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The team who delivered the work comprised Anne Beegan, Andrew Strong, Mark Jones and Urvisha Perez.

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Summary report

Introduction and background

1 Our structured assessment work helps inform the Auditor General's views on Cardiff and Vale University Health Board's (the Health Board's) arrangements to secure efficient, effective and economic use of its resources. Our 2016 work found that despite the Health Board having some effective arrangements in place, governance has deteriorated over the last year resulting in weaknesses in some aspects of scrutiny, an unapproved three-year plan, limited progress in responding to previous recommendations and a financial position that is unsustainable and unlikely to be balanced at the end of 2016-17.

2 As in previous years, our 2017 structured assessment work 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 also used this year's structured assessment to gather evidence to support a pan-Wales commentary. It will set out how relevant public sector bodies are working towards meeting the requirements of the Wellbeing of Future Generations Act (Wales) 2015. That commentary will be reported separately early in 2018.

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

5 In September 2016, the Welsh Government, under its Joint Intervention and Escalation Arrangements, moved the Health Board's status from 'enhanced monitoring' to 'targeted intervention'. At that time, the Welsh Government communication highlighted the need for improvement on specific issues, mainly related to the three-year integrated medium term plan (IMTP).

6 In November 2016, the former Chief Executive Officer left the Health Board. The Director of Public Health and Deputy Chief Executive took up the post as interim Chief Executive, until a substantive appointment was made in July 2017.

7 In March 2017, the Welsh Government commissioned Deloitte to undertake an external review of the Health Board's financial governance arrangements. The findings of this review are broadly consistent with and complement our previous structured assessment work. The Health Board has responded positively, and progress against the recommendations is being monitored closely through the Audit Committee, with a number of recommendations now implemented.

8 Following its July 2017 meeting to discuss the escalation status of NHS bodies, the Welsh Government confirmed its intention for the Health Board's escalation status to remain unchanged. Subsequent communication identified the need for the Health Board to focus on the following concerns:

- that despite having a strategic plan, the Health Board does not yet have an approved three-year integrated medium term plan (IMTP);
- there were still concerns regarding financial and governance issues; and
- there was a need for ongoing improvement in and delivery of its financial position.

9 In July 2017, the Auditor General also issued his first public interest report for an NHS body. This report[1] focused on weaknesses in governance arrangements at the Health Board relating to the procurement and subsequent appointment of its previous Director of Workforce and Organisational Development in 2015 and 2016 respectively. Following the publication of the report, the Health Board responded positively and identified clear actions for improvement. The Audit Committee and Board are overseeing implementation of the actions, with good progress being made.

Key findings

10 Our overall conclusion from 2017 structured assessment work is that **savings approaches are helping to curtail the growing financial deficit, but while operational arrangements are largely robust, there are weaknesses in governance arrangements and informatics are not yet effectively supporting services**. We summarise the reasons for this conclusion below.

Financial planning and management

11 In reviewing the Health Board's financial planning and management arrangements we found that **the Health Board now has effective arrangements in place to support the planning and monitoring of savings, but is facing an increased deficit position for the three-year period ending March 2018.**

Financial performance

12 **Savings for 2017-18 are well managed, but historical under achievement of savings targets and recent overspends against resource limits means that the Health Board is forecast to have a cumulative increasing deficit position of £61 million by March 2018.**

13 Historically the Health Board has set ambitious annual savings targets. Although it has achieved significant amounts of savings, the Health Board has not achieved its annual targets and target levels have gradually reduced over time. Since 2015 the savings target has become more realistic and in 2016-17 in particular, although it

[1] Audit of Cardiff and Vale University Health Board's Contractual Relationships with RKC Associates Ltd and its Owner

had not identified all of the required savings schemes at the start of the year, the Health Board almost achieved its £26 million savings

14 For the three-year period 2014-17, the Health Board however failed its duty to spend within its financial allocation, overspending its allocation by £50.5 million. The Welsh Government did not approve the Health Board's three year integrated medium term plan (IMTP) and for 2017-18, the Health Board has been working to an annual operating plan.

15 In 2016-17, a delegated savings target of 3% was applied to each of the Health Board's nine clinical and service boards, but only two met the target. In recent years, the proportion of recurring savings had been high but in 2016-17, the proportion fell to 50% of all savings. Non-pay and medicines management accounted for over half of the target savings.

16 In 2017-18, the Health Board has a savings target of £35 million, and a planned annual deficit of £30.9 million. This planned deficit is a slightly worsened position on the reported annual deficit for 2016-17. At month six, the Health Board was on target to deliver its savings target and the in-year planned deficit position. A more recent update at month nine would indicate that the Health Board continues to remain on target. Due to historical spend, the three-year rolling deficit for 2015-18 however is forecast at £61 million, which is £10 million worse than the cumulative deficit to the 31 March 2017. Despite improved in-year delivery against savings targets and the overall financial position, the level of savings being identified and subsequently achieved however is not yet sufficient to reduce a growing cumulative deficit.

Financial savings planning and delivery

17 **The planning of savings is aligned to the Health Board's three-year planning cycle and delivery is supported by corporate services, however, there is scope to revisit the allocation of targets to take advantage of areas with greater savings opportunities.**

18 The Health Board has a top-down approach to savings planning, meaning the corporate finance team sets a Health Board wide target, which is applied equally across the clinical and service boards. Service areas are responsible for identifying individual savings schemes, and planning and delivering these through their cost improvement plans.

19 The Health Board introduced its 'turning the curve' programme in the latter part of 2016-17. This has provided a platform to address the Health Board's financial issues. Although this programme is under review, the Health Board continued to strengthen its financial governance arrangements by introducing a new Finance Committee and developing a Cost Improvement Programme (CIP) tracker. The tracker is a planning and monitoring tool and used to monitor progress.

20 Savings planning is aligned with the Health Board's IMTP planning cycle; with a requirement for clinical and service boards to develop their savings plan over a

three-year period. There is a flat rate approach to savings and CIP performance suggests that savings targets are achievable. However, the flat line approach means that opportunity to identify areas with a greater potential to save more are missed, and there is now scope for the Health Board to identify higher targets to areas where there is greater potential to save more.

21 Finance and workforce functions are integrated within clinical and service boards, and play a key role in developing the IMTP and savings plans. Other support functions such as informatics also support the clinical and service boards. The Health Board has five crosscutting themes, which are supported by the Programme Management Office. The Health Board has also recently set up a Transformation Board, which recognises that service transformation is required to make longer-term savings.

Financial savings monitoring

22 **There are strong scrutiny and monitoring arrangements of financial savings at Board, committee and operational levels, and good mechanisms for learning lessons.**

23 The Health Board has a Finance Committee, which meets monthly. This committee receives a detailed report on the Health Board's latest financial position, including delivery against savings targets by clinical and service board. This report is also presented to the Board, which meets bimonthly.

24 Delivery of savings at a clinical and service board level is monitored on a weekly basis, and issues discussed at monthly executive level performance reviews. These reviews are chaired by the Chief Executive and include all executive directors. Escalation arrangements are in place if CIP delivery for a clinical or service board is off-track. Directorates also monitor their savings plans and report up to clinical and service board meetings. Crosscutting themes are monitored through the crosscutting steering group.

25 The Health Board has a number of mechanisms for sharing ideas and learning lessons at various operational levels. The Health Board is also represented well at national level forums.

Governance and assurance

26 In reviewing the Health Board's corporate governance and board assurance arrangements, we found that **operational arrangements are generally effective but there are weaknesses in Board oversight and assurance, and it is unlikely that the new data protection regulations will be met in time.**

Strategic planning

27 **Strategic planning is generally effective and increasingly joined up across the organisation, however scrutiny of delivery remains a gap at Board and committee level, despite close monitoring at an operational level.**

28 The Health Board failed its duty to have an approved three-year integrated medium term plan, and, for the second year running, has been working to an annual operating plan. Initial drafts of the 2017-18 plan included an increased planned deficit position. The Board finally agreed the 2017-18 plan in May 2017 with the revised planned deficit position of £30.9 million.

29 The Board receives regular updates on IMTP planning and development, but there are gaps in scrutiny at Board and committee level in relation to delivery of the plan. The committee responsible for scrutinising delivery was stood down in May 2017, and the new Strategy and Engagement Committee is still in its infancy. There are, however, increasingly better links between the plan and the Health Board's financial position, and there is robust monitoring of the delivery of the plan at an operational level through the executive level performance reviews.

Organisational structure

30 **The Health Board's organisational structure continues to mature with steps being taken to improve joint working across the organisation, though concerns about corporate governance capacity remain.**

31 During the year, the Health Board did not make any fundamental changes to its organisational structure although it now has a full executive team in place. The new Chief Executive joined in July 2017 with a new Director of Workforce and Organisational Development following in October. At the time of our fieldwork, the Health Board was about to appoint a substantive Chief Operating Officer.

32 As the clinical board structure can however promote silo working, the executive team acted to promote increasing cross-organisational working, particularly through the executive level performance reviews. Corporate service teams work across the clinical boards, with finance and workforce resources embedded within each of the clinical boards. However, other support functions are not as embedded although integrated working is improving.

33 The corporate governance team plays an active role in providing challenge and support to the executive team and the wider organisational structure. Even though a new Head of Corporate Governance was appointed in April 2017, our previously reported concerns around team capacity remain.

Board effectiveness, Board assurance and governance structures

34 **The Board and some of its committees are not providing sufficiently rigorous and consistent oversight, partly due to turnover in membership, and until the**

two new committees are fully established, there are risks to assurance on performance and planning.

35 The Health Board experienced a significant turnover of independent members (IMs) during 2017. Seven new IMs have been appointed, although a further two IMs were due to leave at the end of December 2017. This level of turnover has posed risks to Board continuity, although outgoing IMs have provided legacy statements and extended support to ensure a smooth transition. Of the seven new IMs, only one has had previous NHS Board experience, placing increasing pressure on the Health Board to get the new IMs up to speed through its Board development programme.

36 Our observations of Board and some of its committees indicate that the level of scrutiny and challenge varies, as does committee administration. The Finance Committee and the Quality, Safety and Experience Committee are two of the better run committees. The previous People, Planning and Performance (PPP) Committee was disbanded in May 2017, and two new committees were established. However, these committees (Strategy and Engagement Committee, and Resources and Delivery Committee) have only held two meetings and are still in their infancy. The time lag between standing down the PPP committee, setting up the new committees and now waiting for them to establish themselves means the Board risks gaps in assurance.

37 Papers and minutes for committees are generally well written, though the long length of papers is a concern as this could hinder good scrutiny. The Chief Executive and Chair have recognised that discipline around papers in relation to quality and size needs to improve, and are taking action to make them more focussed.

Risk management

38 **The Health Board recognises that risk management needs to improve and is reviewing operational and corporate risk management processes, however due to capacity issues within the corporate governance team this will be a slow process.**

39 The Health Board's combined Corporate Risk and Assurance Framework (CRAF) is currently under review. The CRAF has been in place for four years, however the Health Board recognises that risk management needs to improve to give better assurance to the Board.

40 The CRAF is a live document and is clearly laid out, but risks are not yet aligned to the corporate objectives, the risks lack clarity, are not reducing as a result of mitigating action and a number were assigned to the previous PPP committee for some months after it was disbanded.

41 A risk management workshop was held in May 2017 and improvement actions have already started including improved reporting of risks. The Health Board aims to launch a new version of the CRAF in 2018, alongside a wider review of the risk

management policy. This is a substantive piece of work but capacity to undertake it is limited.

Information governance

42 **The Health Board's information governance arrangements are not yet developed enough to effectively implement the new General Data Protection Requirements (GDPR) by May 2018.**

43 The Health Board has made progress in addressing recommendations from the Information Commissioner's Office 'limited assurance' review but the majority of actions remain ongoing, despite the need for these to be addressed ahead of the GDPR coming into force in 2018.

44 The Health Board has recognised the legislative changes and what other actions are required in readiness of the GDPR but progress in addressing these actions has been slow. Compliance with information governance training is well below the target of 85% and response times to information requests are slow. The Health Board's information governance strategy also needs to be aligned to the national digital strategy. The Health Board has a small information governance team and its ability to meet the GDPR effectively will be challenging within the timescales.

Performance management

45 **Operational performance management is robust and comprehensive, but Board and committee oversight is as yet ineffective.**

46 The Health Board has strong performance management arrangements. The executive team holds all clinical and services boards to account through regular performance review meetings, which are focused, and well organised. As well as holding to account, the review meetings offer support and encouragement, and provide opportunities to discuss national issues and cross-board working. Comprehensive performance dashboards support the performance review meetings.

47 At Board level, the new Resources and Delivery Committee is responsible for providing assurance on performance and workforce. However, the information reported to the committee is less detailed than that reported to Board, which focuses on priority targets or performance areas that have deteriorated. More information should be made available to the committee to support its scrutiny function and improve its effectiveness in providing assurance to the Board.

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

48 In reviewing the Health Board's arrangements to support the efficient, effective and economical use of resources, we found that **workforce and estates are**

increasingly supporting the goals of the Health Board, though informatics is struggling to keep pace

Workforce management

49 **Approaches for recruitment, retention and supporting workforce management are generally effective, and while some aspects of training and development present challenges, the Health Board is taking steps to tackle them.**

50 The Health Board has a workforce and organisational development framework to support its annual operating plan. Progress against the framework is reported to the newly formed Resources and Delivery Committee, although scrutiny is not yet effective. Workforce is scrutinised however at an operational level through the performance review meetings.

51 During the year, the Health Board had a number of recruitment successes, although some professional groups and specialties remain hard to recruit. Despite this, agency spend is low. The Health Board implemented a number of successful initiatives to support workforce productivity and these are now having a positive impact. Sickness absence rates are also reducing.

52 However, turnover of staff is higher than the average for Wales, and the length of time to recruit is also above the average. Compliance with mandatory training and performance appraisals also needs to improve, with both medical and non-medical appraisal rates falling short of the 85% target. Work is underway to improve access to training and, since the appointment of the new Director of Workforce and Organisational Development, there has been an increased focus on training and appraisals at performance management reviews. These actions should help to improve performance over the next six months.

Estates management

53 **The Health Board is developing strategic plans to make its estate fit for the future whilst also responding to existing problems of deterioration of parts of the current estate.**

54 The Health Board has continued to focus its attention on estates. A recent internal audit review of how it is managing compliance with statutory requirements provided ‘reasonable assurance’.

55 The risks associated with backlog maintenance are slowly reducing, although the level of significant risks that the Health Board is carrying remains high, with the majority of this risk associated with the main University Hospital of Wales (UHW) site in Cardiff. The Health Board has taken steps to develop a series of estates management plans which articulate how the Health Board intends utilising its estate over the next ten years.

Information management and technology

56 **The Health Board faces a number of challenges in its arrangements for the use of information technology, deployment of national IT systems and securing appropriate resources to deliver the informatics strategic outline programme.**

57 The Health Board has developed its informatics strategic outline programme (SOP) for 2016-2021 although Welsh Government capital and revenue funding was not sufficient to cover the SOP intentions. Consequently, an annual plan was developed which set out the informatics priorities for the year.

58 The Health Board continues to have an aging IT systems infrastructure and the need to replace legacy IT systems. The Health Board has been making prioritised investments under its 'keeping the lights on' capital programme, albeit that capital funding is constrained. IT systems are being maintained whilst waiting for the deployment of the national IT programme, although some systems are likely to be passed their 'end-of-life' date by the time the national IT systems are rolled out.

59 The low level of investment on IT infrastructure and informatics resources increases the risk of potential threats arising from cyber-attacks. As yet, the Health Board does not have a dedicated IT security officer.

60 The Health Board can further strengthen the IT Key Performance Indicators (KPIs) measured and reported. The Health Board measures IT KPIs but these focus mostly on the performance of the IT service desk and call resolution.

Recommendations

61 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 complete.

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

Exhibit 1: 2017 recommendations

2017 recommendations
Financial savings R1 For 2018-19, the Health Board needs to use intelligence such as benchmarking data to identify stretch targets on a case-by-case basis in areas where greater levels of savings could be made.

2017 recommendations
Strategic planning R2 To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the annual operating plan, and subsequent three year integrated medium term plans.
Committee effectiveness R3 To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable. R4 To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner.
Risk management R5 The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by: • mapping risks to the Health Board's strategic objectives; • reviewing the required assurances; • improving clarity of risk descriptors; and • clarifying to the reader the date when risks are updated and/or added.
Information Governance R6 The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include: • updating the information governance strategy; • putting in place arrangements for monitoring compliance of the primary care information governance toolkit; • developing and completing an Information Asset Register; • ensuring that an identified data protection officer is in place; and • improving the uptake of information governance training.
Performance management R7 The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: • ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; • expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.

2017 recommendations	
Information management and technology	
R8	The Health Board needs to revisit its Informatics Strategic Outline Plan in light of the financial resources available and seek Board approval of the revised strategic approach.
R9	To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.
R10	To improve scrutiny of the Health Board’s informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.

Detailed report

Savings approaches are helping to curtail the growing financial deficit, but while operational arrangements are largely robust, there are weaknesses in governance arrangements and informatics are not yet effectively supporting services

63 The findings underpinning this conclusion are detailed below.

The Health Board now has effective arrangements in place to support the planning and monitoring of savings, but is facing an increased deficit position for the three-year period ending March 2018

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

Savings for 2017-18 are well managed, but historical under achievement of savings targets and recent overspends against resource limits means that the Health Board is forecast to have a cumulative increasing deficit position of £61 million by March 2018

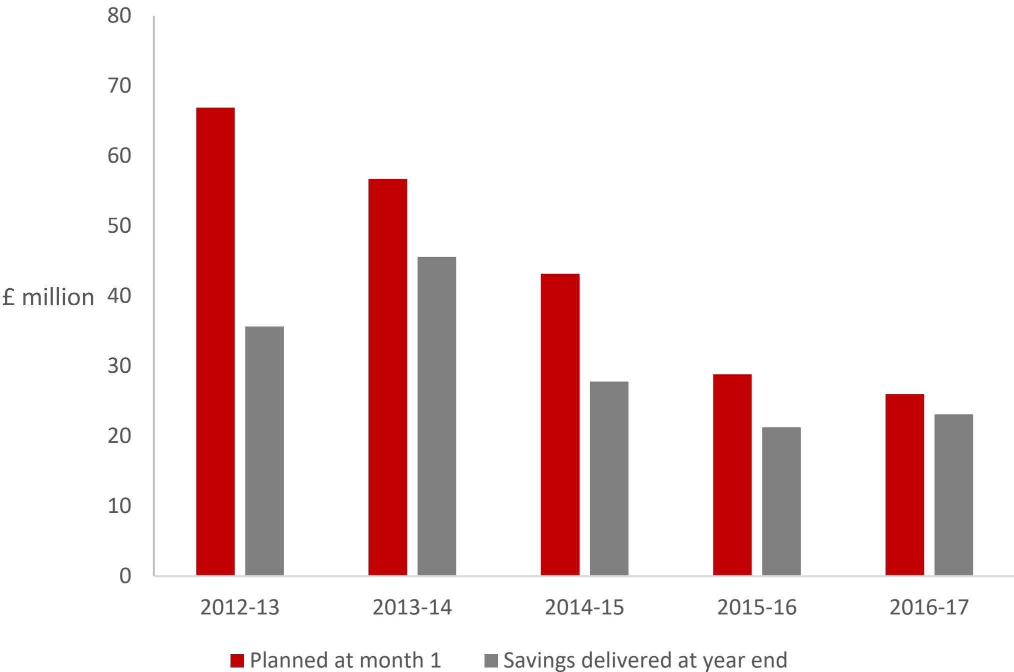
65 Each year, the Health Board is allocated revenue by Welsh Government to provide the resources for the Health Board to pay for locally provided and contracted healthcare services for its resident population. This allocation is known as the Revenue Resource Limit (RRL). Each year there are increases in the RRL allocated at the beginning of the year by Welsh Government. These increases in revenue help to address inflationary costs of healthcare, which include growth in pay costs, medication costs, and increasing demand for services. In addition, the Health Board receives additional income through the commissioning arrangements for the provision of tertiary services for the wider South Wales population.

66 As part of the requirements of the NHS Finance Act (Wales) 2014 (the Act), the Health Board must spend within its financial allocations over a rolling three-year financial period. The period ending 2016-17 was the first year health boards were assessed against this obligation. The Health Board failed to meet this duty because it spent £50.5 million over the £2.5 billion that it was authorised to spend over the three-year period ending 2016-17. In 2017-18, the Health Board has had to manage new cost pressures as well as trying to reduce the £50.5 million accumulated deficit. Because of the Health Boards financial position, Welsh Government did not approve the Health Board's three-year integrated

medium term plan (IMTP). For 2017-18, the Health Board has been working to an annual operating plan, endorsed by the Board but unapproved by Welsh Government.

67 Over the last five years, the Health Board has set ambitious annual savings targets, but over the years, the target has gradually reduced. Exhibit 2 shows the levels of savings planned at the start of each financial year (month 1) and the actual savings achieved at year-end. It is clear that between 2012-13 and 2015-16 the Health Board was planning for savings at the start of the year that were unachievable. However, in 2016-17, the Health Board set an annual savings target of £26 million but at the start of the year had only identified half of the required amount (£13.2 million). The full £26 million had been identified by month 12 but at year-end the Health Board narrowly missed its target by £2.9 million.

Exhibit 2: savings planned at month 1 and delivered at month 12 between 2012-13 and 2016-17



Source: Savings reported by the Health Board in its monitoring returns to Welsh Government

68 At the start of each year, the corporate finance team delegates a savings target to each of the clinical and service boards[2] and the executive team. In 2016-17, the target was 3% of their annual budget, the overall Health Board savings target being £26 million. As stated above, the Health Board missed its overall savings target by 11%, which can be attributed to a number of delegated targets being missed.

[2] The Health Board has nine clinical and service board areas. It has eight clinical boards – Primary Community and Intermediate Care (PCIC), Mental Health, Clinical Diagnostics and Therapies (CDT), Dental, Surgery, Specialist Surgery, Children and Women and Medicine. It has one service board area – Capital Estates and Facilities.

Exhibit 3 shows that out of the ten-delegated targets only two were met. The Primary, Community and Intermediate Care (PCIC) clinical board and Specialist Services clinical board both over delivered against their respective targets. The rest of the clinical and service board areas under delivered by between 4% (Clinical Diagnostics and Therapies (CDT) clinical board) and 62% (Medicine clinical board). However, in the last two years, the Health Board has been working towards strengthening budgetary grip and control, and accountability. It has also recently improved financial performance escalation procedures.

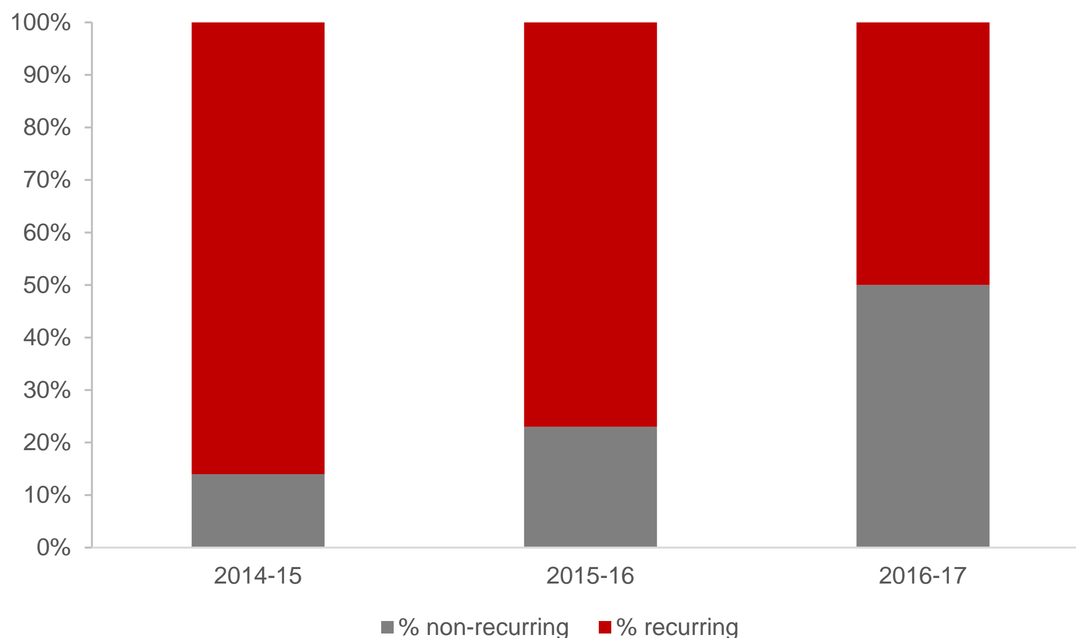
Exhibit 3: clinical and Service Board performance against savings targets in 2016-17

Clinical/Service Board	In-year target for 2016-17 (3%) £m	Savings delivered at month 12 £m	Difference between target and delivered £m	% delivered
Primary Community and Intermediate Care	5.031	6.036	1.005	120
Mental Health	2.277	2.012	-265	88
Clinical Diagnostics and Therapies	2.917	2.814	-103	96
Dental	727	672	-55	92
Surgery	3.984	2.269	-1.715	57
Capital Estates and Facilities	1.594	910	-684	57
Children and Women	3.351	1.605	-1.746	48
Medicine	3.519	1.336	-2.183	38
Specialist Services	3.826	4.176	350	109
Corporate Executive Team	1.517	1.254	-263	83
Central allocations	-2.743		2.743	
Totals	**26.000**	**23.084**	**2.916**	**89**

Source: Wales Audit Office analysis of Cardiff and Vale University Health Board data

69 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. Over the last three years the levels of recurring savings achieved at the Health Board has fallen. Exhibit 4 shows that in 2014-15 and 2015-16 the majority of savings were recurrent (86% and 77% respectively) but in 2016-17 the proportion had fallen to just 50%. This suggests the Health Board is finding it increasingly difficult to find recurring savings. A high proportion of non-recurrent savings is unsustainable, as services are required to identify savings opportunities each year.

Exhibit 4: proportion of recurrent and non-recurrent savings achieved between 2014-15 and 2016-17

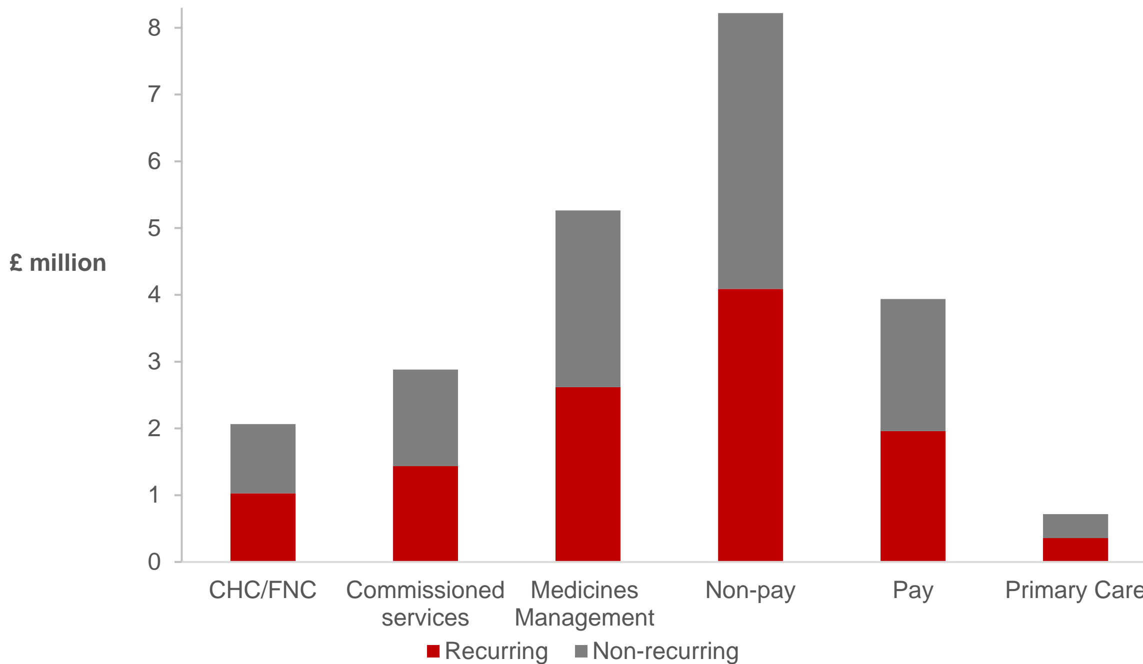


Source: Savings reported by the Health Board in its monitoring returns to Welsh Government

70 When broken down by category[3], Exhibit 5 shows that in 2016-17 the majority of savings were attributed to non-pay (£8.2 million in total) and medicines management (£5.3 million in total) schemes. These schemes accounted for over half of the total savings. Across all categories, there was an equal split between recurrent and non-recurrent savings.

[3] Categories as used in monthly finance returns to Welsh Government.

Exhibit 5: recurring and non-recurring savings achieved in 2016-17



Source: Savings reported by the Health Board in its monitoring returns to Welsh Government

71 For 2017-18, the Health Board has a savings target of £35 million, made up of £17.3 million devolved savings, of which 75% should be recurrent. If achieved, the Health Board forecasts an in-year deficit of £30.9 million. As at month six, the Health Board is on track to meet its savings target and in-year planned deficit position. At month six, the Health Board had identified £30.7 million of savings. The remaining £4.3 million gap is profiled for the last quarter of the financial year. However, even if the in-year planned deficit position is achieved, over a three-year cycle the Health Board's rolling deficit for the period ending 2017-18 is forecast, at best, at £61 million. This is at least £10 million worse than the three-year deficit to 31 March 2017, so while savings are being delivered, they are not supporting a reduction in the overall cumulative deficit.

The planning of savings is aligned to the Health Board's three-year planning cycle and delivery is supported by corporate services, however, there is scope to revisit the allocation of targets to take advantage of areas with greater savings opportunities

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

The approach to planning savings is realistic and linked to the IMTP planning cycle, although there is scope to review the allocation of targets to take advantage of areas with greater savings potential

73 In 2016-17, clinical and service boards and the executive team were required to save 3% of their annual budget. The 2017-18 devolved target is 2%. Whilst this represents a reduction in the target, it is more specific in that it includes 1.5% recurrent and 0.5% non-recurrent savings elements.

74 In monetary terms, the Health Board is required to save £35 million in 2017-18, this is broken down as:

- £17.3 million devolved target (£13.0 million recurrent and £4.3 million non-recurrent);
- £2.7 million for Health Board wide transformation; and
- £15 million stretch target.

75 The Health Board has a top-down approach to savings planning, meaning the corporate finance team sets a Health Board wide target, which is applied equally to the clinical and service boards and the executive team. Service areas are responsible for planning and delivering their cost improvement plans, and identify savings in a number of ways. For example, clinical boards identify medicines management savings[4] through benchmarking, looking for cheaper alternatives drugs (biosimilar), using off patent drugs, reducing waste and variation, and transferring services to the most cost effective place of delivery.

76 The Health Board has not significantly changed its approach to planning savings since the latter part of 2016-17 when the Health Board introduced 'turning the curve'. This was a programme introduced to address the Health Board's financial issues. It provided a platform for all senior leaders to meet, update on performance and ideas, and for the executive team to cascade messages. The programme delivered savings towards the end of 2016-17. Whilst the format of 'turning the curve' is currently under review, the Health Board has continued to strengthen governance arrangements, such as making the interim Finance Committee permanent. The Health Board has also continued to improve financial management through budgetary efficiency, and financial control measures, in order to manage budgets and reduce overall cost escalation. This includes developing a Cost Improvement Programme (CIP) tracker.

77 The CIP tracker is both a planning and monitoring tool used to ensure savings plans are being progressed. The tracker is based on a traffic light system. Green schemes are fully developed and ready to implement, amber schemes are nearly ready to implement and red schemes are future potential ideas. Unlike green and amber schemes, service areas are not monitored on the progress of red schemes; but clinical and service boards are expected to continually add ideas. To make sure savings schemes were in place for delivery in 2017-18, the targets below were set and achieved:

- 1st April – 65% green schemes, 25% amber schemes, 10% unidentified schemes in place;
- 1st June – 80% green schemes, 15% amber schemes, 5% unidentified schemes in place; and
- 1st October – 100% green schemes in place.

[4] Medicines management at the Health Board is devolved to clinical boards.

78 The Health Board has a rolling savings process, all schemes have a start date so clinical and service boards have the freedom to add new schemes to their cost improvement plans at any time of the year and profile as appropriate to the scheme. However, they must set out the profile of recurrent and non-recurrent savings across the year. In past years, under-delivered clinical board savings were written-off corporately, which was a disincentive to meet the target. However, starting from this year, clinical and service boards will carry their deficit forward so there is more accountability and clinical boards carry their own risk.

79 Savings planning is aligned with the Health Board's IMTP planning cycle. All clinical and service boards develop an IMTP that feeds into the Health Board's overall plan. In previous years, service areas were required to develop detailed savings plans for year one but savings profiling for years two and three were just headlines. However, from this year, to get clinical and service boards in the mind-set of making and planning recurrent and longer-term savings beyond an in-year focus, a three-year planning template has been introduced. This is the first year that the executive team will also go through the same process, promoting a more sustainable and longer-term focus to savings planning.

80 To help with planning savings schemes, aligning to IMTP plans and understanding their impact, a project outline document (POD) must be completed for each scheme. The POD template which needs to be signed off at clinical board level asks for the following types of information:

- the purpose of the change, how it contributes to clinical board plans and the Health Board 10 year strategy, and outcome targets;
- areas that are in and out of the scope, key actions to be delivered and interdependencies for example, impact on other clinical boards, other health boards and external partners;
- risks and mitigating actions;
- how key stakeholders will be engaged in designing the service change, and equality and health impact;
- key milestone, workforce change, financial change and delivery outcomes over the next three years, broken down by quarter;
- outline of project team; and
- document sign off and approval.

81 The Health Board's approach to planning savings is of equal distribution and current CIP performance suggests the savings targets are achievable, with some areas over achieving. However, given the Health Board's negative financial position, there is scope to explore a more tailored approach to savings target identification, with service areas with more opportunity to save delegated greater targets than those with less opportunity. The Health Board recognises that the majority of their savings are non-pay and to make larger savings they will need to tackle pay costs. In response, the Health Board is auditing their establishment lists, pushing to reduce agency spend by recruiting to substantive posts and scrutinising non-clinical vacancies through the corporate vacancy scrutiny.

82 In 2016, we made the following recommendations relating to financial planning. Exhibit 6 describes the progress made.

Exhibit 6: progress on 2016 financial planning recommendations

2016 recommendation	Description of progress
R2 Ensure cost reduction plans are adequately supported prior to the start of the financial year.	**On track but not yet complete** The Health Board's Project Outline Document (POD), which must be signed off at clinical board level, coupled with the weekly monitoring of the cost improvement tracker, ensures savings schemes are supported prior to implementation, however the Health Board is not yet in a position that savings are identified as far as possible prior to the start of the financial year.

Corporate services are helping to deliver savings and the Health Board is strengthening arrangements to support transformation projects

83 The Health Board has a number of support networks to help clinical and service boards plan and deliver savings. Enabler functions, such as finance and workforce, are part of each clinical and service board and play a key role in developing the IMTP and savings plans. Heads of finance will support the respective directors of operations and budget holders in driving the development of savings plans in line with the strategic direction of the clinical board. Those we interviewed as part of our medicines management tracer fed back that clinical board pharmacists and prescribing advisers work closely with heads of finance. As well as the integrated enablers, the health board has other support functions such as the informatics team who support savings planning by triangulating benchmarking and internal data to identify savings opportunities.

84 However, the Health Board has realised that its organisational structure can promote silo working. As such, it is thinking about how best to encourage cross working in situations where the work of one clinical board affects another. It is also thinking about how best to incentivise over-delivery; for example by returning some of the savings back into the service to support reinvestment. However discussions about incentives also raises question about penalties for under-delivery of savings, which the Health Board has not yet considered.

85 The Health Board has five crosscutting themes that support the delivery of devolved savings targets, these are:

- medicines management;
- procurement;
- medical productivity;
- nursing productivity; and
- workforce productivity.

86 The crosscutting themes are executive led work streams that span the Health Board. The advantage being that it provides opportunities for the Health Board to achieve economies of scale and plan wider, more sustainable savings and efficiencies. Crosscutting schemes form part of clinical board cost improvement plans and as such, they own and deliver the savings. However, the executive leads are

ultimately responsible for the target, which is £7.5 million across all work streams. The programme management office (PMO) supports the crosscutting programme, and the corporate finance team plays a part in identifying crosscutting opportunities and supporting the clinical boards in delivery. Overall progress is monitored though the Crosscutting Steering Group, which is chaired by the Director of Finance. Discussions observed at the October Crosscutting Steering Group suggests that all of the work streams, except for workforce productivity, are delivering.

87 The Health Board recognises that the only way to make longer-term sustainable savings and reduce the deficit gap is through service transformation. As such, the Health Board has recently set up a Transformation Board, which meets monthly and is chaired by the Director of Public Health (and interim chief executive until July 2017). Under the Transformation Board, there are three transformation teams, each of which is responsible for one of the following work streams:

- unscheduled care;
- planned care; and
- primary care.

88 The transformation teams, which are still in their infancy, are clinically led. Finance, workforce, the PMO, the Continuous Service Improvement team, and the informatics team also support them. As stated earlier, for 2017-18 the Health Board has set a £2.6 million target for savings through transformation projects.

There are strong scrutiny and monitoring arrangements of financial savings at Board, committee and operational levels, and there are good mechanisms in place for learning lessons

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

90 At the Health Board, savings are reported at all levels of the organisation:

- Board level – Board and Finance Committee;
- Corporate level – Clinical and Service Board executive performance review meetings, Transformation Board and Crosscutting Steering Group; and
- Operational level – Clinical and Service Board meetings.

91 The Health Board set up an interim Finance Committee in the latter part of 2016-17. The committee is now permanent and meets every month. The committee receives an overall monthly finance report, which gives a high-level position against the savings target with the latest weekly CIP tracker summary appended. In addition, the committee receives a specific report on the cost reduction programme. This report details progress against the devolved cost reduction programme, which includes crosscutting themes and progress by clinical and service boards. The Board, which meets every two months, receives the latest version of the monthly finance report. We observed the Finance Committee in September and October 2017. Overall, we found that in-year savings performance was well scrutinised and reported.

92 As part of this review, we asked the Health Board to complete a self-assessment survey. One of the questions asked the extent to which the Health Board agreed with a series of statements about

scrutiny of savings. Exhibit 7 sets out the Health Board's response and it is clear that the Health Board is confident about the level and robustness of the scrutiny provided and lines of accountability.

Exhibit 7: Health Board's response to a series of statements about in-year scrutiny and challenge on the progress of savings schemes.

Statements about scrutiny of savings schemes	Health Board response
The scrutiny and challenge received from the Board and its delegated committee on the in-year progress of the delivery of savings is robust.	Strongly agree
Scrutiny is timely, allowing sufficient time for remedial action to be taken.	Strongly agree
The impacts on service quality is properly considered by those scrutinising delivery of saving schemes.	Strongly agree
There are clear lines of accountability for the delivery of savings schemes.	Strongly agree

Source: Health Board's return of Wales Audit Office financial savings module self-assessment.

93 Clinical and service board CIPs are monitored on a weekly basis and performance circulated to the executive team and senior managers. Any unidentified savings gaps are discussed at monthly executive level performance reviews and appropriate support mechanisms are put in place if required. The review meeting is chaired by the Chief Executive and gives the Director of Finance and other executive directors the chance to challenge clinical and service board's savings plans, their keys risks to delivery and forecast year-end positons. In addition, each month the Deputy and Assistant Finance Directors review the CIP trackers with Clinical Board heads of finance.

94 The Health Board has recently introduced new escalation measures for clinical and service boards that are not forecasting a break-even position. The Chief Executive chairs the new Financial Forecasting Meeting and only clinical and service boards that have been escalated by the Director of Finance are required to attend. The escalated services are 'stood down' when a forecast breakeven position can be demonstrated. At the time of our fieldwork, one clinical board had been escalated and one meeting had taken place.

95 At an operational level, directorates monitor their savings plans and report up to clinical and service board meetings. For medicines management, the Health Board has robust performance management arrangements. The Health Board has a corporate medicines management group, which includes clinical board directors and heads of pharmacy and finance. A medical director or head of pharmacy chairs the meeting, which reports to the Hospital Services Management Board (HSMB). As medicines management is devolved, each clinical board has a medicines management group which reports into the clinical board meetings, and then to the corporate medicines management group. Medicines management is also a crosscutting theme so savings delivery is monitored through the Crosscutting Steering Group.

96 The Health Board has a number of mechanisms in place to share ideas and learn lessons. Internally, good practice is identified through:

- monthly one to one meetings between the Deputy Director of Finance and heads of finance;
- the executive performance review meetings;
- at cross-clinical board meetings such as the fortnightly 'Turning the Curve' meetings; and
- through the weekly CIP tracker leader board email, which is sent out to all senior leaders and includes the Health Board wide savings tracker so everyone is sighted of each other's schemes.

97 At a national level, the Health Board is part of the national efficiencies group. The Director of Finance and Deputy Director of Finance lead on the all-Wales efficiency framework, and are encouraging health bodies to share and learn from each other's savings plans. The all-Wales director and deputy directors of finance forums also share and discuss best practice. There are also national forums for medicines management, for example, the chief pharmacists peer group, and joint pharmacy and finance group, which has a specific work stream on savings. Both of these forums have Health Board representation.

98 In 2016, we made the following recommendations relating to financial reporting. Exhibit 8 describes the progress made.

Exhibit 8: progress on 2016 financial planning recommendations

2016 recommendation	Description of progress
R1 Strengthen financial reporting arrangements by including additional information within the financial report to the Board and the new Finance Committee relating to: a. a dashboard summarising performance against key financial performance indicators; and b. the issues and detail of actions being taken to manage budget overspend and deliver necessary savings by clinical area.	**Complete** The Finance Report submitted to the finance committee and the Board includes: a. a finance performance dashboard which is RAG rated; and b. a section on clinical board financial performance that includes a narrative on clinical boards that are overspending against their budgets and actions to rectify this. There is also a section on savings performance with an appended table, which breaks down performance by clinical board.

Operational arrangements are generally effective but there are weaknesses in Board oversight and assurance, and it is unlikely that the new data protection regulations will be met in time

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

Strategic planning is generally effective and increasingly joined up across the organisation, however scrutiny of delivery remains a gap at Board and committee level, despite close monitoring at an operational level

100 The findings underpinning this conclusion are based on our review of the Health Board's approach to strategic planning and the arrangements that support delivery of the strategic change programmes underpinning the annual operating plan. We have also considered the progress made in addressing previous recommendations relating to strategic planning. Our key findings are set out below.

101 As stated previously, the Health Board failed its duty under the NHS Finance Act (Wales) 2014 in 2016-17 and Welsh Government did not approve the Health Board's three-year integrated medium term plan (IMTP). For 2017-18, and for the second year running, the Health Board has been working to an annual operating plan.

102 In January 2017, the Health Board submitted to Welsh Government an initial draft of their annual operating plan, which included a planned deficit of £69.9 million. Welsh Government asked the Health Board to resubmit the plan in March 2017 with an improved planned deficit position. The amended version of the plan was submitted to the Board in March 2017 with an improved planned deficit position of £45.8 million. However, because of the size of the planned deficit, the Board was not in a position to approve it. Instead, it endorsed its adoption, recognising that further work was required. The Board reconsidered the annual operating plan in May 2017 where it agreed to deliver a deficit position no worse than £30.9 million.

103 Whilst the Health Board's annual plan is for 2017-18, it is still written within a three-year context (2017-18 to 2019-20). The plan includes a section setting out the strategic context which includes the following local drivers for change:

- population changes, mainly an aging population and population growth;
- new legislation, such as the Wellbeing of Future Generations Act and the Social Services and Wellbeing Act;
- technology opportunities, such as keeping up with technological advances;
- workforce challenges, pitched as a short-term risk, but with opportunities to innovate the workforce; and
- an aging infrastructure, both IT and estates.

104 The annual operating plan states that it reflects both the Health Board's Shaping Our Future Wellbeing 10-year strategy and the NHS Planning Framework.

105 A review of 2017 Board papers shows that the Board receives regular updates on IMTP planning and development. In July 2017, the Board received a paper that detailed the process for developing the

2018-19 IMTP including key milestones such as submission and approval dates. The paper also identifies improvement areas for the Health Board's IMTP and for developing the clinical and service board operational plans that feed into it. The improvements aim to ensure decisions are timely and assurance is set at the right level. The areas for improvement are:

- engagement on a refresh of the Health Board's Commissioning Intentions;
- strengthening the Strategic Commissioning Framework;
- clear and timely IMTP deliverables for 2018-19 and beyond;
- alignment of corporate functions (such as finance, workforce and organisational development, information management and technology, and corporate nursing), with the planning process; and
- strengthening the Health Board's business case process.

106 Whilst it is positive that the Board regularly considers the development of the IMTP, there are gaps in scrutiny at committee level. The People, Planning and Performance (PPP) Committee was stood down in May 2017, and scrutiny of strategic planning has been assigned to the new Strategy and Engagement (S&E) Committee. This committee met for the first time in July 2017. In September, the S&E Committee received the Health Board's draft commissioning intentions. We observed the meeting and it was clear that the committee was not yet mature enough to scrutinise the plan in detail, in part because the remit of the committee was not yet clear.

107 In 2016, we found that scrutiny of IMTP delivery was fragmented at Board and committee level, and this issue remains. Whilst there are regular updates on IMTP planning and development, there is little evidence to show the Board and its committees are adequately updated on IMTP delivery. This is covered later in this report.

108 However, Executive Directors generally feel the Health Board is in a better position this year because there are better links between planning and finance. In addition, there is more robust financial and performance management of IMTP deliverables at an operational level. Moreover, the IMTP planning process is now stronger and the Health Board is working towards a better balance between performance, finance and quality. The Health Board has also continued to improve its annual approach to managing planned care, specifically delivery to RTT (Referral to Treatment) targets, which have been met for the past 11 quarters and have seen the best 36-week position for seven years.

109 In 2016, we made the following recommendations relating to strategic planning and reporting. Exhibit 9 describes the progress made.

Exhibit 9: progress on 2016 strategic planning and reporting recommendations

2016 recommendation	Description of progress
R3 When developing the 2017-18 three-year plan, ensure that there is: a. clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans and requirements such as the Health & Social Care Wellbeing Act and Future Well Being Generations Act; and b. a clear understanding of the benefits expected from the actions and priorities set out in its plan.	**On track but not yet complete** a. The Health Board's annual plan for 2017-18 sets out the strategic connect which includes the Wellbeing of Future Generations Act and Social Services and Wellbeing Act. In addition, it states that it reflects the Health Board's Shaping Our Future Wellbeing 10-year strategy. b. The Health Board has a series of plans to improve their IMTP; this was detailed in the paper submitted to the Board in July 2017. One of the improvements included clear and timely IMTP deliverables for 2018-19 and beyond.
R4 Establish the new Strategic Planning Committee as a matter of urgency to ensure that sufficient time is allocated to scrutinise the development of the 2017-18 three-year plan.	**On track but not yet complete** The Strategy and Engagement Committee was set-up in July 2017. This was after the annual plan had been developed, but the committee is in place to scrutinise the 2018-19 plan.
R5 Strengthen progress reporting on delivery against plan by including aspects identified in our comparative review of progress reports, and ensure that progress is considered on a regular basis by the Strategic Planning committee, in line with the new requirements of the NHS Planning Framework for 2017-20.	**On track but not yet complete** The process has been strengthened at an operational level i.e. through clinical and service board performance management reviews, but progress against delivery is not yet adequately considered at the two new committees replacing the PPP committee.
R6 Undertake an evaluation of planning capacity to provide assurance to the Board that the Health Board has sufficient planning capacity and capability within the organisation. This evaluation should also include its change management capacity to minimise the continuous need for the Health Board to commission external support.	**Little or no progress has been made** There is no evidence to suggest the Health Board has reviewed its planning capacity. Since our 2016 structured assessment work however a member of the planning team has left and not been replaced.

The Health Board's organisational structure continues to mature with steps being taken to improve joint working across the organisation, though concerns about corporate governance capacity remain

110 The findings underpinning this conclusion are based on our review of the Health Board's organisational structure. Our key findings are set out below.

111 In 2017, the Health Board did not make any changes to the structure of the organisation, except there is now a full executive team in place. The new Chief Executive joined the organisation in July 2017, the Director of Workforce and Organisational Development in October and at the time of our fieldwork, the Health Board was in the process of appointing a permanent Chief Operating Officer. We received positive feedback about how the Chief Executive has integrated into the organisation. Those we interviewed felt the Chief Executive is clear about his priority areas, in particular improving the financial standing of the organisation, is approachable, respectful and visible.

112 The current structure comprises eight clinical boards and one service board, all of which are supported by integrated enablers such as finance and workforce. Whilst the structure is fit for purpose, the Health Board has recognised that it risks promoting silo working. As a result, the executive team has recently taken action to encourage cross working between clinical and service boards, for example by initiating conversations through monthly performance review meetings. Other services such as estates and facilities, ICT and informatics work across clinical and service boards. Clinical boards broker help from these departments as and when they are needed. We were told that overall, this system works, however at times there was need for executive level brokering to resolve operational issues that require enabler input. This suggests there is need for clearer procedures for accessing support from departments that work across clinical boards.

113 The Director of Corporate Governance and his team play an important part in providing challenge and governance advice and support to executive officers on matters yet to reach the Board and its committees. Our structured assessment work over a number of years has raised concerns with the capacity within the corporate governance team. In April 2017, a new Head of Corporate Governance joined the team. However, this was a substantive post that had been vacant since the latter part of 2015. The team has also benefited from a graduate trainee, who has been seconded to the team, but this is not a permanent arrangement. This means the team has not been expanded and capacity remains an issue.

114 In 2016, we made the following recommendation relating to organisational structure. Exhibit 10 describes the progress made.

Exhibit 10: progress on 2016 organisational structure recommendation

2016 recommendation	Description of progress
R12 Undertake a further evaluation of the corporate governance capacity to ensure that the Health Board has sufficient governance capacity and capability within the organisation to provide the necessary assurances to the Board. The views of independent members on what assurances are needed should be sought as part of this evaluation.	**Little or no progress has been made** The substantive Head of Corporate Governance post has been filled, but this has not improved the capacity of the Corporate Governance team. The team has gained a graduate management trainee but this is a temporary measure.

The Board and some of its committees are not providing sufficiently rigorous and consistent oversight, partly due to turnover in membership, and until the two new committees are fully established, there are risks to assurance on performance and planning

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

116 This year the Health Board, along with others in Wales has experienced a significant turnover of independent members (IMs). Four members have left including the vice chair of the Board, and the chair of the Audit Committee. In addition, the Health Board was holding three existing IM vacancies. Having recruited seven new IMs during 2017 to bring the Board to full establishment, a further two IMs were due to leave at the end of December 2017. Of the seven new IMs, only one has had previous NHS Board experience. This placed increasing pressure on the Health Board to get the new IMs up to speed through its Board development programme.

117 To manage risks to Board continuity, and ensure a smooth transition for new IMs, out-going IMs have provided a legacy statement and have offered to be contactable for advice after they have left. The Health Board has also developed an induction programme, which is taking place between October 2017 and January 2018. The programme includes:

- an introduction to the Health Board;
- one to one sessions with Executive Directors;
- all-Wales training and seminars provided through Academi Wales and the NHS Confederation;
- site visits; and
- Board development sessions.

118 Now that the seven new IMs are in post, the Health Board is looking to refresh its programme of patient safety walkabouts. This will help new members gain a better understanding of how individual services and wards work. It will also make IMs more visible to staff on the ground.

119 Our observation of Board and the key committees[5] indicate that there is variation in the level of scrutiny, challenge, and committee administration between committees. This in part is due to a number of Board changes such as, new IMs, new committee chairs and the establishment of two new committees. The Finance Committee and Quality, Safety and Experience Committees are two of the better run committees. These committees were chaired by the chair of the Board as an interim measure, pending IM recruitment, but new chairs have now been appointed. Both of these committees have well balanced agendas with good coverage of priority issues, are well chaired and well administered. However, scrutiny and challenge at Board and the other committee meetings has been limited, as new IMs get up to speed. Finance Committee papers are also slow to be uploaded on the Health Board's website. At the time of writing this report, two months of papers were missing (October and November).

120 Following the Health Board's review of its committee structure in April 2016, a decision was made to split the People, Planning and Performance (PPP) committee into two new committees. However, this was delayed until IM vacancies had been filled and the governance team had more capacity to set up the new committees. In March 2017, the Board agreed to move forward with this decision and in May 2017, the PPP committee was stood down. The two new committees, Strategy and Engagement (S&E), and Resource and Delivery (R&D), held their first meetings in late summer.

121 On observing the two new committees, it is clear that they are in their infancy; at the time of this review both had only met twice. Whilst both committees have a terms of reference, their remit is not clear and the agenda balance between the two committees needs to be reviewed. Exhibit 11 shows which aspects of Health Board business each committee will receive assurances on and monitor, as set out in their terms of reference. This highlights that the S&E Committee has a much larger remit than the R&D Committee, which only picks up the performance elements of the old PPP Committee. The S&E Committee risks being overloaded which was one of the reasons why the responsibilities of the PPP Committee was spilt, as well as the risk of considering interrelated matters in isolation such as strategy and planning, alongside workforce. The Health Board will be reviewing both committees in six months and is holding a meeting in December to discuss the future of the R&D Committee. The time lag between standing down the PPP committee, setting up the new committees and now waiting for the new committees to establish means the Board risks gaps in assurance around strategic planning and performance.

[5] As part of our structured assessment work, we observed the Board and the following committees – Finance Committee, Quality Safety and Experience Committee, Strategy and Engagement Committee, Resources and Delivery Committee and Audit Committee

Exhibit 11: comparison of responsibilities of the Strategy and Engagement, and Resource and Delivery committees

Strategy and Engagement Committee	Resource and Delivery Committee
In particular the Committee will monitor and receive assurances in respect of the following: • Strategy • Collaboration • Integrated medium term plan • Engagement • Capital • Commercial development.	In particular the Committee will monitor and receive assurances in respect of the following: • the delivery of Welsh Government Delivery Framework and other priority targets; and • workforce key indicators, organisational development and performance.

Source: Terms of reference for the Strategy and Engagement and Resource and Delivery committees

122 Generally, the Board and its committees receive papers through a templated cover report; this ensures clarity and coverage of important information. Overall, the reports are well written, clearly state where assurance can be taken from and indicate the purpose of the paper, for example for the Board or committee to note, endorse or approve. Meeting minutes also clearly note decisions, agreed actions and the main discussion points. However, cover reports are not provided for all reports and concerns were raised about the turnaround time for minutes. In addition, there is scope to reduce the size of Board and committee papers, some of which span 900 pages. The volume of information may hinder good scrutiny and officers need to report by exception. As part of the Board and committee structure review in 2016, it was agreed that cover reports would be no longer than 2-3 sides and full reports would be included as a hyperlink. As yet this practice is not being consistently applied. The Chair of the Board and Chief Executive have recognised that discipline around papers has lapsed and are taking steps to tackle it.

123 During 2017, the Board met its annual reporting requirements by publishing its annual report, which includes its annual governance statement, annual quality statement and accounts in the required timeframe. In 2016, we made the following recommendations relating to board and committee effectiveness. Exhibit 12 describes the progress made.

Exhibit 12: progress on 2016 board and committee effectiveness recommendations

2016 recommendation	Description of progress
R8 Ensure compliance with all requirements of the Welsh Health Circular (reference WHC/2016/22) on transparent public reporting. Specifically, the Health Board should ensure that the following are easily accessible via the Health Board's website: • citizen engagement plan; • complaint/concerns raising policy; and • flexible visiting times policy.	**On track but not yet complete** The Health Board's website includes a homepage link to a page called 'get involved with your Health Board'. This page includes links to: • volunteering • work experience • concerns, complaints and compliments • engagement and consultation' and • patient surveys Another homepage link called 'information for patients, carers and visitors' takes you to information about visiting times by hospital. Since our 2016 structured assessment work however, the Health Board has introduced a new Finance Committee. Supporting papers for this committee are not placed on the Health Board's website in a timely manner.
R9 As a matter of urgency, ensure that all independent member vacancies are filled and that post holders are in post to support quorate running of committees.	**Complete** The Health Board recruited seven new independent members and the Board is at full complement. Committee membership has been reviewed and enhanced, and new chairs have been appointed to QSE and Finance Committees, both of which were being chaired by the Chair of the Board. Two further IM's are due to depart at the end of December 2017, which will create further gaps in Board membership. However, steps are already being taken to replace these at pace.

124 In 2016, we undertook a detailed review of Board Assurance Frameworks across the NHS in Wales. The Health Board's Corporate Risk and Assurance Framework (CRAF), which combines the Board Assurance Framework and corporate risk register, generally compared well against other NHS bodies. However, there were opportunities for improvements and the Health Board has recently started a wholescale review of the CRAF, discussed further in the following risk management section of this report.

The Health Board recognises that risk management needs improving and is undertaking a review of operational and corporate risk management processes, however due to capacity issues within the corporate governance team this will be a slow process

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

126 The Corporate Risk Assurance Framework (CRAF) combines the Health Board's corporate risk register and board assurance framework. The CRAF has been in place for four years and is well established; however, the Health Board recognised that risk management needed improvement to give better assurance to the Board. Therefore, in May 2017, a Board development session was held on risk management. The workshop, delivered by an external company, resulted in a number of actions to improve risk management, some of which have already been implemented. For example, improved reporting of risks to Board and committees by making reports more visual and presenting low and high risks.

127 The CRAF is a live document uploaded to the Health Board's website. The document is updated as and when risks are updated, usually following a Board or committee meeting. The CRAF has a logical layout, each risk is assigned to the Board or a committee for oversight, there is a lead executive, and it is clear to see which clinical or service board each risk is applicable to. However, on reviewing the document, a number of risks are not described well, do not have milestones and risks are not aligned to objectives as set out in the Health Board's 10-year strategy. We reviewed the CRAF updated in September and November 2017 and there was no movement on any of the 87 risks, despite review at Board and committee meetings. Whilst the document is live and dated, it is not clear when each risk was first added, or which risks have been updated and when.

128 As stated earlier, the PPP committee was stood down in May 2017. There were a number of risks assigned to this committee, which were not reassigned to the two new committees until November 2017, meaning there was a five-month gap in oversight and assurance.

129 It is clear that further improvement is needed and the Health Board is currently undertaking an extensive review of risk management and the CRAF. The Head of Corporate Governance is the lead for this piece of work and has been working on:

- piloting short risk identification and risk register guidance for staff. This is to clarify the risk management process and help identify and describe risks clearly;
- working with clinical and service boards to make sure only appropriate risks are escalated for inclusion in the CRAF;
- checking that all corporate teams have a risk register so the CRAF is considering all corporate risks;
- reviewing individual risks on the current CRAF with the lead committee or Board to assess whether it belongs on the CRAF. A template report has been developed which is being piloted at the Health and Safety Committee; and.
- aligning each risk on the CRAF with the Health Board's 10-year strategic objectives.

130 The Health Board aims to launch a new version of the CRAF in April 2018, although many of the actions described above will still be work in progress. The Health Board's risk management policy, which was last updated in 2013, will be reviewed in line with this process. This is a large and important

review and capacity to undertake this piece of work is limited. Progress will be slow as this is only part of the Head of Corporate Governance's role and other members of the Corporate Governance team do not have risk management expertise.

131 In 2016, we made the following recommendation[s] relating to risk management. Exhibit 13 describes the progress made.

Exhibit 13: progress on 2016 risk management recommendation.

2016 recommendation	Description of progress
R7 Review the way objectives are defined in the Corporate Risk Assurance Framework to facilitate the ability to identify what success looks like and what needs to be done to achieve these objectives, ensuring that these are further aligned with those set out in the ten-year plan.	**On track but not yet complete** The Health Board is undertaking a major review of the CRAF and risk management processes. The Health Board aims to launch the new CRAF in April, which will align risks to objectives in the 10-year strategy and include clear risk descriptors. This is also an opportunity to review the strategic risks to achieving corporate objectives and the required assurances, strengthening the overall board assurance framework, alongside improvements to the CRAF and overall risk management.

The Health Board's information governance arrangements are not yet developed enough to effectively implement the new General Data Protection Requirements (GDPR) by May 2018

132 The findings underpinning this conclusion are based on our review of the effectiveness of information governance arrangements. Our key findings are set out below.

133 Up until recently, the Health Board had two committees responsible for the scrutiny of information governance, and information management and technology. Both of these committees reported into the PPP Committee. In October, both of these committees were merged into a single committee Information, Technology and Governance Committee, which now reports into the Resources and Delivery Committee.

134 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 (GDPR)[6].

135 The Information Commissioner's Office (ICO) found 'limited assurance' of the Health Board's data protection arrangements in 2016, and made a number of recommendations. The Health Board has started to address these recommendations through 2017, with a documented action plan and monitoring arrangements in place. However, the majority of actions remain ongoing although the Health Board will need to address these to be fully ready for GDPR.

[6] EU Data Protection Regulation http://www.eugdpr.org/eugdpr.org.html

136 The introduction of the 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 changes:

- 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;
- scope of the act now extends beyond the boundary of Europe, for data processing of European data subjects. This might affect Health Bodies who participate in global research studies;
- penalties for breach of policy can extend to an upper limit of 4% of turnover, or €20 million (whichever is the greater); and
- changes in rights including right to access, right to be forgotten and erasure and improving clarity of consent.

137 The Health Board, led by the Senior Information Risk Officer has recognised the legislative changes and has a transition programme underway to assess readiness for implementing the new requirements under the GDPR. Although some initial progress has been made, a number of actions remain in progress and further improvements are needed. These include developing and completing an Information Asset Register, appointing a Data Protection Officer, Privacy Impact Assessments for information flows, and processing and further developing, where required, the network of information asset owners. The Health Board should ensure it has adequate resources in place to implement the GDPR requirements by May 2018.

138 The Health Board also has opportunity to strengthen its information governance arrangements in 2018 by updating its strategic approach to information governance and aligning this to the national digital health and social care strategy. The Health Board has a small central information governance team, and therefore constrained resources for providing guidance and mandatory training on information governance and confidentiality issues. The pressure on resources is especially challenging for these functions whilst implementing effective arrangements to meet the new GDPR requirements.

139 The Health Board has a mandatory information governance training programme which should be completed every two years by all staff. Staff compliance with information governance training is currently 55% compare to the target of 85%. The Health Board's information governance training programme can help mitigate risks from inappropriate access by staff to patient medical records and inappropriate disclosure of confidential information due to poor record keeping standards and human error.

140 The national NHS Informatics Service (NWIS) has rolled out the new Information Governance (IG) Toolkit for Primary Care to all GP practices within the Health Board. GP practices who are the data controller are completing the IG Toolkit by the end of 2017. Dentists and Optometrists are not yet included in this requirement. The arrangements for monitoring compliance of the primary care IG toolkit and the Health Board's role within this framework were unclear during our work.

141 In addition to this compliance activity, the Health Board needs to ensure that it responds to statutory information access requests relating to the Freedom of Information and Data Protection Acts. There is scope for the Health Board to improve its performance against statutory targets for responding to information requests particularly for the Freedom of Information Act. The Health Board's performance

for 2016-17 for responding to information requests within the required timeframe, compared to the national target of 95% was:

- 64% in respect of Freedom of Information Act requests; and
- 74% in relation to Data Protection subject access requests.

142 Overall, the Health Board is demonstrating that it is making some preparations for addressing the ICO data protection recommendations and the new data protection legislation but will need to provide additional resources to effectively meet the requirements of GDPR in the timescales. The Health Board also needs to ensure that it maintains the timeliness of responses to statutory information access requests, which are expected to rise once GDPR is implemented. The Health Board may need to keep its resources under review over the next 6 to 12 months to ensure that it balances these requirements.

Operational performance management is robust and comprehensive, but Board and commitee oversight is as yet ineffective

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

144 At an operational level, the Health Board has strong performance management arrangements. The executive team holds all clinical and service boards to account through monthly performance review meetings (except for dental clinical board, which has a review meeting every two months). The Chief Executive chairs the meetings and all executive directors are part of the scrutiny panel. All of the performance review meetings take place in the same week and last no longer than one and half-hours. Planning the meetings this way ensures they are focused and that the executive team can deliver consistent messages across all clinical and service boards.

145 The agendas and papers for performance review meetings are well balanced and clear. They all cover:

- financial performance, which includes the forecast year-end position and progress on cost improvement plans;
- performance against Tier 1 and local targets, split by quality, workforce and activity;
- progress against IMTP deliverables; and
- discussion of wider risks and Health Board wide solutions.

146 As part of this review, we observed a selection of meetings, and saw strong challenge from executive directors, but clinical board management teams were also given support and encouragement where appropriate. The largest part of the meeting was dedicated to progress on clinical board IMTPs, but there was also good discussions about national issues and updates and encouraging cross-clinical board working. Those we interviewed were positive about the performance review meetings.

147 At a committee level, the new Resources and Delivery Committee should be scrutinising Health Board performance and providing assurance to the Board. At the November Resources and Delivery Committee, which we observed, the committee received a high-level performance report against key Tier 1 targets and other local priorities. The report was not discussed and contained less detail than

the performance report submitted to the Board. There was no narrative to explain current performance, issues or risks.

148 The Resource and Delivery Committee is also responsible for providing assurance to Board on workforce performance. At the November 2017 meeting, the committee received a six-month update presentation on the 2017-18 workforce and organisational development delivery plan. However, papers were not provided ahead of the meeting, which hindered meaningful scrutiny.

149 Comprehensive performance dashboards are produced for the monthly executive level performance review meetings. The Resource and Delivery Committee should have sight of a summarised version of these dashboards, showing data by clinical and service board. In 2016, we made a recommendation to this affect but it has not been progressed. Implementing this recommendation will give the committee a more detailed overview of performance against quality, workforce and activity KPIs and IMTP delivery (finance is scrutinised at the monthly Finance committee). This would give the committee assurance that performance is being managed across the organisation and that the performance review meetings are effective, which in turn can be reported to the Board. Clear and more comprehensive performance reporting will highlight areas that the committee may need further assurance on by requesting a detailed report or deep dive review of a specific area of performance.

150 The Board receives a detailed performance report. This includes a dashboard with all corporate KPIs and an exception report on measures that have been prioritised by the Board or where performance has deteriorated. The Health Board has 60 KPIs in total that include both Tier 1 targets and local priority targets. The performance dashboard uses a traffic light system and as at November 2017, 19 KPIs were green, 24 were amber and 17 were red. The areas that were considered as red performance included:

- delivery of the 31 day and 62 day cancer access standards;
- reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA); and
- four hour waits in emergency departments.

151 Compliance with its financial requirements and a number of workforce indicators were also included.

152 In 2016, we made the following recommendations relating to performance management at committee level. Exhibit 14 describes the progress made.

Exhibit 14: progress on 2016 performance management recommendations

2016 recommendation	Description of progress
R10 Establish the new 'Resources and Delivery' Committee as a matter of urgency to ensure that robust scrutiny is given to the Health Board's performance.	**On track but not yet complete** The Health Board has set up a new Resources and Delivery Committee; however, the committee is in its infancy and is not fully established or effective yet.
R11 Ensure that relevant performance information is made available to the new 'Resources and Delivery' Committee, including the sharing of the clinical board performance reviews, to enable it to focus its attention on the areas of performance which need the greatest scrutiny.	**Little or no progress has been made** This recommendation has not been progressed.

Workforce and estates are increasingly supporting the goals of the Health Board, though informatics is struggling to keep pace

153 In reaching this conclusion, we found:

Approaches for recruitment, retention and supporting workforce management are generally effective, and while some aspects of training and development present challenges, the Health Board is taking steps to tackle them

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

155 The Health Board has a workforce and organisational development (OD) delivery plan, which forms part of its annual operational plan. The delivery plan is based on five key objectives, these being:

- efficient workforce;
- sustainable workforce;
- capable workforce;
- transforming workforce; and
- engaged workforce.

156 Every six months the Director of Workforce and Organisational Development provides a committee level update on progress against the workforce and OD plan. This update was previously reported to PPP Committee but is now received by the new R&D Committee. At the R&D Committee we observed, the paper presented was detailed, but it was not provided to committee members prior to the meeting, which prevented proper scrutiny.

157 Workforce KPIs are scrutinised at an operational level through groups such as monthly executive performance reviews and monthly Hospital Services Management Board (HSMB) meetings. However, as noted earlier, information from performance reviews does not filter up to committee or Board levels. Previously, a workforce dashboard was reported to the former PPP committee, and the Health Board should look to reinstate this for the new R&D Committee to ensure greater assurance is provided to Board.

158 At the time of our review, the new Director of Workforce and Organisational Development had only recently joined the organisation, so we interviewed the interim director that had been covering the post. In 2017, the Health Board has successfully recruited to all substantive posts in the executive team, all heads of nursing are in post, there are no gaps at assistant director level and has 14 new emergency unit doctors. However, recruitment of band 5 nurses, a clinical director for ophthalmology, a director of operations for medicine, and consultants in neuro-interventional radiology, psychiatry, and paediatric surgery remain an issue.

159 Whilst recruitment is problematic for certain professions and specialities within the Health Board, the Health Board has maintained relatively low levels of agency spend over the past two years. In 2015-16 and 2016-17, the Health Board had one of the lowest proportions of agency spend (as a proportion of overall workforce spend) compared to other health bodies in Wales. In addition, whilst the all-Wales average rose from 4.1% to 4.7%, the Health Board maintained agency spend at 1.6% of their total workforce spend.

160 The Health Board has focused on reducing agency costs, with workforce productivity being one of its crosscutting themes. The theme tackles medical, nursing and non-clinical productivity and each sub-theme has a programme of activities aimed at increasing productivity and meeting cost saving targets. For example 'Project 95%' aims to fill 95% of all substantive band 5 and 6 nursing posts by March 2018, thereby reducing agency nursing spend and creating a stable workforce. The Health Board has not used high-cost, off-contract, agency nurses since May 2016 and aims to do the same for Health Care Support Workers. The Health Board is undertaking a consultant job plan audit, specifically looking at job plans with more than 12 sessions and three SPAs (supporting professional activities); and is tackling administrative and clerical staff overtime.

161 The Health Board also has initiatives aimed at modernising and improving ways of working, which benefit both patients and staff, and make the best use of diminishing resources. For example, it has developed an app to make it easier for 'bank nurses' to book themselves on shifts, which in turn reduces the amount of time spent on organising rosters. The 'Model Ward' project, which is being piloted on two wards, aims to promote healthy eating by getting the right combination of staff on wards and working in a different way. For example, dietetics assistants on wards working with nurses and housekeeping staff. The Health Board is also introducing more services in the community for example physiotherapists based in GP surgeries, which reduces the need for in-hospital services.

162 Over the past two years, the Health Board has had an above average staff turnover rate when compared with the all-Wales average. In 2015-16, the overall rate was 9.7% compared to an all-Wales average of 8.7% and in 2016-17, the rate was 10% compared to the all-Wales average of 9.6%. Over the past four years, the average time to recruit has fallen across the NHS in Wales. However, Exhibit 15 show that at the Health Board, the average time to recruit increased by 2.3 days between 2015-16 and 2016-17. In 2016-17, the average time to recruit at the Health Board was 11.1 days longer than the all-Wales average.

Exhibit 15: average time to recruit at the Health Board compared to the average across Wales between 2013-14 and 2016-17

Source: Data from NHS Recruitment Services; 2013-16 database of recruitment activity, 2016-17 TRAC recruitment system. NB: Does not include vacancy approval.

163 During 2017, the Health Board has taken steps to improve recruitment practice such as by leading collective recruitment campaigns where several directorates need similar posts and by sharing good practice within the organisation. The Health Board now has a regular cycle of management graduate trainee intake and is getting better at forecasting numbers, with intake numbers forecast up to September 2018. For nursing recruitment, the Health Board has employed a recruitment manager and officer, who have led on recruitment campaigns such as to recruit 104 healthcare support workers. The Health Board is also keen to develop its apprenticeship offer and as such has a working group in place and is launching an apprentice framework. The apprenticeship will focus on both school leavers and people that are more experienced. The main aim of the framework is to show educational pathways to various careers and promotions, for example from healthcare worker to nurse. However, the framework is also mindful of those wanting to stay and excel in their current roles. The Health Board wants to be an organisation that welcomes those without a degree.

164 The Health Board has been successful in reducing sickness rates, especially over the past two years. Exhibit 16 shows that sickness rates at the Health Board had been higher than the all-Wales average, but since 2014, rates started to reduce and at 4.9% in 2016, was lower than the all-Wales average of 5.2%. However, there are high rates of sickness amongst certain staffing groups such as health assistants, support workers and nursing, midwifery and health visiting staff, but this is similar to other

health boards. For 2017-18, the Health Board has set a target to reduce sickness to 4.2%. As at September 2017, performance was at 4.8%.

165 Improving staff health and wellbeing is key to reducing sickness rates and having a more productive workforce. In recognition of their commitment to employee wellbeing, the Health Board achieved gold and platinum Corporate Health Standard, which is an externally assessed national standard. The assessors highlighted a number of strengths, which included union involvement and ownership of the health and wellbeing agenda, healthy catering provisions and the extent to which the Health Board's values and behaviours underpin its wellbeing agenda. The assessors also noted some areas for further development, such as sharing its achievements both within the organisation and beyond, engaging staff groups that it has failed to reach in the past such as porters, catering and estates staff and further developing work on mental wellbeing.

Exhibit 16: Sickness absence rates at the Health Board, compared to the Wales average between 2012 and 2016

Source: NHS electronic staff record. Collated by Workforce Services, NHS Wales Shared Services Partnership. Data taken from StatsWales website.

166 There are 13 statutory and mandatory training modules, which all clinical and non-clinical staff are required to complete. Staff must then ensure they refresh their training within a period of 1-3 years depending on the course. The Health Board has set a target of 85%; however, concerns about high-levels of non-compliance were raised at the September Board meeting. The Health Board is taking action to improve mandatory training rates by making training more accessible. For example by making more courses available as e-learning modules and improving the electronic staff record (ESR).

The improved ESR will automatically update staff training records when e-learning is completed, send training reminders and can be accessed via smartphones and tablets. The Health Board also runs three mandatory training campaigns per year (mandatory May, September and November) where classroom based training is run for staff who prefer this method of learning. Compliance with statutory and mandatory training is monitored through the executive performance review meetings, but is not part of the performance dashboard reported to the Board, nor the Resources and Delivery Committee. At the meetings we observed, executives sent a strong message to the clinical board management teams about mandatory training compliance. The interim Director of Workforce and Organisational Development was confident that performance would improve over the next six months.

167 As at September 2017, performance appraisal development review (PADR) rates for non-medical staff was 57%, and medical performance appraisal rates were at 76%. Both are below the corporate target of 85% requiring continued focus by the Health Board.

The Health Board is developing strategic plans to make its estate fit for the future whilst also responding to existing problems of deterioration of parts of the current estate

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

169 In previous structured assessments, we have highlighted the condition of the Health Board's estates as a significant risk. In 2016, we reported that the Health Board had increased its focus on estates, providing regular updates at committee level. We also completed a separate review of estates that highlighted the positive steps the Health Board was taking to improve estate management, but recommended that it would benefit from introducing a strategic plan to direct activities.

170 In 2017, the Health Board has continued its focus on estates and an internal audit of the Health Board's arrangement for managing compliance with statutory requirements provided 'reasonable assurance'. Although the Health Board's overall backlog maintenance is reducing, the level of significant risks[7] is the second highest in Wales valued at £26 million. The majority of which is associated with the University Hospital of Wales (UHW) site. Given the continued risk of an aging estate, the Health Board is in the process of developing a series of estate management plans. An update paper was submitted to the September Board meeting. The estates plans include:

- clinical services plans, including regional plans such as those forming part of the South Wales Programme, plans in partnership with other health boards, and plans to provide more services in the community and closer to home;
- an estates plan for the next decade, which will set out the priorities to take forward to ensure the right infrastructure is in place to support clinical services and manage demand in the most appropriate settings / environments; and
- a masterplan for the University Hospital of Wales (UHW), which is a long-term plan for the replacement of UHW.

171 The Board has also continued to receive updates on other estate related matters such as traffic management changes at UHW and the draft sustainable travel and car parking action plan.

[7] Based on the NHS Estate Dashboard Report for 2016-17

The Health Board faces a number of challenges in its arrangements for the use of information technology, deployment of national IT systems and securing appropriate resources to deliver the informatics strategic outline programme

172 The findings underpinning this conclusion are based on our review of informatics services. Our key findings are set out below.

173 The Health Board developed its Informatics Strategic Outline Programme (SOP) for 2016-2021 and submitted this to Welsh Government in October 2016. The Health Board's People, Planning and Performance Committee agreed the SOP in October 2016. Whilst aligned to the national digital health and social care strategy, the majority of the capital and revenue funding required to deliver the SOP has not been fully committed. The Health Board needs to reprioritise the SOP based on current sustainable national resource levels available and seek Board approval for the revised strategic approach in early 2018, although in the interim, it has developed a 2017-18 annual plan, which sets the in-year informatics objectives and priorities.

174 The Health Board has asked its clinical boards to put forward proposed business cases for IT enabled initiatives to deliver service change, efficiencies and modernisation, for challenge and scrutiny. The Health Board also formed a 'turning the curve' group of clinicians, in October 2017, to look at ways of delivering a more effective clinical digital environment. The informatics team plays a key advisory role in supporting the business case development process, inform decision making on the best use of IT and deploy secure and resilient technology solutions.

175 The Health Board's informatics department has historically experienced capital and revenue funding constraints and within this environment is attempting to balance its resource and focus across:

- the day-to-day operational aspects of maintaining and supporting the current IT infrastructure used throughout the Health Board and replacing ageing technologies and systems to improve systems resilience, for example, upgrading the desktop technology platform used and data centre controls in 2017;
- taking on new requirements such as technology support for Health Board initiatives, for example, investigating, piloting and implementing lync for business for telehealth and digital health initiatives; and
- supporting new initiatives and developments such as emergence of technologies which support clinical service transformation where required, for example, the deployment of digital dictation technologies, major system implementation and also national IT initiatives.

176 The Health Board continues to have a legacy from its IT estate and environment, which includes ageing IT systems infrastructure and replacement of legacy IT systems, for example, the pathology system, and also different systems, which support similar functions across its sites. This makes support of the systems challenging and could inhibit standardisation of clinical practice, efficient workflow across sites, and consistency and timeliness of information reporting. The Health Board has been making prioritised investments under its 'keeping the lights on' capital programme to replace ageing IT infrastructure.

177 The Health Board is managing a number of issues over the replacement of legacy IT systems, for example, Theatres and Pathology, whilst waiting for the deployment of the national IT programme by the NHS Wales Informatics Service (NWIS). The Health Board faces issues with the hardware and software support and licensing costs with the prospect that NWIS remains unable to deliver the

national IT systems by the legacy system ‘end-of-life’ date. The Health Board is replacing older and unsupported operating systems and devices such as Windows Server 2003 and Windows XP, by February 2018 with updated devices.

178 The Health Board faces risks from cyber security attacks as the low level of investment on IT infrastructure and informatics resources increases the risk of potential threats arising from cyber-attacks. The Health Board updated and approved its Information and IT security policy in 2017, which may help mitigate some of these risks if the policy is effectively adopted by staff. Whilst the NHS ‘Wannacry’ cyber-attack in May 2017 did not seriously affect the Health Board, this was time consuming for the informatics department in time spent assessing the threats, patching or upgrading IT systems. Since the NHS ‘Wannacry’ cyber-attack, the Health Board has been updating the IT asset register for the network devices used and continued upgrading ageing wireless access points. Although, the Health Board is replacing Windows Server 2003 and Windows XP devices, it does not have a dedicated IT security officer or team and resources to identify, assess and address cyber security risks in an integrated strategic approach.

179 The Health Board can further strengthen the IT Key Performance Indicators (KPIs) measured and reported. The Health Board measures IT KPIs but these focus mostly on the performance of the IT service desk and call resolution. The Health Board can strengthen the IT KPIs measured by identifying the cause and impact of incidents to enable proactive fault diagnosis and resolution.

180 Processes are in place to identify, manage and track local and national informatics issues and risks the Health Board faces and examples include the:

- pace, timeliness and effectiveness of ongoing national plans for deployment of the remaining national IT systems including the Laboratory Information Management System modules, the replacement FUJI PACS and the new Welsh Community Care Information System;
- effectiveness of support and delivery provided from NHS Wales Informatics Service and monitoring of service performance levels;
- IT Business Continuity and Disaster Recovery plans which have only been developed, approved and tested in some clinical board areas;
- use of medical devices by clinical boards that are not known, procured or managed by the Informatics department. These medical devices could pose a potential cyber security threat if there are vulnerabilities within their technical security design. The Health Board has identified a number of medical devices used across clinical boards, for example, foetal monitors, ultrasounds and MRI scanners, that use out-of-date operating systems and which cannot easily be upgraded; and
- concerns over the safe and secure storage of paper medical records in Health Board locations and the availability of health care records when required.

Appendix 1

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

The Health Board's management response had not been completed at the time of publication.

Exhibit 18: management response

Recommendation		Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	For 2018-19, the Health Board needs to use intelligence such as benchmarking data to identify stretch targets on a case-by-case basis in areas where greater levels of savings could be made.						
R2	To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the annual operating plan, and subsequent three year integrated medium term plans.						

Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3 To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable.						
R4 To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner.						
R5 The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by: • mapping risks to the Health Board's strategic objectives; • reviewing the required assurances; • improving clarity of risk descriptors; and • clarifying to the reader the date when risks are updated and/or added.						

Recommendation		Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6	The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include: • updating the information governance strategy; • putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and • developing and completing an Information Asset Register; • ensuring that an identified data protection officer is in place; and • improving the uptake of information governance training.						

R7 The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: • ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; • expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.						

Recommendation		Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R8	The Health Board needs to revisit its Informatics Strategic Outline Plan in light of the financial resources available and seek Board approval of the revised strategic approach.						
R9	To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.						
R10	To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.						

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