

Paper: Recovery Plan

Where there is an outstanding action for the Health Board this is highlighted by bold and underlined text in the Health Board Response field.

Unplanned cost pressures within/partly within HDdUHB's control

The table below summarises the key cost pressures above plan together with their impact prior to mitigation and the recommended action. The Health Board's response to the recommendation is also provided.

RAG rating key:

 No impact on EOY outturn

 Low impact on EOY outturn

 High impact on EOY outturn

Cost Pressure	Within HDdUHB control/outside of control	Full Year Impact if not mitigated	Recommended next steps	Health Board response
Long Term Agreements (LTAs) 	Yes, for LTAs	Net cost pressure of £1.1m (being mainly Swansea Bay: £0.8m and Cardiff: £0.4m) – included in run rate	<ul style="list-style-type: none"> Swansea Bay and Cardiff LTA performance review required over period October/ November with focus on: - Referral authorisation controls; - Hywel Dda University Health Board (HDdUHB) available capacity checks prior to authorisation. Review to be conducted by end November to analyse LTA activity being performed by other HBs together with the potential for HDdUHB to perform such activity if capacity was available 	<ul style="list-style-type: none"> The LTA budgets were zero-based for 2019/20 position, informed by the 2018/19 outturn plus known inflationary and other growth cost pressures. However, by nature there will always be an element of volatility due to demand and acuity of patients. There is now a contracting approach to repatriate activity whilst reducing activity through expedited discharge and end to end pathways.
Demand on Acute Services 	Yes	Significant overspend of £7.6m: £3.1m Unscheduled Care (mainly Wilybush)	<ul style="list-style-type: none"> Continued focus on demand reduction to decrease variable pay issues arising on surge – to be incorporated into emerging clinical strategy. 	<ul style="list-style-type: none"> Demand management is being incorporated into our approach for 2020/21, better recognising the link between demand and financial performance. Winter pressures funding has assisted with overspends

Cost Pressure	Within HDdUHB control/outside of control	Full Year Impact if not mitigated	Recommended next steps	Health Board response
		General Hospital (WGH) of £2.0m); £0.6m for Radiology and £0.7m Women & Children's Services	<ul style="list-style-type: none"> Consider pay establishment freeze if individuals not in post and long standing vacancy not being filled by agency. 	relating to surge in the latter part of the year. However this continues to be a source of cost pressure given the level of substantive vacancies, recruitment challenges and (over the winter months particularly) staff sickness rates.
NICE and High Cost Drugs ●	Limited–some patients on pathway which cannot be changed	Secondary drug cost pressures mainly for Oncology. Full year impact of £1.6m	<ul style="list-style-type: none"> Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification. 	<ul style="list-style-type: none"> Any opportunities to prescribe alternative, clinically appropriate, drugs have been captured within savings schemes. A Pharmacy Leads workshop was conducted in January 2020, which assigned Leads to specific service areas focused on areas of variation.
Primary Care Prescribing ●	Limited	Cost pressure greater than £1.2m for revised prices for Primary Care drugs by Pharmaceutical Services Negotiating Committee (PSNC)	<ul style="list-style-type: none"> Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification 	<ul style="list-style-type: none"> As above. A priority Value-Based Prescribing Review has been completed, and has highlighted the areas of Prescribing to be targeted to improve value-based prescribing, manage demand, and improve delivery against national prescribing indicators. Analysis by cluster and British National Formulary category, prioritised by level of expenditure, highlights <u>actions in Cardiovascular, Endocrine, Central Nervous System, Pain Management, Diabetes and at a cluster level Amman Valley and Llanelli.</u>

Cost Pressure	Within HDdUHB control/outside of control	Full Year Impact if not mitigated	Recommended next steps	Health Board response
Continuing Health Care (CHC) ●	Partially	Cost pressure of £0.2m due to increased demand and complexity of cases (note: pressure is partly mitigated by increased investment of £3.4m.	<ul style="list-style-type: none"> Continue the development of Core and Community-based services for Mental Health & Learning Disability (MH&LD) Transformation – to be incorporated into emerging clinical strategy. Develop Joint Funding Guidance. 	<ul style="list-style-type: none"> Both recommendations form part of the clinical strategy. There is recognition that a number of more complex patients thus requiring increased packages of care. Community based services for both general CHC and MH&LD are being devised, so that these services can be wrapped holistically around the patient. This will support the market and wider costs associated with CHC.
TB Costs ●	No	Estimated at £0.8m. Potential for costs to increase to c. £1m based on extended screening programme. Expectation of funding from WG.	<ul style="list-style-type: none"> Regular meetings being held with Public Health Wales to monitor the number of active cases. Currently being managed by HDdUHB internal resources. 	<ul style="list-style-type: none"> This continues to apply. A new model for a TB team is being put in place to support a sustainable long term strategy,
Final Pension Charges ●	No	Full year impact of £0.4m based on 3 cases.	<ul style="list-style-type: none"> Seek advice on managing pensions risk, including discussion with WG. 	<ul style="list-style-type: none"> No further significant issues have been identified.

2019/20 Potential Initiatives

The following pipeline schemes will require further work to quantify and plan the changes:

Category	Initiative	Indicative annualised value £'000	Actions to accelerate
Commissioning	Mobile Catheter lab to repatriate activity from neighbouring Health Boards and reduce spend and potential to sell capacity.	300	Value to be quantified and PID finalised Q4 19/20
Commissioning	Cardiology - Pacing - 3 months of local provision and reduce spend.	200	Discussion with Service Lead and quantification for Q4 19/20
Radiology	MRI capacity issues –review utilisation to reduce outsourcing costs	200	Discussion with Service Lead and quantification for Q4 19/20
Medicines Management	Pharmacy / medicine spend - Low priority funding treatment expenditure reduction.	150	Discussion with Service Lead and quantification for Q4 19/20
Medicines Management	One-off reduction in stock holdings. Excess medicine stock - Reduce stock days to average to reduce obsolescence and disposal costs. (Non recurrent).	100	Discussion with Service Lead and quantification for Q4 19/20
Planned Care	Theatres: Out of hours provision Bronglais General Hospital.	TBC	Further discussion with Planned Care Service Leads and Finance required if it can be accelerated in 19/20.
Planned Care	Theatres: Standardisation / bulk ordering schemes extension.		
Planned Care	Waiting List (WL): Centralisation of WL across HB, increased flexibility and use across sites.		

Category	Initiative	Indicative annualised value £'000	Actions to accelerate
Planned Care	Outpatients Department (OPD): Apprentices in OPD bringing potential to re-evaluate the current B2 roles and B4/5 roles.		
Planned Care	OPD: Linking with Phlebotomy re. nurses currently undertaking blood tests in OPD.		
Planned Care	OPD: Collaboration with Primary Care regarding location of clinics in HB.		
Planned Care	Urology: SKYPE clinics		
Planned Care	Urology: Patient knows best		
Planned Care	Rheumatology: 1 stop ERA pathway on 1 or 2 sites		
Planned Care	Orthopaedics: Reduction WL / Backfill costs by employing movable consultant.		
Planned Care	Ophthalmology: Age-related Macular Degeneration (AMD) in non-NHS setting.		
Planned Care	Ophthalmology: Pre-assessment model review		
Non pay inflation assumptions	Anticipated inflationary impact of 0.54% Mainly for utilities, rates, estate maintenance and medical equipment contracts for service and repair. Reduce prices and defer spend.	500	
CHC	Review of CHC packages for Community and Mental Health patients.	500	
Ward staffing review	Review of ward staffing -Nurse staffing act impact.	200	

Health Board Response:

The above items are included in the Opportunities Framework.

2020/21 and Beyond - Potential Initiatives

The following initiatives require service changes and are likely to have a longer lead time and require further work to quantify and plan the changes:

Category	Initiative	Indicative annualised value £'000
Learning disabilities	Service review to transform learning disabilities.	1,500
Community	New models of district nursing care which make use of mobile technology could increase productivity and deploy remote monitoring services whilst increasing the number of patient contacts.	500
Mental Health	Service modernisation - To review adult mental health packages of care (£275k), to increase supported living provision (£20k) and to review contract arrangements (£38k).	333
Rationalise - Medical coding	Medical coding - follow above aggregation per medical records.	200
Commissioning	Review SLA with Swansea.	120
Commissioning	Review of income recovery for treatment of out of area residents.	100
Rationalise - Medical records	Medical records - shift first from five repositories, to one, then moving to electronic records.	TBC
Procurement	Review spend on equipment across 3 areas - hypothesis that there is opportunity to standardise.	
Procurement	Podiatry - patients appliance budget - working with procurement and outside to find cheaper stock.	
Service redesign	Palliative care opportunity - overarching strategy and approach across three areas.	
Facilities	Maintenance contracts – increase use of in-house provision.	
Commissioning	LTAs/SLAs - To review current Long Term Agreements and Service Level Agreements.	
Planned care	Ophthalmology: Emergency Nurse Practitioner (ENP) for Rapid Access Consultation and Evaluation Unit (RACE) opportunity for workforce redesign.	
Planned care	Ophthalmology: Extended roles in nursing.	
Workforce	Transforming our hospitals: Align with Transforming Clinical Services (TCS) pathway review/ workforce redesign for the future introduction of Physicians Associates on the medical wards and Emergency Department, Advanced	

Category	Initiative	Indicative annualised value £'000
	Nurse Practitioners, Emergency Nurse Practitioners and Care of the Elderly / Rehab departments and initiate service redesign in line with our strategy.	
Service redesign	Transforming our hospitals: Withybush General Hospital (WGH) Improve Cardiology services commissioned to neighbouring Health Boards Develop and enhance the Frailty Model within WGH (subject to Business Case approval) Review and enhance day surgery services	
Service redesign	Standardise Community Care pathways including a revised model for assessment of ADHD patients to support reduction of current waiting times and achievement of the 26 week Neurodevelopmental assessment target	
Workforce	Theatres: Flexible job planning for surgeons, run surgeons as a group rather than in portfolios	
Service redesign	Waiting List: Telephone hub for endoscopy	
Service redesign	Orthopaedics: Robotic knee surgery development	
Service redesign	Ophthalmology: Hub and spoke model	
Service redesign	Ophthalmology: Day surgery centre	
Facilities	Benchmarking - specific areas: Areas identified from Corporate Services / Facilities benchmarking eg high energy costs, staffing numbers and mix in support services etc	
Mental Health	Introduce liaison officers at each acute hospital to reduce pressure on Mental Health care	
Back office	Reduce the overhead of support services - "back office"	2,280
Review on call Paediatrics	Implement Paediatric Task & Finish Group proposals to review on-call consultant cover in the south of the UHB	To be quantified by the Health Board
Review Stroke	Review of services	
Review Breast	Review of services	
Service redesign	Review of dementia and EMI services for specific improvement programmes	
Community	Review community pharmacies service and enhanced service provision	800
Primary care	Review and aggregate administrative and management functions for four managed practices	300

Category	Initiative	Indicative annualised value £'000
Rationalise - Sterile services	Sterile services - have 4 departments - short term operational improvement opportunities; medium and longer term potential to rationalise services	300

Recommended actions to accelerate:

- Discussions required with service to test idea, route to cash and develop action plans;
- Opportunities based on interviews and benchmarking and efficiency documents but require testing and work up with Operational Leads.

Health Board Response:

- Based upon our strategic direction, “A Healthier Mid & West Wales”, the Health Board already has long term transformation plans in train, underpinned by three distinct programmes that directly focus upon communities, hospitals and Mental Health & Learning Disabilities respectively. As noted by KPMG above, this section of potential opportunities are likely to have a longer lead time and horizon.
- An Opportunities Framework has been developed and rolled out from January 2020, in part being tailored to complement/ inform these transformation strategies. This approach is designed to evaluate, record, disseminate and follow up all material opportunities notified to or generated by work within the Health Board. The above opportunities have been added to this formal process.
- The opportunities themselves will directly feed into the organisation’s hierarchy where possible, to direct the opportunities to an appropriate Lead, and this will best fit the more improvement/ technical efficiency/single specialty-oriented opportunities. The more complex/ transformative/ allocative efficiency/ multi-directorate opportunities are likely to be directed to Senior Leaders in the first instance, which will include making them directly available to the relevant Transformation Programme for consideration as and when appropriate during their standardised Discover, Design, Deliver (3Ds) project cycle. Please also refer to ‘Hywel Dda Way’ as our response in the Delivery Framework section.
- Alongside this, a Value-Based Healthcare approach will complement more holistic and systemic review of conditions and pathways, aiming to ensure that quality and outcomes are captured, alongside relevant costs, and that Value through the prudent and effective use of resources is either sustained or improved by transformative change.
- Note: for the “Back Office” item, the Executive Director of Finance will be **leading a project to refine support services**.

Paper: Delivery Framework

The purpose of this report was to review the Delivery Framework in place within HDdUHB and provide recommendations that will enable the Health Board to achieve their Control Total in 19/20 and achieve a sustainable financial trajectory going forward.

The existing arrangements were reviewed at various management levels and across various functions and recommendations have been provided to enhance and strengthen delivery of the financial position at various points during this programme. This was undertaken through a mix of interviews, surveys and observations at meetings and working group meetings with the senior Finance Team, Workforce Manager, PMO Project Manager and Turnaround Director, and review of key documentation. The key meetings that were observed included the Holding To Account (HTA) meetings, Finance Committee, Audit Committee, and Directorate finance meetings.

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RAG rating key:



Room for improvement



To be addressed as a matter of importance



To be addressed urgently

1. Turnaround Governance and Accountability

The following section outlines the findings and recommendations of a review of the arrangements supporting the monitoring and challenge of the savings plans, risk assessment of the plans and reporting arrangements. The objective is to strengthen the Delivery Framework to support delivery of the savings plans. Most of the issues relate to effectiveness of the process; compliance issues have been flagged as such.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Directorate financial performance meetings	1.1 Monthly Directorate financial performance meetings are held at Month end. Weekly meetings to discuss operational finance and savings scheme performance may be held during the month and are variable in content and frequency. [Process issue]	<ul style="list-style-type: none"> Weekly Directorate meetings with the Triumvirate, Finance Business Partner, Human Resources (HR) and Project Management Office (PMO) (where appropriate) to be established with agreed agenda so actions to progress savings are turned around quicker and pace increases; use of leading indicators to take timely corrective action. 	●	Executive Director of Finance (DoF)	<ul style="list-style-type: none"> All Directorates have at least monthly meetings, with many Directorates now having weekly meetings, however these are yet to have a <u>consistent format or lead indicators</u>. Those Directorates not yet in a weekly cycle represent an area of focus as part of the new processes and

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		<ul style="list-style-type: none"> Proactive ideas generation and closing the gap actions at the weekly meetings 			transformation and other support teams, and will evolve during 2020/21.
Directorate financial performance meetings	1.2 The attendance includes the Clinical Director, General Manager, Nursing Lead and Finance Directorate. The teams report on the financial performance however the level of proactive planning, challenge and support to close the gap is variable, as is the weekly forecasting	<ul style="list-style-type: none"> Information for the meetings to be agreed to ensure constructive challenge and support. Forecasts to be updated on a weekly basis as agreed with the service 	●	DoF	<p>The Lead Indicators gap will be addressed through the Power BI reporting tool (more detail in section 4).</p> <ul style="list-style-type: none"> Savings tracking and reporting is refreshed weekly. The “Hywel Dda Way” has been launched, which will provide a new project management structure to facilitate and strengthen this process. The HR Business Partnering model business case is included in the Draft Financial Plan for 2020/21.
Directorate financial performance meetings	1.3 The schemes and reporting are more transactional rather than transformational. This appears to be due to capacity and capability (project management and understanding of savings delivery) gaps.	<ul style="list-style-type: none"> Finance Business Partners (FBP) and PMO to provide challenge, support and coaching to develop more transformational schemes with the rigour of project management tools 	●	DoF	<ul style="list-style-type: none"> The Opportunities Framework (see section 2.2) will capture both transactional and transformational opportunities and provide a platform for a decision making process to convert into savings schemes. The governance of reporting “rejected” opportunities to Finance Committee will ensure that

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
					<p>there is appropriate challenge and rigour in the process.</p> <ul style="list-style-type: none"> • A “<u>Building Opportunities for Delivery</u>” workshop is scheduled in February 2020 with a wide finance, clinical and operational representation to facilitate Health Board-wide, cross-service and cross-site opportunity identification. • The “Hywel Dda Way” will accelerate the Health Board’s strategy, which is focused on transformation.
Directorate financial performance meetings	1.4 The level of constructive challenge provided by the Finance Business partners at these monthly meetings is variable	<ul style="list-style-type: none"> • Prioritised areas KPIs and dashboards to track delivery of schemes to be used by FBPs and appropriate training on tools for route to cash and operationalising schemes 	●	DoF	<ul style="list-style-type: none"> • Finance Business Partnering is not yet fully embedded in Finance or the culture of the organisation, having been the operating model for less than a year; however this is now fully resourced and gaining traction with the service. • The DoF will begin a process of <u>sitting in on local meetings to gauge performance</u> and improve consistency and quality. • The Lead Indicators gap will be addressed through

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
					the Power BI reporting tool (more detail in section 4).
Directorate financial performance meetings	1.5 Ownership and engagement from clinical directors is variable	<ul style="list-style-type: none"> Clinical engagement and ownership to be consistently strengthened through coaching and allocation of protected time. 	●	DoF	<ul style="list-style-type: none"> A Medical Leaders Forum has been established to provide a platform for clinical leads to engage and influence one another. A Financial Development Plan will support a change to the organisation's culture. Organisation Development are running a senior leaders training programme with representation from corporate, clinical and operational teams, which supports the coaching objective.
Holding to Account meetings	1.6 Currently 8 Directorates are engaged with the HTA process chaired by the Executive Director of Finance, the Turnaround Director (now Executive Director of Finance), and the Chief Operating Officer attending whenever possible and 8 that are escalated to the Chief Executive Officer (CEO). The CEO HTA apply to Directorates that require further escalation (also attended by the COO, DoF, Turnaround	<ul style="list-style-type: none"> Strengthen directorate performance and accountability sessions so the majority of schemes are proactively managed and issues resolved in a timely manner with only those that require Executive support escalated to HTA meetings. The HTA meetings need to be weekly/fortnightly for high-risk areas and higher value schemes. The de-escalation will need to be introduced in a phased manner as the 	●	Turnaround Director (now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> HTA savings reporting has been refreshed to prioritise high risk schemes and ensure that HTA discussions are appropriately focused. The HTA Framework will follow a risk based approach. The Director of Operations has reviewed his operational structures and our reviews will follow his revised structure.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	Director (now Executive Director of Finance) and Nurse Director). The number of Directorates in escalation suggests a push upwards of responsibility to problem solve. [Process issue].	<p>Directorate level governance becomes more robust.</p> <ul style="list-style-type: none"> Consider aggregating Directorates to units/ divisions for more effective management. 			<ul style="list-style-type: none"> Assessing the service on a locality basis is part of the strategy. The current best proxy is the combined HTA meetings in place for Unscheduled Care and Counties which allows discussion of the interaction between Community and hospital(s) in each county.
Holding to Account meetings	1.7 The attendances at the meetings observed seemed to be good with the Operational Lead and Finance Lead attending, however engagement from clinical leads was variable [Compliance issue]	<ul style="list-style-type: none"> Triumvirate attendance at the HTA meetings needs to be mandatory so it is being driven by the Clinical Lead. 	●	Turnaround Director (now Executive Director of Finance)/ CEO	<ul style="list-style-type: none"> A small number of areas have achieved this consistently. See 1.6 above.
Holding to Account meetings	1.8 There is an escalation process, the HTA meetings have a drumbeat and Executives assign protected time to attend, showing it is a priority for the organisation; however, it can be strengthened. [Process issue]	<ul style="list-style-type: none"> Increase frequency and focus on fewer high risk areas so majority are being resolved at Directorate and workstream level 	●	Turnaround Director(now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> As the weekly Directorate financial performance meetings grow in maturity (see above) this will be able to be achieved.
Holding to Account meetings	1.9 There was no link to the workstreams within the observed HTA meetings although there were themes that came through as issues. [Process issue]	<ul style="list-style-type: none"> Themes need to be supported and resolved at the Workstream meetings that are led by Executive Senior Responsible Officers in a proactive and timely manner and only if unable to resolve should be escalated to 	●	Turnaround Director(now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> Applying the “Hywel Dda Way” to HTAs will resolve this.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		HTA. Regular feedback loop to workstreams from HTA meetings.			
Holding to Account meetings	1.10 There are standard dashboards supporting these meetings and preparation sessions by the Directorates. However, a number of the Directorates did not come prepared with worked up ideas to close the gap and the discussion for new ideas happened at the HTA level rather than Directorate level. Therefore, some of the issues discussed were not material in value. [Compliance issue]	<ul style="list-style-type: none"> Strengthening the weekly Directorate and workstream meetings will help filter the issues discussed at the HTA meetings. Prioritisation criteria for the HTA meetings to be agreed, with examples of schemes in delivery that are slipping by value (amber/red schemes that should have turned green), and plans to close the gap. 	●	Turnaround Director (now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> As the weekly Directorate financial performance meetings grow in maturity (see above) this will be able to be achieved. HTA savings reporting has been refreshed to prioritise high risk schemes and ensure that HTA discussions are appropriately focused.
Workstreams	1.11 The workstreams have generic terms of reference that need to be customised to the workstream. They are led by an Executive SRO, who oversees and drives the programme; effectiveness is variable depending on the workstream. It is attended by operational representatives from the Directorates, however, they do not have a Clinical lead. [Process issue]	<ul style="list-style-type: none"> Workstream governance to be strengthened with clear roles and responsibilities and accountability/ reporting arrangements to the Programme Board and fortnightly formal meetings with Clinical Lead, project management tools and PMO support. Feedback loops required to Directorate and HTA meetings. 	●	Workstream Exec SROs	<ul style="list-style-type: none"> The “Hywel Dda way” will redirect resource to co-ordinate all Health Board projects, feeding into governance forums to create a means of working and managing projects.
Workstreams	1.12 Theatres Productivity has been stood down as a turnaround workstream. The intention is to run it as an	<ul style="list-style-type: none"> It is suggested Theatres Productivity is monitored and reported as part of the Turnaround Programme, as the 	●	Workstream Exec SROs	<ul style="list-style-type: none"> See 1.11 above.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	operational workstream and there has been an initial meeting but the risk is that it does not get the required focus from the Turnaround Programme. [Process issue]	Values work has identified a significant opportunity.			
Workstreams	1.13 There was minimal PMO support, HR, Finance and Information Management and technology (IMT) support which is a contributing factor to lack of pace. [Process issue]	<ul style="list-style-type: none"> PMO, HR, Finance and IMT Lead to be assigned to main workstreams eg theatres, OP, Ops effectiveness 	●	Workstream Executive SROs	<ul style="list-style-type: none"> See 1.11 above.
Workstreams	1.14 There is no consistency in the use of dashboards and KPIs reflecting performance on a timely basis. At the observed meetings, there was a lack of robust project management tools and processes such as programme plans, KPIs, proactive forecasting and risk logs. There was an action log however there was insufficient pace and work between meetings, potentially reflecting the lack of capacity. [Process issue]	<ul style="list-style-type: none"> Refresh of dashboards and responsibility to be assigned for circulating the dashboards and KPIs for the meeting. Programme plan, KPIs, forecasts and risk logs to be used as standard tools in addition to action logs with leads and deadlines. 	●	DoF	<ul style="list-style-type: none"> See 1.11 above The Power BI reporting tool (more detail in section 4) will be extended to ensure consistent and meaningful <u>dashboards</u> are produced <u>for each workstream</u>. A draft <u>dashboard</u> was completed for some <u>workforce metrics</u> in January 2020 – once this is <u>finalised</u> it can be piloted before the equivalent dashboards are designed.
Workstreams	1.15 The route to cash was also not clear from the work being discussed.	<ul style="list-style-type: none"> Route to cash to be agreed for all schemes at Project Initiation Document (PID) stage. 	●	DoF	<ul style="list-style-type: none"> This will form part of the 20/21 planning and in-year process.
Executive Turnaround	1.16 There was good attendance from most Executives at the observed	<ul style="list-style-type: none"> It is suggested that the challenge and associated actions have greater rigour and pace with 	●	CEO	<ul style="list-style-type: none"> See 1.11 above.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Programme Board	Turnaround Programme Board but the effectiveness can be enhanced. This is a monthly forum where Executives provide oversight of the programme and a level of challenge to SROs. [Process issue]	deadlines between the formal meetings and frequency is increased to fortnightly meetings.			
Executive Turnaround Programme Board	1.17 With regard to content, the Group went through all the Amber-rated schemes and assigned Executive Leads to progress them. The agenda can be amended to be more effective as it does not reflect prioritisation of schemes that have maximum benefit. [Process issue]	<ul style="list-style-type: none"> It is suggested that the Amber and Red-rated schemes are progressed at workstream and Directorate level, and summary updates are provided at the Programme Board, with high risk areas and decisions required being raised. at the Programme Board, based on scheme value. The focus of the group needs to be weighted towards closing the gap from the Directorates and workstreams rather than existing schemes as the HTA meetings should deal with these. 	●	CEO	<ul style="list-style-type: none"> See 1.11 above.

2. Savings Plans

The following section outlines the findings and recommendations of a review of the arrangements supporting the monitoring and challenge of the plans, planning process, reporting arrangements and risk assessment of plans. The objective is to strengthen the Delivery Framework to support delivery of the savings plans.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Process	2.1 There is a PID and Quality Impact Assessment (QIA) process that has been established as part of the Turnaround Programme.	<ul style="list-style-type: none"> This is the first year that PIDs and QIAs have been developed and approved. 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> This process will continue and be improved by the implementation of CAMMS, an electronic project management system.
Process	2.2 The identification of schemes is undertaken annually at year end for the following year and therefore the new year starts with a gap in addition to slippage of schemes. The continuous planning of savings opportunities is not robust within workstreams and at best is variable e.g. Outpatients is more advanced than other workstreams. [Process issue]	<ul style="list-style-type: none"> The identification of schemes and PIDs development needs to be a continuous cycle through the weekly Directorate sessions and regular workshops so there are sufficient schemes coming through the pipeline to cover slippage as well as being proactive for the following year. Workstream agenda to include a continuous cycle of planning and provide the steer and challenge to deliver savings. 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> An Opportunities Framework is under development (first draft was presented to the Executive Team in January 2020) to capture in one location identified opportunities. This combines internal benchmarking, Finance Development Unit (FDU) and KPMG analysis, existing workstreams and directorate ideas/schemes. The process will be to capture opportunities as widely as possible to identify leads to assess and validate whether the opportunity can be converted into a formal savings scheme, at which point there is an agreed Finance, Service and Executive Lead and the savings governance process is applied. Any “rejected” opportunities will

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
					be formally reported to the Finance Committee for appropriate scrutiny and challenge. An audit trail of decisions will therefore be available on the Framework.
Process	2.3 The quality of PIDs is variable and the Red Amber Green (RAG) rating is variable with a strong optimism bias and route to cash not clearly articulated. [Compliance issue]	<ul style="list-style-type: none"> The Directorates need further coaching on PIDs completion so there is consistency of key aspects eg. Key Performance Indicators (KPIs) and route to cash identified and RAG rating in the tracker, reflective of the planning stage and/or delivery risk. 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> See 1.11 above
Process	2.4 The PIDs are submitted to the PIA to quality check and hold centrally, There is insufficient capacity within the PMO to perform this function for over 100 PIDs all coming through over a similar time period (1 PMO manager)	<ul style="list-style-type: none"> Capacity within the PMO needs to be increased to support the governance and project management support/ challenge of the schemes. 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> See 1.11 above – the “Hywel Dda Way” will ensure that a consistent management approach is adopted across the Health Board. The CAMMS system will ensure that all required fields are completed.
Content	2.5 There is no differentiation between high and low value PIDs.[Process issue]	<ul style="list-style-type: none"> Consider having a threshold for PID requirement c25k 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> The agreed threshold from 20/21 is £100k.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Governance	2.6 Of the 107 amber/green schemes over 50k, 43 did not have PIDs, these were mainly corporate and medicines management although there were a few other Directorates as well. [Compliance issue]	<ul style="list-style-type: none"> There needs to be consistency for PIDs requirement for schemes over an agreed threshold value 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> For 20/21 all Directorates will be required to prepare PIDs for schemes >£100k. The “Hywel Dda Way” will ensure that a consistent management approach is adopted across the Health Board.
Governance	2.7 The PIDs were approved by the DoF and TD (now EDoF) and Nurse Director. The Medical director was not involved in reviewing the QIA. The schemes did not have formal QIA approval although they were all reviewed and feedback provided. [Compliance issue]	<ul style="list-style-type: none"> Consider having an electronic approval process. The QIA needs to be signed off by the Medical director as well. QIAs to be formally approved for schemes. 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> The CAMMS system has a hierarchy of mandatory escalating approvers which is tailored to the organisation.

3. Planning and Budget Setting

The following section outlines the findings and recommendations of a review of the 19/20 financial planning and budget setting arrangements.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
19/20 Annual planning and budget setting	3.1 The 19/20 Annual planning and budget setting commenced in August 2018 with the approach and plan detailed in a Finance Committee paper tabled in Sept 18.	The KPMG review and budget survey has identified significant improvements required to strengthen the annual planning and budget setting process.	●	DoF	<ul style="list-style-type: none"> A “Building Opportunities for Delivery” workshop is scheduled in February 2020 with a wide finance, clinical and operational representation to facilitate Health Board wide, cross-service and cross-site opportunity identification.
	3.2 Finance BPs initially worked with budget holders to populate a budget template (using month 5 18/19 outturn, adjusted for non- recurrent items, existing cost pressures, new unavoidable cost pressures, new developments and investments, savings plans, capital investments and workforce). These were then sent to general managers for review, approval and final submission to the Finance Planning Team for aggregation. The Planned Care Directorate template was only partially completed for cost pressures with some marked as TBC.	<p>Recommendations include:</p> <ul style="list-style-type: none"> An Executive hosting a budget setting workshop to set out the planning process with all Directorate budget holders/ employees with budget holder responsibility and their supporting Finance Business Partners to confirm accountability and need for collaboration. 		DoF	<ul style="list-style-type: none"> The Investment Schedule templates have been refreshed to increase the robustness of plans and to clearly identify sources of funding and assessment of financial and clinical benefits. The “Building Opportunities for Delivery” workshop will focus on the acceleration of the Strategy and this will also focus on demand and activity.
	3.3. The Directorate returns were then aggregated by the Finance Planning Team with overlay of national planning assumptions e.g. increased income allocations and pay awards and HDdUHB strategic	<ul style="list-style-type: none"> Finance challenge sessions to be hosted to ensure completion of templates and to test the robustness of assumptions made to support the preparation of robust plans, including: <ul style="list-style-type: none"> Alignment with HDdUHB strategy; Testing triangulation of demand/ activity forecasts and workforce (including capacity modelling and setting budgets based on actual establishment i.e. not prior year spend) 			

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	service developments.	<ul style="list-style-type: none"> ○ Focus on addressing the drivers of the deficit; 		DoF	<ul style="list-style-type: none"> • The Opportunities Framework will address this (see 2.2 above).
19/20 Annual planning and budget setting	<p>3.4 The aggregated HDdUHB 19/20 plan for income and expenditure was reviewed at a high level basis by Finance, focusing on the bottom line deficit position.</p> <p>3.5 A uniform percentage cost reduction target was applied to all Directorates to deliver a planned deficit of £29.8M. Survey results -The results highlight low percentage ratings for: — Confirmed budget holder involvement:</p> <ul style="list-style-type: none"> • Overall = 49%; £3M — £10M = 89% • BUT >£10M = 50% • Setting of realistic budgets: Overall = 43%; £3M £10M = 33% and >£10M = 14% • Integrated budget informed by operational plans: Overall = 37%; £3M - £10M = 45% and >£10M = 21% 	<ul style="list-style-type: none"> • Test the robustness of assumptions, including completeness of cost pressures, supporting evidence for new cost pressures, approvals for new service developments and completeness of risks and opportunities identified, taking into account key learning from the current year (e.g. unplanned cost pressures and known demand changes); • Honest and transparent conversations regarding savings targets to develop realistic and achievable plans owned by Directorates and budget holders (supported by analysis and benchmarking). Any gaps to planned deficit should be highlighted to enable savings schemes to close the gap 	●	DoF	<ul style="list-style-type: none"> • The robustness of financial assumptions has been challenged internally within Finance. Work that needs to be built on for the 2021/22 planning cycle is the identification of non-recurring gains that are reflected in the ongoing Directorate position. • Significant work has been undertaken on the Opportunity Framework during 2019/20 and embedding this as part of the 'Hywel Dda Way'. This process will be a continuous process and not a process that stops and start with the Planning Cycle.
19/20 Annual planning and budget setting	3.6 Base budget deficit of £29.8M (including Cost Improvement Programmes – CIPs) was flat-phased equally	<ul style="list-style-type: none"> • Budgets (including supporting savings targets) should be appropriately phased and take into account key learning from 	●	DoF	<ul style="list-style-type: none"> • The Financial Plan provides the overall quantum of budgets for the year, the Business

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	into 12 months in the original plan submitted to WG (WG). Survey results -The results show a high % for appropriately phased budgets across all budget holder groups: Overall = 76%	the current year (e.g. seasonality trends, M12 accounting adjustments, number of working days and expected timing of key events to allow meaningful variance analysis as the year progresses).			Partnering teams have the flexibility to review and revise the phasing of their budgets.
19/20 Annual planning and budget setting	3.7 The budget was updated for full year forecast outturn at M9. The overall budget deficit of £29.8M was however maintained despite run rate cost pressures of £1.4M through pay assumptions (for example the Agenda for Change pay award) being reduced by a corresponding amount.	<ul style="list-style-type: none"> To maintain the integrity of budget assumptions and consequent performance reporting and forecasting for the budget year, new cost pressures based on review of existing run rates should be investigated and accounted for (where not capable of being mitigated prior to the budget year commencing) with savings targets updated accordingly. The planned introduction of Power BI will enable HDdUHB to plan based on 'run rates' which are activity-driven. 	●	DoF	<ul style="list-style-type: none"> The content of the 2020/21 Financial Plan has been refreshed monthly since September 2019 as updated information has become available on cost pressures and revised forecasts.
Budget approval and signoff process	3.8 A 'draft interim' plan was presented to the Board on 28th March 2019 and approved for onward submission to the WG. 3.9 The Finance Team then retrospectively initiated the process of signing off budgets from the Directorates with a letter sent to 52 budget holders on 10 April 2019, to be returned by 23 April 2019.	<p>The KPMG review and budget survey has identified significant improvements required to strengthen the budget approval and signoff process.</p> <p>Recommendations include:</p> <ul style="list-style-type: none"> A review of budget holders and employees with budget responsibility to be undertaken to 	●	DoF	<ul style="list-style-type: none"> Review of budget holders undertaken in 2019/20 by Deputy Director of Finance, there are currently 11 Executive Level and 44 Senior Manager budget holders who will be expected to sign off accountability letters for 2020/21 budget.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	<p>However, there are approximately 182 budget holders and 200 individuals with budget responsibilities in the Board. As at month 5, signed accountability letters are still outstanding for the Chief Executive Officer (CEO) and Primary Care (due to some historic discrepancies to be concluded during September). Letters were not sent to all budget holders as there was not capacity in Finance to explain budgets at that level to all budget holders.</p> <p>3.10 The plan was revised to a Control Total deficit of £25M (approved by the Health Board in May) to reflect Control Total agreement with WG with the additional savings requirement of £4.8M back end-loaded. (compliance issue).</p>	<p>ensure appropriate spans and layers of authority/ delegation;</p> <ul style="list-style-type: none"> All budget holders and those with budget responsibility to be required to agree to their budgets prior to submission and approval by the Board and prior to submission to WG before the start of the new year (the annual planning cycle needs to allow sufficient time for this while budget preparation monitoring arrangements need to escalate non-compliance to the Executive). 			<ul style="list-style-type: none"> Accountability letters will be sent out by 6th March 2020 for return by 20th March 2020.
Budget approval and signoff process	<p>3.11 It is noted that:</p> <ul style="list-style-type: none"> There is no cascade process in place that requires lower level budget holders to agree that they will adhere to their budget and the required procedures. The current system is email-based, which is less 	<ul style="list-style-type: none"> Consider the possibility of an electronic signoff system. Such systems can be used for multiple issues (e.g. that other policies have been read and will be adhered to). 	●	DoF	<ul style="list-style-type: none"> Work is undertaken between HR and Finance to align the Financial Plan but timelines need to be aligned to ensure that there is sufficient time for triangulation between, HR Finance and Operational teams

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	<p>robust and more time-consuming and prone to errors than a policy management system.</p> <ul style="list-style-type: none"> Budget holders have up to 45 active cost centres to manage. <p>Survey results -The results show a low % for signoff of budgets: Overall = 37%; £3M - £10M = 44% and >£10M = 57%</p>				<ul style="list-style-type: none"> Consideration will be given/ has been given to establishing a Performance and Finance Committee. The Finance Committee was set up to specifically deal with the Financial Agenda of the organisation in turnaround. The Transformation agenda is currently reviewed, managed and supported through the Strategic Financial Planning Group and the Strategic Change Finance Director.
Alignment of Planning, Finance, Workforce and Transformation	<p>3.12 In developing the financial plan, there is a lack of robust alignment between operational, workforce, activity and financials. This is reflected in the relative silo working of the various teams.</p> <p>3.13 This lack of alignment is also reflected in having two separate committees for Finance and Performance and therefore the decision-making process is not aligned.</p> <p>3.14 In addition to the above there is no clear roadmap from the current state (operationally,</p>	<ul style="list-style-type: none"> There needs to be closer working between HR, Finance and Operations in developing the Operational and Financial Plan, with clear links to reflect how the plans impact on each other. Consider having a Performance and Finance Committee Develop a robust roadmap to Transformation with Transformation teams supporting the priorities of the organisation at every stage of its improvement journey including Turnaround. 	●	CEO	<ul style="list-style-type: none"> Work is underway between HR and finance to align the Financial Plan. Consideration has been given to a Performance and Finance Committee. The Finance Committee was set up specifically to deal with the financial agenda of an organisation in turnaround, and this remains necessary. However, better alignment of operational

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	financially and in terms workforce) to the Transforming clinical services strategy that is aligned to the annual plans				and financial reporting is being undertaken.

4. Financial Management/ Reporting

The following section outlines the findings and recommendations of a review of financial management and reporting arrangements.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Monthly reporting on Health Board performance to Board and committees	<p>4.1 Reports showing financial performance against budget are prepared on a monthly basis for the Health Board as a whole.</p> <p>4.2 The Finance & Turnaround Update and Finance Committee papers are in a consistent reporting format for Month 1 with the same level of detail provided to each. This raises the risk of duplicate discussion and impacts the ability of the Finance Committee to provide assurance / complete its remit.</p> <p>4.3 Papers presented to the Health Board report historic positions and focus on providing background to Year To Date (YTD) positions and savings delivery, for example, no cash flow forecasts are provided. There is also limited</p>	<ul style="list-style-type: none"> Review the information provided to ensure that it enables the user to identify where areas of challenge are to take appropriate action. Report by speciality in addition to Directorate as this is likely to result in additional challenges/ opportunities being identified. Include appropriate financial and non-financial KPI and workforce and activity information to triangulate performance. Reports should also include required actions, dates for completion and progress made. A summary page which shows the position by Directorate – YTD Actual, YTD Variance, Forecast, Forecast Variance, Savings YTD (Act vs Target), Savings (Forecast vs Target), Risk would link it all together and could be 	●	DoF	<ul style="list-style-type: none"> The Finance paper has been shortened to provide greater focus on key information. The same report is provided to Board and Finance Committee for consistency, however Finance Committee is now provided with a supplementary report providing more detailed Directorate level and technical information. This will allow Finance Committee to properly fulfil its remit. Scoping work is underway for specialty and locality intelligence reporting. A Power BI project has been launched, led by Finance, to identify and validate non-financial metrics, such as activity, and assess the linkages to financial performance. This will be an

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	<p>view of the medium / long term in the papers which could inhibit completeness and accuracy of risks reported in risk registers.</p> <p>4.4 As there are a significant number of Directorates (38), the Finance and Turnaround Update report shows only the largest 14 Directorates, with others grouped together. This reporting shows Directorate YTD financial performance against budget without any further specialty split or full year financial forecast for HDdUHB or Directorates</p>	<p>RAG rated to provide clarity on key items.</p> <ul style="list-style-type: none"> • Reports need to focus on analyses of actual run rate trend and forecast outturn as opposed to variances of actual to budget for YTD and full year. • Ensure the reports are aligned to the savings tracker and ledger. 			<p>iterative process to initially triangulate core and available drivers, progressing to capture data which may need improvements to quality or availability and to identify areas where new data recording processes need to be implemented in order to continuously improve.</p> <ul style="list-style-type: none"> • The Finance Paper has a dedicated section to the forecast financial outturn, which factors in savings forecast. There is also a dedicated section for the savings forecast. • Monthly finance dashboards are currently produced for every directorate and circulated to budget holders to inform on-going discussions with FBPs and the HTA process. These include the suggested financial information and action log in the Recommendation. • Both the Finance Papers and the directorate dashboards are produced using the same ledger and savings tracker data.
Monthly reporting on	4.5 The papers present results at a Directorate level and then	<ul style="list-style-type: none"> • A rolling 12-month cash position forecast (i.e. past year end) 		DoF	<ul style="list-style-type: none"> • See section 4.1-5 above.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Health Board performance to Board and committees	<p>consider specific HDdUHB line items such as pay expenditure, non-pay expenditure, income and savings. This creates a fragmented report, which can make it difficult for a user of the report to identify consistent messages and trends.</p> <p>4.6 The lack of consistency throughout the papers makes it difficult to identify specific trends or themes, for example, is not possible to identify through the reporting which Directorates have an improving or worsening position over time. This clarity would assist in highlighting areas of concern or potential future risks earlier in the reporting cycle.</p> <p>4.7 In the ledger, HDdUHB offsets the planned deficit for the year through a corresponding reserve 'income' adjustment to set a balanced budget. This reserve can then be re-phased in the year to 'smooth out' actual performance for aggregated Health Board performance.</p>	<p>should be prepared to support the I&E forecast.</p> <ul style="list-style-type: none"> The Board should not smooth out any monthly fluctuations in YTD or full year budget phasing through release of central reserves –as this impacts the robustness of the monthly variance analysis. The planned introduction of Power BI and activity profiling will help inform understanding and forecasting of monthly performance. 			<ul style="list-style-type: none"> Cash-flow forecasting is an area of lesser risk compared to the financial outturn. Assessments of end of year strategic cash requirements from WG are regularly assessed and reported to WG from Month 6 to year end. However, for 2020/21, a rolling cash forecast will be implemented and reported to the Finance Committee. The planned deficit is not "offset" as described – it is a centrally held gross line. Variances to budget are described both in terms of variance to breakeven and operational variance (i.e. variance to plan) for clarity. The description of Reserves is inaccurate – these are not treated as Income – Reserves is a centrally held budget which is allocated to Directorates once an appropriate phasing profile can be validated.
Monthly reporting on Health Board performance to	4.8 HDdUHB monitors in-year performance for each Directorate, comparing actual performance versus budget.	<ul style="list-style-type: none"> HDdUHB should compare actual YTD performance with the original plan. If there are material changes to circumstances which 	●	DoF	<ul style="list-style-type: none"> The comparison of financial performance against live budgets is appropriate if budgets are permitted to be

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
Board and committees	<p>However, the budgets being compared are the updated budgets, with no comparison of actual performance against original plan / budget.</p> <p>4.9 Additionally, HDdUHB reports the 'variances' to these revised budgets in their management reports, and comments on month-on-month changes to variance to plan - real performance against plan is therefore difficult to understand if the budget has been changed or reserves have been re- profiled.</p>	<p>warrant updates to the budget, the management reports should compare actual YTD performance with the revised plan, as well as show the original plan as part of the analysis, supported by commentary.</p> <ul style="list-style-type: none"> • Reports and in-year performance management need to focus on actual run rate trend and forecast outturn as opposed to variances to budget for YTD and full year outturn. By being forward looking, the capability of Finance and BI functions can support the front line to take corrective, timely action to improve forecast performance (particularly given variance analyses is backward looking with budget assumptions often outdated). The quality of reporting for Board members and the WG to understand likely full year outturn and actions required to improve is also significantly increased 			<p>fluid during the financial year, as this ensures that the ledger is the single source of "truth". Budgets are fluid during the year to allow for virements between Directorates, savings scheme adjustments (e.g. newly identified schemes), recognition of e.g. workforce structure changes etc.</p> <ul style="list-style-type: none"> • It was not possible to track performance against the original plan in 2019/20 as no process had been implemented to ensure this was possible. For 2020/21, a <u>clear audit trail of the planned growth areas of income and expenditure</u> will be recorded, which will allow in-year performance tracking. • The <u>forecasting process is being refined</u> ahead of 2020/21 with a view to improving the accuracy of the directorate and Health Board-wide level forecasting.
Financial reporting to Directorates	<p>4.10 A monthly finance dashboard for each Directorate is produced and provided to budget holders. This details in-month performance against plan, actual and normalised</p>	<ul style="list-style-type: none"> • This is a strong start to increasing grip on Directorate performance and addresses some of the development points raised above. In addition, we would recommend: 		DoF	<ul style="list-style-type: none"> • The forecasting process is being refined ahead of 2020/21 with a view to improving the accuracy of the directorate and Health Board wide level forecasting.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	<p>expenditure trend, saving plan performance, pay trend (by type of staff and nature of spend e.g. substantive, bank and agency), non-pay trend (drugs, clinical and other) and projected outturn. In addition, the dashboard highlights some operational indicators (e.g. surge pressures), key required actions together with responsibility and due dates.</p>	<ul style="list-style-type: none"> ○ Expanding the current forecast model to reflect 12 month actuals and 18 months forward look which is then underpinned by statistical analyses, demand and capacity modelling, operational ‘business’ drivers (together with agreed in-year tolerances/ early warning indicators to highlight when action is required) and planned outcomes (financial and non-financial). 			<p>Prophix, as the embedded software, will provide the platform to produce annual and three-year forecasting.</p> <ul style="list-style-type: none"> ● However, this will not be as sophisticated as incorporating demand and capacity modelling. This type of modelling would not be in the remit of Finance, so would require an alternative “owner”. Further, the data required and complexity of the model would be beyond current capabilities – this would be a longer term strategic aim. Non-financial outcome data is also in a state of infancy across the NHS.
<p>Financial reporting to Directorates</p>	<p>4.11 Financial information is not provided to budget holders of individual cost centres. Budget holders are able to review their financial position through QlikView though it is unclear how extensive use of this functionality is.</p> <p>Survey results:</p> <ul style="list-style-type: none"> ● A high % of budget holders have access to monthly management accounts or 	<ul style="list-style-type: none"> ● Training for budget holders to use QlikView and/ or monthly emails to budget holders of the financial performance against budget, with appropriate follow up by the relevant BP where adverse. ● Update QlikView if required to ensure the reporting is user-friendly and enables effective management. 		<p>DoF</p>	<ul style="list-style-type: none"> ● The need for budget holders to access Qlikview will be replaced by the Power BI reporting tool (more detail in section 4). ● Regular training for budget holders is provided by both the Finance Systems Team and Finance Business Partners. ● An audit report is available to identify which users are accessing Qlikview and to what extent.

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	<p>budget reports: Overall = 96%</p> <ul style="list-style-type: none"> • Most budget holders report within 2 weeks of month-end (36% of budget holders however responded with 'not applicable' which implies that they are not involved in month-end reporting). • A high % do not undertake validation of the monthly management accounts: Overall = 46%; £3M - £10M = 33% and >£10M = 29% 				
Financial reporting to HTA (Holding to Account meetings)	<p>4.12 There are a standard set of reports for the monthly HTA meetings which highlight YTD variances to plan and full year forecast outturn on a Directorate level based on forecast run rate, risks identified, mitigations (where developed) and opportunities. However the forecast savings do not match the CIP tracker forecast that is reported in the monitoring returns [Compliance issue].</p>	<ul style="list-style-type: none"> • There needs to be one version of the truth between the CIP tracker and HTA documentation with an owner reconciling the two information sets — Reports need to focus on analyses of actual run rate trend and forecast outturn as opposed to variances of actual to budget for YTD and full year. 		DoF	<ul style="list-style-type: none"> • WG guidelines for the completion of the monitoring returns does not allow any changes to the plan values for savings schemes and, as such, the plan values do not match the live tracker (which generates the HTA reports) which is reconciled to the financial ledger. The financial ledger, tracker and HTA report all match and reconcile to the Finance Papers presented to Board and Finance Committee. The reason for this is to maintain a focus on the real situation and risks/ issues rather than on the budgeted plan at the

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
					beginning of the financial year.
Workforce Reporting	4.13 Ensure workforce reporting focuses on key elements of variable pay spend (agency, bank, overtime etc.) and supports the financial reporting	<ul style="list-style-type: none"> Weekly/ monthly reporting as appropriate to areas of the Health Board (including Directorates) in relation to staffing based on agreed metrics and covering all staffing groups but focused on variable spend. — Establish a headcount tracker and reconcile to workforce information systems, underling data sets and all reports to ensure 'one version of the truth' for reported establishment 	●	DoF	<ul style="list-style-type: none"> As Workforce is a workstream, this will be addressed by the Power BI reporting tool (more detail in section 4). Limitations to reporting headcount and whole time equivalents currently exist in respect of the medical and dental cohort (substantive and temporary) due to data limitations and work needed on e-job planning (see Grip and Control Paper)
Savings Tracker	4.14 Forecasts are not consistently updated on the tracker although it is updated in the HTA documentation. Therefore monitoring returns do not have an updated savings forecast [Compliance issue]	<ul style="list-style-type: none"> Savings tracker must be kept updated on a 'live' basis and as a minimum weekly with owners for the schemes and overall tracker. There needs to be one version of the truth between the tracker and HTA documentation. 	●	DoF	<ul style="list-style-type: none"> The savings tracker is now refreshed weekly. The tracker records both the finance lead and service owner. The HTA report has been generated from the savings tracker for all of 2019/20.
Savings Tracker	4.15 RAG rating for schemes that are not expected to deliver is also not updated	<ul style="list-style-type: none"> The RAG rating on the tracker need to reflect the status of the PIDs with expected 'Go Green' dates that are monitored weekly. 	●	DoF	<ul style="list-style-type: none"> The RAG rating is updated and if a scheme moves between either Green/ Amber and Red the ledger is adjusted to ensure that it reconciles to the tracker – this practice has been in place for all of 2019/20. "Date to Green", "Date to Amber" and "Date to Red"

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
					fields have been added to the tracker, and the HTA process is used to escalate missed deadlines.
Savings Tracker	4.16 There is inconsistency of recording of pipeline and Red schemes in the CIP tracker with a number of ideas that are being worked not being recorded on the tracker. This means there is no visible central repository of a continuous savings pipeline	<ul style="list-style-type: none"> Pipeline schemes need to be recorded on a tracker and monitored with a 'Go Green' date on a weekly basis/ live basis 	●	DoF	<ul style="list-style-type: none"> "Ideas" was not a savings category adopted by the Health Board as this was not a recommendation in the FDU savings guidance issued for 2019/20 (which concluded that having too many RAG categories was overly complex). The Opportunities Framework will supersede this recommendation.
Reporting locations	4.17 While we recognise that Finance do know which sites cost centres relate to (though some are Health-Board wide), HDdUHB's ledger codes do not have corresponding locations tagged, making it difficult to track budget or spend by location. This is particularly relevant in relation to spend where there are controls at a site level (e.g. nursing agency).	<ul style="list-style-type: none"> Include mapping of cost centres to locations to assist in internal cost and efficiency benchmarking, identifying opportunities for efficient utilisation of resources across sites, consistent monitoring of financial performance across locations, and engaging with relevant frontline staff to collaboratively address budget variances. 	●	DoF	<ul style="list-style-type: none"> Cost centres have been reviewed and amended where appropriate. Locality based reporting will supersede this over 2020/21.
Reports preparation	4.18 We note that Finance prepares monthly reports from an extract of the ledger taken out from Oracle, processed in Qlikview, manually processed in MS Excel and subsequently	<ul style="list-style-type: none"> Review reporting processes to identify opportunities for automation and self-serve, to free Finance resource to deliver more value-added activity. 	●	DoF	<ul style="list-style-type: none"> Oracle data is not extracted as described – Qlikview is used for data extract as this is an automated direct feed of Oracle data. Excel is currently the only software

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	copied into MS Word with commentary added to it.				platform available to finance, so is used to generate automated analysis and graphs/tables using standard templates which are refreshed monthly. The Power BI tool (see section 4) will improve the automation of this process further, however it will still be a requirement to produce a written report in Word in order to provide a supporting narrative.
WG Monitoring returns	4.19 Savings forecasts in the monitoring returns did not reflect the risk associated with Green/ Amber schemes. This is due to the risks being considered as operational pressures in the returns and netted off against mitigating actions [Compliance issue]	<ul style="list-style-type: none"> It is suggested that savings forecasts are updated on a weekly basis with programme risks reflected in the returns and actions separately identified. 	●	DoF	<ul style="list-style-type: none"> The savings forecast (and associated RAG rating) in the monitoring return is identical to that reported to Board, Finance Committee and Directorates. A high level risk assessment of future non-delivery of those schemes is included in a separate Table of the monitoring return, as required by WG guidance. The Directorate forecasts will include any projected over/non-delivery of savings schemes as this will be a key factor in financial performance. The monitoring return Tables do not treat non-delivery of savings schemes as an operational

Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
					pressure – these are explicitly presented as gross items.

5. Financial Performance Management

The following section outlines the findings and recommendations of a review of financial management and reporting arrangements.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
Month end HTA performance meetings	<p>5.1 Any Directorate with an adverse variance to assigned budget, or a projected adverse variance to assigned budget of £200k or more, is escalated into the Holding to Account (HTA) process. Although the month end HTA meeting attended was well chaired, it highlighted opportunities for improved business partnering (e.g. the ability to be a critical but challenging friend) and the need for forecasting to be underpinned by operational drivers and associated tolerances/ early warning signs for required action as well as continued demand & capacity modelling.</p> <p>Survey results:</p> <ul style="list-style-type: none"> That the % of budget holders having regular monthly meetings with their finance manager to clarify 	<ul style="list-style-type: none"> There needs to be an increased focus on development of Finance Function capability, including effective corporate service business partnering through a potential finance function review and through provision of appropriate training. It is important that Finance transforms from a back office scorekeeper to a front line enabler for driving improvement. This can be achieved through a continued shift to a financial forecast management system. By being forward-looking ('mindset') and developing forecasts that are underpinned by an understanding of demand, what is required to service that demand and key operational 'business' drivers (together with their non-financial and financial impacts), corporate business partners (Finance, BI and workforce) can then develop the 		DoF	<ul style="list-style-type: none"> Finance Business Partnering is not yet fully embedded in Finance or the culture of the organisation, having been the operating model for less than a year; however this is now fully resourced and gaining traction with the service. See response to 4.10. "Toolset" will be enriched with the Power BI dashboards. A budget holder training framework is being developed as part of the finance strategy.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	<p>or explain variances is low at HDdUHB = 54% BUT high for £3M - £10M = 89% and >£10M = 93%</p> <ul style="list-style-type: none"> • A high proportion of budget holders do not keep a documented audit trail of actions being taken to address any variances (and their impact). Overall = 47%; £3M - £10M = 33% and >£10M = 36% • A high proportion of budget holders are not asked to report a projected year end budget position. Overall = 52%; £3M - £10M = 33% BUT >£10M = Nil% • A high proportion of budget holders felt they would benefit from receiving regular training on budget setting and monitoring. Overall = 77%; £3M £10M = 78% and >£10M = 64% 	<p>'skillset' to support the front line to plan effectively and to take corrective, timely action to improve actual forecast performance (including in-month).</p> <ul style="list-style-type: none"> • It will also require a change in toolset i.e. timely, visual system data and dashboards for operational drivers and in-month leading indicators to highlight deviation from budget/ forecast. • All budget holders with significant budgets should receive budget holder setting and monitoring training to improve the capability of HDdUHB for improving non-financial and consequent financial performance (quality, access, workforce, productivity and value). It is pleasing to see that a high number of respondents are seeking such training. 			
Business cases	<p>5.2 HDdUHB has revised its approval process (effective autumn 2018) for revenue business cases to improve grip on:</p> <ul style="list-style-type: none"> • Preparation, particularly evidence for alignment to HDdUHB's and Directorate strategy, options testing, 	<ul style="list-style-type: none"> • Whilst the process for preparation and sign-off of revenue business cases has been strengthened, it is important that the focus now shifts to monthly monitoring of actual post-implementation costs and benefits realisation for newly approved cases so that 	●	DoF	<ul style="list-style-type: none"> • A new investments template has been developed to require new business cases/ investments to demonstrate an expected 3:1 payback ratio before funding is authorised. The "Hywel Dda Way"

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	<p>planned financial and non-financial benefits and pay and non-pay investment.</p> <ul style="list-style-type: none"> • Required approvals; • Consideration through the relevant management (and accountability) structure and corporate functions including Finance and Workforce. This includes sign-off from Director, Directorate Manager, Other affected managers, Finance Business Partner; • Executive approval at fortnightly meeting (documented in minutes); • Finance Committee approval for all cases above £100k. 	<p>corrective action can be identified where required and key individuals held to account. This should include disinvestment if required.</p> <ul style="list-style-type: none"> • Given reviews are not currently taking place, we would recommend that the performance for all business cases (approved in the past 12 months and with significant planned benefits and investments costs) is analysed and a decision made on potential disinvestment where these are underperforming. 			<p>will bring consistency to the approach to business cases. This will include a <u>post-investment assessment of implementation costs and benefits. A review of investments in the last 12 months</u> will be conducted to assess the performance compared to the original business case.</p>
Finance Committee observation	<p>5.3a Our observations highlighted the following:</p> <ul style="list-style-type: none"> • There was appropriate challenge from the Chair and Independent Members ('IMs') throughout the agenda. Responses from Executive Directors ('EDs') and officers were clear and addressed the questions. For example: <ul style="list-style-type: none"> ○ IMs pressing for a completion date for outstanding action. 	<ul style="list-style-type: none"> • The meeting ran over time with a large volume of papers to review prior to the Committee, despite a number of items being deferred to later committees. Whilst the discussions summarised key papers and the presentation of the Finance Report highlighted key items, we recommend that the agenda is streamlined to reduce the volume of reports provided to each Committee. • RTT, establishment control and capital projects were not 	●	DoF / Chair of Finance Committee	<ul style="list-style-type: none"> • Papers are circulated a minimum of seven days prior to a Committee meeting to allow members sufficient time to read and consider. • Whilst the agenda is long, given the significant financial deficit, and the current adverse run rate against plan, the role of the Committee is critical and its remit requires a broad and up-to-date

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	<p>Clarification of whether surge beds were included within the forecast position and how this could be linked to DTOC.</p> <ul style="list-style-type: none"> ○ Requesting a report to come back to the Committee on grip and control following challenge around the management of bank and agency staff. ● The Chair focused on the need for assurance to be provided to the Committee, in line with the objectives outlined in the Terms of Reference. For example, the need to provide assurance on the balance of transactional vs transformational saving schemes, certainty of the pipeline and assurance over 2021 plan. 	<p>discussed due to time pressures – the reports did not appear to be key requirements and therefore may not be required each month. We recommend that such papers should be staggered over a three month period, with RTT being provided in month 1, establishment in month 2 and capital in month 3 to spread the volume of reports across the periods).</p> <ul style="list-style-type: none"> ● The Turnaround report was not discussed in detail as key items were already discussed in the financial report. Given the inherent links between the items, we recommend that the reports are merged so reducing the detail included in papers 			<p>assessment of the key drivers. The Committee’s workplan is kept under review as developments arise.</p> <ul style="list-style-type: none"> ● The Committee needs to be able to provide assurance to the Board in a timely manner on key financial areas of risk and pressure. ● Capital is typically a brief item during the meeting, unless there are exceptional circumstances. ● The Turnaround report provides members with scheme-level detail to enable them to provide detailed scrutiny of progress/ issues by scheme (questions are typically raised by exception). The Finance Report is very high level by comparison in order to present the Health Board-wide position. No change to these reports is considered appropriate at this time.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
Finance Committee observation	<p>5.3b Although the majority of the Committee was looking at the current financial position and focused on the short term, this reflected the timing in the financial year. There was discussion around the medium term, including the expected financial targets for the 2021 financial year.</p> <p>Detailed presentations were provided in relation to the financial position. This included detail of the Directorate positions and YTD and forecast position. The presentation clearly noted the 'risk' of £7.1m to forecast and £5m of savings and there was discussions around plans to mitigate the £12.1m gap.</p> <p>The close period at the meeting was used to reflect on the meeting and agree key items to be reported to the Board.</p>	<ul style="list-style-type: none"> The Finance Report contained a presentation and detailed report for committee members. The detailed report could be moved to a 'for information' section of the agenda, or provided as an accompanying paper, as the presentation picks out the key items for discussion. This will allow members with limited time to focus on other papers which are not presented in as much detail. 	●	DoF / Chair of Finance Committee	<ul style="list-style-type: none"> Papers are shared electronically using iBabs, members can choose to only refer to those papers which they wish to focus on as the agenda has hyperlinks to navigate quickly and easily to the relevant paper. Therefore there would be no real benefit in this change.
Finance Committee observation	<p>5.3c Each member of the Committee was given appropriate opportunity to present reports, with time also available for relevant challenge. Our analysis noted</p>	<ul style="list-style-type: none"> Given the heavy agenda for the Committee, it may not be beneficial to allocate such large portions of meetings to the Deep Dives. The Committee may also benefit from providing a template 	●	DoF / Chair of Finance Committee	<ul style="list-style-type: none"> It is important to retain 'Deep Dives' in order for the Committee to properly assess areas of concern or opportunity.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	<p>a relatively even split of discussion time between IMs and Health Board management.</p> <p>The Deep Dives gave useful information and background to the relevant areas, but the sessions lasted over one hour in total and it was not clear how the content discussed helped the Committee to address the objectives. For example, there was limited discussion over the savings plans or future financial challenges in the relevant areas</p>	<p>for Deep Dives to ensure the relevant information is provided and key areas addressed.</p>			<ul style="list-style-type: none"> It is noted, however, that some form of <u>guidance/ template/ key questions</u> could be provided to those presenting in advance to ensure that the outcome addresses the objectives of the Committee when instructing the <u>Deep Dive</u>.
Finance Committee observation	<p>5.3d There was limited reporting from HTA meetings or the Programme Board directly, with the Committee challenging EDs to provide assurance from these meetings.</p> <p>All reporting provided in the meeting focused on financial performance. Whilst this satisfies the remit of the Committee, the challenge from IMs often related to how this linked to performance, such as surge beds, DTOC, use of agency/ bank staff.</p>	<ul style="list-style-type: none"> There is a need for a reporting mechanism for HTA or the Programme Board to the Committee so that it can be assured that the meetings achieve their objectives and there is robust challenge and discussion. The Committee may benefit from increased integration with the relevant Performance Committees so that finance and performance can be reviewed as one integrated report to ensure members see the full picture. From the observed meeting, there are limited links to other 	●	DoF / Chair of Finance Committee	<ul style="list-style-type: none"> The Finance Committee is an assurance Committee; delivery is overseen by the relevant Executive Director reporting to the Chief Executive via the Executive Team. The Executive Director is the accountable officer and the governance arrangements are that the relevant Executive Director holds its hierarchy of budget holders to account. Escalation processes are

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		<p>committees. The Finance Committee has an objective to review financial control and therefore needs to ensure appropriate links to the Audit and Risk Assurance Committee (ARAC). For example, where finance related internal audit reports are reported to ARAC, the actions are referred across to be followed up by the relevant committee.</p> <ul style="list-style-type: none"> The Committee currently holds the EDs to account for performance – the Committee should look to hold Directorates to account directly, for example, through the Deep Dives, to ensure accountability takes effect at relevant levels within the UHB. 			<p>in place to provide oversight and assurance of the actions taken.</p>
<p>Audit Committee observation</p>	<p>5.4a Our observations highlighted the following:</p> <ul style="list-style-type: none"> The Chair and Independent Members ('IMs') provided appropriate challenge throughout the agenda. Responses from Executive Directors ('EDs') and officers were generally clear and addressed the questions. The Chair made it clear that Financial Performance was 	<ul style="list-style-type: none"> None 	<p>●</p>	<p>Board Secretary / Chair of Audit Committee</p>	<ul style="list-style-type: none"> n/a

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	<p>the remit of the Finance Committee and that the role of the Audit and Risk Assurance Committee (ARAC) was to provide assurance on wider financial matters via the Financial Assurance Report.</p> <ul style="list-style-type: none"> The Chair focused on the need for assurance to be provided to the Committee. For example, the need to provide assurance on the productivity and efficiency of UHB's estate, with a clear plan for how that could be achieved requested for the next meeting. Analysis of agenda items identified that the majority of the meeting was spent on items providing assurance rather than items for note or discussion. — Each member of the Committee was given appropriate opportunity to present reports, with time also available for relevant challenge. Our analysis noted a relatively even split of discussion time between IMs and UHB management. 				

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
<p>Audit Committee observation</p>	<p>5.4b From the observed meeting, there were clear links made to other committees. The Chair summarised clearly at the end of each item the actions that were required. For example, if a report needed to be presented at another committee or if an update to a later meeting was required.</p> <p>The meeting kept largely to time and lasted 3.5 hours. The volume of papers was large but members attending had clearly read papers beforehand and provided relevant comment and challenge. For example, one member, when referring to the Clinical Audit Annual Report, questioned how plans would need to change in line with the UHB's transition plans.</p> <p>— The Committee's Audit Tracker brings together and tracks recommendations from a wide range of external bodies, such as internal and external audit, but also Health Improvement Wales, Wales Audit Office and the Coroner.</p> <p>— A closed period at the end of the agenda was used to reflect on the meeting's</p>	<ul style="list-style-type: none"> The Audit Committee should streamline the audit tracker to enable more focus on the most high risk outstanding actions. 	<p>●</p>	<p>Board Secretary / Chair of Audit Committee</p>	<ul style="list-style-type: none"> The tracker is presented to ARAC for oversight to make the Committee aware of new external sources of assurance that have been issued and changes to the tracker since the previous reporting period to provide assurance that the Health Board is continuing to respond positively to recommendations it is issued with. It is important to note that the Red RAG-rated recommendations are also reported through the Performance Framework where pace of delivery can be challenged by the Executive Team. The tracker report to ARAC shows all open reports that have outstanding recommendations.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	effectiveness and agree key items to be reported to the Board.				
	<p>5.4c The Committee reviews audit recommendations via an Audit Tracker. The Tracker is very long (over 20 pages) and contains a lot of historic information. Many deadlines in action plans and audit trackers show evidence of slippage, despite tough challenge from lay members. For example, recommendations related to Consultant job planning remain outstanding from a review in 2016.</p> <p>The quality of papers and their delivery by managers varied. For example, the paper on Primary Care Applications Committee was clear and succinct and provided the Committee with the assurance they needed on progress. Whereas the Estates Progress Report, while succinct, did not provide the Committee with sufficient information to demonstrate assurance and prompted hard challenge from IMs. Some reports also contained unnecessary levels</p>	<ul style="list-style-type: none"> The quality of papers and level of detail contained in them should be appropriate to provide the Committee with sufficient assurance 	●	Board Secretary / Chair of Audit Committee	<ul style="list-style-type: none"> When reviewing progress against previous reports and management responses, the Committee has asked that the report includes the original report and the agreed management response, with clear updates detailing the action taken or to be taken to ensure recommendations are fully responded to. This is to ensure the Committee has access to all relevant information to enable constructive and robust challenge. The Committee will request progress updates where there have been issues with pace of delivery or non-delivery of actions to seek assurance.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
	of detail, such as the management response to the WAO job planning report with an appendix that ran to 21 pages listing the 23 original recommendations, although only two recommendations remained outstanding.				

6 Capacity and Capability; Culture and Leadership

The following section outlines the findings and recommendations of a high level review of the CIP capacity and capability and the culture and leadership observations over a 3-week period.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
Capacity	6.1 The capacity within the Directorates to progress schemes at pace is limited. Although there are actions that can be taken by having weekly directorate CIP meetings, the scale of change required within tight timescales is significant.	<ul style="list-style-type: none"> Project management support for larger schemes/ Directorates. Increase PMO/ Finance challenge at Directorate meetings 	●	DoF	<ul style="list-style-type: none"> See 1.1 and 1.11 above.
Capacity	6.2 The capacity within the Turnaround PMO is severely limited (1 project manager) and therefore it cannot support project management, challenge and delivery within the Directorates. To be noted that the organisation is recruiting 3 additional Project Managers to support turnaround.	<ul style="list-style-type: none"> The turnaround PMO for an organisation this size and in distress needs to be at least 6-7 people working alongside Finance with a project management, challenge, governance and monitoring function. Ideally there will be a central PMO function which can be used flexibly across Turnaround, Transformation, 	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> See 1.1 and 1.11 above.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		Planning and Service Improvement, depending on the stage of the organisation in its journey.			
Capacity	6.3 The capacity within Finance seems to be sufficient as per the new business partnering arrangement that have been put in place recently.	<ul style="list-style-type: none"> The Business Partners are aligned to Directorates; however there also needs to be Finance input into the workstreams 	●	DoF	<ul style="list-style-type: none"> See 2.2 above – the Opportunities Framework will address the finance input.
Capacity	6.4 Workforce does not have a business partnering model and therefore does not have the capacity to embed within Directorates to support the drive for savings schemes. They provide a level of support for specific projects.	<ul style="list-style-type: none"> Review the capacity and structure of the Workforce function to ensure there is sufficient capacity to support the significant workforce changes required to be implemented by the organisation 	●	Workforce Director	<ul style="list-style-type: none"> The HR Business Partnering model business case is included in the Draft Financial Plan for 2020/21.
Capability	6.5 The project management capability within the Directorates is variable but may also be impacted by capacity constraints.	<ul style="list-style-type: none"> Coaching in specific areas on an ongoing basis within the department will help upskill and maintain skills within the team 	●	DoF	<ul style="list-style-type: none"> A budget holder training framework is being developed as part of the Finance Strategy.
Capability	6.6 The Senior Finance Business Partners have experience and capability to support the Directorates. There are some coaching requirements for the Business Partners in areas such as weekly forecasting, risk assessment and providing challenge to the Triumvirate	<ul style="list-style-type: none"> Coaching in specific areas on an ongoing basis within the department will help upskill and maintain skills within the team 	●	DoF	<ul style="list-style-type: none"> All Finance Business Partners and Senior Finance Business Partners have attended interactive coaching training sessions. Further coaching and management training has commenced (“Senior Finance Leadership Programme”) in 2020.

Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
Clinical Engagement	6.6 The engagement of clinical leads at the HTAs is variable. This could indicate a reliance on Finance and operational leads to solve the financial challenge.	<ul style="list-style-type: none"> Commitment is required from the clinical leads with time allocated to support the programme; this may necessitate backfill support. Coaching for clinical leads by the PMO and Finance to drive the programme. 	●	Medical Director / Nurse Director	<ul style="list-style-type: none"> See 1.5 above.
Operational engagement	6.7 The capacity (in terms of financial savings) of the operational leads appears to be limited although they do attend the HTA regularly (which shows willingness). The capability gaps relate to project management/ delivery of savings.	<ul style="list-style-type: none"> Coaching for operational leads by the PMO and Finance to drive the programme. 	●	COO	<ul style="list-style-type: none"> See 1.11 above.
Executive leadership	6.8 The Executives are committed to the Turnaround Programme and have made time for the HTA meetings however there has been a softer approach with Directorates and workstreams. The slowness of pace of more complex transformational schemes could also be due to the political context in which the Health Board operates	<ul style="list-style-type: none"> To step up performance, Executives need to prioritise high value and high risk areas with a greater appetite towards more challenging options to close the gap. 	●	CEO	<ul style="list-style-type: none"> See 2.2 above – the Opportunities Framework will increase the focus and governance arrangements around considering all opportunities and moving the focus to pursue transformational schemes.

Paper: Assessment of 2019/20 Financial Plan

Where there is an outstanding action for the Health Board this is highlighted by bold and underlined text in the Health Board Response field.

Cost Pressures, Pre-Commitments and Inflation, Growth and Service Demand

A review of areas of cost growth identified and quantified in the 2019/20 Financial Plan was completed to assess the level of expenditure in relation to each area compared to Plan.

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
Pay Inflation	6.5	Impact of A4C and other pay settlements ('Out of Hours' holiday entitlement) as per national framework (average 1.86% uplift and 1% medical pay inflation).	No significant variation identified	None	<ul style="list-style-type: none"> n/a
Non-pay Inflation	3.3	Anticipated inflationary impact of 0.54% and additional cost pressures (provided by Directorates in Sept.18), mainly for utilities, rates, estate maintenance and medical equipment contracts for service and repair. Additional spend for Office 365 rollout.	Risk of in-year overspend given other non-pay YTD M6 adverse variance of £1.1 million	<ul style="list-style-type: none"> HDdUHB to conduct a review by the end of November to identify opportunities to negotiate reduced prices (to include benchmarking) - to be incorporated into savings programme/ opportunities identification To include identification of opportunities to defer spend (post impact assessment) for maintenance and medical equipment and identify alternative, more affordable, equipment and consumables. 	<ul style="list-style-type: none"> The Non-Pay Assurance Group meets monthly and considers the items listed. The Head of Procurement has identified the top 100 suppliers and is meeting to re-negotiate contracts – this work is on-going in 2020.
Continuing Health Care (community and mental)	3.1	Inflation estimate of £2.0m assumed (subject to negotiation later in the year) and activity growth of £1.0m - based on	No growth variation Potential full year inflation	<ul style="list-style-type: none"> Continued monitoring of potential £0.8m inflation benefit. HDdUHB review of potential for transfer of patients to lower cost 	<ul style="list-style-type: none"> The current assessment is that the planned reserve will be

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBbase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
health patients)		analyses of activity trends for past 5 years (prepared by CHC team in Sept. 2018).	saving of £0.8m based on YTD performance	care packages on transfer from healthcare setting to nursing home/ at home care needs to be expedited (deadline set for end of October) with reviews to become 'Business as Usual' - to be incorporated into savings programme/ opportunities identification	<p>sufficient, after accounting for the £0.8m benefit.</p> <ul style="list-style-type: none"> There is a weekly process, which reviews and scrutinises the current caseload. The purpose is to identify areas of opportunity for reducing and/or stepping down patients to lower cost packages. This includes all packages including high cost 1 to 1s and those patients in secure placements. Further, High Cost placements are only used when absolutely clinically necessary and there is no alternative.
Statutory Compliance	0.5	Implementation of external review recommendations for Shared	Recruitment delays in M1-	None	<ul style="list-style-type: none"> n/a

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
		Services Fire team (£0.1m) & Health & Safety Executive Compliance team (£0.4m) – provided by Directorates in Sept. 18.	M2 but posts now filled		
General Medical Services	0.9	Cost increases provided by GMS team based on 18/19 YTD M6 extrapolation for: - HDdUHB Managed Practices (£0.3m) and transfer of previous GMS practice (£0.2m impact); - Direct Enhanced Services for Care Homes and NOAC (anti-coagulation) of £0.4m.	No significant variation identified	<ul style="list-style-type: none"> Continued development of plans to support savings target of £0.8m based on transfer to GMS contract. If not successful, to include: <ul style="list-style-type: none"> Review of potential to close (to be completed by November) Targeted campaign to convert Locums to substantive. 	<ul style="list-style-type: none"> Converting managed practices back to independent status and Locums to substantive members of staff is a continuous area of focus and is linked to some in-year savings schemes.
Quality & Safety	0.3	All pay related to predominantly county schemes to address known quality and safety concerns provided by Directorate teams in Sept 18	No significant variation identified	<ul style="list-style-type: none"> Review whether resource requirement remains to deliver the quality improvement required. 	<ul style="list-style-type: none"> The review concluded that the current level of budget and spend is required.
Other	0.7	Wide range of cost pressures provided by Directorates in Sept. 18 with values of less than £0.1m (e.g. Unfilled GP shifts £0.1m, Equipment stores £0.1m, critical care & outreach £76k, ART – Part fund mainstream workforce £65k, Telemedicine £50k).	No significant variation–not tracked individually as immaterial	<ul style="list-style-type: none"> Even though these are small variances there needs to be a review conducted in October/November to identify opportunities to cease expenditure where it is not committed - to be incorporated into savings 	<ul style="list-style-type: none"> Control Total Action plans across all Directorates have required a review of all discretionary spend and any

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
				programme/ opportunities identification.	opportunities to defer spend.
Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and LTAs	6.1	Assumes 2% inflation (£1.9m) and growth (£4.2m) based on: <ul style="list-style-type: none"> • 18/19 YTD M6 extrapolated performance and known 19/20 service developments, supported by notification from WHSSC & WG and EASC; • Changes to risk share allocation assumed cost neutral. £1.7m risk of understatement due to increased 18/19 M6-M12 LTA activity (Swansea Bay and Cardiff and WHSSC). 	YTD LTA cost pressure of £0.4m for M1 to M6 and £1.1m full year (being mainly Swansea Bay: £0.8m and Cardiff: £0.4m)	<ul style="list-style-type: none"> • Swansea Bay and Cardiff LTA performance review required over period October/ November with focus on: <ul style="list-style-type: none"> - Referral authorisation controls; - HDdUHB available capacity checks prior to authorisation. • Review to be conducted by end November to analyse LTA activity being performed by other HBs together with the potential for HDdUHB to perform such activity if capacity was available 	<ul style="list-style-type: none"> • HDdUHB has worked closely with WHSSC on its arrangements and planning for next year. • Monthly activity flows are now reviewed. A number of monthly remedial actions are then agreed, such as, working with key specialties to reduce demand and/or repatriate activity.
NICE and High Cost Drugs	3.0	Forecast based on provisional estimates which subsequently aligned to the Horizon Scanning report released in November/ December.	Secondary drug cost pressures mainly for Oncology of £0.8m YTD M5 and £1.6m full year.	<ul style="list-style-type: none"> • Analyse opportunity to reduce costs over period by end of November through review and benchmarking of type and volume of drugs used based on patient conditions i.e. identify opportunity for alternative lower cost drugs and/or reduced usage. To be incorporated into 	<ul style="list-style-type: none"> • Any opportunities to prescribe alternative, clinically appropriate, drugs have been captured within savings schemes.

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
				savings programme/ opportunities identification.	
Demand on Acute Services	5.4	Relates mainly to non-delivery of 18/19 saving schemes to reduce Unscheduled Care activity of £3m (e.g. planned bed reductions). Additional pay establishment investment of £1.2m for Pathology agency consultant (£0.2m); Dermatology (£0.2m); Urology (£0.3m); Orthopaedics (£0.1m); Unscheduled Care (£0.2m); Radiology (£0.2m)	Overspend of £3.6m YTD M5 with significant full year overspend of £7.6m: £3.1m Unscheduled Care (mainly WGH of £2.0m); £0.6m for Radiology and £0.7m Women & Children's Services.	<ul style="list-style-type: none"> Continued focus on demand reduction to decrease variable pay issues arising on surge – to be incorporated into emerging clinical strategy. Consider pay establishment freeze if individuals not in post and long standing vacancy not being filled by agency 	<ul style="list-style-type: none"> Winter pressures funding has assisted with overspends relating to surge in the latter part of the year, however this continues to be a source of cost pressure, given the level of substantive vacancies, recruitment challenges and (over the winter months particularly) staff sickness rates.
Primary care developments	1.2	Includes £0.3M for Pacesetter, £0.2M for GP and Paramedic increases and £0.6M for Primary Care contract increases as notified by Directorates based on 18/19 YTD M6 extrapolation & known full year impact of 18/19 developments.	No significant variation	<ul style="list-style-type: none"> Contracting Team to review all 3rd party contracts (LTAs, SLAs, GMS and Other) over next 3 months for cost reduction opportunities and to introduce a Contracts Register and Contract Framework for improved grip to be incorporated into savings programme/ opportunities identification. 	<ul style="list-style-type: none"> A Contracts Register has been developed and a plan is in place to ensure all contracts are being fully reviewed to demonstrate value for money.

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
					<p>This will be used to inform the Opportunities Framework.</p> <ul style="list-style-type: none"> All contracts will go through a continuous process of review. All expenditure associated within said contracts must be justified by the relevant budget holder. Where value is not established, the contract/SLA will be terminated.
Primary Care Prescribing	0.7	Budgeted price increase for NCSO (No Cheaper Stock Obtainable) – only one supplier therefore limited bargaining potential, based on average growth in 17/18 and 18/19.	M5 YTD overspend of £0.5m for revised prices for Primary Care drugs by Pharmaceutical Services Negotiating Committee (PSNC). Full	<ul style="list-style-type: none"> Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification. 	<ul style="list-style-type: none"> Any opportunities to prescribe alternative, clinically appropriate, drugs have been captured within savings schemes

Cost Growth Area	£'m in Plan	Assumption/ EvidenceBase	Full year Impact if not Mitigated	Recommended Next Steps	Health Board Response
			year impact of £1.2m.		
Continuing HealthCare	0.3	Known demand increase for Mental Health from 2018/19 fully budgeted for based on 18/19 YTD M6 extrapolated	M5 YTD and full year cost pressure of £0.2m	<ul style="list-style-type: none"> Continue the development of Core and Community based services for MHLD Transformation – to be incorporated into emerging clinical strategy Develop Joint Funding Guidance 	<ul style="list-style-type: none"> Both recommendations form part of the Clinical Strategy
Nurse Staffing Act	1.0	Phased implementation over 2018/19 to 2020/21 (3 years) at £1m per year. Budget for 2019/20 has been allocated in M5 for implementation from M6.	No significant variation identified	<ul style="list-style-type: none"> Review potential to defer costs if appropriate. 	<ul style="list-style-type: none"> As this is a statutory requirement, deferring costs is not considered clinically appropriate.
Winter Pressures	1.0	HDdUHB has assumed costs of £1.0m (based on a potential Winter Plan forecast range of £1.5m to £2.5m). We note that HDdUHB has not assumed any winter funding given this is still to be announced. According to HDdUHB, any additional planned spend for winter pressures will only be incurred after funding is agreed.	No significant variation identified	<ul style="list-style-type: none"> Continue to develop and test winter plans to reduce costs where possible. 	<ul style="list-style-type: none"> Winter funding has been provided by WG and plans to utilise the funds have been completed. Weekly monitoring of the spend against plan is completed.
Integrated Care Fund	2.4	Pass through spend to match increase in ICF allocation for dementia and therapies.	No significant variation identified	<ul style="list-style-type: none"> n/a 	n/a

Paper: Financial Grip and Control

An experienced Turnaround and Financial Governance Team from KPMG reviewed the standard financial improvement controls across Hywel Dda University Health Board.

Where there is an outstanding action for the Health Board this is highlighted by bold and underlined text in the Health Board Response field.

RAG rating key:

 Room for improvement

 To be addressed as a matter of importance

 To be addressed urgently

Area	RAG	Recommendation	Health Board Response
Sickness Compliance with existing control		Reducing sickness rates can take time with benefits likely to be primarily in the next financial year. Focus on reducing sickness rates in areas which are significantly above average through identification of long term sick individuals, ensuring the relevant procedures have been followed and ensuring appropriate support to enable accelerated return to work is provided.	<ul style="list-style-type: none"> Focus upon Wellbeing, with events planned for early 2020/21. Training is being rolled out to managers, focusing on the Compassionate Leadership element. (HDdUHB continues to have the lowest sickness absence rates among the larger Health Boards. Sickness absence data is regularly issued to Directorates and discussed at HTA meetings, and is regularly reviewed at W&OD Sub-Committee meetings.
Agency booking process and control Environment and compliance failures		Communicate to agencies that only bookings made through the Bank Office will be paid for and put in place procedure to ensure this is adhered to. Holding to Account meetings to be held for those who circumvent the process (e.g. retrospective bookings) or who have unacceptably high agency spend. Introduce a cascade system for bookings based on time to shift, e.g.: — anything more than 15 days away is only visible to bank staff — 0-15 days is visible to bank and contract agencies Ensure that unfilled shifts which need to be filled are sent to the Bank Office >35 days from the date of the shift (i.e.	<ul style="list-style-type: none"> Letter to Agencies addressing limited access to agency on weekend sent in October 2019. Direct booking in Glangwili General Hospital (GGH) not allowed – in other hospitals direct booking is still done in response to increase in fill rate required due to winter pressures. Risk assessments are live for all areas for hours worked after 8pm. Tier the availability of shifts to agency – a trial is ongoing with an agency for block booking and cover requests. Block booking is maximised

Area	RAG	Recommendation	Health Board Response
		within a week of the roster being completed). Refresh and re-issue to all requesters and bookers the revised agency booking processes (along with seasonal reminders and kit-card/help cards).	<p>where possible dependant on on-contract agency cover.</p> <ul style="list-style-type: none"> • <u>Pilot Long Term Rostering</u> – this will be completed in line with the <i>Allocate</i> rollout.
<p>Controls over staff leaving the Health Board ('exit controls') Compliance failure</p>	●	<p>Whilst responsibility for exit date should remain with line managers, there needs to be (i) immediate communication to HR and Payroll (to reduce time to start recruiting to required roles and to reduce the risk of any staff overpayments) and (ii) an independent check that a decision is not unduly made to release staff early which places increased burden on remaining staff, as well as the need for agency staff – which will increase the financial cost to the Health Board.</p> <p>HR should ideally review the exit date of the employee after discussion and update payroll accordingly. Saving will largely relate to agency.</p>	<ul style="list-style-type: none"> • A Task and Finish Group has been set up, with representation from Finance, Payroll, ESR and Counter-Fraud Departments. • An <u>All-Wales Overpayment Policy</u> is being developed. Payroll Department will link in to ensure changes required to strengthen the process are included. • A <u>resource pack will be developed</u> to ensure all forms/ links to forms are easily accessed, and that there is clear signposting and clarity around the Termination process. • Communication will be sent to managers via the Global Email system and a <u>Manager's Communication List</u> will be developed, comprising managers within Manager Self Service (MSS) in ESR to allow reminders to be distributed. • Work is ongoing between HDdUHB and NHS Wales Shared Services Partnership (NWSSP) to develop <u>electronic forms</u> for roll-out in March 2020. An issue has been identified with regard to HDdUHB's roll-out of Office 365. IT will be tasked to identify whether this will impact the roll-out of the electronic forms. • <u>Overpayments</u> are in future to be <u>reported to the Directorate Performance Reviews</u> to ensure increased accountability.
<p>WTE budgets</p>	●	<p>Undertake a rapid establishment review (demand/capacity) of those areas which are over-budget. Focus on over-established Directorates first, as over-</p>	<ul style="list-style-type: none"> • The majority of areas that appeared to be over-established during the review period were found to be due to incorrect budgeted Whole Time

Area	RAG	Recommendation	Health Board Response
Control and compliance failure		established cost centres may be matched by an off-setting under-established cost centre. Where establishment is inappropriate, rectify in the financial system. Where genuinely over established, ensure the relevant parts of the Health Board which should challenge external recruitment/internal transfers (VCP, HR, Finance) are sufficiently robust to block requests which would result in over-establishment. Ensure no variable pay is being incurred and exit or transfer the excess staff. Review how Executives are held to account for their areas of the Health Board to ensure they are adequately challenged.	Equivalent (WTE) information in the financial ledger. These corrections have been made. There are a small number of genuinely over-established cost centres, which is due to the managed practices in Primary Care. These issues are being managed.
Rostering Compliance	●	Re-start the Rostering Efficiency Meetings to review rosters for the next week and cancel excess temporary staffing. Extend and accelerate e-rostering to all wards (and monitor impact on agency usage after changes made). We understand that there is a feature within the rostering system which requires the roster planner to sign off that their roster meets the policy. This should be switched on. Cease short duration agency bookings where possible by improving roster management. Ensure the balance of shift times is spread evenly across the workforce where possible.	<ul style="list-style-type: none"> ● Dashboard developed to provide reporting functionality to Health Board. To be validated and maintained. ● Demand and capacity detail to be discussed in an Allocate Project Implementation Group meeting with all rotas Red/ Amber/ Green (RAG)-scored prior to sign-off by Steering Group. This will run concurrently with the introduction of <i>Allocate</i>.
Overtime / additional hours Potential to strengthen control	●	Change the policy such that overtime will not be granted except in extraordinary circumstances where it will need to be approved by the Director of Nursing or their deputy and it will not be granted for less than 2 hours. Additional hours to be worked through bank. This will require effective planning and implementation to ensure appropriate usage of bank / overtime / agency staffing.	<ul style="list-style-type: none"> ● Overtime breakdown provided weekly to all Senior Operational Managers. ● Project Management Office (PMO) Team leading a review of overtime trends across all staff groups with a focus on alternative solutions. Estimated completion March 2020.
Target reduction Off-contract usage	●	Off-contract shifts to be approved by exception by Director of Nursing or Deputy Director of Nursing. Targeted focus on wards using significant off-contract to ensure rosters are developed in a timely fashion, unfilled shifts are advertised to the Bank Office in a timely fashion, hours	<ul style="list-style-type: none"> ● Clinical Decision Unit (CDU) specialist role to be confirmed. Discussions held with Nursing Directorate. ● Direct booking stopped in GGH only.

Area	RAG	Recommendation	Health Board Response
Potential to strengthen control		owed have been utilised, vacancy is well managed. We believe that the controls above should be introduced as a first step and then reviewed.	<ul style="list-style-type: none"> • Large gap in CDU establishment – <u>recruitment drive to support CDU</u>. • On-contract agencies unable to fill requirement over Winter pressure period from beginning of November. • Plan to review use of specialist Bank staff for CDU; Intensive Therapy Unit (ITU), even with specialist Bank staff, have had to increase use of off-contract staff due to Winter pressures. • Off-contract agency are also struggling to fill – with only a 49% cover rate in December 2019.
HCSW agency	●	HCSW agency requests to be approved by Director of Nursing or Deputy Director of Nursing. Along with dashboard reporting (and change in policy communicated to not use HCSW)	<ul style="list-style-type: none"> • Issues with Mental Health (MH) Recruitment – there is a <u>new plan for 2020/2021 to ensure HCSW for MH prioritised for Bank</u> and then Level 4 RSI Training. Issue raised around communications – in contact with • Communications Team to <u>set up Facebook page</u> for vacant shifts for HCSW. • Discussions held regarding moving variable pay into substantive posts; the average Bank cover for Band 2 staff 12 Full Time Equivalent (FTE) for per month between April and November 2019. Meeting arranged with MH Directorate in February 2020 to <u>look into the issues above</u>.
Paid breaks	●	Ensure that agency breaks are in line with contracts and review compliance	<ul style="list-style-type: none"> • This is complete with no issues noted.
High usage agency Control	●	Targeted recruitment programme for high usage agency. Consider implementing a pause for top ten agency workers where alternative cover is available and seek to recruit substantively, or other innovative strategies as determined by the Health Board. If successful repeat.	<ul style="list-style-type: none"> • The clinical risk means that a ‘pause’ is not a viable option at this time. • The Health Board will always seek to recruit substantively where this is possible and there are a number of targeted recruitment programmes on-going at any one time.

Area	RAG	Recommendation	Health Board Response
Policy on nursing staff returning as agency Control	●	Make bank more attractive to existing staff (see below). Understand drivers for leaving and put in place a retention programme. Ensure 6 month policy is enforced to make it less attractive to leave the organisation for agency working.	<ul style="list-style-type: none"> Bans live around leavers from HB Bank to agency within 6 months.
Promote Bank sign up Opportunity	●	<p>Concerted recruitment campaign to Bank. Implement other recommendations noted herein to make agency less attractive relative to Bank.</p> <p>Consider paying Bank staff at a high rate than current band (e.g. at Trusts we have seen payment to band 5 at band 6 rate). Although the financial impact and knock-on impact for substantive shifts needs to be considered and modelled.</p> <p>In line with other healthcare providers, the Health Board should consider auto-enrolment of all new staff onto the Bank (with an opt-out rather than opt-in approach adopted) to maximise availability of the Bank.</p>	<ul style="list-style-type: none"> Process changed for substantive nursing – staff now able to get secondary assignment within 72hrs working with Recruitment and Payroll. Allocate system has been procured and contract signed – to be implemented. Opt-out not viable at this time. A letter has been drafted to all Band 2 HCSW explaining Bank opportunities. Facebook page plan drafted – awaiting feedback from Governance before goes live. Work on-going with new nurses in the area and existing staff to sign them up onto Nurse Bank; also work on-going with community to provide a larger Nurse Bank.
Promote Bank usage Opportunity	●	Bank notification systems should be enhanced to ensure that Bank users can easily see what shifts are available and book on. (We understand that there is a setting within Roster Pro which can be enabled (R Roster Plus) which would allow staff to view and sign up for available shifts but that it has not yet been approved by IT). It is possible for shifts booked by agency staff to be replaced by Board Bank staff. At present, shifts which have been booked by agency staff are not visible to Bank staff.	
Rostering policy Control	●	Draft rostering policy to be reviewed and approved as appropriate. To include recommendations from this report and a review of the compliance (including swapping shifts, annual leave bookings etc.)	<ul style="list-style-type: none"> Overarching policy reviewed, and specific Nursing appendix added to provide guidance on efficient staffing of wards in line with nursing staffing levels in Wales in draft form. To be signed off by March 2020.
Job plans Compliance	●	Enable electronic job planning across all areas.	<ul style="list-style-type: none"> The Audit and Risk Assurance Committee (ARAC) has confirmed that e-job planning is now mandated from 01.01.2020. The trajectory for

Area	RAG	Recommendation	Health Board Response
		<p>Review all job plans (old ones as a priority) to ensure they are appropriate, efficient, in line with best practice and delivering best value for the Health Board.</p> <p>This is expected to reduce demand from agency/locum medical staff and from substantive.</p>	<p>full compliance (100%) of completed e-job plans is 31.12.2020. However, 100% <u>compliance for all job plans</u> (paper and e-job plans) is expected and on trajectory for 31.03.2020.</p>
<p>Rota management Control and Compliance</p>	<p>●</p>	<p>Transition to electronic rota preparation which offers improved visibility, control and assurance and would be expected to lead to a reduction in run-rate. They are also simpler to prepare and there is a drive across the NHS towards electronic rotas/rosters.</p> <p>This is expected to reduce demand from agency/locum medical staff and from substantive staff.</p>	<ul style="list-style-type: none"> • <i>Single Rota for A&E:</i> Conversations have been held with General Managers and Health Directors at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) regarding the potential benefits for improved rota management and associated efficiencies within Emergency Departments (ED). This initiative has been highlighted further by the additional fragility in both the Consultant and Middle grade rotas at these two sites, resulting from recent reductions in substantive staff members. An Urgent Response Group (URG) has been created to respond to this additional fragility, with a single rota proposal being one option considered. This <u>piece of work will be progressed by the A&E URG group</u>. Estimated completion by December 2020. • <i>Centralised Rota Management/Electronic Rostering System for Medical and Dental (M&D) Staff Group:</i> It is recommended that this be treated as a medium-term objective. The current Nurse rostering system is being upgraded, and e-job planning for the M&D staff group is being progressed. <u>These two programmes of work need to be prioritised</u>. Timescales will be influenced by capacity, linked to roll-out of new rostering system for Nursing and successful implementation of e-job planning. At this stage,

Area	RAG	Recommendation	Health Board Response
			<p>a date cannot be provided to progress e-rostering for medical staff.</p> <ul style="list-style-type: none"> • <i>Medical Bank Model to manage Demand and Supply for Roster Gaps:</i> HB representatives will shortly attend an NHS Wales workshop to review options for HB, Regional or NHS Wales Medical Bank models. Estimated completion date between 30.09.20 and 31.03.21 depending on NHS Wales work direction. • <i>Rate Control:</i> The Standardised Rate Card has already been implemented (October 2017). Any breaches of the Rate Card must be requested for approval by the Workforce Expenditure Control Panel.
Long term temporary staff	●	<p>Approach agency medical and locums who are working extensively at HDdUHB to seek to bring them on as substantive staff / communicate that the Health Board is actively reducing reliance on temporary workforce and therefore they may not have an on-going role unless it is substantive.</p> <p>Develop exit and succession plans for all long term agency / fixed term contractors – and require skills transfer and handover for any temporary workers not converting to substantive.</p>	<ul style="list-style-type: none"> • A meeting has taken place to improve tracking of exit strategies for agency workers, to include progress since last update and tracker against recruitment. The intention is to present this at Holding to Account (HTA) meetings, with variable pay metrics for medical staffing. The KMPG dashboard will include metrics relating to Medical Agency workers. A meeting took place in January to review all progress against the exit strategies. • A draft paper has prepared on the 'Refer a Friend' scheme. • Issues relating to conference attendance will be revisited through the Consultant Study Leave approval process and Medical Director newsletter.
Acting down and unpaid breaks Control and Compliance	●	<p>Use middle grade agency or substantive staff in place of Consultants acting down, at approximately 25% of the cost. Review instances where hours were 4, 8 or 12 to ensure that breaks were not claimed. Communicate with</p>	<ul style="list-style-type: none"> • Work is on-going, with review of current practices across the Directorates and an analysis of the shifts where Consultants have

Area	RAG	Recommendation	Health Board Response
		relevant agencies and communicate with all timesheet approvers (and specific emails to any who have not identified unpaid breaks being paid).	<p>acted down, identifying whether terms and conditions have been applied consistently.</p> <ul style="list-style-type: none"> • <u>A paper will now be finalised</u> and presented to the Executive Director of Operations, Medical Executive Director and Executive Director of Workforce & Organisational Development (W&OD) in the first instance to explore options for resolution and recommendations by the end of February 2020. • No action required with regard to Medical Agency cases, as rest breaks are deducted automatically using an electronic system for timesheet approval. <u>Internal ad hoc Locum cases link to a much larger piece of work to introduce a Medical Bank Model</u>, involving significant capacity requirements in order to complete at pace in this financial year. Further discussion needed, linked to the vision for a Medical Bank Model and to the pace of developments at NHS Wales level relating to this matter.
Agency mileage Control	●	Review terms of agreement with agency workers to remove mileage costs if material and being paid for travel from home. If arising due to work required at two sites in one day, seek to manage rotas so as to remove this requirement.	<ul style="list-style-type: none"> • Data audited. One example of 'home to assignment' mileage claimed in error by Agency Worker and approved in error by the Authoriser of the timesheet. Error addressed and refund being processed. Guidelines for authorisers of timesheets re-issued to stress that only internal mileage from base site of assignment to another Health Board site can be claimed.
On-call rates	●	On-call rates at Trusts in England we have reviewed have been agreed at 50%. Seek to reduce the agreed pay for non-resident on-call to 50% in discussions with the supplier.	<ul style="list-style-type: none"> • The Health Board works to an agreed reduction rate of 40% of the day time rate. It is often challenging to achieve this, given current labour market conditions.

Area	RAG	Recommendation	Health Board Response
Agency authorisation process Compliance	●	Hold to Account meetings to challenge Directorates as to why there are any shifts without approval. Monthly report of instances to be sent to the Executive.	<ul style="list-style-type: none"> All medical agency worker shifts are approved via the weekly workforce expenditure control panel which is Executive Director led.
Locum authorisation process Control	●	Considering this is the main driver of medical temporary spend, this should be controlled so that there is much greater visibility and control being exercised centrally to enable effective monitoring	<ul style="list-style-type: none"> For external Locums, a review of the authorisers have been completed and re-communication of guidelines will be issued. For internal Locums, a review of the control process and recording of shifts is underway.
Agency requests Control	●	The AG1 form at present does not include a requirement to specify the establishment and contracted position of the cost centre –this should be included.	<ul style="list-style-type: none"> See Agency booking process and control section above.
Discretionary spend	●	Targeted campaign to reduce these key spend areas through: deselection of catalogue choices on procurement, targeted emails to users of these items, removing relevant budgets (and finance to monitor compliance), dashboard reporting of non-compliance, providing guidance (and escalation channels) to reduce spend areas and procurement/finance to challenge requisitions in these areas.	<ul style="list-style-type: none"> Catalogue is continuously updated and reviewed monthly by the procurement team. This looks at reducing non-catalogue spend and replacing with catalogue /contract alternatives. From December 2019 to current month, 2,800 lines have been added. As well as more closely controlling discretionary spend and obtaining improved value for money, this also provides significant efficiency improvements across the P2P process. Additionally, discretionary spend is closely scrutinised as all non-cat / non-clinical requisitions are now personally reviewed and challenged by the Head of Procurement. These are then either approved or returned for further justification of the requirement or switched in to a contract alternative.
Month 12 spike Compliance	●	Close financial performance management in Month 11 and Month 12 (potentially including centralisation of historical underspends) to seek to defer, reduce or cancel spend which is outside of budgets or above normal run rate of spend	<ul style="list-style-type: none"> The Control Total requirements issued to Directorates in Quarter 3 for delivery in Quarter 4 included the need to defer, reduce or cancel expenditure outside of the delivery of core services.

Area	RAG	Recommendation	Health Board Response
Reduce clinical preference	●	Standardise supplies such that the number of suppliers for the same product are reduced to as few as possible. Setup clinical preference meetings (hosted by MD or similar) to make clinical preference decisions – supported by Procurement	<ul style="list-style-type: none"> The Head of Procurement has met with Transformational Director and PMO to start the establishment of a clinical governance and approvals process for driving <u>standardisation and innovation in the procurement of clinical consumables</u>. This is a work in progress.
Enforce no PO no pay policy Compliance	●	Continue the No-Purchase Order (PO) No-Pay Policy and monitor effectiveness on an ongoing basis to ensure suppliers in breach on a regular basis are identified at an early stage. As we are not able to identify the amount of 'inappropriate' POs or lost VFM without reviewing all non-PO items, we recommend the Health Board monitors and seeks to identify improvements in compliance and then determine any financial benefit to be quantified.	<ul style="list-style-type: none"> A dashboard has been developed to provide reporting functionality to Health Board. To be <u>validated and maintained</u>.
Business cases –post implementation review	●	Ensure that benefits in relation to business cases are tracked and where they materially deviate from expectations, reviews are performed to identify if the benefits can be improved.	<ul style="list-style-type: none"> The Investment Schedule templates have been refreshed to increase the robustness of plans and to clearly identify sources of funding and assessment of financial and clinical benefits.
Stock management	●	Update relevant policy to ensure that stock levels are brought into line with UK average and kept there. This benefit may affect working capital by reducing inventory levels (i.e. less cash tied up) but may also reduce stock wastage. The impact on wastage cannot be easily quantified as it is highly dependent on inventory changes throughout the year. We recommend the health board track these changes through wastage reports and then reduce the costs in the relevant budgets next year	<ul style="list-style-type: none"> The <u>Stock Management Policy will be reviewed</u> and updated in May 2020 in line with the Audit Committee's plan.