ABM Youth Council and Children's and Young People's Charter; the launch an Older Peoples Charter; and development of a Strategic Framework for Adult Mental Health with Local Authority partners.

208 The Health Board has also developed a new Consultation and Engagement Framework in consultation with the Community Health Council (CHC), with whom the Health Board has a very good relationship. The framework is being applied to all service changes requiring consultation with the CHC or wider public. The submission of potential service changes to the CHC, including those arising from annual planning, is being centrally coordinated. However, there is a potential risk that timescales and volume of proposals could create a capacity risk for the CHC, and the Health Board.

209 In 2016 we made the following recommendations relating to stakeholder engagement. Exhibit 13 describes the progress made.

Exhibit 13: progress on 2016 stakeholder engagement recommendation

2016 recommendation	Description of progress
2016 R5 Update the engagement and communication framework in addition to completing development of a structured engagement plan for IMTP development	**Action Complete** • As described above

Appendix 1

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

The Health Board's management response will be inserted into Exhibit 14 once the response template has been completed. The appendix will form part of the final report to be published on the Wales Audit Office website once the report has been considered by the board or a relevant board committee.

Exhibit 14: management response

Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1						
R2						
R3						
R4						
R5						
R6						

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone : 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru