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Structured Assessment 2018 – **Hywel Dda University Health Board**

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The Health Board continues to strengthen governance and management arrangements, but there is recognition that there remain some weaknesses in quality and safety governance arrangements, more needs to be done to streamline the organisational structure to support implementation of the new strategy, and the efficiency of both resources and assets in the short to medium term could be further improved.

About this report

1 This report sets out the findings from the Auditor General's 2018 structured assessment work at Hywel Dda University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 Our 2018 structured assessment work has included interviews with officers and Independent Members, interviews with each of the directorate management teams, observations at board and committee meetings and reviews of relevant documents, performance and financial data. We also conducted a survey of board members across all health boards and NHS trusts. Twenty-one[1] of the 30 board members invited to take part at the Health Board responded.

3 This year's structured assessment work follows similar themes to previous years' work, although we have broadened the scope to include commentary on arrangements relating to procurement, asset management and improving efficiency and productivity. The report groups our findings under three themes – the Health Board's governance arrangements, its approach to strategic planning and the wider arrangements that support the efficient, effective and economical use of resources. The report concludes with our recommendations.

4 Appendix 1 summarises the action that has been taken to address previous year's structured assessment recommendations. Appendix 2 sets out the Health Board's response to the recommendations arising from our 2018 work.

Background

5 The Health Board is currently escalated to targeted intervention status under the NHS Wales Escalation and Intervention Framework. This reflects significant and ongoing challenges in respect of the organisation's financial position, its ability to meet the requirements of an approvable Integrated Medium Term Plan (IMTP) and concerns around specific aspects of its performance, most notably in relation to unscheduled care and referral to treatment times.

6 At the end of 2017-18, the Health Board reported a financial deficit of £69.6 million, against an agreed deficit total of £58.9 million. A growing year-on-year cumulative deficit stood at £150 million at the end of March 2018, accounting for more than 40% of the total deficit across Wales. For 2018-19, the Welsh Government has recognised the demographic and scale challenges that the Health Board faces and has allocated recurring funding of £27 million, with an agreed deficit total for the year of £35.5 million.

7 The Health Board was unable to meet the requirements of an approvable IMTP for 2018-2021 and is currently working to a one-year operational plan. The Health Board also undertook a substantial

[1] Of the 21 members responding, ten were executive officers, eight were independent members and three were associate directors.

engagement exercise to develop options to inform its health and care strategy[2], and during 2018, it consulted on the proposed options. The outcome of the consultation was considered at the Board meeting in September 2018, and a preferred option agreed. This has formed the basis of the Health Board's ten-year clinical strategy, the first three years of which are set out in more detail to inform the annual IMTP process. The first draft of the strategy was approved at the Board meeting in November.

8 By the end of March, the Health Board failed to meet key waiting targets set by the Welsh Government for time spent in A&E, ambulance handover times, referral to treatment targets and therapy waits, although some of these measures were showing signs of improving. Cancer and stroke performance was some of the best in Wales, except for thrombolysis compliance. There were also no diagnostic breaches and there were signs of improvement in relation to infection control, although healthcare acquired infection targets were not met.

9 During the last 12 months, there has been some turnover at the Board level both in respect of executives and Independent Members. The Director of Therapies and Health Science formally took up post in January, completing the executive team. However, the Director of Finance stood down in September, and the post was filled on an interim arrangement for three months, until a permanent appointment in December. Two experienced Independent Members completed their terms in April 2018. Two new Independent Members were appointed to the Board, with an additional Associate Member appointed specifically to chair the Board's Finance Committee.

10 Our 2017 structured assessment acknowledged that the Health Board was facing financial challenges and although there had been several improvements in strategic planning, stakeholder engagement and informatics, increasing maturity at an operational level was required to support its governance and performance arrangements.

11 This report provides a commentary on key aspects of progress and issues arising since our last structured assessment review. This report should therefore be read with consideration to our previous review.

Main conclusions

12 This year's Structured Assessment work has demonstrated that the Health Board continues to strengthen governance and management arrangements, but there is recognition that there remain some weaknesses in quality and safety governance arrangements, more needs to be done to streamline the organisational structure to support implementation of the new strategy, and the efficiency of both resources and assets in the short to medium term could be further improved.

13 The findings which underpin these conclusions are considered in more detail in the following sections. The Health Board has made progress against previous recommendations but, in many areas, further work is needed to address them in full. This is highlighted throughout the report and cross-referenced with a summary of overall progress against recommendations in Appendix 1.

[2] A healthier Mid and West Wales: Our future generations living well

Governance

14 As in previous years, our structured assessment work has examined the Health Board's governance arrangements. We comment on the way in which the Board and its committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. We also looked at the information that the Board and its committees receive to help them oversee and challenge performance and monitor the achievement of organisational objectives. We have drawn upon the results from our survey of board members to help understand where things are working well, and where there is scope to strengthen arrangements.

15 We found that **while the Health Board has generally good governance arrangements, the Board has recognised that quality and safety governance arrangements still have room for improvement, and that the current organisational structure needs to be revisited to support delivery of its new strategy**.

Conducting business effectively

16 We looked at how the Board organises itself to support the effective conduct of business. We found that **while there are generally good arrangements to support board and committee effectiveness, there are weaknesses in its quality and safety governance arrangements which the Health Board recognises and is addressing**.

17 The Board continues to be generally well run with the quality of Board-level scrutiny and challenge good. The Board has a full complement of Independent Members with a good range of knowledge, skills and experience, and the Chair continues to make good use of the variable contractual terms available to her when making appointments. A comprehensive programme of development for Independent Members is in place, making good use of both internal and external resources, and there are effective arrangements to support handover as Independent Members leave, new members are appointed, and new chairs of committees are put in place. A programme of organisational development is currently in place to develop the Independent Members, as well as strengthen the Board as a whole, supported by regular six-monthly reviews on an individual basis. Independent Members were complementary of the training and development opportunities in place, although scope to make use of visits to departments and wards to develop their knowledge was highlighted. This has been identified through recent appraisals and plans are in place to address this, including the inclusion of Independent Members in the Chair's Employee of the Month visits.

18 Board agendas are well structured, with a clear focus on governance items, strategic issues and performance. There is also clarity between items for noting and those that require Board decision, but agendas can be long, with meetings generally running for a full day to allow sufficient time to consider all agenda items. The volume of papers is also substantial, with papers often running to 1,000 pages. This is largely due to background information being included following requests from Independent Members to have access to the detail. Board papers are available seven days before the meeting, in line with the Health Board's Standing Orders but the volume of papers can be challenging with only half of the Independent Members responding to the Board member survey identifying that they have sufficient time to prepare within their contracted time. The quality and appropriateness of information provided were also raised as an issue in the Board member survey with 15 out of 21 (71%) members responding that they were confident:

- in the quality and accuracy of information presented to the Board (83% across Wales);
- that the Board receives sufficient information to inform decision making (86% across Wales);
- that the information supports effective scrutiny (78% across Wales).

19 The Board continues to rotate its meetings across its catchment areas to enable wider engagement with its public. Since April 2018 it has been making more use of web-casting to enable board discussions to be accessible to members of the public who are unable to attend. The Board is proactive in seeking questions from the public, with an agenda item now included in all Board meetings to publicly respond to those questions. Discussions that take place during the private sessions are limited to only those that are of a sensitive nature and there is an overall positive view from the Board member survey that the Board is conducted in an open and transparent way.

20 There is an improving focus on primary and community care, with regular papers which consider the primary and community services of the area in which the Board meeting is being held. The routine focus on performance, however, is largely dominated by acute operational delivery and the Health Board's financial position, both of which are key areas of focus as part of targeted intervention. Board agendas, however, lack a routine focus on the quality and safety of services provided, although specific areas of concern have been included as they arise, such as the fragility of services. Feedback from the Board member survey identified that while the Health Board places quality and safety at the top of its priorities, only 13 of the 21 (62%) members agreed that the agendas sufficiently focused on patient experience and the quality and safety of services. This compares with 81% across Wales. This has been recognised by the Board and work is underway to increase the level and range of information provided to the Board on quality and safety, including patient experience, although the pace of this work is slow.

21 Of the Board's committees[3], we have reviewed the three main committees: the Audit and Risk Assurance Committee (ARAC), the Business Planning and Performance Assurance Committee (BPPAC) and the Quality, Safety and Experience Assurance Committee (QSEAC). The current chairs of the Board's committees are effective in their roles and cross representation is enabling good flows of assurance, issues and risks between committees and up to the Board. Chairs are given sufficient time to present matters on the Board agendas, and a tracker is in place to monitor progress against actions referred between committees. There is an ongoing review cycle of committees using annual self-assessments, as well as self-reflection at the end of each meeting although this is not yet included on all committee agendas. Regular reviews also take place of the committee structures to ensure that they are fit for purpose. The appointment of an Associate Member to chair the Finance Sub-Committee, and the subsequent establishment of it as a Board Committee in September 2018, were because of these reviews (see paragraph 81).

22 The ARAC and BPPAC committees function generally well although there is recognition that the QSEAC needs to further improve. Work has taken place to revisit and refine the QSEAC supporting structures, but agendas remain long, duplication exists between sub-groups and many issues discussed are best placed at an operational level. A further review of the supporting structures is due

[3] The Board has eight committees. We have reviewed the three main committees, as well as the Finance Committee which became a committee in September 2018. The remaining committees are the Charitable Funds Committee, Mental Health Legislation Assurance Committee, Primary Care Applications Committee, and the University Partnership Board.

to take place in early 2019. The focus of the QSEAC agendas is also limited to a handful of key quality and safety priorities and information does not yet include a sufficient range of quality and safety measures. Papers presented provide a good understanding of the issues and actions being taken to address the quality and safety priorities, but, on occasions, Independent Members are unable to take assurance from the information presented to them. We are undertaking a separate review to consider the QSEAC structures and the wider Health Board arrangements to manage quality, safety and experience. This work is due to be reported in January. The other committees have been streamlined over the last 12 months, with the ARAC and the BPPAC increasingly managing within a shorter agenda, whilst maintaining a good balance of agenda items and allowing sufficient time for scrutiny and challenge.

Managing risks to achieving strategic priorities

23 We looked at the Board's approach to assuring itself that risks to achieving priorities are well managed. We found that **there is a well-developed Board Assurance Framework in place which is being refreshed as new strategic objectives are developed.**

24 The Health Board has historically had a well-developed Board Assurance Framework. This is currently being refreshed to take account of revisions to its strategic objectives following the Board's decision in September and the subsequent development of the Health Board's health and care strategy. The Board Assurance Framework clearly sets out the risks to delivering against the strategic objectives, set out in the 2018-19 one-year operational plan. Over time the presentation of the Board Assurance Framework has improved to aid the reader in understanding the controls in place, the different sources of assurances using the three lines of defence model, where gaps exist and the performance indicators that are used to measure progress. Underpinning the Board Assurance Framework is a comprehensive Regulatory and Review Body Assurance Framework which focuses attention on high-risk areas both in terms of likelihood and the impact on non-compliance with regulations and legislation. This includes, for example, the Human Tissue Authority.

25 The Board Assurance Framework is supported by a well-documented Corporate Risk Register, which has been updated following a Board development session in August 2018. The Board Assurance Framework now also includes the Board's risk appetite, which had previously been a gap. The Board Assurance Framework and Corporate Risk Register have been aligned to the Board and its committees and are used to inform their respective work plans. The Board Assurance Framework is reviewed on an annual basis. The Corporate Risk Register is reviewed twice a year.

26 Last year, we identified the need for the Health Board to further embed its revised risk management framework (**Recommendation 9, 2017**). The Head of Assurance and Risk has been working closely with all directorates over the last 12 months to improve the identification and recording of risks, which is evident in the improved quality of directorate risk registers. The Corporate Risk Register is also now routinely considered monthly by the Executive Team, and the management of risks at a directorate level are now also considered as part of the regular performance reviews. The Health Board could benefit from undertaking some work to group together consistent risks across directorates to identify risks that should be escalated more clearly.

27 Findings from the Board member survey indicate a general satisfaction with the Board Assurance Framework and supporting risk management arrangements. Information presented to the Board and its committees to effectively scrutinise actions, however, is an area for improvement, which may reflect

the need to review the Board Assurance Framework on a more regular basis. Only 12 out of 21 (57%) members responding agreed that the information presented to the Board allows members to effectively scrutinise actions taken to mitigate risks, compared to 77% across Wales.

Embedding a sound system of assurance

28 We also examined whether the Health Board has an effective system of internal control to support board assurance. We found that **some aspects of governance are stable and well organised, but others need to be further developed particularly in relation to quality and safety arrangements.**

29 Our work has identified that Standing Orders are up to date, with a comprehensive interactive Scheme of Delegation approved by the Board in November, which we have identified as good practice. The Standing Financial Instructions follow the 2014 all-Wales model and will be updated in line with ongoing national work, although all specific Health Board references are up to date.

30 Arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship are in place and reviewed annually by ARAC. Following previous Wales Audit Office work to review arrangements, the Health Board has adopted an online system to capture declarations. The register of Board member declarations is available via the Health Board's website, and in addition, all members are asked to declare interests at the start of every Board and committee meeting. The Health Board recognises that compliance by wider staff groups, however, is low. Work is continuing to improve awareness and completion of the register during 2018-19 through a range of annual communication campaigns, for example, through pay slips.

31 The Health Board has a comprehensive Internal Audit programme of work in place, with sufficient resources for delivery, and effective approaches for reporting assurances or concerns. However, the way in which Internal Audit provide their assurance ratings can be perceived as being ambiguous at times by ARAC members, with some significant issues raised in reports, yet an overall assurance rating of reasonable or substantial assurance, and vice versa. A new Head of Internal Audit took up post in December 2018. There are also plans in place to have a detailed discussion on the Internal Audit assurance rating process in February 2019, to minimise any future concerns over the ratings given to reports.

32 The Health Board has implemented a new Quality Improvement Framework, but this is still in its infancy. Our work on the Health Board's quality and safety arrangements (paragraph 22) has examined the arrangements at directorate level, and these have been found to be highly variable. There is early development work on a quality and safety dashboard which will be underpinned by directorate-based dashboards. The high-level dashboard was reported at the QSEAC in October as an early draft, with a more fully populated version to the December committee meeting. The dashboard, however, has not yet been reported to the Board and directorate-based dashboards are still being developed. Patient safety walkabouts are now embedded following their introduction in January 2018 which has enabled Independent Members and executive officers to undertake visits to specific departments and clinical areas. These visits demonstrate the increasing focus by Independent Members on the need to triangulate sources of assurance and feedback to date has suggested that the visits have proved useful in providing triangulation for Board members on the key quality and safety challenges that the Health Board faces.

33 Capacity to deliver the current clinical audit programme is an issue with a risk-assessed approach having to be applied against participation in national clinical audits, along with a low uptake of local

audits. The clinical audit plan is regularly reviewed by the ARAC and concerns have been raised around capacity, as well as the commitment to clinical audit from operational teams. If the Health Board is to improve its focus on the quality and safety of the services it provides, capacity to support the full implementation of clinical audit needs to be addressed.

34 Performance during 2018-19 against a few of the Health Board's quality and safety indicators is below Welsh Government targets. Rates of healthcare associated infections (HCAI) are some of the highest in Wales, although rates are reducing. Except for mental health, delayed transfers of care (DTOC) performance is deteriorating while there is an improvement in the number of healthcare acquired pressure ulcers. **Putting Things Right** processes and complaints response arrangements are improving, and although the Health Board is not yet compliant with the Welsh Government's timeliness of responses target, discussions through ARAC are providing assurance that the quality of responses and the way in which they are handled is improving. This has resulted in a reduction in the number of cases being referred to the Public Ombudsman for Wales.

35 Last year we identified the need for the Health Board to continue to improve its Integrated Performance Assurance Report (IPAR) to the Board (**Recommendation 11, 2017**). Performance reporting arrangements have since been improved with the IPAR developing into an interactive tool which ensures the key areas of underperformance are more prominent. The report includes both key deliverable targets as well as a suite of locally developed targets. Performance reporting arrangements are continually being improved and there is a recognition that more measures, which focus on patient experience and outcomes, are needed, to provide a more holistic review of performance, cost and quality. This is reflected in the findings from the Board member survey, which also identified gaps in understanding on productivity and efficiency (Exhibit 1).

Exhibit 1: percentage of board members responding to the survey who agreed that the information received gives them a good understanding about how well the organisation performs

Aspects of performance	Health Board (%)	Wales average (%)
Operational delivery	86	86
Service quality	67	80
Financial performance	90	97
Workforce productivity	24	40
Service efficiency	38	52
Care outcomes	24	47
Patient experience	29	64

Source: Wales Audit Office Board Member Survey 2018

36 Since our 2017 work, the Health Board's performance management arrangements have also improved (**Recommendation 10, 2017**). Quarterly performance reviews with each directorate, chaired by the Chief Executive, are now in place. These cover performance, workforce, quality and safety, and risk and finance. Depending on the directorate's financial position, finance discussions may be limited as more detailed discussions take place through the separate turnaround holding to account meetings.

To date, there has not been an explicit focus within the performance reviews on delivery against plans, but elements of planning are covered through the wider discussion on performance delivery. This is because the current operational plan is largely focused on delivering key performance targets, with wider oversight and assurance provided through the planning sub-committee of BPPAC. Although executive officers are involved in the performance reviews, some officers are considered essential (or core). Up until recently, attendance by the Medical Director has been limited, although attendance by other executive officers has been good. Medical representation from the directorates has also been limited, which we refer to later in paragraph 46.

37 Performance reviews are undertaken quarterly due to the number of directorates. However, in addition to the performance reviews, directorates are required to attend fortnightly or monthly turnaround meetings, as well as IMTP meetings which have recently been introduced. There are also review meetings with the Director of Operations and holding to account meetings chaired by the Chief Executive if the financial position warrants escalation. All meetings are held within the Health Board's main headquarters in Carmarthen except for the turnaround meetings which are held across the Health Board. Our work has identified that the operational teams spend a considerable amount of time in meetings, and that duplication of discussions can be a challenge. Some of these meetings are now also running into the evening which is not conducive to a positive work life balance for staff. Operational teams also reported that a separation of different aspects of performance into separate meetings is not always helpful and can lead to tensions between agreed actions, for example, the need to contain costs whilst meeting key deliverable performance targets. There is scope to amalgamate some of these meetings so that all aspects of performance are considered in a comprehensive way. This should enable performance to be reviewed on a more frequent basis, however, we recognise the benefit that having a separate turnaround process is currently providing the health board with, to maintain a grip on its financial position. The Chief Executive has requested a review of the operational meetings that are taking place to look at ways to streamline the number of meetings and to free up some of the time spent in meetings.

38 The Health Board has a robust process for tracking recommendations by all regulators, not just those identified by External and Internal Audit, which we have identified as good practice. The tracker is regularly reported to the ARAC and executive officers are held to account for the pace of delivery, with detailed progress updates reported back to ARAC at regular intervals. This process, however, is resource intensive for the corporate governance team to maintain the tracker. The ARAC has recently approved an escalation process for late or non-delivery of recommendations, which will help focus attention on addressing recommendations, with progress monitoring now delegated to the performance reviews. This process should be more manageable for the governance team but is reliant on robust governance arrangements at an operational level, and time on the quarterly performance review agenda to allow monitoring discussions to take place.

39 During the year, information governance arrangements have been further strengthened but still require more work. The Health Board has an effective Information Governance sub-committee in place but during the year lost the Information Governance Manager recruited in 2017, with a three-month gap before a replacement started. The Health Board has been taking a proactive approach to preparing and responding to the requirements of the General Data Protection Regulations (GDPR). An information asset register is now in place, and compliance with the mandated Information Governance training is improving but is still short of the 85% target at 71%. During the year, the Health Board had an external cybersecurity assessment. The overall assessment was broadly positive of the

arrangements in place, but did identify several improvement actions. These actions are reliant on additional resources being made available which, at the time of our work, were yet to be agreed.

Ensuring organisational design supports effective governance

40 We looked at how the Health Board organises itself to deliver strategic objectives collectively while ensuring clear lines of accountability for delivery. We found that **the current organisational structure needs to be revisited to support strategic ambition, which has also been recognised by the Board.**

41 Last year, we highlighted scope for the executive team to work more collectively together. As part of the Health Board's organisational development programme during 2018, work focusing on the executive team prompted the development of a new Executive Performance Review framework. This includes the development of new objectives for each member of the executive team. These objectives have provided clarity to executive roles and responsibilities, are directly linked to objectives in the 2018-19 operational plan and should help promote better joint working. Executive officers have shared these with their direct reports, and the totality of the objectives and how they interrelate have also been shared across the executive team and the Board.

42 The executive objectives have encouraged wider involvement in operational issues, than has previously been the case. Whilst this is evident in part, our interviews with the directorates commented that it remains largely the Director of Operations who supports operational delivery. They also highlighted that the executive team more generally are not as visible as they could be with some not able to name several of the executives (**Recommendation 8, 2017**). The wider involvement of the executive team in the performance reviews is helping address this gap, but as these meetings are held in headquarters, visibility is limited to operational management teams.

43 Cross organisational working and clear lines of accountability are also problematic. In 2017, we recommended that the Health Board revisit its organisational structure, particularly in relation to primary care and community services, as the structure did not promote integrated working and effective management of operational issues (**Recommendation 7, 2017**). Since our work last year, the post of Director of Primary, Community and Long-Term Care has been filled on a substantive basis, and two County Director roles were filled following the retirement of the previous post holders. The two new County Directors have been appointed on an interim basis to allow time to reflect any changes needed to support the implementation of the health and care strategy. All County Directors are now responsible for many aspects of primary care, including the GP cluster leads, which has helped realign the focus on primary and community care. The third County Director post is substantive, and responsibilities also include oversight of the Bronglais Hospital Directorate. The County Directors report to the Director of Primary, Community and Long-Term Care, but County Directors expressed some confusion as to whom they were accountable. This was because individual performance appraisals had been undertaken by the Director of Operations, and during the year they were being held to account for delivery also by the Director of Operations.

44 Over the year, elements of scheduled care have moved to the hospital directorate structure with the hospital directorates now responsible for the ward staff and the beds. The medical staff, support functions and service delivery managers remain under the management of the Scheduled Care Directorate. It is recognised that the changes have helped to ensure a whole system focus, and improved line management of ward staff. However, this split arrangement has presented challenges to

managing bed flow and can cause delays in dealing with concerns if they relate to a combination of issues that must be dealt with by both directorates. It is recognised, however, that these issues are inherent in any structural arrangement and are best solved through close working and good communication.

45 The Health Board's overall organisational structure is a combination of county, hospital and health board wide directorates, which risks the creation of tensions. Although, increasingly, the hospital and county directorate are coming together, for example, in holding-to-account meetings. The hospital directorates are a key component of the current organisational structure, which include elements of scheduled care, resulting in acute services having a greater profile. Radiology services are also included under the management of the Glangwili Hospital Directorate, which is currently placing workload pressures on the general manager. Up until recently, therapies had also been included in the hospital directorate structure, but this is now overseen by the Director of Therapies, pending the decision to create a new therapies directorate. The Board has recognised that if it is to implement its strategic vision, primary and community services need to be much more prominent in the organisational structure.

46 The Health Board has also implemented an organisational structure which is designed to be clinically led. There is currently no medical leadership in the county directorate teams, although there are GP cluster leads below the directorate level. The GP cluster leads and the medical leads for the other directorates, however, are not as involved as they could be in day-to-day management. Their management time, over recent months, has largely been taken up with involvement in the Transforming Clinical Services (TCS) consultation process (referred to further in paragraph 52). Very few clinical directors, however, attend the performance reviews for example, although some are present at holding to account meetings. There is recognition that the medical members of the management teams do not have the capacity to support as much as the general managers and lead nurses do, due to their own clinical workloads and the need to maintain the provision of otherwise fragile clinical services. Their capacity, however, is also hampered by a misalignment between clinical commitments and when management meetings take place. Since our 2017 structured assessment work, the Health Board has set up a Clinical Executive Team, with the aim to bring the executive officers and medical leads together on a regular basis. Time pressures from their involvement in the TCS process meant that medical staff struggled to attend the Clinical Executive Team meetings, and consequently the meetings were paused. Medical leads are now members of the new Health Strategy Committee. When considering the scope to align meetings, the Health Board should also consider the potential to have 'management days' and aligning the job plans of medical leads to ensure that they are able to contribute.

47 Previously, we highlighted concerns about the configuration of corporate services to support operational delivery. When we reported in 2017, the finance department was embarking on an organisational change process (OCP) to develop a business partnering model to align with the directorates. This process is nearing a conclusion but has required a substantial shift in resources to implement the model (**Recommendation 2, 2017**). We recommended that lessons needed to be learnt from the finance OCP and applied to other corporate directorates (**Recommendation 6, 2017**). Although the OCP in the finance department is only just coming to an end, the Health Board has used the OCP to reflect on changes needed elsewhere in the corporate structures, which will start to take shape in early 2019. Our interviews with the directorates identified that corporate support to enable the directorates to deliver is a challenge, and they would welcome the business partnering model to be

applied to other service areas, although there is recognition that there are named contacts for the workforce directorate. Capacity to implement a business partnering model is, however, a challenge as some of the corporate functions are lean. This is particularly the case for informatics, which the directorates feel is detached from the operational teams more so than other corporate functions.

Strategic planning

48 Our work examined how the Board sets strategic objectives for the organisation, and how it plans for the short, medium and long term. We assessed how well the Health Board plans how it will achieve its objectives, using funding, people and other resources that it has, or can make available. We also asked if plans are sufficiently joined up, both externally and internally and if they are well informed. Finally, we wanted to know if the Health Board is monitoring progress with these plans effectively.

49 We found that **the Health Board is to be commended for its engagement and ambitious approach to longer-term strategic planning but needs to develop joined-up and streamlined planning and delivery arrangements, and ensure there is sufficient capacity to drive through the necessary change.**

Setting the strategic direction

50 We looked at how the Board goes about setting its priorities in engagement with key stakeholders and whether agreed objectives are clearly defined in strategic plans. We found that **the longer-term strategic approach and partnership planning are progressing well.**

51 Significant work has been undertaken by the Health Board to engage and consult on its TCS programme over the last 18 months, culminating in the Board deciding in September 2018 on the preferred option for its scheduled and unscheduled care services. Over 140 consultation events were held over the summer across a wide range of localities and community groups, including Health Board staff. This work followed the process previously used for Transforming Mental Health Care Services, which has been recognised as best practice.

52 There has been strong medical leadership in TCS, with the Medical Director responsible for developing the Health Board's clinical strategy. The clinical directors and lead clinicians have also been at the forefront of the consultation exercise, with positive involvement also from a wider range of other healthcare professionals. The findings from our board member survey were overwhelmingly positive in relation to effective engagement when developing and setting strategic objectives, particularly with the clinical leaders.

53 The decision at the September Board meeting has now enabled the development of a 10-year clinical strategy to commence. An outline strategy was presented to, and approved by, the November Board meeting, which will form the basis of the three-year IMTP for 2019-2022 (**Recommendation 4, 2017**).

54 The Health Board plays an active role in the Regional Partnership Board (RPB). Our ongoing Integrated Care Fund work has identified that there is generally good partnership working across West Wales. The RPB has been a key stakeholder in the engagement and subsequent consultation of TCS, and through the Transformation Fund, has agreed to submit a bid which will go some way toward supporting the implementation of the health and care strategy. The Health Board also has strong partnership working with its Public Service Boards and with its neighbouring health boards. This is through the joint regional planning arrangements with Abertawe Bro Morgannwg University Health

Board, which has included joint Board meetings, and with Powys Teaching Health Board through the Mid Wales Health and Social Care Committee. A Regional Collaboration for Health (ARCH) and the Mid Wales Healthcare Collaborative both also form a key part of the health and care strategy.

55 Alongside the clinical strategy, the Director of Public Health is making good progress with developing a 20-year population health vision. The vision has three key goals which replace the Health Board's previous ten strategic objectives, which were population health focused but disease specific. The new goals are centred around 'starting and developing well', 'living and working well', and 'ageing and growing older well'. The Director is a key member of the West Wales Public Service Boards and the strategic direction is aligned with the Wellbeing of Future Generations (Wales) Act 2015. The high-level vision is included in the health and care strategy, which was approved by the Board in November.

Developing strategic plans

56 We considered the Health Board's approach to developing its annual and medium-term plans, and whether the approach is underpinned by appropriate analyses of costs, resources and potential savings. We found that **there are ambitious plans to develop an IMTP for 2019-2022 but the planning process is not sufficiently joined up.**

57 Last year, the Health Board recognised that without a clear vision for TCS it was unlikely to get an approved IMTP and agreed with the Welsh Government to submit a one-year operational plan. The plan was submitted in line with the Welsh Government timescales but following a need to revise its plans for delivering against the RTT priorities, it was not formally signed off until July. The operational plan was supported by detailed workforce, financial, IT and capital plans.

58 Given the agreement by the Board on its health and care strategy, the Health Board is aiming to submit its first IMTP to the Welsh Government for approval for 2019-2022. Timescales are ambitious but considerable work is underway to make sure that the draft IMTP is ready for consideration by the Board before submission to the Welsh Government. Several workshops have already taken place, and a series of check and challenge meetings have been set up with each of the directorates to consider and challenge the development of their plans. Each directorate will have three meetings between October and March, all of which are chaired by the Chief Executive. The meetings will help shape the first three years of the ten-year clinical strategy and plans will be challenged with the three strategic goals of the 20-year population health vision in mind.

59 Each of the directorates is required to complete a series of templates which will facilitate the development of the IMTP. These include the need to consider delivery against key performance targets, and finance and turnaround improvement requirements. They also include maximising low-value opportunities, recognition of cost pressures alongside saving requirements, quality and safety improvement, management of risk, digital and capital requirements, and workforce needs and opportunities. Fundamentally, they also need to include the service shifts required over the next three years to implement the health and care strategy.

60 The mechanisms that the Health Board is putting in place to develop its three-year plan are comprehensive and robust. However, more needs to be done to enable the plans coming up through the directorates to be co-ordinated, and for the corporate services to be on hand to support the directorates to develop their plans. While the directorates are being asked to identify areas that need to be integrated into the plans of other directorates, the Health Board's planning capacity to proactively

co-ordinate plans is limited. As mentioned in paragraph 47, the finance business partnering model is only just being embedded with several other corporate functions not having the capacity or configuration to provide a business partnering model currently. It is therefore important that the relevant directors (or their assistant directors) are involved in the check and challenge process.

Monitoring delivery of the strategic plan

61 Finally, we looked at whether progress with implementing strategic plans and supporting strategic change programmes is effectively monitored. We found that **arrangements for monitoring delivery against plan could be strengthened and capacity to deliver significant change is a challenge**.

62 Progress against the key actions set out in the one-year operational plan is reported through the BPPAC in the quarterly update report. This makes use of RAG ratings to identify whether delivery against each of the actions is on track. This report is currently being refreshed into an Integrated Planning Assurance Report, using the basis of the now well-established Integrated Performance Assurance Report. Although delivery against the plan is reported to the Board, our board member survey identified that only 16 out of the 21 (76%) members responding agreed that information to the Board gives a good understanding about how well the Health Board is performing in relation to delivery of the plan. This compares with 89% across Wales. With the move to three, ten and 20-year strategies, the Health Board needs to make sure that the Board is fully sighted of progress with implementation, which the Integrated Planning Assurance Report should address.

63 Planning, however, is not currently a formal part of the performance reviews with the directorates. Due to the nature of the operational plan, current discussions are focused on the plans directorates have in place to meet key performance deliverables by the year-end. As the Health Board moves to more transformational changes as part of its new health and care strategy, a more focused discussion on delivery against plan will need to be included within the performance reviews with the directorates.

64 Capacity to deliver significant strategic change has been an issue for the Health Board. Both the implementation of Transforming Mental Health Care Services, and Transforming Women and Children's Services, are largely reliant on the relevant operational teams to deliver the change on top of the routine business, as well as additional capital and revenue funding being available. Programme management capacity has been made available but the recent update to the Board on TMHS identified that this capacity is limited. The Health Board has recognised that it will need additional capacity if it is to deliver against its intended timescale for implementation of its health and care strategy. A request for additional capacity has been submitted to the Welsh Government and discussed through Joint Executive Team and Targeted Intervention meetings, but at the time of fieldwork, funding had not been made available.

Wider arrangements that support the efficient, effective and economical use of resources

65 Efficient, effective and economical use of resources largely depends on the arrangements the organisation has for managing its workforce, its finances and other physical assets. In this section we comment on those arrangements, and on the action that the Health Board is taking to maximise efficiency and productivity. We also examine if the Health Board is procuring goods and services well.

66 We found that **the management of workforce is improving, and the Health Board is strengthening arrangements for financial management and accountability, but significant financial challenges remain, and it needs to address asset management risks and to increase its focus on improving the efficiency of services**.

Managing the workforce

67 The workforce is the Health Board's biggest asset, not least because pay represents such a significant proportion of expenditure. It is important that the workforce is well managed and productive because staff are critical for day-to-day service delivery and for delivering efficiency savings and quality improvements. We found that t**he Health Board is managing its workforce effectively, but vacancies continue to present challenges and there is a need to put in place a learning and development plan for the workforce**.

68 The following table shows how the Health Board is performing in relation to some key measures compared with the Wales average.

Exhibit 2: Performance against key workforce measures at July 2018[4]

Workforce measures	Health Board	Wales average
Sickness absence	5.1%	5.3%
Turnover	8.6%	6.9%
Vacancy	2.1%	2.6%
Appraisals	70%	67%
Statutory and mandatory training	72%	73%

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales

69 Exhibit 2 shows that the Health Board's performance compares better than the all-Wales average across three of the five measures. Sickness absence rates are some of the lowest in Wales, with good scrutiny of sickness and the associated costs at the workforce sub-committee of QEASC. Compliance

[4] Sickness: rolling 12-month average at July 2018; Turnover: 12-month period July 2017 to June 2018; Vacancy: based on advertised vacancies during July 2018; Appraisal: preceding 12 months at July 2018; Statutory and mandatory training: at July 2018.

with appraisal rates is improving, with the compliance for medical staff the best in Wales, and, overall, the vacancy rate is lower than the all-Wales average. However, the Health Board continues to have some hard-to-fill medical posts, and turnover rates are high, particularly for medical staff, although this is largely due to retirement.

70 Compliance with statutory and mandatory training is just below the all-Wales average, but compliance amongst the medical staff is significantly low at just 15%. The Health Board's own workforce figures also identify that while most consultants have job plans, compliance with up-to-date job plans is low at just 21%. Gaps in both medical and nursing staffing levels have meant that the Health Board has had to rely on the use of temporary staff. Although agency and temporary staff costs are reducing, the Health Board still has one of the highest levels of agency spend across Wales. Project managers are in place to continue to drive reductions in medical and nursing variable spend as part of the Health Board's financial savings plan and turnaround process.

71 The Health Board has seen an overall increase in staff numbers due to some very proactive recruitment campaigns using the 'Train Work Live' initiative. This has started to address some of the Health Board's shortfalls in staffing levels, but challenges remain. The Health Board has generated several innovative initiatives to attract candidates or to develop their own workforce, such as the creation of the Apprentice Academy and Bevan Clinical Fellowship, as well as the 'Grow our Own' campaign. It is also modernising its workforce using advanced practitioners and other such roles, but funding for posts can be an issue as well as a lack of suitable candidates on the labour market. As the Health Board moves to implement its ten-year clinical strategy, it will need to overcome these challenges if it is to reconfigure services and upskill its primary and community workforce.

72 The Health Board has taken a pragmatic approach to responding to the requirements of the Nurse Staffing (Wales) Act 2016. Work undertaken has identified that it needs 165.6 whole-time equivalents to meet the requirements at a cost of £4.9 million, but it recognises that an accelerated focus on recruiting the quantum of staff needed would destabilise other care sectors, as well as have financial consequences. Instead a phased risk-based implementation plan has been adopted focusing on high-risk clinical areas first. This approach has been supported by the Welsh Government.

73 Staff engagement, recognition and wellbeing are generally positive in the Health Board. Bi-monthly pulse surveys take place to capture staff views, and the patient safety walkabouts provide opportunities for staff to raise concerns directly with Board members. The Chair's Employee of the Month award is also now well-established. The Health Board has a good working relationship with the Partnership Forum and there is a strong staff member on the Board.

74 Although the response rate to the 2018 NHS staff survey was low at 26%, the findings indicate an improvement in engagement, particularly in relation to the case for change. Some areas previously identified in the 2016 staff survey remain an issue, for example, bullying and harassment. Learning and development also compare less favourably to the all-Wales position, despite some improvements. Our work has found that the Health Board lacks an organisational-wide learning and development plan to identify how it can more broadly develop its staff. A pilot is currently taking place with one directorate to start to take this forward, but up to this point, learning and development needs have been largely addressed at a directorate level based on short-term gaps and performance appraisal and development reviews (PADRs).

75 Over the last year, the Health Board has put in place a substantive programme of organisational development following receipt of funding from the Welsh Government. The programme has not only

focused on the Board but a wide range of staff groups, including all the operational management teams and medical leaders (**Recommendation 5, 2017**). Progress with implementing the medical leadership organisational development programme, however, has been slow, and while there were early plans to refresh the assistant medical director structure, appointments have only recently taken place.

Managing the finances

76 We considered financial and budget management, financial controls, and operational support and processes. We found that **financial management and accountability have improved, but significant challenges remain.**

77 The Health Board's financial position remains a significant and long-term challenge. For the year 2017-18, the Health Board reported a £69.6 million deficit against the revenue resource limit. During 2018-19, the Welsh Government awarded the Health Board an additional £27 million (recurring) funding because of the unique set of challenges it faces in relation to its demography and scale that contribute to the continuing financial position. Consequently, for 2018-19, the Health Board has an agreed deficit total of £35.5 million after taking planned savings into account. At month seven the Health Board was still predicting a year-end deficit of £35.5 million, although an adverse variance of £0.9 million was reported.

78 Our annual accounts work has consistently identified that the Health Board has adequate budgetary financial management and control arrangements. The controls are designed to ensure clear lines of delegated budgetary responsibility, ensure accuracy of operational financial reporting, and drive compliance with required financial standards and legislation. However, we are not yet confident that there is sufficient financial accountability and, irrespective of the control arrangements in place, the Health Board continues to overspend against its allocation.

79 During the year, the finance team has undergone significant change, shifting from a traditional finance structure to a business partnering model to support budget holders. This should help improve financial accountability and delivery across the Health Board, alongside the continuing turnaround process which has provided much needed rigour to achieve savings. The Health Board's savings target for 2018-19 totals £30.7 million. This is an ambitious but not unrealistic target, compared to last year's target of £28.6 million, of which £25.1 million were delivered. The turnaround programme has strengthened the internal processes to be able to achieve its savings target, with fortnightly holding-to-account meetings with directorates, 60-day cycle meetings to identify new areas of efficiencies, and a new escalation process with the Chief Executive for directorates that are failing to deliver.

80 Compared to previous years, the Health Board had clearer savings plans in place earlier in the financial year for 2018-19, but unplanned cost growth driven by demand for unscheduled and scheduled care, and care packages during the year remain a challenge. This growth places greater pressure on saving schemes to recover the financial position and directorates have been asked to submit financial recovery plans to ensure savings targets for the year are met. At month seven, eight directorates were forecasting that they would not meet their savings target. Further work is needed to fully understand the cost drivers at a directorate level, with the current savings approaches largely reliant on schemes focussed on in-year savings rather than longer term (**Recommendation 1, 2017**).

81 Since last year, the Finance sub-committee of BPPAC, first established at the end of 2017, has been established as a formal committee of the Board. The committee meets monthly and, since July, has

been chaired by an experienced Associate Member with significant NHS finance experience who was specifically appointed to this role. The information provided to the committee is improving and allows good scrutiny and challenge of areas of concern to deliver the required financial position within the year. To get the 2019-2022 IMTP approved, the Health Board will need to demonstrate a viable financial plan for the next three years. As part of the development of its ten-year clinical strategy, the former Director of Finance was appointed to develop the underpinning strategic financial plan. This needs to be done alongside the development of the IMTP to make sure that they both align. Both will need to take account of a medium to longer-term focus on recurring efficiencies through transformation of services. The Health Board needs to focus on utilising this committee to focus on driving improvement and efficiencies into the medium to long term.

82 The Health Board's procurement arrangements are largely devolved to the NHS Wales Shared Services Partnership. The Health Board makes use of the all-Wales Procurement Strategy, which is underpinned by an all-Wales business plan. There is an overarching service level agreement between the Shared Services Partnership and the Health Board, with good day-to-day relationships with the procurement service, focused on operational procurement and procurement cost reduction. A local procurement savings plan is in place, totalling £1.9 million for 2018-19. This forms part of the Health Board's turnaround process and is regularly monitored by the Director of Finance as the accountable officer. Procurement activity is also regularly reported and scrutinised through the ARAC. The focus on procurement, however, is largely transactional, with some signs of an early value-based approach starting to evolve. This is particularly the case for medicines management, with the procurement of drugs delegated to the pharmacy service, but value-based procurement needs to be upscaled across the organisation if it is to have any significant impact.

Improving performance, efficiency and productivity

83 We looked at what the organisation is doing to improve performance, efficiency and productivity. We found that **some performance metrics are improving, but the Health Board needs to increase its focus on improving efficiency and embedding value-based healthcare**.

84 Through the turnaround programme, the Health Board is focusing on efficiency and productivity of services. This is limited to a small number of workstreams including theatre utilisation, outpatient performance, length of stay and patient communication. The Health Board has a service improvement team in place to help to support wider improvements in efficiency, but capacity is tight, and resources have been drawn into the longer-term clinical strategy discussions and the turnaround process. Overall performance against several efficiency measures since April remains mixed with:

- improvements in elective length of stay and day case rates, but waiting times, follow-up outpatient backlogs and Did Not Attend (DNA) rates in outpatients remaining an issue;
- improvements in emergency length of stay, rates of admission, bed numbers and stroke performance, but four-hour and 12-hour waits in A&E, and DTOC performance deteriorating;
- a deterioration in diagnostic waits, and therapy waiting times being some of the worst in Wales.

85 The Health Board's IPAR makes use of benchmarking and trend data to show comparison against other NHS bodies and improvements over time. The Health Board is also an active participant in NHS Benchmarking exercises. The organisation is data-rich but its ability to use the data as intelligence to inform decision making and performance management is limited. The current informatics infrastructure

is not fit for purpose, in line with the rest of Wales, and capacity within the informatics team to respond to queries from directorates is limited. Since our 2017 work, the Programme Management Office (PMO) is now at full complement. Although the project manager has been drawn into the longer-term clinical strategy discussions, the PMO hosts several data analysts who have become more available to support the directorates manage operations, such as demand and capacity planning.

86 The Health Board is at the very early stages of adopting value-based healthcare. A paper submitted to the Welsh Government to develop a joint infrastructure with Abertawe Bro Morgannwg University Health Board and Swansea University has recently been agreed, supported by funding for two years. The Health Board is already leading value-based healthcare around the lung pathway but recognises that it currently lacks both outcome and cost data which is needed to take value-based healthcare forward across other specialties and pathways. The Health Board is, however, using data from the International Consortium for Health Outcomes Measurement (ICHOM) and the interim Director of Finance is starting to drive the discussion around patient level costing. Clinical engagement with value-based healthcare is also lacking, with the intention that some of the funding received from the Welsh Government will be used to roll out training. This will also be used to increase the focus on prudent healthcare, which already features as a strategic objective in the one-year operational plan.

87 As part of its developing Quality Improvement Framework, a value-based healthcare steering group has recently been set up, but this is still in its infancy. An Innovation Hub, however, has been set up through the organisational development programme to help drive the improvement agenda. The first hub has been established in Llanelli and there are plans for a second hub to be set up in Aberystwyth. The hubs are overseen by the organisational development team.

Managing the estate and other physical assets

88 Finally, we considered how the estate and physical assets are managed. We found that some of **the Health Board's assets are deteriorating and it needs to risk assess and prioritise action to replace them.**

89 The Health Board has a large legacy estate and asset base, and while some of this is relatively new or recently refurbished, there remains a significant backlog maintenance requirement. Although reduced, high-risk estate backlog maintenance is currently £59 million. Coupled with the out-of-life assets now totalling a further £53 million makes this a real concern. Our fieldwork identified that some parts of the current estate are unlikely to support new service models and promote efficient ways of working. Financial constraints also mean that it will be difficult to bring some of the estate to the required environmental standards. A capital estates audit is currently being undertaken in partnership with the Welsh Government to ascertain the extent to which some of the Health Board's current estate stock could be repurposed.

90 The Health Board has an Infrastructure Enabling plan which supports its current one-year operational plan. This sets out the estate requirements needed in the short term and how these will be funded. Like many other health boards, availability of discretionary capital to support estate, ICT infrastructure, medical equipment and other related assets, however, is limited. The Health Board flexes and responds to new priorities, for example, where urgent and unexpected health and safety risks occur, or there is unexpected equipment failure. However, this can place financial pressure on the service with the estates department currently escalated in the turnaround process due to its inability to deliver against its savings target.

91 As part of our work, we found:

- improving reporting of estates performance within the IPAR to the BPPAC; and
- ongoing work to update and ensure corporate policies and processes for managing asset and estate are fit for purpose.

92 Although capital project and expenditure are reported into the BPPAC through the Capital, Estates and Information Management and Technology sub-committee, we found, however, that the information on capital expenditure could be presented more succinctly.

93 The findings from the Board member survey identified that only five out of 21 (24%) members responding felt confident that the way assets are managed achieves value for money. The Health Board has committed to develop an estates strategy to support its new health and care strategy recently approved by the Board, in particular the first three years. As it moves towards consideration of a new hospital which forms part of the strategy, the Health Board will need to ensure that the design of the new build takes into account the Well-being of Future Generations (Wales) Act.

94 The Health Board does have a digital strategy in place but many of its IT systems are not fit for purpose, and implementation of the strategy is intrinsically linked to the wider implementation of the health and care strategy and is reliant on additional funding and staffing being made available.

Recommendations

95 Some of the areas for improvement identified in this year's Structured Assessment are already either covered by recommendations from previous years' work, or form part of ongoing improvement activity by the Health Board. The Health Board needs to maintain its focus on ensuring that our previous recommendations are addressed. In addition to previous recommendations, we do make several new recommendations which are set out in Exhibit 3. Recommendations relating specifically to areas for improvement in relation to the Health Board's quality and safety arrangements will be included in our separate report.

Exhibit 3: 2018 recommendations

2018 recommendations	
Board effectiveness	
R1	To enable Independent Members to make well-informed decisions and to effectively scrutinise, the Board should agree the level and quality of information that it expects to receive, using the findings from the Board member survey to inform where improvements need to be made.
R2	To improve the effectiveness of committees, the Health Board should consider including time on committee agendas to reflect on the administration and conduct of the meeting, and the quality of information provided for scrutiny and assurance.

2018 recommendations
Operational meetings R3 To free up capacity for both executive and operational teams, and to enable a more joined-up focus on the use of resources, the Health Board should streamline the number of holding-to-account or performance review meetings with operational teams by: • reviewing the frequency and timing of these meetings; • reviewing the location of these meetings, to improve visibility of the executive team; and • aligning these meetings with management sessions contained within job plans for clinical directors to enable them to participate fully.
Strategic planning R4 To ensure the delivery of its health and care strategy, the Health Board should seek to resolve the outstanding request for funding from the Welsh Government to support the capacity needed to implement the strategy with the intended timescales.
Financial sustainability R5 To support its longer-term financial position, the Health Board should ensure that the Finance Committee continues to develop its role and to provide increasing scrutiny and challenge on the plans to achieve efficiency savings in the medium to long term.

Appendix 1

Progress implementing previous recommendations

Exhibit 4: actions in response to 2017 and outstanding previous recommendations

Recommendation	Action taken in response	Completed
R1 The Health Board needs to improve the identification and design of saving schemes through:		
a. increasing the use of data and intelligence to identify opportunities for efficiency improvements reflecting them in more meaningful and realistic savings targets for different areas of the business;	The Health Board is starting to make use of data to better identify opportunities for efficiencies, including the use of cost data but this is still at the early stage. Overall targets remain a top-down approach.	Part
b. avoiding over-reliance on in-year cost control, accountancy gains and non-recurrent savings; and	The level of non-recurrent savings planned for 2018-19 is a slight decrease on the previous year but for the Health Board to deliver its intended financial position, it is going to be reliant on in-year cost control and accountancy gains.	Part
c. embedding the 60-day cycle process to identify where longer-term and sustainable efficiencies can be achieved through service modernisation, and approaches such as value-based healthcare and productivity improvements.	The 60-day cycle continues to form part of the Health Board's turnaround process with new areas of efficiencies identified for 2018-19. The Turnaround Director post is due to end in June 2019, however, and it is unclear whether the 60-day cycle process will continue beyond then. The Health Board is, however, now starting to focus on embedding value-based healthcare, although this is still at the early stages and will require the availability of cost and outcome data to significantly improve.	Part

Recommendation	Action taken in response	Completed
R2 The Health Board needs to develop the financial management capabilities within the operational directorates and service departments by progressing with the organisational change process (OCP) for the finance department. The change will see the finance staff align with the operational structure and provide greater opportunity for them to provide support and challenge on a day-to-day basis.	The organisational change process within the finance department is nearing completion with the final posts recently filled. The new structure does promote a business planning model, which is welcomed by the operational directorates, but it will take some time to embed. During the organisational change process, the Director of Finance stood down and the newly appointed Assistant Director of Finance is currently acting as Interim Director until a substantive appointment is made. This has placed some immediate pressure on capacity as several staff are backfilling during the interim period.	Yes
R3 The Health Board needs to adopt a more proactive approach to learning and sharing good practice about savings and wider financial planning. This should include making more use of initiatives such as the Welsh Government's 'Invest to Save' schemes.	The routine turnaround meetings continue to be embedded within each of the directorates, along with the 60-day cycle to focus on areas of efficiencies. Learning and sharing are made available through the turnaround meetings on an ad hoc basis but there is no formal mechanism for sharing learning across the Health Board when developing savings plans. Although the Health Board has made use of initiatives to help save money in the long run, such as through the Invest to Save schemes, this is limited largely due to the Health Board's short-term in-year focus, rather than over a longer period to aid transformational change.	Part
R4 To enable the development of a three-year integrated medium-term plan, the Health Board needs to ensure that it has a clear outcome from its Transforming Clinical Services programme to inform the 2019-2022 planning round.	The outcome of the TCS consultation exercise was considered at the September Board meeting. This has now enabled the development of a ten-year clinical strategy to commence. An outline strategy was presented to the November Board meeting, and approved, the first three years of which will now form the IMTP process for 2019-2022.	Yes

Recommendation	Action taken in response	Completed
R5 The Health Board needs to progress its work to develop its clinical directors at pace and provide the necessary support to its wider triumvirate teams to develop their management capabilities.	The Health Board has put in place a substantive programme of organisational development following receipt of funding from the Welsh Government. The programme has focused on a wide range of staff groups, including all the operational management teams and medical leaders. Progress in implementing the medical leadership organisational development programme, however, has been slow.	Part
R6 Following the implementation of the proposed planned changes to the finance department, the Health Board needs to ensure that the structures of the other corporate functions appropriately support and challenge the operational directorates.	Although the OCP in the finance department is only just coming to an end, the Health Board has used the OCP to reflect on changes needed elsewhere in the corporate structures which will start to take shape in early 2019.	Part
R7 The Health Board needs to revisit its operational structure, and the position of primary care and community services in particular, to ensure that it fully supports integrated working and effective management of operational issues.	All County Directors are now responsible for many aspects of primary care, including the GP cluster leads, which has helped to realign the focus on primary and community care. Changes have also been made to the management of scheduled care, with the hospital directorates now responsible for the ward staff and the beds. The medical staff, support functions and service delivery managers remain under the management of the Scheduled Care Directorate. These changes have helped an improved whole system focus, and improved line management of ward staff, but have created other challenges in the effective management of operational issues, for example, managing bed flow.	Part

Recommendation	Action taken in response	Completed
R8 To show leadership, visibility of the executive directors across the Health Board needs to extend to all directors and consideration needs to be made to holding meetings with operational teams away from the headquarters wherever possible.	The revised executive objectives which have been put in place should help to engage some of the executive directors in operational issues, but feedback from the operational teams indicates that the visibility of some executive directors, particularly when services are under pressure, remains an issue. Wider involvement of the executive team in the performance reviews is helping address this gap, but not all directors are present, and these meetings are held in headquarters. Many other meetings are also held in headquarters, except for the routine turnaround meetings which are held across the various sites. The visibility of the executive team was highlighted as an issue in the recent staff survey, albeit that the proportion of staff who were positive was the highest in Wales.	Part
R9 The Health Board needs to further embed its revised risk management framework and to continue its work with its operational teams to refine the recording of risks.	The Head of Assurance and Risk has been working closely with all directorates over the last 12 months to improve the identification and recording of risks, which is evident in the improved quality of directorate risk registers. The Corporate Risk Register is also now routinely considered monthly by the Executive Team, and the management of risks at a directorate level is now also considered as part of the regular performance reviews. The Health Board would benefit from grouping together consistent or common directorate risks to enable easier identification of risks that should be escalated.	Yes

Recommendation	Action taken in response	Completed
R10 The Health Board needs to strengthen its performance management framework at an operational level by: • ensuring sufficient time is allowed within the bi-monthly performance management reviews to consider all elements of performance, including finance, workforce and delivery against plan; • ensuring that the process includes wider representation from across the directors; • ensuring that governance approaches at operational and service level are standardised and include a comprehensive review of performance; • expanding the range of performance metrics that are considered at an operational level, particularly in relation to quality and safety; • exposing the operational directorate teams to scrutiny at both the BPPAC and QSEAC on areas of underperformance.	The performance reviews continue to cover performance, workforce, quality and safety and finance, and now include consideration of risk but delivery against plan is not as explicit as it could be. Depending on the directorates' financial position, finance discussions may be limited as more detailed discussions take place through the separate turnaround holding-to-account meetings. Since our last structured assessment, the performance reviews are now chaired by the Chief Executive on a quarterly basis. This has reduced the frequency of reviews for each directorate. The length of time available for the meeting is still not sufficient to cover everything that is needed. As well as being chaired by the Chief Executive, more executive officers are also included in the review meetings. Attendance by some directors is considered essential, although not all have been able to attend. Attendance by clinical directors from the operational teams also remains an issue. The governance arrangements at an operational level are variable and do not all include the same range of information as that needed at the performance reviews. Quality and safety arrangements still need strengthening with the development of quality and safety dashboards at an early stage. Operational directorates have not yet been exposed to scrutiny by either the BPPAC or QSEAC, although themes of underperformance are now more routinely considered.	Part

Recommendation	Action taken in response	Completed
R11 The Health Board needs to continue to improve its integrated performance assurance report by drawing the reader's attention to areas of underperformance, expanding the range of local performance metrics that are included within the report to provide a more rounded view of performance, where appropriate.	The IPAR has since been developed into an interactive tool which ensures key areas of underperformance are more prominent. The report includes both key delivery targets as well as a suite of locally developed targets. The report is continually being improved and there is a recognition that more measures, which focus on patient experience and outcomes, are needed.	Yes

Appendix 2

Health Board's response to this year's recommendations

Exhibit 5: management response to 2018 recommendations

Recommendation	Management response	Completion date	Responsible officer
Board effectiveness R1 To enable Independent Members to make well-informed decisions and to effectively scrutinise, the Board should agree the level and quality of information that it expects to receive, using the findings from the Board member survey to inform where improvements need to be made.	The key themes from the Board Members' Survey will be reviewed and an improvement plan drafted for discussion and agreement at a workshop with Independent Members. Feedback will also be incorporated within the existing Standard Operating Procedure for the Management of Board and Committees and training programmes to reinforce the agreed level and quality of papers expected by the Board and Committees.	September 2019	Board Secretary

Recommendation	Management response	Completion date	Responsible officer
R2 To improve the effectiveness of committees, the Health Board should consider including time on committee agendas to reflect on the administration and conduct of the meeting, and the quality of information provided for scrutiny and assurance.	A 'reflective summary' of the meeting is already included at the end of the agenda template for ARAC, BPPAC and QSEAC on Ibabs. The minutes capture these reflections and any actions are taken forward and considered for shared learning. The following actions will be undertaken: • Extend reflective summary to include time for a reflection on the administration and conduct of the meeting. • Ensure all Board level committees have a reflective summary on agendas and understand the purpose of this requirement.	April 2019	Board Secretary

Recommendation	Management response	Completion date	Responsible officer
Operational meetings R3 To free up capacity for both executive and operational teams, and to enable a more joined-up focus on the use of resources, the Health Board should streamline the number of holding-to-account or performance review meetings with operational teams by: • reviewing the frequency and timing of these meetings; • reviewing the location of these meetings, to improve visibility of the executive team; and • aligning these meetings with management sessions contained within job plans for clinical directors to enable them to participate fully.	Agreed to review the PMAF and how this fulfils the wider organisational objectives, not just NHS outcomes. At this stage the Health Board is unlikely to step down the HTA process as financial discussions/plans do require more time than current performance management meetings allow. This aspect will be reviewed at the end of June 2019-20. As much as possible the Health Board aligns job plans and arranges operational meetings at a time convenient for clinical leaders, the Health Board also recognises that clinicians' leadership roles are normally on top of almost full-time important productive clinical roles, and it is sometimes difficult to completely align all medical leadership sessions across the Health Board. Therefore, the interaction with and support of other members of the triumvirate (manager and nurse) who are normally in full-time positions are key to allowing the medical leaders to be effective. The operational and medical leadership structure is being reviewed and expected to be implemented in Q1/Q2 of 2019-20.	June 2019 September 2019	Director of Planning, Performance, Informatics and Commissioning/ Turnaround Director Medical Director/ Director of Operations

Recommendation	Management response	Completion date	Responsible officer
Strategic planning R4 To ensure the delivery of its health and care strategy, the Health Board should seek to resolve the outstanding request for funding from the Welsh Government to support the capacity needed to implement the strategy with the intended timescales.	Funding has been agreed for the Health Board by the Welsh Government for the 2018-19 financial year, and this allocation has been provided in Month 10.	Complete	Director of Finance
Financial sustainability R5 To support its longer term financial position, the Health Board should ensure that the Finance Committee continues to develop its role and to provide increasing scrutiny and challenge on the plans to achieve efficiency savings in the medium to long term.	One of the key operational objectives of the Finance Committee is to undertake detailed scrutiny of the organisation's overall performance against savings delivery and the cost improvement programme. It receives updates at each meeting on delivery and challenges progress. More detailed work regarding savings strategy for 2019-20 and beyond is being presented to the Committee for scrutiny and will continue to be on a regular basis.	Complete	Director of Finance

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