Bundle Finance Committee 20 May 2019

1 GOVERNANCE

1.1 Welcome and Apologies
Presenter: Chair

1.2 Declarations of Interest
Presenter: All

1.3 Unapproved Minutes of Previous Meeting Held on 25th April 2019
Presenter: Chair
- 1 3 Unapproved Finance Committee Minutes 25 04 19

1.4 Matters Arising and Table of Actions from Meeting Held on 25th April 2019
Presenter: Chair
- 1 4 Table of Actions 25 04 19

1.5 Finance Committee Outcome of Self-Assessment of Performance
Presenter: Huw Thomas
- 1 5 Finance Committee Outcome of Self-Assessment of Performance 2018-19 SBAR
- 1 5 Appendix 1 Finance Members Data
- 1 5 Appendix 2 Finance In-Attendance Data

2 FOR DISCUSSION

2.1 Finance Report Month 1
Presenter: Fiona Powell
- 2 1 Finance Report Month 1
- 2 1 Finance Month 1 Presentation

2.2 Turnaround Report Month 1 and Savings Plan
Presenter: Andrew Carruthers
- 2 2 Turnaround Report Month 1 SBAR
- 2 2 Turnaround Update

2.3 Financial Projections Report (Consolidated Risks from HTA Process)
Presenter: Huw Thomas
- 2 3 Financial Projections Report SBAR

2.4 RTT Month 1
Presenter: Keith Jones
- 2 4 RTT Month 1 SBAR
- 2 4 RTT spend Month 1 19-20

2.5 Establishment Control
Paper deferred

2.6 Capital Financial Management
Presenter: Huw Thomas
- 2 6 CRL Capital Financial Management May 19

2.7 Contracting Update
Deferred to June Committee meeting

2.8 Finance Team Strategy
Deferred to June Committee meeting

2.9 Year End Debrief
Presenter: Huw Thomas (Verbal)

2.10 External Finance Review
Presenter: Huw Thomas (Verbal)

2.11 Addressing Recommendations from the Deloitte Zero Based Review
Presenter: Huw Thomas
- 2 11 Addressing Recommendations into the Deloitte Zero Based Review

2 11 Appendix 1 Zero-based review of HDdUHB

3 FOR ASSURANCE

3.1 Corporate Risks

Presenter: Fiona Powell

3 1 Corporate Risk Report SBAR

3 1 Appendix 1 FinCommitteRiskReport.170519.pdf

3.2 Finance Operational Risks

Presenter: Fiona Powell

3 2 Finance Operational Risk Report

3 2 Appendix 3 RR May 19.updated170519

3 2 Appendix 4 Finance Themed RR May 19

3.3 Winter Planning 2018/19

Presenter: Joe Teape

3 3 Winter Planning_May19

3.4 Deep-dive into Medicines Management and Aseptic Unit

Presenter: Jenny Pugh-Jones

3 4 Meds Mgmt Presentation

3.5 Deep-dive into Continuing Health Care

Deferred to July Committee Meeting

4 FOR APPROVAL

5 FOR INFORMATION

5.1 Draft Annual Accounts 2018/19

Presenter: Huw Thomas

5 1 Draft Annual Accounts 2018-19 SBAR

5 1 Appendix 1 HDHB LHB ACCS 2018-19 Draft

5 1 Appendix 2 Draft Accounts 2018-19 Presentation

5.2 Impact of International Financial Reporting Standard (IFRS) 16

Presenter: Huw Thomas

5 2 Impact of IFRS 16

5.3 Defining Value-based Healthcare in the NHS - CEBM

Presenter: Huw Thomas

5 3 Appendix 1 Defining Value based healthcare in the NHS

5 3 CEBM_DefineValueReport_2019 final

5.4 Financial Efficiency Framework

Presenter: Huw Thomas

5 4 Financial Efficiency Framework Final.pdf

5 4 Appendix 1 Financial Efficiency Framework Presentation

5 4 Appendix 2 Efficiency Framework - FDU update

5 4 Appendix 3 Efficiency Framework - DG update

5 4 Appendix 4 AG to CEs re Efficiency Healthcare Value and Improvement Group

5.5 Finance Committee Update Report to Previous Board

Presenter: Huw Thomas

5 5 Finance Committee Update Report to Board - 25th April 2019

5.6 Scheme of Delegation

Presenter: Fiona Powell

5 6 Scheme of Delegation SBAR May 2019

5 6 Finance SoD from HDdUHB Scheme of Delegation Nov18 for Board

5.7 Welsh Government Monitoring Returns Month 1

Presenter: Huw Thomas

5.8 Finance Committee Annual Workplan

Presenter: Chair

5 7 Finance Committee Annual Workplan 2019-20

5.9	Reflective Summary *Presenter: Huw Thomas (Verbal)*
6	ANY OTHER BUSINESS
7	DATE OF NEXT MEETING: Tuesday 25th June; 2.00-5.00pm; Boardroom, Ystwtyth

COFNODION HEB EU CYMERADWYO O GYFARFOD Y PWYLLGOR CYLLID/ UNAPPROVED MINUTES OF THE FINANCE COMMITTEE MEETING

Date and Time of Meeting:	9.30 am 25th April 2019
Venue:	Ty Gorwel, Building 14, St. David's Park, Carmarthen

Present:	Mr Michael Hearty, Associate Member (Chair) Mr Steve Moore, Chief Executive Mr Paul Newman, Interim Health Board Vice Chair, Mr Huw Thomas, Director of Finance Mr David Powell, Independent Member Mr Joe Teape, Director of Operations/Deputy CEO (part) Mr Andrew Carruthers, Turnaround Director (part) Mrs Ann Taylor-Griffiths, Union Representative (part)
In Attendance:	Mrs Sarah Bevan, Committee Services Officer (Secretariat) Ms Alison Gittins, Head of Corporate Governance Mrs Fiona Powell, Assistant Director of Finance Mr Keith Jones, Head of Financial Planning (part)

AGENDA ITEM	ITEM	
FC(19)46	**INTRODUCTIONS AND APOLOGIES FOR ABSENCE**	**Action**
	Mr Michael Hearty welcomed everyone to the meeting. Apologies for absence were received from: • Mr Mike Lewis, Independent Member (Vice Chair) • Mrs Lisa Gostling, Director of Workforce & OD • Mrs Judith Hardisty, HDdUHB Interim Chair	

FC(19)47	**DECLARATIONS OF INTERESTS**	
	There were no declarations of interest made.	

FC(19)48	**MINUTES OF PREVIOUS MEETING HELD ON 25TH MARCH 2019**	
	RESOLVED – that the minutes of the Finance Committee meeting held on 25th March 2019 be **APPROVED** as a correct record, subject to the following amendment: • **FC(19)42 Capital Financial Management** – to include the action ascribed to Mr Huw Thomas on the Table of Actions. • **FC(19)39 Turnaround Report Month 11** – to amend 'Mr Steve Moore advised that quality and performance would be a key part of planning next year' to 'Mr Steve Moore advised that quality and performance would **continue** to be a key part of planning next year.'	**SB**

FC(19)49	**MATTERS ARISING AND TABLE OF ACTIONS FROM THE MEETING HELD ON 25TH MARCH 2019**	
	An update was provided on the Table of Actions from the meeting held on 25th March 2019 and confirmation received that all outstanding actions had been progressed, with the exception of: • **FC(19)38 Financial Projections Month 11** - Mr Huw Thomas informed Members that the report detailing plans for Medicines Management and Aseptic Unit arrangements for 2019/20 would be presented to the May 2019 Finance Committee meeting to accommodate Ms Jenny Pugh-Jones availability. Otherwise, all remaining items on the Table of Actions are reflected on the agenda for today's Committee meeting.	

FC (19)50	**FINANCE COMMITTEE TERMS OF REFERENCE**	
	Members were presented with the Finance Committee Terms of Reference which were approved on the basis that no changes were required since their creation in September 2018.	
	The Committee **APPROVED** the Finance Committee Terms of Reference.	

FC (19)51	**FINANCE COMMITTEE ANNUAL WORKPLAN 2019/20**	
	Members were presented with the Finance Committee Annual Workplan. Mr Paul Newman suggested inclusion of an update capturing the Health Board's underlying deficit. Mr Hearty welcomed this inclusion on the workplan as a standing agenda item. Mr David Powell highlighted that for consistency purposes, the key for the workplan needed to reference either job titles or initials.	**HT** **SB**
	The Committee **NOTED** and **APPROVED** the Finance Committee Annual Workplan 2019/20.	

FC (19)52	**FINANCE REPORT MONTH 12, 2018/19**	
	Members were presented with the Finance Report Month 12, and noted the Health Board's deficit position at the end of Month 12 as £35.4m, an improvement on the year-end forecast of £35.5m. Members noted that the year end position reflects year end delivery with no underlying operational issues to report. Key cost drivers remain the same as reported throughout the year, and the position is £138,000 better than initially planned. *Mrs Ann Taylor-Griffiths joined the Committee meeting* Members further noted that section 2 of the report illustrates the shifts in Month 12 within Continuing Healthcare and Primary Care prescribing. Mr Thomas informed Members of the range of assessments that take place	

within Medicines Management. Members were also informed that figures reflect the ongoing issues with No Cheaper Stock Available (NCSO) and the Aseptic Unit.

Mr Newman queried the upward trend illustrated by the Medicines Management graph and Mr Thomas responded that, in addition to the aforementioned factors, the data available is by default 2 months in arrears, and therefore includes two months of estimates.

Mr Thomas further assured Members that the budget profile for the coming year and based on known reasonable adjustments.

Mr Powell enquired whether predictions could be made to avoid any further surprises next year, particularly in terms of utility costs. Mr Thomas made reference to seasonal trends, however accepted that for 2018/19, the full extent of the increase in utility costs had not been accounted for initially. Mr Thomas assured Members that greater provision had been made for future growth in the budget for 19/20. This would be factored into utility costs for next year, however as prices are not easily predictable by the Heath Board, and are dependent on many external influences, any potential increase in costs could constitute a risk.

Mr Joe Teape joined the Committee meeting

Mr Powell queried the ability for recompense within the biomass and combined heat and power plant contracts held by the Health Board. Mr Thomas confirmed that whilst there is a mechanism in place, the amount of recompense does not cover all costs arising from any downtime. This is carefully monitored.

In terms of the data in relation to drugs costs, Mr Thomas informed Members that the trend in Oncology remains largely the same as the previous few months with a slight improvement noted within Unscheduled Care. Mr Thomas further informed Members that the first of a series of reviews, from a value based healthcare perspective, will commence with Respiratory, with the aim of assessing the totality of spend in order to determine provider and commissioner costs for Primary Care. This review will be presented to the May 2018 Committee meeting. Mr Thomas reiterated the pressures around the Aseptic Unit and confirmed that Ms Pugh-Jones would be attending the Finance Committee in May to discuss this further. **HT**

Mr Thomas reminded Members of the query raised at the previous Committee meeting on Continuing Healthcare and advised that a response had since been received which he undertook to share. This response demonstrates a reduction in average spend due to a reduction in the number of 1:1 hours. However, despite unit prices decreasing, client numbers are increasing. It is intended that a report outlining these care packages would be presented to the next Committee meeting in May. **HT** **HT**

Mr Andrew Carruthers joined the Committee meeting

	Mr Thomas informed Members that with regard to savings delivery, the Health Board over-achieved on the expected position by £0.2m in March. Mr Hearty requested that the savings achievement be recorded in the minutes.	
	The Committee **NOTED** and **DISCUSSED** the financial position for Month 12, 2018/19.	

FC (19)53	**TURNAROUND REPORT MONTH 12, 2018/19**	
	Members were presented with the Turnaround Report Month 12, providing a summary of the position of each Directorate at the end of the year, with a breakdown of this spend included in Section 4 of the report. Mr Andrew Carruthers drew Members' attention to a difference in the figures within the savings table of this report and figures reported within the Savings Plan later on in the Committee's agenda. This is due to figures fluctuating on a daily basis and Members were assured that this would be addressed in future reporting to avoid any discrepancies. Mr Carruthers suggested the Committee could take an assurance from the Holding to Account (HTA) scrutiny processes in place, to recognise any non-recurrent and savings efficiencies. In terms of the use of E-referrals for Outpatients within the report, Mr Powell queried whether this had now been rolled out to all GP practices. Mr Carruthers responded that not all GP practices are utilising the system and recognised the need for further work to roll this out to the remainder of the practices. Mr Steve Moore agreed with the need to ensure all GP practices share the same vision. Mr Powell requested clarification on the reasons for the full year end figures being lower than the part year end figures within Section 4 of the report. Mr Thomas responded that these relate to non-recurrent elements and Mr Powell requested that this be clarified in future reports. Mr Moore commended the Health Board for meeting its financial plan for 2018/19 and for reducing its deficit at year end. Mr Moore referred to debate across Wales on how to measure savings, and informed Members that although HDdUHB achieved the highest percentage of savings compared to the rest of Wales, there are even greater challenges ahead and therefore an increased need for assurances in the processes that are already in place. Mr Moore reiterated the need to build upon the Turnaround process, including HTA, and business partnering arrangements in order to enable effective forecasting. The proof of concept is evident from 2018/19 and there will be a need to continue this drive into 2019/20. Mr Carruthers acknowledged the need to avoid complacency and familiarity within the HTA process and Mr Thomas confirmed that it had been helpful to have the Director of Nursing, Quality and Patient Experience involved in this process to introduce a quality perspective. Mr Thomas informed Members that at the HTA meetings on 26th April 2019, a forecast year end position at directorate level would be made available. Whilst relatively early in the year to share this, it is considered critical to	

	have early discussions with Directorates on the risks and mitigating strategies in place. Mr Newman queried the perception of staff when agreeing to the content within the accountability letters issued, and how they are held to account by this process. Mr Thomas responded that these letters are concentrating the minds of accountable officers, and proving an effective means of enabling dialogue to be held on the expectations anticipated. Mr Thomas advised that a directorate by directorate debrief would be held on 3rd May 2019, to focus on the lessons learned from the HTA process over the past year. From the responses received to date, Mr Carruthers noted an increased maturity in dealing with the risks involved in meeting accountabilities, and assured Members that where risks are identified, mitigating actions must be articulated, which ties back in with the HTA process. Mr Teape advised that from an operational perspective, the process has worked well although possibly less so for corporate Directorates who have not been an area of focus during 2018/19. Whilst recognising risks can often sit within other Directorates, Mr Teape shared with Members a higher level of confidence going into this year's budget setting round which was welcomed. Mr Hearty enquired whether information from this process is being gathered together at Executive level and Mr Thomas agreed to present a report consolidating the risks from the HTA meetings and the risks identified within the accountability letters. Mrs Ann Taylor-Griffiths suggested a mechanism is required to deal with instances where patients are remaining in NHS care unnecessarily, and to reduce patients' length of stay, in order to facilitate beds being used more effectively for those that need them most. Mr Teape responded that regular reviews and Multi-Disciplinary Team (MDT) meetings are being held to facilitate this step change. Mr Teape also advised that this has been highlighted to Local Authorities and to Welsh Government. Mr Hearty suggested the Committee could take an assurance that the organisation is not viewing HTA meetings as one-off events but as a month on month process, with the product of these meetings available 12 times throughout the year. However, Mr Hearty further suggested that where savings delivery is falling behind trajectory, there is no visibility of flash reports to alert those required and to enable the trajectory to get back on target. Mr Hearty felt that the Committee is unsighted in this respect. Mrs Taylor-Griffiths referred to the unprecedented demand on services over the recent Easter period which had not necessarily been anticipated, and queried the plans in place for the forthcoming Bank Holidays. Mr Thomas suggested the need to explore predictive analytic capacity i.e. the need to work on operational predictors and how these link in with financial predictive analytics for that month. Mr Thomas accepted that the current KPIs produced do not allow for this, therefore, further work is	**HT**

	required to determine how analytics can be used more effectively and link in with finances to provide an earlier in-month picture. Mr Thomas recognised the need to track actions as a lead indicator of delivery, recognising that savings are a consequence of actions taken. Mr Thomas assured Members that a new project management system would enable the tracking of performance against actions, after it is fully implemented.	
	The Committee **DISCUSSED** and **NOTED** the Turnaround Programme update report.	

FC (19)54	**FINANCE COMMITTEE ANNUAL REPORT 2018/19**	
	Members were presented with the Finance Committee Annual Report 2018/19. Ms Alison Gittins informed Members that the Finance Committee Annual Report 2018/19 is produced for submission to the extraordinary Public Board meeting on 29th May 2019 for approval, and is presented to the Finance Committee in draft form for endorsement. Mr Thomas informed Members that the Annual Accounts have been submitted for audit and could be shared with Members on request. Mr Hearty noted the assurance role of an annual report on accounts. The Committee agreed that it would be useful to receive the draft Annual Accounts at the next Committee meeting.	**HT**
	The Committee **ENDORSED** the Finance Committee's Annual Report 2018/19, for onward submission to the Board.	

FC (19)55	**ESTABLISHMENT CONTROL**	
	Members were presented with the Establishment Control work programme to view the progress made. In Mrs Lisa Gostling's absence, Mr Thomas drew Members' attention to the data presented in appendix 2a and 2b which is being actively reviewed by Mrs Gostling, the Director of Nursing, Quality and Patient Experience and the finance team. In addition, the data presented within appendix 3, provides a forward look at the status at a ward and shift level, which is useful to identify any areas of concern or particular hotspots. Mr Thomas acknowledged there may be an alternative way of presenting this data from an assurance reporting perspective, however it is already proving to be a useful management tool. Mr Thomas drew Members attention to Bronglais General Hospital as a particular area of concern given its heavy reliance on agency staff, where this tool should provide an improved method of managing rosters. Mr Newman recognised that the data being produced could also be useful for other Committees in terms of guiding their workplans, such as the Quality, Safety & Experience Assurance Committee.	

	Mrs Taylor-Griffiths provided Members with examples of issues experienced by staff with e-rostering, including under and overpayments received, and emphasised the need for assurance that this would be addressed. Mr Teape suggested the need to identify issues as and when they occur, rather than anecdotally, in order to ensure improvements can be made. Mr Powell commented that whilst the report provides assurance, it also highlights a number of constraints, and queried whether, for example, sickness trends can be identified. In Mrs Gostling's absence, Mr Teape assured Mr Powell that this information is discussed at performance review meetings, where areas of high level sickness are scrutinised and subsequently targeted by the workforce team. Mr Hearty commented that whilst this serves as a helpful tool, further work may be required to consider the financial aspects of establishment control in future reporting. Mr Hearty acknowledged the model as exemplary, and advised that the work undertaken by HDdUHB thus far has garnered interest from Betsi Cadwaladr University Health Board.	
	The Committee: • **DISCUSSED** and **NOTED** the content of this report • **SUPPORTED** the progression of the work involved	

FC (19)56	**CAPITAL FINANCIAL MANAGEMENT**	
	Members were presented with the Capital Financial Management Report. Mr Thomas informed Members that the Health Board met its capital expectation at year end, due in no small part to the hard work undertaken to push through levels of spend for the Cardigan Integrated Care Centre and Women & Children Phase II Scheme in Glangwili, for which thanks were conveyed to the teams involved. Members noted that the plan for next year has a healthier expenditure profile in terms of front ending capital spend, as illustrated on page 4 of the report, whilst acknowledging that further capital may become available later on in the year. Mr Thomas highlighted the Health Board's dependence on Interserve to conclude the Cardigan Integrated Care Centre and the Women & Children's Phase II Scheme. However, guidance from Cabinet Office has suggested trading to continue with the company. Members also noted Dawnus' status of administration and the resulting delay in the progress of Cylch Caron. Mr Hearty queried how the savings plan, including capital spend, ties in with this capital financial management plan, and Mr Carruthers acknowledged the need to identify early on any requirement for capital as part of the planning process. Members noted the small amount of capital left to be allocated, with the discretionary allocation for 2019/20 consisting mainly of small sums of	

	money. Mr Thomas also noted there are contingency and balance funds not yet allocated thereby providing further opportunities. Mrs Taylor-Griffiths queried the mechanisms in place to establish the financial status of companies prior to trading with them. Mr Thomas responded that a credit checking system is undertaken as part of the standard procurement process. It was noted that the Cabinet Office carry out checks on larger firms but the internal procurement team carries out checks on smaller, local firms.	
	The Committee: • **NOTED** the 2018/19 Capital Resource Limit and unaudited out-turn position • **NOTED** the update on Interserve's financial position • **NOTED** the potential impact of Dawnus going into administration on the Cylch Caron Project • **NOTED** the Capital Resource Limit for 2019/20 and expenditure allocations and profile	

FC (19)57	**SAVINGS PLAN 2019/20**	
	The Savings Plan 2019/20 was presented to the Committee, setting out the Health Board's position in terms of savings plans received to date. Savings of £24m are required in order to meet the year end position of a £29.8m deficit, although this figure may vary as a result of work being undertaken on Referral to Treatment Time (RTT). Mr Carruthers highlighted that the report does not reflect the change in control total set by Welsh Government, with the potential for a further £5m added pressure on this year. It was acknowledged that this would need to be managed at a strategic as opposed to an individual Directorate level. Members noted the report summarises the RAG rated savings plans received by Directorates to date, with £10m currently rated Green, £6m rated Amber and £4.1m rated Red, equating to a £20.1m savings delivery for 2019/20. Whilst acknowledging there is still a gap to close, Mr Carruthers assured Members that all schemes now have Project Initiation Documents (PIDs) in place to provide greater assurance that plans are robust and can be managed effectively. In comparison to the previous year where there were approximately 450 schemes in place, there are 220 schemes in place for 2019/20. Mr Carruthers further assured Members that a fewer number of larger schemes would more successfully contribute to the outcome required. Mr Carruthers anticipated there could be areas not yet considered as part of the accountability process which may help in achieving the savings plan and that it was hoped for an improved RAG rating position at the HTA meeting scheduled for 26th April 2019.	

	Mr Powell enquired whether in light of the increase in control totals, the savings total is expected to increase and that Directorates would have to find these savings individually. Mr Powell also enquired how the perceived lack of robustness within the schemes, as outlined in the targeted intervention letter from Welsh Government, is being addressed. Mr Carruthers responded that Welsh Government's view is that even with the Health Board's reduced number of schemes, there are too many small schemes and not enough hard-hitting schemes in place. Mr Carruthers hoped to be in a position to report an identified £24m savings to the Board in May 2019, for delivery over the remaining 10 months of the year. Mr Hearty acknowledged the challenge posed by Welsh Government and queried at what point in the year the Committee could expect to see the financial programme from a transformational perspective rather than a transactional one. Mr Carruthers responded that many of the RAG rated schemes are transformational in nature, i.e. a focus on community and local services, and the redesign of pathways such as Cardiology in PPH. Mr Carruthers stressed the risks associated with having insufficient support capacity in place to enable schemes to progress. Mr Moore referred to occasional tensions in discussions with WG who have challenged the Health Board's schemes as not being sufficiently transformational or strategic, whilst acknowledging the organisation's need to maintain current services in the meantime. Mr Newman suggested it may be helpful for the Committee to have sight of the schemes in place to gain an assurance that they are delivering against what is anticipated, to provide the Committee with a confidence in their outcome. A report detailing the transformational schemes and their ability to deliver, to be brought to the May Committee meeting.	**AC**
	Mr Carruthers agreed that it would be useful to develop a method of reporting assurance to the Committee, and to Welsh Government, on progress. It was confirmed that details of these schemes had previously been presented to the Board and Finance Committee as part of a full savings tracker. Mr Carruthers advised that consideration would be given to the most suitable point at which to share details of these schemes more widely, taking into account the level of engagement that may need to be undertaken with staff, in order to manage the process and expectations involved. Mr Moore confirmed that schemes in receipt of transformation funding are in the public domain. Mr Thomas maintained the need to improve upon communicating the positive work that has been undertaken to date. Resources have been identified for the Communications Team to facilitate this and further discussion will be held on how best to utilise this resource. Mr Carruthers added that discussions have already taken place with the Communications Team to create a short end of year animation video on the progress of the schemes to date. Mr Thomas expressed some concern regarding the resourcing of this Project Management Office (PMO). Mr Carruthers assured Members on	

	the plan in place although there may be a time lag in appointing staff to post, with the anticipation that it would take the remainder of the quarter for the team to become established. Mr Thomas suggested that a savings profile would need to be in place for Month 1 reporting, and queried at what point in the year there would be a confidence in achievement of the savings delivery. Mr Carruthers expressed a level of confidence in reaching the £24m target, although not necessarily the additional £5m requirement from Welsh Government. Mr Carruthers suggested it could take a further 6-8 months to reach this conclusion. Mr Hearty commented that this suggested a risk for the Finance Committee in terms of the gap in the savings plan for the first 6 months of the year. Mr Moore noted that RTT and winter pressures had not previously been a focus within these schemes, and whilst there is a need to address the £25m internally, there are opportunities with the Transformation Fund and possible slippages in year. Mr Hearty concluded by noting for the record the Committee's apprehensiveness in the organisation's ability to meet the savings plan challenge given the lack of assurance that could be provided at this point in time.	
	The Committee **NOTED** the current value of savings plans and the challenge ahead in meeting the savings plan, with the additional control total set by Welsh Government.	

FC (19)58	**DRAFT FINANCIAL PLAN IMPLEMENTATION 2019/20**	
	Members were presented with the Draft Financial Plan Implementation 2019/20 report and received a presentation detailing the Financial Breakdown with Control Totals. Members noted that the control total for 2019/20 stands at £25m. Current assessment against the control total identifies a £5.5m resource requirement for RTT and identifies non-recurrent opportunities to manage the gap. Mr Thomas reiterated that the potential opportunities outlined in the presentation had not yet been widely discussed, for example, addressing the additional funding required to comply with the Nurse Staffing (Wales) through establishment control. Mr Thomas advised that these only represent potential opportunities at this stage which could serve to de-risk the current plan in order to reduce it to £25m. Mr Thomas acknowledged the size of the remaining gap and that delivery of £29.5m savings would require harder decisions and risks to be taken. The gross challenges currently stands at £4.0m relating to the savings challenge; £5.5 m relating to RTT delivery and £4.8 m relating to the impact of the control total. Mr Thomas informed Members of a Turnaround meeting scheduled for the following week where discussions would be held with Executive Directors. Challenges in relation to the higher control total will not be	

	posed to the organisation as a whole, but will be directed at a Directorate level within HTA meetings. Mr Thomas further informed Members of the £10m risk associated with the Red and Amber rated schemes in delivering the £25 million control total, which poses a significant risk in addition to the gap. The focus of the upcoming HTA meetings will be to de-risk these schemes. The numbers of signed accountability letters received to date were shared with Members, with it noted that the majority had been received from the larger budget areas with the smaller Directorates, in the main, remaining outstanding. Members were assured that these would be picked up via the HTA process and escalated accordingly if necessary. Mr Thomas concluded that, in regard to budgeting, there is a process in place to debrief the finance team on the most recent cycle in order to identify lessons learned and opportunities to adapt and improve upon for 2019/20. Mr Thomas agreed to present the outcomes of this debrief to the Finance Committee at the May meeting.	**HT**
	The Committee **NOTED** and **DISCUSSED** the Financial Plan Implementation 2019/20.	

FC (19)59	**RTT MONTH 12 and RTT PLAN 2019/20**	
	Members were presented with the RTT Month 12 report and Mr Keith Jones informed Members that performance in respect of RTT, Diagnostics and Therapies targets had been positive during 2018/19 and had delivered a £1.2m under-commitment. This meant the Health Board successfully avoided any resultant financial penalties. Mr Jones expressed some disappointment at being slightly under the forecast under-commitment identified, although it was acknowledged that there may be some variances not yet analysed, with a more accurate picture available once all outstanding invoices are received and checked. Mr Jones advised that an initial review and reflection on the experiences gained during 2018/19 has highlighted potential learning opportunities. For example a review of the forecasting systems and processes for both internal and external claims will enable time-lags between activity and the submission of claims to be accounted for. Mr Jones informed Members that extra activity comes at a premium rate and a review needs to take place to explore whether this can be undertaken more cost-effectively e.g. the possibility to invest in theatre staff within core resources. Gaps within core capacity in areas where it is common to go above core capacity in order to deliver activity is also to be addressed, with work ongoing to establish if this is feasible. Mr Jones noted that cancellations are a consistent concern, particularly as these need to be recovered at year end often at a premium rate. Mrs Taylor-Griffiths suggested having staff on standby in order to deliver activity or having a more appropriate selection of patients when	

	anticipating demands over, and following, Bank Holidays. Mrs Taylor-Griffiths also reiterated the need to ensure that systems are in place to enable patients to be discharged in a timely manner following treatment. Mr Carruthers advised Members that Critical Care is a high cost area of spend and that work is being carried out to address the appropriateness of cases within Critical Care units. Mr Jones highlighted activity and capacity within Therapy services and the further work needed to address the current system of manual tracking as opposed to the electronic tracking of patients. Members were also presented with the RTT Plan 2019/20 and Mr Jones informed Members that the forecast of the delivery requirement for 2019/20 stands at £5.5m, with £4.5m being variable. Opportunities to potentially reduce the overall cost of delivery by approximately £0.5m have been identified. In addition, further reviews are being conducted in respect of Orthopaedic and Dermatology delivery plans. A planned care delivery plan is in place to consider how orthopaedic cases can be delivered at a lower cost. As Dermatology is highly dependent on external support, a locum consultant has been appointed to improve internal capacity in order to reduce external spend. Mr Jones noted that ongoing efforts to increase internal capacity to enable delivery should become apparent in June 2019. In recognising the high RTT costs at weekends, Mrs Taylor-Griffiths commented that staff are already often working overtime due to exceeding their core hours. Mr Jones proposed the exploration of operating a core 7 day a week service, as opposed to a core 5 day a week service. Mr Jones concluded that it had been useful for him to attend the Finance Committee and was happy to continue providing monthly update reports.	
	The Committee **NOTED** the progress to Month 12 (March 2019) in respect of the financial plan and planned expenditure trajectory to support Referral to Treatment (RTT), Diagnostic and Therapy service waiting times delivery for 2018/19. The Committee **NOTED** and **DISCUSSED** the proposed RTT Plan for 2019/20.	

FC (19)60	**FINANCE COMMITTEE UPDATE REPORT TO PREVIOUS BOARD MEETING**	
	The Finance Committee Update to Board report was received for information.	
	The Committee **NOTED** the Finance Committee Update to Board report.	

FC (19)61	**FINANCE COMMITTEE ASSURANCE REPORT TO ARAC**	

	Members were presented with the Finance Committee Assurance report to ARAC.	
	The Committee **NOTED** the content of the Finance Committee Assurance Report to ARAC and took assurance that the Finance Committee had been operating effectively during 2018/19 since it had been constituted.	

FC (19)62	**REFLECTIVE SUMMARY**	
	Mr Thomas outlined the key topics discussed during the meeting for inclusion in the Finance Committee update report to the next Public Board meeting: • 2018/19 year end out turned at £35.4m – an improvement on plan and a reduction in deficit. This has been as a result of collective hard work across the organisation. • Plan for 2019-20 – a recognition of the risks of savings not identified and a need to de-risk the savings plan; a recognition also of the challenging control total. • RTT delivery 2018/19 achieved within reduced resource requirement; delivery for 2019/20 has a price tag of £5.5m. • Capital – utilised capital allocated for 2018/19. A recognition of where the organisation outturned, with the 2019/20 plan less back ended.	
	The Committee **NOTED** the key topics discussed during the meeting for inclusion in the Finance Committee Update Report to the next Public Board meeting.	

FC (19)63	**ANY OTHER BUSINESS**	
	No other business was raised.	

FC(19)64	**DATE OF THE NEXT MEETING**	
	9.30 am, 20th May 2019, Boardroom, Ystwyth Building, St. David's Park, Carmarthen	

TABLE OF ACTIONS FROM
FINANCE COMMITTEE (FC) MEETING
HELD ON 25th April 2019

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
FC(19)48	**Minutes of Previous Meeting held on 25th March 2019 –** FC(19)39 Turnaround Report Month 11: to amend 'Mr Steve Moore advised that quality and performance would be a key part of planning next year' to 'Mr Steve Moore advised that quality and performance would **continue** to be a key part of planning next year.'	SB	May 2019	Action complete
FC(19)51	**Finance Committee Annual Workplan 2019/20 –** Underlying deficit to be reported to Finance Committee. External Finance Review to be added to the annual workplan as a standing agenda item	HT SB	May 2019	Forward planned for inclusion on the Finance Committee agendas for the remainder of the year
FC(19)51	**Finance Committee Annual Workplan 2019/20 -** Key to be amended to reference either job titles or initials	SB	May 2019	Action complete
FC(19)52	**Finance Report Month 12 –** details of the outcome of a value based healthcare review of Respiratory to be included within the Finance Team Strategy report to be presented to the Committee	HT	June 2019	Forward planned for inclusion on the Finance Committee agenda for June 2019.
FC(19)52	**Finance Report Month 12 -** A report outlining CHC packages to be presented to the Committee	HT	June 2019	Forward planned for inclusion on the Finance Committee agenda for June 2019.
FC(19)52	**Finance Report Month 12 -** A report detailing plans for medicines management and Aseptic Unit 2019/20 arrangements to be presented to the Committee	HT	May 2019	Forward planned for inclusion on the Finance Committee agenda for May 2019.

FC(19)53	**Turnaround Report Month 12 -** A report consolidating the risks arising from the HTA meetings and those highlighted within the accountability letters to be presented to the Committee	HT	May 2019	Forward planned for inclusion on the Finance Committee agenda for May 2019.
FC(19)54	**Finance Committee Annual Report 2018/19 -** Draft Annual Accounts 2018/19 report to be presented to the Committee	HT	May 2019	Forward planned for inclusion on the Finance Committee agenda for May 2019.
FC(19)57	**Savings Plan 2019/20 -** A report detailing the transformational schemes and their ability to deliver, to be brought to the Committee	AC	May 2019	Forward planned for inclusion on the Finance Committee agenda for May 2019.
FC(19)58	**Draft Financial Plan Implementation 2019/2 -** An outcome from the forthcoming debrief exercise to be presented to the Committee	HT	May 2019	Forward planned for inclusion on the Finance Committee agenda for May 2019.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CEISIADAU GOFAL SYLFAENOL
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20th May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Committee Self-Assessment of Performance 2018/19 – Composite Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Michael Hearty, Associate Member Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Finance Committee (FC) the outcomes from the annual self-assessment exercise 2018/19, to consider the suggested actions and any further improvements that could be made.

Cefndir / Background

Members and In Attendance Members of the Finance Committee have been asked to complete a questionnaire to consider the Committee's effectiveness, and also to consider their individual understanding, role and contribution to the Committee.

The 2018/19 version of the questionnaire has been updated in response to the requirement for continual improvement of the self-assessment process, and to include additional questions suggested by Wales Audit Office.

The questionnaire has also been designed to invite comments on any improvements for consideration to assist the Committee in drawing up its own plan for improvement, either in terms of requesting future training and/or development, or in changes to its own processes and procedures.

The self-assessment questionnaire was circulated on 3rd April 2019 and reminders were sent prior to the closing date to encourage its completion.

Of the 4 invited responses from FC Members, 4 have been completed and returned. Of the 8 invited responses from FC In Attendance Members, 2 have been completed and returned.

Asesiad / Assessment

The full results from the outcome of the self-assessment exercise are attached in the following appendices:

- Appendix 1 – FC Members
- Appendix 2 – FC In Attendance Members.

In terms of FC Members, whilst there was general agreement around many of the responses received with either Agree or Strongly Agree cited in response to the questions raised, identified below are those areas where Members responses elicited either a Somewhat Agree, a Somewhat Disagree or an Unable to Assess/Don't Know response. Suggestions for how these could be improved or remedied have been made within the body of the report, however it is acknowledged that these may also warrant FC Members further consideration.

Role/Purpose of the Committee

- **The Committee has established and follows an agreed plan for the year's work**
  Responses to this question were split between 1 Strongly Agree response, 2 Agree response, and 1 Somewhat Agree response. This was supported by the statement 'The Committee is relatively new – only being formally established mid-year'. This split response suggests the action taken to introduce the Finance Committee Annual Workplan as a standing item on the FC agenda should pay dividends going forward.

Assurance

- **The Committee is effective in scrutinising and providing oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability)**
  Whilst there was a general consensus of a Strongly Agree response to this question (3 out of 4 responses), there was also 1 Somewhat Agree response. This suggests the Committee has been focussed on short term financial delivery. However, as work on the underlying deficit is progressed and a longer term strategy is developed, the Committee will increasingly focus on the longer term financial and investment plans.
- **The Committee is effective in conducting detailed scrutiny of all aspects of financial performance, the financial implications of major business cases, projects and proposed investment decisions on behalf of the Board**
  Responses to this question were split between 1 Strongly Agree response, 1 Agree response, 1 Somewhat Agree response and 1 Somewhat Disagree response. This split response suggests the need for a greater focus and a better understanding of the challenges faced in order to contribute to improved financial performance.
- **The Committee is effective in regularly reviewing contracts with key delivery partners**
  Responses to this question were split between 1 Agree response, 1 Somewhat Agree response, 1 Somewhat Disagree response and 1 Unable to Assess/Don't Know response. This was supported by the statement 'The Committee does not review any contracts in detail'. This split response together with the Unable to Assess/Don't Know response indicates a lack of contracts presented to the Committee to review during 2018/19. Where there are contracts to be reviewed there is expected to be sufficient detail within the accompanying SBAR to enable efficient scrutiny and consideration.
- **The Committee is effective in seeking assurance on the management of principle risks within the BAF and CRR allocated to the Committee (financial risks), and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk appetite is exceeded, lack of timely action**

Responses to this question were split between 1 Strongly Agree response, 2 Agree responses and 1 Somewhat Agree response. This suggests the need to ensure the Committee receives regular corporate risk reports to provide the Committee with the opportunity challenge effectiveness/completeness of controls, lack of action, and poor assurances. As part of the discussion the Committee should agree what level of assurance/concerns should be included in the Committee Report to the Board. The corporate risks should also be used to inform the agenda and workplan of the Committee.

- **The Committee is effective in recommending acceptance of risks that cannot be brought within the Health Boards risk appetite/tolerance to the Board through the Committee Update Report**
  Whilst there was a general consensus of an Agree response to this question (3 out of 4 responses), there was also 1 Somewhat Agree response. This suggests the need for the Committee to challenge the effectiveness of the planned actions to reduce risks, challenge target risk scores before reporting/recommending to the Board that a risk requires a higher level of tolerance.
- **The Committee is effective in providing assurance, raising appropriate concerns and making recommendations to the Board as a consequence of the Committee's role in relation to short term focus, medium term focus and improving financial management**
  Responses to this question were split between 2 Strongly Agree responses, 1 Agree response and 1 Somewhat Agree response. This suggests that the reflective summaries undertaken at the end of each Committee meeting is an important exercise and one which must continue to be undertaken to ensure appropriate recommendations from the Finance Committee are presented to the Board.
- **The Committee is effective in reviewing and approving financial procedures on behalf of the Health Board**
  Responses to this question were split between 1 Strongly Agree response, 2 Agree responses and 1 Somewhat Agree response. This split response indicates a lack of financial procedures presented to the Committee to approve during 2018/19. HDdUHB has a number of old financial policies that need review and will be brought back to the Committee as part of a longer term plan. This will also be incorporated into the Finance Committee Annual Workplan, as and when required.

Membership

- **Committee members received induction, advice, support and on-going development opportunities to support them in their role**
  Responses to this question were split between 2 Agree responses, 1 Somewhat Agree response and 1 Somewhat Disagree response. It is anticipated that outcomes from this self-assessment exercise will assist in determining the approach to be taken to induction and on-going development for FC Members. The overall Independent Member induction programme is also being refreshed.
- **Committee members have the collective skills, knowledge and experience to fulfil its Terms of Reference and to advise and assure the Board**
  Responses to this question were split between 2 Strongly Agree responses, 1 Agree response and 1 Somewhat Agree response. As a practical step, briefings to support the Committee's work will be placed on the resource section within iBabs, with a view to making these available to FC Members. A Finance Committee Handbook to guide and support FC Members is also under development.
- **The Committee is the right size and sufficiently diverse**

Responses to this question were split between 2 Strongly Agree responses, 1 Agree response and 1 Somewhat Agree response. This relates to the previous question and suggests the need to ensure In Attendance Members with the appropriate skills, knowledge and experience attend each Committee meeting to guide Members in their deliberations. It also underlines the need to maintain the annual review of FC's Terms of Reference on the FC Work Programme, together with an annual review of the Committee membership.

- **Attendance at Committee meetings is evaluated as a criterion for continued membership on the Committee**
  Responses to this question were split between 1 Strongly Agree response, 2 Agree responses and 1 Somewhat Agree response. This split response suggests a general lack of awareness on this issue. This needs to be understood as part of both Welsh Government's and HDdUHB's monitoring arrangements. Where poor attendance arises, this is discussed through meetings with the Health Board Chair, through Independent Members appraisal, through submissions to Welsh Government on Independent Member re-appointments and through HDdUHB's Annual Governance Statement.

Support for the Committee

- **The Committee receives clear and concise papers which focus on the key issues and priorities**
  Responses to this question were split between 1 Strongly Agree response, 2 Agree responses and 1 Somewhat Agree response. This suggests the need for the Corporate Governance Team to maintain its quality assurance role of all papers submitted for FC's consideration, to ensure that the papers that are presented are succinct and supported by SBARs which are well populated and guide Members to consider the relevant and salient points, and to roll out training on the standards required for report writing through current agreed mechanisms i.e. Managers Passport and Managers Passport Plus training.

Whilst the foregoing identifies those areas of questions which elicited either a Somewhat Agree, Somewhat Disagree or Disagree response, and makes suggestions where further improvements could be made, it is pleasing to note Members agreement on either Agree or Strongly Agree responses to the following questions:

- The role of the Finance Committee is understood and clearly defined in its Terms of Reference
- Committee Members understand their individual role and what is expected of them.
- The Committee has clear mechanisms in place to keep it aware of topical, legal and regulatory issues, in relation to financial performance and delivery.
- The Committee is aware of the areas in which it can take decisions under the Scheme of Delegation.
- The frequency and scheduling of Committee meetings are sufficient to carry out its functions and responsibilities.
- The Committee receives sufficient and timely information to review, understand and assess the issues for discussion, on which to base its decisions.
- The quality of presentations made to the Committee is appropriate.
- The Committee understands the issues which are on the horizon for the Health Board which may impact on its areas of work.
- The work of the Committee culminates in appropriate recommendations to the Board.
- The Board takes due regard of the recommendations from the Committee.

- The Committee has effective escalation arrangements in place to alert relevant individuals and committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.
- The Committee is effective in reviewing financial performance and reviewing any areas of financial concern.
- The Committee is effective in providing assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern.
- The Committee is effective in developing and regularly reviewing the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.
- Overall, the Committee is effectively fulfilling its Terms of Reference.
- Committee meetings are scheduled with sufficient time to cover all agenda items, including discussion and answering questions.
- Committee meetings are managed and controlled effectively, and conducted in a business-like manner.
- The Committee meeting dynamic encourages full participation and open communications.
- Meeting time is used well with issues getting the time and attention proportionate to their importance.
- The length of the Committee's meetings is appropriate in relation to the agenda.
- Committee Members have a good understanding of the Health Board's financial performance, delivery on the Health Board's financial plans and objectives, and on financial control.
- Committee Members come to meetings prepared and ready to contribute.
- There is consistent attendance and timely arrival by Members at Committee meetings.
- An appropriate agenda is set before Committee meetings and is followed.
- The agenda and papers are received in a timely manner in advance of the meetings to allow time for appropriate review and preparation.
- The Committee receives appropriate advice from or via the Executive Team and staff.
- The Committee enjoys a good working relationship with management and significant issues are reviewed with the Chief Executive Officer or the relevant Lead Executive Director.
- The minutes of the meetings are accurate and reflect the discussion, next steps and/or action articulated by Members.

In terms of In Attendance Members responses, in many cases these reflected the responses made by full FC Members, however the tendency to award lower scores to the questions posed was noted. This may suggest a cause for concern in terms of assurance as it could have been anticipated that In Attendance Members, being more operational, would have a better understanding of the challenges faced by the Health Board than their Member counterparts.

However, it is still pleasing to note In Attendance Members agreement on either Agree or Strongly Agree responses to the questions identified below:

- The role of the Committee is understood and clearly defined in its Terms of Reference.
- Committee Members understand their individual role and what is expected of them.
- The Committee has clear mechanisms in place to keep it aware of topical, legal and regulatory issues, in relation to financial performance and delivery.
- The Committee is aware of the areas in which it can take decisions under the Scheme of Delegation.
- The frequency and scheduling of Committee meetings are sufficient to carry out its functions and responsibilities.
- The Committee has established and follows an agreed plan for the year.
- The Committee receives sufficient and timely information to review, understand and assess the issues for discussion, on which to base its decisions.
- The quality of presentations made to the Committee is appropriate.
- The Committee understands the issues which are on the horizon for the Health Board which may impact on its areas of work.
- The work of the Committee culminates in appropriate recommendations to the Board.
- The Board takes due regard of the recommendations from the Committee.
- The Committee has effective escalation arrangements in place to alert relevant individuals and committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.
- The Committee is effective in scrutinising and providing oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability).
- The Committee is effective in reviewing financial performance and reviewing any areas of financial concern.
- The Committee is effective in providing assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern.
- The Committee is effective in providing assurance, raising appropriate concerns and making recommendations to the Board as a consequence of the Committee's role in relation to short term focus, medium term focus and improving financial management.
- The Committee is effective in developing and regularly reviewing the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.
- The Committee is effective in reviewing and approving financial procedures on behalf of the Health Board.
- Overall, the Committee is effectively fulfilling its Terms of Reference.
- Committee meetings are scheduled with sufficient time to cover all agenda items, including discussion and answering questions.
- Committee meetings are managed and controlled effectively, and conducted in a business-like manner.
- The Committee meeting dynamic encourages full participation and open communications.
- Meeting time is used well with issues getting the time and attention proportionate to their importance.
- The length of the Committee's meetings is appropriate in relation to the agenda.

- Committee Members receive induction, advice and ongoing development opportunities to support them in their role.
- Committee Members have the collective skills, knowledge and expertise to fulfil its Terms of Reference and to advise and assure the Board.
- Committee Members have a good understanding of the Health Board's financial performance, delivery on the Health Board's financial plans and objectives, and on financial control.
- The Committee is the right size and sufficiently diverse.
- Committee Members come to meetings prepared and ready to contribute.
- There is consistent attendance and timely arrival by Members at Committee meetings.
- Attendance at Committee meetings is evaluated as a criterion for continued membership on the Committee.
- An appropriate agenda is set before Committee meetings and is followed.
- The Committee receives clear and concise papers which focus on the key issues and priorities.
- The agenda and papers are received in a timely manner in advance of the meetings to allow time for appropriate review and preparation.
- The Committee receives appropriate advice from or via the Executive Team and staff.
- The Committee enjoys a good working relationship with management and significant issues are reviewed with the Chief Executive Officer or the relevant Lead Executive Director.
- The minutes of the meetings are accurate and reflect the discussion, next steps and/or action articulated by Members.

Many of the comments made by In Attendance Members mirrored those of the full Members, particularly in regard to the remedies offered to improve the Committee's effectiveness, however some further pertinent insights and suggestions were made including:

- The Committee's key success in the past year was providing specific focus to the finance agenda and delivery to the financial and turnaround plan.
- The Committee's major shortcoming in the past year was necessarily focused on shorter term in 2018/19 and the need to add to this in 2019/20 by also reviewing medium and long term issues and actions.
- There needs to be recognition of whilst keeping a close focus on in-year delivery, a move to medium/longer term issues would also be helpful.

In summary, the suggestions and actions as described above will be taken forward by the Corporate Governance Team and the Finance Team as part of their respective workplans for 2019/20. The themes and outcomes from the self-assessment questionnaire will also contribute to the Finance Committee's on-going development.

Argymhelliad / Recommendation

The Finance Committee is asked to:

- Discuss the findings of the FC self-assessment exercise 2018/19;
- Support the suggested actions by the Corporate Governance Team and the Finance Team;
- Consider any further improvements that could be made to increase the Committee's effectiveness.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation, including that of any sub committees established.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

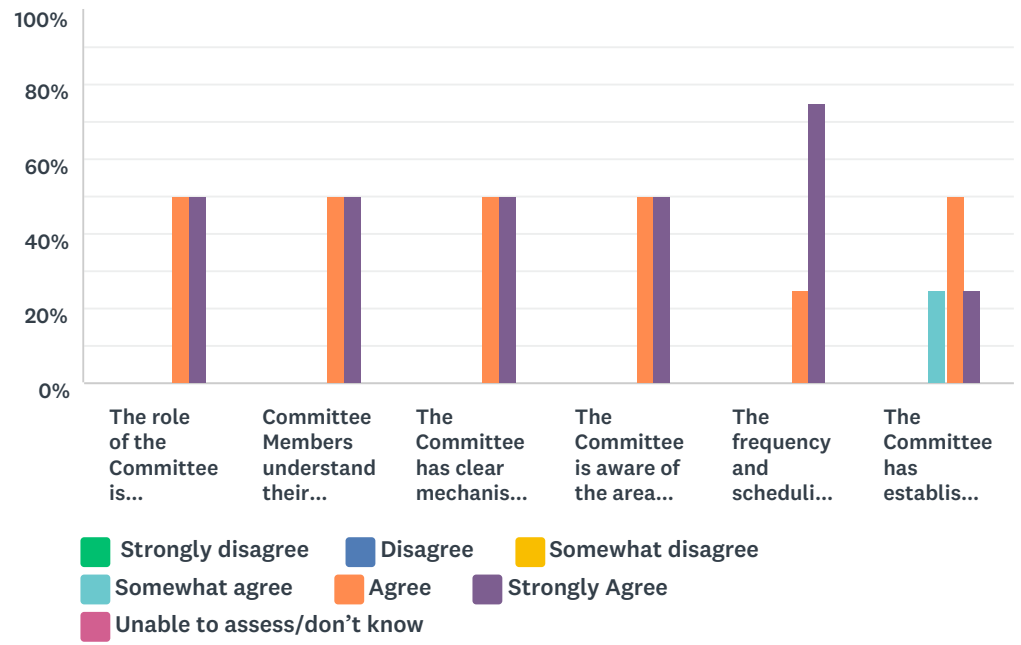
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	FC Terms of Reference
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	FC Members & In Attendance Members

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not Applicable

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not Applicable
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Q1 The Role/ Purpose of the Committee

Answered: 4 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
The role of the Committee is understood and clearly defined in its Terms of Reference.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50
Committee Members understand their individual role and what is expected of them.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50
The Committee has clear mechanisms in place to keep it aware of topical, legal and regulatory issues, in relation to financial performance and delivery.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50
The Committee is aware of the areas in which it can take decisions under the Health Board's Scheme of Delegation.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50

The frequency and scheduling of Committee meetings are sufficient to carry out its functions and responsibilities.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75
The Committee has established and follows an agreed plan for the year's work.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	50.00% 2	25.00% 1	0.00% 0	4	5.00

#	COMMENTS FOR "THE ROLE OF THE COMMITTEE IS UNDERSTOOD AND CLEARLY DEFINED IN ITS TERMS OF REFERENCE."	DATE
	There are no responses.	

#	COMMENTS FOR "COMMITTEE MEMBERS UNDERSTAND THEIR INDIVIDUAL ROLE AND WHAT IS EXPECTED OF THEM."	DATE
	There are no responses.	

#	COMMENTS FOR "THE COMMITTEE HAS CLEAR MECHANISMS IN PLACE TO KEEP IT AWARE OF TOPICAL, LEGAL AND REGULATORY ISSUES, IN RELATION TO FINANCIAL PERFORMANCE AND DELIVERY."	DATE
	There are no responses.	

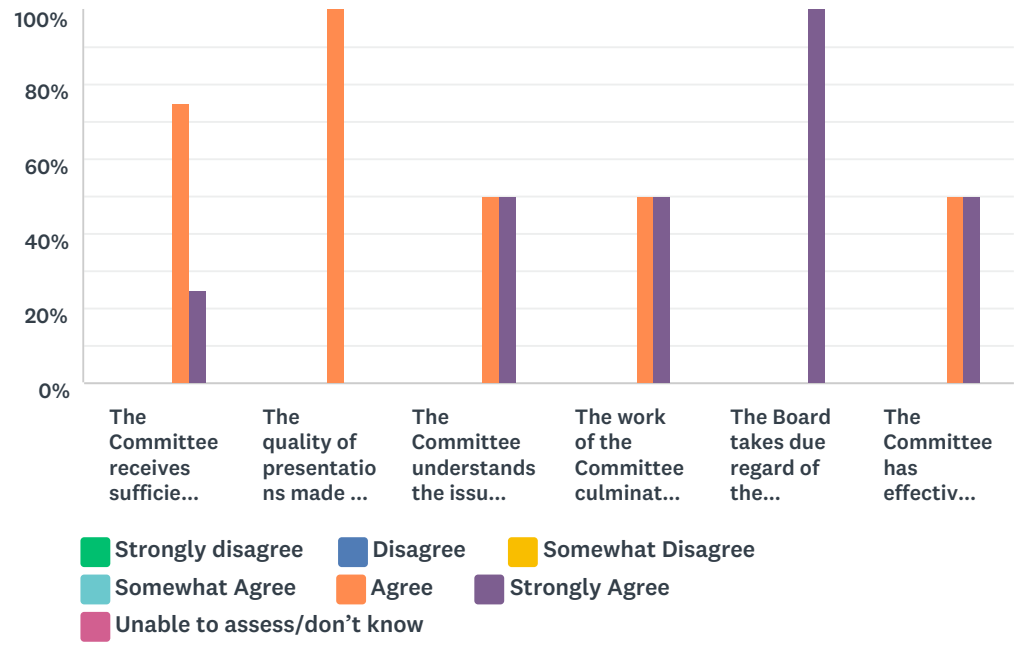
#	COMMENTS FOR "THE COMMITTEE IS AWARE OF THE AREAS IN WHICH IT CAN TAKE DECISIONS UNDER THE HEALTH BOARD'S SCHEME OF DELEGATION."	DATE
	There are no responses.	

#	COMMENTS FOR "THE FREQUENCY AND SCHEDULING OF COMMITTEE MEETINGS ARE SUFFICIENT TO CARRY OUT ITS FUNCTIONS AND RESPONSIBILITIES."	DATE
	There are no responses.	

#	COMMENTS FOR "THE COMMITTEE HAS ESTABLISHED AND FOLLOWS AN AGREED PLAN FOR THE YEAR'S WORK."	DATE
1	The Committee is relatively new - only being formally established mid-year.	4/12/2019 11:53 AM

Q2 Scope of work

Answered: 4 Skipped: 0



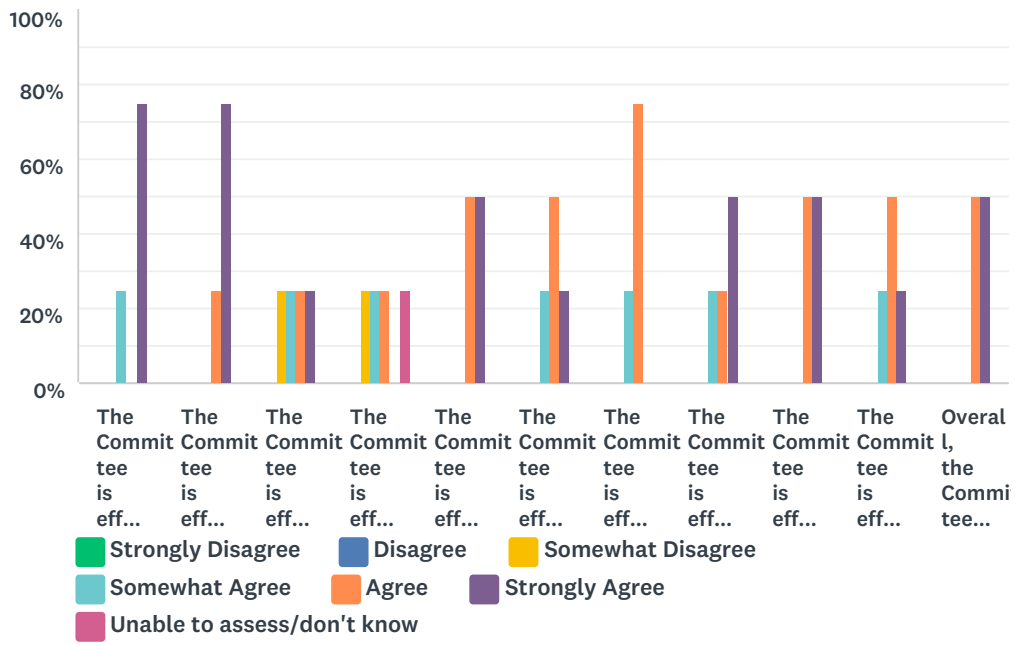
	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
The Committee receives sufficient and timely information to review, understand and assess the issues for discussion on which to base its decisions.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	75.00% 3	25.00% 1	0.00% 0	4	5.25
The quality of presentations made to the Committee is appropriate.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 4	0.00% 0	0.00% 0	4	5.00
The Committee understands the issues which are on the horizon for the Health Board which may impact on its areas of work.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50
The work of the Committee culminates in appropriate recommendations to the Board.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50

The Board takes due regard of the recommendations from the Committee.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 4	0.00% 0	4	6.00
The Committee has effective escalation arrangements in place to alert relevant individuals and committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50

#	COMMENTS FOR "THE COMMITTEE RECEIVES SUFFICIENT AND TIMELY INFORMATION TO REVIEW, UNDERSTAND AND ASSESS THE ISSUES FOR DISCUSSION ON WHICH TO BASE ITS DECISIONS."	DATE
	There are no responses.	
#	COMMENTS FOR "THE QUALITY OF PRESENTATIONS MADE TO THE COMMITTEE IS APPROPRIATE."	DATE
1	Sometimes presentations deviate from the written reports.	4/12/2019 11:53 AM
#	COMMENTS FOR "THE COMMITTEE UNDERSTANDS THE ISSUES WHICH ARE ON THE HORIZON FOR THE HEALTH BOARD WHICH MAY IMPACT ON ITS AREAS OF WORK."	DATE
	There are no responses.	
#	COMMENTS FOR "THE WORK OF THE COMMITTEE CULMINATES IN APPROPRIATE RECOMMENDATIONS TO THE BOARD."	DATE
	There are no responses.	
#	COMMENTS FOR "THE BOARD TAKES DUE REGARD OF THE RECOMMENDATIONS FROM THE COMMITTEE. "	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE HAS EFFECTIVE ESCALATION ARRANGEMENTS IN PLACE TO ALERT RELEVANT INDIVIDUALS AND COMMITTEES OF ANY URGENT/CRITICAL MATTERS THAT MAY COMPROMISE PATIENT CARE AND AFFECT THE OPERATION AND/OR REPUTATION OF THE HEALTH BOARD."	DATE
	There are no responses.	

Q3 Assurance

Answered: 4 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
The Committee is effective in scrutinising and providing oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability).	0.00% 0	0.00% 0	0.00% 0	25.00% 1	0.00% 0	75.00% 3	0.00% 0	4	4.75
The Committee is effective in reviewing financial performance and reviewing any areas of financial concern.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.00

The Committee is effective in conducting detailed scrutiny of all aspects of financial performance, the financial implications of major business cases, projects, and proposed investment decisions on behalf of the Board.	0.00% 0	0.00% 0	25.00% 1	25.00% 1	25.00% 1	25.00% 1	0.00% 0	4	4.25
The Committee is effective in regularly reviewing contracts with key delivery partners.	0.00% 0	0.00% 0	25.00% 1	25.00% 1	25.00% 1	0.00% 0	25.00% 1	4	4.50
The Committee is effective in providing assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.00
The Committee is effective in seeking assurance on the management of principle risks within the BAF and CRR allocated to the Committee (financial risks), and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk appetite is exceeded, lack of timely action.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	50.00% 2	25.00% 1	0.00% 0	4	4.75
The Committee is effective in recommending acceptance of risks that cannot be brought within the Health Boards risk appetite/tolerance to the Board through the Committee Update Report.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	0.00% 0	4	4.75
The Committee is effective in providing assurance, raising appropriate concerns and making recommendations to the Board as a consequence of the Committee's role in relation to short term focus, medium term focus and improving financial management.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	25.00% 1	50.00% 2	0.00% 0	4	4.75
The Committee is effective in developing and regularly reviewing the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.00
The Committee is effective in reviewing and approving financial procedures on behalf of the Health Board.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	50.00% 2	25.00% 1	0.00% 0	4	4.75

Overall, the Committee is effectively fulfilling its Terms of Reference.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.00

#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN SCRUTINISING AND PROVIDING OVERSIGHT OF FINANCIAL AND THE REVENUE CONSEQUENCES OF INVESTMENT PLANNING (BOTH SHORT TERM AND IN RELATION TO LONGER TERM SUSTAINABILITY)."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN REVIEWING FINANCIAL PERFORMANCE AND REVIEWING ANY AREAS OF FINANCIAL CONCERN."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN CONDUCTING DETAILED SCRUTINY OF ALL ASPECTS OF FINANCIAL PERFORMANCE, THE FINANCIAL IMPLICATIONS OF MAJOR BUSINESS CASES, PROJECTS, AND PROPOSED INVESTMENT DECISIONS ON BEHALF OF THE BOARD."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN REGULARLY REVIEWING CONTRACTS WITH KEY DELIVERY PARTNERS."	DATE
1	The Committee does not review contracts in any detail	4/12/2019 11:53 AM
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN PROVIDING ASSURANCE ON FINANCIAL PERFORMANCE AND DELIVERY AGAINST HEALTH BOARD FINANCIAL PLANS AND OBJECTIVES AND, ON FINANCIAL CONTROL, GIVING EARLY WARNING ON POTENTIAL PERFORMANCE ISSUES AND MAKING RECOMMENDATIONS FOR ACTION TO CONTINUOUSLY IMPROVE THE FINANCIAL POSITION OF THE ORGANISATION, FOCUSING IN DETAIL ON SPECIFIC ISSUES WHERE FINANCIAL PERFORMANCE IS SHOWING DETERIORATION OR THERE ARE AREAS OF CONCERN."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN SEEKING ASSURANCE ON THE MANAGEMENT OF PRINCIPLE RISKS WITHIN THE BAF AND CRR ALLOCATED TO THE COMMITTEE (FINANCIAL RISKS), AND PROVIDE ASSURANCE TO THE BOARD THAT RISKS ARE BEING MANAGED EFFECTIVELY AND REPORT ANY AREAS OF SIGNIFICANT CONCERN E.G. WHERE RISK APPETITE IS EXCEEDED, LACK OF TIMELY ACTION."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN RECOMMENDING ACCEPTANCE OF RISKS THAT CANNOT BE BROUGHT WITHIN THE HEALTH BOARDS RISK APPETITE/TOLERANCE TO THE BOARD THROUGH THE COMMITTEE UPDATE REPORT."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN PROVIDING ASSURANCE, RAISING APPROPRIATE CONCERNS AND MAKING RECOMMENDATIONS TO THE BOARD AS A CONSEQUENCE OF THE COMMITTEE'S ROLE IN RELATION TO SHORT TERM FOCUS, MEDIUM TERM FOCUS AND IMPROVING FINANCIAL MANAGEMENT."	DATE
	There are no responses.	

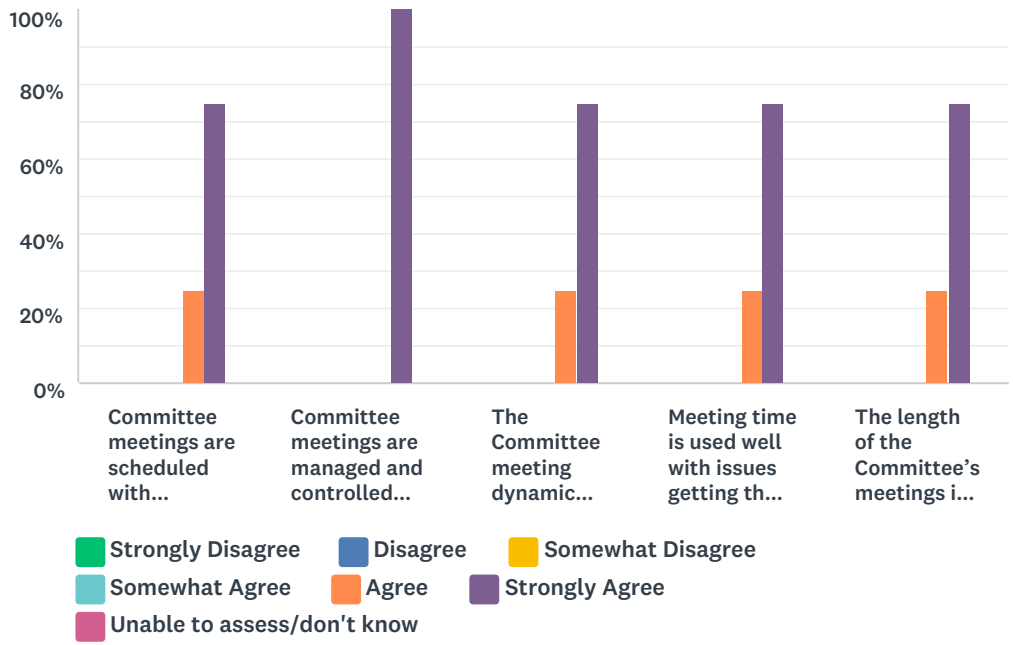
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN DEVELOPING AND REGULARLY REVIEWING THE FINANCIAL PERFORMANCE MANAGEMENT FRAMEWORK AND REPORTING APPROACH, ENSURING IT INCLUDES MEANINGFUL, APPROPRIATE AND INTEGRATED, TIMELY PERFORMANCE DATA AND CLEAR COMMENTARY RELATING TO THE TOTALITY OF THE SERVICES FOR WHICH THE BOARD IS RESPONSIBLE."	DATE
	There are no responses.	

#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN REVIEWING AND APPROVING FINANCIAL PROCEDURES ON BEHALF OF THE HEALTH BOARD."	DATE
	There are no responses.	

#	COMMENTS FOR "OVERALL, THE COMMITTEE IS EFFECTIVELY FULFILLING ITS TERMS OF REFERENCE."	DATE
	There are no responses.	

Q4 Meetings

Answered: 4 Skipped: 0

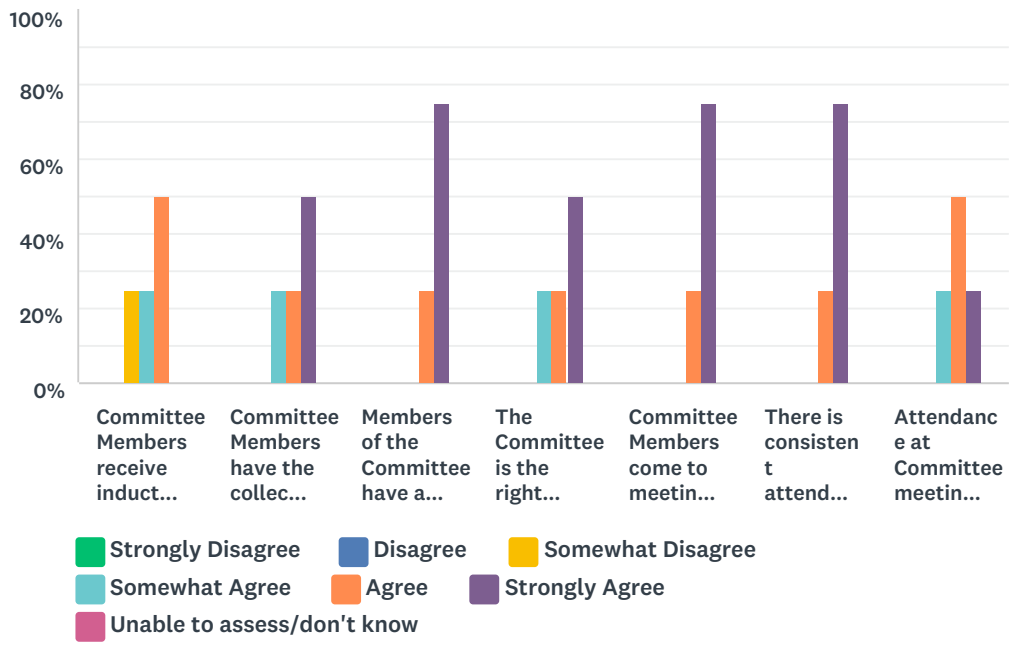


	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
Committee meetings are scheduled with sufficient time to cover all agenda items, including discussion and answering questions.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75
Committee meetings are managed and controlled effectively and conducted in a business-like manner.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 4	0.00% 0	4	6.00
The Committee meeting dynamic encourages full participation and open communications.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75
Meeting time is used well with issues getting the time and attention proportionate to their importance.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75

The length of the Committee's meetings is appropriate in relation to the agenda.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75

Q5 Membership

Answered: 4 Skipped: 0

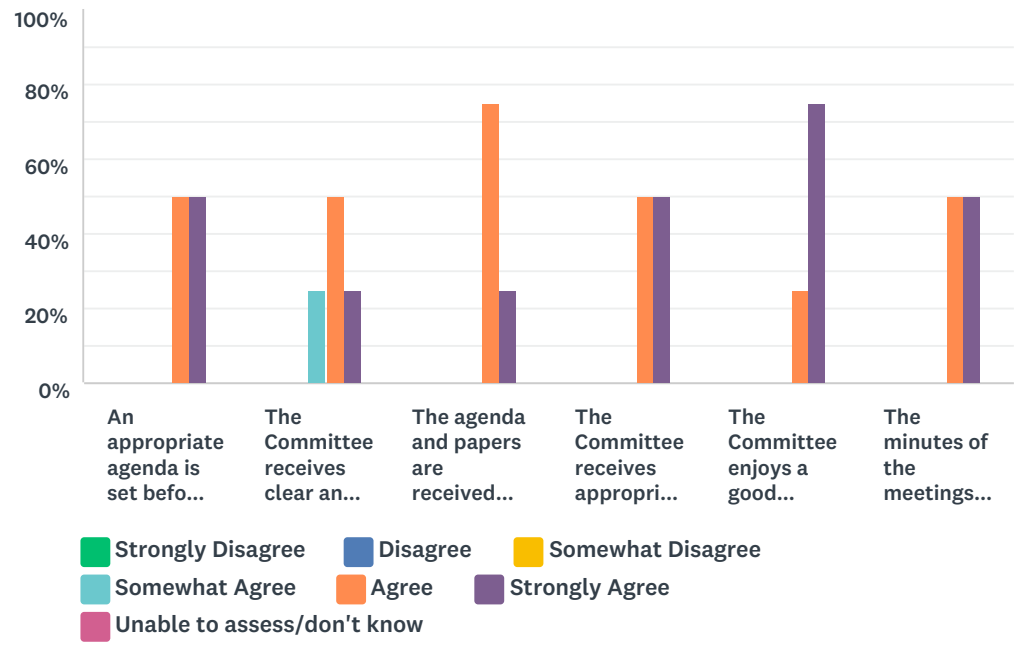


	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
Committee Members receive induction, advice and ongoing development opportunities to support them in their role.	0.00% 0	0.00% 0	25.00% 1	25.00% 1	50.00% 2	0.00% 0	0.00% 0	4	4.25
Committee Members have the collective skills, knowledge and experience to fulfil its Terms of Reference and to advise and assure the Board.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	25.00% 1	50.00% 2	0.00% 0	4	5.25
Members of the Committee have a good understanding of the Health Board’s financial performance, delivery on the Health Board's financial plans and objectives, and on financial control.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75

The Committee is the right size and sufficiently diverse.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	25.00% 1	50.00% 2	0.00% 0	4	5.25
Committee Members come to meetings prepared and ready to contribute.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75
There is consistent attendance and timely arrival by Members at Committee meetings.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75
Attendance at Committee meetings is evaluated as a criterion for continued membership on the Committee.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	50.00% 2	25.00% 1	0.00% 0	4	5.00

Q6 Support for the Committee

Answered: 4 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
An appropriate agenda is set before Committee meetings and is followed.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50
The Committee receives clear and concise papers which focus on the key issues and priorities.	0.00% 0	0.00% 0	0.00% 0	25.00% 1	50.00% 2	25.00% 1	0.00% 0	4	5.00
The agenda and papers are received in a timely manner in advance of the meetings to allow time for appropriate review and preparation.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	75.00% 3	25.00% 1	0.00% 0	4	5.25
The Committee receives appropriate advice from or via the Executive Team and staff.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50

The Committee enjoys a good working relationship with management and significant issues are reviewed with the Chief Executive or the relevant Lead Director.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	25.00% 1	75.00% 3	0.00% 0	4	5.75
The minutes of the meetings are accurate and reflect the discussion, next steps and/or action articulated by Members.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 2	50.00% 2	0.00% 0	4	5.50

Q7 General Comments

Answered: 4 Skipped: 0

ANSWER CHOICES	RESPONSES	
The Committee's key successes in the past year were:	100.00%	4
The Committee's major shortcomings in the past year were:	50.00%	2
What could be improved at the Committee's meetings, and how:	100.00%	4
What areas would help you perform your Committee role more effectively:	25.00%	1
What areas should the Committee focus on in future:	50.00%	2

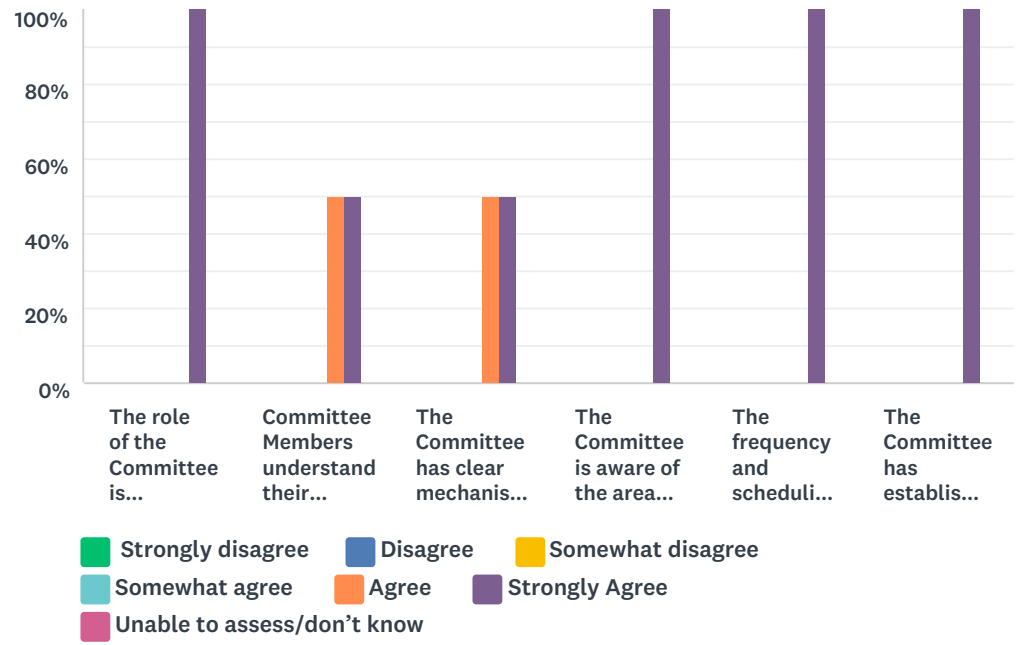
#	THE COMMITTEE'S KEY SUCCESSES IN THE PAST YEAR WERE:	DATE
1	As a new Committee established in September 2018, it settled into its role very quickly.	4/12/2019 11:53 AM
2	This Committee has developed well and is now working effectively	4/7/2019 11:42 AM
3	The committee has matured and developed over the past year. It is now providing effective scrutiny and oversight of financial performance. This has led to greater focus on and better understanding of the challenges faced. This has contributed to the financial performance improving this year.	4/4/2019 9:46 PM
4	Achieving the control total; development of the establishment control project	4/3/2019 4:51 PM
#	THE COMMITTEE'S MAJOR SHORTCOMINGS IN THE PAST YEAR WERE:	DATE
1	None	4/4/2019 9:46 PM
2	Delivery of the savings plan; focus on financial improvement	4/3/2019 4:51 PM
#	WHAT COULD BE IMPROVED AT THE COMMITTEE'S MEETINGS, AND HOW:	DATE
1	Better consistency between presentations and written reports.	4/12/2019 11:53 AM
2	In future to give enough time to scrutiny's the establishement control work which has started	4/7/2019 11:42 AM
3	Fewer presentations!	4/4/2019 9:46 PM
4	Some of the papers could be more concise and sharper focused	4/3/2019 4:51 PM
#	WHAT AREAS WOULD HELP YOU PERFORM YOUR COMMITTEE ROLE MORE EFFECTIVELY:	DATE

1	I think there is scope for further training on how to exercise appropriate oversight. Some examples of what a good finance committee looks like would be helpful. It may be useful if the chair of the committee was able to share some of the good and bad practice he may have seen through performing the same role in other organisations.	4/4/2019 9:46 PM

#	WHAT AREAS SHOULD THE COMMITTEE FOCUS ON IN FUTURE:	DATE
1	If the health board is successful in some of its capital bids especially those associated with TCS it will be necessary to exercise greater focus on scrutiny of capital projects. Further training on this may be necessary. More focus on benchmarking and the learning from that would be helpful. Also the work on understanding our underlying deficit.	4/4/2019 9:46 PM
2	In year financial management, delivery of the savings plan, transformation, getting the fundamental financial building blocks in place, managing short and medium term financial risks	4/3/2019 4:51 PM

Q1 The Role/ Purpose of the Committee

Answered: 2 Skipped: 0

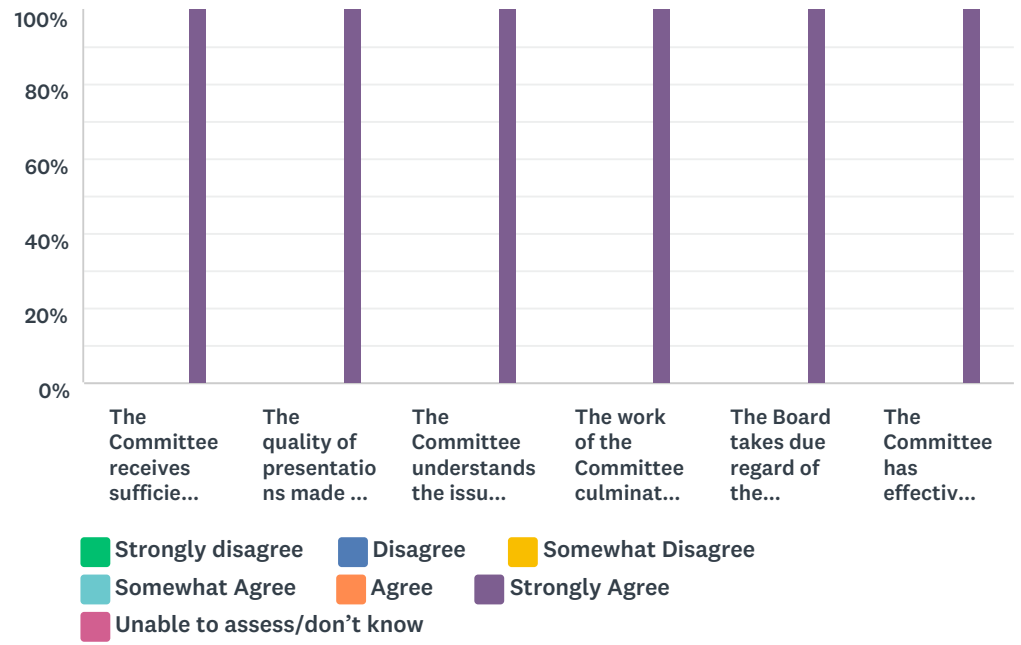


	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
The role of the Committee is understood and clearly defined in its Terms of Reference.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
Committee Members understand their individual role and what is expected of them.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.50
The Committee has clear mechanisms in place to keep it aware of topical, legal and regulatory issues, in relation to financial performance and delivery.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.50
The Committee is aware of the areas in which it can take decisions under the Health Board's Scheme of Delegation.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

The frequency and scheduling of Committee meetings are sufficient to carry out its functions and responsibilities.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The Committee has established and follows an agreed plan for the year's work.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

Q2 Scope of work

Answered: 2 Skipped: 0

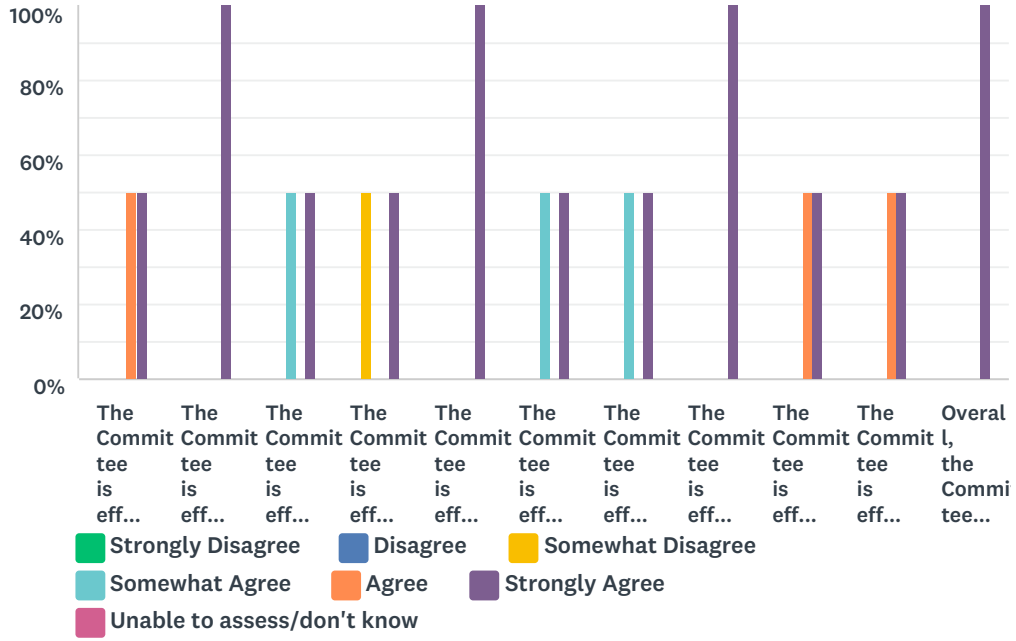


	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
The Committee receives sufficient and timely information to review, understand and assess the issues for discussion on which to base its decisions.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The quality of presentations made to the Committee is appropriate.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The Committee understands the issues which are on the horizon for the Health Board which may impact on its areas of work.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The work of the Committee culminates in appropriate recommendations to the Board.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

The Board takes due regard of the recommendations from the Committee.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The Committee has effective escalation arrangements in place to alert relevant individuals and committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

Q3 Assurance

Answered: 2 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
The Committee is effective in scrutinising and providing oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability).	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.00
The Committee is effective in reviewing financial performance and reviewing any areas of financial concern.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	5.00

The Committee is effective in conducting detailed scrutiny of all aspects of financial performance, the financial implications of major business cases, projects, and proposed investment decisions on behalf of the Board.	0.00% 0	0.00% 0	0.00% 0	50.00% 1	0.00% 0	50.00% 1	0.00% 0	2	4.50
The Committee is effective in regularly reviewing contracts with key delivery partners.	0.00% 0	0.00% 0	50.00% 1	0.00% 0	0.00% 0	50.00% 1	0.00% 0	2	4.00
The Committee is effective in providing assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	5.00
The Committee is effective in seeking assurance on the management of principle risks within the BAF and CRR allocated to the Committee (financial risks), and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk appetite is exceeded, lack of timely action.	0.00% 0	0.00% 0	0.00% 0	50.00% 1	0.00% 0	50.00% 1	0.00% 0	2	4.50
The Committee is effective in recommending acceptance of risks that cannot be brought within the Health Boards risk appetite/tolerance to the Board through the Committee Update Report.	0.00% 0	0.00% 0	0.00% 0	50.00% 1	0.00% 0	50.00% 1	0.00% 0	2	4.50
The Committee is effective in providing assurance, raising appropriate concerns and making recommendations to the Board as a consequence of the Committee's role in relation to short term focus, medium term focus and improving financial management.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	5.00
The Committee is effective in developing and regularly reviewing the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.00
The Committee is effective in reviewing and approving financial procedures on behalf of the Health Board.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.00

Overall, the Committee is effectively fulfilling its Terms of Reference.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	5.00

#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN SCRUTINISING AND PROVIDING OVERSIGHT OF FINANCIAL AND THE REVENUE CONSEQUENCES OF INVESTMENT PLANNING (BOTH SHORT TERM AND IN RELATION TO LONGER TERM SUSTAINABILITY)."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN REVIEWING FINANCIAL PERFORMANCE AND REVIEWING ANY AREAS OF FINANCIAL CONCERN."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN CONDUCTING DETAILED SCRUTINY OF ALL ASPECTS OF FINANCIAL PERFORMANCE, THE FINANCIAL IMPLICATIONS OF MAJOR BUSINESS CASES, PROJECTS, AND PROPOSED INVESTMENT DECISIONS ON BEHALF OF THE BOARD."	DATE
1	In relation to major business cases this is an area the committee has not, so far, needed to examine although it is its a clear intention to do so	4/24/2019 12:31 PM
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN REGULARLY REVIEWING CONTRACTS WITH KEY DELIVERY PARTNERS."	DATE
1	Not an area the committee has focussed on particularly	4/24/2019 12:31 PM
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN PROVIDING ASSURANCE ON FINANCIAL PERFORMANCE AND DELIVERY AGAINST HEALTH BOARD FINANCIAL PLANS AND OBJECTIVES AND, ON FINANCIAL CONTROL, GIVING EARLY WARNING ON POTENTIAL PERFORMANCE ISSUES AND MAKING RECOMMENDATIONS FOR ACTION TO CONTINUOUSLY IMPROVE THE FINANCIAL POSITION OF THE ORGANISATION, FOCUSING IN DETAIL ON SPECIFIC ISSUES WHERE FINANCIAL PERFORMANCE IS SHOWING DETERIORATION OR THERE ARE AREAS OF CONCERN."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN SEEKING ASSURANCE ON THE MANAGEMENT OF PRINCIPLE RISKS WITHIN THE BAF AND CRR ALLOCATED TO THE COMMITTEE (FINANCIAL RISKS), AND PROVIDE ASSURANCE TO THE BOARD THAT RISKS ARE BEING MANAGED EFFECTIVELY AND REPORT ANY AREAS OF SIGNIFICANT CONCERN E.G. WHERE RISK APPETITE IS EXCEEDED, LACK OF TIMELY ACTION."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN RECOMMENDING ACCEPTANCE OF RISKS THAT CANNOT BE BROUGHT WITHIN THE HEALTH BOARDS RISK APPETITE/TOLERANCE TO THE BOARD THROUGH THE COMMITTEE UPDATE REPORT."	DATE
	There are no responses.	
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN PROVIDING ASSURANCE, RAISING APPROPRIATE CONCERNS AND MAKING RECOMMENDATIONS TO THE BOARD AS A CONSEQUENCE OF THE COMMITTEE'S ROLE IN RELATION TO SHORT TERM FOCUS, MEDIUM TERM FOCUS AND IMPROVING FINANCIAL MANAGEMENT."	DATE
	There are no responses.	

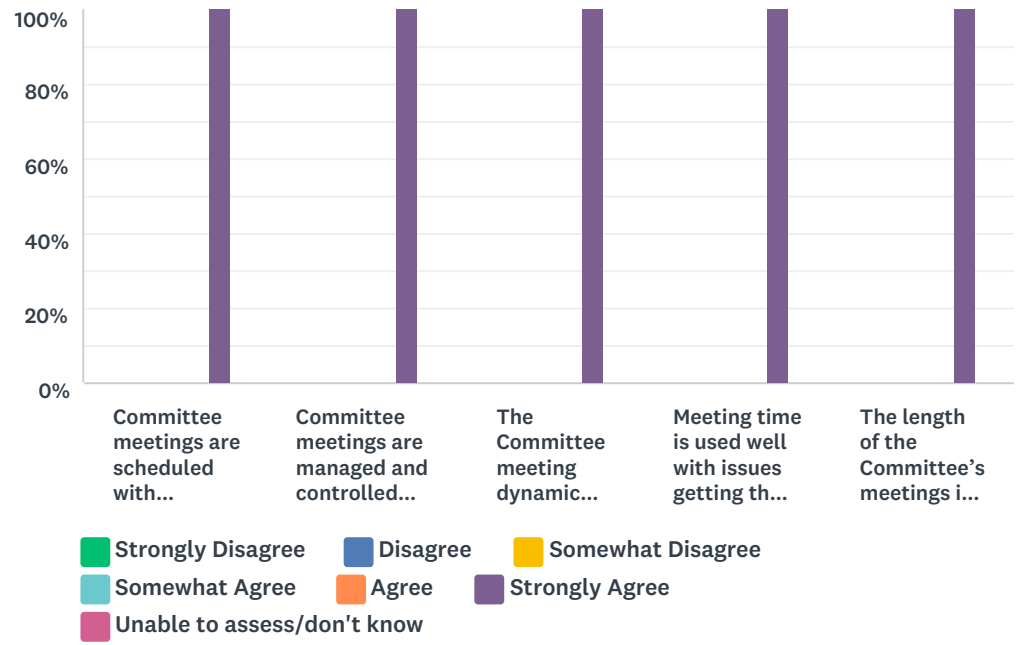
#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN DEVELOPING AND REGULARLY REVIEWING THE FINANCIAL PERFORMANCE MANAGEMENT FRAMEWORK AND REPORTING APPROACH, ENSURING IT INCLUDES MEANINGFUL, APPROPRIATE AND INTEGRATED, TIMELY PERFORMANCE DATA AND CLEAR COMMENTARY RELATING TO THE TOTALITY OF THE SERVICES FOR WHICH THE BOARD IS RESPONSIBLE."	DATE
	There are no responses.	

#	COMMENTS FOR "THE COMMITTEE IS EFFECTIVE IN REVIEWING AND APPROVING FINANCIAL PROCEDURES ON BEHALF OF THE HEALTH BOARD."	DATE
	There are no responses.	

#	COMMENTS FOR "OVERALL, THE COMMITTEE IS EFFECTIVELY FULFILLING ITS TERMS OF REFERENCE."	DATE
	There are no responses.	

Q4 Meetings

Answered: 2 Skipped: 0

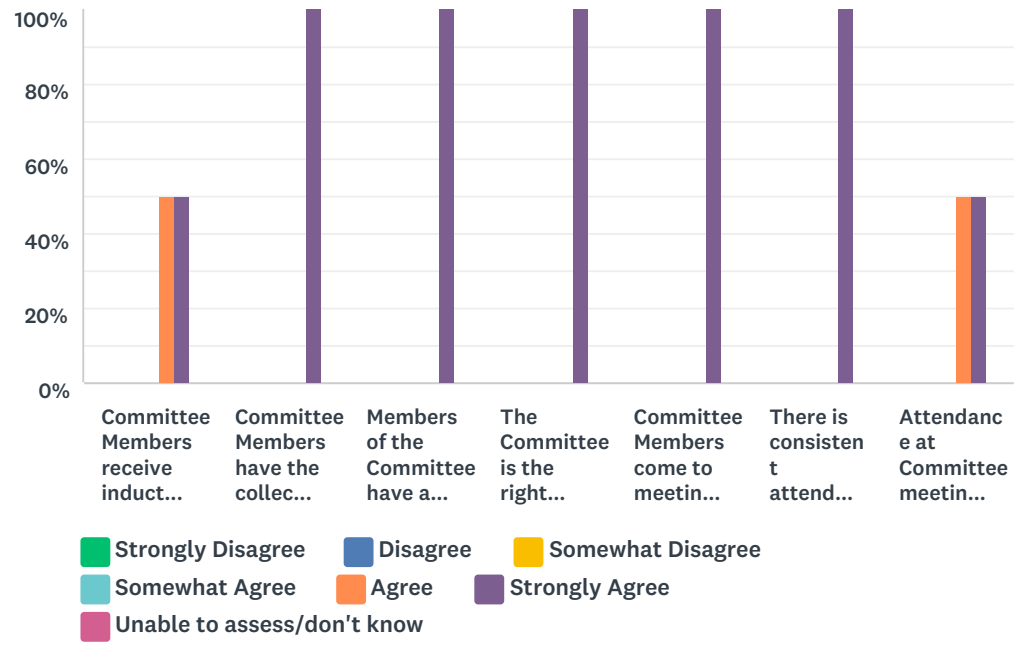


	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
Committee meetings are scheduled with sufficient time to cover all agenda items, including discussion and answering questions.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
Committee meetings are managed and controlled effectively and conducted in a business-like manner.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The Committee meeting dynamic encourages full participation and open communications.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
Meeting time is used well with issues getting the time and attention proportionate to their importance.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

The length of the Committee's meetings is appropriate in relation to the agenda.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

Q5 Membership

Answered: 2 Skipped: 0

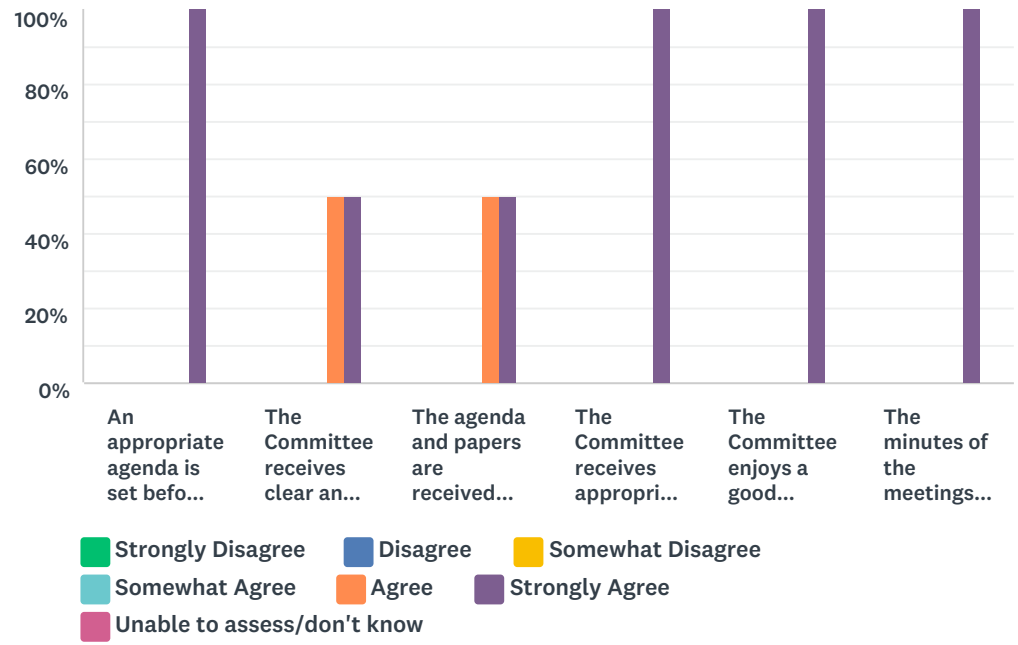


	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
Committee Members receive induction, advice and ongoing development opportunities to support them in their role.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.50
Committee Members have the collective skills, knowledge and experience to fulfil its Terms of Reference and to advise and assure the Board.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
Members of the Committee have a good understanding of the Health Board’s financial performance, delivery on the Health Board's financial plans and objectives, and on financial control.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

The Committee is the right size and sufficiently diverse.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
Committee Members come to meetings prepared and ready to contribute.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
There is consistent attendance and timely arrival by Members at Committee meetings.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
Attendance at Committee meetings is evaluated as a criterion for continued membership on the Committee.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.50

Q6 Support for the Committee

Answered: 2 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	UNABLE TO ASSESS/DON'T KNOW	TOTAL	WEIGHTED AVERAGE
An appropriate agenda is set before Committee meetings and is followed.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The Committee receives clear and concise papers which focus on the key issues and priorities.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.50
The agenda and papers are received in a timely manner in advance of the meetings to allow time for appropriate review and preparation.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2	5.50
The Committee receives appropriate advice from or via the Executive Team and staff.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

The Committee enjoys a good working relationship with management and significant issues are reviewed with the Chief Executive or the relevant Lead Director.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00
The minutes of the meetings are accurate and reflect the discussion, next steps and/or action articulated by Members.	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 2	0.00% 0	2	6.00

Q7 General Comments

Answered: 1 Skipped: 1

ANSWER CHOICES	RESPONSES	
The Committee's key successes in the past year were:	100.00%	1
The Committee's major shortcomings in the past year were:	100.00%	1
What could be improved at the Committee's meetings, and how:	0.00%	0
What areas would help you perform your Committee role more effectively:	0.00%	0
What areas should the Committee focus on in future:	100.00%	1

#	THE COMMITTEE'S KEY SUCCESSES IN THE PAST YEAR WERE:	DATE
1	Providing specific focus to teh finance agenda and delivery of the financial and turnaround plan	4/24/2019 12:31 PM
#	**THE COMMITTEE'S MAJOR SHORTCOMINGS IN THE PAST YEAR WERE:**	**DATE**
1	Necessariliy focussed on shorter term in 2018/19 - need to add to this in 2019/20 by also revieing medium and long term issues/actions	4/24/2019 12:31 PM
#	**WHAT COULD BE IMPROVED AT THE COMMITTEE'S MEETINGS, AND HOW:**	**DATE**
	There are no responses.	
#	**WHAT AREAS WOULD HELP YOU PERFORM YOUR COMMITTEE ROLE MORE EFFECTIVELY:**	**DATE**
	There are no responses.	
#	**WHAT AREAS SHOULD THE COMMITTEE FOCUS ON IN FUTURE:**	**DATE**
1	Whilst keeping a close focus on in-year delivery, a move to medium/longer term issues would also be helpful	4/24/2019 12:31 PM

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Update – Month 1 2019/20
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Fiona Powell, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date against our Annual Plan and Control Total requirement; and assess the key financial projections and risks for the financial year.

Cefndir / Background

The Health Board's financial position at the end of Month 1 represented an adverse variance against plan of £0.4m. This position was driven by Surge bed pressures in Unscheduled and Critical Care.

The Health Board's control total is £25m and plans are being developed to achieve this position. This is a required improvement of £4.8m on the Health Board's Annual Plan deficit of £29.8m, which will require the identification of further actionable Savings schemes.

£0.8m of Savings schemes were delivered in Month 1. The total required savings is £28.8m for the year. The current gap in identified assured savings schemes is £10.3m, against which there are identified pipeline opportunities of £8.3m.

The risk of delivering the forecast is rated High given the balance remaining of pipeline and unidentified savings schemes and in recognition of the critical need for the delivery profile to accelerate significantly in order to achieve the full savings requirement.

With the in-month operational run rate being £0.4m, there must also be acknowledgment that there will always be an operational risk that needs to be managed. Escalated Holding to Account meetings are being held with the challenged Directorates to convert

Asesiad / Assessment

The Health Board's key targets are as follows:

Revenue: to contain the overspend within the Health Board's planned deficit
Savings: to deliver savings plans to enable the revenue budget to be achieved
Capital: to contain expenditure within the agreed limit
PSPP: to pay 95% of Non-NHS invoices within 30 days of receipt of a valid invoice
Cash: While there is no prescribed limit for cash held at the end of the month, WG encourages this to be minimised and a rule of thumb of 5% of monthly expenditure is used. For the Health Board, this is broadly £4.0m.

Key target		Annual limit	YTD limit	Actual delivery	Forecast Risk
Revenue	**£'m**	25.0	2.5	2.9	**High***
Savings	**£'m**	28.8	0.8	0.8	**High***
Capital	**£'m**	39.3	1.7	1.7	**Medium**
Non-NHS PSPP	**%**	95	95	n/a in Month 1	**Low**
Period end cash	**£'m**	4.0	4.0	2.7	**Medium****

* Inclusive of the Welsh Government Control Total requirement.
** Assumes Welsh Government strategic repayable support for the planned deficit position.

Argymhelliad / Recommendation

The Finance Committee is asked to note and discuss the financial position for Month 1.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF S09-PR20 BAF SO10-PR33
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5. Timely Care 7. Staff and Resources Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system.
Rhestr Termau: Glossary of Terms:	BGH – Bronglais General Hospital CHC – Continuing Healthcare CIP – Cost Improvement Programme ENT – Ear, Nose and Throat DES – Direct Enhanced Services FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili General Hospital GMS – General Medical Services MHLD – Mental Health & Learning Disabilities MDT – Multi-Disciplinary Team NICE – National Institute for Health and Care Excellence OOH – Out of Hours PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics VC – Video Conferencing VFM – Value For Money WG – Welsh Government WGH – Withybush General Hospital WRP – Welsh Risk Pool WHSSC – Welsh Health Specialised Services Committee YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Health Board's Finance Team Health Board's Management Team Executive Team Finance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.

Gweithlu: **Workforce:**	The report considers the financial implications of our workforce.
Risg: **Risk:**	Financial risks are detailed in the report.
Cyfreithiol: **Legal:**	The Health Board has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: **Reputational:**	Adverse variance against the Health Board's financial plan will affect our reputation with Welsh Government, the Wales Audit Office, and with external stakeholders
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

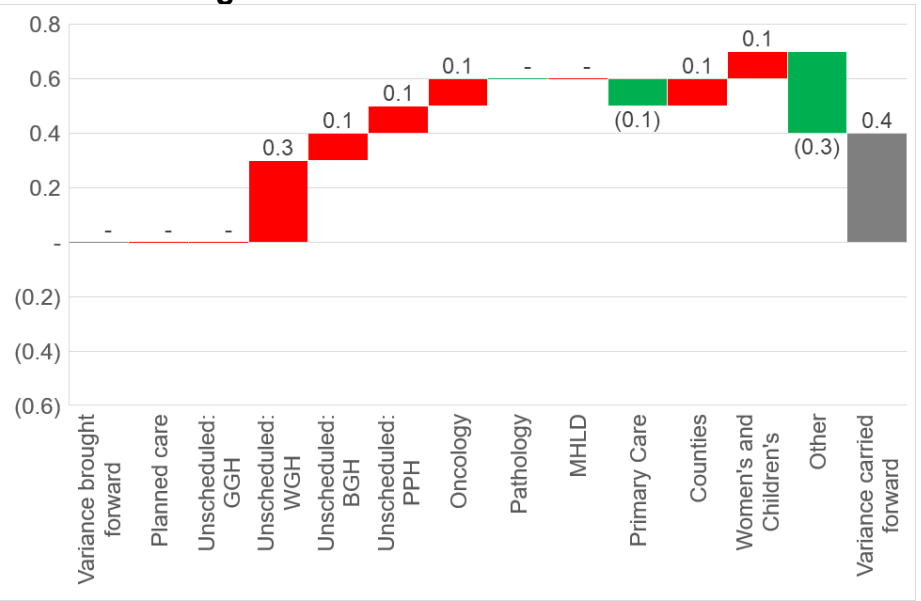
1. Directorate revenue position

2.1 Directorate financial performance

Year to date

	Month 1 Actual £'m	Month 1 Variance £'m	%
Planned	8.6	0.0	-
Unscheduled - GGH	1.9	0.1	5.3
Unscheduled - PPH	2.3	0.1	4.3
Unscheduled - WGH	3.6	0.0	-
Unscheduled - BGH	2.7	0.3	12.5
Radiology	1.4	0.0	-
Pathology	1.7	0.0	-
Women's and Children's	3.2	0.1	3.1
Cancer	1.2	0.1	9.1
Carmarthen County	1.0	0.0	-
Pembrokeshire County	2.1	0.0	-
Ceredigion County	1.8	0.1	5.9
MHLD	6.2	0.0	-
Facilities	3.2	0.0	-
Medicines Management	6.4	0.0	-
Primary Care	8.8	(0.1)	(1.1)
Corporate	3.2	0.0	-
Commissioning	8.2	0.0	-
Other	6.5	(0.3)	(4.4)
Total	**74.0**	**0.4**	**0.5**

In-month change

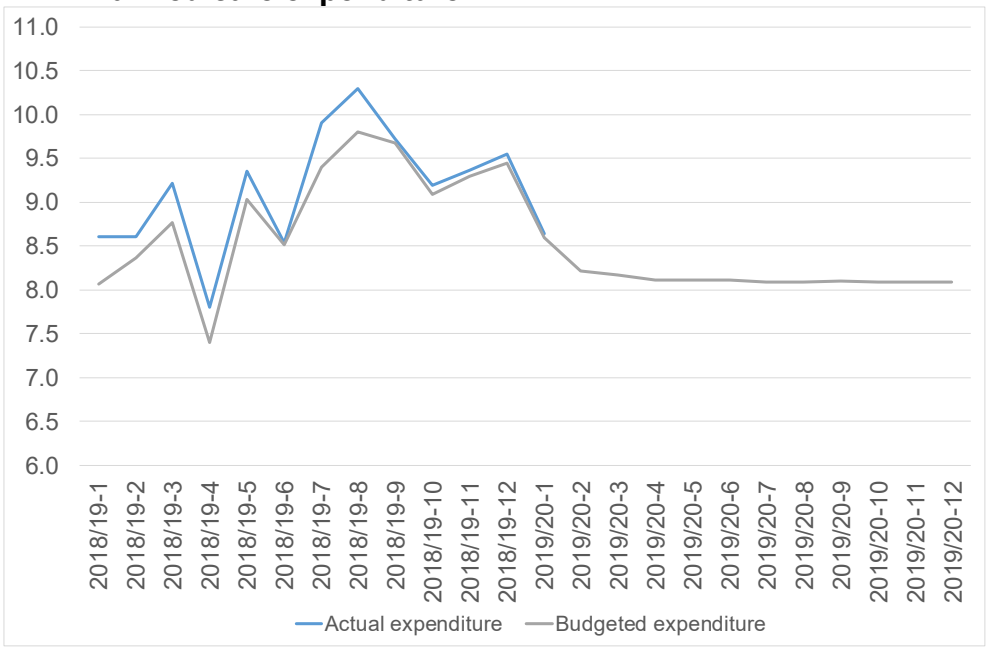


- In the current month was over spent by £0.4m due to surge bed pressures in Unscheduled and Critical Care.
- The year to date pressure has been particularly pronounced in Unscheduled Care (£0.5m, driven by bed capacity).
- Material positions are reported in Section 2.2.

1. Directorate revenue position

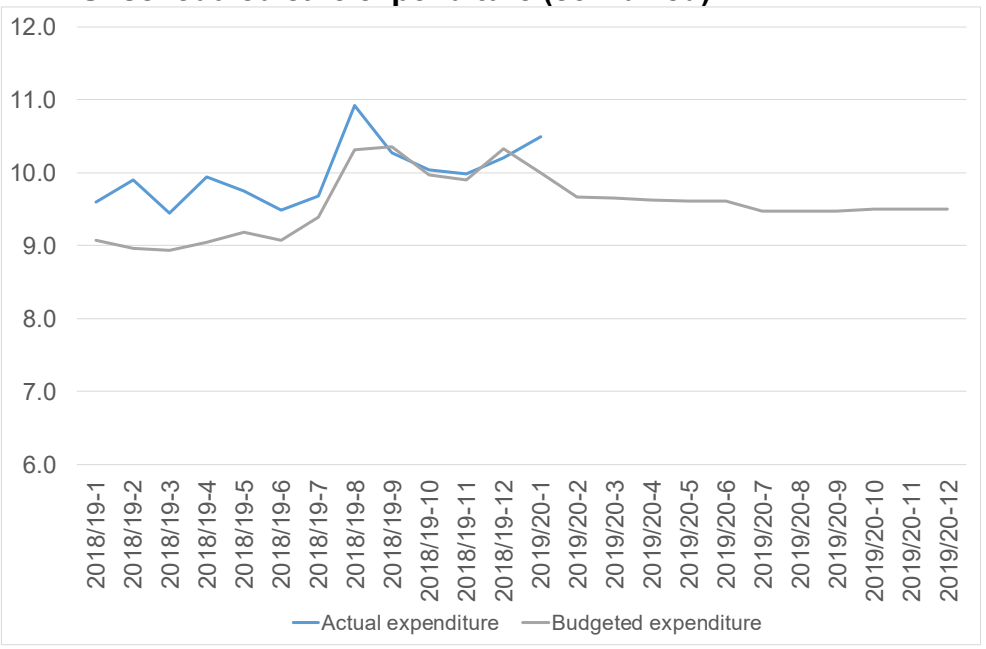
2.2 Material directorate area deficits

2.2.1 Planned care expenditure



- The in-month position showed a small adverse variance to budget of £36k, with over-spends in Medical and Nursing variable Pay due to excess surge in Critical Care, especially in Withybush General Hospital (WGH).
- The Directorate is expecting a significant benefit in efficiency and productivity, which will support the maintaining of our Referral to Treatment performance for the financial year.

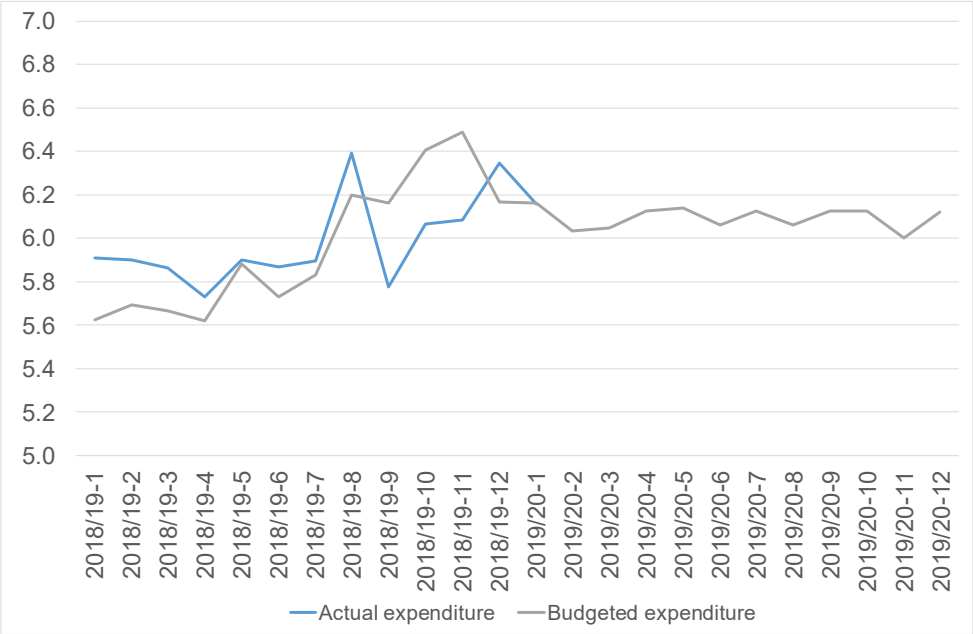
2.2.2 Unscheduled care expenditure (combined)



- Bronglais General Hospital (BGH) reported an over-spend in-month, driven by surge beds, with some use of off-contract agency workers. WGH reported a significant over-spend in-month, also driven by surge beds, leading to the use of off-contract agency Nursing and over-spend on Health Care Support Workers. Glangwili General Hospital (GGH) reported a slight in-month overspend mainly due to Qualified Nursing costs associated with excess surge, offset by Clinical Supplies. PPH was over-spent in-month, especially in Medical pay due to consultant and specialty registrar vacancies covered by Locums.
- Delayed discharges of medically fit patients and unfunded surge capacity remain key drivers to the costs, which requires a system-wide focus.

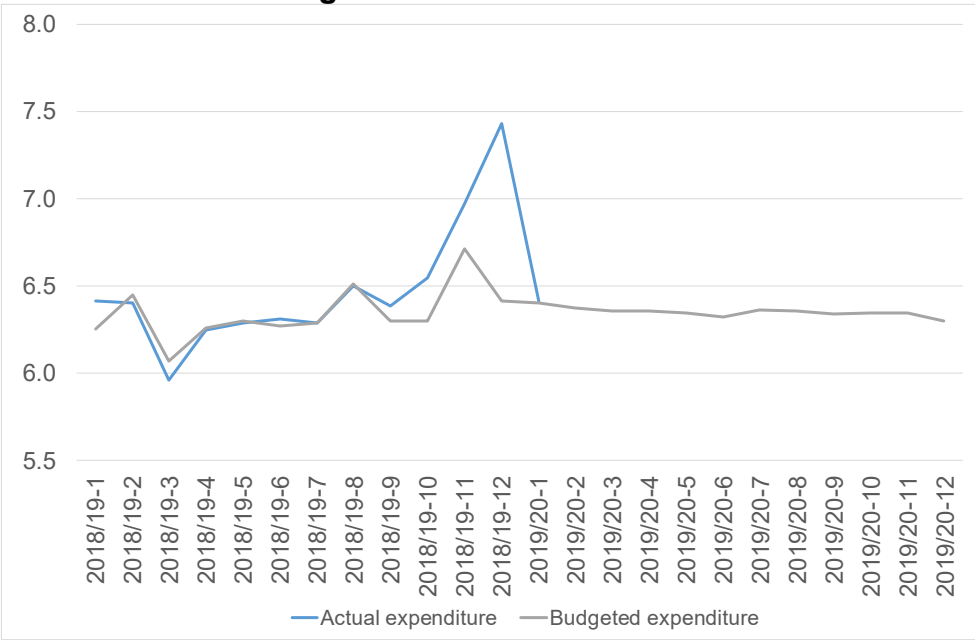
1. Directorate revenue position

2.2.3 MHLD expenditure



- The Directorate has reported a breakeven position in-month, predominately due to a high level of staff vacancies offsetting the pressures in CHC costs.
- There continues to be difficulty recruiting into medical posts resulting in extra locum sessions being incurred.
- The greatest YTD pressure within MHLD is the continued growth in CHC placements and their associated costs. Client numbers increased in month and a higher number of clients were assigned complex packages of care. Careful control of CHC, within its growth assumptions, will be key to deliver an improvement in the expenditure run rate.
- Robust care review processes have been implemented in order to manage the risks arising under CHC.

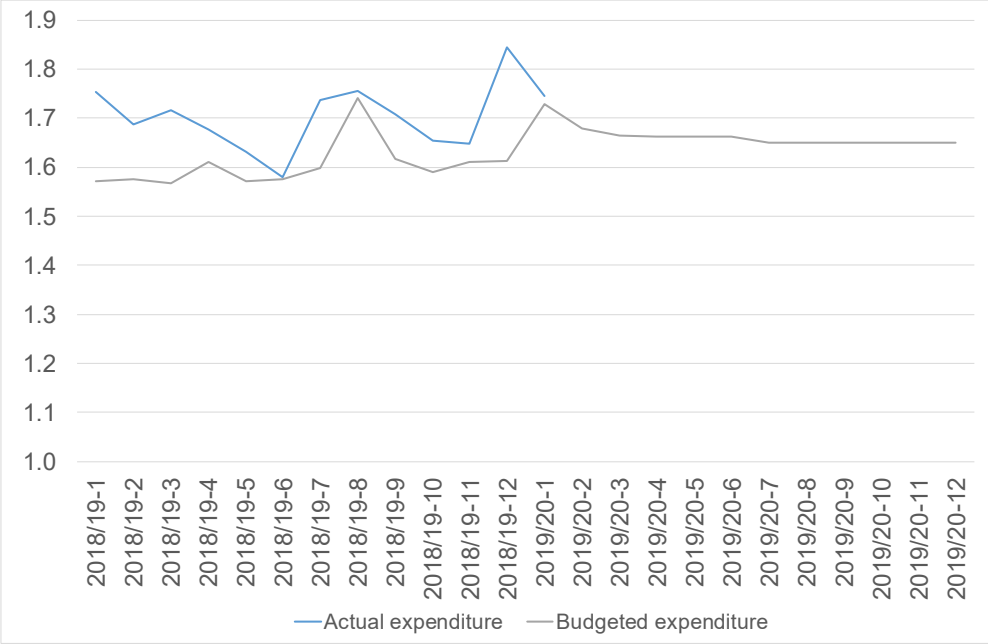
2.2.4 Medicines Management



- The directorate reported a slight over-spend in-month, which is projected to the end of the financial year based on modelling outturn on a number of scenarios. The latest data continues to cause concern around the ongoing impact of No Cheaper Source Obtainable (NCSO). However, we are confident that the risk from 2018/19 has been addressed; further modelling is required to gain assurance over 2019/20. The outturn is reliant on delivering the £2.9m savings plans, which are delivering on plan to Month 1, however further work is urgently required to address the unidentified balance of schemes.
- There are risks of £0.6m mainly associated with item growth, the New Oral Anti Coagulant Local Enhanced Service, NCSO and Category M. Item growth is in the range of -1% to 1% but there has been a significant increase in Category M prices.

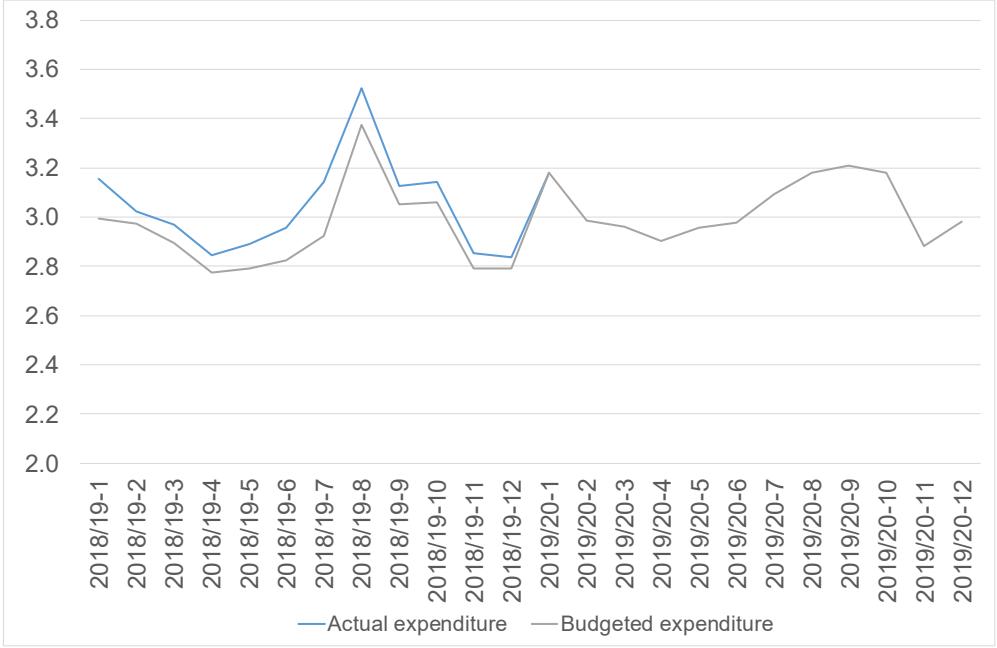
1. Directorate revenue position

2.2.5 Pathology



- The Directorate reported close to breakeven in-month.
- There has been an over-spend on medical staffing pay due to the use of agency locum consultants to cover vacancies.
- This was off-set by a decrease in costs arising from Service Level Agreements and Haematology drugs.
- The Directorate is reviewing ways of working with services to reduce demand through ensuring only appropriate test requests and through avoiding duplication.

2.2.6 Facilities



The Directorate reported a net breakeven position in-month.
The main areas of variance are:

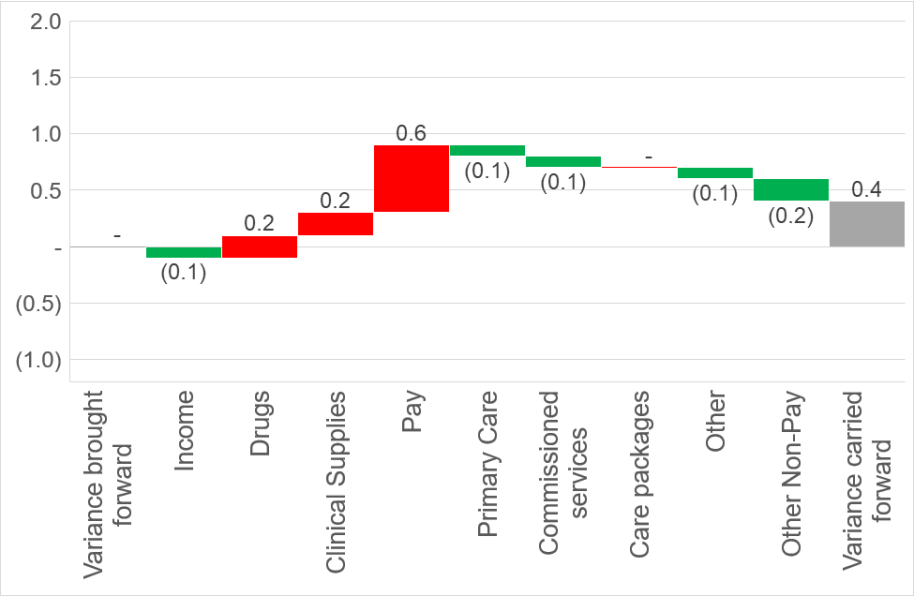
- Operations – an over-spend on bank Pay costs for Domestics staff and postage costs, partly offset by vacancies are the main contributors to the over spend of £50k.
- Property – small under-spend of £30k. Heating Oil is overspent due to being utilised as a back-up when the biomass is off-line. Water consumption remains high in PPH. This was offset by an under-spend on Gas consumption.
- Specialist Services – an over-spend on Pay, mostly in relation to Bank usage, was offset by under-spends in consumables and increased income from price increases.

2. Subjective revenue position

3.1 Subjective summary

	Month 1 Actual £'m	Month 1 Variance £'m	%
Income	(4.1)	(0.1)	0.0
Primary Care (excl prescribing)	10.3	(0.1)	(0.0)
Prescribing	5.7	0.0	-
Pay	35.6	0.6	0.0
Clinical supplies	2.6	0.2	0.1
Drugs	3.6	0.2	0.1
Other non-pay	4.7	(0.2)	(0.0)
Commissioned services	11.4	(0.1)	(0.0)
Care packages	3.8	0.0	0.0
Other	0.4	(0.1)	(0.3)
Total	**74.0**	**0.4**	**0.0**

In-month change

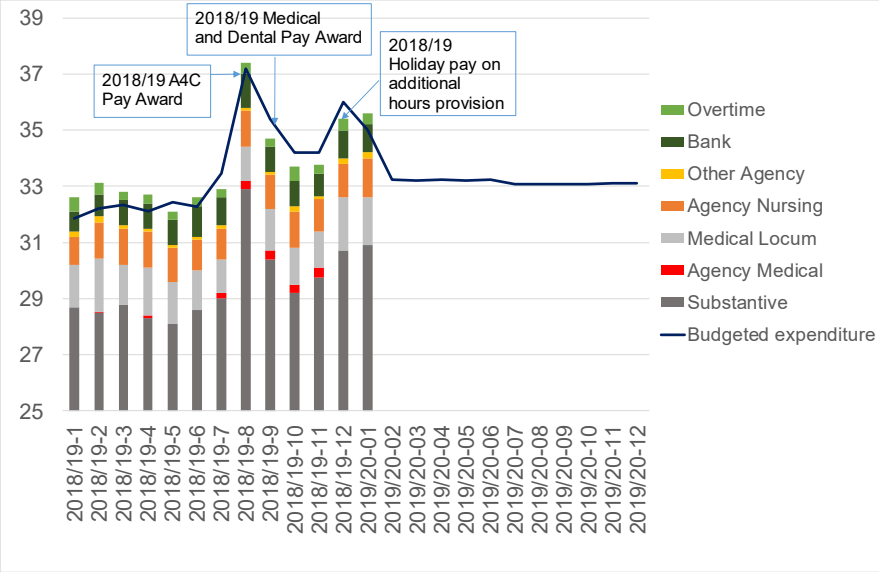


- The main pressures on the in-month position relate to Pay, Clinical Supplies and Drugs; offset by Income, Commissioned Services and Other Non-Pay.
- Detail on the changes in material cost drivers follows in Section 3.2.

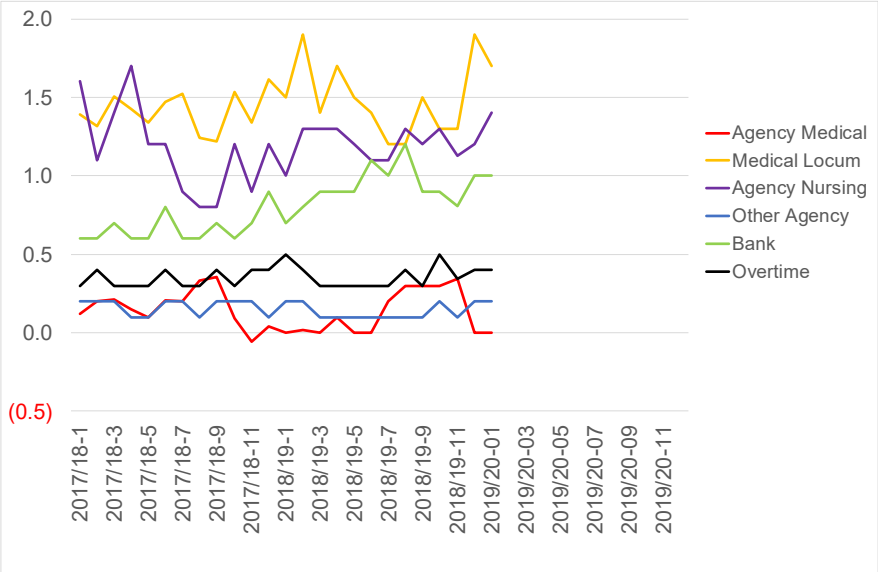
2. Subjective revenue position

3.2 Material Cost drivers

3.2.1 Pay



Temporary pay costs

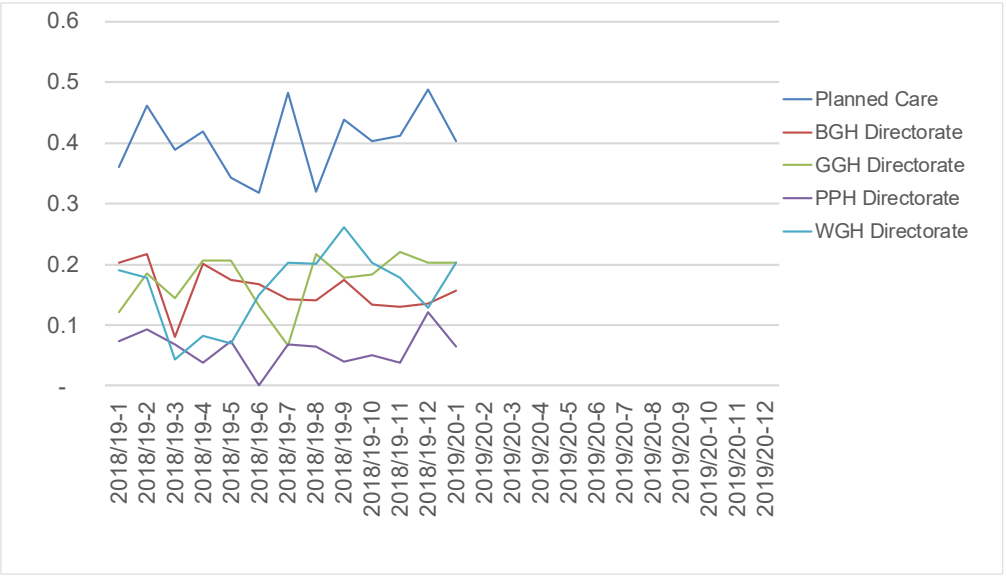


- The Month 1 expenditure is higher than budget due to the pressures arising from unfunded surge beds in Unscheduled and Critical Care.

- The cost of substantive staffing is greater than last year. In Month 12 there was a one off provision for holiday pay on additional hours of £1.1m. In Month 1 there is a one off payment of £1.2m for all staff at the top of their respective bands at the end of March 2019 in line with the new Pay deal, which is the driver for the high in-month cost.

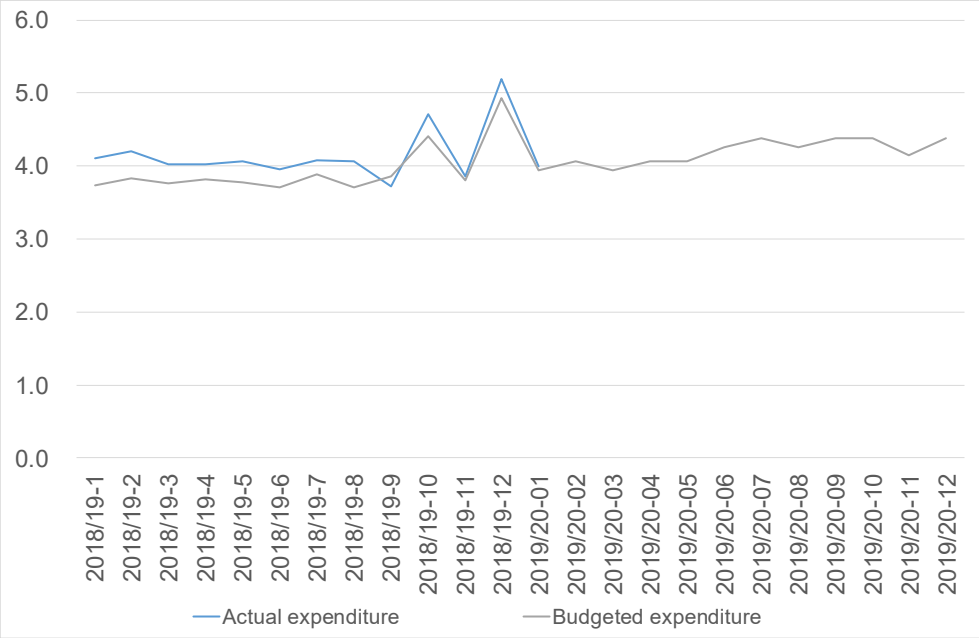
- Increases in substantive pay and Nursing Agency costs were partially offset by a reduction in Medical Locum costs.

Medical locum costs



2. Subjective revenue position

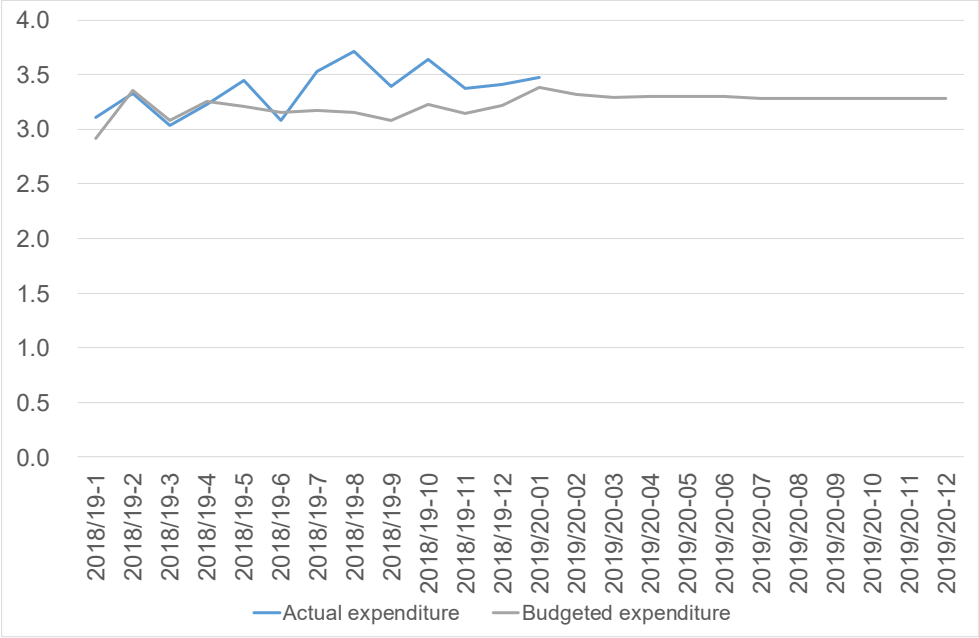
3.2.2 Care packages (CHC and FNC)



- The total number of cases increased in-month. The increase in budget from Month 6 relates to the recognition of expected FNC rate changes and CHC inflation. Full confirmation is awaited, and remains a risk to the position. The complexity of cases remains a key cost driver.
- Total spend to Month 1 is £4.0m resulting in an overspend of £0.1m, of which:

£'m	Spend	Over/(under) spend
FNC/CHC	1.9	0.0
LD	1.2	0.1
MH	0.8	0.0
Children	0.1	0.0
Total	**4.0**	**0.1**

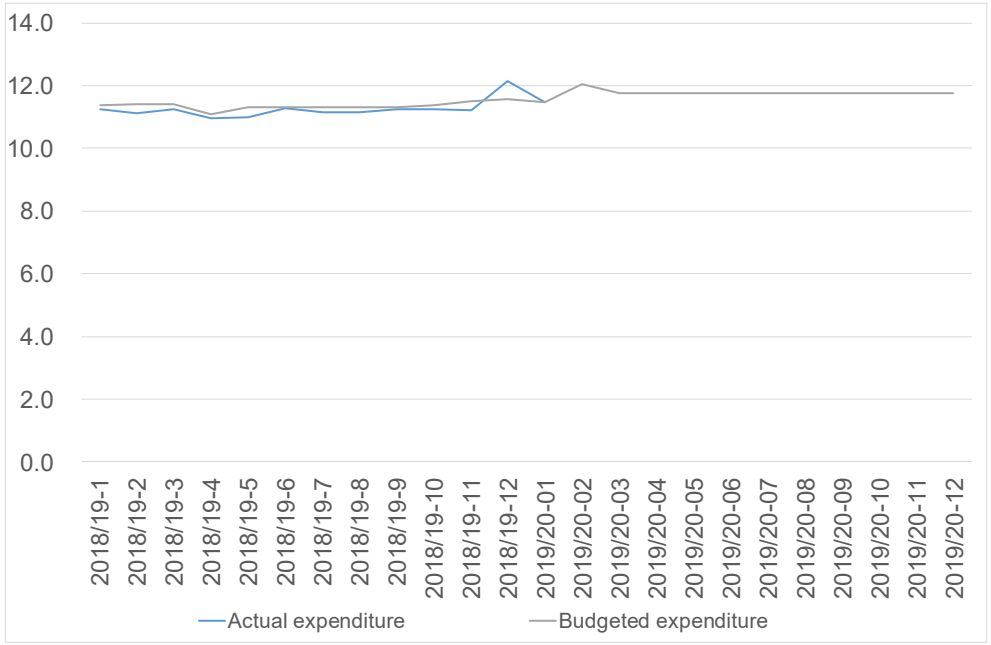
3.2.3 Drugs



- Drugs costs have increased over the past year, and there is a risk that this trend will continue for this year, with an adverse in-month impact.
- Continued support will be needed from the Pharmacy team to address this growth and a number of initiatives are in place to do this. Whilst specific savings schemes are delivering in-month, pressures are being seen in other areas, particularly Dermatology, Rheumatology and Ophthalmology. The Head of Medicines Management is working with Directorates to identify and mitigate the issues.
- There has been a disruption to the local service provision of Aseptic services; as a result work has been outsourced at a premium to another provider. This is expected to continue for a number of months, for which mitigating actions will need to be identified.

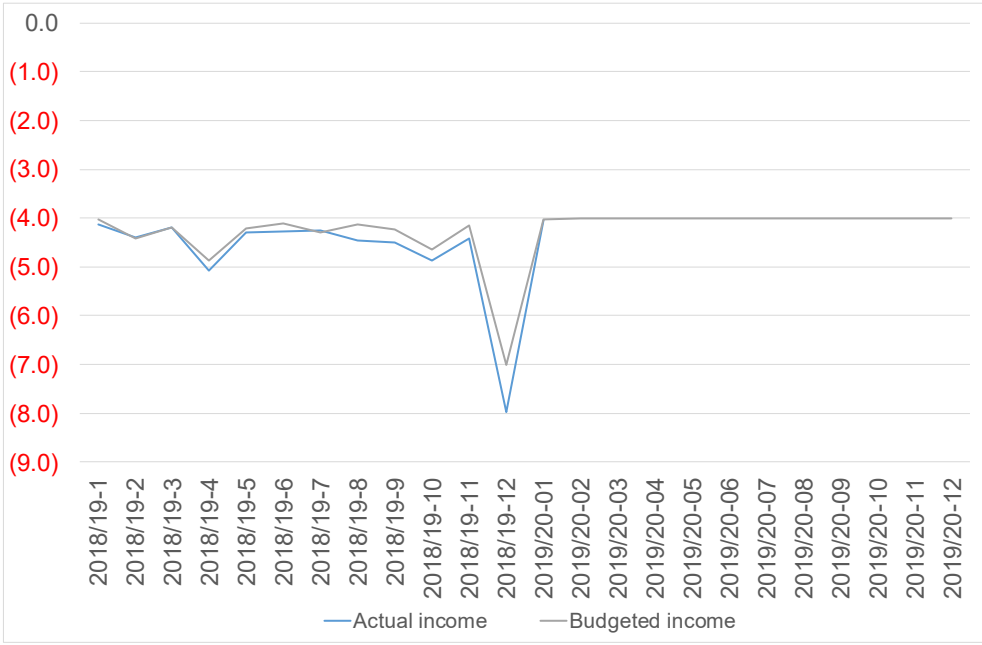
2. Subjective revenue position

3.2.4 Commissioned services



- Services that are commissioned from other NHS providers are based on activity data up to Month 12.
- As key LTA contracts have not yet been signed, an assumption of breakeven to budget has been made for Month 1 following a zero-based review of required budgets as part of the 2019/20 financial planning process. Until inflationary uplifts are confirmed this is the best estimate of the financial position.
- There is a risk of pressures in respect of Specialised Services given the significant impact in Month 12 2018/19 and Management Group discussions, despite a significant increase in budget for the current year.
- The impact of the re-basing of the Specialised Services Risk Sharing Framework is expected to be factored in to WG allocations, although the value has not yet been confirmed.

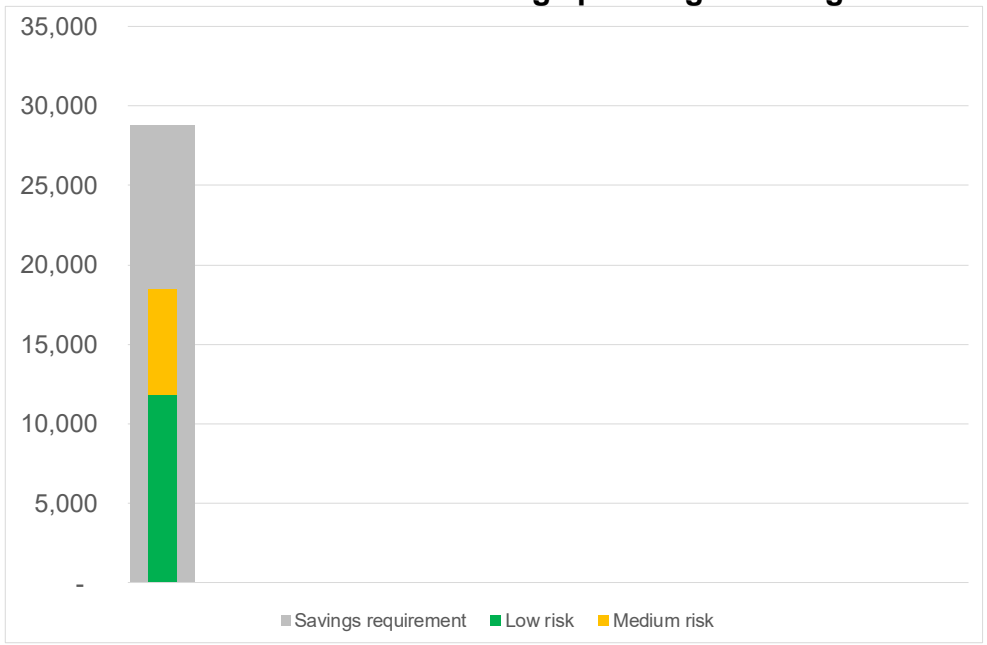
3.2.5 Income

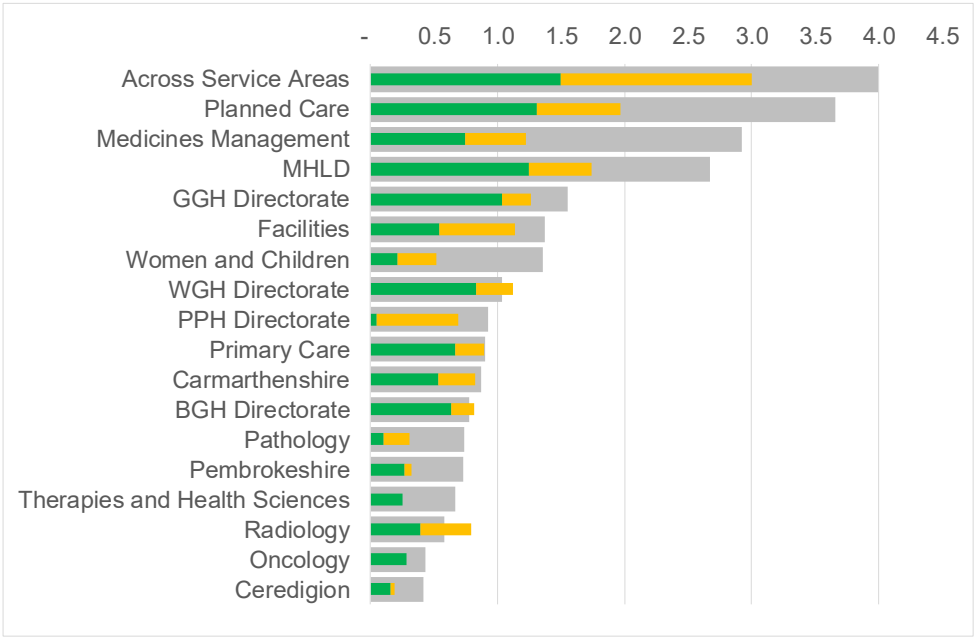


- As key LTA contracts have not yet been signed, an assumption of breakeven to budget has been made for Month 1 following a zero-based review of required budgets as part of the 2019/20 financial planning process. Until inflationary uplifts are confirmed this is the best estimate of the financial position.

3. Savings and turnaround actions

4.1 Risk-assessed directorate savings plans against target

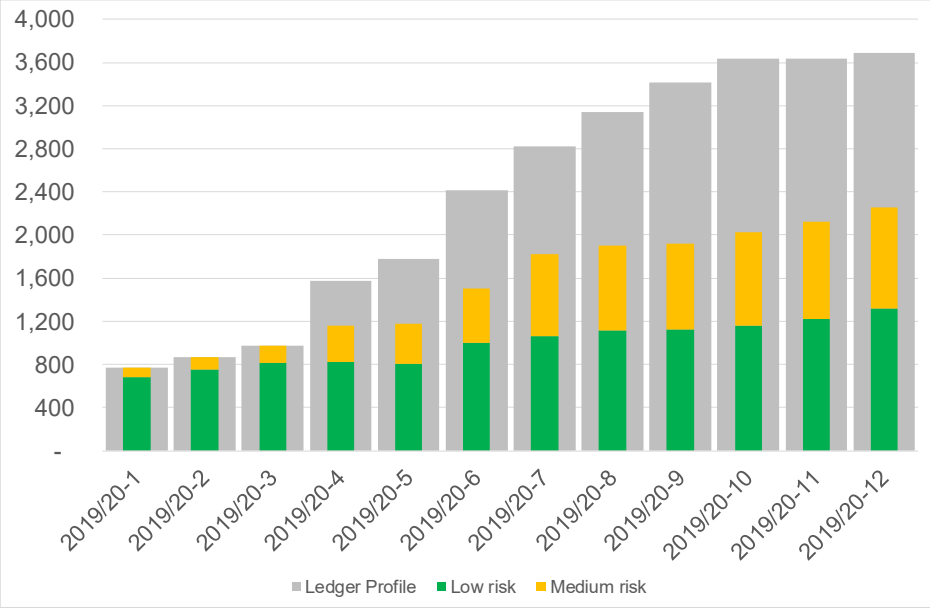




- Total Green and Amber schemes of £18.5m identified to Month 1, of which £11.9m are Green.
- Operational savings pipeline of £8.3m needs to be actively pursued and developed into actionable plans.
- Further opportunities required of £2.0m to close the gap in the savings pipeline.
- The Holding to Account process is focused on deliverable high value opportunities and the unidentified balance. Further opportunities are being identified using work underway in respect of Ward staffing, Establishment control and the benchmarking and opportunities framework.

3. Savings and turnaround actions

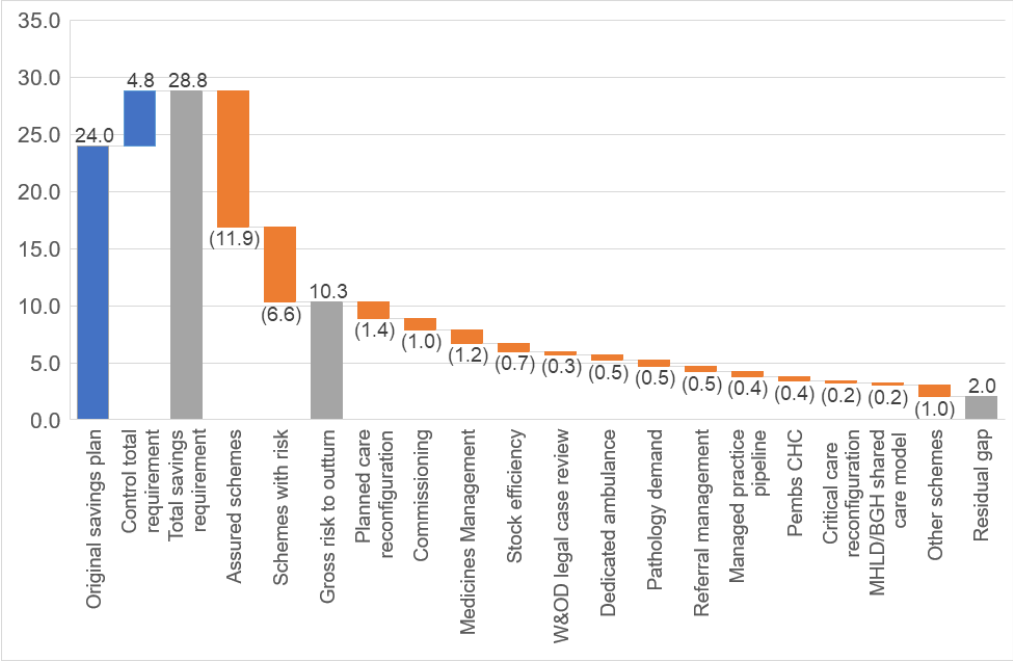
4.2 Planned savings profile, risk and delivery



- The forecast delivery for the remainder of the year is in line with the total requirement of £28.8m. This position has been reflected in the risk assessment in section 5.2 below.
- In-month delivery of £0.8m in line with the plan.
- Limited step required for remainder of first quarter as pipeline schemes are converted into robust actionable Plans. Significant acceleration in delivery is required from Month 4.

4. Financial projections, opportunities and risks

5.1 Financial projection



- While the financial position in Month 1 represents a significant risk to the Health Board, and there are significant risks to savings delivery and operational cost management, **the Health Board's financial forecast is to achieve the required Control Total of £25.0m.**

- The operational run rate is £0.4m in the current month. The risk of delivering the forecast is rated High given the balance remaining of pipeline and unidentified savings schemes. Escalated Holding to Account meetings are being held with all Directorates to convert pipeline into robust schemes and identify additional recovery actions and additional opportunities.

- We recognise that there are a number of gross risks that could materialise that, if mitigating actions were not identified, could affect the financial projection. These risks are presented below in section 5.2.

- This will require the Board as a whole to ensure a focus on ensuring that divisions operate within their budgets, deliver savings and manage their risks.

4. Financial projections, opportunities and risks

5.2 Risks and risk management strategy

Potential Risk	£'m	Risk management approach
Budget deficit	**29.8**	
Welsh Government Control Total requirement	**(4.8)**	
Restated budget	**25.0**	
Residual gap in pipeline savings schemes	2.0	Escalated Holding to Account meetings are being held with all Directorates to convert pipeline into robust schemes and identify additional recovery actions and additional opportunities.
Non-delivery of savings schemes in pipeline	8.3	
Aseptic Unit closure	0.5	Action plan in place to escalate re-opening of local provision of Aseptic services
Total Planning Risk	**10.8**	
Unfunded Surge bed pressures are not contained	1.5	Work ongoing to triangulate bed base, establishment and budget to better target surge pressures
Medicines Management – NCSO	0.6	If item prices were to return to the level seen in late 2019; protracted Brexit period may impact on NCSO costs
Unfunded Dental inflation	0.6	Paper to next Executive
Inflationary pressures on CHC exceed budget	0.2	Fee rates are being negotiated, and this risk will need to be managed through the negotiation process.
Specialised activity exceeds available budget	0.9	Regular reports are received from WHSSC, and the Health Board is represented at the Committee.
Total deficit forecast and risks	**39.6**	

5.3 Opportunities

- The focus is now being narrowed by considering the key drivers of the cost base identified through benchmarking with other Health Boards via national costing returns. Detailed information has been shared with Directorates and is being utilised as part of the Recovery Plan refinement in-year. We will continue to use this in conjunction with the Efficiency Framework to translate the opportunities identified into detailed Savings Plans in support of our Financial Plan. The Finance Committee has reviewed and endorsed this approach.

- Opportunities available via Invest to Save, Integrated Care Fund and Transformation funding are being explored. Key areas of operational inefficiency being targeted are: CHC and packages of care, unfunded escalation beds and patients awaiting tertiary referral.

4. Financial projections, opportunities and risks

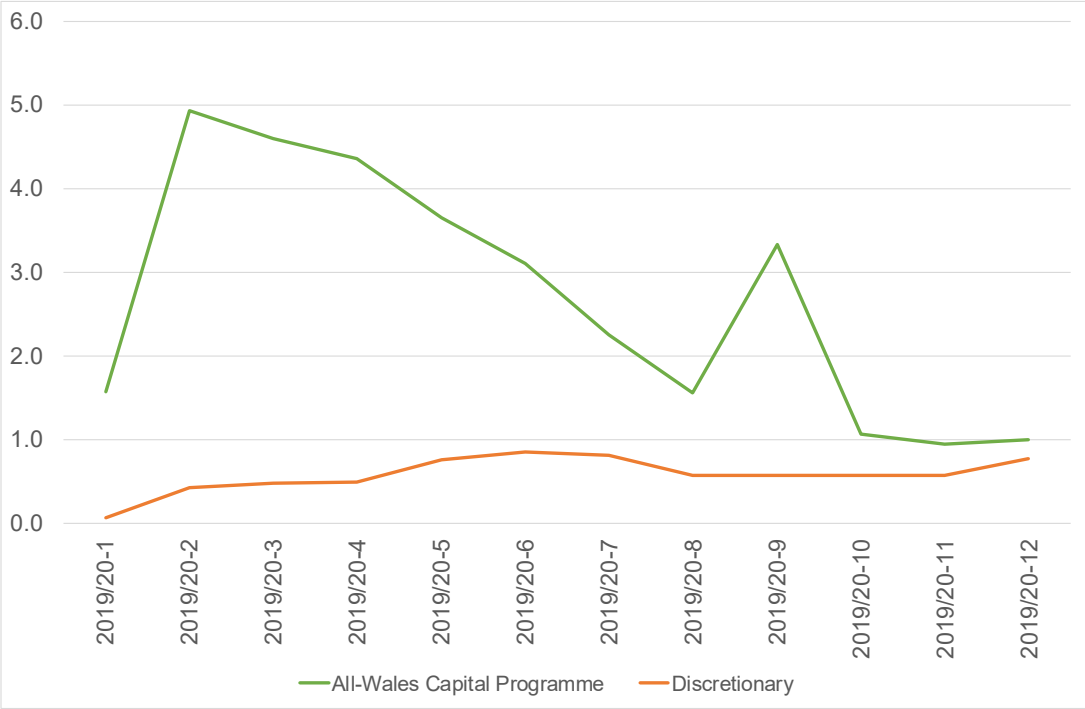
5.4 Reserves

£'m	Month 1 close
ICF Bids	**10.7**
LTAs – Inflation, Pay Award, WHSSC	**3.4**
CHC Inflation and Growth	**3.2**
Hosted Allocation – Critical Care	**1.0**
Nursing Standards	**1.0**
Medical and Dental Pay Award	**1.0**
Winter Pressure reserve	**1.0**
RCCS	**0.5**
Primary Care Improvement grant	**0.4**
Eye Care Sustainability	**0.4**
Other	**0.1**
Total	**22.7**

- The Health Board's centrally-retained reserves are committed and all relate to specific anticipated cost pressures.
- ICF funds will be distributed based on finalised plans for utilisation of the funds across Healthcare and Local Authority. As Plans are not yet agreed, the reserve has been phased based on draft plans and historical indicators.
- The LTA reserve is based on the anticipated value of contractual uplifts and will be distributed once these contracts are agreed and signed.
- CHC and FNC growth and inflation have been phased according to the timeframes in which costs are anticipated to impact.
- The Health Board holds funding of £1.0m on behalf of Welsh Government to support costs incurred on behalf of the Critical Care network across Wales.
- Nursing Standards reserve will be distributed following agreement and approval by the Executive Team.
- Winter Pressure Support will be allocated to Directorates based on finalised plans for utilisation of the funds. At present the assumption is that this Reserve will be drawn over Months 9 to 12.
- Reserves held for future cost pressures will be carefully managed and work is ongoing to ensure future cost pressures are minimised wherever possible.

5. Capital expenditure and working capital management

6.1 Capital expenditure

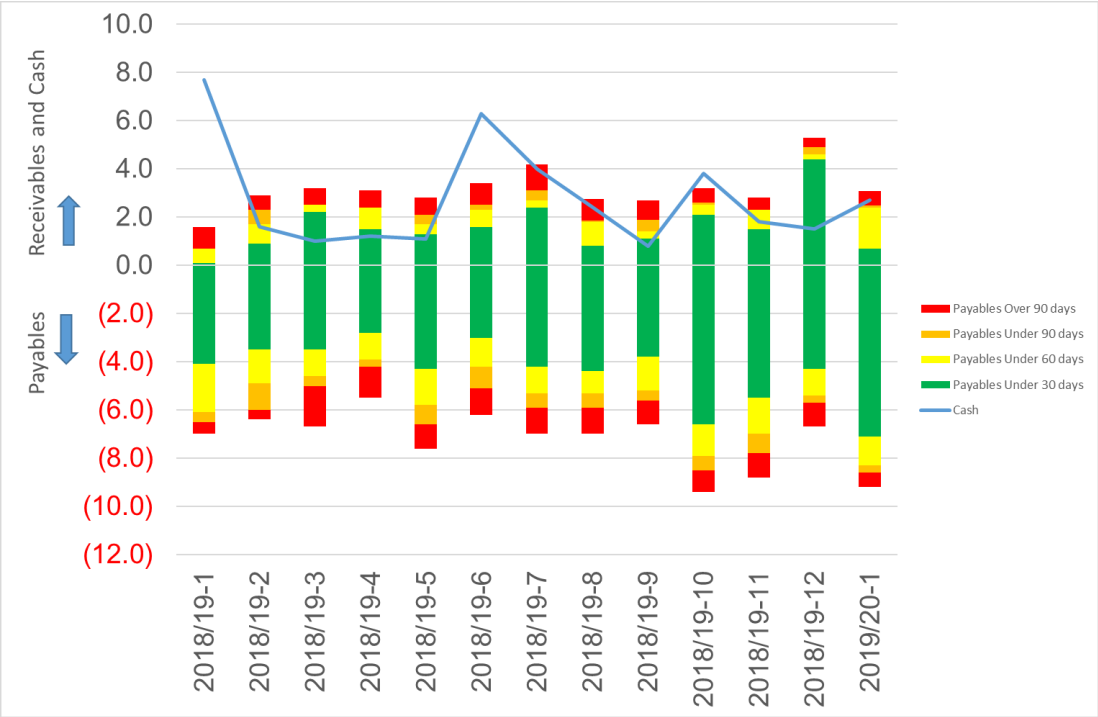


Provisional capital expenditure plan	£'m	£'m
Bronglais MRI	4.4	
Women and Children Phase II	13.8	
Wards 9 and 10 Withybush	1.8	
Aberaeron Integrated Care Centre	0.9	
Cardigan Integrated Care Centre	10.1	
Fees for development of Cross Hands	0.9	
Total all-Wales funded schemes		**31.9**
Medical equipment	1.6	
Estates	1.9	
IM&T	1.1	
Other	2.8	
Total discretionary		**7.4**
Total capital		**39.3**

- The Health Board has an approved Capital resource limit of £39.3m for 2019/20.
- Capital expenditure against the £39.3m total funding allocation was £1.7m in Month 1.

5. Capital expenditure and working capital management

6.2 Working capital management



- Income collected from sources other than Welsh Government is collected through the invoicing process. It is imperative that this is collected promptly to reduce reliance on cash support from WG. Balances owed to the Health Board are £3.1m in Month 1.
- It is also important that the Health Board pays its suppliers promptly. At the end of Month 1, £9.2m was owed to suppliers, of which £7.1m are less than 30 days old. Further work is ongoing with colleagues in NHS Wales Shared Services to address older balances through improving the purchase-to-pay cycle.
- Cash at the end of Month 1 was £2.7m.

6. Conclusions and recommendations

7.1 Conclusions

- The Health Board has a savings plan requirement for the year of £28.8m.

- Assured schemes of £11.9m and schemes with some risk of £6.6m are identified. Of the residual gap of £10.3m, pipeline opportunities of £8.3m are being actively pursued.

- The Month 1 deficit is £2.9m which is £0.4m adverse against Plan. This reflects pressures in Unscheduled Care, mainly in WGH and in Critical Care.

- The Health Board's control total is £25m but there are planning risks of £10.8m against this and operational cost management risks of £3.8m, which need to be carefully managed

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Financial Performance – Month 1

Health Board confirmed control total of £25m

Savings summary

- £28.8m total savings requirement to meet control total
  - £11.9m of secure plans (green)
  - £6.6m of plans with some risk to delivery (amber)
- Risk to delivery is therefore £10.3m

Budgeting summary

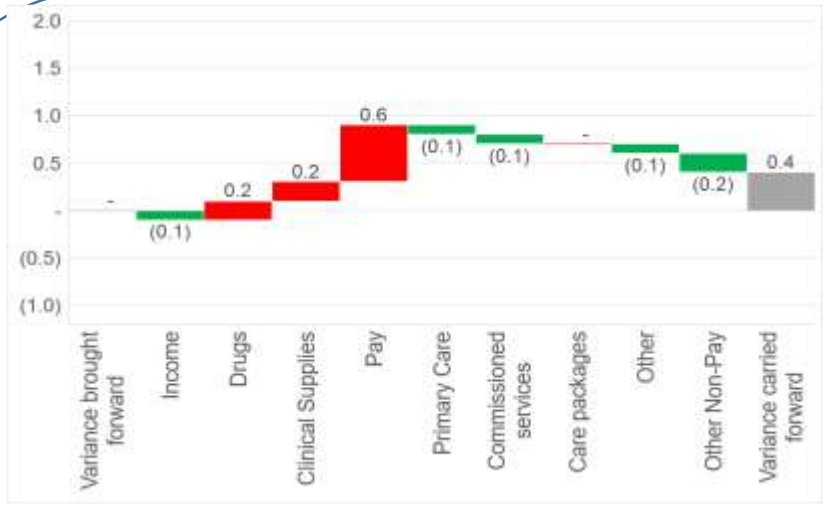
- Aseptic Unit closure risk of £0.5m

Month 1 position

- Month 1 position is £0.4m variance to plan
  - Operational surge impact of £0.3m
  - Critical care surge £0.1m
  - Recovery and management within available resources critical over Q1

Further actions

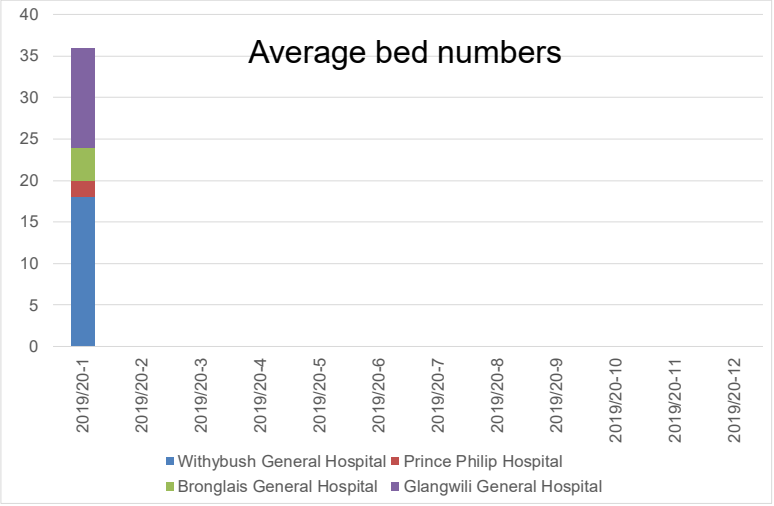
- Opportunity pipeline of £8.3m needs to be actively pursued and developed into actionable plans
- Further opportunities required of £2.0m to close savings gap
- Recovery actions required of £0.9m to recover month 1 position and close budgeting risk

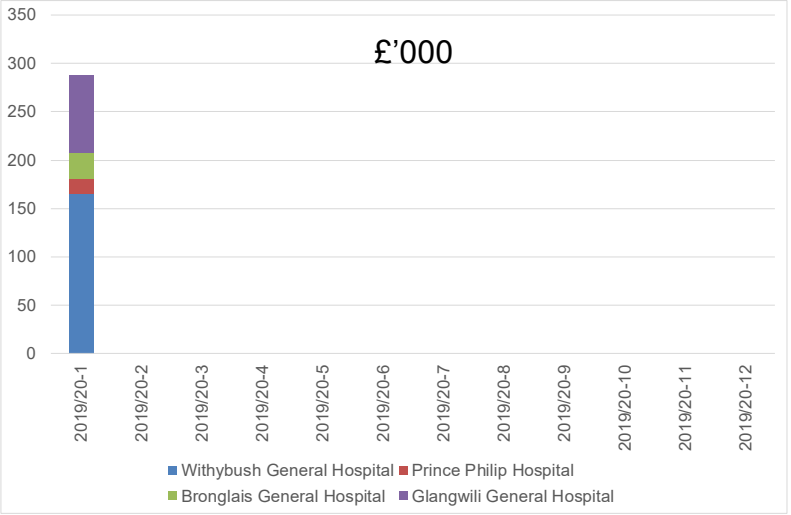


Key Actions for In-Month focus areas

- Urgent review of savings pipeline opportunities to convert into assured schemes;
- Holding to Account Meetings will focus on this and mitigating actions to address operational risks.

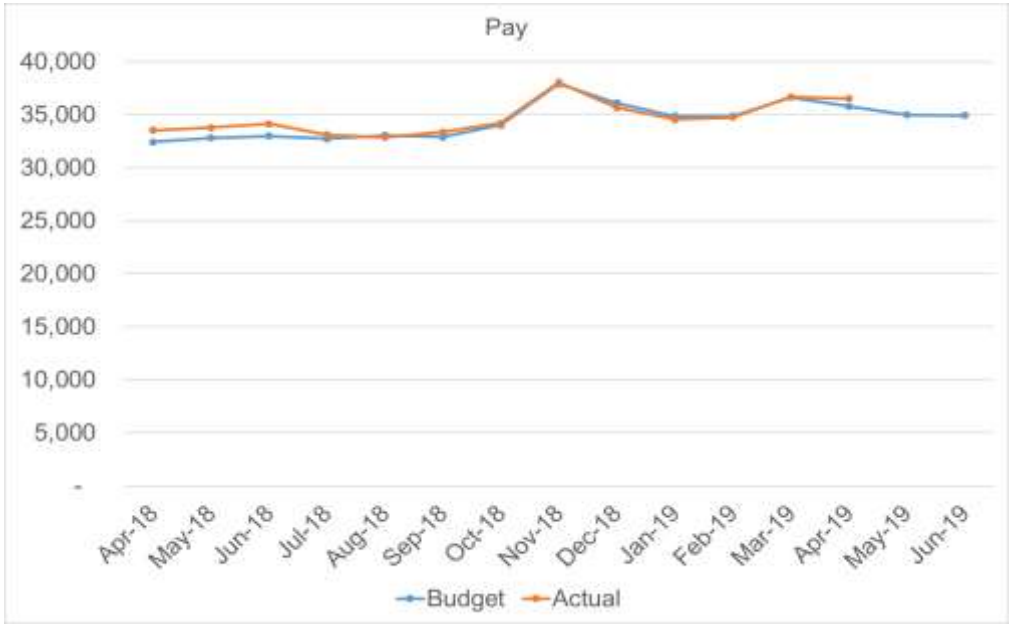
Bed pressures

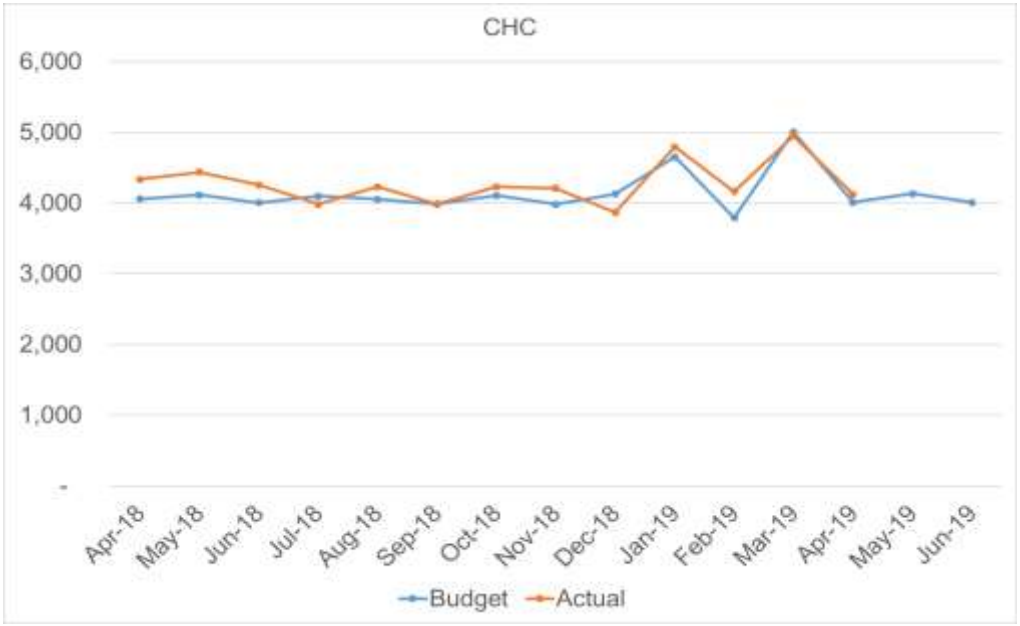


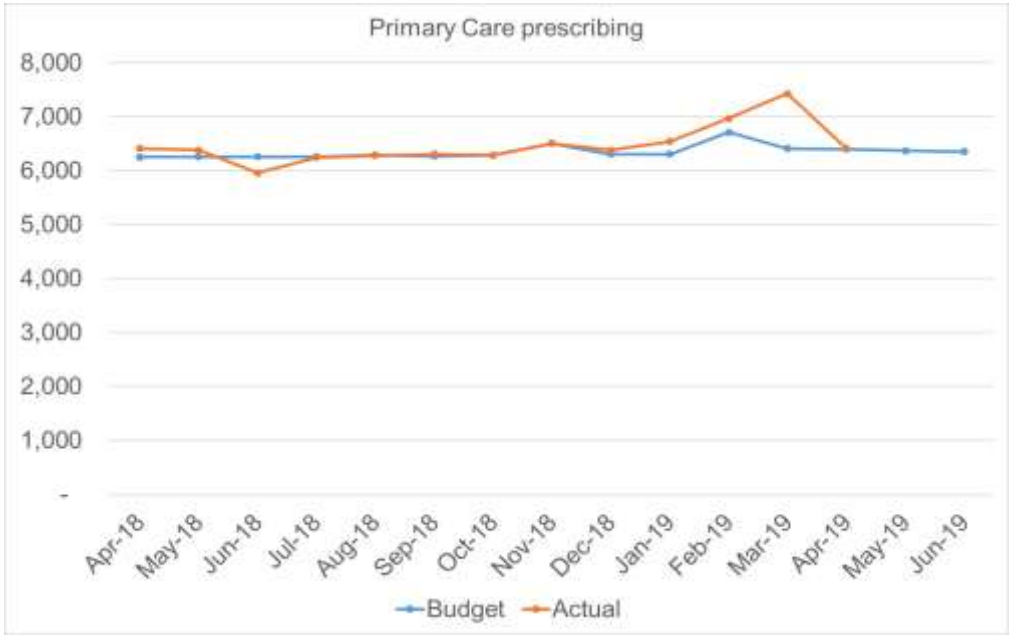


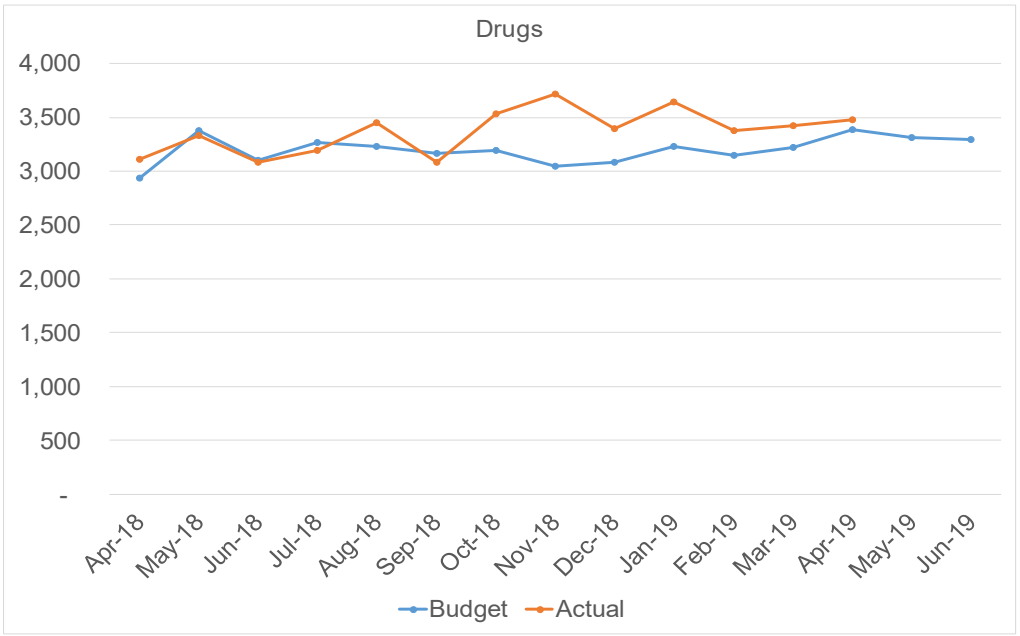
Critical Care surged on 32 occasions in Month 1, which was predominately driven by patient acuity rather than the number of beds.

Run Rate


Pay
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Budget
Actual

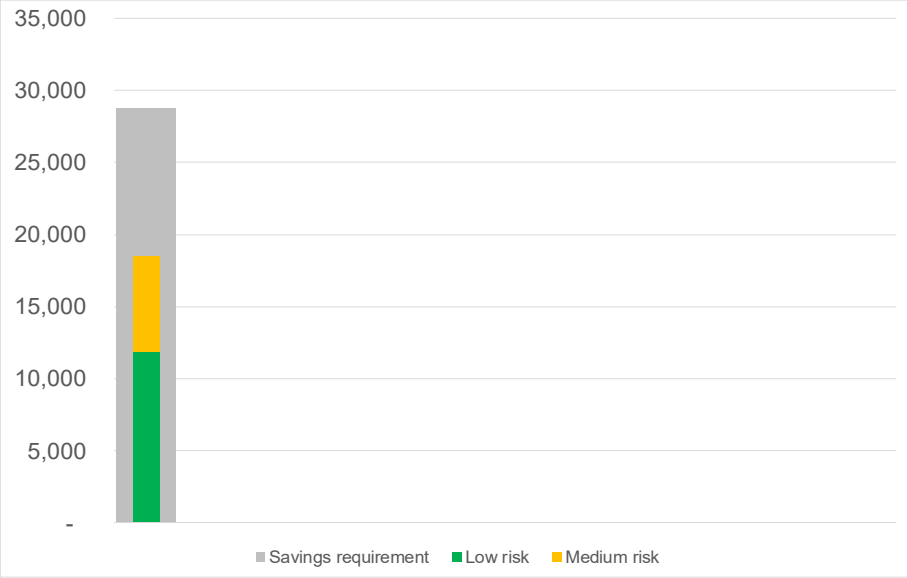

CHC
6,000
5,000
4,000
3,000
2,000
1,000
-
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Budget
Actual


Primary Care prescribing
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Budget
Actual

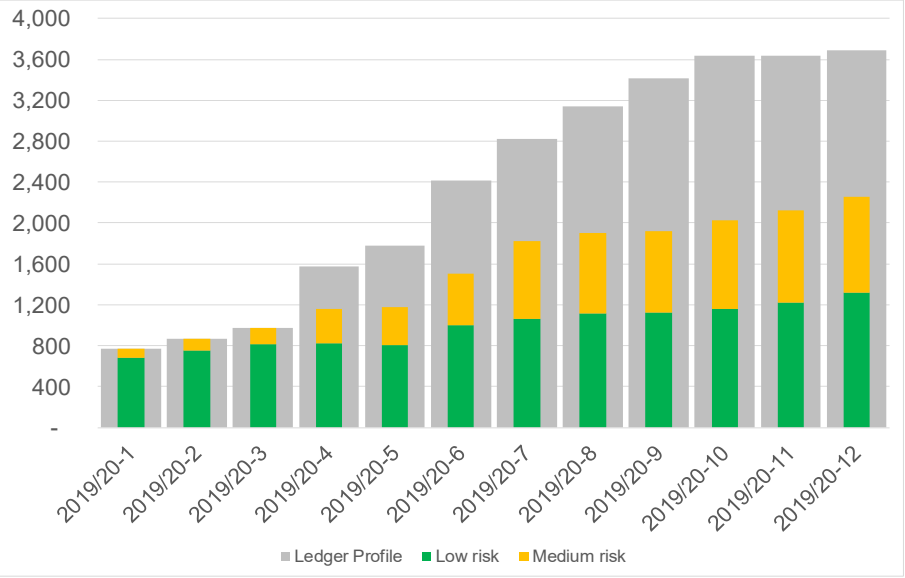

Drugs
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
-
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Budget
Actual

Savings type	Assured (£'m)	Some risk (£'m)	Total (£'m)
Non-recurrent	3.4	0.3	3.7
Recurrent	8.5	6.3	14.8
Total	**11.9**	**6.6**	**18.5**
Pipeline Opportunities			8.3
Residual Gap			2.0
Total requirement			**28.8**

Savings identification



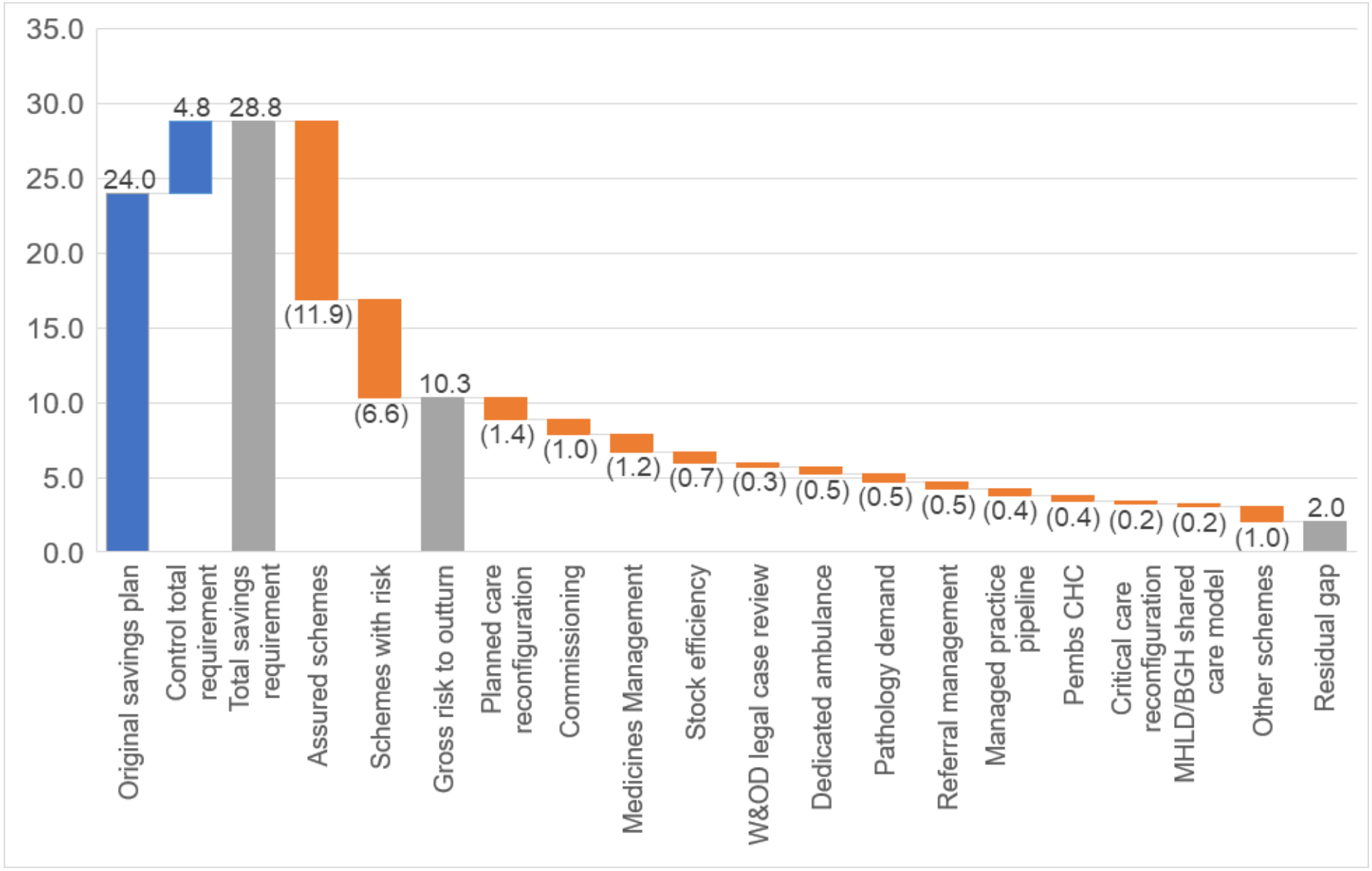
Savings delivery



- HTA process focused on deliverable high value opportunities and unidentified balance
- Further opportunities being identified using:
  - Ward staffing work
  - Establishment control work
  - Benchmarking and opportunities framework

- In-month achievement of £0.8m is in line with Plan
- Significant acceleration in delivery required from Month 4

Position against control total

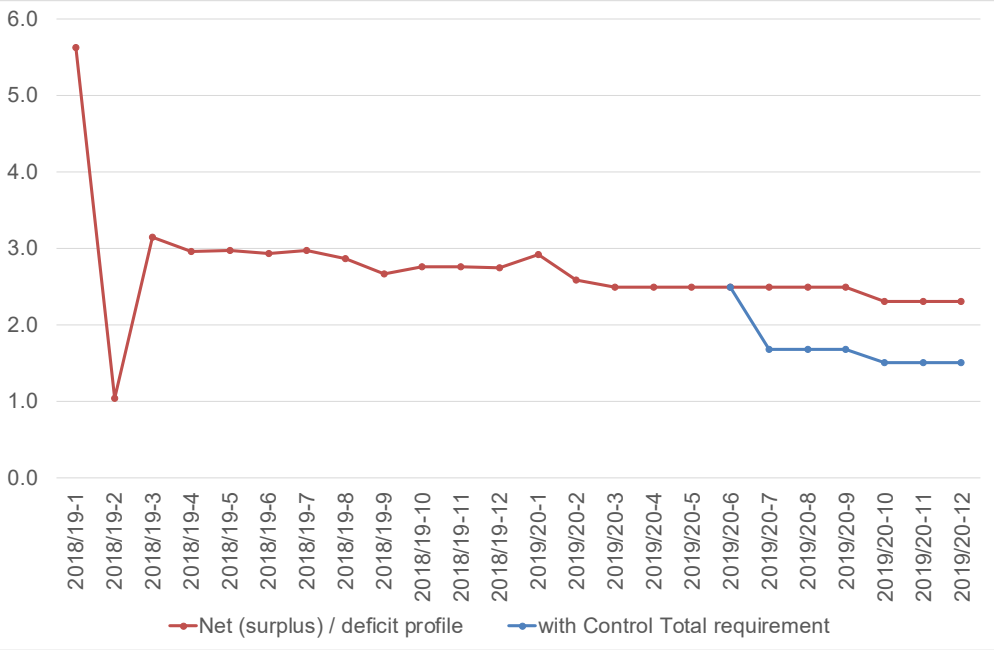


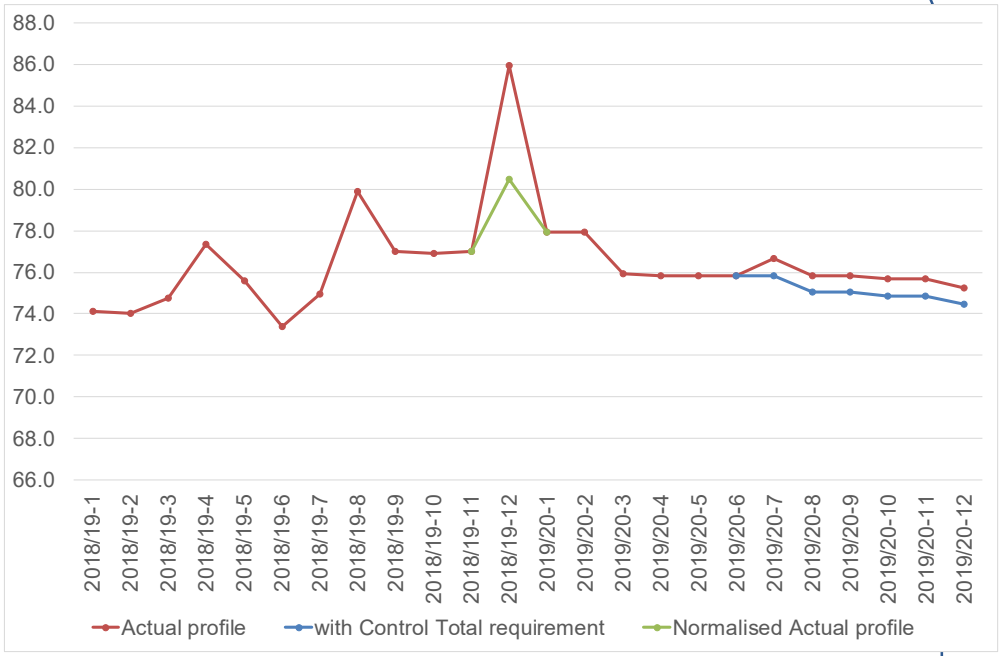
- Draft interim Annual Plan for 2019/20 approved by Board March 2019 with deficit of £29.8m; Welsh Government have since confirmed that the Health Board's Control Total requirement is a deficit of £25.0m.

- Directorate level projections are currently in line with the Annual Plan of £29.8m

- To achieve the Control Total requirement additional actionable savings plans will need to be urgently identified, which will rely on both Corporate and Directorate level delivery.

Projections Profile





- Control Total requirement profile is a significant step change in financial performance, which presents a significant risk to end of year position.
- Phased from Month 7 to allow time for assured and actionable plans to be developed.

Variance to breakeven	YTD £'m	EOY Projection £'m
Budget	2.5	25.0
Operational pressures (see below)	0.3	3.8
Savings delivery	0.0	10.3
Aseptic Unit closure	0.1	0.5
	2.9	**39.6**

The following currently need action to mitigate:

Risks	£m	Risk Rating
Non-delivery of savings schemes in pipeline	8.3	Medium
Residual gap in pipeline savings schemes	2.0	High
Aseptic Unit closure	0.5	Medium
Total Planning Risk	**10.8**	
Unfunded surge bed pressures are not contained	1.5	Medium
Medicines Management – No Cheaper Source Obtainable	0.6	Medium
Unfunded Dental inflation	0.6	Medium
Inflationary pressures on CHC exceed budget	0.2	Medium
Specialised activity exceeds available budget	0.9	Medium
Total Operational Risk	**3.8**	
Total Risk	**14.6**	

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 April 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Turnaround Update – Month 1, 2019/20
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Turnaround Director
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Carruthers, Turnaround Director

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an update to the Finance Committee on the Turnaround Programme as at Month 1.

Cefndir / Background

The Turnaround Programme was established in 2017 to provide a robust process for the delivery of savings to ensure that the Health Board meets its statutory duty to break-even over a three-year rolling basis.

This report provides an update on Turnaround activities including a savings position, recovery actions agreed, and achievements.

Asesiad / Assessment

The appended report comprises four sections:

Section 1 – Provides a summary of the 2019/20 Month 1 position for Directorates who are being monitored through the Chief Executive Holding to Account meetings. These Directorates are at an escalated status due to the assessed risk of them delivering their financial plans.

Schemes are RAG rated, in accordance with the approach agreed at Targeted Intervention:

- Green – Delivering
- Amber – Some risk to manage but will deliver
- Red – Pipeline scheme. Needs more scoping and work up before moving to delivery and Amber.

At the Month 1 HTA meetings, the CEO requested confirmation that green schemes are on track for delivery. A number of actions were also agreed to move amber and red schemes to green status.

The CEO has made it clear that schemes cannot impact on quality and safety of patient care or tier 1 performance. Directorates were also asked to identify all risks and mitigating actions.

The next CEO Holding to Account meetings will be held on 17th May 2019.

Section 2 - Provides a summary of the 2019/20 Month 1 position for Directorates being monitored though the Turnaround Director Holding to Account meetings. These Directorates were considered to be on track with delivery of their financial plans.

Following their April 19 HTA meeting, Pembrokeshire County have been escalated to CEO HTA status due to the high risk of delivering their savings plan and year-end budget position.

The next Turnaround Director Holding to Account meetings will be held on 15th May 2019.

Section 3 – Provides an update position on the achievements of the Turnaround Delivery Programmes as at Month 1. These schemes focus on pan-organisation opportunities to drive patient focused benefits as well as savings. Meetings are scheduled on a fortnightly or monthly basis and provide an opportunity for the Turnaround Team to positively engage across the organisation.

Argymhelliad / Recommendation

The Finance Committee is asked to discuss note the Turnaround Programme update report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5.1 Undertaking detailed scrutiny of the organisation's overall: • Monthly, quarterly and year to date financial performance; • Performance against the savings delivery and the cost improvement programme; assurance over performance against the Capital Resource Limit and cash flow forecasts; • Oversee and monitor the Health Board's turnaround programme.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable

Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Turnaround update

Section 1 – Summarises 19/20 Directorate savings plans against required savings target of 3.7% for Directorates that are escalated to the Chief Executive Holding to Account meetings. The figures included in this section are based on the known position of Month 1 as at 10th May 2019 and will be subject to change with the identification of further savings opportunities.

Facilities	**19/20 target saving £'000s**	**1,385**	**Total of saving plans £'000s**		541	596	187	**1,324**	**Variance £'000s**	**61**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**					
	Green schemes	(39)	(38)	1	N/A					
	Amber schemes	0	0	0	Potential shortfall of £195k against utilities savings. Actions have been identified that could potentially mitigate £67k of this shortfall. The CEO has requested further work on the methodology used in this assessment by 17th May 19.					
	Red schemes	0	0	0	Visits have been arranged to other sites to understand other internal benchmarking opportunities, beyond the cleaning costs work already undertaken. £125k savings for internal benchmarking opportunities have been included in the plan, although as there is no clear scheme in place as yet, consideration needs to be given at the next CEO HTA meeting on 17th May 19 as to whether this scheme can be included within the savings plan.					
	Total	**(39)**	**(38)**	**1**	Other actions agreed Further plans to be identified to meet the required target savings by 17th May 19.					

Mental Health	**19/20 target £'000s**	**2,691**	**Total plans £'000s**		1,245	494	112	**1,851**	**Variance £'000s**	**840**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**					
	Green schemes	(176)	(176)	0	N/A					
	Amber schemes	(54)	(54)	0	Non recurrent elements of LD Tudor house scheme are green. The longer term plan recurrently remains amber until the plan is signed off with LA. Changes to the TRAC system mean that all redeployed posts and change of circumstances need to be advertised, which could delay delivery. The Turnaround Director and Director of Nursing will raise this at the next Workforce Panel.					
	Red schemes	0	0	0	Collaborative Care paper being presented to ET on 29th April 19. Concerns that clinical leadership constraints could delay the success of the pilot. Joint BGH and MH CEO HTA meetings may be required to ensure this scheme becomes green. To be considered at next meeting on 17th May 19.					
	Total	**(230)**	**(230)**	**0**	Other actions agreed Further plans to be identified to meet the required target savings by 17th May 19.					

Pathology	19/20 target £'000s	741	Total plans £'000s	106	202	442	749	Variance £'000s	(9)
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(5)	(4)	1	The YTD variance is in relation to the Patient Access scheme. This will be discussed at the CEO HTA meeting on 17th May 19.				
	Amber schemes	(2)	(2)	0	Recruitment to substantive consultant posts is challenging. Turnaround Director to raise opportunities around workforce issues with the Director of Workforce & OD.				
	Red schemes	0	0	0	Information dept working on dashboard to support a programme of demand optimisation work. Assumptions for a £421k saving are based on a 10% reduction in activity. Demand optimisation plans appear to be having an impact. e.g. ESR test requesting has reduced from 5,000 per month down to 500. The CEO has requested a detailed delivery plan by the next CEO HTA meeting on 17th May 19. The CEO to ask the Director of Planning to be the Executive Lead for this scheme.				
	Total	**(7)**	**(6)**	**1**	Other actions agreed Further plans to be identified to meet the required target savings, including a review of what further mitigating actions can be taken in year non-recurrently to manage the in-year risk by 17th May 19.				

Scheduled Care	19/20 target £'000s	3,682	Total plans £'000s	1,310	658	1,784	3,752	Variance £'000s	(70)
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(72)	(68)	4	The YTD variance is in relation to Loan Kit rationalisation and housekeeping schemes . These will be discussed at the CEO HTA meeting on 17th May 19.				
	Amber schemes	0	0	0	Demand management - work to be progressed on understanding what proportion of the £530k identified savings identified through a job planning exercise will be cash savings and what will avoid RTT spend.				
	Red schemes	0	0	0	Other actions agreed • A formal plan to deliver the Critical Care bed reduction scheme to be produced for discussion at the next CEO HTA meeting on 17th May 19 to ensure that the scheme is implemented by July 19. • Orthopaedic plan (£1.4m). The CEO has requested that a plan be produced by the next CEO HTA meeting on 17th May 19 to include a breakdown of the two schemes (Ophthalmology 600k, Orthopaedics £800k), a clear mechanism for delivery, early Comms input and wider orthopaedic related savings particularly around procurement.				
	All schemes	**(72)**	**(68)**	**4**					

BGH USC	19/20 target £'000s	786	Total plans £'000s	639	175	162	976	Variance £'000s	(190)
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(34)	(36)	(2)	N/A				
	Amber schemes	0	0	0	Length of Stay plans being developed and progress monitored through the Operational Effectiveness Delivery Programme. Savings profiled to commence from Aug 19.				
	Red schemes	0	0	0	Collaborative Care paper being presented to ET on 29th April 19. Concerns that clinical leadership constraints could delay the success of the pilot. Joint BGH and MH CEO HTA meetings may be required to ensure this scheme becomes green.				
	Total	**(34)**	**(36)**	**(2)**	Other actions agreed Whilst delivering on green savings schemes, BGH are showing an £89k overspend in Month 1. This has been driven by a one-off accrual from 18/19 and an increase in variable pay due to a couple of busy weekends at BGH during April 19. The Directorate will reduce the deficit through close monitoring of HCSW spend. The CEO has requested a plan to address the deficit by the next CEO HTA meeting in June 19.				

GGH USC	19/20 target £'000s	1,557	Total plans £'000s	1,032	229	0	1,261	Variance £'000s	296
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(44)	(57)	(13)	N/A				
	Amber schemes	0	0	0	Length of Stay plans being developed and progress monitored through the Operational Effectiveness Delivery Programme. Savings profiled to commence from Oct 19.				
	Total	**(44)**	**(57)**	**(13)**	Other actions agreed Further plans to be identified to meet the required target savings by 17th May 19.				

PPH USC	19/20 target £'000s	931	Total plans £'000s	48	645	0	693	Variance £'000s	238
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(2)	(2)	0	Recruitment opportunities for nursing are being explored.				
	Amber schemes	(1)	(1)	0	• In the short-term, current MIU savings are based on opportunistic savings as a result of OOH vacancies. A longer-term solution is being worked through with the next steps being a discussion Llanelli GPs. • Recruitment to posts to support the Intermediate Care scheme is underway.				
	Total	**(3)**	**(3)**	**0**	Other actions agreed Further plans to be identified to meet the required target savings by 17th May 19.				

WGH USC	19/20 target £'000s	1,125	Total plans £'000s	828	297	0	1,125	Variance £'000s	0
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(33)	(41)	(8)	N/A				
	Amber schemes	0	0	0	Ambulatory care and ED streaming – The CEO has requested clarity on the impact of an enhanced ACU at WGH and and understanding of what action is necessary to turn this scheme by 17th May 19. Executive Director leadership to be confirmed.				
	Total	**(33)**	**(41)**	**(8)**	Other actions agreed Directorate to consider how the expected overspend from Month 1 is recovered as part of the savings plan in year and report back at next CEO HTA meeting on 17th May 19.				

Oncology & Cancer	19/20 target £'000s	438	Total plans £'000s	284	0	0	284	Variance £'000s	154
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(24)	(24)	0	N/A				
	Total	**(24)**	**(24)**	**0**	Other actions agreed • The Aseptic Unit issue is causing an in-year cost pressure of £500k. The CEO has asked for mitigating non-recurrent actions that can be taken to mitigate the 6 months cost pressure in year. Scoping work has also been requested to understand what opportunities there may be once the Aseptic Unit issue is resolved in the second half of FY20. • The CEO has asked for a plan to mitigate the £94k high cost drug cost pressure. Finance are working with Pharmacy to ensure the risk is being closely monitored. • Finance are working with the Directorate to look at vacancy opportunities and issues and will also review SLA to identify savings opportunities.				

Section 2 – Summarises 19/20 Directorate savings plans against required savings target of 3.7% for Directorates that are monitored through the Turnaround Director Holding to Account meetings. The figures included in this section are based on the known position of Month 1 as at 10th May 2019 and will be subject to change with the identification of further savings opportunities.

Carmarthenshire County										
	19/20 target £'000s	**884**	**Total plans £'000s**		536	289	0	**825**	**Variance £'000s**	**59**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**					
	Green schemes	(4)	(10)	(6)	A paper to be presented to the Executive Team in May setting out the plans for the Amman Valley Hospital Service scheme.					
	Amber schemes	(13)	(8)	5	Savings of high cost high frequency care packages on continence assessment to be confirmed.					
	Total	**(17)**	**(18)**	**(1)**	Other actions agreed Review palliative care unit costs, service model and funding arrangements.					

Ceredigion County										
	19/20 target £'000s	**415**	**Total plans £'000s**		155	35	0	**190**	**Variance £'000s**	**225**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**					
	Green schemes	(12)	(11)	1	N/A					
	Amber schemes	(1)	0	1	N/A					
	Total	**(13)**	**(11)**	**2**	Other agreed actions • County and BGH to work together to identify actions that would release funds from the acute hospital to invest in community services in relation to discharges/LOS. • A workshop to be arranged to consider opportunities to meet the savings target deficit. • Update on bed plans for Tregaron Hospital to be provided for the next CEO HTA meeting in June 19.					

Pembrokeshire County										
	19/20 target £'000s	**729**	**Total plans £'000s**		270	53	388	**711**	**Variance £'000s**	**18**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**					
	Green schemes	(22)	(18)	4	To be discussed at TD HTA meeting on 15th May 19.					
	Amber schemes	0	0	0	Delivery from July 19					
	Red schemes	0	0	0	To be discussed at TD HTA meeting on 15th May 19					
	Total	**(22)**	**(18)**	**4**	Other actions agreed • Finance to confirm the number of beds funded in the budget settlement. • Formal plan to address 19/20 savings gap to be produced by next TD HTA on 15th May 19.					

Women & Children	19/20 target £'000s	1,359	Total plans £'000s	211	312	108	630	Variance £'000s	729
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(7)	(3)	4					
	Amber schemes	0	0	0	• Plans in place to operationalise Withybush MLU staffing model. Engagement has been started with staff, OCP process will need to be discussed at the Partnership Forum prior to progressing. • Antenatal provision – premises issue. Paper to go to Executive Team in May 19.				
	Red schemes	0	0	0	• C-section Scheme – work to be done to understand the cost of C-sections in March 19				
	Total	**(7)**	**(3)**	**4**	Other agreed actions Need to understand potential risks of cost increase for paediatric diabetic consumables. Potentially £260k - only £160k risk in the plan.				

Primary Care	19/20 target £'000s	790	Total plans £'000s	670	227	388	1,285	Variance £'000s	(495)
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	0	0	0	Planned delivery from Sept 19				
	Amber schemes	0	0	0	• Directorate to work through the impact of delay in implementing local GP Hub. • 4 GPs have moved to salaried status already, with a 5th in progress.				
	Red schemes	0	0	0	Planned delivery from May 19				
	Total	**0**	**0**	**0**	Other agreed actions Potential cost pressure identified in respect of Orthodontics and dental inflationary funding. Directorate to clarify the position on dental funding within the plan for FY20.				

Radiology	19/20 target £'000s	584	Total plans £'000s	390	405	0	795	Variance £'000s	(211)
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**				
	Green schemes	(20)	(20)	0	N/A				
	Amber schemes	0	0	0	Planned delivery from Aug 19				
	Total	**0**	**0**	**0**	Other actions agreed MRI issue in April 19 incur a cost pressure on the budget due to the need to outsource activity. Plan to be in place to address this within the next 2 weeks.				

Section 3 – provides an update position on the Turnaround Delivery Programmes. The Delivery Programmes focus on pan-organisational opportunities to drive patient focused benefits and support Directorates to achieve their savings target. Savings highlighted here are not in addition to savings identified in Sections 1 and 2 above.

Operational Effectiveness – Length of stay				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To support the Health Board deliver a reduction in length of stay, enabling the closure of unfunded surge capacity, through a focus on demand and capacity opportunities, bed configuration and quality improvement.	1,852	4	Terms of Reference have been reviewed and membership and objectives updated to reflect the 19/20 work plan. All acute sites are developing detailed length of stay action plans that will sit beneath the USC Board Action Plan. LOS plans will include metrics, measurements, timescales and anticipated outcomes.	

Operational Effectiveness - Cataract pathway				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To increase cataract productivity so that the need to spend RTT is negated.	600	0	A Project Group and Action Plan are place to progress the necessary actions to increase cataract productivity, including the move of W-AMD services to appropriate locations to free up theatre space.	

Outpatients				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To make efficiency and productivity improvements that increase availability of core capacity and mitigate the need for other high cost, premium rate activity relating to national waiting times and access targets.	796	0	Outcome forms –the Health Board needs to improve compliance to ensure that it meets the new Welsh Government targets that will be introduced in shadow form from Sept 19. A process for the monitoring and reporting of compliance to be introduced in outpatients, with the support from clinic nurses	Orthopaedic virtual clinic started in March 19 - 8 patients per week are currently receiving this service, with a view to increasing this to 10. Plans are in place to commence virtual clinics in Bronglais in May 19.

			Implementation of a policy to manage non-responders to follow-up invitations to be discussed at the next meeting.	

Continuing Health Care				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To improve the CHC patient pathway and strengthen in-house delivery.	418	0	The agreed focus following a workshop in February was: • A review of the sustainability policy and how it can be utilised to maximum effect (this will make recommendations for further work) • A scoping exercise/Training Needs analysis to inform training in CHC decision making and negotiation skills • A root cause analysis of section 117 decisions in the context of the component part of the decision making process with EMI patients and where different decisions may be made in the future. The top 9 (expensive) Carmarthenshire cases will be reviewed.	

Patient Communications				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To reduce the cost of patient communications in relation to appointment letters and results.	200	0	Key areas of continued focus for 19/20 will include: • Text reminder service • Patient Knows Best • Electronic reporting of results • Centralised post processing and distribution No meetings have taken place in 19/20.	Compared to the same period last year, a simple data extraction shows that DNAs in orthopaedics have reduced since the confirmation letters have ceased. | | Jan | Feb | Mar | Apr | |---|---|---|---|---| | 2018 | 107 | 75 | 75 | 112 | | 2019 | 89 | 46 | 54 | 53 |

Theatres				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To reduce non-pay expenditure through better procurement and standardisation of items used.	100	0	PICC Lines – Group established and working towards standardisation of products and application. Other opportunities to standardise items are being progressed.	Loan kit rationalisation has achieved £7.5k in April 19 with a further £12.5k anticipated in May.
To focus on efficiency opportunities around process and pathways.	TBC	TBC	An audit on Theatre start will commence on 20th May, with a session returns audit already underway. A data cleansing exercise is being undertaken to remove access for staff who no longer need to use the system. A process for the signing out of doctors is to be implemented. Recycling - avoidance of clinical waste – the Environment Team are looking at Theatres and Critical Care.	
To review maintenance contracts for Theatres equipment and services.	TBC	TBC	Plans ongoing.	

Workforce - Roster Efficiency				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To reduce usage and expenditure on of temporary nursing staff and to ensure that temporary staffing (overtime, bank and agency) are only used when clinically assessed as necessary.	TBC	TBC	A work plan for 19/20 has been agreed and will include Theatres, Paediatrics, Maternity Services, Endoscopy and A&E sites (incl AMAU PPH). A Gantt chart is being developed to map out audits over the coming months. Progress will be monitored against a number of themes including 6 week rosters, management of time balances and annual leave.	

			Consideration is being given to aligning the Roster Efficiency and establishment Control Group work.	

Housekeeping - Travel and Subsistence				
Objective(s)	**Savings identified 19/20 (£000's)**	**Savings delivered 19/20 (£000's)**	**Update**	**Achievements**
To identify and co-ordinate a consistent approach to travel and subsistence claiming processes.	57 (TBC)	1	Although this group has not met in 19/20, work has been ongoing to understand the opportunities to reduce the use of grey fleet. An update on this work will be provided at the next meeting on 20th May 19. Other areas of focus for 19/20 will include the robust management of the Study Leave policy for non-mandatory training and a review of community staff bases.	

CYFARFOD PWYLLGOR CYLLID FINANCE COMMITTEE MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Projections Assurance
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Fiona Powell, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation This report outlines to the Committee the financial projection for the year.
Cefndir / Background The ability to project accurately is a critical requirement in order to ensure that the Health Board delivers against its plans and can take remedial actions in a timely and proportionate way.
Asesiad / Assessment • Draft interim Annual Plan for 2019/20 approved by Board March 2019 with deficit of £29.8m; Welsh Government have since confirmed that the Health Board's Control Total requirement is a deficit of £25.0m. • Directorate level projections are currently in line with the Annual Plan of £29.8m. • To achieve the Control Total requirement additional actionable savings plans will need to be urgently identified, which will rely on both Corporate and Directorate level delivery.
Argymhelliad / Recommendation The financial projections are discussed and noted.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Risk Register Reference:	BAF S09-PR20 BAF SO10-PR33
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability 5. Timely Care 7. Staff and Resources

Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working: Hyperlink to Well-being and Future Generations Act 2015 - The Essentials Guide	Please explain how each of the '5 Ways of Working' will be demonstrated
	Long term – financial sustainability is critical for the long term planning of services within the Health Board.
	Prevention – addressing issues highlighted in this report will prevent the financial position deteriorating.
	Integration – supports the Welsh Government's requirement for the Health Board.
	Collaboration – the Health Board's financial position is the result of expenditure across our services and improvement requires collaboration with staff, contractors, providers and partners.
	Involvement – managers across the Health Board have been involved in setting budgets and in managing their financial positions.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system.
Rhestr Termau: Glossary of Terms:	Refer to the accompanying finance report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cylid: Parties / Committees consulted prior to Finance Committee:	Health Board's Finance Team Health Board's Management Team Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.
Gweithlu: Workforce:	The report considers the financial implications of our workforce.
Risg:/Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	The Health Board has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against the Health Board's financial plan will affect our reputation with Welsh Government, the Wales Audit Office, and with external stakeholders.
Gyfrinachedd:/Privacy:	Not applicable
Cydraddoldeb:/Equality:	Not applicable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

FINANCE SUB-COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	RTT Financial Plan & Trajectory 2019/20– Month 1 Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joe Teape, Deputy Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	Keith Jones, Assistant Director of Acute Services

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This paper describes progress to Month 1 (April 2019) in respect of the financial plan and planned expenditure trajectory to support Referral to Treatment (RTT), Diagnostic and Therapy service waiting times delivery for 2019/20.

Cefndir / Background

In April 2019, the Finance Sub-Committee received a report outlining the Referral to Treatment (RTT), Diagnostic and Therapy service waiting times delivery plan and supporting financial plan for 2019/20.

The total financial plan to support RTT, Diagnostics and Therapy delivery proposals for 2019/20, above core operational Directorate & service specific budgets was summarised as below:

Total forecast cost of delivery 2019/20 (as reflected in Annual Plan)		
Stage 1 additional activity	£719,052	
Stage 2&3 additional activity	£60,000	
Stage 4 additional activity	£3,690,258	
Sub Total		£4,469,310
Supporting investments	£1,083,000	
Sub Total		£1,083,000
Total		**£5,552,310**

Unlike previous years, Welsh Government has requested the Health Board to reflect the cost of delivery of these targets into the overall Annual Plan (and supporting financial plan) for 2019/20. The above sum has therefore been built into recurrent operational financial plans for 2019/20 (although held for monitoring purposes as a separate RTT / Diagnostics / Therapy services reserve to be drawn down into individual service budgets as agreed costs are incurred) and is subject to a savings and efficiency & productivity improvement challenge in a similar manner to all operational budgets.

With specific regard to the RTT, Diagnostics and Therapy delivery plan for 2019/20, a savings target to the value of £1.4m has been agreed spanning the following service areas:

- **Ophthalmology** – improvements to internal core capacity levels which will reduce the dependency (and cost) of planned outsourcing via the private sector through 2019/20
- **Orthopaedics** – proposals to further increase the volume of elective patients treated at Prince Philip Hospital and reduce forecast backfill / WLI costs
- **Breast Surgery** – proposals to reduce operating costs for 2019/20

The above proposals are reflected in the Planned Care Directorate overall savings plan for 2019/20. Opportunities for further improvements continue to be assessed across all related service areas.

Based on the above, it is therefore expected that maximum additional cost of RTT, Diagnostics and Therapy delivery proposals for 2019/20, above core operational Directorate & service specific budgets will be as follows:

Total available additional funding to support delivery 2019/20:	
Forecast cost of delivery	**£5,552,310**
Less Savings Target Proposals	**(£1,400,000)**
Sub Total	**£4,152,310**

In return, the Health Board is required to deliver:
- RTT – zero 36 weeks + breaches
- Diagnostics – zero 8 week + breaches in all disciplines
- Therapies – zero 14 week + breaches

Asesiad / Assessment

RTT, Diagnostics & Therapies Delivery Financial Plan 2019/20 – Progress as at Month 1

Progress to Month 1 (April 2019) in respect of the financial plan and planned expenditure trajectory, and any changes to previous assumptions are described below.

A monthly tracker to monitor detailed progress against the financial plan has been developed jointly between the Planned Care Directorate and supporting finance team. Funding released up to Month 1 is based on actual invoices received together with accruals for planned activity not yet invoiced. This is summarised in Appendix 1 and shows:

- Activity to Month 1 shows total additional expenditure of £244.5k.
- This below expected levels during Month 1 due to the impact on activity levels of the Easter holiday period, reduced Ophthalmology outsourced activity and the absence of externally provided Neurology clinics during the month.

Performance

In line with expectations, the Health Board reported 213 36 week + breaches as at the end of April 2019. Recovery towards zero breach performance is expected by the end of Quarter 1 2019/20. Details by specialty will be reflected in the latest IPAR report.

Argymhelliad / Recommendation

The Finance Sub-Committee is requested to note progress to Month 1 (April 2019) in respect of the financial plan and planned expenditure trajectory to support Referral to Treatment (RTT), Diagnostic and Therapy service waiting times delivery for 2019/20.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Risk Register Reference:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	3.1 Safe and Clinically Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	9. To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Support people to live active, happy and healthy lives
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working: Hyperlink to Well-being and Future Generations Act 2015 - The Essentials Guide	Please explain how each of the '5 Ways of Working' will be demonstrated
	Long term – can you evidence that the long term needs of the population and organisation have been considered in this work? The RTT Delivery plan promotes improved access to care and treatment for our population.
	Prevention – can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health? Faster access to treatment will help prevent disease progression for patients with chronic conditions.
	Integration – can you evidence that this work supports the objectives and goals of either internal or external partners? Plan has been developed with support from Welsh Government
	Collaboration – can you evidence working with internal or external partners to produce and deliver this piece of work? Plan reflects joint working between hospital sites, planned and unscheduled care teams and community based services.

	Involvement – can you evidence involvement of people with an interest in the service change/development and that this reflects the diversity of our population? Eye care plans have been developed in association with the UHB's Eye Care Collaborative Group.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Paper reflects delivery plan in support of a key WG Tier 1 performance target.
Rhestr Termau: Glossary of Terms:	Included in paper.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Welsh Government Delivery Unit Planned Care Directorate

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Outlined in paper.
Ansawdd / Gofal Claf: Quality / Patient Care:	Improved waiting times is a key component for patient experience and service quality.
Gweithlu: Workforce:	Outlined in paper.
Risg: Risk:	Outlined in paper.
Cyfreithiol: Legal:	External outsourcing activity commissioned in accordance with NHS Wales Shared Services guidance and procedures.
Enw Da: Reputational:	Reduced waiting times impacts directly on the UHB's service & delivery reputation.
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	Paper reflects plans to reduce waiting times for all patients.

RTT Month 1 Spend 2019/20

INTERNAL:- (Based on claims received to date for specialties funded in the plan)		
	Actual	
Specialty/Activity	£000's	Notes
SUMMARY BY SPECIALTY:-		
INTERNAL:-		
Cardiology	0.5	
COTE		
Dermatology		
Endocrinology		
Endoscopy		
ENT		
Gastroenterology		
General Surgery		
Breast	0.0	
Vascular		
Neurophysiology		
Pain Management		
Ophthalmology	0.2	
Orthopaedics	82.5	Claims received to date
Respiratory		
Urology	0.1	
Neurology		
Gynaecology		
Mobile Cardiac Lab		
Therapies		
Audiology		
Other	0.8	Medical records
Sub Total	**84.1**	
OUTSOURCING:		
Neurology		
Ophthalmology	**119.6**	Werndale cataracts (Patients treated in April)

RTT Month 1 Spend 2019/20

Orthopaedics		
Dermatology	**15.0**	Additional Insourcing Booked 18th and 19th April (Not yet Invoiced)
Sub Total	**134.6**	
Total Variable	**218.7**	
Agreed Additional items included in Plan:		
Neurology Consultant & Secretary	**9.4**	
Eye Care Coordinators	**6.7**	
Supporting pathology diagnostic ca	**0.0**	
Additional endoscopy diagnostic ca	**9.7**	
Therapies & Audiology	**0.0**	
Sub total	**25.8**	
Total Actual Month 1	**244.5**	

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on All-Wales Capital Programme - 2019/20 Capital Resource Limit and Capital Financial Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper is presented to the Finance Committee to:

- Note the Capital Resource Limit for 2019/20 expenditure allocations and profile
- Note the work being done to manage the financial risks identified.

Cefndir / Background

Following previous reports to the Finance Committee, and the Capital, Estates and Information Management and Technology Sub-Committee, this report provides an update on the Capital Resource Limit for 2019/20.

Asesiad / Assessment

Capital Resource Limit (CRL) 2019/20

The CRL for 2019/20 has been issued with the following allocations:

Expenditure	£m
All Wales Capital Programme	31.837
Discretionary Programme	7.421
Balance	**39.258**

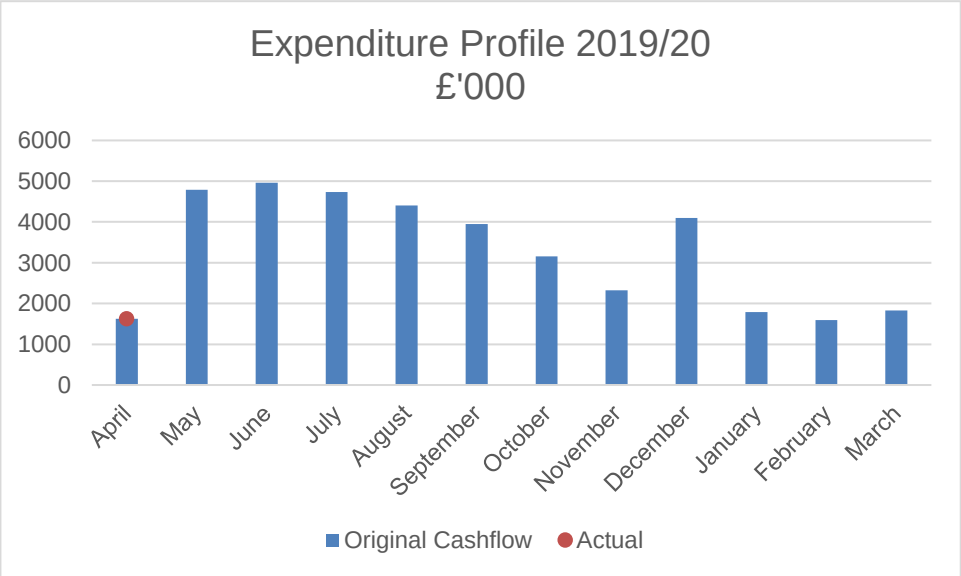
The All Wales Capital Programme (AWCP) schemes being funded in 2019/20 year are:

- Bronglais MRI
- Women and Children Phase II Scheme, Glangwili
- Cardigan Integrated Care Centre
- Aberaeron Integrated Care Centre
- Ward 9 and 10 Refurbishment, Withybush
- Fees for the development of the Cross Hands Integrated Care Centre Business Case

The following split of the Discretionary allocation for 2019/20 has been discussed at the Capital, Estates and IM&T Sub-Committee and agreed at the Business Planning and Performance Assurance Committee in February 2019.

Expenditure	£m	£m
Pre-commitments		3.000
• Withybush Data Centre		0.300
• Autoclaves		0.500
• Autoclaves(works)		0.500
• Penlan Development		0.700
• Telepath DCX payback		0.444
• IT I2S repayment		0.150
• Asbestos W&C payback		0.065
• W&C provision		0.341
Equipment		0.500
IM and T		0.700
Estates Infrastructure		0.500
Estates Statutory		0.700
Capital Support		0.300
Business Case Development		0.350
Contingency		0.300
Balance not yet allocated		1.071
Balance		**7.421**

The expenditure profile for 2019/20 is shown below:



Further work is being undertaken by HDdUHB's cost advisors on the All Wales Capital Programme profiles for 2019/20. The discretionary capital profile will be further reviewed with Estates, IT and the Deputy Director of Operations over the next 4-6 weeks.

Expenditure against the £39.258m allocation, as at the end of Month 1, was £1.628m.

Financial Risks

During 2018/19 one of the key risks that had to be managed by HDdUHB arose through slippage identified against expenditure plans, particularly on the Women and Children Phase II scheme. To mitigate against the risk of this occurring in 2019/20 HDdUHB will, along with the supply chain partner and cost advisor, continue to review the progress of actual expenditure against plan on a monthly basis. The following actions have been agreed:

- A robust analysis of monthly financial forecasting by the cost advisor will be required. This will be linked to robust scrutiny and challenge of contractor's programmes.
- A quarterly review of cashflow delivery against plan, led by the cost advisor in conjunction with both the Project Manager and Contractor, to build assurance that HDdUHB has strong governance arrangements on both project programme and financial management.
- Quarterly root and branch review of the programme and cashflow planning.
- A requirement for the cost advisor to work with the Project Manager and Contractor to develop a mitigation plan on areas where expenditure can be accelerated if required. This will take the form of a pre-prepared expenditure plan identifying opportunities to bring forward works/activities. This plan will be in place from late august 2019 and will be continually update.

Welsh Government and Shared Services will also be scrutinising the profiles and progress plans on the larger capital schemes across Wales on a quarterly basis. This will better inform the in-year capital expenditure position on an All Wales basis.

Interserve update

At the time of preparing this report, there have been no further Cabinet Office updates. The contractor is progressing well with the delivery of the 2 schemes currently on site.

Dawnus and Cylch Caron update

Discussions are currently ongoing with an alternative provider who also submitted a tender for the scheme. The provider was deemed appropriate for consideration to deliver the scheme. Current indication from this provider is that the scheme can be delivered but at an additional capital cost. The Project Board, held on 9th May 2019, agreed to explore alternatives to bridge this shortfall in capital. There is potential for this issue to cause a delay in the submission of the Full Business Case to Welsh Government.

Argymhelliad / Recommendation

The Finance Committee is requested to:

- Note the Capital Resource Limit for 2019/20, along with expenditure allocations and profile
- Note the work being done to manage the financial risks identified

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.5 Provide assurance to the Board that robust arrangements are in place for financial planning, financial performance and financial forecasting. 5.13 Provide assurance to the Board that arrangements for Capital, Estates and IM&T are robust.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Capital priorities included within service risk registers Risk 624 - Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives – Current Risk Score 16
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners All business cases for capital investment require alignment to the UHB's Well-being Objectives where applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Capital Allocation and prioritisation process. Capital Investment procedure and all relevant Welsh Government guidance.
Rhestr Termau: Glossary of Terms:	IM&T – Information Management and Technology
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Capital Monitoring Forum Capital Planning Group Individual Project Boards of Capital Schemes Welsh Government Capital Review Meeting Capital Estates and IM&T Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Included within individual business cases and Capital prioritisation process
Gweithlu: **Workforce:**	Included within individual business cases and Capital prioritisation process
Risg: **Risk:**	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within the UHB
Cyfreithiol: **Legal:**	Included within individual business cases and Capital prioritisation process
Enw Da: **Reputational:**	Included within individual business cases and Capital prioritisation process
Gyfrinachedd: **Privacy:**	Included within individual business cases and Capital prioritisation process
Cydraddoldeb: **Equality:**	Equality assessments are included within individual business cases and Capital prioritisation process when required

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Addressing Recommendations from the Deloitte Zero Based Review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Welsh Government (WG) commissioned Deloitte to undertake a zero based review of acute healthcare services provided by Hywel Dda University Health Board (HDdUHB). The purpose of the review was to allow WG to understand the potential impact of HDdUHB's current configuration and resources which limited the ability to produce an approved Integrated Medium Term Plan (IMTP).

WG funding of £27m was received, on a recurring basis in 2018/19 as a consequence of the unavoidable costs which were identified during the course of the review. The review highlighted further opportunities to improve efficiencies in the short, medium and long term. Progress in achieving these are summarised in this paper.

Finance Committee Members are asked to discuss the actions being taken to progress opportunities highlighted in the review.

Cefndir / Background

The Deloitte's Zero Based Review of Hywel Dda (the Review) (August 2017) was commissioned by WG (the Owner) as part of Targeted Intervention (TI), to undertake a zero based review of acute healthcare services provided by HDdUHB. The purpose of the Review was to allow WG to understand the potential impact of HDdUHB's current configuration and resources which limited its ability to produce an approved Integrated Medium Term Plan (IMTP). These included sustaining services on 4 hospital sites; the challenging environment and its impact on recruitment and retention; an older and frailer population; and, our current resource allocation. Deloitte Limited Liability Partnership (LLP) worked with both WG and HDdUHB on the evidence base underpinning the Review and the final document was formally accepted by WG. Any discussion/action resulting from the Review is being addressed through the TI meetings. Deloitte LLP shared the report with HDdUHB for information purposes only and it was published as part of HDdUHB Board meeting papers in March 2018 on that basis. The complete report is attached at Appendix 1 for information.

The Review suggested that there are several unavoidable costs resulting in WG providing recurrent funding of £27m. However, there are also opportunities to deliver efficiencies over the short, medium, and longer term.

Asesiad / Assessment

The Review, written for WG, made four recommendations as to next steps (pages 21 and 22 of Appendix 1) summarised below:

Next Steps	Response
Consider the extent to which unavoidable costs are accounted for in the current allocation formula.	This is an area for WG to resolve. £27m funding has been provided on a recurring basis.
Consider the way the clinical strategy can support by providing the right care to a changing population.	The Clinical Services Strategy 'A Healthier Mid & West Wales' has been approved by the Board and is now in the Implementation phase.
Continue to develop further efficiency areas and drive these forward.	The identification of savings and the Turnaround process is identifying further efficiencies. (see below)
Consider what temporary measures may be appropriate in areas where costs are avoidable only in the medium or long term.	Again, covered by the Turnaround process.

Continue to develop further efficiency areas and drive these forward / Consider what temporary measures may be appropriate in areas where costs are avoidable only in the medium or long term.

The zero based review did not explicitly identify where these efficiencies were to be found; therefore, it was not separately executable in this regard albeit it gave extra weight to the Turnaround imperative.

Finance Committee receives regular updates on Turnaround and savings progress. There is a seperate paper on the agenda outlining the actions being taken locally to progress opportunities identified on the Efficiency Framework, which is instigated by the Director General for Health and Social Care through the Efficiency, Healthcare Value and Improvement Group.

Argymhelliad / Recommendation

The Finance Committee is asked to discuss the actions being taken to progress opportunities highlighted in the Review.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5.1 Undertaking detailed scrutiny of the organisation's overall: • Monthly, quarterly and year to date financial performance; • Performance against the savings delivery and the cost improvement programme; assurance over performance against the Capital Resource Limit and cash flow forecasts. • Oversee and monitor the Health Board's turnaround programme.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	646 - Ability to achieve financial sustainably over medium term
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Included in attachment
Rhestr Termau: Glossary of Terms:	Included in report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Paper has previously been discussed at Public Board meeting

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Achievement of Draft Interim Financial Plan is dependent on savings/efficiency delivery.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No adverse impact
Gweithlu: **Workforce:**	No adverse impact
Risg: **Risk:**	No adverse impact
Cyfreithiol: **Legal:**	No adverse impact
Enw Da: **Reputational:**	No adverse impact
Gyfrinachedd: **Privacy:**	No adverse impact
Cydraddoldeb: **Equality:**	No adverse impact

Deloitte.

Zero based review of Hywel Dda University Health Board

Final report

For the Welsh Government | August 2017

Important notice

This final report (the "Final Report") has been prepared by Deloitte LLP ("Deloitte") for the **Welsh Government** in accordance with the contract with them dated **15th June 2017** ("the Contract") and on the basis of the scope and limitations set out below.

The Final Report has been prepared solely for the purposes of informing its review of the cost of the current configuration or Hywel Dda healthcare services, as set out in the Contract. It should not be used for any other purpose or in any other context, and Deloitte accepts no responsibility for its use in either regard.

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Contents

Background

In the context of continued financial challenge, the Welsh government has commissioned this report on Hywel Dda University Health Board's cost base

Hywel Dda University Health Board (HDUHB) is one of seven health boards in Wales that is responsible for meeting the healthcare needs of its population within the resource available. HDUHB provides primary, community, acute, and mental health care to the population of Carmarthenshire, Ceredigion, Pembrokeshire, and HDUHB's four general hospitals also provide services for some residents of the neighbouring counties.

Every year, HDUHB prepares an Integrated Medium Term Plan (IMTP) for a rolling three year period for submission to the Welsh government. For the years 2014/15, 2015/16, and 2016/17, HDUHB's IMTPs were not approved, and in 2017/18 HDUHB highlighted a set of issues limiting its ability to produce an IMTP that is approvable. Several key issues were identified for further investigation as to their impact on service as set out below:

- HDUHB has identified having four 'front doors' as a key cost driver as it develops and implements its strategies and plans. Specifically, HDUHB notes, sustaining services on four main sites leads to costs associated with **operating at a low scale**, and remoteness may lead to a more **challenging environment for the recruitment and retention** of staff and, consequently, costs.
- The HDUHB view, to be to tested, is that the population of HDUHB is sufficiently **older and more frail** than is generally the case in Wales, which places HDUHB at a material disadvantage in the resource allocation process to the extent that the resource allocation process does not adequately capture the impact of demographics on health need.

In this context, the Welsh government has appointed Deloitte to undertake a zero based review of acute healthcare services provided by HDUHB. The purpose of the review is to understand the potential impact of the above-mentioned factors and of **efficiency** on HDUHB's cost base.

Hywel Dda University Health Board Overview

Population served:[1]
c. 390k (2015/16)

Total activity 2015/16:[2]
108k – attendances at major A&Es
40k – minor attendances
400k – inpatient days
100k – first outpatient attendances

Context in Wales:[3]
HDUHB represents almost a quarter of Wales' landmass, however it only covers c.12% of the total population

Area coverage:
Carmarthenshire, Ceredigion, Pembrokeshire and its bordering counties

Financial position (2015/16):[4]
£31.2m deficit reported (c. 5% of HDUHB's resource allocation)

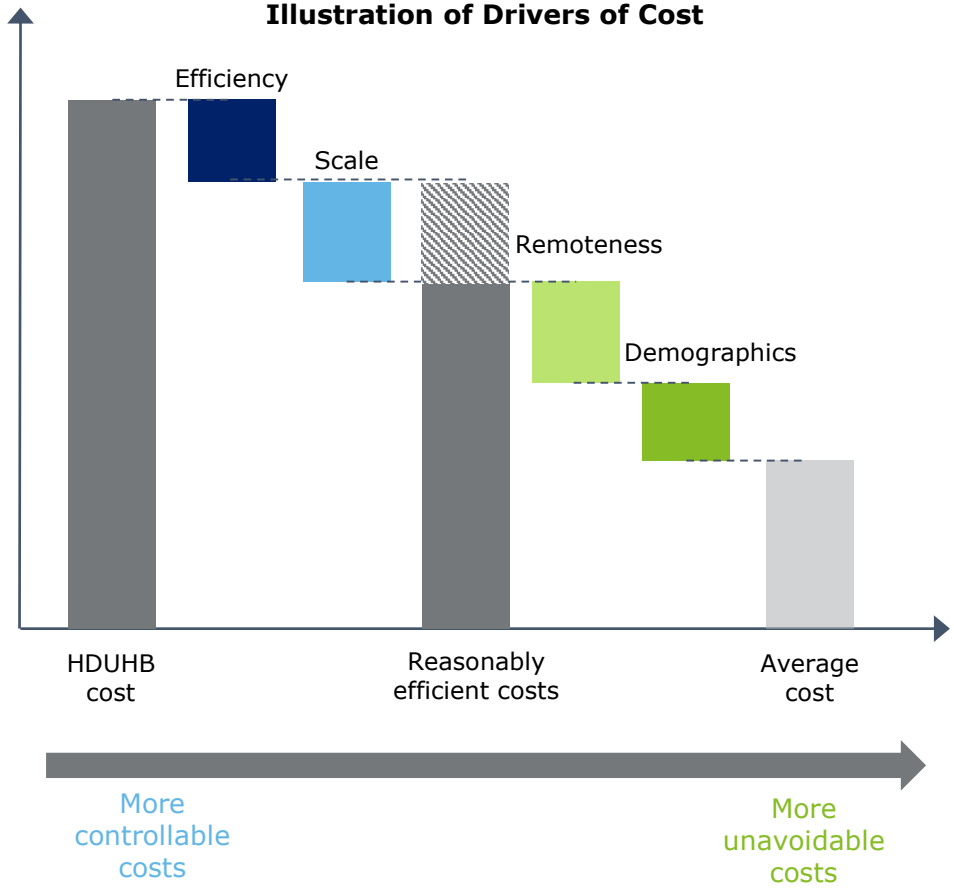
[1] Welsh Costing Returns 1 (WCR1)
[2] WCR2 and WCR1
[3] HDUHB IMTP 2016/17
[4] HDUHB Annual Report 2015-16. Resource allocation of £684m. This deficit is after non recurrent support such as Withybush contingency measures (£5.7m), contributions to achieve waiting time targets (£3.5m) and additional mental health funding (£1.3m)

Background

Four areas of cost have been estimated to understand HDUHB's uncontrollable cost base in the short and longer term

In order to understand the possible drivers of HDUHB's cost base, the review focuses on the four broad drivers of more controllable and less controllable health costs (demographics, remoteness, scale, and efficiency), as set out below. For each of the four areas that may affect HDUHB's cost base, estimates have been developed comparing HDUHB's cost to the Welsh average to assess the extent to which these factors could drive costs.

Some areas – demographics and remoteness – may generate costs that are unavoidable even in the long term. However, some of the areas – in particular, efficiency and scale – may be controllable by HDUHB in the short or longer term. To understand the possible short/medium term impacts, the analysis incorporates sensitivities around scale and the level of efficiency that may be attained.



Demographics - unavoidable
Demographic composition of the catchment population may impact health needs and costs. In particular, a higher proportion of elderly residents, along with characteristics such as ethnicity and deprivation may be associated with greater health needs and cost.

Remoteness - unavoidable
Remoteness and rurality may add pressures to the local health economy through increased difficulty in recruiting and retaining staff. This could result in costs in terms of locums or agency pay that would be specific to the area.

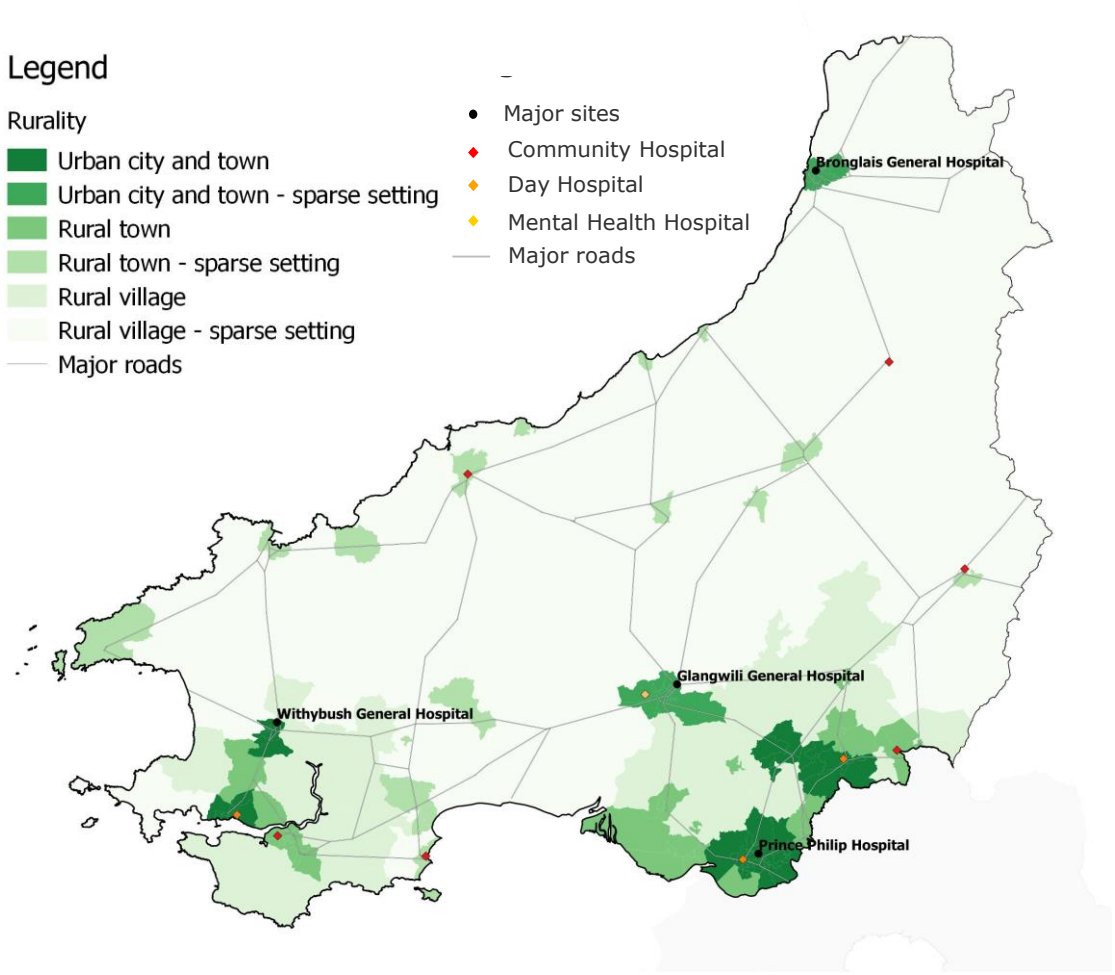
Scale - partially controllable in the medium to long term
The size of the catchment area and the low population density may suggest that the health board needs to provide healthcare services across the area to relatively low numbers of patients per site, to ensure access. This may mean that sites may only have relatively low levels of activity, and operate at lower than efficient scale (resulting in higher cost per unit of activity).

Efficiency - controllable in the short to long term
Relatively lower levels of efficiency may mean funding allocations are not used in the best way and savings could be realised through increased efficiency or productivity. Efficiency could come from ensuring patients are seen in the most appropriate setting (activity) or from taking steps so that treatment is delivered in the most cost effective way (cost).

Background

HDUHB provides services across four district general hospitals in a rural area, with four front doors and three full A&Es

HDUHB – Rurality by LSOA and main hospital sites[1]



Services by Site

Bronglais General Hospital

34.5 % FCE from outside HDUHB [2]

A&E	✓
Outpatient	✓
Maternity services	✓
UHB specialist centre	×

Glangwili General Hospital

3.6% FCE from outside HDUHB

A&E	✓
Outpatient	✓
Maternity services	✓
UHB specialist centre	✓

Withybush General Hospital

4.5% FCE from outside HDUHB

A&E	✓
Outpatient	✓
Maternity services	✓
UHB specialist centre	×

Prince Philip Hospital

3.3 % FCE from outside HDUHB

A&E	**Minors**
Outpatient	✓
Maternity services	×
UHB specialist centre	×

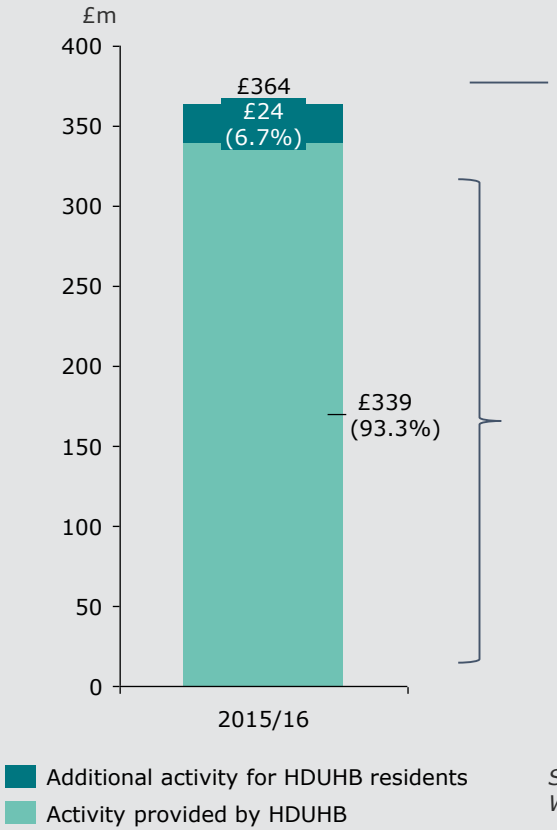
[1] Rural Urban Classification (2011 classification), which is part of the Census 2011. Lower super output area is a geographic area for small area statistics in England and Wales, which has a mean population of 1,500

[2] In particular, from Betsi Cadwaladr University Health Board (BCUHB) and from Powys. FCE relates to finished consultant episodes. Figures based on activity provided by HDUHB.

Background

This analysis is based on HDUHB's estimated acute cost base (c. £364m in 2015/16)

Acute care cost base for HDUHB residents in £m (estimated based on 2015/16 WCR1 and WCR13):[1]



Acute care for HDUHB residents (c. £364m) includes c. £24m net of outsourced activity costs for core secondary care, and c. £339m provided in HDUHB hospitals, based on the 2015/16 WCR1/ WCR13. The Welsh average equivalent figure for acute care for residents is c. £336m to serve a population of HDUHB's size.[1]

Provider cost base serves as a proxy for the general acute activity provided in district general hospitals. It is estimated at c. £339m for HDUHB. The Welsh average equivalent figure is c. £328m to serve a population of HDUHB's size.[1]

Source: Based on data from WCR1 and WCR13, 2015/16

- The focus of this review is on the cost base associated with acute care.
- The **acute cost** base for HDUHB is estimated based on the 2015/16 WCR1 and WCR13 costing returns.
- HDUHB's cost base for providing **acute care in HDUHB district general hospitals (DGHs)** is estimated at **c. £339m,** which includes the costs from the WCR1 related to:
  - A&E (including minor units, only a fraction of which is seen outside of Prince Philip)
  - Critical care
  - Most outpatient and inpatient activity[2]
  - Cancer screening and direct access[3]
  - Excludes daycare, specialised, homecare drugs, therapies (which may take place in a community or acute setting) and other costs
- This compares **to c. £328m for the Welsh average** based on the same approach (figure based on population the size of HDUHB).
- In addition to the costs of HDUHB DGHs, some of the **acute cost of caring for HDUHB residents** takes place in neighbouring health boards or relates to daycare or homecare drugs. To capture this, a net expenditure/income adjustment of **c. £24m** (based on the WCR13/WCR1) is added to the acute cost base. The total cost of providing acute care to HDUHB residents is estimated at **c. £364m** (**c. £336m based on Welsh average** for a population of HDUHB's size).

[1]WCR1 and 13, 2015/16. Small numbers supressed (discrepancy of c. £10k). Note that as cost is not reported by site, the exact spending of DGHs is not available and has been estimated based on specialty and subjective categories by point of delivery, based on the WCR13 and WCR1, and supporting analysis on out of area spending by HDUHB.
[2]Relates to regular day attenders, day case, inpatient activity, and outpatient activity (incl. procedures and pre-operative assessments) under the surgical, medical, and maternity categories, as well as costs for anaesthetics, clinical oncology, radiology, and A&E in the first sheet of the WCR1 dataset. Does not include mental health, GP led inpatient activity, specialised activity, or other activity categories unless noted.
[3]Costs included under the 'Community' section of the WCR1

Background

There are a number of limitations that should be viewed as context to the results

1. The purpose of these estimates is to understand the contribution of each factor to HDUHB's current cost base based on its current configuration, and to understand the flexibility of each cost area in the short, medium, or long term. As such, the report does not undertake a baselining exercise of HDUHB's future cost base based on growth rates to cost or income.

2. The analysis presented is subject to both data and time constraints, which limit the specificity of the work. In particular, cost data at site level is not available and therefore the review is based primarily on secondary literature.

3. Whilst the report notes what is in and outside of the allocation formula (in the appendix) as it relates to the zero based review, undertaking a review of the funding allocation formula for health boards is not considered in this review.

4. When comparing the different cost drivers against the acute cost base, the following should be considered:

   - The impact of each cost driver has been separately identified. As such, this introduces the risk of **overlap** between factors. Where possible, triangulation and regression estimates from the literature have been applied to the Welsh context to try to account for this. However, there are some areas where overlap may still be present. Further detail on this is set out in the supporting slides of the report.
   - In addition, it should be noted that there is an **interaction between remoteness and scale**, whereby some costs of remoteness are seen through small scale. As such, some of the impact of remoteness may be included in the cost estimates for scale.
   - The results are an **intermediate step** in finding a sustainable way forward for HDUHB, rather than exhaustive and precise estimates of the additional unavoidable costs.
   - There are a number of references to the **literature** used in the summary report. The core literature is set out in footnotes as relevant on each slide, and a wider list is set out in the literature section of the appendix.

As such, whilst the results provide an overall indication of several areas which have a relatively sizeable effect on HDUHB's cost position, they are not summative and should not be considered as such.

The above sets out some of the key limitations. A full list of considerations and limitations that were identified in relation to the review is set out in the considerations section

Demographics

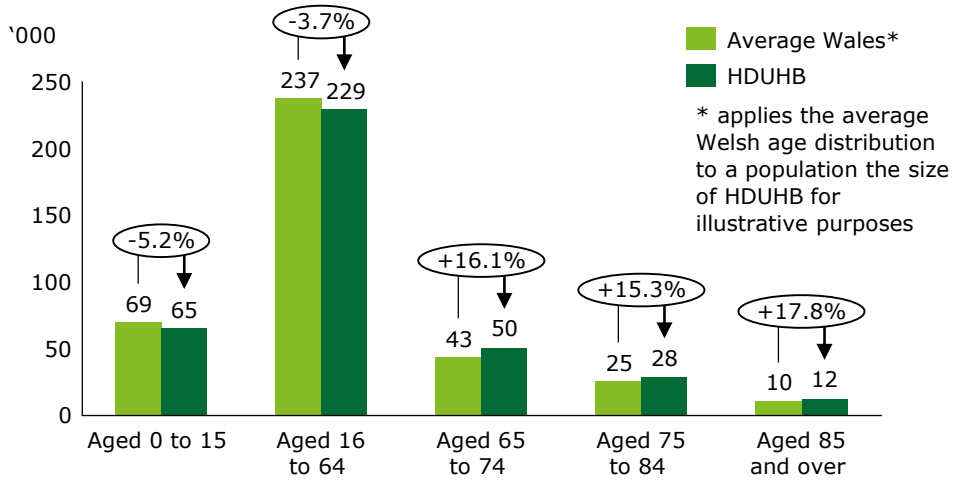
HDUHB's relatively older population may affect utilisation levels and the cost of providing healthcare

- HDUHB has an **older population** than Wales. Its elderly population is over 15% higher than the Welsh average.[1]
- The literature suggests that an older population may be associated with **higher costs**,[2] resulting from two drivers:
  - Higher prevalence of long term conditions, which require more medical treatment and resource utilisation; and
  - Higher frequency of activity because of age-related conditions (e.g. falls).
- In view of its relatively older population, age will be a focus of study, together with the interaction between age and gender.[3]
- Deprivation can also have an impact on costs.[4] However, whilst deprivation is an important characteristic, HDUHB is the median health board in terms of deprivation (as measured by the needs index and WIMD) and so this is not considered in detail.[4]
- Further detail on HDUHB's demographics compared to other health boards is set out in the supporting slides.

[1] Those aged 65 and over.
[2] See e.g. Chaplin et al (2015), Alemayehu and Warner (2004), Caley and Sidhu (2010).
[3] In addition, there is an interaction between age and gender. See e.g. Chaplin et al (2015), Wang et al (2013), and Monitor (2016).
[4] See e.g. Asaria et al (2016), Chaplin et al (2015), HDUHB has relatively few pockets of deprivation but also few pockets of affluence, based on WIMD

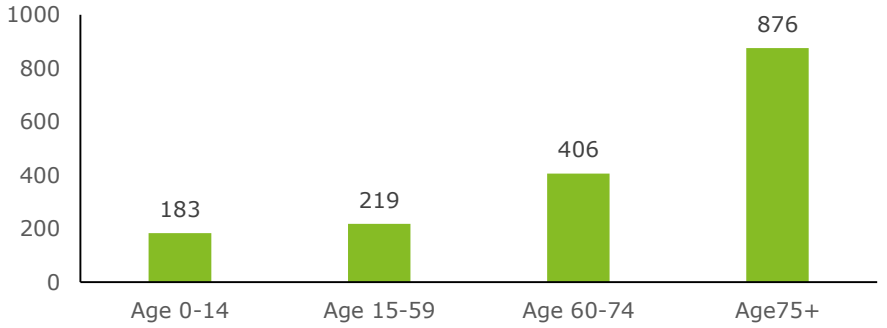
2015 Population Composition (1,000s)
(HDUHB – Wales percentage difference in brackets)

HDUHB has an **older population** than Wales, an elderly population that is over 15% higher than the Welsh average



Data source: StatsWales, Office for National Statistics

Wales – FCE per 1,000 by age band



Data source: Patient Episode Database for Wales (PEDW) tables, NHS Wales

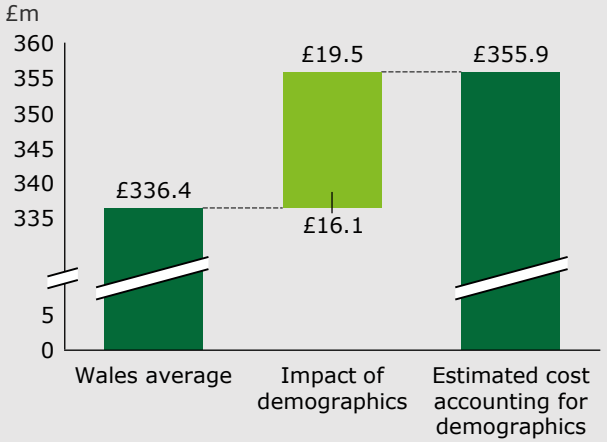
Demographics

Initial estimates suggest age and gender could contribute c. 5% - 6% to HDUHB's acute cost base

Demographics indicative findings

c. 5% - 6% additional acute cost

HDUHB – Demographics cost impact (£m)



Source: Deloitte analysis based on NHS England (2015a), ONS StatsWales, PEDW and WCR2 (2015/16)

Methodology

To estimate the potential impact of age on the acute cost base, the analysis considers three approaches:

- **Compare inpatient utilisation** by age band to estimate what utilisation would be if HDUHB had an age distribution profile similar to the Welsh average.
- Apply the **updated Nuffield formula** estimates of age-gender impact. The Nuffield formula is used by NHS England to estimate the core allocations to clinical commissioning groups (CCGs).[1]
- ***The Path to Sustainability* study**[2] from the Health Foundation also finds that utilisation tends to increase with age. This work has not been used here to estimate increased cost based on the way age and deprivation were modelled and as the reported model could not be applied to available data.

Indicative findings

The initial results indicate that age and gender could contribute **c. 5%** - **6%** to HDUHB's acute cost base, [3] based on the estimates from the first two approaches set out above, or c.£16m - £20m on the estimated acute cost base in addition to the Welsh average cost.

Limitations

- The inpatient utilisation approach does not account for gender differences.
- The updated Nuffield formula as applied accounts for the impact of long term conditions to cost by broad age bracket (children, ages 15 - 65, age 65+) rather than for each year of age.
- The updated Nuffield formula is applied to inpatient data and then uplifted to arrive at an estimate for the broader acute cost base for the HDUHB population. This estimate is based on the English system, which may differ from relationships in Wales.
- Estimates are based on actual activity and do not capture the impact of unmet need or the differences in unit cost within healthcare resource group (HRG) by age/deprivation.
- Cost uplift is based on average unit cost (average Welsh reference costs). Whilst there may be a decrease in economies of scale if activity were lower, this may be counteracted to a certain extent by using the Welsh average cost, which is based on the average Welsh scale. Further work testing this against marginal cost approaches could be a next stage.
- Deprivation is not included in the estimates set out.

[1]NHS England (2015a). *Refreshing the current CCG formula (Revised);* [2] Watt T and Roberts A (2016). *The Path to Sustainability*, The Health Foundation; [3] Range based on estimates set out for the utilisation-based and Nuffield formula-based approaches.

Remoteness

Remoteness may impact HDUHB's cost base through recruitment costs or by affecting a site's economies of scale (considered separately)

- Remoteness may affect a hospital's cost base through two broad mechanisms – scale and recruitment. This section focuses on the recruitment aspect. Scale will be discussed separately in the Scale section.
- Remoteness has been associated with a range of workforce cost drivers in the economic literature [1, 2] (see the literature section of the appendix) and discussions with HDUHB stakeholders indicated a number of examples of how scale may affect costs for HDUHB.

Remoteness

Recruitment

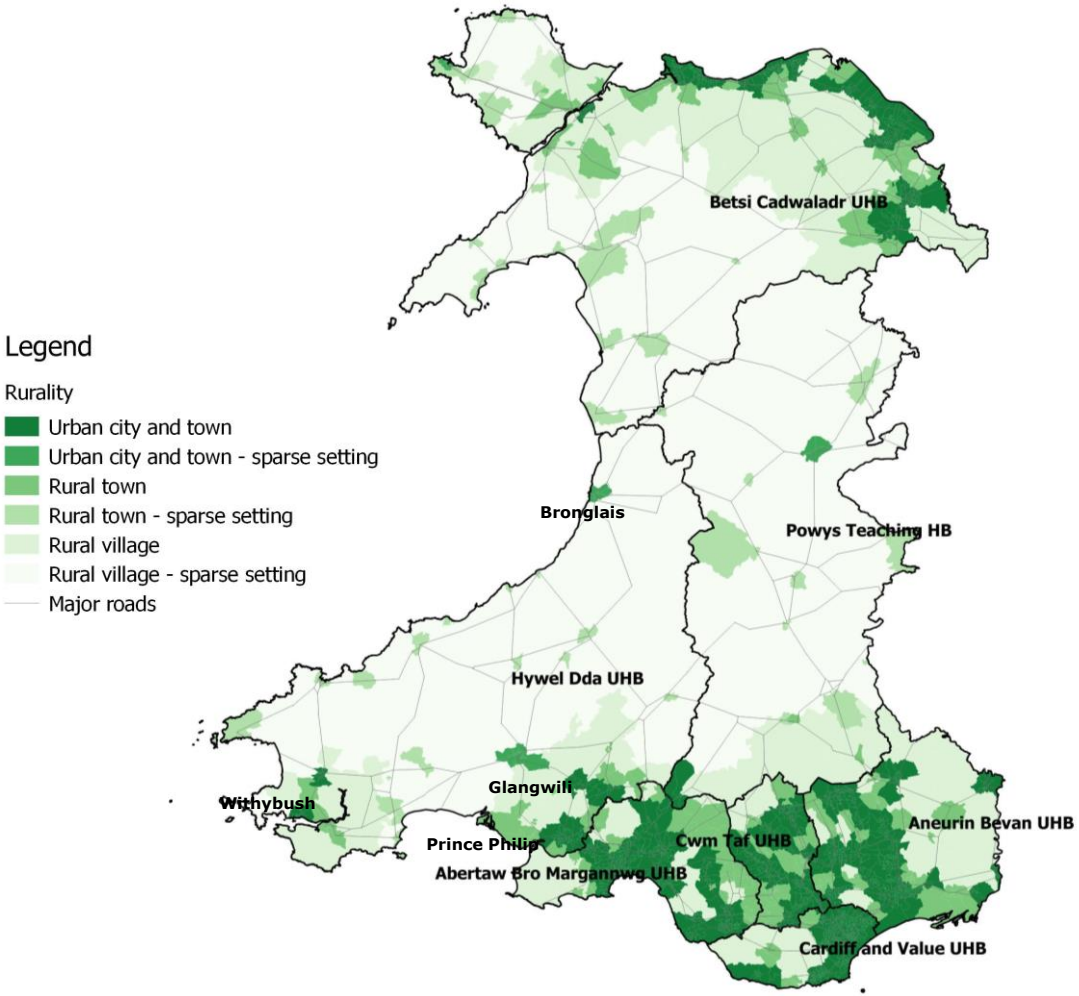
- **International evidence suggests recruitment challenges in remote areas.** [1] The economic literature indicates that medical staff may not prefer working in remote areas. Across advanced economies, there is lower density of medical staff in remote areas, in particular in larger countries. In some countries, staff receive higher pay to locate in remote areas.
- **Evidence in the UK suggests that hospital location may be an important factor in doctors' decisions on where to work.** A survey of junior doctors in the UK found that junior doctors may prefer training posts in hospitals located where their spouse can find a job, or where they are close to their family. This could disadvantage remote areas if they are far from job markets and transport links.[2]
- **In the UK, recruitment challenges may be channelled through higher agency costs rather than higher wages, which will be the focus of the analysis in this report when evaluating the relationship with remoteness.** In other systems, less desirable posts may be compensated by higher pay, whilst under NHS pay schedules, there are limits to meeting the wage premium required to work in more remote locations. As such, the costs may be seen through higher vacancy rates and agency spend.

[1] See e.g. Tomoko Ono, Michael Schoenstein and James Buchan (2014). *Geographic Imbalances in Doctor Supply and Policy Responses ;* Dussault, G. and M. C. Franceschini (2006). *Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce.* See the literature section of the appendix for more.
[2] Health Economics Research Unit (2016). *Junior doctors training: is it really location, location, location?*

Remoteness

Compared to other health boards, HDUHB's remoteness profile may have an impact on cost

Wales – Rurality by LSOA[1]



- HDUHB covers a more rural area than other health boards in Wales.
- Around 30% of lower layer supper output areas (LSOAs) are counted as 'Rural Village – Sparse Setting' in HDUHB, compared to 9.5% for Betsi Cadwaladr University Health Board (BCUHB), one of the most comparable health boards.[1]
- Withybush and Bronglais are particularly remote, being greater than a 60 minute private drive time to more urban areas near Swansea.[2]
- Furthermore, Bronglais hospital covers an area with limited access to other hospitals indicating that Bronglais plays a role in providing healthcare in this area. [2]

[1] Lower super output area is a geographic area for small area statistics in England and Wales, which has a mean population of 1,500. RUC 2011 classifications, Census 2011. The RUC 2011 classifies geographic areas into categories of rurality and urbanisation based on population density, settlement size and structure. For the approach to BCUHB as a comparator, see the appendix.
[2] Doogal – travel time analysis. Based on weekday morning private drive times, 2017

Remoteness

The analysis does not support the hypothesis of a relationship between HDUHB's remoteness and higher staff costs

Remoteness indicative findings

No impact identified

Approach

Peer comparisons, cross site analysis, and bivariate analysis of agency cost and remoteness were used to investigate the relationship between remoteness and higher staffing costs. Further detail is set out in the supporting slides.

Indicative findings

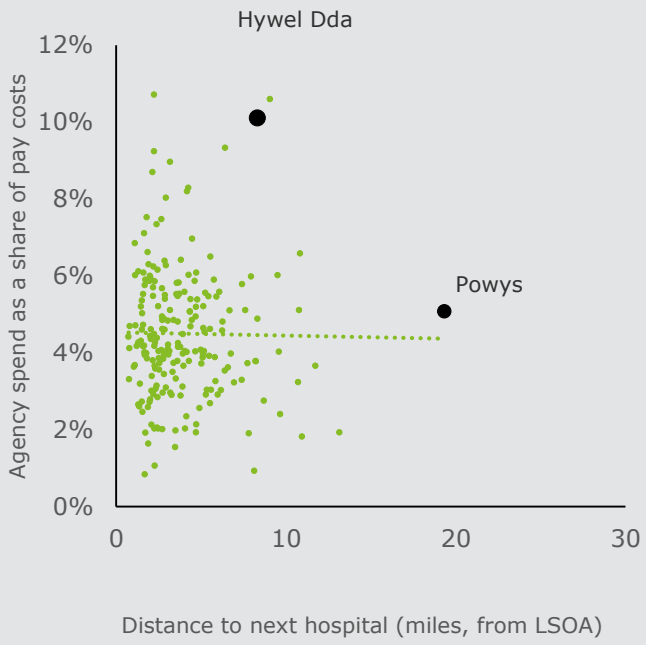
No clear relationship has been identified between several different measures of remoteness (distance to the next hospital, distance to large cities, rurality, and property price)[1] and higher total staff cost (measured using agency costs and vacancy rates across all staff types). For example, analysis of the distance between hospitals and large urban centres was undertaken, and this did not demonstrate a statistically significant relationship between agency spending and distance. This suggests that, while areas such as Bronglais may be remote, the remoteness is not related to higher agency spending.

Closer analysis was conducted for medical staff, as the literature (see the literature section of the appendix) and HDUHB stakeholders noted that recruitment may be particularly challenging for doctors. For medical staff, the data is weakly suggestive of a potential relationship between more remote sites and higher agency spend (see supporting slides for further detail). However, there is limited data available to test this, and the relationship is not statistically significant based on the available data.

Limitations

- This analysis was limited by the availability of data across England and Wales.
- In particular, the lack of data on vacancies and staffing costs across England and Wales has limited the analysis to agency spend at the trust and health board level.
- Whilst this investigation did not find any relationship between remoteness and workforce cost, there was limited data available on specific workforce groups (e.g. medical staff). Further investigation with a richer dataset with more observations of medical agency costs would be needed to conclude that there is no remoteness impact on costs for specific types of staff.
- There have been significant changes to the agency market in recent years, and so statistical analysis should be interpreted with caution.

England and Wales - Agency spend and distance to next hospital, LSOA level[2]



Source: Data from Welsh Government, HSJ, Monitor, ONS[2]

[1] Property price was used as a further approach to testing the relationship between agency spending and attractiveness of an area, after examining the relationship between agency and other proxies of remoteness. Some stakeholders have noted that higher property prices in parts of HDUHB may reflect the retiree rather than working age population, and so this is used as a secondary rather than primary proxy.

[2] The analysis was performed at CCG and health board level. See the appendix to the supporting evidence slides for notes on mapping of hospitals to CCGs. Calculations based on geographic coordinates.

Scale

The literature suggests that smaller scale may be associated with higher unit costs

- Literature on economies of scale in healthcare suggests that hospitals exhibit economies of scale in activity (see the literature section of the appendix). [1]
- HDUHB has four small sites, which may affect the cost of providing care in HDUHB.

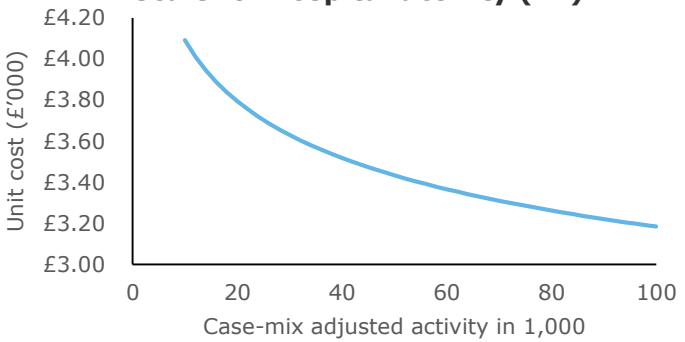
Economies of scale in the healthcare sector

Economies of scale are present when unit costs decrease as activity increases. In the healthcare sector this can apply to hospital activity in terms of admissions and episodes as well as hospital beds.

Evidence suggests HDUHB's cost base could include costs due to scale

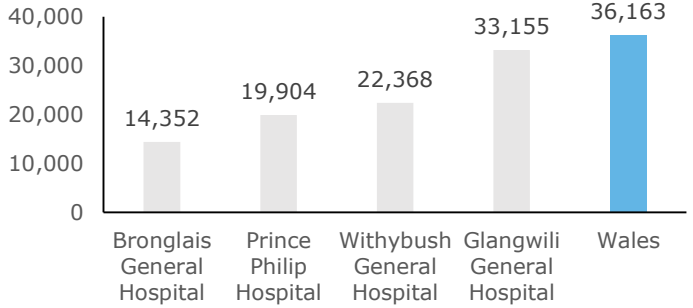
- HDUHB's four sites operate at a smaller scale than the rest of Wales, with the average case-mix adjusted activity per site of c. 22,000 compared to c. 36,000 in Wales.[2]
- There is a variety of UK and international literature that suggests that smaller hospitals may have higher costs.[1]
- Applying the most relevant literature to HDUHB suggests that scale could have an impact on HDUHB's cost base.
- The indicative findings set out in the next slide estimate the potential cost of small scale, not of remoteness. It is possible that some element of this cost may be avoidable. For example, by changing the optimum location of sites as populations change. However, this is not part of this study.

Cost curve estimate - economies of scale for hospital activity (£k)



Source: Calculations based on calibration of NHS England (2015b) for the Welsh context and data from PEDW, WCR2 2015/16

Case-mix adjusted activity[2]



[1] Monitor (2016). *Evidence on efficiency for the 2016/17 national tariff*; NHS England (2015b). *Costs of unavoidable smallness due to remoteness;* and Deloitte (2014). *Evidence for the 2015/16 national tariff efficiency factor;* Yuejen Zhao, Margaret Foley, Kathy Eagar (2011) ; Frontier Economics and The Boston Consulting Group (2012), G. Marini and M. Miraldo, (2009), Leleu, H., J. Moises, and V. Valdmanis (2012), H. Azevedo and C. Mateus (2013), Troels Kristensen, Peter Bogetoft and Kjeld Moeller Pedersen (2010).

[2] Case-mix adjusted activity (CMAA) uses HRG unit costs to account for the complexity differences across acute activity. See the supporting slides for detail.

Scale

Initial estimates suggest scale could contribute c. 2% - 6% to HDUHB's acute cost base

Scale indicative findings

2%-6%
additional acute cost

Approach

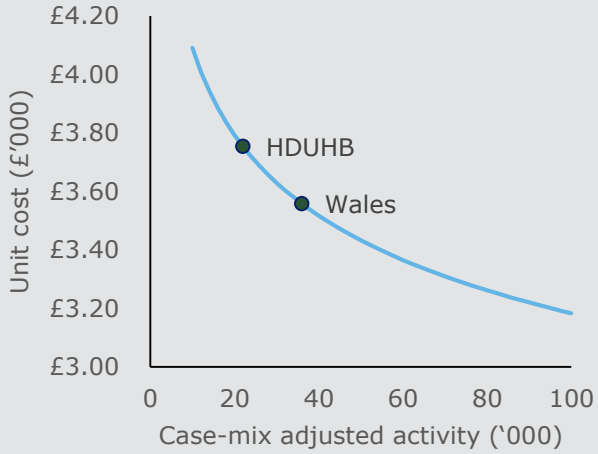
The impact of HDUHB's four small-scale DGHs was investigated by applying estimates developed by the NHS England Allocations Project Team (NHS England, 2015b).[1] This paper was selected on the basis that it was:

- Estimated in England (not internationally), which has a similar health system and similar way of recording activity data.
- Specifically designed to study the impact of scale; the unit of analysis is unit cost for the average site per hospital.
- Used as the basis for funding in England.

Indicative findings

- Applying the estimates from NHS England (2015b) based on HDUHB having **four separate** sites indicates that scale could contribute c. £12m to £19m [2] to HDUHB's acute cost base, as the estimated unit cost would be 5% higher for HDUHB compared to the average Welsh site as shown in the chart.
- However, Glangwili General Hospital (GGH) and Prince Philip Hospital (PPH) sites, whilst not co-located, do work closely together. As such, they may share some costs and benefit from economies of scale, meaning that the estimated £12m - £19m impact of scale on HDUHB's acute cost base may overstate the true impact.
- Determining the exact level of integration across these two sites would require detailed bottom-up work beyond the scope of this review. However, assuming that half of costs are shared across GGH and PPH could reduce the impact of scale on HDUHB's cost base to £7m - £11m.
- Accounting for this close working widens the overall cost base impact to £7m - £19m (2% to 6%). This is a broad range, highlighting the importance of more work in this area.

Economies of scale – HDUHB unit cost based on four separate sites (£k) [4]



Source: Calculations based on calibration of NHS England (2015b) for the Welsh context and data from PEDW, WCR2 2015/16

Limitations

- All specifications were initially estimated based on English provider data and have been applied to Wales.
- The specification does not reflect if economies of scale are particularly large for small hospitals or comment on the interaction between scale and remoteness.
- The model was calibrated based on inpatient data, and the original model included A&E and outpatient costs.

[1] NHS England (2015b); [2] This range is based on a confidence interval around the estimated impact of scale, and looks at the change in unit cost on the same increment of activity which could be achieved should all sites operate at the same scale as the Welsh average.

Efficiency

Within HDUHB's current cost base, there may be scope for reducing cost by reducing activity or unit cost

- Whilst part of HDUHB's cost base may be driven by uncontrollable factors, such as remoteness and demographics, there may be efficiency savings which can be delivered.
- Both the activity opportunity and unit cost opportunity for HDUHB are considered.

Areas of Efficiency Estimation

1 Activity opportunity

Can activity be reduced? How much cost savings could a reduction in activity lead to (after considering the cost of re-investment and noting that fixed and semi-fixed costs may not decrease?)

2 Unit cost opportunity

What is the scope for reducing unit costs, based on benchmarking against other health economies?

3 Total cost opportunity

Overall, there may be scope to reduce total costs based on activity and/or unit cost reductions within the current cost base.

- This review does not seek to comment on how the position will change in future years, but rather what part of the existing cost base may be avoidable. Furthermore, this review does not set out plans for implementation.
- Stakeholders highlighted a number of cost pressures (based on growing activity levels, changes in funding, etc.) in the course of this review as becoming increasingly important in future years. Depending on funding, these efficiencies are likely to be required to abate the impact of such pressures.
- Efficiency is estimated on a top-down basis.

Efficiency

Activity and unit cost benchmarking methods have been used to understand the potential savings compared to Wales and more widely

The efficiency opportunity has two components – the activity opportunity and unit cost opportunity. Each opportunity is estimated by comparing performance to the Welsh average. Whilst the approaches employed have sought to adjust for some of the uncontrollable factors, in practice this is difficult. As such estimates should be seen as indicative.

In addition to Welsh averages, additional analysis has been undertaken to look at other potential efficiency opportunities.

1 Activity opportunity

Wales Average. Regression based benchmarking is used to estimate the expected level of activity for HDUHB, given the age, gender, location and socio-economic characteristics of the catchment population. [1] If actual activity is above expected levels, this could indicate an opportunity to reduce activity. Based on this approach it is estimated that there could be a c. 3% activity opportunity. This could translate to <1% improvement in costs incurred.
Wider opportunity. Using the Welsh average to measure the potential assumes this is a reasonable aspiration. An alternative approach is to use existing literature on potential out of hospital schemes and translate these into potential shifts in activity and ultimately cost. Based on the NHS England Anytown model, which allows for such an approach, c. 15% of activity could be reduced.

Indicative findings

After accounting for re-investment costs and fixed/semi-fixed costs (it is assumed that these cannot be removed), the activity reductions for the average and wider opportunity are estimated to give a **reduction of up to 1.5%** of acute costs. See the supporting slides for more details.

Limitations

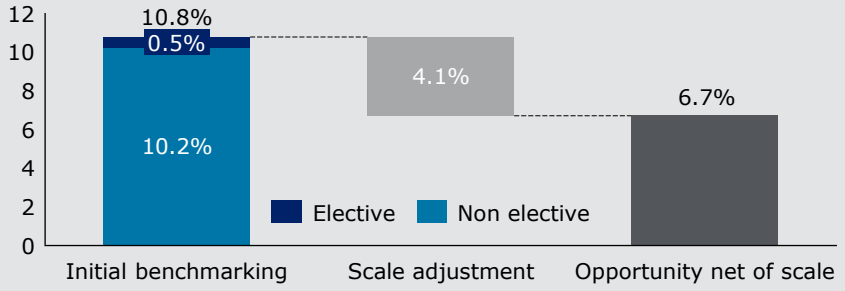
- Wales average analysis was performed on outpatient referrals data and emergency admissions only.
- Only a select set of characteristics was included in the Welsh average analysis based on age, location and socio-economic factors used in NAO (2012), and may have overlap with other areas such as hospital proximity.
- Activity data used relates to Wales only. To account for the impact of this, controls for distance/time to hospitals are included, and outliers excluded.
- The wider opportunity does not account for out-of-hospital QIPP (Quality, Innovation, Productivity and Prevention) schemes that HDUHB may have in place already.

2 Unit cost opportunity

The unit cost opportunity is estimated by benchmarking inpatient HRG costs to the Welsh average, which suggests an opportunity of c. 11%.[2] However, this estimate may include the increased cost of a number of HDUHB's sites operating at a small scale. After taking this impact out, the unit cost efficiency opportunity is estimated at **c. 6.7%** compared to Welsh averages.

Whilst this provides an estimate to the Welsh average there might be further opportunity to go beyond this. As there are insufficient benchmarks in Wales, it is not possible to estimate meaningful stretch targets to upper quartile or decile. However, evidence from England suggests that moving from average to top decile could generate c. 5% efficiency beyond moving to average.[3] More bottom-up efficiency analysis would be required to test whether this might also apply in Wales.

HDUHB unit cost savings compared to Welsh average [2]



Data Source: NHS Wales, 2015/16 WCR2

[1] Activity estimate uses socio-economic metrics of needs index, based on National Audit Office (2012). *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland,* age-gender metrics, and location metrics; [2] Unit cost savings based on analysis of WCR2 data. Excludes the 20th percentile of HRGs by volume for HDUHB, and is based on unit cost data differences at the HRG level excluding the top 15% and bottom 15%. May include specialties relating to e.g. metal health care; [3] See Deloitte (2014) on the national tariff efficiency factor in England.

Efficiency

Initial estimates suggest efficiency could contribute c. 6% - 9% to HDUHB's current acute cost base

Efficiency indicative findings

c. 6% - 9% of the current cost base

1 Activity opportunity

Regression based benchmarking and QIPP based opportunity assessment is used to estimate the activity opportunity. The analysis indicates a cost reduction opportunity from activity reductions of:

Welsh average c. 0.2%
Wider opportunity: c. 1% – 1.5%

2 Unit cost opportunity

Unit cost for elective and non-elective activity is benchmarked for HRG codes. The analysis indicates a unit cost saving opportunity of:

Welsh average: c. 6% - 8% [1]

3 Total cost opportunity

Combining unit cost and activity savings opportunity indicates an overall savings opportunity of:

Opportunity: c. 6% - 9% (c. £20m to £32m)

One limitation of this estimate is the interaction between activity reduction and complexity, which may mean reductions in activity lead to higher unit costs for activity due to a more challenging case-mix.

[1] Unit cost savings based on analysis of WCR2 data. Excludes the top 20th percentile of HRGs by volume for HDUHB, and is based on unit cost data differences at the HRG level excluding the top 15% and bottom 15%. Range based on sensitivities around the level of activity excluded from the analysis (between 10% and 20% at the top and bottom of the range).

Short, medium and long term cost base

Of the factors estimated, efficiency and scale may be controllable in the short term (17/18), medium term (18/19-19/20) or long term (20/21-21/22)

Demographics
Is unavoidable

Remoteness
Is unavoidable

Scale
may be partially controllable in the medium – long run

Efficiency
is controllable in the short term by the health board

Flexibility in the short to long term

Scale may be partially controllable in the long term. This could be the case if service provision were adapted to reflect changes in the population.

Approach

Understanding how the impact of scale may be altered in the long term requires detailed work around where scale can be increased. This is not within the scope of this study.

Instead, sensitivities are developed, which provide hypothetical examples of HDUHB's cost base if it had a hospital model like other health economies. Comparator health economies were developed in discussion with HDUHB, and might be flexible in the long term (see supporting slides for detail).

Indicative findings

Scale (cost pressure)	**£7m-£19m**
Sensitivity in the short term	£0
Sensitivity in the long term[1]	£7m – £19m

Flexibility in the short to long term

Efficiency is a factor that is controllable in the short, medium and long term. Within the efficiency envelope some areas may be pursued in the short term (e.g. variable pay), whilst in other areas this may take a much longer time (e.g. any opportunities that shift care to more cost-effective settings).

Approach

The efficiency envelope is estimated at c. £20m to £32m in the current cost base. Evidence suggests that only c. 3% efficiency is achievable in a year. [2] However, some of the 3% will relate to general trends (c. 0.5% to 1.3%). [3] This means that only c. 1.7% to 2.5% of the envelope could be achieved each year. At this rate, it could take c. three to six years to achieve, before considering any cost pressures.

Indicative findings

Efficiency envelope	**£20m - £32m**
Avoidable in the short term[2]	c. £6m to £9m
Avoidable in the medium term[2]	c.£12m to £17m
Avoidable in the long term[2]	c.£0m to £14m

[1] Only a small part of this could be achievable in five years, with most of the possible changes from scale being longer term; [2] For estimates see Monitor and NHS England, *2015/16 National Payment System: Engagement on national prices*; Adam Roberts and Anita Charlesworth (2014). *A Decade of Austerity in Wales?* Nuffield Trust; Audit Commission and Monitor (2012). *Delivering Sustainable Cost Improvement Programmes;* [3] See Watt and Roberts (2016) and Deloitte (2014).

Summary findings

The findings of the review suggest HDUHB has cost elements that may be unavoidable in the short and long term

- The zero-based review estimated the impact of more controllable factors (efficiency, scale) and more uncontrollable factors (remoteness and demographics) on HDUHB's current cost base.
- The review did not seek to a) account for demographic and non-demographic cost pressures in the future, b) evaluate HDUHB's income, or c) suggest possible avenues for reducing HDUHB's deficit.
- The figures set out below may include overlap. For example, there may be overlap between efficiency and demographics, and some of the demographic impact may be included in the existing allocations formula. As such, the figures are not additive and further consideration would be needed to understand the impact of this.

Cost pressure and opportunity for reduction (£m) – 2015/16 cost base estimate

	Total impact	Unavoidable	Short term opportunity (2017/18)	Medium term opportunity (2018/19 – 19/20)	Long term opportunity (2020/21 – 21/22)
Demographics	£16m to £20m	£16m to £20m	£0	£0	£0
Remoteness	£0	£0	£0	£0	£0
Scale	£7m to £19m	£0	£0	£0	£7m to £19m[1]
Efficiency[2]	- £20m to - £32m	£0	- £6m to - £9m[1]	- £12m to -£17m	£0m to -£14m

Some element of the cost base may be structurally different, requiring **long term solutions**

Efficiency may reduce some part of the cost base, however not all of the efficiency can be delivered in the short term. Planning to deliver medium/long term savings and an interim solution may be needed

Any changes to scale would likely be medium to long term, with **scale** being unavoidable in the short term. The extent to which scale can be changed – as well as the change timeframe – would be dependent on the clinical strategy

[1] Part of this may be unavoidable, even in the long term, as a result of access considerations
[2] Figures do not account for any cost pressures in future years.

Next steps for the health economy

To address the financial challenge in the short to long term, a number of substantive and temporary next steps could be explored

Substantive measures

1 Efficiency

- HDUHB has developed a QIPP plan for 2017/18 of £32m at the time of writing, and work is ongoing to develop the governance and responsibility structure to support these plans.
- In view of growing cost and other pressures, further work to develop more ambitious reductions, alongside patient experience and outcomes objectives, and the right structure to deliver these in the medium term will be important to reducing the cost base.

2 Clinical strategy

- HDUHB has an ageing population as well as an increasing deficit. This may put pressure on HDUHB's ability to deliver care that meets the needs of the local population with current services.
- A clinical strategy that is cognisant of the effects of scale, demographics, and remoteness and the impact of these as HDUHB's population changes will be needed to allow for sustainability in the medium and long term.
- However, developing a clinical strategy is a long term process, involving consultation and business case preparation, and it can take c. 10 years from the initial strategy to implementation.

3 Allocations

- The Welsh Allocation formula takes account of remoteness in community care and age when allocating funding to health boards (see supporting slides).
- The extent to which this accounts for HDUHB's unavoidable costs may merit reviewing, in particular if there have been structural changes over the last 10 years.
- Also, if HDUHB has unavoidable costs from small hospitals that provide access to remote populations, a remoteness adjustment could be considered, similar to England.
- This may be separate to the rurality adjustment regarding travel times in community care.

Temporary measures

4

Some of the factors identified that drive HDUHB's costs – for instance, scale – may be partially within HDUHB's control in the longer term, but may be relatively fixed in the short term. As such, these factors may be contributing to a deficit position, and an approach to addressing this challenge in the short term may need discussion and agreement.

Summary

The review indicated a series of factors that may affect HDUHB's costs, with further work needed to better determine the way forward

Challenges

- HDUHB has an older population than the Welsh average and has hospital sites that serve remote populations. This makes HDUHB different to the Welsh average.
- The zero based review has looked at HDUHB's current acute cost base to understand the drivers of cost. Demographics, remoteness, scale, and efficiency were reviewed to understand HDUHB's unavoidable costs, and whether these may be influenced in the short to long term.

Findings of this review

- HDUHB may have unavoidable costs in relation to its **older population**, which may lead to costs c. 5% to 6% (£16m - £20m) higher for providing care to residents compared to the Welsh average. These costs are relatively unavoidable.
- Based on HDUHB's current structure of having four DGHs, there are estimated to be costs associated with HDUHB's relatively small **scale** sites, which could lead to costs c. 2% to 6% (£7m - £19m) higher compared to having the average Welsh site size. It is not within the scope of this work to comment on what level of the cost could be reduced in the long run and to what extent small scale is unavoidable. However, if HDUHB were able to have a model more similar to other health economies, there may be scope to reduce costs.
- There is room for HDUHB to achieve **efficiencies**. Some efficiencies can be targeted in the short run, as HDUHB has relatively high variable pay costs that could be targeted for reduction and can be changed with near immediate effect. Other opportunities may be targeted in the medium or long term.
- There is little evidence to support the hypothesis that relatively higher agency costs are driven by HDUHB's **remote** location.

Next steps

- Consider the extent to which unavoidable costs are accounted for in the current allocation formula.
- Consider the way the clinical strategy can support by providing the right care to a changing population.
- Continue to develop further efficiency areas and drive these forward.
- Consider what temporary measures may be appropriate in areas where costs are avoidable only in the medium or long term.

Considerations

Considerations

Considerations and limitations

The analysis in this report is based on the following considerations and limitations:

- There are a large number of possible ways to estimate the unavoidable costs of care. The analysis presented in this report is subject to both data and time constraints, which limit the specificity of the work.
- The report is based on secondary literature and is limited in the time available and data available.
- At the time of writing, HDUHB's clinical strategy has not been developed. As such, modelling of the impact of any changes to service could not be undertaken as part of this report.
- Data analysis has been limited because cost data was not available at site level across Wales. This has limited the ability to conduct bivariate analysis on a Welsh cohort to understand the impact of remoteness (a site level characteristic) on cost.
- The analysis in this report focuses on the cost base in relation to the district general hospitals and acute service only.
- The analysis presented is based on the current cost base, and does not include a baselining exercise of HDUHB's future cost base based on growth rates.
- A range of estimates are provided for the cost driver areas as it is not possible to account for the overlap between each estimate.
- Whilst this report notes what is in and out of the allocation formula as it relates to the zero based review, undertaking a review of the funding allocation formula for health boards is not considered as part of this report.
- Bottom up workforce modelling is beyond the scope of this report.
- Undertaking econometric analysis to determine relative efficiency using Welsh health board data is beyond the scope of this report.
- Undertaking multi-variate analysis to estimate the impact of scale on unit costs is beyond the scope of this analysis; existing estimates from existing literature have been used to inform findings in this report.
- Benchmarking analysis is conducted based on publicly available information across Wales and England.
- The efficiency review considers the total efficiency envelope, rather than a detailed review of individual saving schemes.
- The demographic analysis considers three characteristics; age, gender and deprivation.
- The short term is taken to mean 2017/18, medium term 2018/19 and 2019/20, and long term refers to areas that could be changed from 2020/21 and 2021/22.
- The information provided and collected from third parties has not been audited or validated.

Overlap between the four factors

There may be some overlap between the analysis conducted across the four factors and therefore the results are indicative, not additive

- The analysis for each of the four factors has been conducted independently and therefore it is likely that there is some overlap between some of the results.
- Therefore, the results should not be taken as additive and should instead be viewed as four separate results.
- Areas of potential overlap are set out below, although this is not exhaustive. Whilst steps have been taken to mitigate the overlap, this has not always been possible.

The following areas may have some overlap:

- The efficiency estimates may include some areas of scale that are not accounted for. Scale is controlled for by adjusting certain efficiency estimates for scale (as estimated in this work), and in some cases by peer group comparison with health economies that are demographically and geographically similar. However, there may be additional factors that are not accounted for.
- Remoteness may also include an element of demographics as low population density may be associated with areas having an older population.
- There may be an interaction between remoteness and scale, as smaller scale sites may be required to serve remote populations. As set out in the summary report, the element of scale that may be less avoidable is not considered in the scope of this report.
- The demographics section only looks at age and gender as HDUHB differs from other health boards in these factors. However, even though HDUHB does not appear to differ markedly in terms of deprivation, it has small pockets of deprivation in rural areas which may impact travel times. More deprived households may be more likely to use public transport and the rurality component may mean access to public transport is more limited than in an urban area. Therefore demographics and remoteness could be an overlap here.
- There may be an interaction in savings between areas. For example, a reduction in activity could lead to increases in the cost per admission if less acute cases lead to a concentration of more acute or complex care in acute settings.
- To the extent that HDUHB has implemented robust pathways to transfer patients to the most cost-effective and appropriate setting of care, there may be a lower opportunity around activity reductions for efficiency for HDUHB.
- The following slides do not consider the overlap in the costs identified and whether these are included fully within the Welsh resource allocations formula.

Supporting evidence

Supporting Evidence

Structure of the report

Background

Background

A number of characteristics of HDUHB are considered in the context of understanding HDUHB's cost base

This section sets out the context around several areas. Each of the areas covered forms part of the basis for the analysis of the cost base.

- **Service overview.** The current configuration of HDUHB's healthcare services could be contributing to its financial challenge. HDUHB has become increasingly challenged financially in the last years, with an estimated deficit of £49.6m in 2016/17 (c.7% of total resource). Whilst this review does not look at the future cost pressures, the trend in pressure is important context for the current cost base review and for considering next steps. This review focuses on the acute cost aspect of the total cost base, which is estimated at c. £364m.

- **Demographic profile.** The catchment area for HDUHB is characterised by an ageing population, a slightly higher proportion of females and average levels of deprivation. Demographic factors such as these may affect the cost of providing healthcare. Age in particular may affect HDUHB's cost base in comparison to other health boards across Wales.

- **Rurality and remoteness profile.** HDUHB serves a relatively rural area compared to the rest of Wales (not including Powys). In addition, two of the four hospitals in HDUHB are far from an urban centre suggesting the level of remoteness differs across the four hospitals. Remoteness may contribute to the cost of healthcare provision as remote areas are associated with low population density, which may mean relatively lower activity and therefore the inability to benefit from economies of scale. It may also affect staff costs if staff prefer to live and work in less remote areas, affecting recruitment.

Service overview

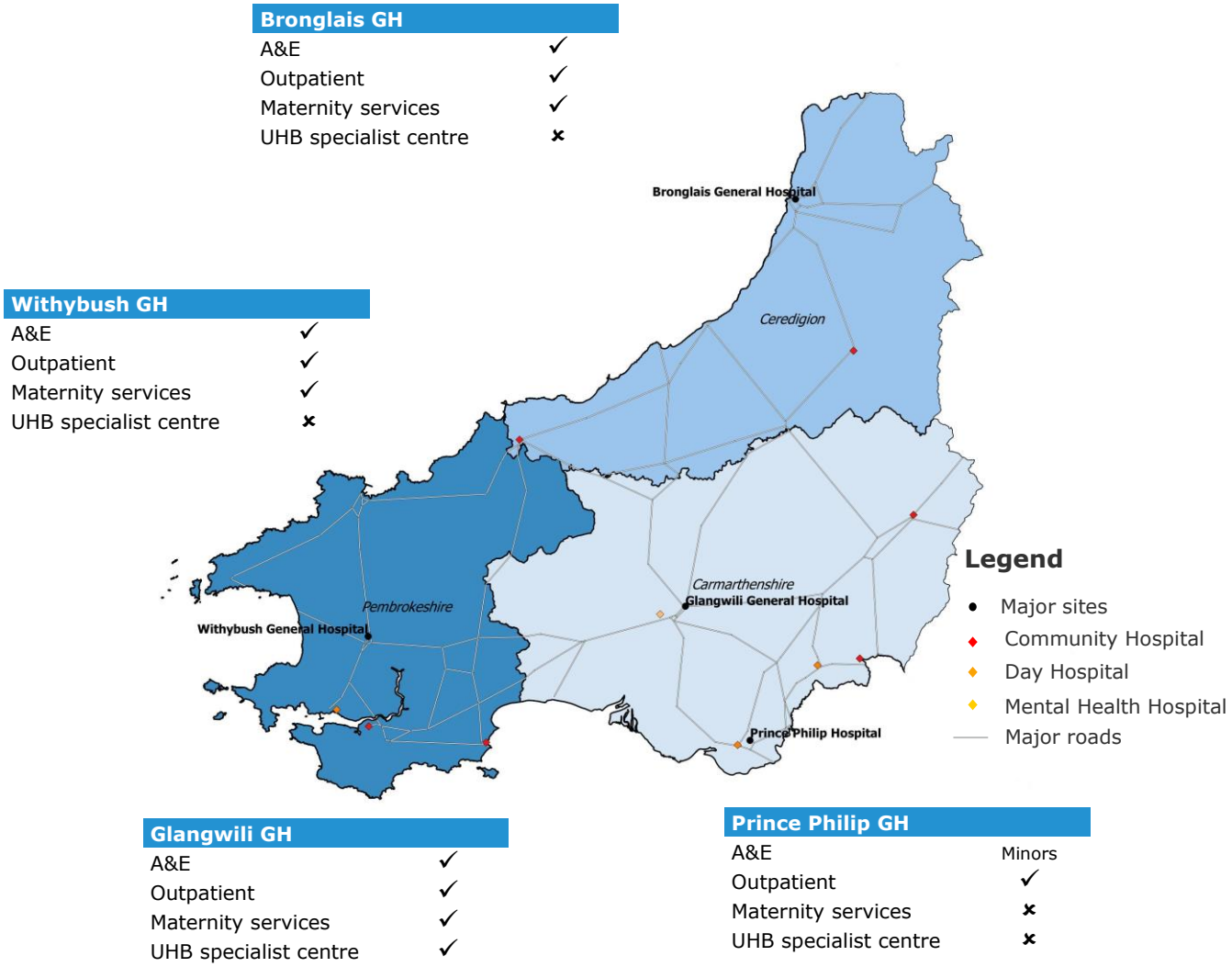
Service overview

HDUHB provides care across Ceredigion, Carmarthenshire, and Pembrokeshire, with four acute hospitals and three major A&Es

Overview of health care in HDUHB [1]

Acute care	**4** General hospitals	**45%** (or c. £364m) on acute activity excluding WHSSC[2]
Community care	**7** Community hospitals	**11%** (or c. £82m) of spend on community care
Primary care	**54** General medical practices	**21%** (or c. £172m) of spend on primary care (incl. c. 11% on prescribing)
Mental health	**6** Mental health hospitals	**2%**[3] (or c. £19m) of spend on mental health inpatient care

Map of HDUHB sites and services at acute sites



[1] Spending figures based on WCR1 and WCR13 2015/16, as a percentage of the 2015/16 expenditure (2015/16 HDUHB Annual Report). Excludes Other care (WCR1) and specialised care (WHSSC). Hospital numbers and practices from 2016/17 HDUHB IMTP and from site level costing analysis from HDUHB.
[2] Welsh Health Specialised Services Committee
[2] Based on activity provided from mental health hospitals only

Service overview

HDUHB has performed better than the Welsh average on some performance measures, although it is not reaching the national A&E target or RTT wait

Whilst HDUHB has a better record on the four-hour waiting times than the Welsh average, it is still not meeting the national target of 95% seen within 4 hours. It is below the Welsh average on RTT (referral to treatment) waiting times.

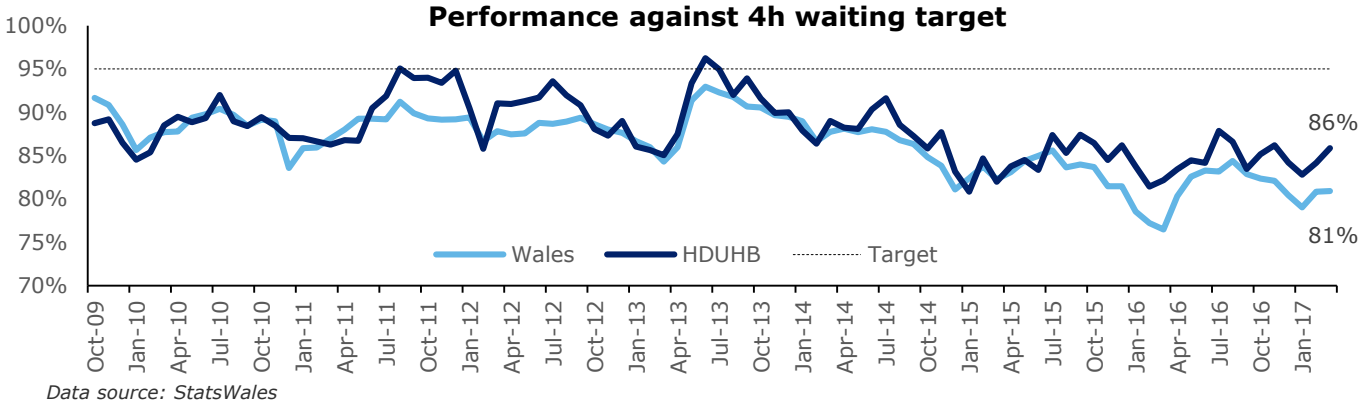
Selected performance indicators

Satisfaction with care received at hospital in 2014-15[1]
(% of very satisfied)

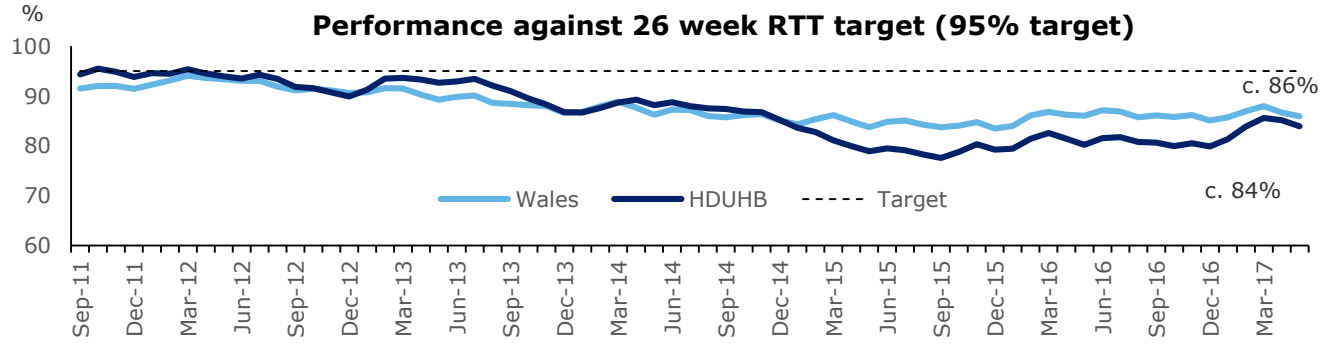
74%	**71%**
in the HDUHB	in Wales

% of patients who waited less than 4 hours in A&E in 2016-17[2]

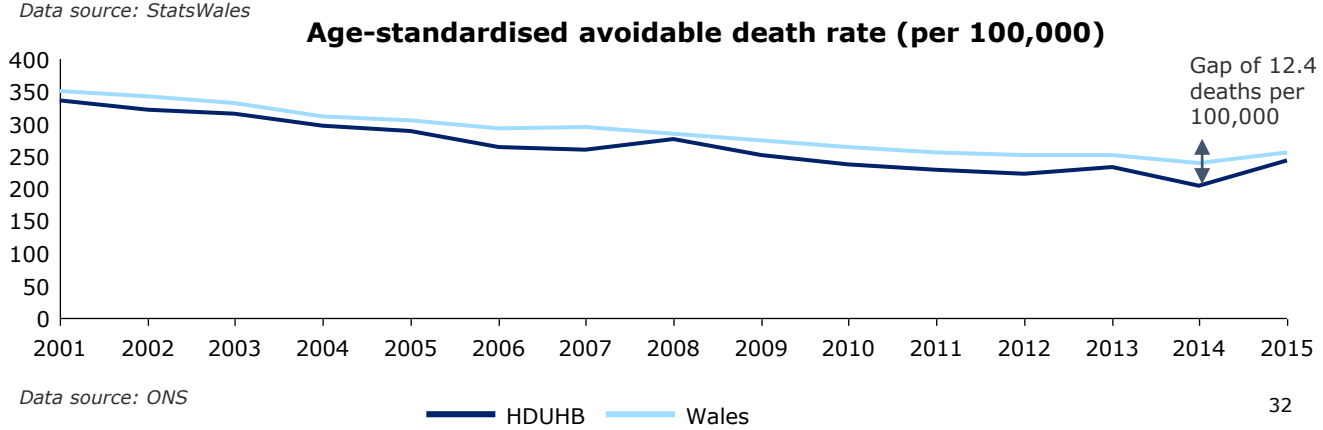
84.9%	**81.9%**
in the HDUHB	in Wales



Data source: StatsWales



Data source: StatsWales



Data source: ONS

[1] StatsWales, National Survey for Wales - hospital services
[2] StatsWales, Accident and Emergency Department statistics

Baseline costs

The estimated £364m of acute care spending on residents accounts for over 60% of secondary care, with an overall cost base in 15/16 of c. £810m

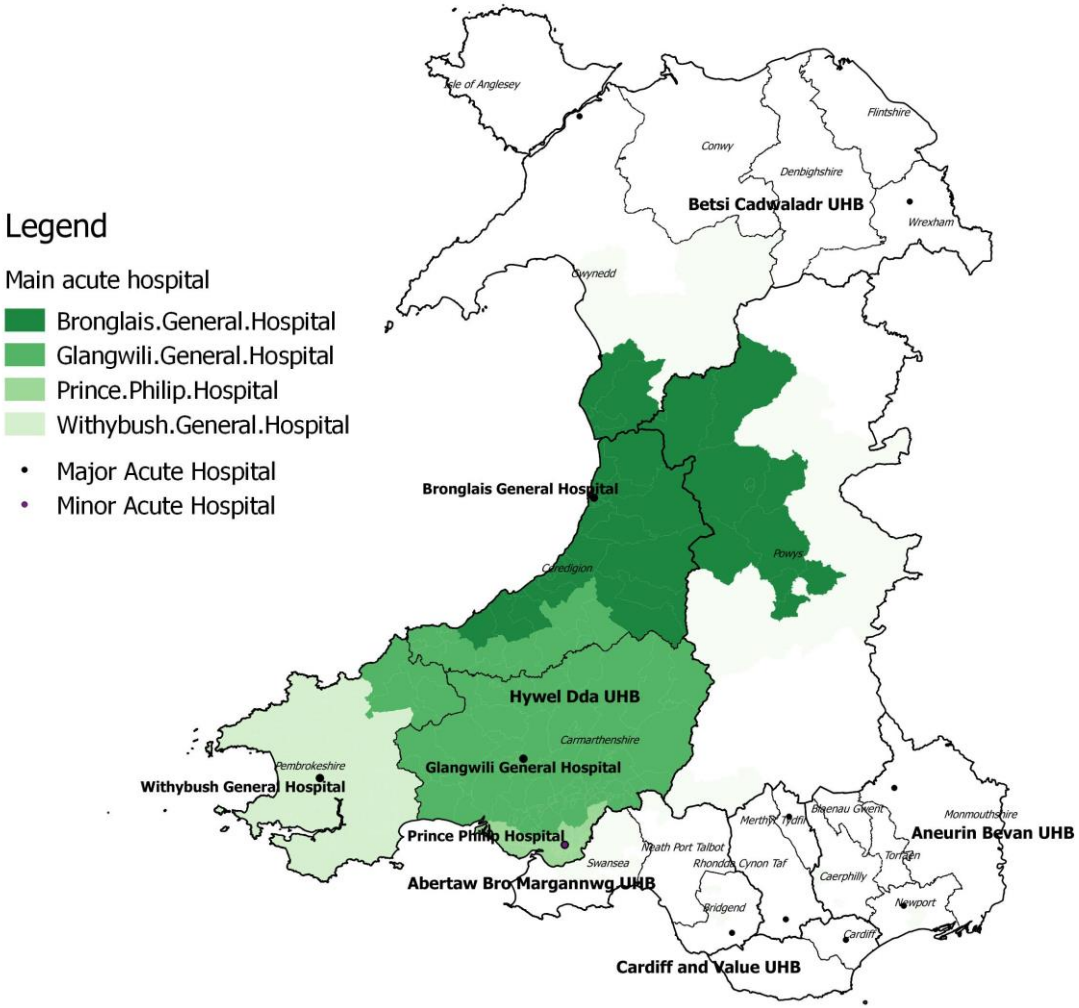
[1]Based on Welsh Costing Returns (WCR) 1, 5 and 13, 2015/16, and 2015/16 Annual Report. Small numbers supressed (discrepancy of c. £10k). Note that as cost is not reported by site, the exact spending of DGHs is not available and has been estimated based on specialty and subjective categories by point of delivery, based on the WCR13 and WCR1, and supporting analysis on out of area spending by HDUHB. See Slide 7 for details of the core acute care and acute care for residents.
[2] Other secondary care includes community, mental health, continuing care, voluntary and local authority, NHS England Activity, and other. WHSSC relates to Welsh Health Specialised Services Committee.

Difference between the geographic and catchment areas

94% of patients at HDUHB hospitals come from within HDUHB and 6% come from outside of HDUHB

Areas served by HDUHB hospitals

Hospital site area assigned based on most inpatient FCEs in MSOA, for MSOAs representing 95% of HDUHB's activity 15/16[1]



Share of patients from outside of HDUHB[1]

Hospital	A&E	FCE
Bronglais	28.9 %	34.3%
Glangwili	6.7%	3.6%
Withybush	12.7%	4.5%
Prince Philip	8.9%	3.3%

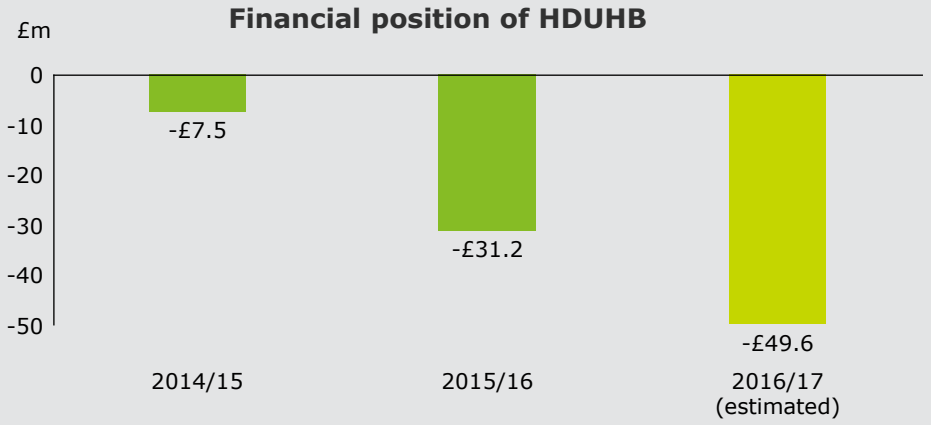
- HDUHB sites, in particular Bronglais, serve a population beyond the borders of HDUHB.
- For significant areas in BCUHB and Powys health board, Bronglais is the only hospital within a 60 minute drive radius; a consideration in terms of remoteness and access.

[1] Based on HDUHB data Medium Layer Super Output Area (MSOA) level activity data provided by HDUHB

Service overview

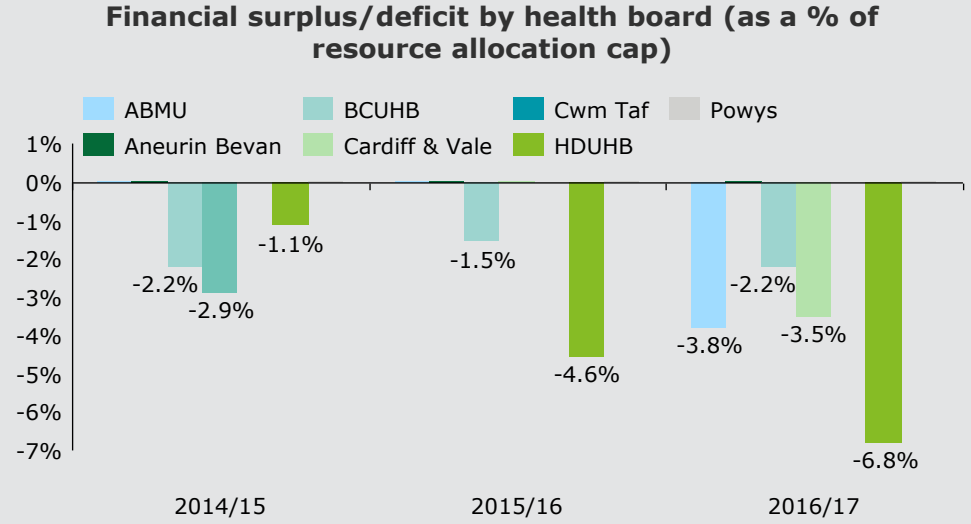
HDUHB also faces significant and growing financial pressures with a deficit c. 7% (c. £50m) of total resource estimated for 2016/17

- HDUHB's financial position has deteriorated over the last three years. From a deficit of c. £7.5m in 2014/15 to an estimated deficit of c. £49.6m in 2016/17 (or almost 7% compared to HDUHB's revenue resource limit allocated from the Welsh Government of c. £730m in 2016/17).[1]
- The cost of hospital and community health services (HCHS), alongside payments to other providers appear to account for much of this change, with increases in 5% (c £23m) and 4% (c. £6m) of spend respectively from 2014/15 to 2015/16. [1]
- In contrast, spending on primary care increased by close to 0% (£30k) from 2014/15 to 2016/17.[1]



Source: Data on annual accounts and resource allocation information provided by Welsh Government
Note that 2016-17 value was estimated

- While HDUHB is not the only challenged health board in Wales, its deficit is larger than the challenge faced by other health boards. The 2016/17 deficits of Abertawe Bro Morgannwg University Health Board (ABMU), BCUHB, and Cardiff are 2.2% to 3.8% of the total resource limit. [1]



Source: Data on annual accounts and resource allocation information provided by Welsh Government

[1] *Annual accounts and resource allocation information provided by Welsh Government; HDUHB annual reports. The resource allocation was £684m in 2015/16.*

Demographic profile

Demographic profile

HDUHB's demographic profile may contribute to its cost base

- Compared to the Welsh average, HDUHB has a higher proportion of older people, a slightly higher proportion of females and median levels of deprivation.
- HDUHB's profile and the possible impact of this is summarised in the table below.
- Having a population with a different age profile to the Welsh average may affect HDUHB's cost base.

HDUHB demographics in comparison to Wales

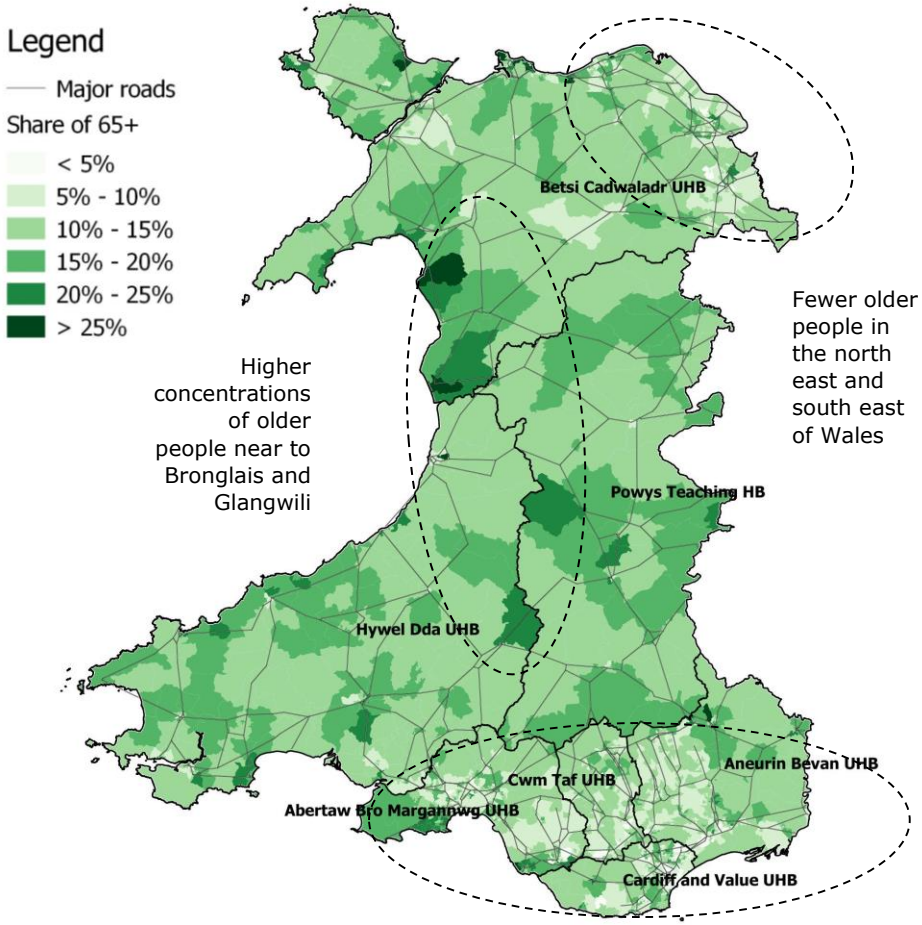
Factor	Summary	Implications
Age distribution	• HDUHB has an older population than the Welsh average. • HDUHB has larger increases in admissions and the population over 65 years as compared to the Welsh average.	• Older patients may be more costly to treat, impacting HDUHB's cost base.
Gender	• HDUHB has a slightly higher female population in the middle age groups than the Welsh average percentage.	• Female patients may require maternity services.
Deprivation	• HDUHB has a median deprivation level, with only slightly less deprivation overall than the Welsh average. Per capita income is also close to the Welsh average. • There are small pockets of deprivation.	• Deprivation may be less relevant for HDUHB's cost base as it is the median health board. • In small areas of deprivation, the population may rely on public transport, which may affect their travel time to health services.

Demographic profile

HDUHB serves an ageing population which could contribute to its cost base

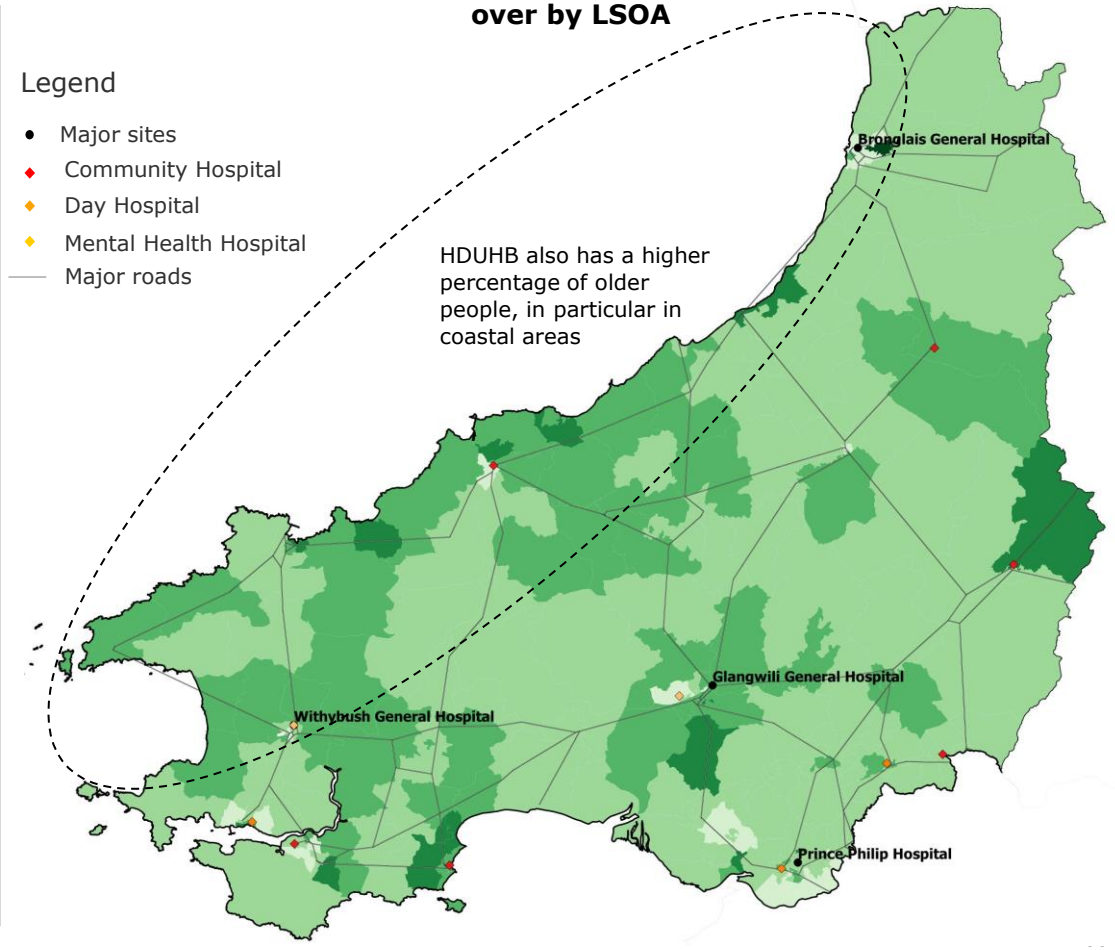
- Whithybush and Glangwili general hospitals are surrounded by an older population, and there are pockets of Bronglais' catchment area where the number of individuals aged over 65 is over 25%.
- As set out in this report, older people may have higher healthcare costs, and therefore this factor may affect HDUHB's cost base.

Wales – Percentage of residents aged 65 years and over by LSOA



Data source: ONS, LSOA Mid-Year Population Estimates, Mid-2015

HDUHB – Percentage of residents aged 65 years and over by LSOA



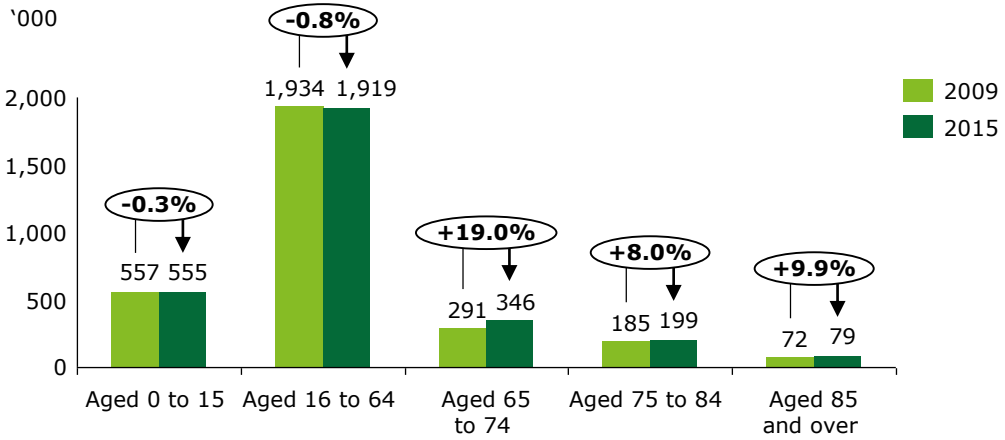
Data source: ONS, LSOA Mid-Year Population Estimates, Mid-2015

Demographic profile

The population of those aged 65+ has increased more than the Welsh average and inpatient activity has also increased

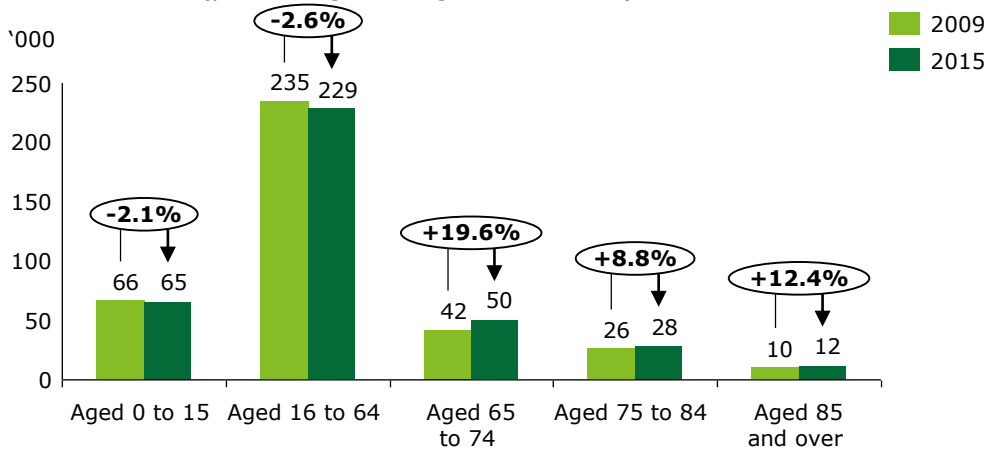
- Admissions in HDUHB have increased at a faster rate than the Welsh average. This was particularly the case for those over the age of 60, as admissions per person aged over 60 grew 2% in Wales between 2010 and 2015, compared to growth of 8% for HDUHB.

Wales – Population Composition (1,000s)
(percentage change in brackets)



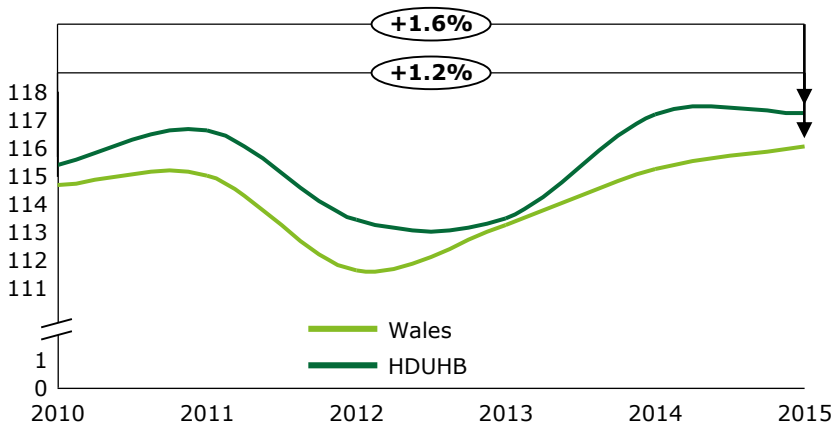
Data source: ONS, LSOA Population Mid Year Estimates

HDUHB – Population Composition (1,000s)
(percentage change in brackets)



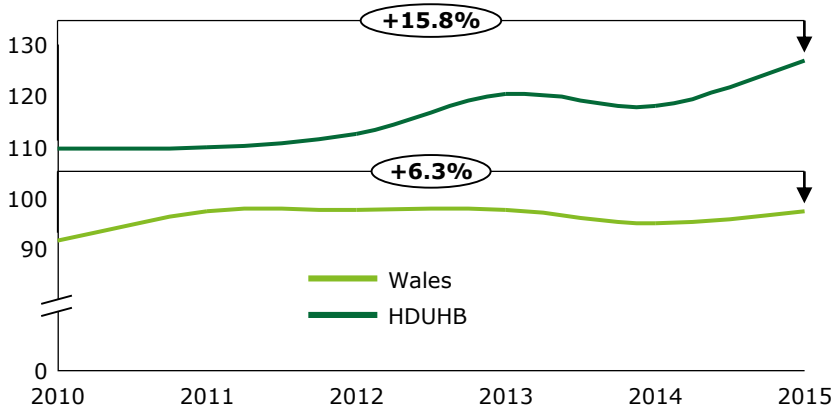
Data source: ONS, LSOA Population Mid Year Estimates

Emergency admissions per 1,000



Data source: PEDW and ONS, LSOA Population Mid Year Estimates

Waiting list admissions per 1,000



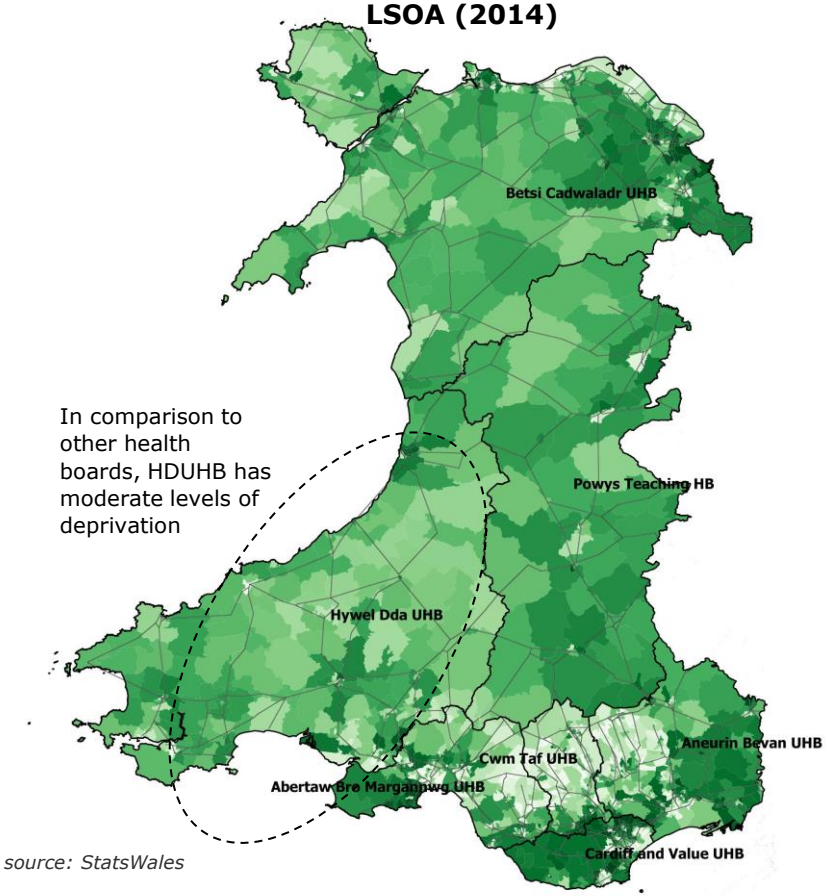
Data source: NHS Wales, PEDW tables and ONS, LSOA Population Mid Year Estimates

Demographic profile

HDUHB deprivation levels are close to the Welsh average

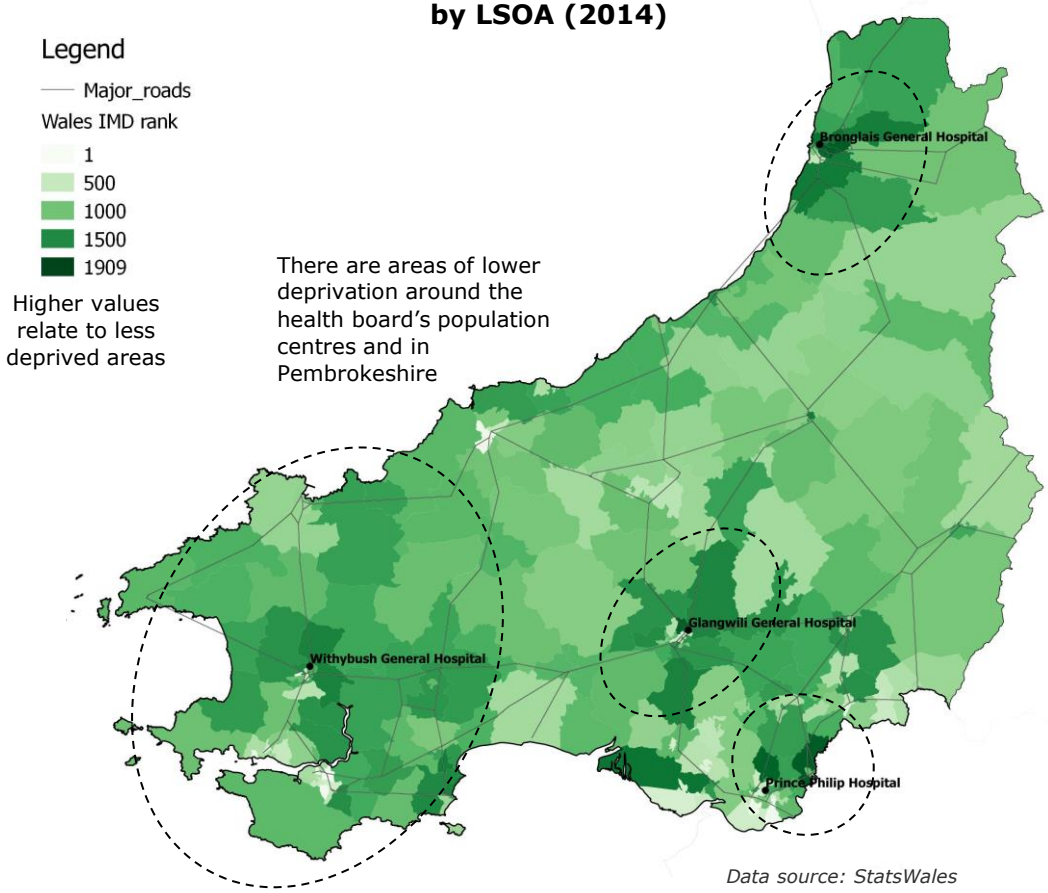
- The Welsh Index of Multiple Deprivation (WIMD) is the Welsh Government's official measure of relative deprivation for small areas in Wales.[1] A lower number reflects a higher level of multiple deprivation. The index takes into account a number of deprivation variables including income.[2]
- Overall, HDUHB has a median level of deprivation in comparison to Wales: The average index for HDUHB is 977 and the Welsh average is 953 (minimum – Powys of 1,167, and maximum – Cwm Taf of 691).[3] As such, deprivation may not have a large impact on health costs for HDUHB specifically compared to Wales overall.
- In HDUHB, few areas are in the lowest or highest quintiles of deprivation. However, there are small pockets of deprivation which could impact access to a hospital, in particular if they are in rural areas and rely on public transport.

Wales – Welsh Index of Multiple Deprivation ranking by LSOA (2014)



Data source: StatsWales

HDUHB – Welsh Index of Multiple Deprivation ranking by LSOA (2014)



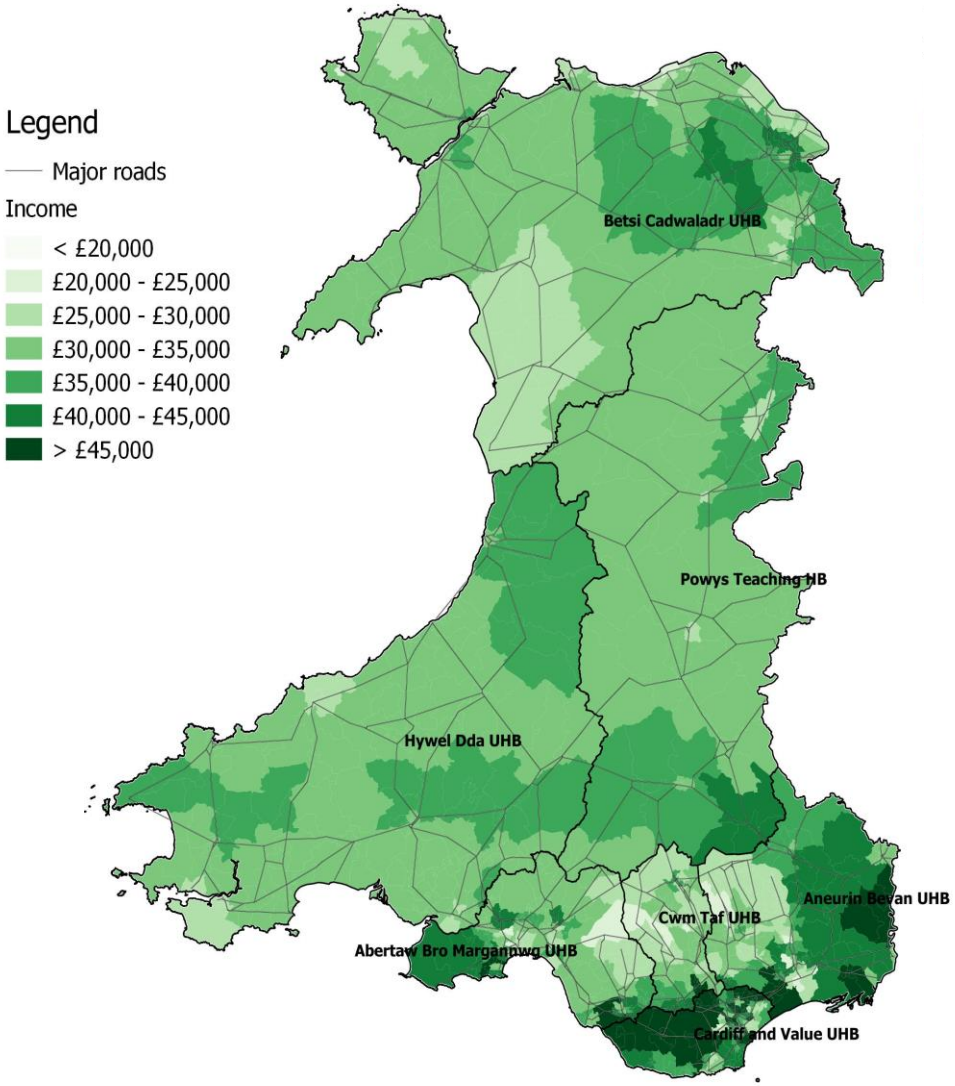
Data source: StatsWales

[1] See Welsh Index of Multiple Deprivation (WIMD) 2014, The Welsh Government.
[2] Other variables include employment, health, education, access to services, community safety, physical environment and housing.
[3] See WIMD 2014, The Welsh Government. Average of LSOAs in the health board.

Demographic profile

HDUHB serves a population with average income levels relatively consistent to the Welsh average

Wales – Income per capita[1]

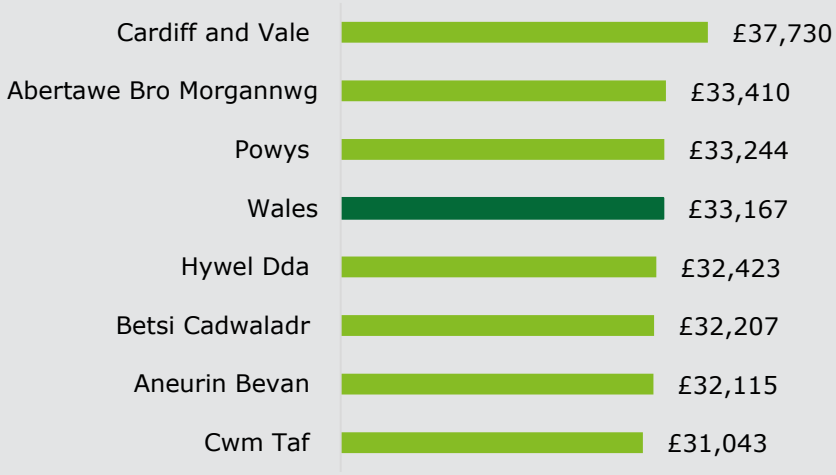


Data source: ONS Nomis, total weekly household income by MSOA 2014

[1] Income is measured as income per capita annual average income by MSOA

- Income is one of the factors that is reflected in the construction of the deprivation index.
- The population served by HDUHB has levels of income per capita close to the average for Wales.
- Consistent with the WIMD, HDUHB is the median health board, Cardiff and Vale University Health Board serves a population with the highest income per capita and the areas served by Aneurin Bevan and Cwm Taf are the most income deprived areas.
- As HDUHB does not differ greatly from the Welsh average, this suggests that deprivation may have less of an impact on HDUHB's cost base.

Income per capita (2014)

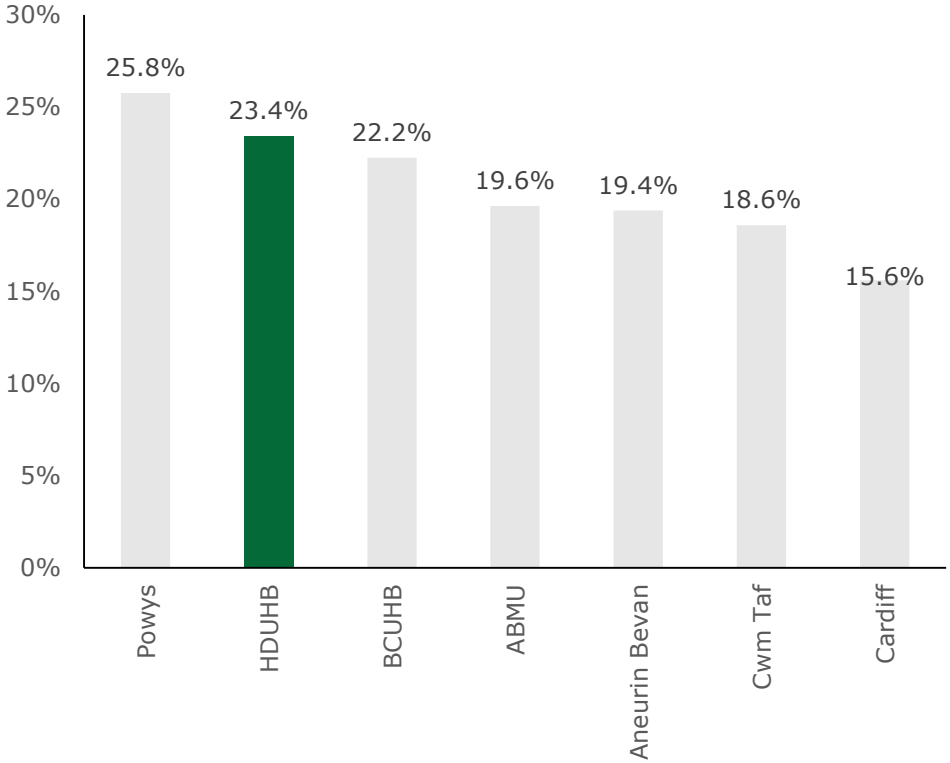


Data source: ONS

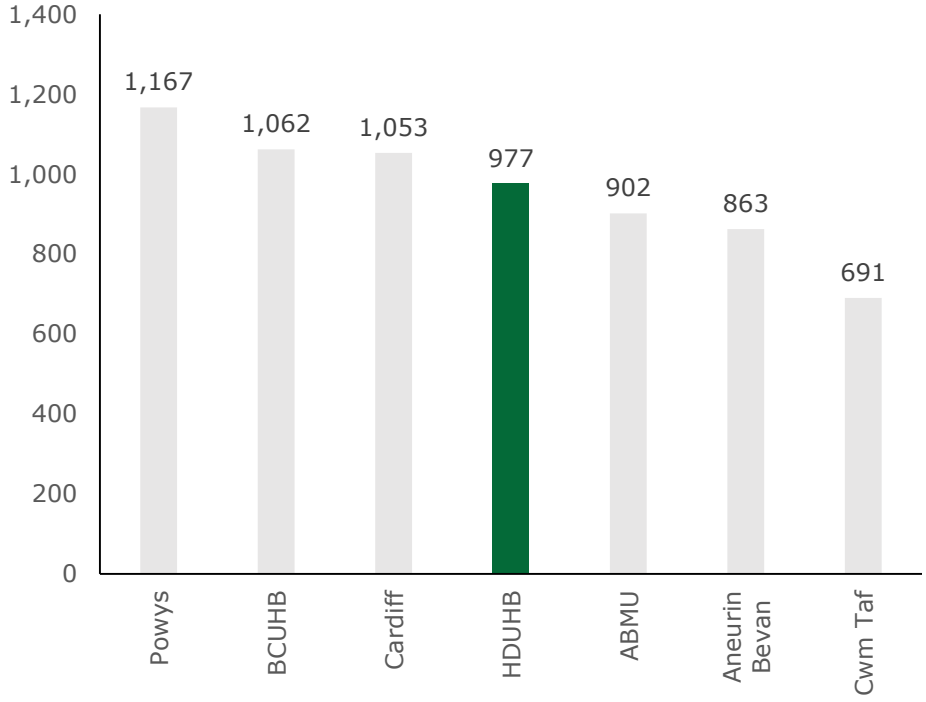
Difference between health boards on key metrics

HDUHB differs from other health boards on age, but less so on deprivation

Proportion of 65+ years old, by health board, 2015[1]



Welsh index of multiple deprivation, average LSOA rank by health board[2]

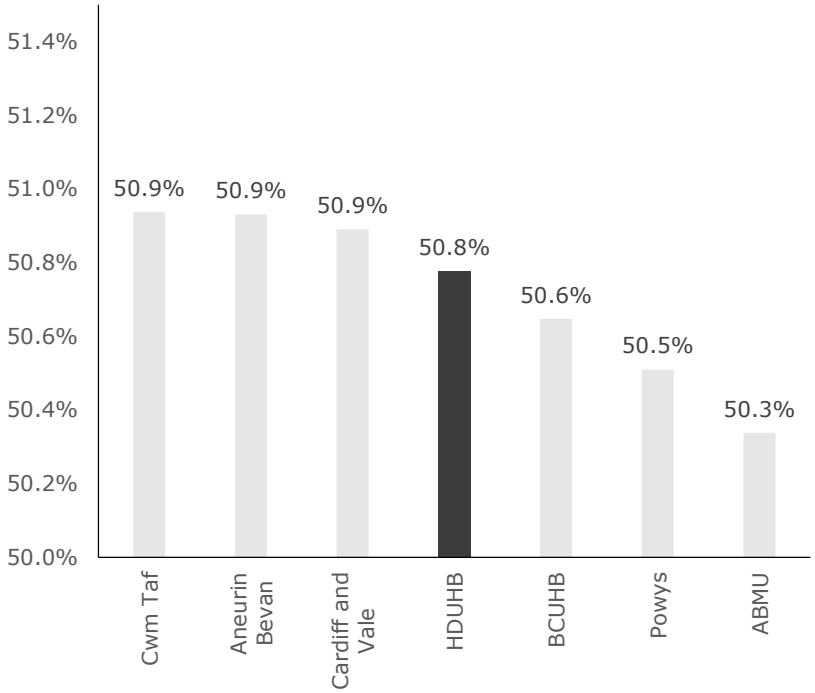


[1] Based on ONS, LSOA Mid Year Population estimates, 2015
[2] Analysis based on StatsWales, WIMD.

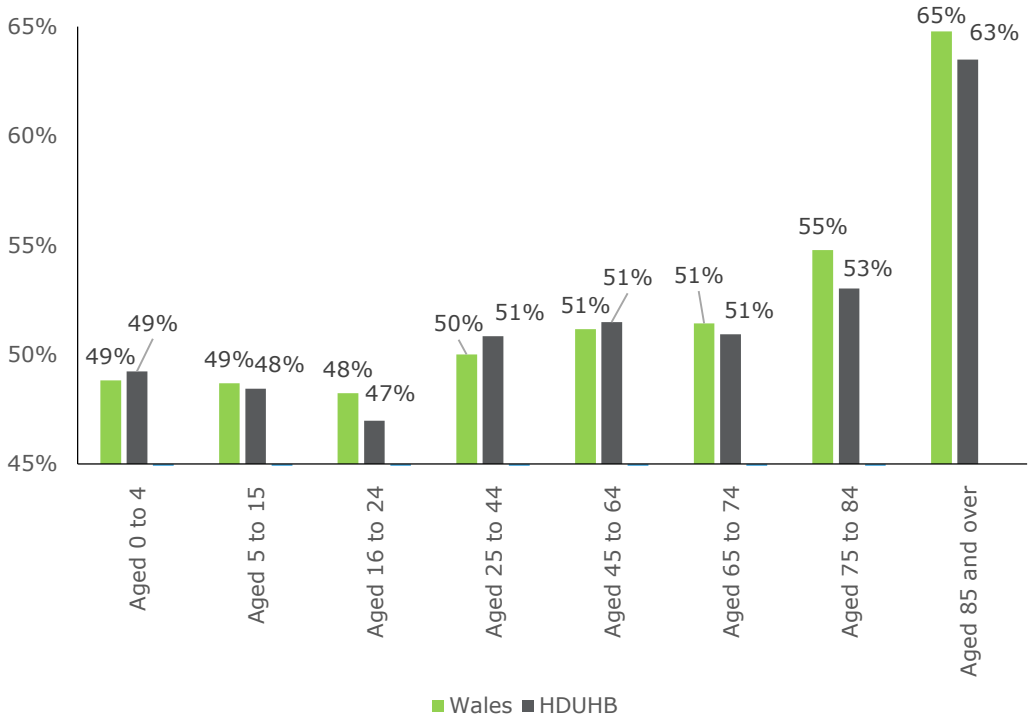
Difference between health boards on key metrics

HDUHB has a slightly higher female population for the working age population

Percentage of females in the population by health board – all ages[1]



Percentage of females in the population for Wales and HDUHB, by age band [1]



[1] Data source: StatsWales 2016

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Difference between the administrative boundaries and catchment areas

HDUHB's catchment population differs only slightly from the population living within its administrative boundaries

The analysis in this report is based on the administrative area covered by HDUHB (Carmarthenshire, Ceredigion, and Pembrokeshire).

However, analysis has been undertaken to understand the profile of the surrounding area. This is on the basis that individuals from neighbouring health boards may use HDUHB services.

The analysis looks at HDUHB's broader catchment area, which is based on the 95th percentile of MSOAs from which HDUHB hospitals draw their activity (see also slide 34).

HDUHB's broader catchment area has a lower population density than the administrative region. It also has a larger share of older and university-aged people compared to the administrative area.

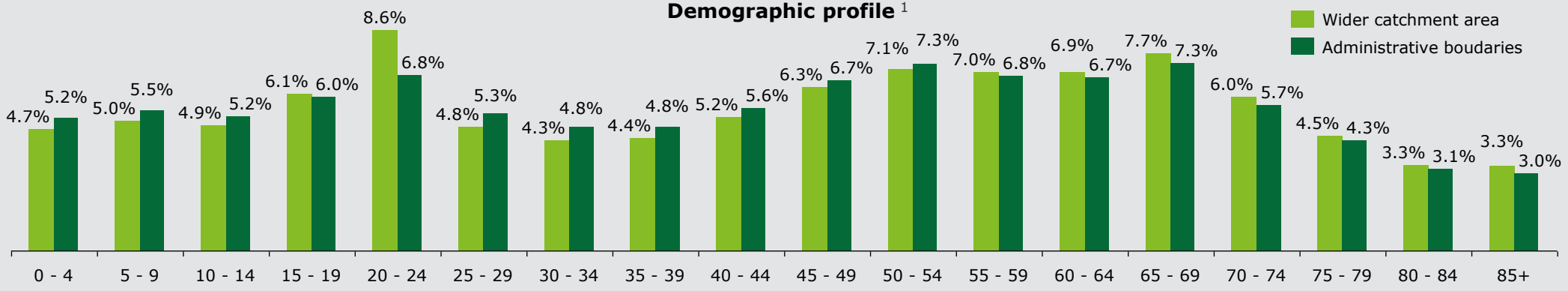
While the cost of care provided to individuals in other health boards should be passed through to their own health board, they may still impact HDUHB's costs, as the demographic served will influence what types of services need to be provided and these individuals may rely on HDUHB sites for access to medical services.

Indicators for catchment and administrative border are similar [1]

Indicator	Catchment area	Administrative boundaries
Population (m)	0.63	0.38
Females (%)	50.1%	50.8%
Non white British (%)	5.1%	4.9%
Population density (p/hectare)	0.29	0.66
Avg. annual household income	£ 32,326	£32,423
Avg. rural urban classification score	6.75	5.56

Source: ONS, Census 2011, Rural Urban Classification, 2011

Demographic profile [1]



Source: ONS

[1] Based on HDUHB data, with MSOAs included in the catchment area if there were 11 admissions or greater in the year. This equates to the 95th percentile of activity from LSOAs

Remoteness and rurality profile

Remoteness and rurality profile

Overall, HDUHB serves a rural population with hospitals in remote locations

- Overall, HDUHB has a more rural population than other health boards in Wales (excluding Powys).
- Average travel times to the next hospital (proxies for remoteness) in HDUHB are slightly higher but comparable to the Welsh average, while distance to the nearest main urban centre (Swansea) differs significantly amongst HDUHB's four hospitals.
- This suggests that certain hospitals are more remote and may therefore face challenges with scale due to their relatively low activity, and they may not be able to benefit from economies of scale (see the section Impact of Scale).
- The table below summarises HDUHB's remoteness profile and the possible impacts of this.

HDUHB geographic profile in comparison to Wales

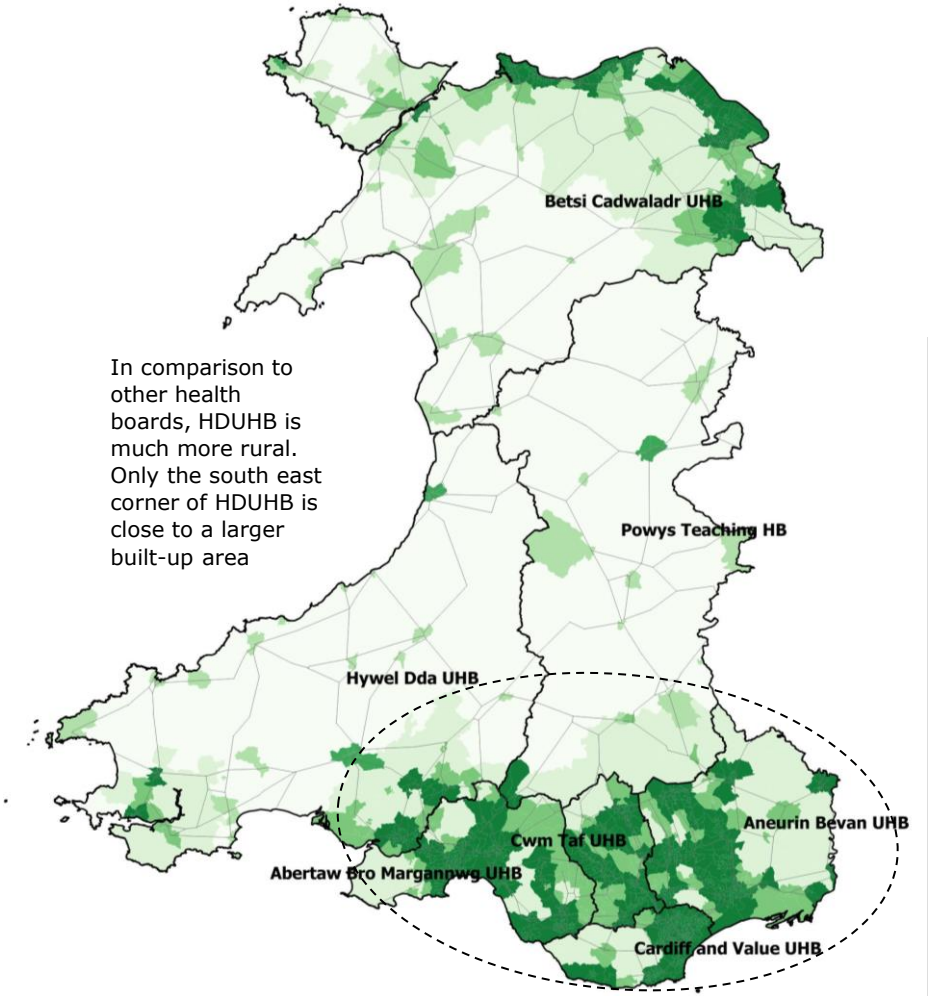
Factor	Summary	Implications
Rurality indicator	• HDUHB has a more rural population than other health boards in Wales. • 30.1% of LSOAs are counted as 'Rural Village – Sparse Setting' compared to 9.5% for BCUHB, the most comparable health board in terms of demographics and geography (see appendix).	• Rurality may contribute to HDUHB's cost pressures.
Distance to hospital	• On average, HDUHB's distance to the nearest hospital is similar to the Welsh average and comparable health boards.	• This suggests HDUHB's population as a whole may have an average level of access to hospitals, although there are areas with low access.
House prices	• HDUHB's house prices are in line with the Welsh average and other comparable health boards.	• If house prices are an indicator of attractiveness, this may suggest that as a whole HDUHB is a relatively attractive area despite remoteness.
Distance to urban centre	• Distance to a large urban centre differs among the four acute hospitals in HDUHB. • Bronglais and Withybush are significantly further away from Swansea than the other hospitals.	• Being further away from an urban centre suggests Bronglais and Withybush are remote. They may face particular challenges (e.g. if they operate at small scale). It could lead to recruitment challenges if remote areas are less desirable to staff and difficult to commute to.
Access to hospitals	• HDUHB's Bronglais hospital covers an area with limited access to other hospitals.	• This may mean that Bronglais in particular may face challenges with scale if it serves a remote population.

Remoteness and rurality profile

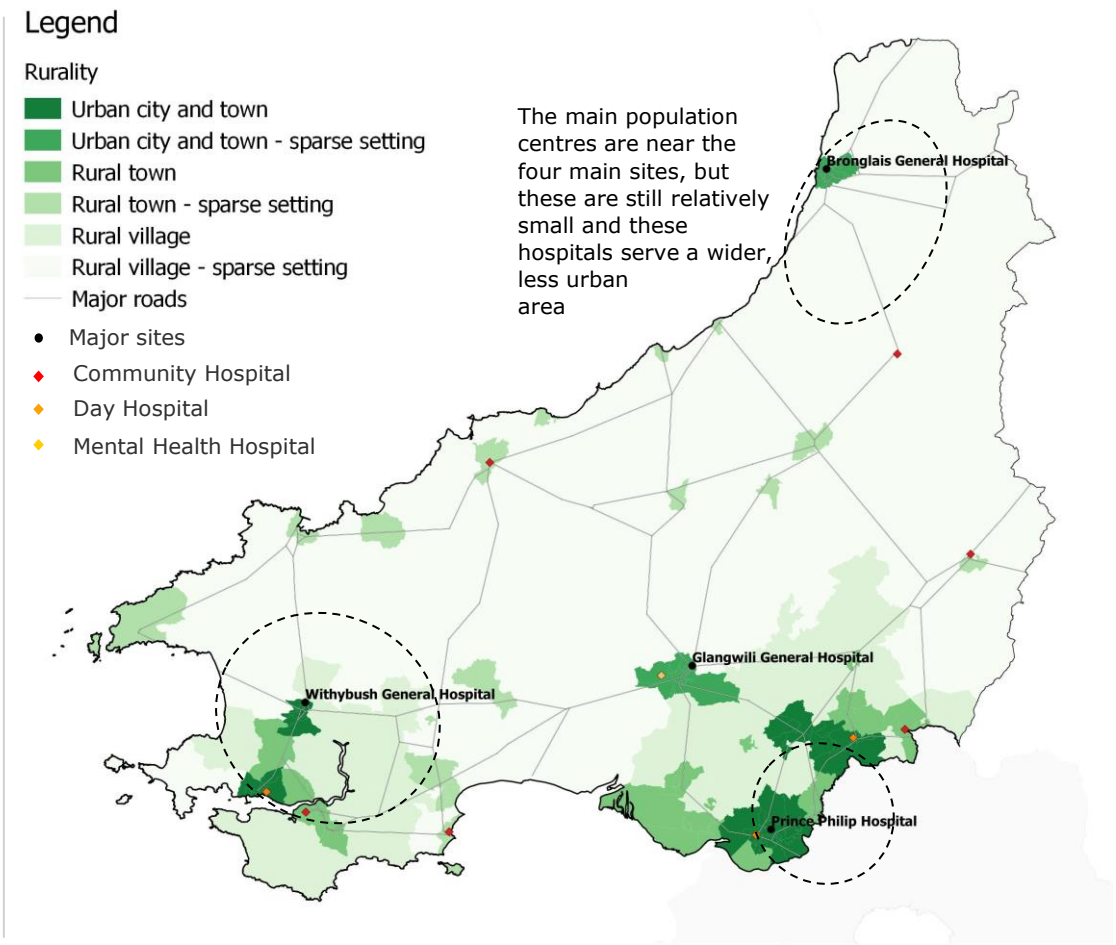
HDUHB is more rural than most health boards in Wales

- HDUHB has a more rural population than other health boards in Wales. 30.1% of LSOAs are counted as 'Rural Village – Sparse Setting'.[1] This compares to 9.5% for BCUHB, one of the most comparable health boards (based on demographics and geography). Powys is also very rural, but does not have acute hospitals.

Wales – Rurality by LSOA[1]



HDUHB – Rurality by LSOA[1]

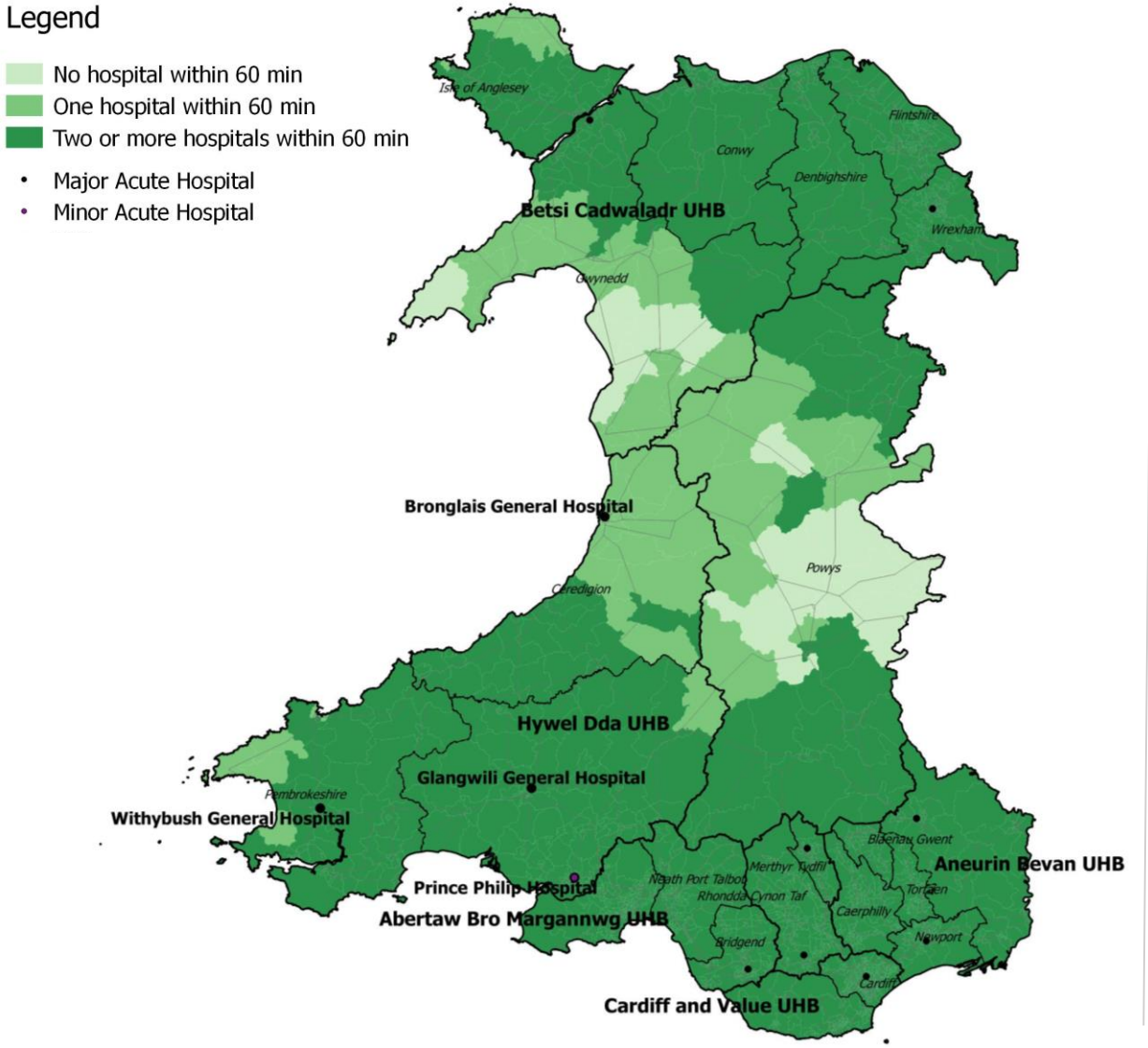


[1] RUC 2011 classification, which is part of the Census 2011

Remoteness and rurality profile

HDUHB's Bronglais hospital provides access to health services for populations with limited access to other hospitals

Wales – 60 minute drive time[1]



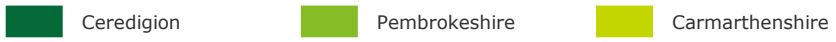
- Remoteness – in terms of distance to hospitals – varies across Wales. Whilst the majority (98.8%) of Welsh LSOAs are within 60 minutes of two hospitals, there are significant areas where only one hospital (or no hospitals) are within an hour's drive.[1]
- Towards the west, there are some populations that can only reach Withybush within an hour, while towards the north/east there are populations that could only reach Bronglais or Glangwili in under one hour.
- Due to its location in Wales, Bronglais hospital plays a significant role in providing care to a remote population in Powys (Powys has no DGH) and BCUHB as well as in HDUHB, with c. 30% of activity from outside HDUHB. See slide 34 for more detail.
- The 60 minute drive time assumes all patients drive to a hospital whereas a number of patients could use public transport which could affect the travel time.
- The time needed to access a hospital in HDUHB may be different for patients traveling with public transport.

[1] Travel times are based on Doogal, based on weekday morning travel private drive times, 2017

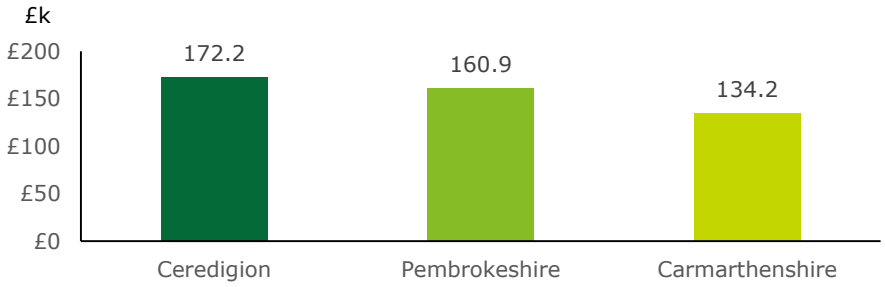
Remoteness and rurality profile

There are some differences in property prices and travel times within HDUHB

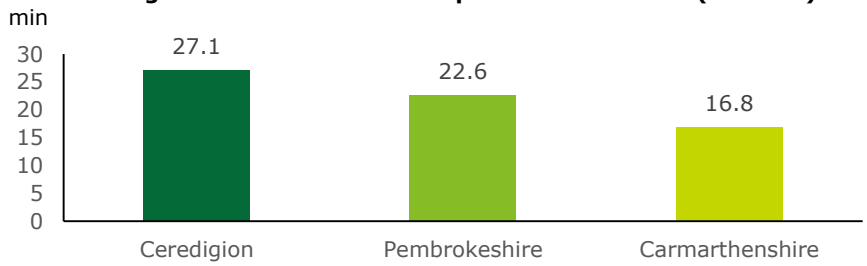
- As well as looking at travel times to hospital (which can indicate access to hospital and remoteness), house prices may be relevant in the discussion of remoteness as it relates to staff. If an area is desirable to live in, demand for property could increase prices. Property prices could serve as an indicator of whether an area is attractive to live and work in, which may be related to whether attracting hospital staff would be difficult due to location.
- Whilst average house prices and travel times to the next hospital in HDUHB are similar to the Welsh average and comparable rural health boards, time to the next hospital and distance to the nearest urban centre (Swansea) differs among the four hospitals. Withybush and Bronglais are relatively more remote, with over a one hour drive from Withybush to Swansea, and just over two hours from Bronglais to Swansea.[1]
- In addition, there is variation in travel times and house prices across the health board, which suggests that while Ceredigion (and the county's hospital, Bronglais) may be more remote, it may have other characteristics that make it desirable to live there (as high house prices in Ceredigion may be a proxy for attractiveness).



Average property prices across HDUHB (£ thousands)[2]

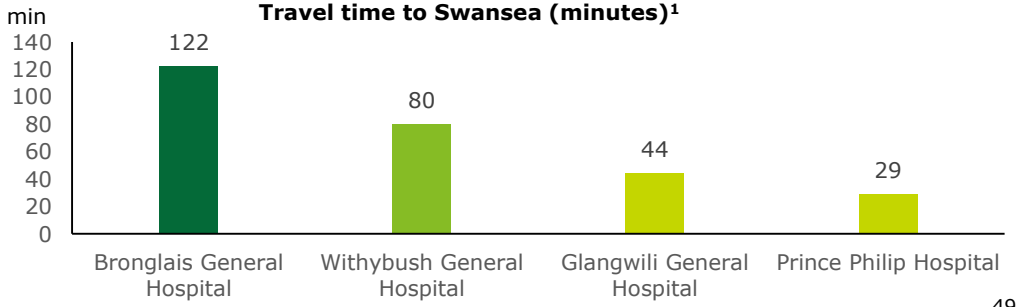


Average travel time to next hospital across HDUHB (minutes)[1]



- Bronglais (in the north of Ceredigion) is the most remote of the sites, with c. 2 hour private drive time to Swansea.[1] In comparison, Withybush's drive time to Swansea is c. 1.5 hours, while Glangwili and Prince Philip are under an hour away. [1] This suggests that Bronglais and Withybush may be more remote.
- Bronglais and Withybush are in counties with longer travel times to hospital (c. 27 minutes and 23 minutes respectively compared to 17 in Camarthenshire). This may indicate that these hospitals serve populations with lower access to hospitals generally.
- Despite its remoteness, property prices are relatively higher in Ceredigion (c. £172k against c.£136k in Wales) and Pembrokeshire (c. £160k). This may indicate that these counties may be relatively attractive places to live.[2] If property prices are an indication of attractiveness, this could suggest that the more remote hospitals may be located in areas that are not unattractive.

Travel time to Swansea (minutes)[1]



[1] This is based on travel time from hospital to a postcode in the Swansea city centre based on travel times sourced from Doogal (2017).
[2] Based on ONS, Land Registry, Q3 2016

Impact estimation

Impact estimation

In the next sections, four areas of cost are estimated to understand HDUHB's unavoidable cost base

Demographics - unavoidable
Demographic composition of the catchment population may impact health needs and costs. In particular, a higher proportion of elderly residents may be associated with greater health needs and cost.

Remoteness - unavoidable
Remoteness and rurality may add pressures to the local health economy, notably through increased difficulty in recruiting and retaining staff. This could result in costs in terms of locums or agency pay that would be specific to the area.

Scale - partially controllable in the medium to long term
The size of the catchment area and the low population density may suggest that the health board needs to provide healthcare services across the area to relatively low numbers of patients per site, to ensure reasonable access. This may mean that sites may only have relatively low levels of activity, and operate at lower than efficient scale (resulting in higher cost per unit of activity).

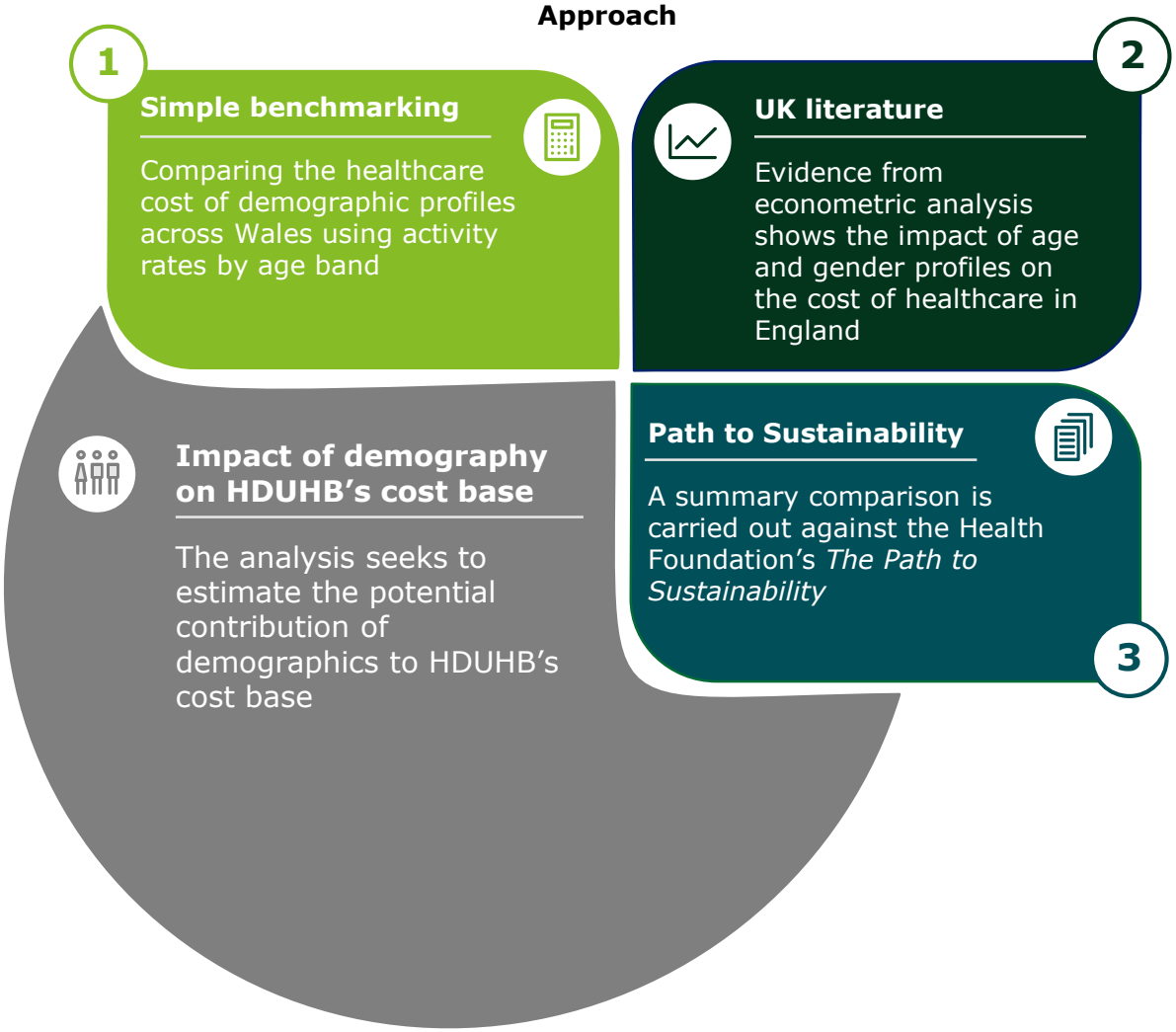
Efficiency - controllable in the short to long term
Relatively lower levels of efficiency may mean funding allocations are not used in the best way and savings could be realised through increased efficiency or productivity. Efficiency could come from ensuring patients are seen in the most appropriate setting (activity) or from taking steps so that treatment is delivered in the most cost effective way (cost).

Impact of demographics

Estimating the impact of demography for HDUHB

The analysis draws on a number of sources

- With a focus on age-gender impacts, three approaches are considered to estimate the impact of demographics on HDUHB's cost base.
- Each approach has limitations, and a combination of approaches is used.
- Sufficient data was not available to apply the model from the report *The Path to Sustainability*, a 2016 Health Foundation report that projected growth in the cost of care in Wales. However, this has been considered as it is a recent source on utilisation projections by age.



- HDUHB has an older population than the Welsh average. This could affect healthcare utilisation and cost as older people may have more long term conditions, and they may have age-specific health needs (e.g. due to falls).
- This section focuses on the impact of age and gender on HDUHB's cost base. Based on benchmarking using Welsh average activity and cost and the UK literature, HDUHB's age profile is estimated to contribute to a cost uplift of 5% to 6% (c. £16m to £20m) in comparison to the Welsh average.
- Sufficient data was not available to apply the model from the Health Foundation report *The Path to Sustainability*. However, their model also indicated that health costs increase with age.
- The Welsh resource allocation formula takes account of age in the funding allocated to health boards. As such, some of the impact estimated here may already be accounted for in the Welsh allocation. However, detailed review of the Welsh allocation formula is beyond the scope of this report.

Age band benchmarking

Age benchmarking suggests demographics may increase HDUHB's cost base by c. 5%

Background

- As set out in the background section, HDUHB has a slightly older population compared to the Welsh average; 30% of HDUHB's population is older than 60 compared to 26% for Wales.
- PEDW data indicates that older individuals tend to use healthcare services more frequently (with average FCE per 1,000 population increasing from c. 200 for ages 15-59 to above 350 for those 60 to 74 and over 800 per 1,000 for those 75 or over).[1]
- This could be a driver of activity and cost for HDUHB.

Methodology

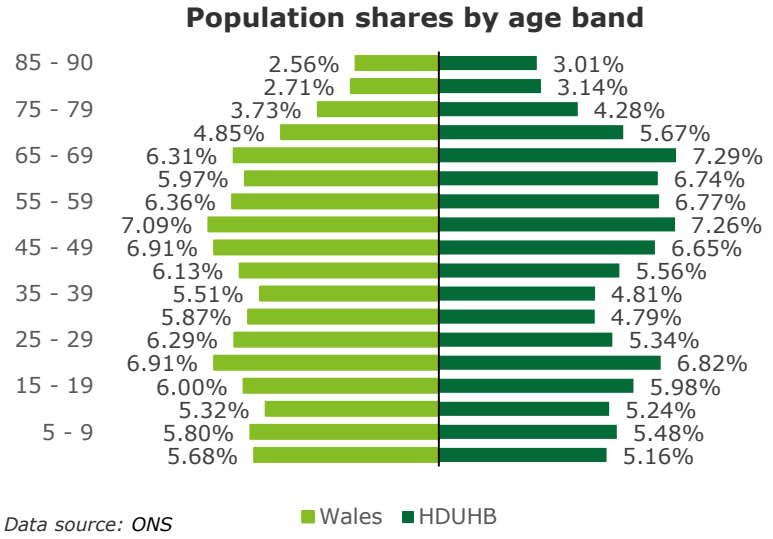
- To understand the impact of age, the analysis estimates the level of activity in HDUHB if the age distribution was equivalent to that of the Welsh average, based on 2015/16 PEDW data by age group.
- The estimate uses inpatient episodes per 1,000 population by age band for Wales to compare how the different age profiles affect total activity.

Indicative findings

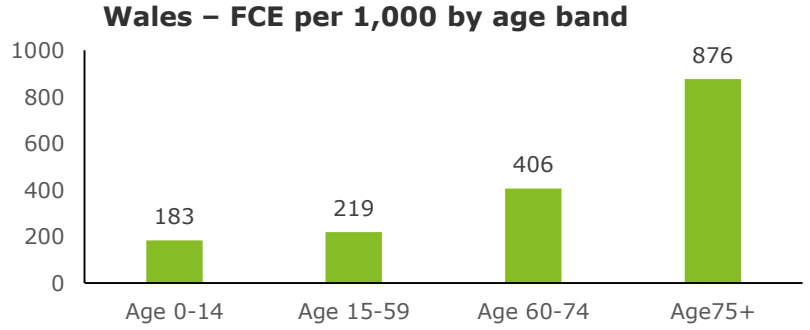
- The results indicate that HDUHB's age profile is associated with an additional c. 5% activity compared to a health economy with the Welsh average age profile and HDUHB's population size.

Limitations

- This analysis only takes into account the age profile of HDUHB and does not account for gender and deprivation.
- Unit costs of activity may differ across age bands. Differences in overall activity may therefore differ from differences in cost.



Data source: ONS



Data source: PEDW tables, ONS

[1] NHS Wales, 2015/16 PEDW

Updated Nuffield formula (1/2)

The updated Nuffield formula suggests an impact of demographics of c. 6%

Background

- The Nuffield formula is used to allocate resources for general and acute and A&E acute activity. NHS England reviewed and updated the Nuffield formula for its 2016/17 allocation publication.[1]
- The formula models cost-weighted need for CCGs using a set of explanatory variables, based on the CCG's population.[2] The weights are estimated based on an econometric model considering demographic factors, including age and gender, on the costs of healthcare provision.
- The estimated model allows estimation of acute healthcare cost for granular demographic profiles based on age banded cost per person by gender.
- The model also studies the question of interest in the zero based review – what factors drive costs and how that affects the expected costs of a given commissioner of care – and includes control variables of interest such as socio-economic factors.

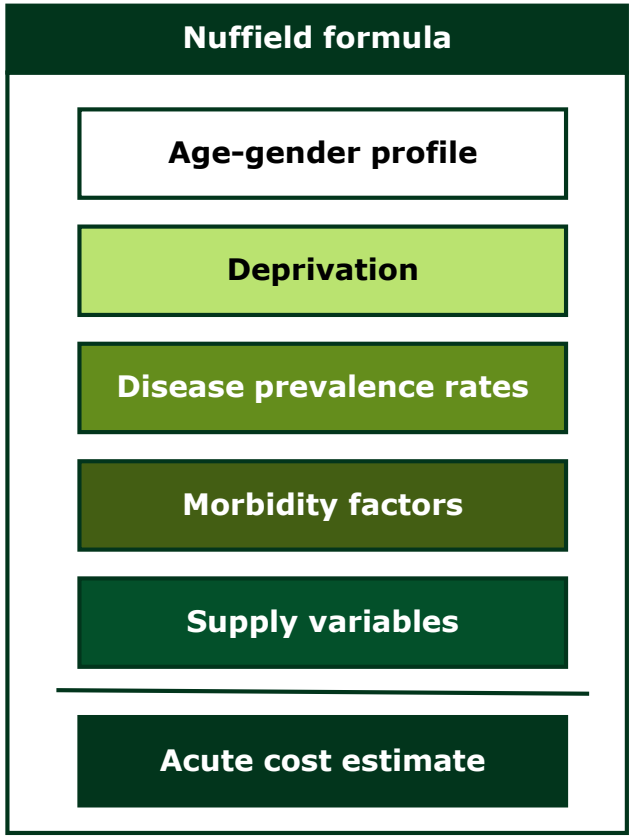
Methodology

- The English allocation formula gives detailed estimates for healthcare costs across age-gender bands for three age groups: 0-14, 15-64 and 65+. These results have been calibrated using Welsh cost data across age bands. [3]
- To estimate the impact of HDUHB's demographic profile, the analysis compares the expected cost for HDUHB (based on its age-gender profile) to the expected cost if HDUHB had the same age-gender profile as the Welsh average. The difference between both estimates is the estimated effect of age-gender demographics on HDUHB's cost compared to the Welsh average.[4] More detail is set out in the technical appendix.

Indicative findings

- The results indicate that HDUHB may face additional costs of c. 6% of inpatient cost due to its age-gender demography.[5]

NHS England – Nuffield formula for allocations

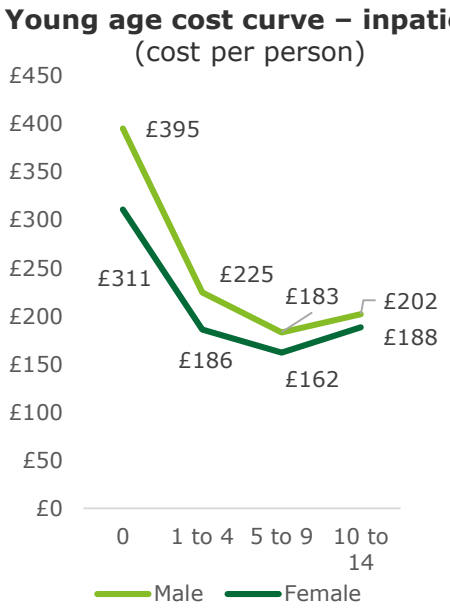


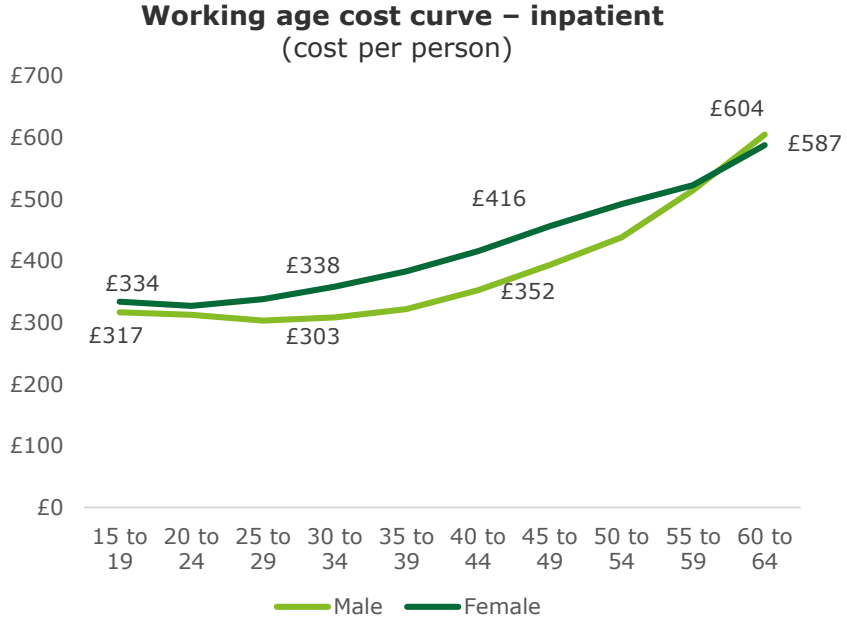
[1] NHS England (2015a) *Refreshing the current CCG formula (revised).*
[2] Base equal to GP registrations
[3] Based on WCR2 data and PEDW data for 2015
[4] The original coefficients were estimated focussing on acute care and thus will only reflect acute costs. The analysis does not replicate NHS England (2015a) but uses estimates of the costs by age band and gender and recalibrates these to the Welsh context (see Technical Appendix for further detail). Difference in unit cost between age bands within an HRG are not captured. Long term conditions captured by broad age bracket only. As the estimates are applied in Wales based on inpatient data only, this assumes that there is a similar relationship between age and cost as in England.
[5] The analysis only takes into account the four district general hospitals of HDUHB as the model is based on acute health care. Uplift is as compared to the Welsh average acute care cost for residents.

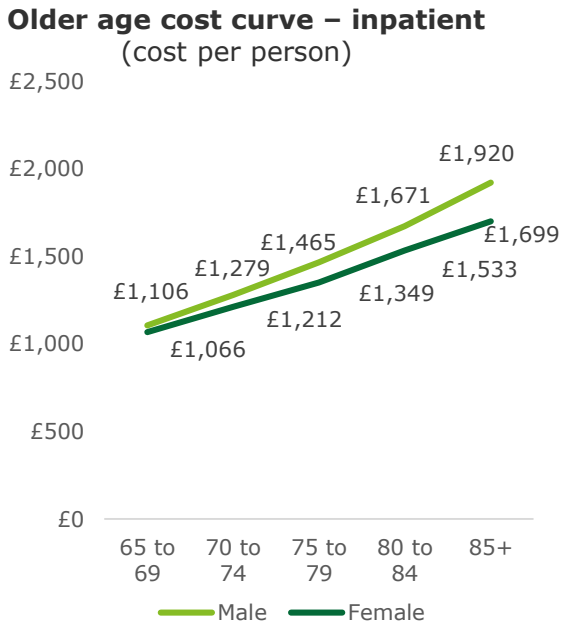
Updated Nuffield formula (2/2)

The updated Nuffield estimation suggests cost increases with age

- The updated Nuffield formula suggests the overall cost increases with age (although not in the early years).
- The graphs set out below show the unit cost per person (by age and gender) for inpatient care as modelled by applying the updated Nuffield formula.







Source: Based on NHS England (2015a), PEDW, WCR2 2015/16

Limitations of the Nuffield Formula:

- The updated Nuffield formula as applied accounts for the impact of long term conditions to cost by broad age bracket only (children, ages 15 - 65, age 65+).
- The updated Nuffield formula is applied to inpatient data. This estimate is based on the English system, which may differ from relationships in Wales.
- Estimates are based on actual activity and do not capture the impact of unmet need or the differences in unit cost by age/deprivation within HRGs.
- Estimates were applied to the resident population, whereas the NHS Estimates were based on the GP registered population.
- Age groups in the PEDW were attributed to the age bands in the refreshed Nuffield formula (children, ages 15 - 65, age 65+).

Health Foundation work

The Health Foundation work also suggests that cost increases with old age, however there was not sufficient information to provide an estimated impact

- The work conducted by for the Health Foundation regarding *The Path to Sustainability* estimated the costs for healthcare in Wales based on age, co-morbidities and gender.
- This work has not been used to provide a third estimate of the demographic impact as the published results were not sufficient to allow for replication of the model. In addition, the impact of gender at older ages is omitted for certain points of delivery, and factors such as deprivation are not accounted for in the model.
- A utilisation curve was approximated based on the published results of *The Path to Sustainability*, and applied to HDUHB's population (rather than the patient population).[1] The approximation is illustrative only of a broad trend, rather than specific utilisation levels.
  - This was approximated by using utilisation rates for the patient population by age, gender, and co-morbidities as set out in *The Path to Sustainability*
  - These were applied to the population (Wales/HDUHB) by age, gender, and an approximation of co-morbidities for the population over 50.[2]
  - No gender effect was reported for those aged over 50 years for non elective or other elective activity.[2]

As with other estimates, these cost curves suggest a similar increase in utilisation in old age, which could increase the cost base.[1]

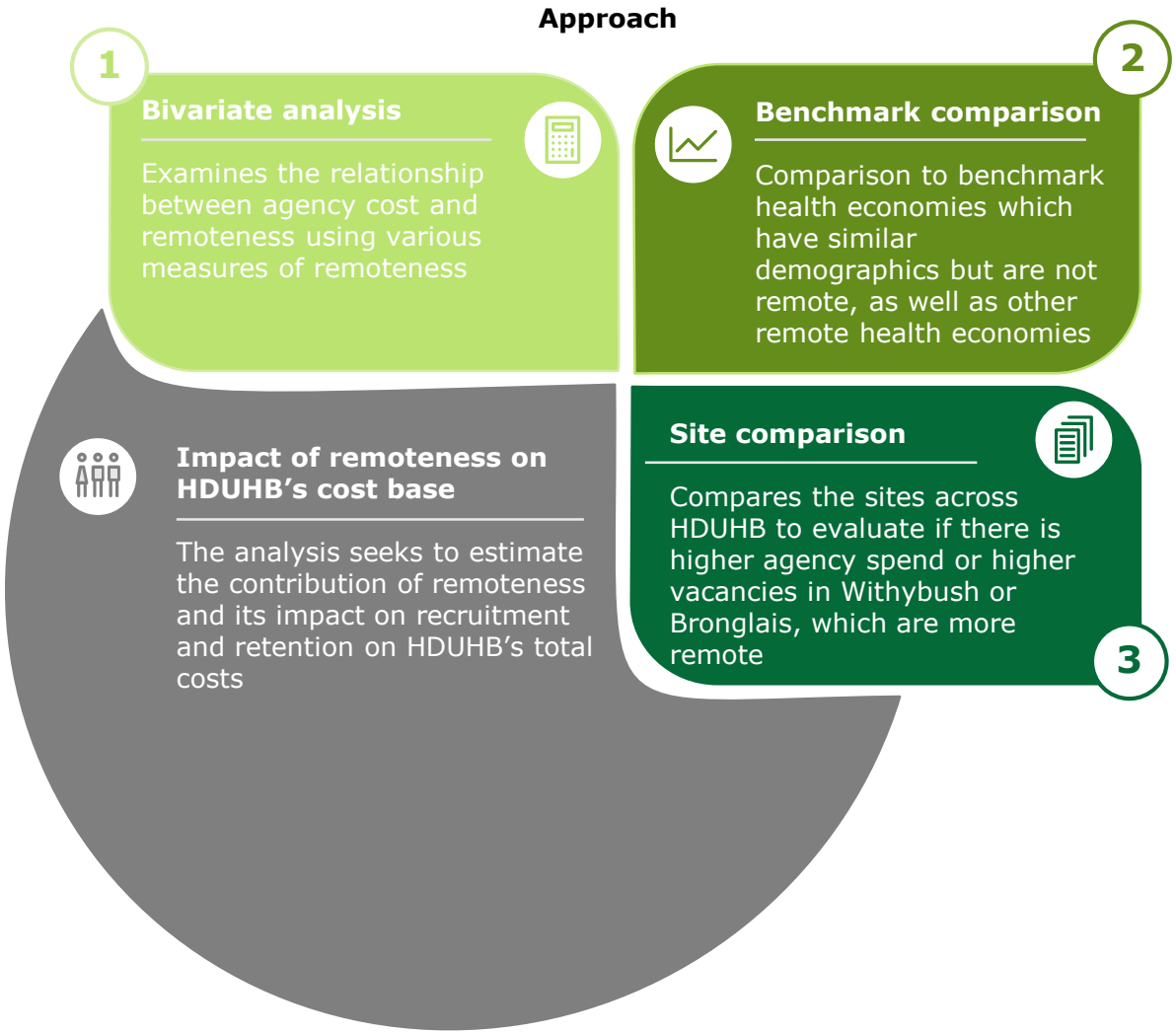
[1] The Path to Sustainability estimates are not applied to this review as the published results in The Path to Sustainability suggest they are expressed in terms of utilisation of certain services among the patient population, not the general population (which includes patients that do not access care). In addition, the approach does not include variables relating to deprivation in the econometric model, which may overestimate the discrete effect of age, it and appears to assume utilisation of care increases in a constant way with age. No gender effect was reported for those over 50 years in age for non-elective and 'other elective' activity.
[2] Comorbidity data by age level was unavailable at a granular level, and the methodology used to identify co-morbidities in the inpatient data was unknown. The above is therefore an approximation based on PEDW data, using the primary ICD10 2 digit code grouping that included the codes used by Watt and Roberts (2016) to identify morbidity as a percentage of inpatient activity. Information on co-morbidity was not available publically, and was instead approximated assuming that morbidity (as a % of inpatient activity) would be as high as the largest single morbidity (as a % of the total inpatient dataset).

Impact of remoteness

Estimating the impact of remoteness for HDUHB

The analysis examines remoteness through three approaches

- Remoteness may affect recruitment and retention if medical, nursing or other health professionals prefer to live and work in areas that are relatively closer to urban centres.
- This could lead to higher agency costs, and could also result in higher base staff vacancy rates.
- If remoteness affects recruitment and retention through higher staff costs, this could affect HDUHB's cost base. It may also affect scale if small hospitals are needed to serve remote populations. The effect of scale is not considered in this section.

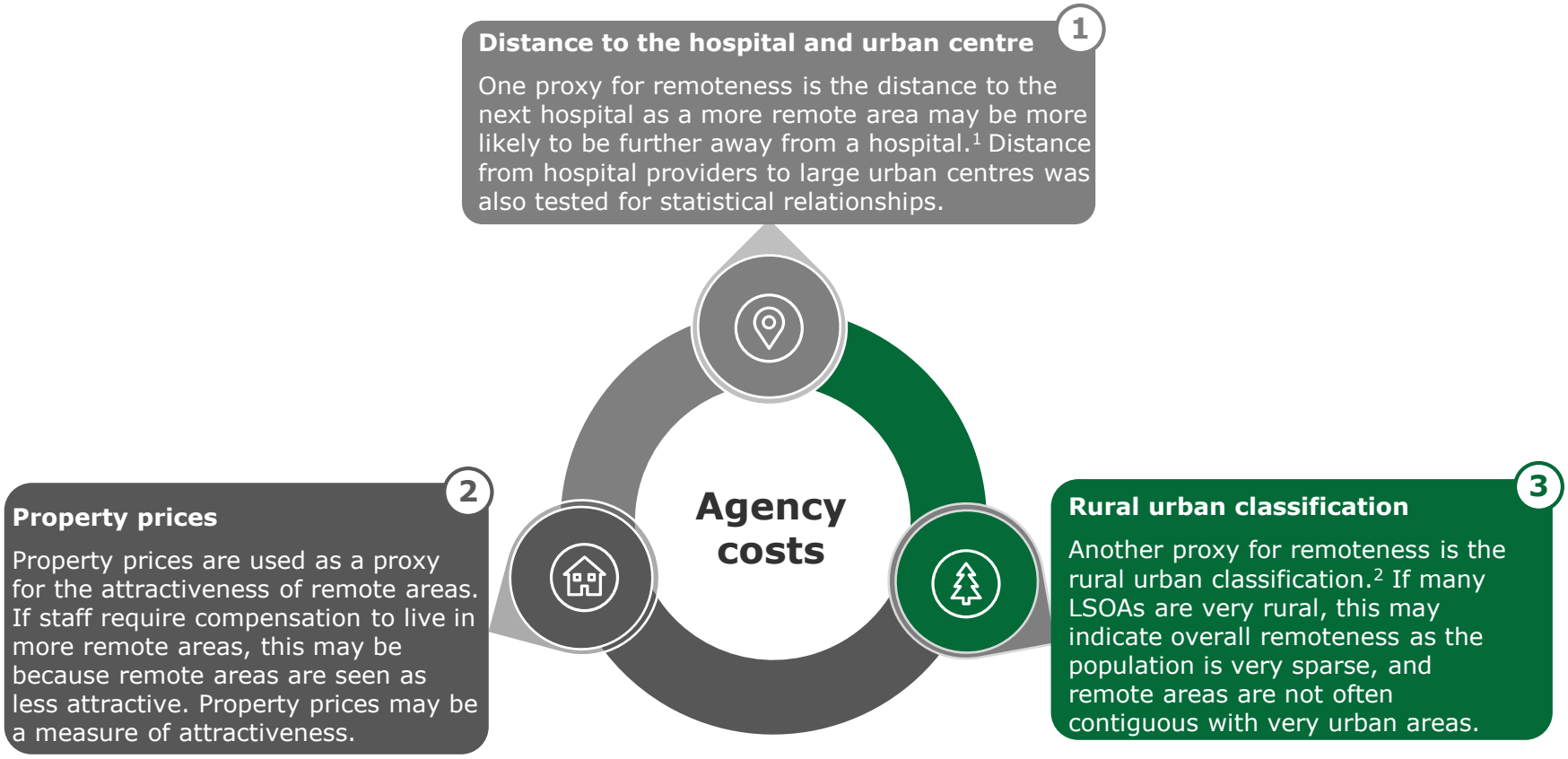


- HDUHB has some hospitals that are located in more remote areas. This could affect HDUHB's cost of service in a number of ways.
- This section investigates whether remoteness may affect recruitment and staff costs. This may be the case if staff prefer to live and work in less remote areas.
- Remoteness may have other effects. For example, there may be higher patient travel times for e.g. outpatient clinics in remote areas, which is not considered here.
- There may also be an interaction between scale and remoteness, if very small sites are needed in certain areas to serve remote populations. Scale is considered separately in the next section. However, these factors may be interrelated.
- The analysis of the effect of remoteness on staffing costs suggests that remoteness does not affect HDUHB's cost base.

Bivariate analysis of agency cost and remoteness

The relationship between agency cost and remoteness is analysed using several measures of remoteness

- The first approach investigates the relationship between location and higher staff costs using bivariate analysis.
- Hospitals in remote areas may face challenges when recruiting staff and may therefore be more likely to use agency to meet staff requirements. Agency staff tend to attract a wage premium. For this reason, **agency spend** is used as a proxy for higher pay costs due to remoteness in this analysis.
- For the remoteness component the analysis considers a series of metrics, including **distance to the next hospital and urban centre**, **property prices** and the **rural urban classification.**
- The literature focuses on medical staff and therefore the analysis takes a closer look at this in later slides.



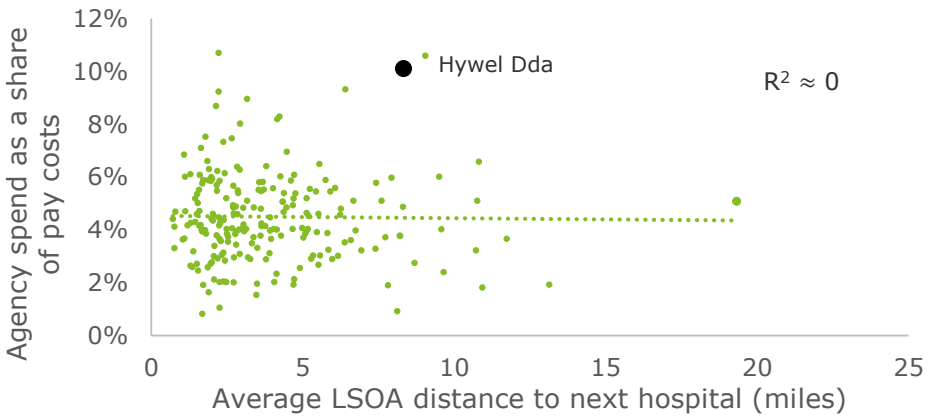
[1] Chris Smyth, Stephen Lorrimer and Michael Chaplin (2015). *Unavoidable smallness due to remoteness – identifying remote hospitals.* NHS England
[2] See e.g. Cheng et al (2010). *What Factors Influence the Earnings of GPs and Medical Specialists in Australia?*

Bivariate analysis of agency cost and remoteness

Evidence from England and Wales suggests there is no clear relationship between distance to the next hospital and agency spend

- The first proxy considered for remoteness is distance to the next hospital. Bivariate analysis shows no statistical relationship between agency spend and distance to the next hospital. The R-squared – which indicates how much of agency cost can be explained by remoteness proxies – is very low for the analysis of England and Wales, suggesting that remoteness proxies considered here through bivariate analysis do not explain variations in agency costs. Similarly the bivariate relationship between agency spend and provider distance to urban centres was not statistically significant.

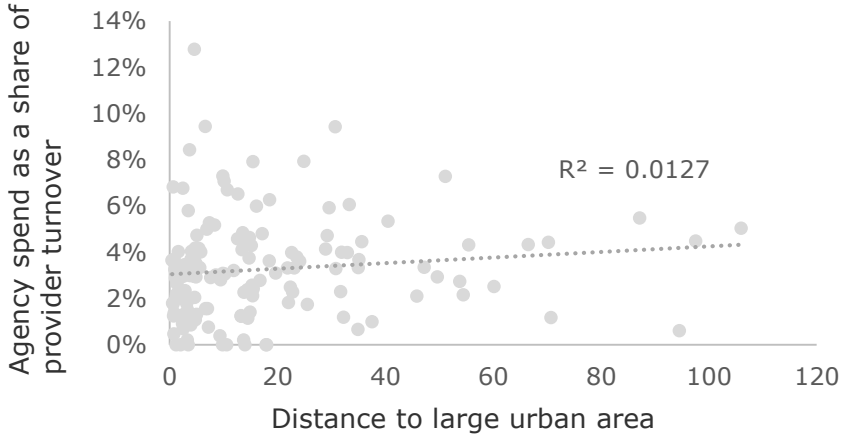
England and Wales - Agency spend and distance to next hospital[1]



Source: Welsh government data, HSJ, Monitor, calculations based on geographic coordinates R-squared is 0 indicating that, alone, distance to next hospital does not explain the variation in agency spend

- Using distance to the next hospital as a proxy for remoteness is based on the hypothesis that remote areas will have fewer hospitals, and so distance to the next hospital will be greater.
- Bivariate analysis across England and Wales on the relationship between distance to the next hospital and agency spend does not indicate that this proxy of remoteness is associated with greater agency spend.

Agency spend and distance to urban centres[2]



Source: ONS, HSJ, calculations based on geographic coordinates. R-squared is 0.01 indicating that, alone, distance to next hospital does not explain much of the variation in agency spend

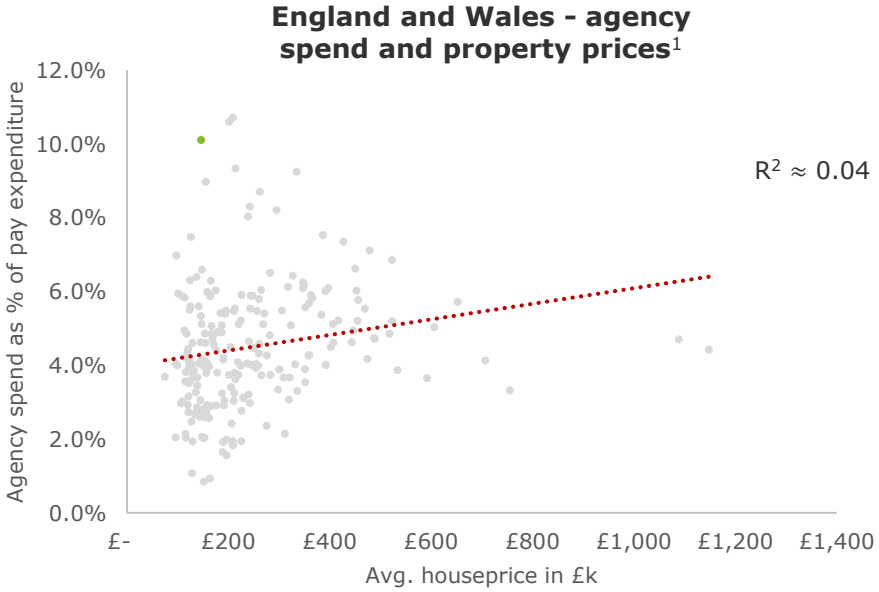
- Sensitivity analysis was also conducted using time from hospital providers to the next urban centre.[2]
- This did not show a statistically significant relationship between hospital distance to urban centres and agency spending.

[1] The analysis was performed on CCG and health board level, with trusts mapped to CCGs based on non-elective pathways. English agency data from 2014/15 and Welsh data from 2016/17 ; [2] Based on data from HSJ and ONS Nomis data on the largest built up areas.

Bivariate analysis of agency cost and remoteness

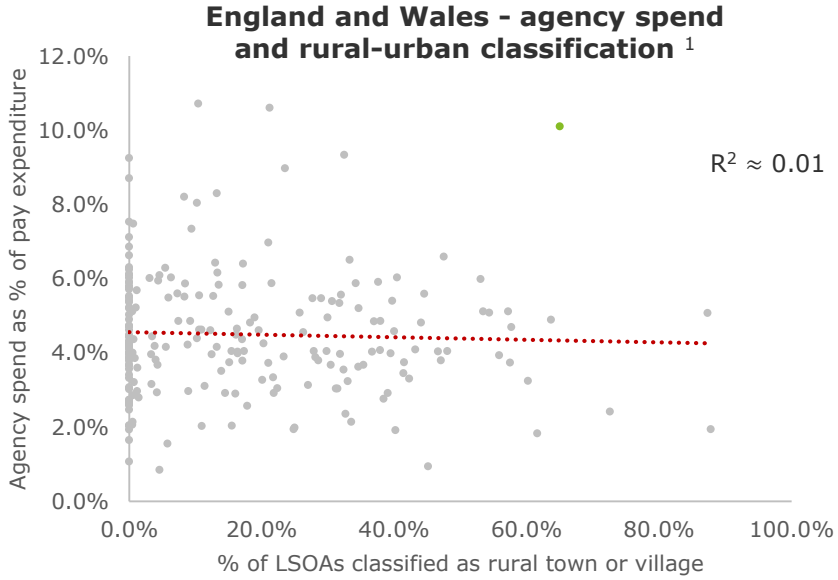
Using other proxies for remoteness and desirability does not affect the analysis

- Other proxies of remoteness (property prices and the rural urban classification) are used to test the finding that distance to hospital is not related to higher agency spend.
- Indicative analysis shows no clear relationship between agency spend and alternate proxies for remoteness in England and Wales. As with the distance to hospital proxies, very little agency spending is explained by differences in property prices or rurality, as suggested by low R-squared values.



Data source: ONS 2016, Welsh government data, HSJ, Monitor
The R-squared is 0.04, indicating that, alone, property prices do not explain the variation in agency spend

- Using property prices as a proxy for remoteness is based on the hypothesis that more remote areas may experience lower real estate demand, leading to lower house prices.
- However, bivariate analysis of the relationship between property prices and agency spend does not indicate that lower property prices are associated with greater agency spend.



Data source: RUC 2011, Welsh government data, HSJ, Monitor
The R-squared is 0.01, indicating that, alone, rurality does not explain the variation in agency spend

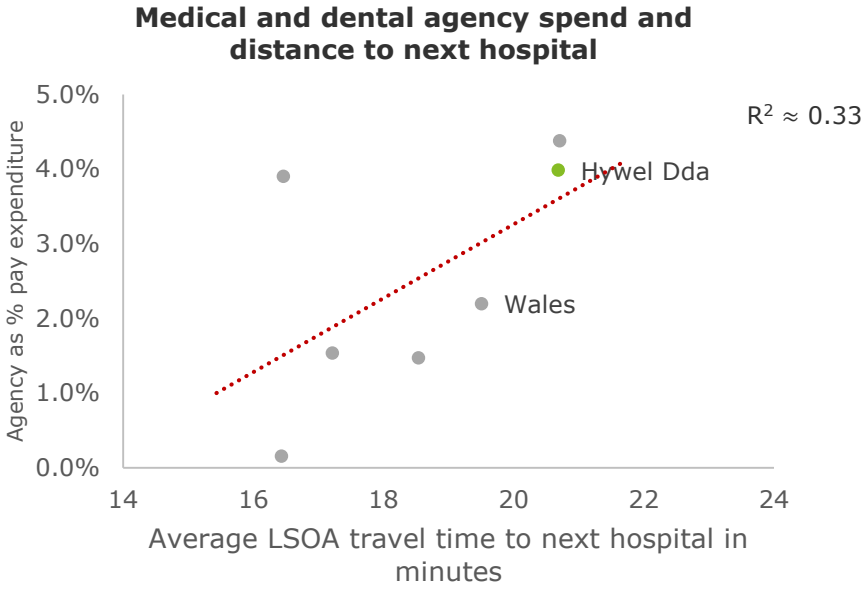
- The 2011 Rural Urban Classification (RUC) categorises each LSOA into one of eight categories according to their rurality. The RUC can be interpreted as a direct measure of rurality.
- The data does not indicate that a higher share of population living in rural LSOAs are associated with greater agency spend for a health board.

[1] The analysis was performed on CCG and health board level. See the Technical Appendix for notes on mapping of hospitals to CCGs. English agency data from 2014/15 and Welsh data from 2016/17

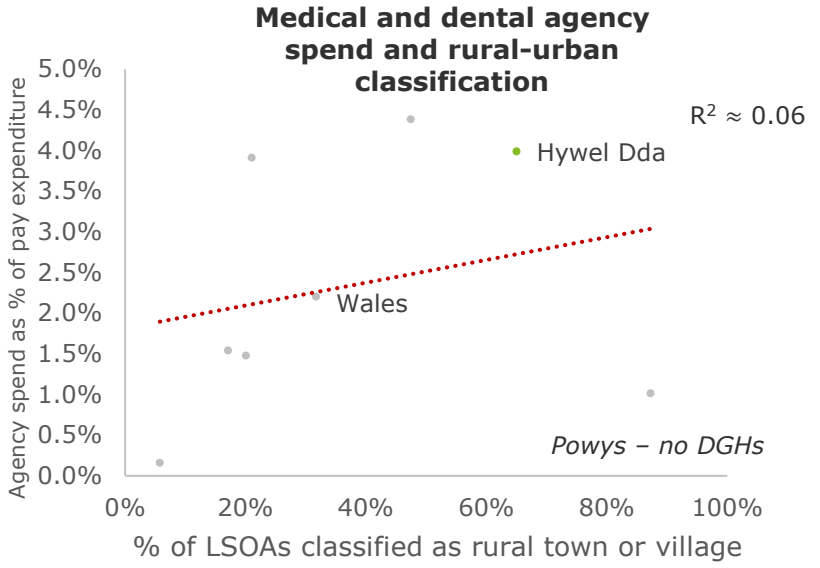
Bivariate analysis of agency cost and remoteness

Remoteness appears to affect medical staff more, but there is insufficient data to find a statistically significant relationship

- There is specific evidence in the literature to suggest that medical staff may prefer less remote areas.[1]
- Discussions with HDUHB stakeholders indicated that HDUHB experience reflects this: HDUHB notes it faces more enduring challenges in recruiting to medical posts (including trainees), in particular in the more remote hospitals Bronglais and Withybush. [2]
- Bivariate analysis of agency spend on medical and dental staff and remoteness indicators does not show a statistically significant relationship. However, this may be because the analysis is limited by the small sample size of only seven health boards.



Data source: Welsh government data, calculations based on geographic coordinates. The R- squared is 0.33, indicating that, alone, distance to next hospital could explain c. 1/3 of the variation in medical and dental agency spend. However, the sample is too small for a relationship to be statistically significant.



Data source: RUC 2011, Welsh government data. The R-squared is 0.06, indicating that, alone, distance to next hospital explains about a 6 percentage points of the variation in medical and dental agency spend. However, the sample is too small for a relationship to be statistically significant.

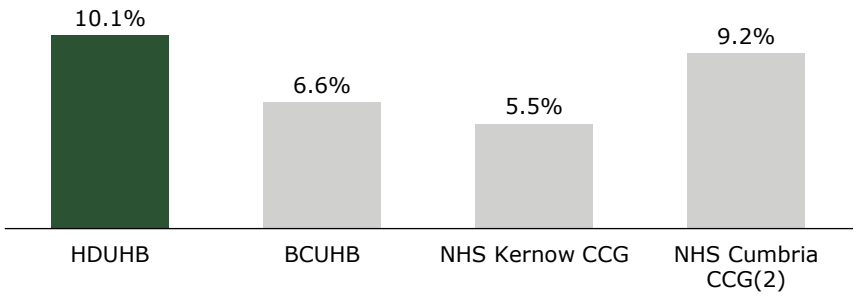
[1] HERU (2016). *Junior doctors training: is it really location, location, location?*
[2] Discussions with HDUHB stakeholders. However, not all voiced this concern, stating that other factors may be more important than location in trainee decisions.

HDUHB benchmarked against closest comparators

Closer analysis of HDUHB compared to demographically and geographically similar peers suggests agency is a problem even in less remote areas

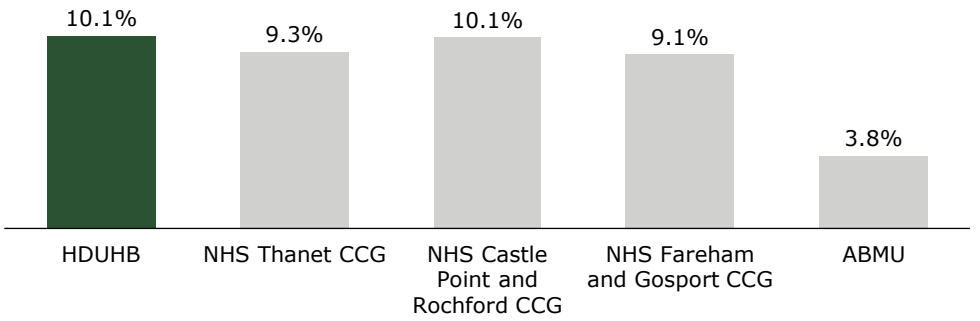
- HDUHB is compared to health economies that are both demographically and geographically similar (other remote health economies) as well as peer health economies that are demographically similar (but are not remote) to provide a closer view on the relationship between remoteness and agency spend.
- There does not appear to be a consistent difference between the agency spend of health economies that have more rural/remote populations (left graph) as compared to those without remoteness (right hand side).
- This supports the bivariate analysis, suggesting no consistent relationship between remote health economies and agency costs.

Other remote health economies - agency as % of pay expenditure[1]



Data source: Welsh government data, HSJ, Monitor, calculations based on geographic coordinates

Demographically similar health economies (not remote) - agency as % of pay expenditure [1]



Data source: Welsh government data, HSJ, Monitor, calculations based on geographic coordinates

[1] The analysis was performed on CCG and health board level. See the Technical Appendix for notes on mapping of hospitals to CCGs. English agency data from 2014/15 and Welsh data from 2016/17

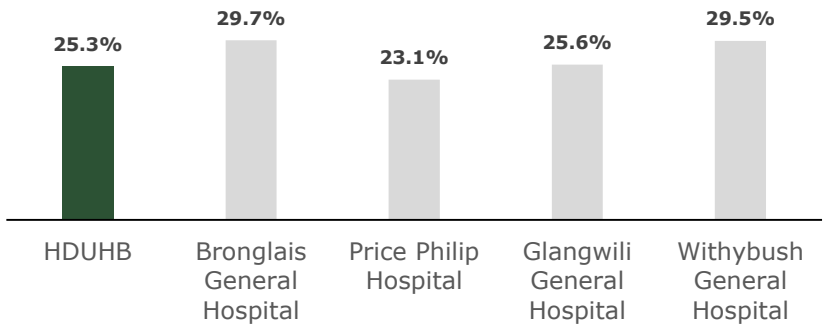
[2] Three sites in Cumbria CCG were considered as rural and sub-scale in the 2016/17 NHS England Target Allocation formula (Furness, West Cumberland, and Cumberland). See NHS England (2016). *Technical Guide to Allocation Formulae and Pace of Change*

Site comparison at HDUHB

Vacancy rates across HDUHB sites are used to investigate if more remote sites within HDUHB may have more staffing challenges

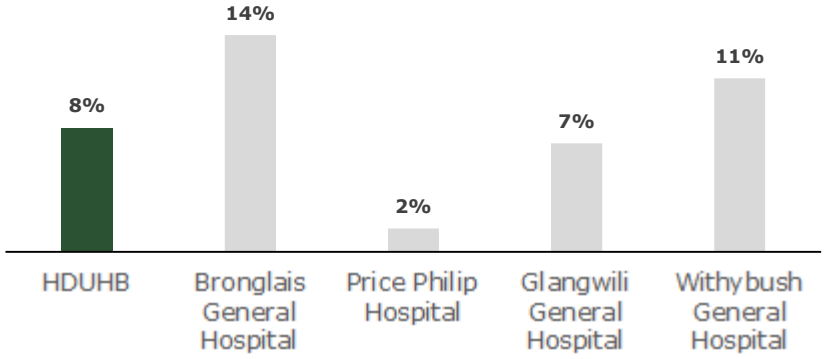
- It may be that the more remote sites (Bronglais and Withybush) could experience particular difficulty in recruitment challenges.
- The vacancy rates vary across sites. While Withybush and Bronglais appear to have higher vacancies, there is insufficient evidence to conclude that this is due to remote drivers. In particular, vacancies appear high across sites for medical and dental staff.

Vacancy rates for Medical and Dental, 2016/17 [1]



Source: Data provided by HDUHB

Vacancy rates for Registered Nurses, 2016/17 [1]



Source: Data provided by HDUHB

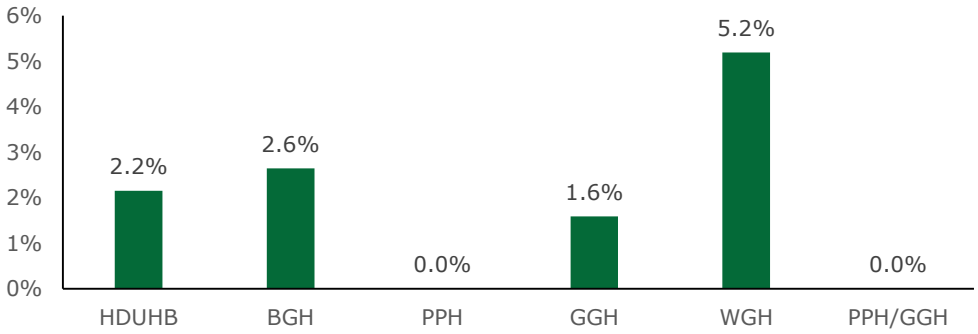
[1] Vacancies based on the number of budgeted staff compared to the actual staff

Site comparison at HDUHB

Agency and locum spend varies across HDUHB's hospitals, but this does not show consistently that remoteness has a negative impact

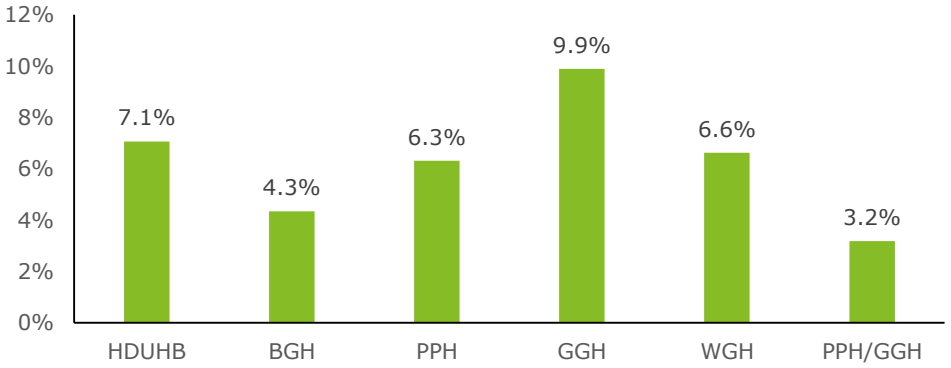
- Medical and Dental agency and locum spending across sites varies. Agency spending appears to be higher at Withybush and Bronglais.
- This may indicate that sites in more remote areas can attract a premium; hoverer, more information would be needed to conclude on this hypothesis.

Medical & Dental – Agency spend as % of pay spending, 2016/17



Source: Data provided by HDUHB

Medical & Dental – Locum spend as % of pay spending, 2016/17



Source: Data provided by HDUHB

Legend

BGH: Bronglais General Hospital

PPH: Prince Philip Hospital

GGH: Glangwili General Hospital

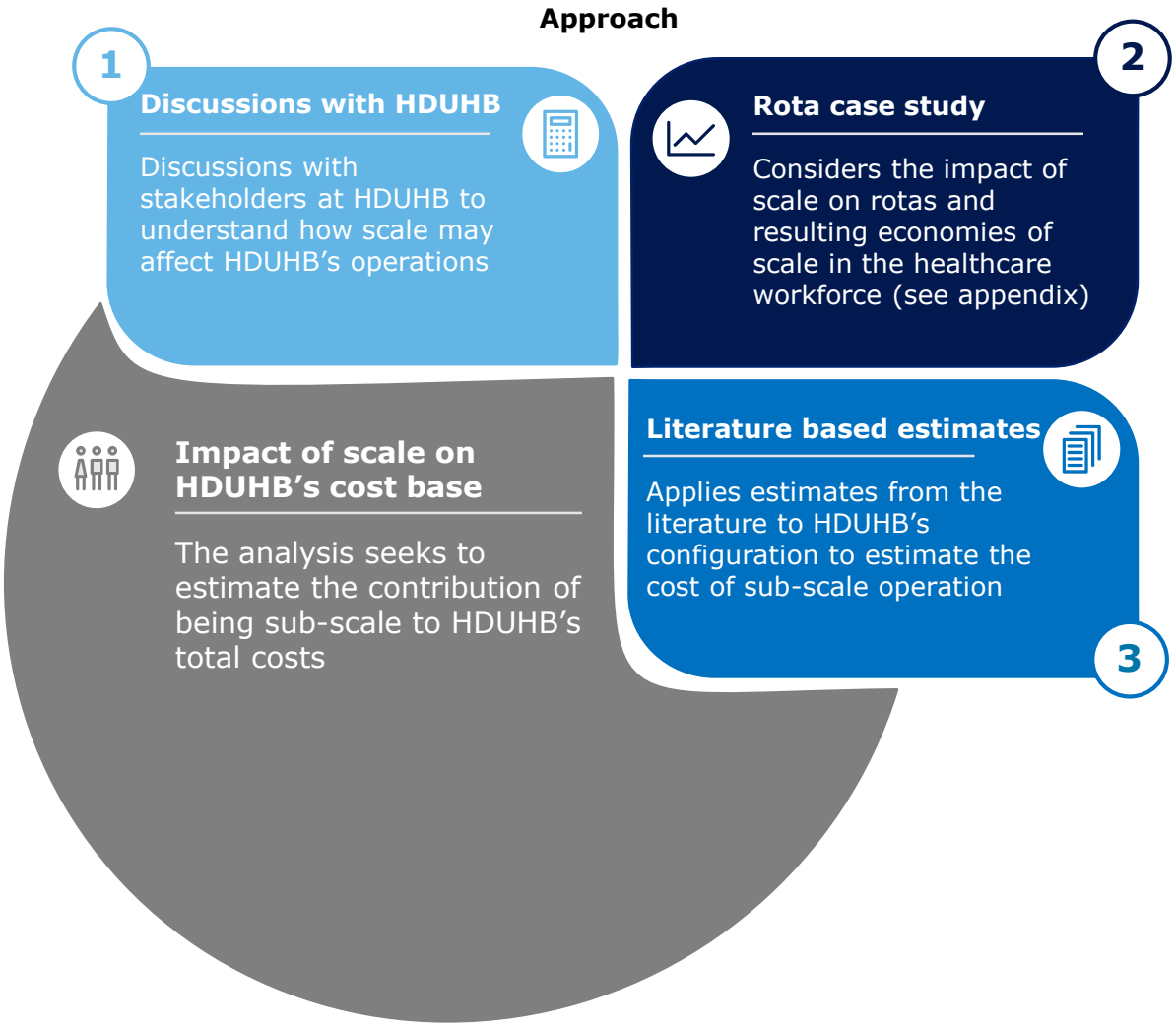
WGH: Withybush General Hospital

Impact of scale

Impact of scale

This section investigates the impact of scale using three approaches

- Qualitative evidence is collected to provide examples of how small scale may affect costs (this is not seeking to be comprehensive).
- A literature based approach is then used to identify existing econometric models which could be used to test whether scale has an impact on costs and to estimate the impact of scale for HDUHB as compared to the Welsh average. Sensitivities are also set out and compared to other health economies to test possible effects of changes to scale in the long term.



- The indicative findings set out estimate the potential cost of small scale, not of remoteness. It is possible that some element of this cost may be avoidable. For example, by changing the optimum location of sites as populations change. However, this is not considered as part of this study.
- Based on the analysis, the estimated impact of scale on HDUHB's cost base is c. 2% to 6% (£7m - £19m).

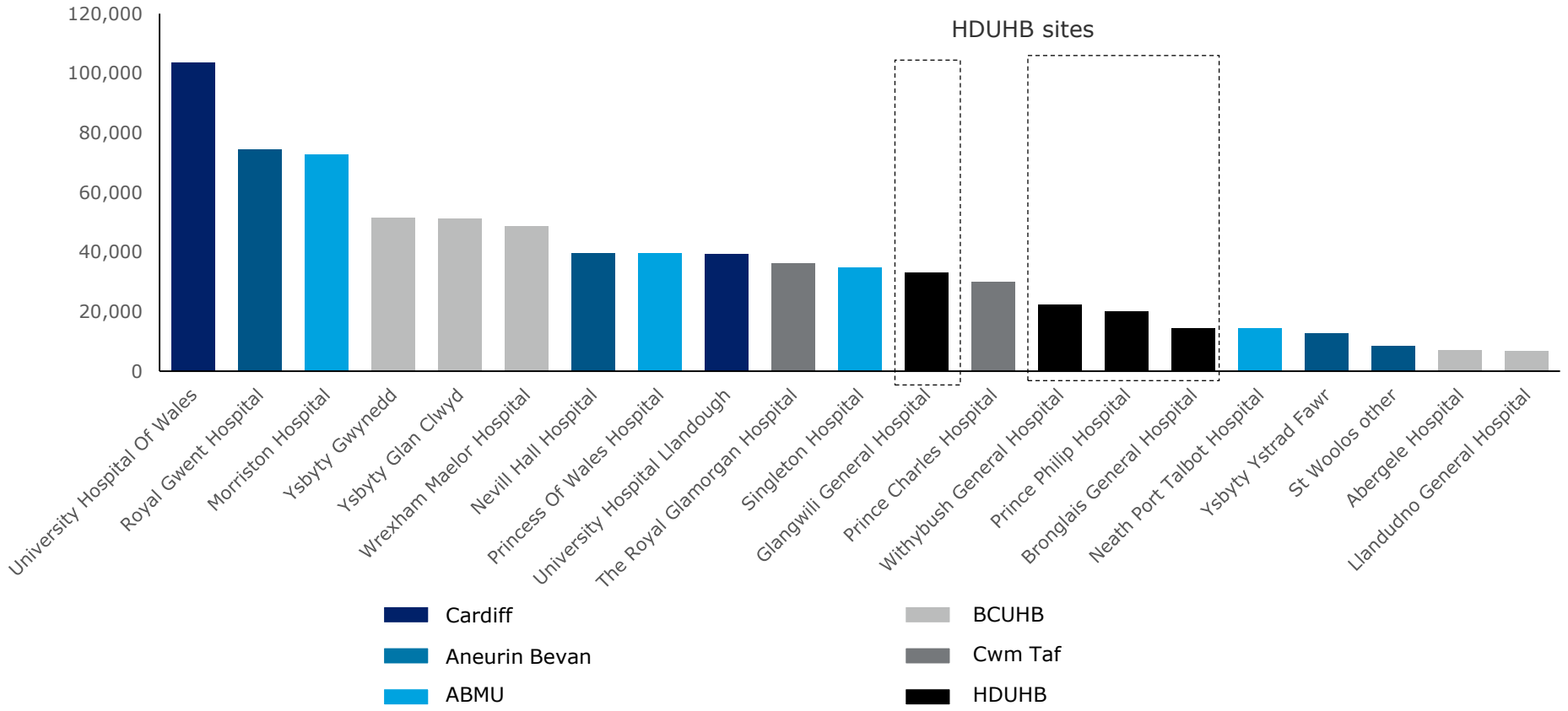
4 Sensitivities around scale as compared to benchmark health economies are set out in the appendix

Impact of scale – Health board site size

HDUHB hospitals are relatively smaller than those of other health boards

- Case mix adjusted activity measures the level of activity, and is weighted for complexity based on HRG. See the technical appendix for further detail.
- Based on case mix adjusted activity across Wales, HDUHB is the only health board with all sites with scale lower than the Welsh average (c. 36,000).

Hospital 2015/16 case mix adjusted activity[1]



Note that Powys is excluded because it does not have any hospital with a case-mix weighted activity above 5,000 units.

[1] Case mix adjusted activity based on data provided by the Welsh Government, PEDW 15/16, WCR2 15/16

Impact of scale

Discussions with HDUHB stakeholders suggest ways that scale and remoteness contribute to HDUHB's cost base

- As part of the review, interviews were held with HDUHB's directors of Operations, Human Resources, and the Medical Director, amongst others.
- In discussions, stakeholders noted that difficulties in sharing rotas across the more remote sites, as well as duplication of fixed costs on each inpatient site are some ways that scale could affect costs.

Examples of the ways in which HDUHB's operations over four DGHs might affect costs (from stakeholder discussions)

- **Non-medical fixed costs on multiple sites.** There are fixed costs for operating on many sites. For example, having wards at each site means that each site needs a bed manager. Each site has a canteen, laundry services, etc. These costs may be incurred even if the volume of activity is very low at the site.
- **Sufficient staff to allow for on-call cover.** Some services may have a relatively low level of activity (low levels of in-hours activity). These services may require an on-call medical rota that operates 24/7. In order to staff the on-call rota, it may be necessary to have in-hours capacity that is in excess of in-hours demand so that medical job plans have a sufficient level of in-hours as compared to on-call work. There may be an interaction with remoteness, as the ability to share on-call rotas between sites may be limited by travel times.
- **Fragile services.** There may be some services where there are a relatively low number of substantive consultants in place, with medical work being conducted by locums. These services may have challenges adapting to change as they rely on one consultant to deliver above and beyond, with little room for cover.
- **Minimum scale.** Some services operate at close to minimum scale. The provision offered is already the minimum required to provide the service, and cannot be reduced even with low activity volumes. In other health economies, the need for a more consultant-based (rather than trainee-based) model has been cited as one consequence of this.

These examples provide an indication of ways in which having four sites with relatively small scale could affect costs as set out by HDUHB staff, but they do not indicate if scale has an impact beyond these areas, or what the estimated impact of scale is, which is set out in the next slides.

Individuals engaged
Clinical Director
Director of Human Resources
Director of Operations
Deputy Director of Operations
Assistant Director of Finance
Members of the finance team
Senior Medical Workforce Manager
Programme Lead for Medical Workforce Utilisation
Acute Medicine consultants at different sites
Service manager

Impact of scale

The estimated cost for HDUHB of having four small scale sites is c. 4% to 6%

- The literature was reviewed to understand the evidence around economies of scale (see the literature section of the appendix for more detail).
- This slide provides supporting material to the summary report, which sets out the estimated cost of scale for HDUHB based on NHS England (2015b).

Background

To estimate the impact of scale for HDUHB, the most applicable paper – NHS England (2015b) – was used as a base case for the reasons set out on slide 15.

Approach

To estimate the impact of scale for HDUHB, the model used in NHS England (2015b) was rebased to the Welsh average, using case-mix adjusted inpatient activity, which controls for variation in complexity between hospitals.[1] This produced cost curves showing the relationship between activity and the cost of activity, after being applied to Welsh data.

From this, the cost curve was applied to the average HDUHB and Welsh site, based on the average size of sites in HDUHB and Wales in order to estimate the expected cost of a unit of activity, given site size. The difference in estimated unit cost for HDUHB compared to Wales was used as the basis for estimating the cost of small scale based on the size of HDUHB's sites.

A range of impacts (scenarios 1 – 3) were defined based on the cost curves associated with the confidence interval around the estimated impact of scale in NHS England (2015b). Further detail is provided in the technical appendix.

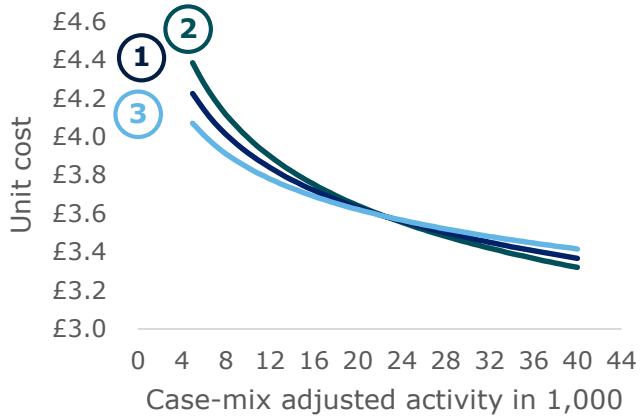
Limitations

- Estimates are based on inpatient activity, while the NHS England estimation included outpatient and A&E activity.
- Estimates are based on an England-based model, and so the estimates assume that Welsh sites would have a similar relationship between scale and cost.
- Estimates are based on average scale per site, and do not show the interaction with remoteness. Remoteness was found to be statistically insignificant in NHS England (2015). However, as remoteness is difficult to capture, it is possible that there are costs associated with scale and remoteness.

Indicative findings

The cost of scale for HDUHB could be in the region of c. £12m to £19m (savings applied to the acute cost base) for four sites, assuming no sharing of costs between Glangwili and Prince Philip (see next slide for further detail).

HDUHB - Economies of scale for hospital activity



#	Scenario	Cost impact (£m)	Impact (%)
1	Baseline – no shared costs	15.6	4.9%
2	Upper estimate	19.3	6.0%
3	Lower estimate	11.9	3.7%

Based on NHS England (2015b) calibrated for Wales, activity and cost based on PEDW, WCR2 (2015/16)

[1] Case mix adjusted activity based on the methodology used in Monitor (2016).

Impact of scale

Sensitivity – shared rotas at Prince Philip and Glangwili hospitals

- Prince Philip Hospital (PPH) and Glangwili General Hospital (GGH) operate as separate sites, each with its own set of fixed costs (e.g. each site has its own bed manager, canteen, radiology service etc.). However, there is a degree of shared working across the two sites, with GGH undertaking more 'hot' work and PPH undertaking more 'cold' work in Carmarthenshire.
- When considering the impact of scale on HDUHB's cost base, it may not be appropriate to treat PPH and GGH as completely distinct sites given the degree of shared working and thus shared costs.
- To determine the true level of shared costs across the sites would entail detailed bottom up modelling which sits outside the scope of this review.
- However, in order to understand the potential impact of shared costs across PPH and GGH, further analysis has been undertaken, as set out below. This high level analysis suggests that under the assumption that 50% of costs are shared across PPH/GGH, the estimated impact of scale on HDUHB's acute cost base reduces from c. £12m - £19m to c. £7m - £11m.
- Noting that there is a degree of sharing across GGH and PPH sites, the estimated impact of scale on HDUHB's acute cost base is £7m - £19m (2% to 6%).

Analysis

Sensitivity analysis was conducted to understand the impact of scale on HDUHB's cost base with GGH and PPH sharing resources and therefore costs.

If PPH and GGH are considered to share all costs, HDUHB's expected cost base is estimated at c. £321m, as compared to £319m if HDUHB's sites were the same scale as the Welsh average site. In contrast, HDUHB's expected cost base if all four of its sites are considered as fully separate is estimated at c. £335m, as compared to £319m for the Welsh average.

However, in reality, PPH and GGH are not fully integrated and therefore do not share all costs. For example, costs related to radiology, canteen, bed manager etc. will likely need to be replicated on each site. Determining the true level of cost sharing requires a bottom up costing exercise which is outside the scope of this review. However, in the absence of further information, a sensitivity assuming that 50% of costs are shared across PPH/GGH is considered. Assuming that 50% of costs are shared across PPH/GGH, the estimated impact of scale on HDUHB's cost base is £7m to £11m.

Assuming as a minimum no costs are shared between PPH/GGH and as a maximum 50% of costs are shared, the estimated impact of scale on HDUHB's cost base is c. £7m to £19m. This is a wide range, highlighting the importance of more work in this area.

Impact of scale

Within HDUHB, certain sites contribute more to the impact of being sub-scale than others

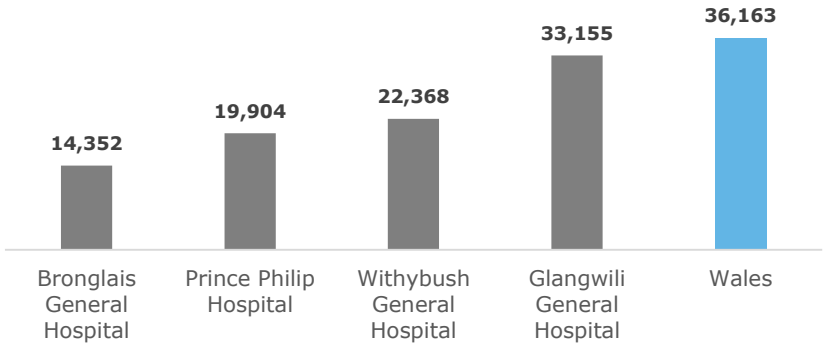
- The estimated impact of having four sub-scale sites is estimated at c. £16m.
- Bronglais has the largest impact on the estimated cost of scale, accounting for c. £5.4m of the £16m.

Site level analysis shows that all HDUHB sites operate sub-scale compared to the Welsh average. While Glangwili General Hospital is reasonably close to the Welsh average, the other hospitals record significantly lower activity levels (CMAA).

The sub-scale operation suggests that cost per unit of activity could be c. 10.4% higher for individual sites based on scale.

The unit cost estimate is the average cost of delivering a unit of case-mix adjusted activity, as estimated by the application of NHS England (2015b) calibrated to Welsh data.

Case-mix adjusted activity[1]

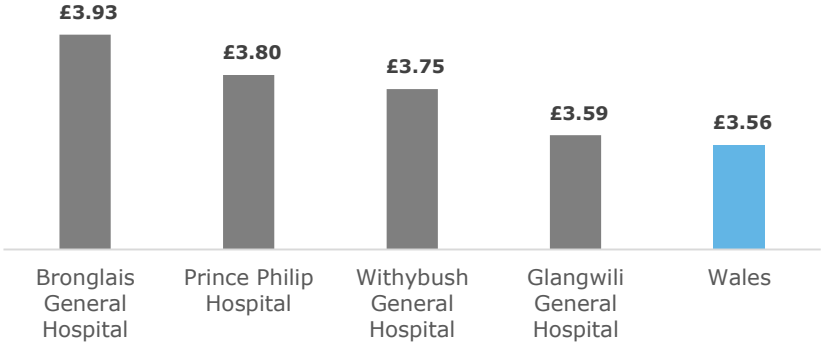


Based on CMAA for Wales represents the average Welsh hospital, PEDW, WCR2 (2015/16)

Cumulative cost of subscale operation (£m) [1]

Based on NHS England (2015b) calibrated for Wales, activity and cost based on PEDW, WCR2 (2015/16)

Unit cost of case-mix adjusted activity (model output), £k



Based on NHS England (2015b) calibrated for Wales, activity and cost based on PEDW, WCR2 (2015/16)

[1] *Hospitals were ordered by unit cost for accumulation.*

Impact of scale - Short, medium and long term

Sensitivities on the cost of scale were developed based on a set of benchmark health economies

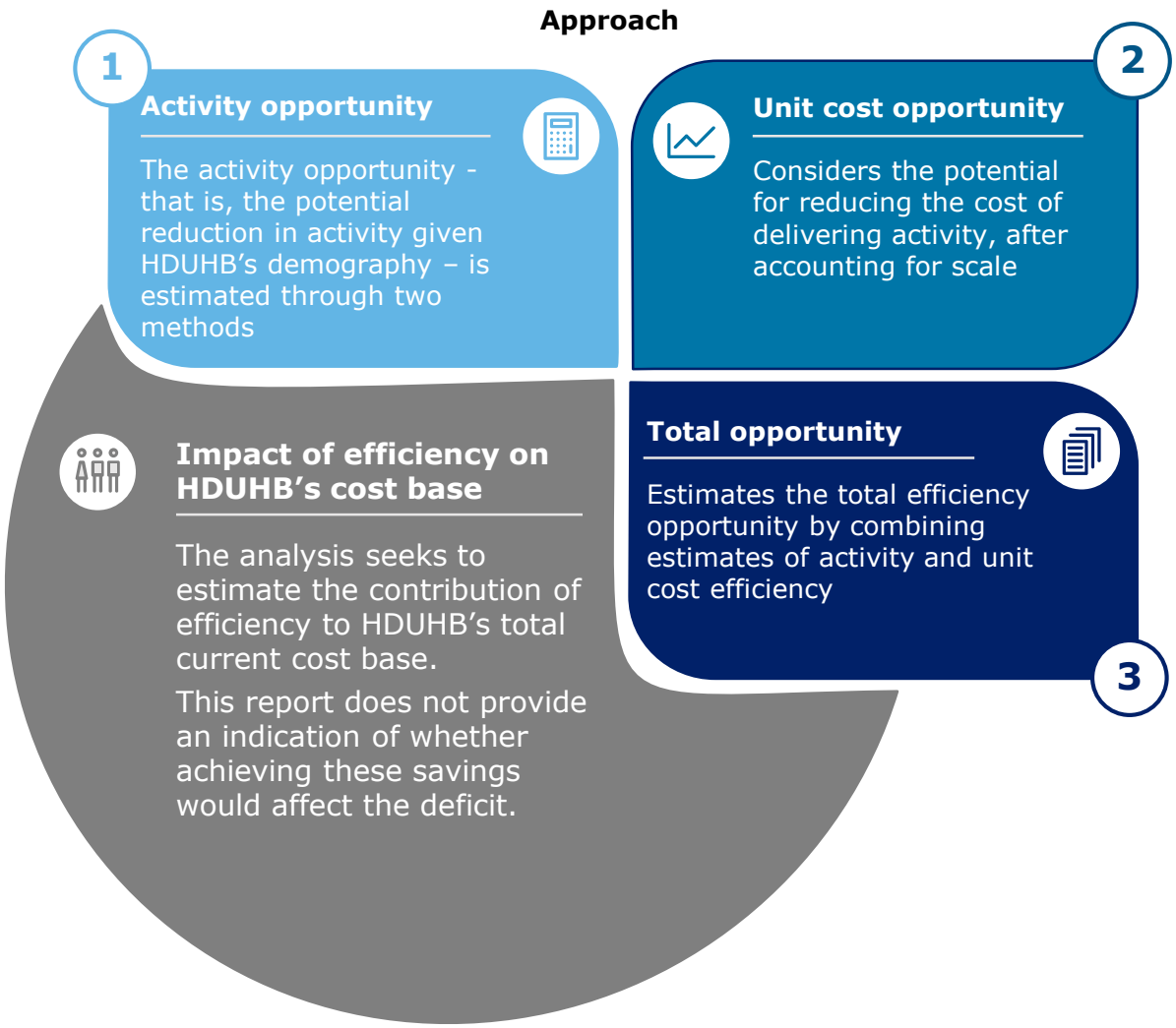
- Scale may be partially controllable if service provision were adapted to reflect changes in the population.
- Typically, there is limited ability to affect scale in the short or medium term. This is often because changes to services require formal consultation, preparation of a business case, and mobilisation to implement which can take ten years.
- The level of scale that is feasible in HDUHB even in the long term would depend on clinical strategy as to what services are needed to meet the needs of a changing population, and the optimal deployment of these services.
- As the clinical strategy is under development, a range of sensitives are tested to understand what HDUHB's cost base might be under a set of different scenarios. Depending on a range of factors the impact of scale could come to a range of different impact figures. Further work would be required later once the clinical strategy is developed to estimate these.
- The sensitivities tested suggest that, if HDUHB looked like other health economies, this could change the cost associated with having sub-scale sites.
- Estimates are hypothetical as they do not take into consideration HDUHB's specific geography or comment on whether achieving the scale of comparator health economies would be feasible for HDUHB, even in the long term.
- Any estimation of the impact of scale once a clinical strategy is developed would need to take into consideration factors such as services to be delivered, PFI, transport links among other factors to arrive at an estimated impact of changes to scale. Areas such as innovative models of care (e.g. nurse-let units) could also form part of this work.

Impact of efficiency

Impact of efficiency

Efficiency is investigated through activity and unit costs

- Despite factors such as scale and demographics affecting HDUHB's cost base, there may still be opportunity to reduce costs by achieving greater efficiency through treating patients in the most appropriate setting, reducing demand, or improving the costs involved when activity is delivered.
- The efficiency envelope has been estimated by looking at both activity levels and unit costs.



- Efficiency is a factor that is more controllable. However, depending on the changes targeted, savings may not be achievable in the short term.
- The efficiency opportunity comprises two components – activity and unit cost. Each of these is estimated in comparison to the Welsh average.
- While the analysis uses different techniques to account for overlap between efficiency and other areas (e.g. scale), in practice this is difficult and so there may still be overlap. As such, results should be treated as indicative only.
- In addition, there may be scope to achieve efficiency beyond the Welsh average. A wider opportunity is estimated with respect to activity reduction, and there might be potential for further opportunity in terms of unit costs.
- The estimated opportunity is c. 6% to 9% (£20 - £32m), which could be achievable in the medium to long term if cost pressures are not considered (for example inflation and demand growth). Cost pressures could significantly impact achievability in a given year and considerably decrease or remove the benefit of efficiency in a given year.

4 Phasing around the possible achievement of the efficiency envelope is set out based on estimates from the literature

Impact of efficiency

The efficiency envelope may be affected by less controllable factors such as scale and configuration

- When considering the level of the efficiency envelope, a number of factors may affect the level of the efficiency, which are listed below.
- There may also be areas of overlap with other factors already considered (e.g. scale and demographics).
- Some key areas of overlap or other areas that may affect costs are set out below along with approaches to account for these.
- However, in practice, it may be difficult to account for these and so the results are indicative.

Examples of the factors that may affect the efficiency opportunity (and ways the analysis considers these).

- **Minimum scale**. When calculating the impact of reducing activity, the amount of semi-fixed costs that can be removed may be limited, as the minimum scale may be reached. To the extent possible, this has been considered in the analysis by applying the estimated impact of scale to the unit cost opportunity and by **assuming only variable costs can be removed when activity is reduced**.

- **Grand-fathered services.** Some of the services provided by HDUHB have been established for many years, and may be provided by individuals that go above and beyond expectations. They may also have been able to provide services without needing to update all clinical practices. If extensive changes are made to the service to achieve efficiency, some stakeholders noted that this could lead to greater costs if clinicians in the new system are not willing to provide a similar level of service, or if new standards need to be met at a high cost.

- **Procurement limits.** For procurement, it may not be possible in some cases to procure from a wide pool of bidders. For example, ancillary services are often provided in-house in Wales, which may not be the case in England and which may limit the ability to have a diverse range of bids. This may affect costs as compared to English health economies. **The estimated efficiency as compared to the Welsh average is intended to account for differences between Wales and England**.

- **Travel time between multiple sites.** Discussion with HDUHB indicated that senior clinicians and management often operate over a number of sites or in remote locations. This may mean that staff have job-planned time for commuting, and locums may need to be paid more to commute to their sessions. To the extent possible, this has been considered in the analysis by including an **adjustment for scale to the unit cost efficiency estimates**. However, this will only capture the impact of working between sites if this is a typical characteristic of hospitals with small sites. If this is unique to HDUHB or is associated with number (rather than strict scale), this factor may be captured in the efficiency estimates.

Source: Discussions with HDUHB clinicians and service managers informed these factors

Impact of efficiency - Activity

The activity opportunity could reduce costs by £0.4m to £5.3m

A Approach A: Welsh Average

Regression based benchmarking is used to estimate the expected level of activity by LSOA, based on each LSOA's location, age, gender, and need (as set out in the National Audit Office 2012).[1] If activity is above the expected level, this could present an opportunity to reduce activity.

Indicative findings

This analysis suggests average activity is higher than the expected level. The activity reduction opportunity could be **c. 3%.**

Limitations

- Analysis is performed on outpatient referrals data and emergency admissions as proxies for the elective and non-elective pathways. It does not account for unmet need.
- Activity data used relates to Wales activity only (not activity in England). To account for the impact of this, controls for distance/time to hospitals are included, and outliers excluded.

B Approach B: Wider Opportunity

This approach models possible savings based on QIPP pathway redesign programmes, aimed to move care closer to home. These programmes are based on the NHS England Anytown model. [2]

Indicative findings

This analysis suggests activity could be reduced by **15%.**

Limitations

This analysis uses a top down approach and does not consider if similar QIPP pathways already exist in HDUHB.

C Translation into cost

Activity reduction opportunities do not themselves allow for a reduction in costs. Even if activity can be reduced, this will only reduce a portion of costs, as fixed costs and semi-fixed costs (e.g. overheads, rotas) cannot be reduced one-for-one. In addition, there is often a requirement to invest in other services (for example in primary care or the voluntary sector) to reduce activity, further reducing the net savings opportunity.

The results of approaches A and B are therefore reduced by 90% to 95% to account for re-investment and the fixed/semi-fixed costs that may not be reduced by incremental activity reductions (detail in next slides).

D Indicative findings

Estimate	Comments	Cost savings	Possible savings (£) [3]
LSOA analysis	Compared to Welsh predicted efficiency	0.1% - 0.3%	**£0.4m - £1.2m**
QIPP analysis	Estimated efficiency may go beyond Welsh average (wider opportunity)	0.6% – 1.5%	**£2.1m to £5.3m**

[1] To account for socio-economic factors, based on needs index NAO (2012). Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland
[2] Anytown tool available at: https://www.england.nhs.uk/2014/01/any-town/
[3] The reductions are based on HDUHB's acute cost base for residents, £364m, on the basis that activity reducing programmes are often place-based rather than site-based, and could affect activity of HDUHB residents outside of HDUHB hospitals.

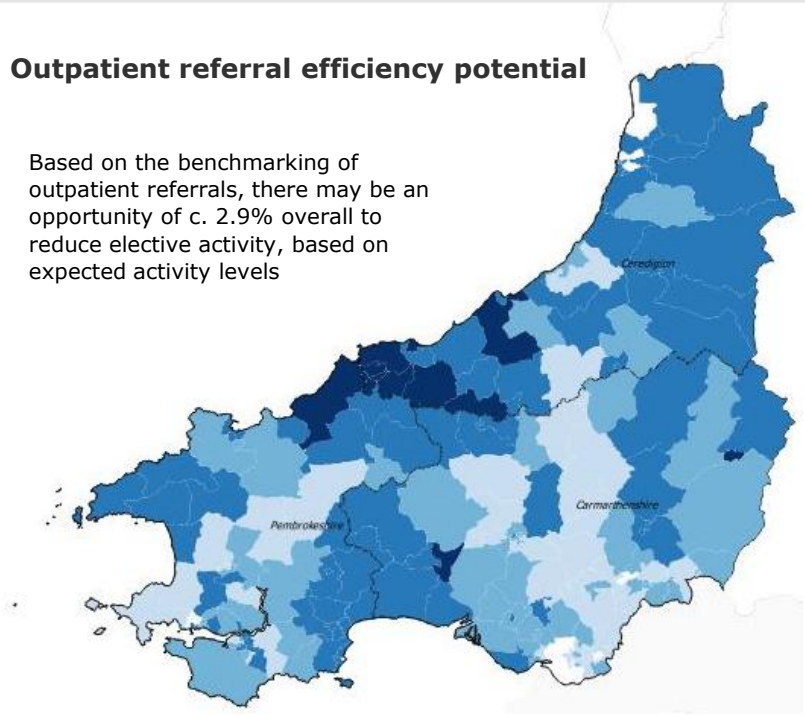
Impact of efficiency - Activity

Welsh efficiency estimate – distribution across HDUHB

- The efficiency opportunities estimated for the elective and non-elective pathways differ across HDUHB. The efficiency estimate is the level of actual activity over the level of activity expected based on an LSOA's demographics and distance to hospitals. This comparison is based on Welsh data and so is efficiency to Welsh average.
- The difference between actual and expected activity is aggregated across HDUHB to estimate the total efficiency to get to the average.
- For elective pathways, referrals are relatively higher on the western coast, while non-elective activity comes more from the south west coast and near ABMU.
- Several factors were used to estimate expected activity (i.e. location and demographic factors). Whilst this approach was guided by studies such as NAO (2012), the estimated activity levels may not account for all factors affecting cost. Further testing would be needed to confirm these results.

Outpatient referral efficiency potential

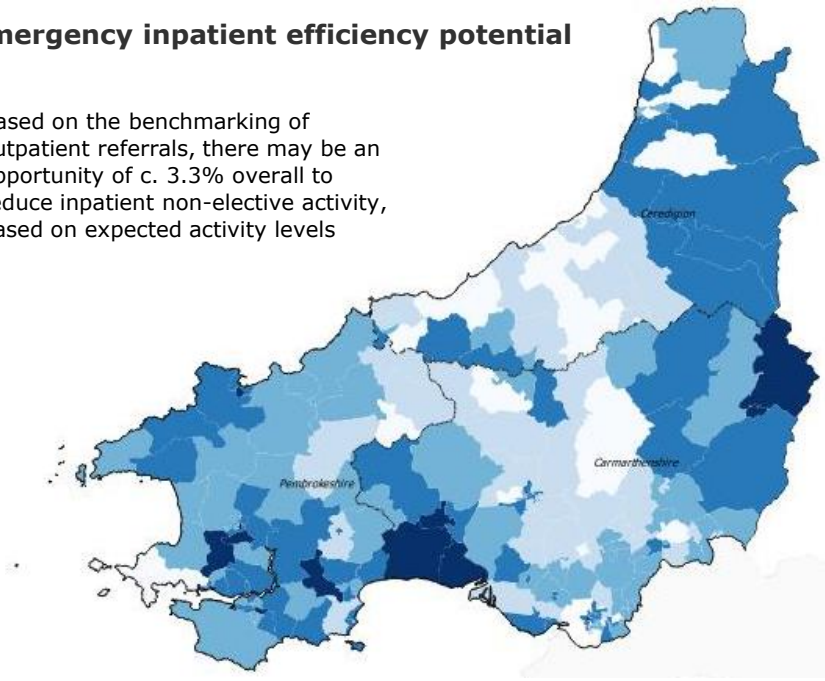
Based on the benchmarking of outpatient referrals, there may be an opportunity of c. 2.9% overall to reduce elective activity, based on expected activity levels



Source: Based on NAO (2012), ONS, referrals data by LSOA from the Welsh Government

Emergency inpatient efficiency potential

Based on the benchmarking of outpatient referrals, there may be an opportunity of c. 3.3% overall to reduce inpatient non-elective activity, based on expected activity levels



Source: Based on NAO (2012), ONS, activity data by LSOA from the Welsh Government

Legend

- Activity per capita >20% higher than expected
- Activity per capita 5% - 20% higher than expected
- Activity per capita within 5% of expected value
- Activity per capita 5% - 20% lower than expected
- Activity per capita >20% lower than expected

Impact of efficiency - Activity

Top down estimates of out of hospital QIPPs suggest a 15% activity opportunity

- To estimate the wider activity opportunity, the possible savings based on QIPP pathway redesign programmes aimed to move care closer to home are used.
- This approach indicates a possible opportunity of c. 15% activity reduction, however this is a theoretical envelope based on pathway redesign, which also requires investment. This estimate may also suggest greater efficiency, going beyond the Welsh average.

- The Anytown model [1] was developed for NHS England and CCGs to model the impact of a defined set of interventions. This model uses high level assumptions around patient cohort use of services in relatively rural, urban and suburban areas to understand how shifts in activity could impact commissioner overall costs.
- This is a top-down estimation of implementing a suite of interventions (see below). However, this does not account for local considerations including existing schemes and local population cohorts. It also does not include more highly ambitious schemes which could deliver further savings. It may therefore overestimate savings.
- Before accounting for re-investment and the translation into cost reduction – which will reduce the impact of the activity reduction (see the next slide) – the opportunity based on the set of interventions below is in the region of c. 15%. This is based on acute activity, and a population mix by patient cohort (see below) as associated with a rural health economy in England.

High Impact Interventions

That have previously been impact assessed and that have demonstrated incremental benefits.

High Impact interventions	Population cohort affected
Early diagnosis	Cancer, LTC
Reducing variability within primary care	All
Self-help: patient-carer communities	All
Telehealth/telecare	All
Case management and coordinated care	Frail/elderly
Mental Health – Rapid Assessment Interface and Discharge (RAID)	Mental health
Dementia Pathway	Dementia
Palliative care	Frail / elderly

Population cohorts

The interventions were aligned to impact one of ten population sub groups

Population cohorts
End of life care - Adults and children
Long-term conditions - Adults
Frailty/dementia - Older people
Complex needs - Adults
Long-term conditions - Children
Good health - Older people
Early years (0-4 years)
Maternity
Good health - Children
Good health - Adults

[1] Anytown tool available at: https://www.england.nhs.uk/2014/01/any-town/

Activity opportunity – Considerations

Activity reduction does not translate one-for-one into cost reduction

- Activity reduction opportunities do not translate directly into a reduction in costs as there may be **fixed or semi-fixed costs** that cannot be reduced as well as **re-investment** costs. Together, these factors reduce the estimated impact of activity reductions on the cost base by c. 90% to 95%.
- Because of HDUHB's relatively small scale, a conservative assumption is used that **cost reductions would only be c. 10% to 20%** for any activity reductions at the margin. This is based on 0% of semi-fixed costs (e.g. substantive staff) being able to be reduced if activity decreases.
- **Re-investment rates of c. 50% to 60%** would further reduce any savings, and could even increase costs depending on the programme.

Fixed, semi-fixed costs

	% reduced when activity changes [1]	% of cost base [2]
Fixed	**c. 0%**	**c. 20%**
Semi-fixed	**c. 0% – 70%[1]**	**c. 60% - 70%**
Variable	**c. 100%**	**c. 10% - 20%**

10% to 20% cost savings from activity reductions is used in the estimates

Re-investment rates (expressed in a ratio of gross to net savings)

Source	Case study	Suggested ratio
Ealing CCG[3]	Main initiatives envisaged include rapid response, case management, outpatients in the community, ICP (based on Outer NWL ICP) and UCC	33-57% (c. 40% across the five main initiatives)
Turning Point[4]	Evaluation of the Support People package for mental health patients	c. 60%
Turning Point[4]	Evaluation of the Integrated Care Co-ordination service of the Brent POPP	c. 10% – c. 30%
Turning Point[4]	Evaluation of a communication based health education programme on individual's self care and decision making	c. 50%
HM Treasury[5]	Evaluation of beneficial health outcomes through self care behaviours and reduction in demand for GP consultations	c. 70%
Croydon CCG[6]	Estimated impact of QIPP programme, 5-Year Financial Plan Update	50%
NHS North West London[7]	Shaping a Healthier Future, Pre-Consultation Business Case	c. 40%

50 - 60% re-investment rate

[1] Typical rule of thumb of up to 70% semi fixed costs can be reduced on activity reduction. However, for units closer to the minimum scale, fewer semi-fixed costs may be removed. Charlesworth and Roberts (2014) report for Nuffield Trust on Wales assumes c. 1/3 of semi-fixed can be removed. [2] Based on a range of health economies, see also Department of Health and NHS Confederation (2010) [3] Better Care, Closer to Home. Our three-year strategy for coordinated, high quality care out of hospital, 2012-2015 (2012); [4] Benefits realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care" (2010); [5] *Wanless Report: Securing good health for the whole population: Final report* (2002); [6] Croydon CCG 5-Year Financial Plan Update (2013); [7] NHS North West London, Shaping a Healthier Future, Pre-Consultation Business Case, Volume 8, Appendix C (2012)

Impact of efficiency – Unit costs

Unit cost benchmarking was performed by comparing HRGs across Wales

Wales average benchmarking

- The unit cost opportunity is estimated by performing HRG level benchmarking of HDUHB to the Welsh average based on the 2015/16 WCR2.
- The analysis compares HDUHB reference costs for each elective and non-elective inpatient HRG to the Welsh reference cost to estimate the difference in cost between HDUHB and the Welsh average.
- As the Welsh benchmarking compares across a number of more and less specialised hospitals, HRGs are excluded where the difference in unit cost is particularly high or low. The estimated efficiency based on these estimates is c. **10.8%** (10% to 12% with sensitivities), which is based on the average difference in HRG reference costs between HDUHB and the Welsh average as a percentage of cost associated with HRGs included in the analysis. [1]
- The efficiency estimate may include costs associated with scale. After taking this into account, the efficiency estimate as compared to the Welsh average is **c. 6.7%** (c. 6% to 8%, or £20m to £27m based on acute cost base at HDUHB hospitals, with sensitivities added).

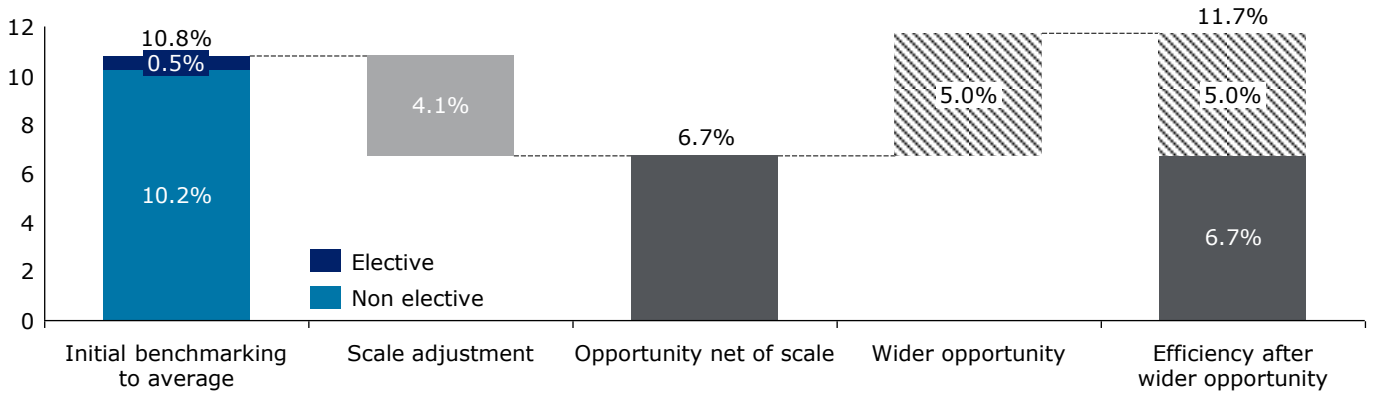
Wider opportunity

- The estimate of 6% to 8% efficiency compares HDUHB to the Welsh average. However there might be opportunity to go beyond this.
- As there are insufficient benchmarks in Wales, it is not possible to estimate meaningful stretch targets to upper quartile or decile. However, evidence from England suggests that moving from average to top decile could generate c. 5% efficiency beyond moving to average. [3]
- If this level of efficiency were to be possible, this might indicate a wider opportunity for HDUHB to reduce costs, with an envelope closer to **c. 11.7%.**
- More bottom-up efficiency analysis would be required to test whether estimates from England might also apply here.

Limitations

Whilst the scale adjustment and analysis of a subset of the cost base are techniques applied to account for the overlap between efficiency and other factors, this is difficult in practice, and figures should be viewed as indicative.

HDUHB unit cost savings compared to Welsh average and wider opportunity [2]

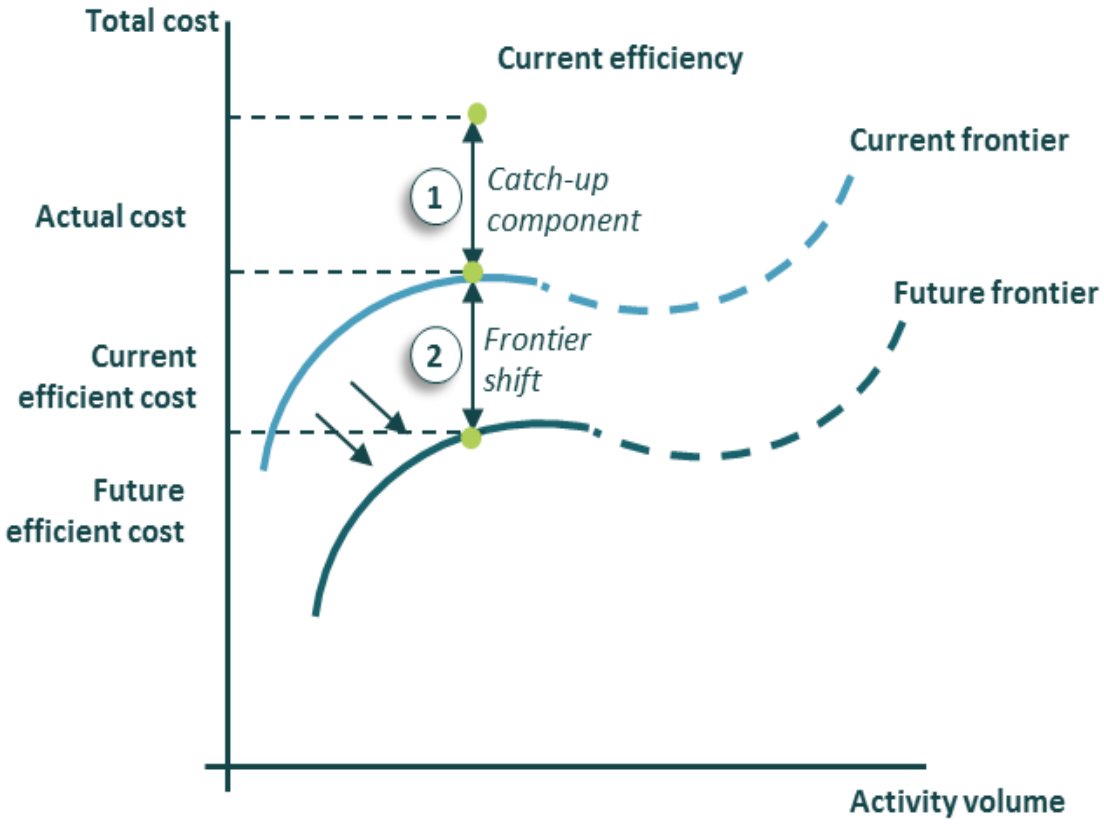


[1] To focus on cost differences that are representative of the majority of HDUHB activity, HRGs that are below the 20th percentile in terms of volume are excluded from analysis (the 20th percentile is 8 and 7 episodes in the year for elective and non-elective activity respectively). After suppression of small numbers below 5. Range is based on the number of HRGs excluded to account for more specialist activity. These exclude the top and bottom 15%,(range 10% to 20%) of HRGs. [2] Unit cost savings based on analysis of WCR2 data. Excludes the top 20 percentile of HRGs by volume for HDUHB, and is based on unit cost data differences at the HRG level excluding the top 15% and bottom 15%, and may include specialties relating to e.g. mental health care. Also see Deloitte (2014); [3] See Deloitte (2014).

Impact of efficiency - Short, medium and long term

Efficiency can be thought of as a catch-up component – the efficiency envelope estimated at c. £20m - £32m – and an additional frontier shift

The overall efficiency savings envelope is a function of the catch-up component and the sector wide frontier shift:



1

Catch-up component

- Captures the efficiency savings associated with the provider becoming as efficient as the most efficient comparable provider in the sector
- The catch-up component is provider specific and allows for benchmarking and the assessment of current provider efficiencies
- This has been estimated as efficiency compared to the Welsh average and the wider opportunity. Typically, catch up is defined in terms of the upper quartile or decile of achievement, rather than average achievement

2

Frontier shift

- Captures efficiency savings from potential future sector wide productivity gains due to technological advances or service delivery optimisations
- This is the forward looking component of the efficiency factor and aims to capture the dynamic productivity change within the sector
- This is assessed based on available literature[1]

[1] *Incl.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499594/2016/17_national_tariff_statutory_consultation.pdf ; Roberts and Charlesworth (2014), *A Decade of Austerity in Wales?* Nuffield Trust

Impact of efficiency - Short, medium and long term

Every year, efficiency of c. 3% could be targeted, of which c. 1.7% to 2.5% may help achieve the efficiency envelope

3 Total efficiency in year

Yearly: c. 3%

The amount of efficiency that could be achieved in a given year is typically limited. As a yearly envelope, estimates between c. 2% and 4% are commonly cited as what may be achievable in terms of total efficiency in a year.[1] The analysis uses an estimate of 3% yearly as the achievable efficiency target.

The 3% total efficiency comprises a catch-up component and a frontier shift component, which cannot be distinguished in practice. Assuming that the frontier shift each year accounts for c. 0.5% to 1.3% of the 3% efficiency achievable in a given year, only c. 1.7% to 2.5% of catch-up component can be achieved per year. This limits the rate at which the 6% to 9% efficiency envelope can be achieved. The achievement of the efficiency envelope would need to be phased over several years based on this.

1 Catch - up component

Overall Efficiency Envelope: 6% - 9% total
with c. 1.7% to 2.5% possible per year

- The efficiency envelope of 6% to 9% (compared to Welsh average) relates to the amount of savings that might be available if HDUHB were as efficient as the Welsh average (after accounting for scale). This is the catch-up component.
- The amount of catch-up in year (i.e. the amount by which the efficiency envelope can be reduced) is based on the total efficiency envelope of c. 3% less the frontier shift (c. 0.5% to 1.3%). This suggests c. 1.7% to 2.5% of the 6% - 9% envelope could be achieved each year.
- Cost pressures are not considered in the estimates. If cost pressures grow, catch-up efficiency achievement in year may not contribute to reducing the deficit.

2 Frontier Shift

Yearly : 0.5% to 1.3%

Based on available literature, the frontier shift in the acute sector has been estimated to be in the region of 0.5% to 1.3%. [2]

This would be realised each year as technology and productivity across the sector improves. The frontier shift forms part of the total 3% efficiency possible in year, reducing the amount of efficiency that could relate to improvement relative to peers (i.e. the amount relating to the efficiency envelope estimated for HDUHB based on the Welsh average).

[1] *Incl.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499594/2016/17_national_tariff_statutory_consultation.pdf ; Roberts and Charlesworth (2014)
[2] Monitor cited a level of c. 2% to 4% savings in year (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499594/2016/17_national_tariff_statutory_consultation.pdf), Roberts and Charlesworth (2014) works up to an estimate of 3.9% based on pay, managing chronic conditions, acute productivity, and other areas. Audit Commission and Monitor (2012) *Delivering Sustainable cost improvement programmes.* Watt and Roberts (2016) note that a maximum (including change s to pay) would be efficiency of c. 2.6%

Impact of efficiency - Short, medium and long term

The efficiency envelope could be phased in over three to six years

- Using an estimate of total efficiency of 3% and a frontier shift estimate of 1.3% or 0.5%, the catch-up (efficiency envelope) that could be reduced in each year is estimated at c. 1.7% to 2.5%.
- With an efficiency envelope of c. £20m, this catch up could be phased in around three to four years under the high and low cases and based on total efficiency achievement of 3% per year. With an efficiency envelope of c. £32m, this could be phased in over three years in the high case and over five (six) in the low case.
- All figures are indicative as further work would be needed to test and scope the possible opportunity.

High

Assumptions (real values)		Source	2017/18	2018/19	2019/20	2020/21	2021/22
Total efficiency	**Total efficiency**	(N1)	3.00%	3.00%	3.00%	3.00%	3.00%
	Frontier shift	(N2)	0.50%	0.50%	0.50%	0.50%	0.50%
	Catch-up component		2.50%	2.50%	2.50%	2.50%	2.50%
Possible catch up (catch up less demand pressure, %)			2.50%	2.50%	2.50%	2.50%	2.50%
Possible catch up (on a static 2015/16 cost base for comparison, £m)			-£9.1	-£8.9	-£8.7	-£8.4	-£8.2
Cumulative catch up possible by this year, £m			**-£9.1**	**-£18.0**	**-£26.6**	**-£35.1**	**-£43.3**

Efficiency envelope of c. £32m possible by 2020/21; Efficiency envelope of £20m possible by 2019/20

Low

Assumptions (real values)		Source	2017/18	2018/19	2019/20	2020/21	2021/22
Total efficiency	**Total efficiency**	(N1)	3.00%	3.00%	3.00%	3.00%	3.00%
	Frontier shift	(N3)	1.30%	1.30%	1.30%	1.30%	1.30%
	Catch-up component		1.70%	1.70%	1.70%	1.70%	1.70%
Possible catch up (catch up less demand pressure, %)			1.70%	1.70%	1.70%	1.70%	1.70%
Possible catch up (on a static 2015/16 cost base for comparison, £m)			-£6.2	-£6.1	-£6.0	-£5.9	-£5.8
Cumulative catch up possible by this year, £m			**-£6.2**	**-£12.3**	**-£18.3**	**-£24.1**	**-£29.9**

Efficiency envelope of c. £32m possible by 2022/23; Efficiency envelope of £20m possible by 2020/21

N1 Monitor cited a level of c. 2% to 4% savings in year (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499594/2016/17_national_tariff_statutory_consultation.pdf), Roberts and Charlesworth (2014), work up to an estimate of 3.9% based on pay, managing chronic conditions, acute productivity, and other areas. Audit Commission and Monitor (2012) *Delivering Sustainable cost improvement programmes*. Watt and Roberts (2016) note that a maximum (including change s to pay) would be efficiency of c. 2.6%.
N2 Roberts and Charlesworth (2014)
N3 Deloitte (2014)

Appendix

Peer group analysis

Peer group selection

Peer health economies were used to estimate the impact of geography (remoteness)

A set of peer health economies was selected for HDUHB based on the three tier approach set out below:

- **A methodology similar to RightCare was used to select a long list of 20 health economies that were demographically similar to HDUHB, and 20 that were demographically similar and remote**. RightCare was developed by NHS England to provide each English CCG with a peer group of 10 similar health economies to assess savings and quality opportunities. The approach combines a set of demographic metrics (including four age brackets, ethnicity, and deprivation metrics) and geographic metrics (including rurality and size metrics) to determine the relevant peer group. This method was used to combine and include metrics to generate 20 peers based on demography and geography.
- **Two to three health economies that are demographically similar** (but are not remote) to serve as a point of triangulation for understanding the impact of geography were selected from the 20 demographically similar peers. These were Thanet CCG, Castle Point and Rochford CCG, and ABMU.
- **Two to three very similar health economies** to sense-check peer benchmarking estimates were selected from the demographically and geographically similar peers. Cumbria CCG, Kernow CCG, and BCUHB were selected.

Factors included in peer group analysis (by type)

Age
Based on five age bracket groups

Deprivation
Based on income and life expectancy

Other demographic factors
Including gender distribution and non-white population share

Geography
Based on population density and rurality classification

Other variables
Based on Referral to Treatment (RTT) waiting times (not included in all specifications)

Peer group includes health economies in Wales (health boards) and England (CCGs)

There are differences between the two health systems which mean that local economies in either system are not fully comparable

Comparator health economies: NHS Thanet CCG

Demographically similar health economy

NHS Thanet CCG's age profile is similar to HDUHB with 9.4% and 9.5% of the population aged 75 and older respectively in 2015.[3] Compared to HDUHB, Thanet is characterised by a higher share of non white British population and a significantly higher population density reflecting Thanet's urbanisation.[4]

Even though NHS Thanet is demographically similar, its high level of urbanisation lead to a different profile compared to HDUHB

Performance

Factor	Thanet CCG
Operating surplus 15/16[1]	£2.1m
CQC rating[2]	Requires improvement
Emergency admissions[2]	77,910
Beds for primary trusts[2]	1,015
Main acute hospitals	Queen Elizabeth The Queen Mother Hospital

Demographic profile

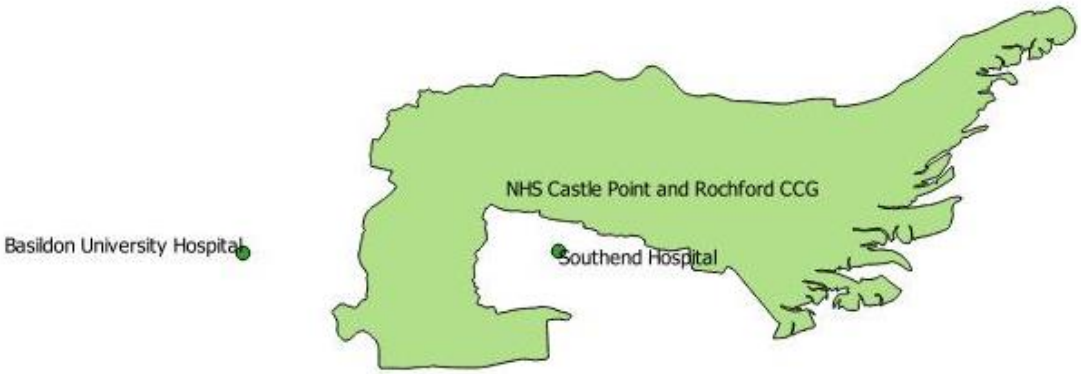
Factor	Thanet CCG	HDUHB
% 75 years and over[5]	9.4%	9.5%
% Age 24 – 75[5]	61.1%	61.8%
Ethnicity (2011)[6]	9.6%	4.9%
Population density[7]	13.5	0.7
Population (m)[8]	0.14	0.38
Life expectancy (F/M)[9]	82.5/77.6	82.9/79.2

Source: ONS, Census 2011

[1] Thanet CCG Annual Report and Accounts 2015/16
[2] NHS Thanet CCG is primarily associated with the provider East Kent Hospitals University FT; 2016 CQC rating, HES Online 2015/16, ERIC returns 2013/14
[3] ONS, population estimates by clinical commissioning group, mid year 2015
[4] Nomis, 2011 Census and ONS RUC2011 Classification
[5] ONS, population estimates by clinical commissioning group, mid year 2015
[6] Nomis, 2011 Census data, proportion of non white British ethnicity
[7] ONS, Population density persons per hectare
[8] ONS, population estimates by clinical commissioning group, mid year 2015
[9] ONS 2010 - 12; ONS 2010 - 2014

Comparator health economies: NHS Castle Point and Rochford CCG

Demographically similar health economy



Performance

Factor	C P & R CCG
Surplus 15/16[1]	£2.2m
CQC rating[2]	Requires Improvement
Emergency admissions[2]	34,203
Beds for primary trusts[2]	619
Main acute hospitals in area	Southend Hospital; Basildon University Hospital

Demographic profile

Factor	CP & R CCG	HDUHB
% 75 years and over[5]	9.6%	9.5%
% Age 24 – 75[5]	63.4%	61.8%
Ethnicity[6]	4.5%	4.9%
Population density[7]	8.1	0.7
Population (m)[8]	0.17	0.38
Life expectancy (F/M)[9]	82.6/79.7	82.9/79.2

Source: ONS, Census 2011

NHS Castle Point and Rochford's age profile is highly similar to HDUHB with 9.6% and 9.5% of the population aged 75 and older respectively.[3] HDUHB and Castle Point and Rochford are characterised by similar shares of non white British population, while the latter has a significantly higher population density reflecting its urbanisation.[4]

Even though NHS Castle Point and Rochford CCG is demographically similar, its high level of urbanisation lead to a different profile compared to HDUHB.

[1] Castle Point ant Rochford CCG Annual Reports and Accounts
[2] Castle Point and Rochford CCG is primarily associated with Southend University Hospital FT; CQC (2017), HES online (2015/16); ERIC returns (2013/14)
[3] ONS, population estimates by clinical commissioning group, mid year 2015
[4] Nomis, 2011 Census and ONS RUC2011 Classification
[5] ONS, population estimates by clinical commissioning group, mid year 2015
[6] Nomis, 2011 Census data, proportion of non white British ethnicity
[7] ONS, Population density persons per hectare
[8] ONS, population estimates by clinical commissioning group, mid year 2015
[9] Based on ONS and Nomis data, ONS 2010 - 12; ONS 2010 - 2014

Comparator health economies: ABMUHB

Demographically similar health economy

Abertawe Bro Morgannwb University Health Board's age profile is highly similar to HDUHB with 62.5% and 61.8% of the population aged 24 to 75 respectively.[4] HDUHB and ABMUHB are characterised by similar shares of non white British population, while the latter has a significantly higher population density reflecting its urbanisation.[5]

Even though ABMUHB is broadly similar, it lower share of 75 years and over (8.1% against 9.5%) and higher population density gives ABMUHB a different profile than HDUHB.[6]

Performance

Factor	ABMUHB
Surplus 15/16[1]	£0.1m
CQC rating	N/A
Emergency admissions[2]	65,378
Beds for primary hospitals[3]	1,153
Main acute hospitals in area	Morriston Hospital, Princess of Wales Hospital, Singleton Hospital

Demographic profile

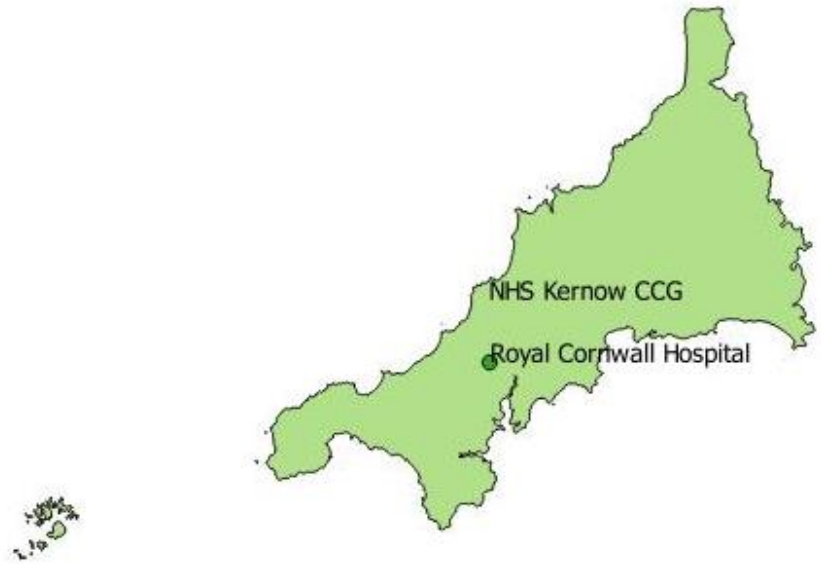
Factor	ABMUHB	HDUHB
% 75 years and over[7]	8.1%	9.5%
% Age 24 – 75[7]	62.5%	61.8%
Ethnicity[8]	4.5%	4.9%
Population density[9]	4.9	0.7
Population[10]	0.53	0.38
Life expectancy (F/M)[11]	81.7/77.4	82.9/79.2

Source: ONS, Census 2011

[1] Abertawe Bro Morgannwg University Health Board, 2016, annual report
[2] Patient Episode Dataset for Wales (2015-16)
[3] StatsWales NHS beds by organisation and site
[4] StatsWales, population estimates by local health board, 2015
[5] Nomis, 2011 Census and ONS RUC2011 Classification
[6] *StatsWales*, population estimates by local health board, 2015
[7] StatsWales, population estimates by local health board, 2015
[8] Nomis, 2011 Census data, proportion of non white British ethnicity
[9] ONS, Population density persons per hectare
[10] StatsWales, population estimates by local health board, 2015
[11] ONS 2010 - 2014

Comparator health economies: NHS Kernow CCG

Demographically and geographically similar health economy



NHS Kernow's age profile is highly similar to HDUHB with 9.5% of the population aged 75 and older for both organisations.[3] HDUHB and Kernow are characterised by similar shares of non white British population, while the latter has a slightly higher population density reflecting.[4] Kernow CCG has a significantly lower level of deprivation.

Kernow CCG and HDUHB are demographically highly similar and exhibit similar levels of population density, however, the former's population is less deprived.

Performance

Factor	NHS Kernow CCG
Surplus 15/16[1]	-£17.4m
CQC rating[2]	Requires improvement
Emergency admissions[2]	41,462
Beds for main trust[2]	699
Main acute hospitals	Royal Cornwall Hospital St Michael's Hospital West Cornwall Hospital

Demographic profile

Factor	Kernow CCG	HDUHB
% 75 years and over[5]	9.5%	9.5%
% Age 24 – 75[5]	63.5%	61.8%
Ethnicity[6]	4.3%	4.9%
Population density[7]	1.5	0.7
Population (m)[8]	0.55	0.38
Life expectancy (F/M)[9]	83.5/79.5	82.9/79.2

Source: ONS, Census 2011

[1] Kernow CCG Annual Report and Accounts 2015/16
[2] NHS Kernow CCG is primarily associated with Royal Cornwall Hospitals FT and Plymouth Hospitals FT. CQC (2016); HES Online 2015/16; ERIC returns 2013/14 relate to Royal Cornwall only
[3] ONS, population estimates by clinical commissioning group, mid year 2015
[4] Nomis, 2011 Census and ONS RUC2011 Classification
[5] ONS, population estimates by clinical commissioning group, mid year 2015
[6] Nomis, 2011 Census data, proportion of non white British ethnicity
[7] ONS, Population density persons per hectare
[8] ONS, population estimates by clinical commissioning group, mid year 2015
[9] ONS 2010 - 12; ONS 2010 - 2014

Comparator health economies: Betsi Cadwaladr UHB

Demographically and geographically similar health economy

BCUHB's age profile is similar to HDUHB with 9.0% and 9.5% of the population aged 75 and older.[4] HDUHB and BCUHB are characterised by similar shares of non white British population, while the latter has a slightly higher population density.[5] BCUHB has a slightly lower level of deprivation.[6]

BCUHB and HDUHB are demographically highly similar and exhibit similar levels of population density and deprivation deprived.

Performance

Factor	BCUHB
Surplus 15/16[1]	-£19.5m
Emergency admissions[2]	74,291
Beds[3]	2,300
Main acute hospitals in area	• Glan Clwyd Hospital • Wrexham Maelor Hospital • Ysbyty Gwynedd

Demographic profile

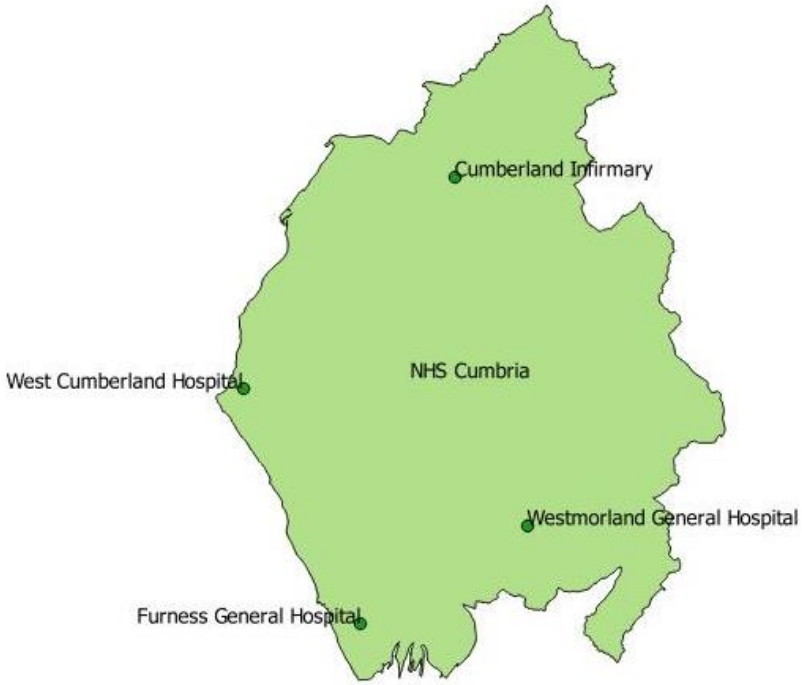
Factor	BCUHB	HDUHB
% 75 years and over[7]	9.0%	9.5%
% Age 24 – 75[7]	62.7%	61.8%
Ethnicity[8]	5.0%	4.9%
Population density[9]	1.1	0.7
Population (m)[10]	0.69	0.38
Life expectancy (F/M)[11]	82.4/78.7	82.9/79.2

Source: ONS, Census 2011

[1] Betsi Cadwaladr University Health Board, 2016, annual report
[2] Patient Episode Dataset for Wales (2015-16)
[3] StatsWales NHS beds by organisation and site
[4] StatsWales, population estimates by local health board, 2015
[5] Nomis, 2011 census and ONS RUC2011 Classification
[6] Welsh government, Welsh Index of Multiple Deprivation, 2014
[7] StatsWales, population estimates by local health board, 2015
[8] Nomis, 2011 Census data, proportion of non white British ethnicity
[9] ONS, Population density persons per hectare
[10] StatsWales, population estimates by local health board, 2015
[11] ONS 2010 - 2014

Comparator health economies: NHS Cumbria CCG[1]

Demographically and geographically similar health economy



NHS Cumbria CCG's age profile is similar to HDUHB with 9.4% and 9.5% of the population aged 75 and older.[4] Cumbria CCG is characterised by lower shares of non white British population and lower deprivation.[5] Both organisations have very similar levels of population density and are similar in overall size.

Cumbria CCG and HDUHB are demographically highly similar and exhibit similar levels of population density, while the former experiences less deprivation.

Performance

Factor	Cumbria CCG
Surplus 15/16[2]	£0.1m
CQC rating[3]	Requires improvement
Emergency admissions[3]	72,740
Beds for primary trusts[3]	1,721
Main acute hospitals	• West Cumberland Hospital • Furness General Hospital • Westmorland General Hospital • Cumberland Infirmary

Demographic profile

Factor	Cumbria CCG	HDUHB
% 75 years and over[6]	9.4%	9.5%
% Age 24 – 75[6]	64.5%	61.8%
Ethnicity[7]	3.4%	4.9%
Population density[8]	0.6	0.7
Population (m)[9]	0.32	0.38
Life expectancy (F/M)[10]	82.4/78.8	82.9/79.2

Source: ONS, Census 2011

[1] NHS Cumbria CCG was split in 2017 with part of the area becoming North Cumbria CCG and another part being absorbed into North Lancashire CCG
[2] Cumbria CCG Annual Report and Annual Accounts 2015/16
[3] NHS Cumbria CCG is primarily associated with North Cumbria University FT, Cumbria Partnership FT and University hospitals of Morecambe Bay FT. CQC (2016, 2017); HES Online (2015/16); ERIC returns (2013/14)
[4] ONS, population estimates by clinical commissioning group, mid year 2015
[5] Nomis, 2011 Census and ONS RUC2011 Classification
[6] ONS, population estimates by clinical commissioning group, mid year 2015
[7] Nomis, 2011 Census data, proportion of non white British ethnicity
[8] ONS, Population density persons per hectare
[9] ONS, population estimates by clinical commissioning group, mid year 2015
[10] ONS 2010 - 12; ONS 2010 - 2014

Allocation formula

The Wales allocation formula

While the allocation formula is not reviewed in this report, presented below is a high level summary of possible areas of overlap with this review

- The Wales allocation formula constructs a weighted population estimate for each health board based on relative need, age and rurality.
- While this report does not seek to comment on the allocation formula, there are some indicators that are not included in the index and will therefore be considered further for the purposes of this analysis. These are set out below.

Factors considered as part of the zero based review

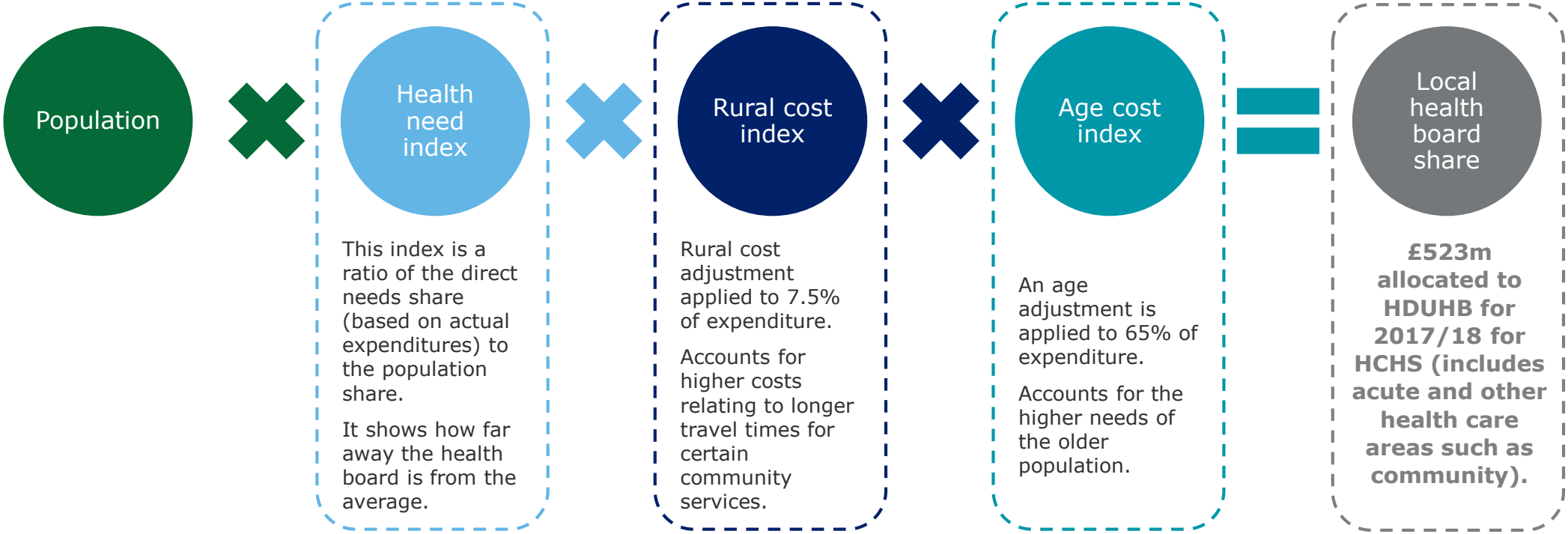
Factors	Included	Considerations
Demographics		
Age	✓	Age is the only demographic factor to be considered directly as part of the allocation formula, reflecting the higher cost of healthcare realised by an older population profile. Even though the allocation formula accounts for age, the zero based review considers this alongside the other demographic factors, in particular the interaction with gender.
Deprivation	✗	Deprivation is not considered in the formula but it may be indirectly reflected through the health needs index component as an area with higher levels of deprivation is more likely to have a higher health need.
Gender	✗	Gender is not included as a component of the formula but could be partly accounted for by the health needs index as an area with a higher proportion of females may be more likely to have a higher health need. This factor is analysed as part of the demographic analysis.
Rurality		
Travel time	✓	Travel time for community services is considered as part of the allocation formula and is not considered as part of this zero based review.
Recruitment and retention	✗	Health boards in rural areas may find it more difficult to recruit and retain staff resulting in higher spending on agency staff. This factor is not considered as part of the rurality adjustment and is analysed as part of this review.
Scale	✗	In addition to the impact on travel times in the community, small hospitals may have to operate in remote areas to provide access, even though the population served is relatively small. This could lead to inefficient scale, which contributes to cost.

The Wales allocation formula

Resources are allocated according to the direct needs model which accounts for health need, rurality and age

- Over the past decade, the National Assembly for Wales has developed a methodology used to allocate resources across Wales.
- A report in 2001 recommended the adoption of the direct needs allocation model and a report in 2005 highlights how this model can help to achieve a fair distribution of health budget across Wales.[1]
- Resources are allocated across Wales by taking the local health board's population and multiplying it by a series of indices - an index that measures the health need of the health board's population **(Health need index)**, an index that accounts for the rurality of the health board **(Rural cost index)** and an index that accounts for the age profile of the health board **(Age cost index)** - to arrive at a final weighted population.
- As part of the phase 1 of the Resource Allocation Review, between June 2011 and December 2014, the datasets underlying this model were updated as new and more relevant data became readily available.[3]

The Direct Needs Allocation Model[2]



[1] Targeting poor health: Professor Townsend's Report of the Welsh Assembly's National Steering Group of the Allocation of NHS Resources (Vol 1), 2001
[2] Inequalities in Health: The Welsh Dimension 2002-2005, The Welsh Assembly Government, 2005.
[3] "Briefing on Resource Allocation Formula Target Shares", provided to Deloitte by the Welsh Government.

The Wales allocation formula

The health needs index indicates that HDUHB is below average

- As part of the allocation formula, population is adjusted by the health needs index.
- The health needs index can be used to understand the relative need of health boards across Wales.
- It is based on a formula for calculating the direct needs target share and the share of the population for each of the health boards.

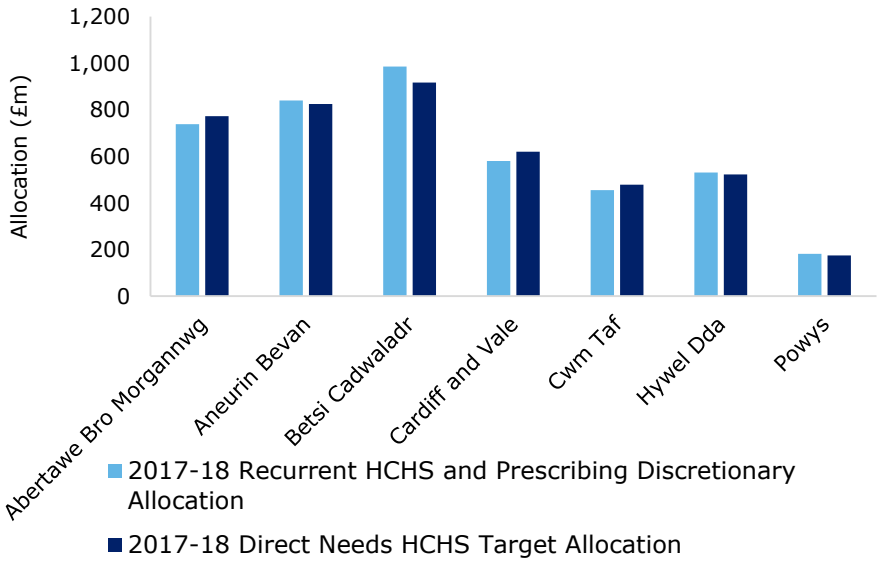
The **direct needs target share** reflects each health board's share of total spend on healthcare services. This is calculated by applying the share of registrations for a selection of conditions to the total spend in Wales of the condition. Combining these provides an overall needs share. This is then applied to the population share in order to calculate the **health needs index** for each health board.

Needs index[1]

Health Board	Direct needs target share	Population share	Needs index
Abertawe Bro Morgannwg	17.9%	16.9%	1.06
Aneurin Bevan	19.1%	18.7%	1.02
Betsi Cadwaladr	21.3%	22.4%	0.95
Cardiff and Vale	14.4%	15.8%	0.91
Cwm Taf	11.1%	9.5%	1.17
HDUHB	12.1%	12.4%	0.98
Powys	4.1%	4.3%	0.94

Source: 2017-18 Allocations Target Shares, The Welsh Government

Direct needs target allocation and distance from target[1]



Source: 2017-18 Allocations Target Shares, The Welsh Government

A value of **0.98** implies that the relative need of HDUHB is 2% lower than the national average.

[1] This is based on figures provided to Deloitte by The Welsh Government

The Wales allocation formula

The population is adjusted for rurality and age

- A health board's population is also adjusted for two factors that have been shown to contribute to the cost of providing healthcare: rurality and age.
- The rural cost adjustment reflects travel-intensive community services.
- The age adjustment reflects the inpatient share of costs.

Rural cost index[1]

- A rural cost adjustment is applied to 7.5% of expenditure on community services
- This adjustment reflects the cost impact of providing community services to a rural area e.g. district nursing will require a longer travel time in rural areas
- A methodology developed in Scotland is applied to the Welsh population distribution which takes account of the excess costs of supplying health care in different urban-rural areas[2]
- This component aims to account for a relationship between the urban-rural setting and the unit cost of the activity
- For community services, this index is calculated on the basis of:
  1. Estimated contact durations for travel-based services
  2. For clinic-based services, rurality weighting from the Scottish Allocation Formula for GP funding

Age cost index

- An age adjustment is applied to 65% of total expenditure on healthcare
- This adjustment reflects the cost impact of an older population demographic given older people may be more likely to have e.g. higher length of stay
- The index is based on evidence of the additional hospital costs per case for older people
- Therefore, the formula reflects the impact of an older population through the following:
  - The needs of older people are reflected within the health needs index
  - The additional costs of treating older people is reflected in the age cost index

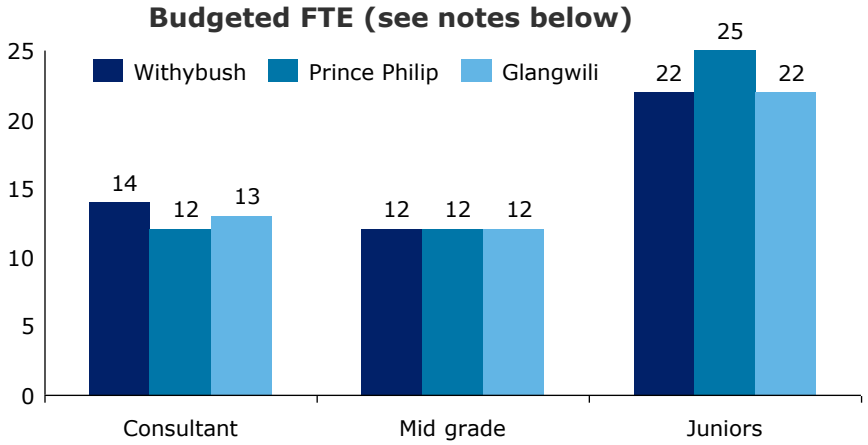
[1] Inequalities in Health: The Welsh Dimension 2002-2005, Welsh Assembly Government, 2005.
[2] How the Resource Allocation Formula works in practice., Information Services Division Scotland.

Sensitivities - scale

Impact of scale – case study

Acute medicine rotas are similar across sites

- Rotas were studied through discussions with HDUHB consultants and service managers to understand the acute medicine service in three sites.
- Three sites studies – Withybush (more remote) and Glangwili and Prince Philip (less remote) – had similar levels of budgeted staff and target rotas.
- The number of mid-grade staff budgeted allows for 1 in 11 rota cover in each hospital in line with Royal College guidelines.
- However, in practice, some sites – Glangwili and Withybush – have challenges with vacancies. This puts pressure on the on-call rotas as there are fewer than 11 mid-grade staff to cover the rota without extra hours or agency/locum cover. In addition, unless efforts are made to ensure that the trainee's training does not suffer from frequent on-calls, that may lead to low morale and affect the desire of future trainees to choose a hospital.



Withybush

At Withybush, for unscheduled acute medicine there are 14 consultants (not all full time, and not all of which participate in the on-call rota), with a 1 in 8 on-call rota with 122 beds.

There are 12 budgeted middle grades, of which 10 are filled and 8 are substantive staff that participate in the on-call rota. While the rota is intended to be 1 in 12, it can be 1 in 9. Agency and added duty hours help complete the rota.

Glangwili

Glangwili has 10 consultants and three clinical decision unit (CDU) consultants full time for acute medicine. This covers seven wards (c. 130 beds) and the CDU with c. 20 to 25 admissions per day. In addition to this, consultants work across sites, with e.g. cardiology consultants providing care across sites for pace-making, angiography, and other areas.

While there are 12 budgeted mid-grades and a 1 in 12 rota, usually only 7 or 8 of these are substantive in-post. The on-call rota is then filled with locums (internal and external) or staff being pulled out of normal duties.

Prince Philip

Prince Philip has 12 budgeted consultant posts for acute medicine, of which one is vacant and a 1 in 11 rota. This relates to five wards, CCU and acute medical assessment unit, through which acutely ill patients can be received and admitted into the hospital

For mid grades, there are 12 budgeted posts, with a limited number of vacancies and a 1 in 11 rota.

Source: Discussions with HDUHB clinicians and service managers

Impact of scale - Short, medium and long term

Sensitivities on the cost of scale were developed based on a set of benchmark health economies

- Estimates are hypothetical as they do not take into consideration HDUHB's specific geography or comment on whether achieving the scale of comparator health economies would be feasible for HDUHB.
- The estimates set out only consider the impact to cost based on scale, and do not comment on any innovative models (e.g. nurse-led units) employed by the comparator health economy or remoteness.

To arrive at sensitivities, HDUHB is benchmarked against other health economies in terms of scale. The health economies benchmarked – Kernow, Northumberland, and Gloucestershire – were selected based on discussion with HDUHB.

The method applied when benchmarking HDUHB to other health economies is as follows:

1. **Understand the hospital pattern of the comparator health economy.** The number of beds per site is used to understand the distribution of activity between sites at the comparator hospital organisation.[1]

2. **Compare the scale of HDUHB to the comparator health economy to exclude very dissimilar providers.** For example, Dorset was initially considered as a comparator health economy based on discussions with HDUHB. However, Dorset has much less A&E activity than HDUHB, and so may be less comparable.

3. **Apply HDUHB's activity levels to the comparator health economy so it is the same size to benchmark against HDUHB.** The comparator health economies have different levels of case-mix adjusted activity than HDUHB. To allow for comparison based on the same activity level, the hospital pattern (i.e. estimated distribution of activity between sites) of the comparator is fit with HDUHB's level of activity. This enables comparison between hospital patterns on the same base.

4. **Estimate the impact of scale.** Once HDUHB are comparable based on size, the NHS England (2015b) model calibrated to Wales is applied. The comparator health economy's unit cost is estimated based on the activity per site. The difference between the unit cost of the comparator health economy and HDUHB is used to estimate the opportunity to benchmark.

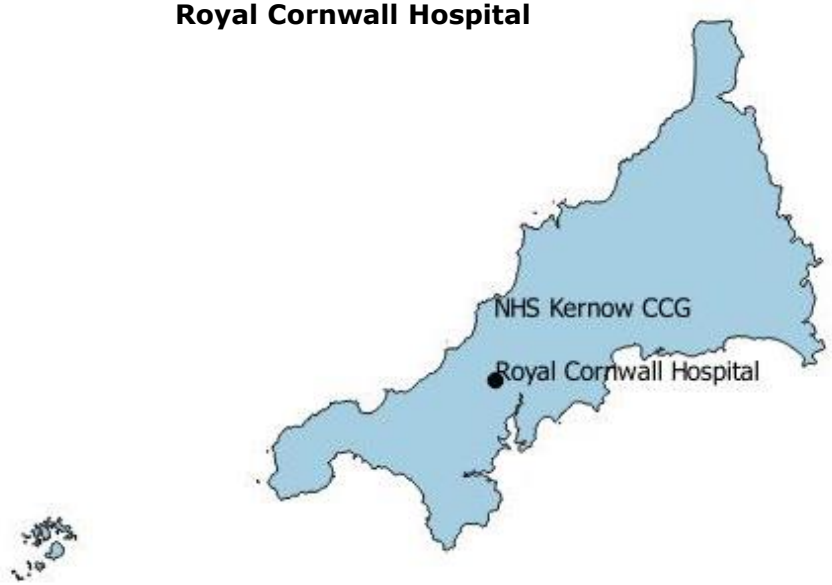
[1] Based on Estates Return Information Collection data, 2013/14 (most recent available)

Impact of scale - Short, medium and long term

Sensitivity I: Royal Cornwall Hospital

- The first comparator is Royal Cornwall Hospital NHS Trust. Royal Cornwall Hospital operates over a single hospital site, and had turnover of £355.8m in 2015-16, with c. 85k A&E attendances in 2015-16.[1]
- If HDUHB had a hospital pattern similar to Royal Cornwall Hospital, it could have a greater scale than that Welsh average site, and might not be at a disadvantage due to scale. However, this analysis does not account for different geographies (e.g. travel times).

Royal Cornwall Hospital

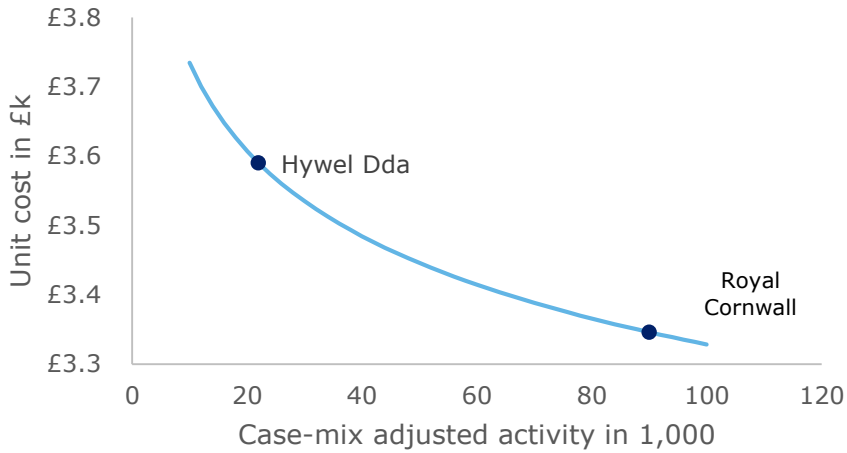


Royal Cornwall Hospital is a hospital provider located in the south west of England and operates one acute hospital with 699 acute beds.[1, 2] The provider had an operating income of £355.8m and generated an operating deficit of £4.6m in 2015/16.[3]

The provider's CQC rating of "Requires Improvement" indicates that the trust faces quality challenges in addition to the financial gap.[4]

[1] A&E Activity data based on A&E Monthly Statistics, NHS Digital and HSJ. Royal Cornwall Hospital 2015/16 Annual Report (deficit)
[2] ERIC Returns 2013/14
[3] Royal Cornwall Hospital 2015/16 Annual Report (deficit)
[4] Care Quality Commission

Benchmarked activity and cost[5]



Hospital Benchmark	Activity (CMAA)	Unit cost (£k)	Total cost (£m)
Site like Royal Cornwall	89,780	£3.35	£300.4

[5] Activity and cost are based on bed distribution across hospitals and HDUHB's activity levels. Unit cost and total cost are based on the methodology of Monitor (2016) and application of NHS England (2015b) to the Welsh context, using PEDW and WCR2 data (2015/16)

Impact of scale - Short, medium and long term

Sensitivity II: Gloucestershire Hospitals NHS Foundation Trust

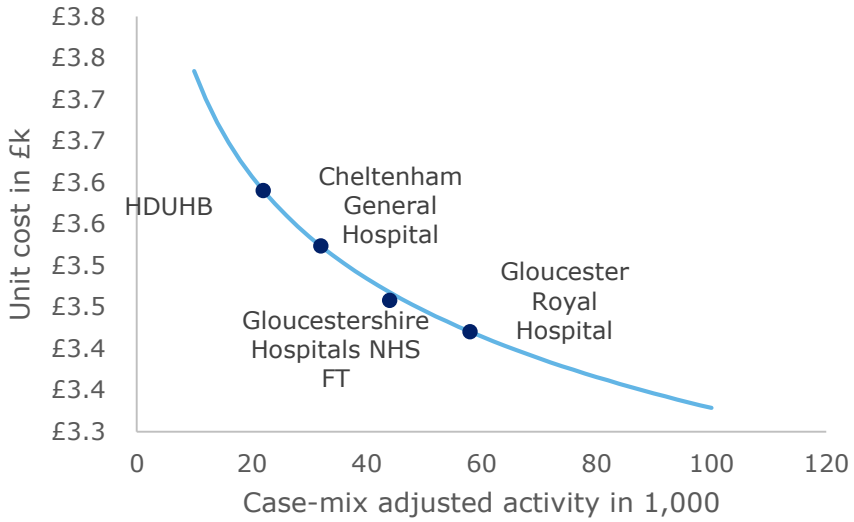
- The second comparator is Gloucestershire Hospitals NHS Foundation Trust (FT). Gloucestershire Hospitals NHS FT operates over two hospital sites, and has a turnover of c. £500m, with 130k A&E attendances.[1]
- If HDUHB had an activity pattern across sites similar to Gloucestershire Hospitals NHS FT, it could operate at a scale higher than the Welsh average, and so HDUHB might not be at a disadvantage because of the small scale of its sites.

Gloucestershire Hospitals NHS FT

Gloucestershire Hospitals NHS FT is located at the border of Wales and England and operates 2 sites with 613 and 371 beds respectively. [2] The provider has an operating income of £499.9m [3] and generated an operating surplus of £15.6m in 2015/16.[3]

The provider's CQC rating of "Requires Improvement" indicates that while financial goals have been achieved, quality remains to be improved.

Benchmarked activity and cost[5]



Hospital Benchmark	Activity (CMAA)	Unit cost (£k)	Total cost (£m)
Site like Gloucester Royal Hospital	57,357	£3.42	£196.3
Site like Cheltenham General Hospital	32,423	£3.52	£114.2
Organisation-wide	89,780	£3.46	£310.5

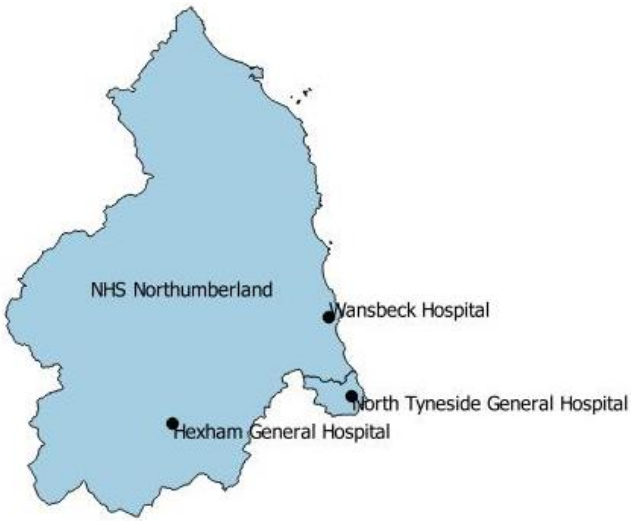
[1] A&E Activity data based on A&E Monthly Statistics, NHS Digital; Gloucestershire Hospitals FT 2015/16 Annual Report
[2] ERIC Returns 2013/14
[3] Gloucestershire Hospitals FT 2015/16 Annual Report
[4] Care Quality Commission
[5] Activity and cost are based on bed distribution across hospitals and HDUHB's activity levels. Unit cost and total cost are based on the methodology of Monitor (2016) and application of NHS England (2015b) to the Welsh context, using PEDW and WCR2 data (2015/16)

Impact of scale - Short, medium and long term

Sensitivity III: Northumbria Healthcare NHS FT

- The third comparator is Northumbria Healthcare NHS FT. Northumbria Healthcare NHS FT operates over three hospital sites, and has a turnover of c. £500m[3], with c. 200k A&E attendances a year[1].
- If HDUHB was like Northumbria Healthcare NHS FT, this could suggest c. £14.2m (4.2%) lower costs. This is the savings based on scale rather than on Northumbria's specific clinical model.

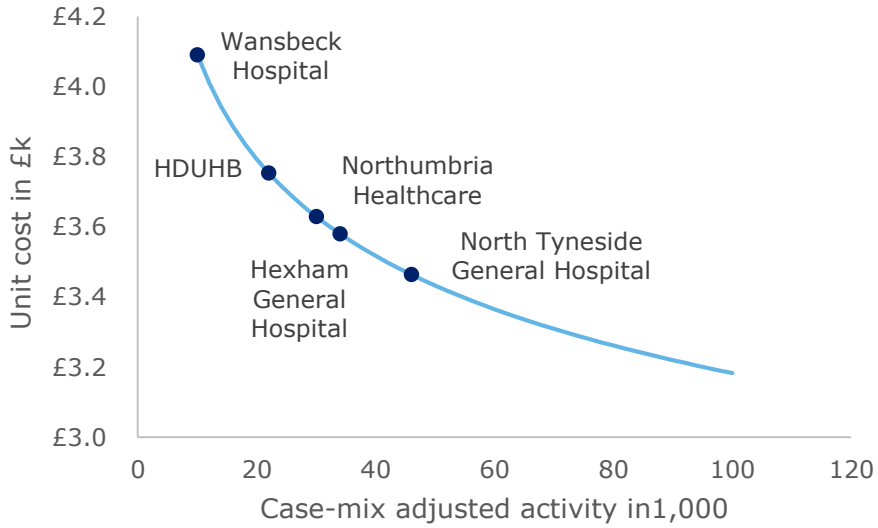
Northumbria Healthcare NHS FT



Northumbria Healthcare NHS FT is located at the English border of Scotland and operates three main sites with 479, 356 and 107 beds respectively. [2] The provider has an operating income of c. £500m and generated an operating surplus of £21.2m in 2015/16.[3]

The provider's CQC rating of "Outstanding" indicates that financial goals have been achieved in accordance with high quality performance.

Benchmarked activity and cost[4]



Hospital Benchmark	Activity (CMAA)	Unit cost (£k)	Total cost (£m)
Site like North Tyneside General Hospital	46,770	£3.46	£161.7
Site like Hexham General Hospital	34,137	£3.58	£122.2
Site like Wansbeck Hospital	8,872	£4.14	£36.8
Organisation-wide	89,780	£3.57	£320.7

[1] A&E Activity data based on A&E Monthly Statistics, NHS Digital
[2] ERIC Returns 2013/14
[3] Northumbria Healthcare NHS FT 2015-16 Annual Report
[4] Care Quality Commission
[5] Activity and cost are based on bed distribution across hospitals and HDUHB's activity levels. Unit cost and total cost are based on the methodology of Monitor (2016) and application of NHS England (2015b) to the Welsh context, using PEDW and WCR2 data (2015/16)

Impact of scale - Short, medium and long term

The below list sets out some areas that may be present at each hospital site to support care, based on discussions with HDUHB

Individuals engaged
General managers and their supporting tiers
Nursing managers and their supporting tiers
Medical managers and their supporting tiers
Therapies managers and supporting tiers
Doctors and nurses accommodation
Radiographers
Endoscopy facilities and supporting staff
Porters
Domestic services
Bed / nurse managers
Porters
IT staff
Canteen facilities and staff
Estates / minor works staff and accommodation
Patient support services
Bereavement
General Office
Front desk
Library staff and facilities
Post / undergrad staff and facilities
Medical records
Outpatients facilities and staff
Theatres facilities and staff

Literature

Evidence on demography and cost

Overall, most of the literature finds that age and deprivation may increase costs and utilisation

Literature review select findings (part 1)

Title	Author(s)	Region/ markets	Demographic factor	Methodology/Main findings
The Lifetime Distribution of Health Care Costs. Health Services Research	Alemayehu, B. and Warner, K. E. (2004)	US	Age	Investigates the distribution of lifetime expenditure across age. Finds that c. half of lifetime expenditure is incurred in an individual's senior years with women overall incurring higher lifetime expenditure.
The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation	Asaria M, Doran T, Cookson R. (2016)	UK	Deprivation	Disaggregates healthcare cost by IMD quintile to show that health care cost increase with multiple deprivation. Shows that hospital admission rate increases with deprivation.
Estimating the future healthcare costs of an aging population in the UK: expansion of morbidity and the need for preventative care	Caley, M. and K. Sidhu (2010)	UK	Age	Estimates that ageing population and increases in overall healthcare expenditure for UK.
The determinants of health care expenditure in Spain: A Reexamination	Cantarero, D. and S. Lago-Penas (2009)	Spain	Age	Uses panel regressions analysis on determinants of healthcare expenditure including demographic factors. Finds that the population share of 75+ is positively correlated with healthcare expenditure.
Impact of deprivation on occurrence, outcomes and health care costs of people with multiple morbidity	Charlton, J., Rudisill, C., Bhattarai, N. and M. Gulliford (2013)	UK	Multiple deprivation	Disaggregates healthcare cost by IMD quintile to show that healthcare costs increase with multiple deprivation.
The path to sustainability (Health Foundation)	Watt T and Roberts A (2016)	Wales	Age	Aims to project the cost of care in Wales; finds that utilisation increases with age.
NHS England (2015) Refreshing the current CCG formula (Revised)	Chaplin, M., Lau, Y., Beatson, S. and C. Smyth (2015)	UK	Age, multiple deprivation	Investigates drivers of healthcare costs across allocation formula component. Find that IMD score and old age increase healthcare costs using regression analysis for maternity and prescribing.
Demographic changes & aggregate healthcare expenditure in Europe	Christiansen, T., Bech, M., Lauridsen, J. and P. Nielsen (2006)	EU	Age, deprivation, life expectancy	Uses panel regression analysis to identify macroeconomic determinants of healthcare expenditure. Find that old age and life expectancy have mixed effects while unemployment decreases healthcare expenditure.

Evidence on demography and cost

Overall, most of the literature finds that age and deprivation may increase costs and utilisation

Literature review select findings (part 2)

Title	Author(s)	Region/ markets	Demographic factor	Methodology/Main findings
Evidence for the 2015/16 National Tariff Efficiency Factor	Deloitte (2014)	UK	Age, gender	Uses panel regression methods to identify efficiency dispersion and trend for UK providers.
A person based formula for allocating commissioning funds to general practices in England: development of a statistical model	Dixon Jennifer, Smith Peter, Gravelle Hugh, Martin Steve, Bardsley Martin, Rice Nigel et al. (2011)	UK	Deprivation, age, gender	Uses panel regression to identify determinants of healthcare expenditure in the UK. Finds that old age and deprivation is associated with higher health care costs, while females are associated with lower costs.
Estimating the costs of health inequalities	Frontier economics (2010)	UK	Deprivation	Estimates the cost of lives lost due to deprivation to UK system. Finds that health inequalities are a significant cost driver.
Evidence on Efficiency for the 2016/17 National Tariff	Monitor (2016)	UK	Deprivation, age, ethnic profile, gender	Updates methodology used by Deloitte and finds that old and female population share is associated with lower costs, while ethnicity and IMD score are insignificant.
Does The Aging Of The Population Really Drive The Demand For Health Care?	Reinhardt, U. E. (2003)	US	Age	Shows that per capita healthcare expenditure increases dramatically in old age.
Do men consult less than women? An analysis of routinely collected UK general practice data	Wang Y, Hunt K, Nazareth I, et al. (2013)	UK	Gender	Shows that females tend to consult more often with GPs, especially during mid-life. Consultation rate for male and female increases with age.
The determinants of health expenditure (World Health Organisation)	Xu, K., Saksena, P., and A. Holly (2011)	143 countries	Age	Uses panel analysis to investigate drivers of healthcare expenditure. Does not find consistent results for the population share above 60.
Ageing of population and health care expenditure: a red herring?	Zweifel, P., Felder, S. and Meiers, M. (1999)	US	Age	Shows that healthcare expenditure overall is increasing in age.

Evidence on remoteness and labour cost from the literature

The literature suggests that remoteness can affect the willingness of health workers to locate in more remote areas

Literature review select findings

Title	Author(s)	Region/ markets	Workforce	Methodology/Main findings
Rural–Urban Distribution of the U.S. Geriatrics Physician Workforce	Peterson, L. E., Bazemore, A., Bragg, E. J., Xierali, I. and Warshaw, G. A (2011)	US	Geriatrics Physicians	Shows that rural areas in the US tend to have lower density of physicians per capita.
Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce	Dussault, G. and M. C. Franceschini (2006)	International literature survey	Overall	Reviews the relevant literature on geographic distribution of the health workforce and highlights that rural areas tend to have a lower density of physicians per capita.
What Factors Influence the Earnings of GPs and Medical Specialists in Australia? Evidence from the MABEL Survey	Terence Chai Cheng, Anthony Scott, Sung-Hee Jeon, Guyonne Kalb, John Humphreys and Catherine Joyce (2012)	Australia	GPs	Evaluates survey responses and shows that GPs in remote areas have higher earnings.
Junior doctors training: is it really location, location, location?	Health Economics Research Unit (2016)	UK	Junior doctors	Evaluates survey responses from Junior Doctors (JDs) and finds that JDs expect a premium for working in a remote, undesirable area.
Competition, Prices and Quality in the Market for Physician Consultations	Hugh Gravelle, Anthony Scott, Peter Sivey and Jongsay Yong (2016)	Australia	GPs	Shows that when GPs are located farther from one another, they may charge higher prices.
Geographic Imbalances in Doctor Supply and Policy Responses	Tomoko Ono, Michael Schoenstein and James Buchan (2014)	OECD countries	Doctors	Shows that doctors are distributed unequally within OECD countries with lower density in rural areas, and that some countries compensate rural doctors.
Getting doctors into the bush: General Practitioners' preferences for rural location	Anthony Scott, Julia Witt, John Humphreys, Catherine Joyce, Guyonne Kalb, Sung-Hee Jeon and Matthew McGrail (2013)	Australia	GPs	Evaluates survey responses of GPs in Australia and finds that GP in urban areas would require large premiums in the range of 37% to 130% of current salary to move to rural area.
Economic Incentives for Medical Personnel Deficit Elimination in Rural Areas	Elena Tarasenko and Olga Khoreva (2016)	Russia	Overall	Shows that economic incentives can improve supply of doctors in rural areas.
Retaining rural doctors: Doctors' preferences for rural medical workforce incentives	Jinhu Li, Anthony Scott, Matthew McGrail, John Humphreys and Julia Witt (2014)	Australia	GPs	Evaluates a discrete choice experiment and shows that economic incentives are key to retain GPs in rural areas.

Evidence on economies of scale in the health sector

The literature suggests that small hospitals to have higher unit costs

Literature review select findings

Title	Author(s)	Region/ markets	Methodology/Main findings
Evidence on Efficiency for the 2016/17 National Tariff	Monitor (2016)	UK	Update of the earlier methodology used by Deloitte and confirm economies of scale.
Evidence for the 2015/16 National Tariff Efficiency Factor	Deloitte (2014)	UK	Uses panel regression to identify determinants of healthcare expenditure in the UK. Find economies of scale for hospital trusts.
Costs of unavoidable smallness due to remoteness	NHS England (2015)	UK	Investigates the cost of unavoidable smallness with research design similar the Monitor efficiency papers.
A study investigating the extent to which there are economies of scale and scope in healthcare markets and how these can be measured by Monitor	Frontier Economics and The Boston Consulting Group (2012)	UK	In-depth study of economies of scope and scale in the UK. Shows that there are significant economies of scale across clinical service lines and clinical support services.
Relative Efficiency, Scale Effect, and Scope Effect of Public Hospitals: Evidence from Australia	Wang, J., Zhao, Z., and A. Mahmood (2006)	Australia	Performs a similar estimation to the Monitor efficiency work set out above. Finds economies of scale for small hospitals, while diseconomies of scale exist for very large hospitals.
Economies of scale and scope in the English hospital sector	G. Marini and M. Miraldo (2009)	England	Shows that economies of scale exist for hospitals in England, with the limitation that very large hospitals exhibit diseconomies of scale.
Assessing Economies of Scale in Public Hospitals	Yuejen Zhao, Margaret Foley, Kathy Eagar (2011)	Australia	Demonstrates significant economies of scale for Public Hospitals in Australia.
Optimal productive size of hospital's intensive care units	Leleu, H., J. Moises, and V. Valdmanis(2012)	US	Detailed study of hospitals finds that majority of hospitals operate with economies of scale, while a minority is subject to diseconomies of scale.
Cost effects of hospital mergers in Portugal	H. Azevedo and C. Mateus (2014)	Portugal	Investigates economies of scale pre and post merger in Portugal. Find economies of scale pre-merger combined with cost increases post-merger indicating diseconomies of scale for large scale hospitals.
Potential gains from hospital mergers in Denmark	Troels Kristensen, Peter Bogetoft and Kjeld Moeller Pedersen (2010)	Denmark	Investigates economies of scale pre and post merger in Denmark. Find economies of scale pre-merger combined with cost increases post-merger indicating diseconomies of scale for large scale hospitals.

Technical appendix

Technical Appendix

Definition and calculation of case-mix adjusted activity (CMAA)

Approach

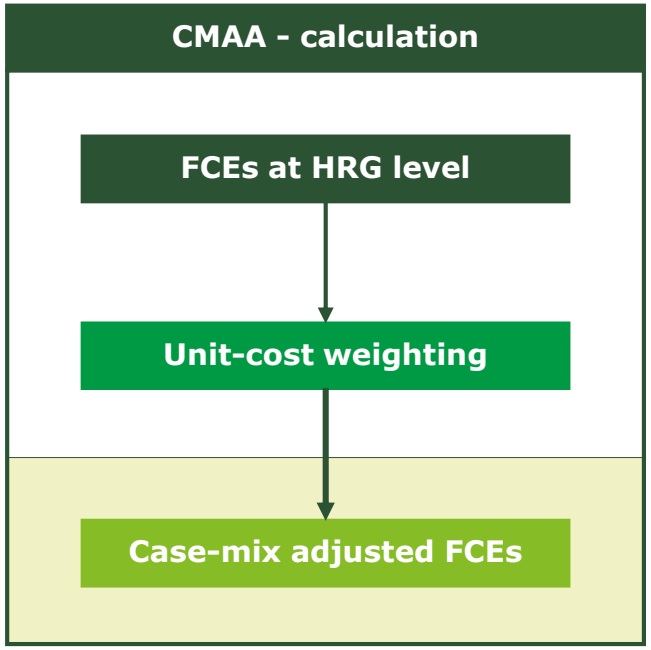
Comparing activity levels across hospitals is often challenging due to differences in services, specialisation, and complexity. CMAA aims to address this by standardising activity and enabling aggregation. This allows comparison of hospital activity based on a single metric instead of using a multitude of different activity levels.

CMAA uses unit cost as a basis for comparing activity across specialities and HRG codes. CMAA is defined as the activity for provider i in the HRG j multiplied by HRG unit cost divided by the average unit cost.

$$CMAA_i = \sum_j Activity_{i,j} * \frac{UC_j}{\overline{UC}}$$

CMAA is a common approach in the UK healthcare literature and has been applied in Deloitte (2014), NHS England (2015b) and Monitor (2016). Implementation for this analysis used unit cost data from WCR2 2015/16 averaged across elective and non-elective as well as activity by HRG code for 2015/16 based in PEDW tables.

For the case of Wales, activity factors range between c. 0.05 for "Phototherapy or Photochemotherapy 13 years and over" to c. 39.6 for "Intermediate Burn (TBSA of 20-59%) with Skin Graft."



Data

- **Unit cost:** Unit cost data by HRG code was sourced from 2015/16 WCR2 across elective and non-elective.
- **Activity:** Activity levels by HRG for 2015/16 were sourced from PEDW tables.

Limitations

- **Data quality:** As CMAA relies on activity and unit cost data, it depends on high data quality for both and consistent reporting standards across the system of interest. This implies that due to different reporting standards for HRGs in Wales an England, CMAA across both might not be comparable. As such, CMAA has been estimated for Wales only.

Technical Appendix

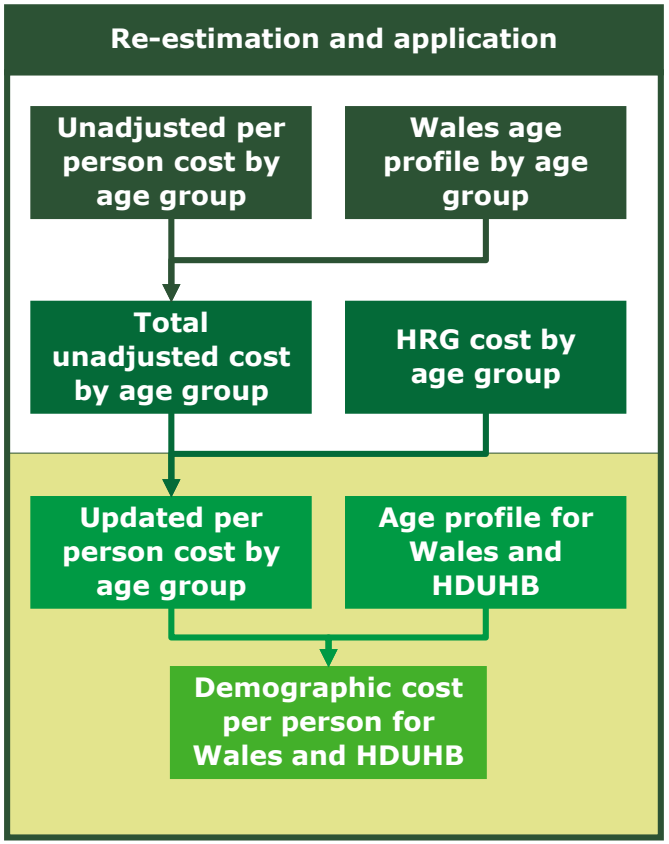
Application of the updated Nuffield formula

Approach

The updated Nuffield formula as published in NHS England (2015a) gives an estimate of healthcare cost per person based on a range of demographic factors, disease prevalence and morbidity factors based on regression analysis. Per person costs are estimated for three age-group equations (ages 0-14, 15-64 and 65+). Each equation has specific estimates by 5-year age band, for males and females separately. The equations include a range of control variables (includes supply factors, morbidity and need factors):

$$Cost_i = \alpha + \sum_{k=1}^{K} \beta_k * Age_k * Gender \quad + \sum_{l=1}^{L} \gamma_l * X_l + \varepsilon_i$$

Where *i* refers to a registered person, *k* to age groups, *X* to other variables (includes supply factors, morbidity and need factors). To apply the updated Nuffield formula, the average cost per person (α) was calibrated for Wales. This applied the impacts on cost by age-gender from the updated Nuffield formula (β_k) to the age and gender profile of Wales, and deducted this from the Welsh total inpatient cost for different age groups (ages 0-14, 15-64 and 65+). Once the model and α was re-calibrated for Wales, the expected cost of the population for HDUHB compared to Wales was estimated by applying the β_k and α estimates to the population by age and gender group.



Data

- **Coefficients:** Coefficients for age specific cost per person were taken from PBRA t-stat selections model reported by NHS England (2015a)
- **HRG cost by age group:** Calculated based on 2015/16 WCR2 unit cost by HRG averaged across elective and non-elective as well as activity by HRG and age group reported in PEDW tables.
- **Population by age group:** Population by age bracket was calculated based on population by age by LSOA as reported by ONS and aggregated to organisation using ONS provided mapping.

Limitations

- **Comparison across England and Wales:** As the updated Nuffield formula was estimated using English data, this approach assumes that age-gender and cost relationships are similar across England and Wales.
- **HRG cost across age groups:** The total cost calculations were based on average cost by HRG and thus do not adjust for different cost across age-groups within an HRG code.
- **Scope:** The updated Nuffield formula was based on GP registered population, and here it is applied to resident population. It is also applied to all acute from a calibration based on inpatient data.
- **Long term conditions:** the cost of long term conditions is captured in the base cost for the different age groups rather than by five year age group.
- **Controls:** The unit costs by age-gender estimated in NHS England (2015a) included controls for socio-economic indicators of deprivation. When the model was calibrated for Wales, the controls should be reflected for age-gender specific impact (β_k), however the differences in deprivation between broad age groups (children, adults, and older people) is not captured.

Technical Appendix

Agency spend by CCG

Approach

Agency spend and turnover was sourced from HSJ at trust level. The mapping to CCGs used non-elective activity share from the trust to a given CCG:

$$Agency_{CCG} = \sum Agency_{Trust} * \frac{Non-elective\ activity_{Trust\ to\ CCG}}{Non-elective\ activity_{Trust}}$$

The same methodology was applied to the turnover reported by HSJ.

Agency spend as a percent of pay expenditure for England using the pay expenditure to overall expenditure factor reported by the trust in their 2015/16 annual report was then applied.

$$\frac{Agency_{CCG}}{Pay\ expenditure_{CCG}} = \frac{Agency_{CCG}}{Turnover_{CCG} * Pay\ expenditure\ factor_{CCG}}$$

Data

- **Agency spend and turnover:** Data was sourced from HSJ
- **Pay expenditure factor:** Calculated based on annual reports for the relevant trusts for 2015/16.
- **Non-elective activity:** Non-elective activity was obtained from Hospital Episode Statistics (HES) for 2014/15

Technical Appendix

Estimation and application of economies of scale

Approach

The impact of economies of scale was estimated based on NHS England (2015b), which estimates a regression of the form:

$$\ln(Total\ cost_i) = \alpha + \beta * \ln(CMAA_i) + \sum \gamma_j * Control_{i,j} + \varepsilon_i$$

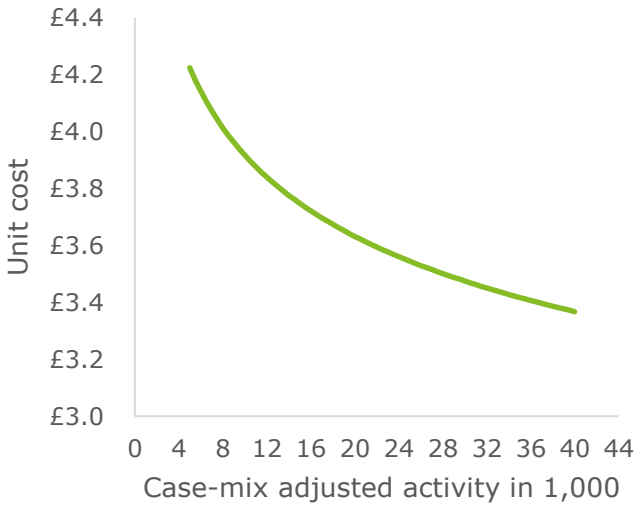
across English NHS providers, for provider *i* , where α is the constant, β is the impact of scale, γ is the effect of control variables, and ε is the error. The results of the regression analysis can be used to estimate total and unit cost for hospitals of different sizes.

NHS England (2015b) estimates β (the effect of scale) at 0.891, which implies that a 10% increase in CMAA leads to a 8.9% increase in total cost. Control variables included were activity concentration, provider type, demographic variables and demand profile.

To apply NHS England (2015b), α was re-estimated for the Welsh dataset. This was done by fitting the model to the Welsh CMAA-cost profile such that on average, their hospitals operate on the unit cost curve.

$$\alpha = \ln(Total\ cost_{Wales}) - \ln\left(\sum (CMAA_i)^{\beta}\right)$$

Economies of scale – Calibrated cost curve



Data

- **Coefficients:** β coefficient was adopted from NHS England (2015b). Sensitivity analysis was done using the 95% confidence interval around the parameter estimate.

Limitations

- **Constant economies of scale:** The estimated model assumes that the relationship between percentage changes across the total cost curve is constant, i.e. regardless of current activity levels, a 10% increase in activity always leads to a $\beta * 10\%$ increase in total cost. There is some evidence that economies of scale might not be present for very large hospitals, however this case should not apply for HDUHB.
- **Comparing across Wales and England:** The estimated models are based on English data and thus estimate the relationship between CMAA and total cost for English hospitals. Applying the formula to Wales is based on the assumption that a similar relationship between CMAA and costs would exist for Wales.
- **Expected vs. actual activity:** NHS England (2015b) used expected CMAA instead of actual CMAA used in this analysis.
- **CMAA is based on inpatient activity,** whereas NHS England (2015b) estimates CMAA based on inpatient, outpatient, and A&E activity.

Technical Appendix

Indicative regression based benchmarking

Approach

Deloitte (2014) and Monitor (2016) have used stochastic frontier analysis, to estimate efficiency based on regression residuals. Their methodology compares costed reference cost data by hospital trust across England, which, due to differences in reporting standards are not comparable to Wales.

Due to the limited number of health boards in Wales, this analysis is not replicable for Wales. Instead indicative regression benchmarking was used as one point of triangulation to estimate efficiency. This was based on reported LSOA level emergency admissions and outpatient referrals.

The following were considered in the regression based benchmarking:

$$Activity\ p.p._{LSOA} = \alpha + \beta * Adj.Needs\ Index + \sum \gamma_i * \frac{Age\ group_i}{Population} + \sum \delta_j * Control_j + \varepsilon_{LSOA}$$

Age groups were calculated based on 5 year age bracket. Control variables included population, distance to next hospital, travel time to next hospital in England and distance to next hospital in England. Distance variables were included to control for access and to control for activity leaving the system. Socio-economic variables were based on NAO (2012) as a broad reference point and adapted to the data. However, further testing would be required to test the specification as applied further, and any findings are indicative only.

The difference between the actual and expected activity per person could present opportunities to decrease excess activity. The efficiency potential is calculated as the population weighted average residual for HDUHB divided by the population weighted average activity per person.

Data

- **Emergency admissions and outpatient referrals by LSOA:** The data was provided by NHS Wales.
- **Population share:** Population composition by age band was calculated based on ONS population data by age and LSOA.
- **Adjusted needs index:** The needs index proxy based on NAO (2012) was used. This includes socio-economic factors, such as the share of population which is a disability allowance claimant, the share of the population without qualifications, the share of the population claiming pension credits, and the unemployment rate.
- **Travel time and distance:** Distance to next hospital and to England was calculated based on latitude and longitude.

Limitations

- **Omitted variables:** Residuals could be correlated with omitted variables that are not covered in the model. A number of control variables are included to limit this concern. However, this may not be exhaustive, and further work would be needed to validate and test these results.
- **Data quality:** Activity per person above or below the 95% confidence interval is not considered to exclude potential outliers and control for data quality. This was necessary as some LSOAs exhibited activity levels significantly below reasonable values.

Deloitte.

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Finance Turnaround Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Report prepared by: Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

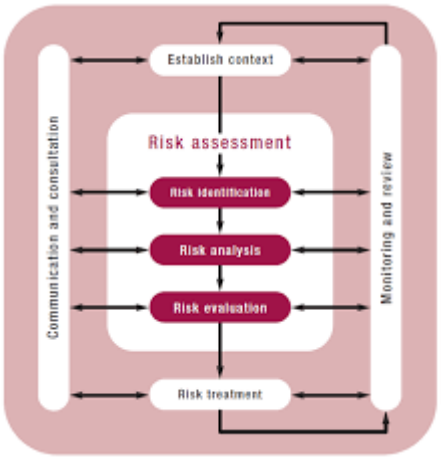
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is asked to request assurance from listed Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

The Board's Committees are responsible for the monitoring and scrutiny of corporate level risks within their remit. They are responsible for:

- Seeking assurance on the management of principal risks on the BAF/CRR and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.

- Reviewing principal and operational risks over tolerance and where appropriate recommend the 'acceptance' of risks that cannot be brought within the UHB's risk appetite/tolerance to the Board through the Committee Update Report.
- Provide annual reports to ARAC on the effectiveness of the risk management process and management of risks within its remit.
- Identity through discussions any new/emerging risks & ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate UHB Committee.
- Use risk registers to inform meeting agendas.

The Executive Team agreed the content of the CRR. These risks have been identified via a top down and bottom up approach and are either:

- Associated with the delivery of the objectives set out in Annual Plan 2019/20; or
- Significant operational risks escalated by individual Directors and agreed by the Executive Team as they are of significant concern and need corporate oversight and management.

Each risk on the CRR has been mapped to a Board level committee to ensure that risks on the CRR are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability i.e. source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence about the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

Risk Reporting in the UHB is outlined at Appendix 1.

Asesiad / Assessment

The Finance Committee Terms of Reference state that it will:

5.3 Seek assurance on the management of principle risks within the BAF and CRR allocated to the Committee (financial risks), and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk appetite is exceeded, lack of timely action.

5.4 Recommend acceptance of risks that cannot be brought within the Health Board's risk appetite/tolerance to the Board through the Committee Update Report.

There are 3 risks were aligned to the Committee from the 29 currently identified on the corporate risk register. These relate to delivery of the UHB's objectives for 2019/20. The BAF is not included within this report as it is currently being reviewed to align with objectives for delivery within 2019/20.

Each of these risks have been entered onto a 'risk on a page' template which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

Changes since last report

Total Number of Risks	3	
New risks	1	*See note 1*
Increase in risk score ↑	0	
No change in risk score →	0	
Reduction in risk score ↓	0	
De-escalated/Closed	1	*See note 2*

The Committee are asked to note that new risk is in the process of being assessed in respect of the successful delivery of the financial plan for 2019/20 which will replace risk 630 (Ability to deliver the Financial Plan for 2018/19).

Note 1 - New Risks
Risk 730 (Realising the efficiencies from the Turnaround Programme in 2019/20) - The Executive Team approved the risk of delivering the savings requirement for 2019/20 by the end of March 2020.

Note 2 Removed/De-escalated Risks
Risk 626 (Realising the efficiencies from the Turnaround Programme in 2018/19) - The Executive Team agreed to close risk 626 following delivery of £30.7m savings by the agreed date of 31st March 2019. This was achieved through operational savings of £26.4m with the gap mitigated through a range of recovery savings actions to the value of £6m.

The Committee is asked not to devolve its responsibility for seeking assurances on corporate risks to its Sub-Committee structure, however it can reassign risks to another Board level Committee if it is agreed that it better fits within their remit.

Argymhelliad / Recommendation

The Committee is asked to seek assurance that:

- All identified controls are in place and working effectively.
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises.
- Challenge where assurances are inadequate.

This in turn will enable the Committee to provide the necessary assurance to the Board, through its Committee Update Report, that the UHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Contained in report
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Contained in report

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts from report however impacts of each risk are outlined in risk description.

Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score May-19	Trend	Target Risk Score	Risk on page no…
730	Failure to realise all the efficiencies and opportunities from the Turnaround Programme in 2019/20	To be agreed	Carruthers, Andrew	Statutory duty/inspections	8	N/A	**4×5=20**	New risk	**2×4=8**	3
630	Ability to deliver the Financial Plan for 2018/19 (Under Review)		Thomas, Huw	Finance inc. claims	6	**4×4=16**	**4×4=16**	→	**2×4=8**	5
646	Ability to achieve financial sustainability over medium term.		Thomas, Huw	Finance inc. claims	6	**3×4=12**	**3×4=12**	→	**2×3=6**	7

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Strategic Objective:	*TBC*

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	08/05/2019
Lead Committee:	Finance Committee	**Date of Next Review:**	08/06/2019

Risk ID:	**730**	**Principal Risk Description:**	There is a risk of the UHB not delivering the planned recurrent savings of £24m by end of March 2020. This is caused by by a failure to realise the opportunities identified in the Turnaround programme This could lead to an impact/affect on a failure to meet its financial statutory duty to breakeven, attain an approvable IMTP, loss of stakeholder confidence in the organisation's ability to deliver its objectives and increased scrutiny by WG.
Does this risk link to any Directorate (operational) risks?	yes		

Risk Rating:(Likelihood x Impact)		***New Risk - No trend Information available***
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	2×4=8	
Tolerable Risk:	8	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
At this point in time there is a possibility that the UHB will fail to deliver the full £24m savings in 2019/20. Currently as at the end of Mar19, the Health Board has identified £20.5m against that target for 2019/20.

Rationale for TARGET Risk Score:
As the Turnaround programme is an intervention aimed at supporting delivery of the overall financial plan, and as such has had the in year recovery actions required to achieve breakeven, the target score has been set to align with the risk to delivery of the overall financial plan.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Turnaround Programme Director in post. Fortnightly 'Holding to Account' (HTA) meetings including a monthly Chief Executive HTA session for the highest risk directorates. Each Directorate has signed up to a savings plan and recovery plan - costed and RAG rated. Identified Exec lead for red schemes and for key Turnaround Improvement Programmes. Specific aspect of Performance Review focus on finance and link to HTA session. Escalation process to HTA monthly meeting. Executive Team Turnaround Meetings.	Lack of sufficient capacity to support and facilitate the delivery of Turnaround programme. Ability to control operational priorities that adversely affect delivery of savings plans, eg, winter pressures, vacancy position. Lack of clarity in organisation about true priorities specially achieving balance quality performance, TCS and finance delivery.	Increase capacity of programme management office (PMO) and service improvement capability to support delivery of Turnaround Programme.	Ryan-Davies, Libby	30/06/2019	Capacity to support the Turnaround programme activity has been agreed by the Board in Mar19 however the recruitment process will mean that the additional capacity will be unlikely to be in place before Jun19.
		Work closely with the Director of Operations to ensure robust operational and contingency plans are in place that minimise additional cost, and align with turnaround savings actions.	Carruthers, Andrew	31/03/2020	Joint Chairs of Operational Effectiveness Group and Unscheduled Care Programme Board.
		Chief Executive setting out the organisations goals for 2019/20 to Executive Team.	Moore, Steve	31/05/2019	Executive Team away day set up to clarify goals and the contribution each portfolio needs to make to them.

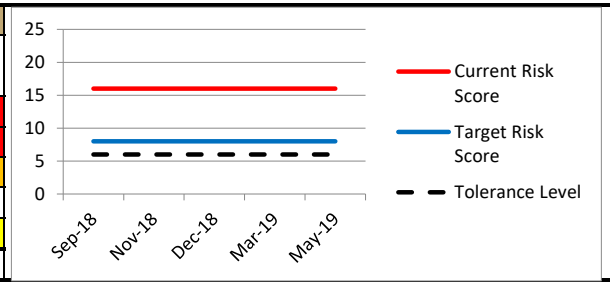
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against agreed savings plan In-month financial monitoring	Performance against plan monitored through HTA meeting with Services	1st			* Mth 12 Finance Report & Turnaround Report - Board Apr19 * Finance Report & Turnaround Report - Mar19 Finance Committee	None				
	Executive Performance Reviews	2nd								
	Finance Committee oversight of current performance	2nd								
	Turnaround & Financial Report to Board & BPPAC	2nd								
	WG scrutiny through Targeted Intervention (TI)	3rd								
	WG scrutiny through Joint Executive Team (JET)	3rd								
	WAO Structured Assessment 2018	3rd								

Strategic Objective:	*TBC*

Executive Director Owner:	Thomas, Huw	**Date of Review:**	10/04/2019
Lead Committee:	Finance Committee	**Date of Next Review:**	10/05/2019

Risk ID:	**630**	**Principal Risk Description:**	There is a risk of the Health Board not achieving its agreed financial plan for the 2018/19 financial year. This is caused by : 1. The savings plans for the year not being delivered; or 2. Operational cost pressures arising from the requirement to meet performance targets of quality measures. This could lead to an impact/affect on a detrimental impact on the Health Board's reputation with Welsh Government and other stakeholders.
Does this risk link to any Directorate (operational) risks?		All directorates	

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

The Health Board has not yet fully identified the savings requirement for the year in full. There are risks which are foreseeable through the operational unscheduled care pressures in particular, especially as we enter the latter part of the year; alongside RTT unfunded, will need to be delivered within the baseline allocation which could lead to cost pressure.

Rationale for TARGET Risk Score:

The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. Given the challenge in delivering the financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Financial reports provided to directorates in a timely way, focused on trends; cost drivers; projected expenditure; risks and actions. Turnaround Director Holding to Account meetings. CEO Holding to Account meetings. Executive Performance meetings. Commissioning arrangements with key partners (Local Authorities; Care home sector; Other NHS providers; Primary Care; Third Sector).	Finance support is not currently sufficient. Responsiveness and accountabilities need to be reinforced. Process to become embedded and refined. Process to become embedded and refined. Variable arrangements, to be harmonised to enable effective commissioning.	Appointments to key finance roles through OCP to support in understanding and developing actions.	Thomas, Huw	01/10/2018	Assistant DoF and Senior Finance Business Partners appointed and in post. Finance Business Partners appointed, majority in post. Band 7 & 6 appointments made. Slotting of Band 5 completed, transitional arrangements in progress over Quarter 1.
		Directorates to sign accountability statements in relation to Budget 2019/20.	Carruthers, Andrew	31/03/2019	Meetings embedded in monthly business processes
		Reviews of recovery plans in Month 3 (August) and approaching system-wide issues (August/September).	Moore, Steve	Completed	Meetings embedded in monthly business processes
		Embedding current approach to assess rounded performance of each directorate.	Moore, Steve	Completed	Held on monthly rotational basis

				Review of contracting arrangements.	Thomas, Huw	TBC	Paper regarding proposed approach to healthcare contract management discussed at Finance Committee November 2018. Team being established as part of Finance OCP - Bands 8c, 8a, 7 and 6 now in post. Regular Papers providing updates on progress timetabled into Finance Committee Agendas.

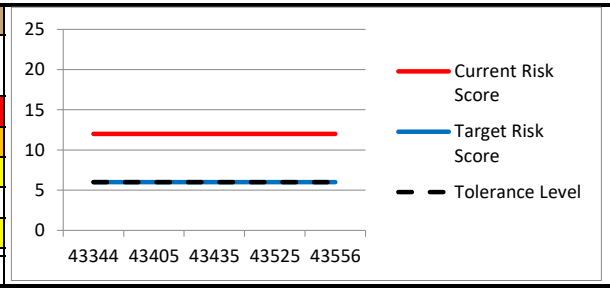
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Identification and delivery of savings schemes. Financial performance and projections reported on a monthly basis. Breakeven recovery plans where deficits are projected. Financial process assurances. Internal Audit and Wales Audit Office reports.	Finance dashboards	1st			Month 11 2018/19 reports issued on 13 March 2019. Month 11 2018/19 reports issued on 25 March 2019. Weekly meetings held throughout February and March 2019. Report presented at 19 February 2019 meeting. May 2018 based on	Process embedded process to be refined for new guidance from FDU regarding monitoring and reporting. Commencing new process.	Holding to Account approach to be further enhanced and reinforced.	Carruthers, Andrew	31/03/2019	Meetings embedded in monthly business processes
	Finance report to Finance Committee and Board	2nd					Further refinement of reporting based on feedback from Finance Committee. Review of terms of reference of Finance Committee.	Thomas, Huw	Completed	Suite of reports timetable for presentation to Finance Committee. Board Reports reviewed in line with Best Practice.
	CEO Holding to Account meetings	1st					Process to become embedded through monthly HTA CEO meetings based on initial recovery plans on 20 July.	Moore, Steve	Completed	Complete and embedded in current business processes
	Financial assurance report to Audit Committee	2nd					Feedback will be sought from the Audit Committee in August.	Thomas, Huw	Completed	Financial Assurance Report prepared for every meeting of Audit and Risk Assurance Committee
	Year-end reporting to Audit Committee	3rd					Risk based approach to audit for 2018/19 and Structured Assessment review.	Thomas, Huw	01/05/2019	Update to be provided.

Strategic Objective:	TBC

Executive Director Owner:	Thomas, Huw	**Date of Review:**	16/05/2019
Lead Committee:	Finance Committee	**Date of Next Review:**	16/06/2019

Risk ID:	**646**	**Principal Risk Description:**	There is a risk of the Health Board not achieving breakeven over the medium term. This is caused by the inability to either: 1. Develop a sufficiently robust financial plan which shows an achievable improvement trajectory, or 2. Manage the necessary changes in such a way that the financial gains are realised and an improvement trajectory is achieved. This will lead to an impact/affect on a detrimental impact on the Health Board's reputation with Welsh Government and other stakeholders.
Does this risk link to any Directorate (operational) risks?		Corporate risk	

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The Health Board has not developed a full long term financial base-case model, which can then be used to assess the impact of TCS and other medium term changes. The Health Board's underlying deficit also requires further work to fully explore and understand the opportunities for improvement which can be realised over the medium term.

Rationale for TARGET Risk Score:
Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and Welsh Government.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Understanding the underlying deficit. An initial assessment has been completed. Very high level base-case long term financial model. Assessing the full financial implications of Transforming Clinical Services.	Calculation has not been subject to operational scrutiny. Assessment not subject to planning scrutiny. High level assessment of resource requirements for social model for health.	Testing the underlying deficit assumptions with directorates.	Thomas, Huw	~~30/11/2018~~ ~~31/05/2019~~ 31/12/2019	Welsh Government and UHB commissioining external advisors to prepare report on deficit position. Specification being agreed.
		Refining assessment in conjunction with W&OD and Planning.	Thomas, Huw	30/11/2018	Initial calculations regarding the effect of the zero based review allocation and early high level affordability for option B of the consultation has been shared via the TCS Design Team and with the Director of Finance. The Strategic Financial Planning Group (Strategy Finance Enabling Group) met on the 2nd May and agreed a series of actions to inform the work of the forthcoming meetings of the 3 Strategy Programme Delivery Groups and Integrated Enabling Group.

					Developing a high level assessment of the resource requirements of "A Heathier Mid and West Wales" Strategy. Understanding full financial implications of TCS, including the Community/Social Care model.	Thomas, Huw	~~31/03/2019~~ 31/03/2020	Activity Based costing refined based on updated Activity and Capacity Assumptions and impact on the 2017/18 baseline financial data + Zero based Review funding (Completed) Collated detail in draft Strategy to begin to build up a bottom up financial costing. Integrated Enabling Group working with Health and Care Strategy Programme Groups to both inform the groups regarding current detail and translate into financial and workforce end point model.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Operational agreement to underlying deficit assessment. Plan in place to develop a long term financial plan. High level financial assessment of TCS in place.	Reporting to Finance Committee .	1st			N/A	Process to be put in place over May and June. Approach to costing impact of TCS to be developed.	Communication with directorates and responses required in July.	Thomas, Huw	~~31/10/2018~~ ~~31/07/2019~~ 31/12/2019	Welsh Government and UHB commissioining external advisors to prepare report on deficit position. Specification being agreed.
							Now Strategy is agreed we are moving on to a bottom up assessment of the Financial Planning options and implications of "A Heathier Mid and West Wales". TCS Finance Enabling "Plan for a Plan" - has been considered by the Strategic Financial Planning Group and Finance Committee.	Thomas, Huw	~~31/03/2019~~ 31/03/2020	Initiating the establishment of a multidisciplinary Integrated Enabling Group as agreed by the Board on 28/03/19 tied into the Strategy Governance to begin to flesh out service design options and trade-offs to inform and promote debate in co-design process. Draft Financial Plan submitted to FDU; comments received. Response and actions to be completed before final submission by the end of Jan19. Intensive work initiated for 2019-20 to support design process, inform 10 year finacial plan and feed into IMTP for 2020-2023.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Operational Risk Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Identified on individual risks
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

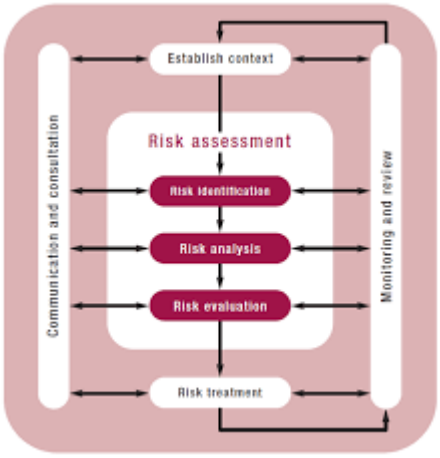
Sefyllfa / Situation

The Finance Committee is responsible for providing assurance to the Board that risks affecting finance are being identified, assessed and managed effectively.

The Committee is asked to seek assurance from lead officers/representatives of the Directorates that the operational risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place, to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

Operational risks must be managed within directorates under the ownership and leadership of individual executive directors, who must establish local arrangements for the review of their risk registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. In addition to these local arrangements formal monitoring and scrutiny processes are in place within Hywel Dda

University Health Board (HDdUHB) to provide assurance to the Board that risks are being managed effectively.

All risks identified within the Datix Risk Module must be aligned to a formal Board Committee, Sub-Committee or Group who will be responsible for monitoring and scrutinising risks which relate to their remit. Appendix 1 shows the different levels of risk registers within HDdUHB. Appendix 2 shows how risk is reported within HDdUHB.

The Committee, Sub Committee and Group structure is responsible for the monitoring and scrutiny of operational risks within their remit. They are responsible for:

- Scrutinising operational risks within their remit; either through receiving the risk registers or through Service Reports.
- Gaining assurance that risks are being appropriately managed, effective controls are in place and planned additional controls are being implemented.
- Challenging pace of delivery of risk actions.
- Identifying, through discussions, new and emerging risks and ensuring these are assessed by those with the relevant responsibility.
- Providing assurance to its parent committee that risks are being managed effectively and report risks which have exceeded tolerance through its Sub-Committee/Group update report.
- Using risk registers to inform meeting agendas.

It is therefore essential that the membership of these Committees and Sub-Committees includes the appropriate representation from Directorates and that they are in attendance to provide assurance and to respond to queries.

The discussion needs to be reflected in the Committee Update Report to the Board to provide assurance on the management of significant risks. This would include risks that are not being managed within tolerance levels (see Risk Appetite Statement), and any other risks, as appropriate.

Asesiad / Assessment

The Finance Committee Terms of Reference state that it will:-

- Ensure corrective action has been initiated and managed where gaps are identified in relation to all financial risks.
- Considering and keeping under review the organisation's medium term financial strategy in relation to both revenue and capital risks.

The 13 risks presented in the attached risk register as at 2nd May 2019 (Appendix 3) have been extracted from Datix based on the following criteria:

- Finance Committee has been selected by the risk lead as the 'Assuring Committee' on Datix
- The current risk score exceeds the tolerance level (discussed and agreed by the Board on 27th September 2018).
- Risks have been approved at Directorate level on Datix
- Risks have not been escalated to the Corporate Risk Register.

The risks have been scored against the following 'impact' domains':

- Finance, including claims: 12 risks
- Workforce & OD: 1 risk.

Below is a **summary** of the 13 risks, ranked highest to lowest by current score, which meet the criteria for submission to Finance Committee May 2019.

Risk Ref	Date Risk Identified	Title	Directorate	Current Risk Score	Rationale for the current risk score	Target Risk Score
519	13/06/18	Health Records risk of inability to balance budget in 2018/19 affecting the whole HB.	Central Operations	20 ⟺	Possible mitigation through extended vacancy factor management.	4
525	18/06/18	Scheduled care financial pressure due to continuation of the BGH theatres compensatory rest policy.	Scheduled Care	16 ⟺	Process is at an impasse with Staff Side relations.	4
527	18/06/18	Non-compliance with financial plans to provide efficiency savings whilst maintaining standards affects Amman V, BGH, GGH, PPH, WGH	Scheduled Care	12 ⟺	Subject to unpredictable influences.	8
132	19/01/17	Difficulty in delivering services within the budget allocated to PPH.	USC: PPH & Diabetes & Respiratory	12 ⇩	External pressures such as increases in demand and levels of DTOC limit the ability of the directorate to deliver a balanced financial plan.	8
238	30/05/17	Financial Plan: Risk to service delivery at BGH unable to deliver £1.5m savings plan.	USC: BGH & Gastrology & Neurology	12 ⟺	Despite the control measures above, recruitment especially for nursing staff continues to be a high risk. Financial savings focus has been on increasing efficiencies and LOS reduction. The clinical risk is mitigated by the use of high cost agency nurses to back fill vacancies, however of course, this impacts negatively on the financial position	8
531	20/06/18	HSDU failure to break even on delegated budget due to dental & podiatry services returning without funding affects Whole HB.	Central Operations	12 ⟺	This risk cannot be reduced further until funding is secured to accommodate the additional workload.	6
526	18/06/18	Scheduled Care financial impact of drugs for AMD treatment affecting Amman V & BGH, GGH, PPH & WGH.	Scheduled Care	12 ⟺	Following the withdrawal of pilot funding for AMD, the cost of the high-cost drugs have continued to increase in line with patient numbers.	3
523	18/06/18	Scheduled Care General Surgery, Financial cost pressure due to Locum use to cover employee relations issues at GGH & WGH.	Scheduled Care	12 ⟺	Financial risk remains fixed due to need to provide clinical teams.	3
593	03/09/18	ICF funding for existing services will be discontinued or cease affecting Pembrokeshire.	3 Counties	9 ⟺	Currently awaiting outcomes of ICF bids for 2019/2020 to be able to review and rework current risk level.	6

528	18/06/18	Financial pressure due to transfer of patients from Humira (Adalinumab) to bio-similar drug affect all 4 hospital sites.	Scheduled Care	9 ⟺	Change point dependent on external factors.	6
516	27/05/16	Health Board wide risk regarding VAT advice on historic Design for Life Schemes is incomplete.	Finance	8 ⟺	No narrative added.	8
522	18/06/18	Financial overspend for Anaesthetics, reduction of supporting professional activity sessions affecting BGH, GGH, PPH & WGH.	Scheduled Care	8 ⟺	Dependent on clinical team compliance and agreement.	2
513	01/05/16	Lack of modernisation of the Finance Directorate resulting in limited financial support across the Health Board.	Finance	8 ⟺	No narrative added.	2

The risk register at Appendix 3 details the responses to each risk, i.e. the risk action plan.

There are no new risks added since last submission.

There are 12 risks where the current risk score remains the same since last submission. ⟺
There is 1 risk where the current risk score reduced from 16 to 12 since last submission (132).
There are 9 risks removed since March 19 submission.

- Risk 379 has been archived closed as the financial year has ended.
- Risk 693 does not meet criteria for submission now at service level.
- Risk 542 does not meet criteria for submission now at service level.
- Risk 376 does not meet criteria for submission is now at tolerance.
- Risk 341 has been archived closed the nature of the risk changed a new risk entered.
- Risk 380 does not meet the criteria for submission now at service level.
- Risk 511 does not meet criteria for submission is now at tolerance.
- Risk 515 does not meet criteria for submission is below tolerance.
- Risk 512 does not meet criteria for submission is below tolerance

Also attached is a risk register containing 107 risks (Appendix 4) which have identified a finance theme, e.g. a risk with an impact on finance that is caused by allocated budgets which are insufficient to deliver core services due to increased activity. These 'themes' have been included on Datix to improve the 'oversight' of risks by specialist areas and functions within HDdUHB, These are able to provide guidance to those responsible for managing risk and can also develop/improve organisational controls, i.e., policies, procedures, systems, processes, in order to reduce the risk to HDdUHB.

A monthly reminder is sent out to Management Leads requesting that the risk assessment and risks actions are reviewed and updated in line with the following timescales for review.

RISK SCORED	DEFINITION	MINIMUM REVIEW FREQUENCY
15-25	**Extreme**	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	**High**	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.

4-6	**Moderate**	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	**Low**	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Argymhelliad / Recommendation

The Finance Committee is asked to:

- Review and scrutinise the risks included within this report to seek assurance that all relevant controls and mitigating actions are in place.
- Discuss whether the planned action will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact should the risk materialises.

This in turn will enable the Committee to provide the necessary assurance to the Board that these risks are being managed effectively.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Contained in report
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained in report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Risk Appetite - *the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009) Risk Tolerance - *the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives* (ISO Guide 73, 2009)

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts from report however impacts of each risk are outlined in risk description.
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Finance Committee Risk Register

Date: May 2019

Risk Ref	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Date Reviewed
519		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	13/06/2018	There is a risk of expenditure exceeding budget at year-end. This is caused by cost pressures identified, not being met in budget setting. This will lead to an impact/affect on overspend in the order of £115,000 arising from subject access request charging ceasing, rent and utilities increases at Llangennech stores and system maintenance within the contact centre. Risk location, Health Board wide, Unit 4 Stradey Business Centre - Hywel Dda Medical Records.	Expenditure scrutiny monthly. Hold to account meetings. Vacancy holds system in place. Budget Validation Process (identifying are budget shortfalls). Vacancy and procurement review panels. Monthly Health Records finance review meetings. Annual staffing review process. Savings proposals review. IMTP proposals.	Finance inc. claims	6	5	4	20	Annual Health Records Staffing Review.	Bennett, Mr Steven	Completed	Staffing review completed for 2018/2019 has been completed by the Deputy Health Records Managers and the departmental supervisors. All vacancies reviewed and recruitment plan agreed.	Finance Committee	2	2	4	02/04/2019
													Monthly Health Records Vacancy Review Process.	Bennett, Mr Steven	Completed	Monthly vacancy review meeting between Health Records Manager and Deputy Health Records Managers fully implemented.					
													Implementation of quarterly budget review and expenditure management meetings.	Bennett, Mr Steven	Completed	Dates agreed for quarterly finance meetings reviewing budget and staffing levels. The first meeting was completed on 24th July 2018.					
													Identify any additional or non funded costs for the 2019/20 Health Records Budget.	Bennett, Mr Steven	Completed	All non funded budget elements and additional costs have been identified within the Health Records service and have been forwarded to the Deputy Director of operations for discussion with the finance team in preparation for budget setting in 2019/20.					
													Complete a savings review proposal identifying any potential cost savings or efficiencies within the Health Records service or Health Board.	Bennett, Mr Steven	Completed	Savings proposal and PID documentation submitted to the Deputy Director of Operations for discussions with the Executive Team.					
													Complete an IMTP plan for the Health Records service identifying potential cost savings and efficiencies.	Bennett, Mr Steven	Completed	IMTP submitted to Assistant Director of Strategic Planning					
													Complete a Health Records staffing review for 2019/2020.	Bennett, Mr Steven	31/05/2019	Meeting scheduled to discuss staffing resource with Deputy Health Records Managers in first week of May 2019.					
525	andard 7.1 Workforce	eduled Care: Theatres	Hire, Stephanie	Knight, Diane	18/06/2018	There is a risk of financial pressure for the department through both payments and the requirement for an increased nursing and Operating Department Practitioners (ODP) workforce to provide safe staffing levels. This is caused by the site specific policy for compensatory rest following on-call weekend	Maintenance of current model of compensatory rest, which contradicts Agenda for Change agreements as identified by the Internal Audit review of theatres. New roster to commence 29/04/2019	Finance inc. claims	6	4	4	16	SBAR for removal of compensatory rest has been submitted for review by the Nursing Directorate.	Knight, Diane	Completed	Subsequent request for Executive Team paper.	Finance Committee	1	4	4	27/03/2019

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	S	Sch				shifts. This will lead to an impact/affect on the financial sustainability of the service. Safe staffing levels through pressure to recruit a larger workforce. Risk location, Bronglais General Hospital.							Implementation plan following the Executive decision to be drafted and agreed with the BGH Theatre team and TU reps..	Nichols-Davies, Mandy	Completed	Discussed at Executive Team meeting 2/5/18; 25/7/18. To be considered again 15/8/18. No agreemtn with SCRUB team on changes OCP begining on the 16/1/19 for 90 days to support changes to Terms of Conditions. Awaiting decision OCP has been concluded					
527		Scheduled Care	Hire, Stephanie	Hire, Stephanie	18/06/2018	There is a risk of non-compliance with financial plans. This is caused by the challenge of providing efficiency and productivity savings whilst maintaining clinical standards. This will lead to an impact/affect on the ability to achieve financial stability and reduce departmental overspend. Risk location, Amman Valley Hospital, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Financial forecasting for 2018/19 undertaken. Directorate structure for monthly oversight of spend in place with finance team partners. Efficiency & Productivity forecasting established, with monitoring forums in place to scrutinise and escalate issues.	Finance inc. claims	6	3	4	12	Mapping of efficiency & productivity profile for 2018/19 by all teams.	Hire, Stephanie	Completed	In conjunction with Efficiency & Productivity Holding to Account meetings	Finance Committee	2	4	8	11/04/2019
													Review of progress to be undertaken for Month 5 delivery.	Hire, Stephanie	Completed	Meeting established. Awaiting month 5 information. December update: - 1 x new list established. Wider implementation plan in place to support development					
													2019/20 programme of efficiencies monitoring process in development.	Hire, Stephanie	31/05/2019	In development with Business Partner					

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132		USC: PPH	Denning, Brett	Jones, Alex	19/01/2017	There is a risk of It is proving difficult to deliver services in PPH within the allocated budget due to increased patient activity. This is caused by multiple risks to savings plans due to variation in demand and inter-dependencies with other services that are also under pressure. This will lead to an impact/affect on ability to deliver service and health board overall over spend. Risk location, Prince Philip Hospital.	Oracle. Quick View. Variable pay controls. Finance reports. Finance meetings with triumvirate. Finance appointment of business partner complete.	Finance inc. claims	6	3	4	12	Undertake a PPH budget allocation review.	Denning, Brett	**Completed**	Being undertaken with budget holders.	Finance Committee	2	4	8	29/03/2019
													Delivery of savings plans for 2017/18.	Denning, Brett	**Completed**	Complete.					
													PPH participating in the turnaround process.	Denning, Brett	~~31/12/2017~~ 31/12/2018	In process and on-going.					
													Delivering 2018/19 financial plans which has been agreed at exective level.	Denning, Brett	**Completed**	Review with the Triumvirant team on a timely basis to ensure plans are being monitored. Business partner has now been appointed.					
238		USC: BGH	Davies, Hazel	Davies, Claire	30/05/2017	There is a risk of The ability of the BGH site to meet its financial savings target remains a risk due to the impact of nurse recruitment and the need to incur the cost of agency premium. This is caused by Inability to easily recruit nurses due to rurality and relative isolation. Significant success however has been achieved in reducing variable pay cost for doctors and removal of all agency premium This will lead to an impact/affect on The nursing deficit (approx. 40%) impacts significantly on the site's financial delivery and ability to achieve turnaround. Other risks inherent describe all efforts to improve this position including a 1-5 year nursing workforce strategy. Risk location, Bronglais General Hospital.	The clinical strategy for Bronglais which recognises its place within Mid Wales is now well understood and sits within the wider Health Board TCS strategy. This is now supported by a developed 5 year Nursing Workforce strategy which will drive local nurse education and enable the growth of our own local workforce. The senior team are working closely with Swansea and Aberystwyth Universities to achieve this. Short term actions - driving down unit price for nurse agency Financial recovery plan which accounts for actions to improve HCSW and Band 4 role development (2 year plan) Incentivised bank - awaiting approval for second launch Bronglais Summit - held in November to ensure executive colleagues are sighted on the risks and supportive of all actions to improve	Finance inc. claims	6	3	4	12	Develop A clinical strategy for Bronglais General Hospital and agree key themes.	Davies, Hazel	**Completed**	Clinical strategy for Bronglais General Hospital will be informed by the current improvement programme of transforming clinical strategy scheduled for public consultation Summer 2018. Regular bronglais specific strategy meetings are held with a final agreement due August 2018. Capita are due to complete a workforce strategy ready to present to the Health Board in November 2018.	Finance Committee	4	2	8	25/02/2019
													Develop a Complimentary workforce strategy which takes account of other non traditional workforce options.	Davies, Hazel	**Completed**	New ANP posts are currently being advertised to support our clinical model with an ANP in cardiology commenced in post. We have also recently appointed an ANP in COTE and frailty. We have also recently appointed three Physician Associates, with two starting in September 2018 and one due to start in December 2018.					

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													Explore ALL options to reduce agency in nursing and medics - including roster improvement to increase utilisation of our own existing staff (links to nursing plan above).	Davies, Hazel	Completed	We have two high cost medics in post, one agency (capped rate) and one NHS (enhanced rate). Both of these will be displaced when the medics recruited are in post. We have successfully recruited doctors to fill the deanery vacancies on our junior medical rota and reduced the number of zero hours locum doctors. We have recruited four staff grade doctors who are due to be in post September 2018. Workforce panel approval is needed for any agency staff appointed and agency and locum cap rates have been introduced which limits the amount we can pay locum staff.					
													Agree a clinical model for colorectal cancer surgery at Bronglais General Hospital. 1 colorectal consultant starts January 2019 2nd consultant awaiting start date CRC model intrinsically linked to the timeline for opening of new theatres at BGH (Scheduled care plan)	Davies, Hazel	~~31/03/2018~~ 30/03/2019	Subject to start date of second CRC surgeon and opening of new theatres, the colorectal model will be able to go live at BGH					
531	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Central Operations: HSDU	Rees, Gareth	Flear, Philip	20/06/2018	There is a risk of failure to break even on delgated year end budget. This is caused by additional dental and podiatry community workload being returned to HSDU for decontamiantion with no additonal funding for the HSDU service. This will lead to an impact/affect on the year end delegated budget due to increased staffing and consumables cost. Risk location, Health Board wide.	Overtime incurred when absolutely necessary. Consumable costs reviewed for potential cost improvement plan.	Finance inc. claims	6	4	3	12	Organsie meeting with community teams to adress the funding concern	Flear, Philip	31/12/2018	Date to be scheduled. Update 23.08.18 Meeting held 20.08.18 a paper to be written and submitted to the decontamination meeting for discussion.26.10.18 The paper was written and presented to the decontamination group meeting 15.10.18. The additional dental workload is causing backlog and delays in the re processing of surgical instruments. Update 27.12.18 Situation is still the same no further update. Update 27.02.19 No further update.	Finance Committee	2	3	6	27/02/2018

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526		Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	18/06/2018	There is a risk of financial pressure to the service to continue to provide the current Age related Macular Degeneration(AMD)treatments of Lucentis and Eylea drugs. This is caused by the cost of on-going high cost drug treatment becoming a departmental cost pressure following the ending of pilot funding from Welsh Government in 2017. This will lead to an impact/affect on the ability of the service to provide assurance for financial prudence. Risk location, Amman Valley Hospital, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Review of medication usage. Review of Ophthalmology patient pathway. Flagging of cost pressure through budget setting.	Finance inc. claims	6	4	3	12	New drug (Avastin) has been identified as providing good outcomes for patients with AMD. The drug was primarily licensed for use on Diabetic retinopathy, but was found to be effective for AMD. It has been adopted by NHS England, but is subject to a judicial review regarding medical licensing. Decision on use is with Welsh NHS.	Wragg, Gordon	~~31/01/2019~~ 31/01/2019	Health Board Clinicians are examining the potential use of the drug for effectiveness vs other treatments. If suitable for adoption may reduce drug costs up to £500K. Awaiting response to Judicial Review SBAR drafted in Sept 2018 Awaiting Welsh NHS decision on licensing.	Finance Committee	1	3	3	12/04/2019
523		Scheduled Care: General Surgery	Hire, Stephanie	Lewis, Caroline	18/06/2018	There is a risk of financial cost pressure. This is caused by the requirement to engage locum clinicians to provide cover for staff currently not in work as a result of employee relation issues. This will lead to an impact/affect on the ability to provide care within the departmental budget. The ability to provide continuity of care to patients. The moral and motivation of the clinical teams involved. Risk location, Glangwili General Hospital, Withybush General Hospital.	Probity on the locum contracts being agreed to ensure continuity of service. Adherence to Health Board HR Policies in the management of cases.	Finance inc. claims	6	4	3	12	Develop management plans for continued locum payments to cover GGH consultant off work due to employment relation issues to be specified, including time line for likely conclusion of situation.	Lewis, Caroline	**Completed**	In progress.	Finance Committee	1	3	3	11/04/2019
													Develop a management plan for continued locum payments to cover WGH consultant off work due to long term sickness, including time line for likely conclusion of situation.	Lewis, Caroline	~~13/08/2018~~ 30/06/2019	HR strategy to bring a solution to issues in development in conjunction with Medical HR.					
													Develop management plans for continued locum payments to cover WGH middle grade covering a consultant off work due to employment relation issues to be specified, including time line for likely conclusion of situation.	Lewis, Caroline	**Completed**	In progress.					

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593		3 Counties: Pembrokeshire	Lorton, Elaine	Hay, Sonia	03/09/2018	There is a risk of ICF funding for existing services will be discontinued or cease. This is caused by by the Integrated Care Fund (ICF) ceasing in March 2020. This will lead to an impact/affect on Financial pressure to county operational revenue budgets through unfunded posts. Staff & cause uncertainty in relation to role & employment. Patients physical and mental health may decline due to a reduction or cease of current service provision, eg, loss of functional ability & deconditioning due to a reduction in rehabilitation funded posts. Timely discharge from acute & community hospitals due to lack of service provision. Risk location, Pembrokeshire.	Existing community services funded by ICF are regularly reviewed. Welsh Government made aware by quarterly reporting of outcomes and impacts of services funded. Position paper highlighting potential impact and risk was shared in SBAR to BPAC in October 2017.	Workforce/OD	8	3	3	9	Ensure all ICF funded projects and services have clear exit strategies.	Hay, Sonia	01/12/2018	Ongoing	Finance Committee	2	3	6	16/04/2019
													Review all vacancies in line with potential ICF posts.	Hay, Sonia	**Completed**	Completed					
													Ensure the potential risk of ICF funding is highlighted on Operational Business Team Meeting for monitoring impact on wider services.	Hay, Sonia	~~25/01/2019~~ 11/06/2019	Ongoing as part of IMTP					
528	Standard 2.6 Medicines Management	Scheduled Care: Rheumatology	Hire, Stephanie	jones, Donna	18/06/2018	There is a risk of financial pressure through the prescription of high cost medication. This is caused by the exclusive license for Humira (Adalinamab) creates a cost pressure for this drug, which is only able to be prescribed from a Hospital Setting. In 2018-19 the patent expires which allows for the prescribing of bio-similar medications. This will lead to an impact/affect on a cost saving per patient with an expected 40% saving on medication costs, resulting in a £250k whole year saving. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Clinical teams are prepared for change over once possible.	Finance inc. claims	6	3	3	9	Transition plan required for patients to map time frame for change over of prescription.	Harry, Debora	**Completed**	Forecasting underway - clinical team mapping the number of patients and how they can be clinically reviewed and transitioned to new drugs.	Finance Committee	2	3	6	11/04/2019
													Transition plan being deployed with expected impact to be felt from M6 2019/20	Harry, Debora	30/09/2019	PID has been developed to support transition and identify potential cost reduction					
516		Finance	Thomas, Huw	Hayes, Rebecca	27/05/2016	There is a risk of the Health Board recovering an incorrect amount of VAT on advice given on historic and incomplete Design for Life Schemes. This is caused by difficulty in obtaining VAT advice from D4L nominated VAT advisor. This will lead to an impact/affect on the capital program with any incorrect or blocked VAT	This contract is managed by NHS Shared Services on behalf of Welsh Government. Welsh Government are informed through Capital Review Meetings. It is likely any issues will be funded by Welsh Government as they arise from an all Wales VAT advice contract.	Finance inc. claims	6	4	2	8	Identify a provider for VAT advice.	Eve, David (Inactive User)	**Completed**	For new D4L schemes the VAT advisory work will be undertaken by the HB current VAT advisors. The issue for new D4L schemes is resolved.	Finance Committee	4	2	8	29/11/2018

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						claims needing to be repaid. This may increase as final reviews are undertaken. Risk location, Health Board wide.							Work with Shared Services and Deloitte's to resolve the older D4L schemes.	Thomas, Huw	30/09/2019 ~~30/06/2017 & 31/12/2018~~	2 schemes are currently with HMRC for closure, another 3 schemes remain outstanding and 1 scheme is on-going. Work continues to resolve the older schemes. Deloitte are supporting the HB with current HMRC queries and correspondence. Discussions between HMRC Policy Team and Deloitte took place in December 2017, with internal HMRC discussions following in January 2018. HMRC visited the HB in July 2018 and reviewed all of the schemes in detail. As a result, Deloitte have prepared revised work in respect of final account assessment; this was submitted to HMRC in October 2018 for feedback. The follow up work on the Front of House scheme has now been passed over to KPMG who are working with the Health Board to respond to HMRC queries.					

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522		Scheduled Care: Anaesthetics	Hire, Stephanie	Knight, Diane	18/06/2018	There is a risk of financial overspend for Anaesthetics. This is caused by the inability to reduce the number of Supporting Professional Activity (SPA) sessions across the consultant body to draw in line with advice from the Medical Director. This will lead to an impact/affect on the financial sustainability of the department. Ability to provide 21 more funded direct clinical care sessions from within the established consultant body. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Job planning in place in line with Medical Directors instructions.	Finance inc. claims	6	4	2	8	Job planning dates to be established for all Consultant Anaesthetists	Knight, Diane	**Completed**	complete	Finance Committee	1	2	2	27/03/2019
													Full review of workload commitments	Knight, Diane	~~30/11/2018~~ 31/03/2019	Being addressed through the electronic job planning process.					
513		Finance	Thomas, Huw	Hayes, Rebecca	01/05/2016	There is a risk of lack of modernisation of the Finance Directorate. This is caused by withdrawal of the earlier Organisational Change Plan OCP. This will lead to an impact/affect on the level of financial support will be less than optimal. Risk location, Health Board wide.	The Director of Finance is in close liaison with the Senior Finance Team on budget performance, the underlying run-rate and Savings profiles. Temporary agency staff are filling some of the vacancies, until permanent recruitment is made, within the department and this will be retained until permanent solutions are concluded as part of the consultation.	Finance inc. claims	6	4	2	8	Recruit finance staff for vacant positions.	Thomas, Huw	~~29/05/2018~~ ~~31/03/2019~~ 30/06/2019	Director appointment in Dec18. OCP commenced its implementation in Jul18 and is on-going; Senior Finance Team appointed and in post by Nov18. OCP process being cascaded down the team. Bands 5, 4 and 3 are in process.	Finance Committee	1	2	2	29/11/2018

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519		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	13/06/2018	There is a risk of expenditure exceeding budget at year-end. This is caused by cost pressures identified, not being met in budget setting. This will lead to an impact/affect on overspend in the order of £115,000 arising from subject access request charging ceasing, rent and utilities increases at Llangennech stores and system maintenance within the contact centre. Risk location, Health Board wide, Unit 4 Stradey Business Centre - Hywel Dda Medical Records.	Expenditure scrutiny monthly. Hold to account meetings. Vacancy holds system in place. Budget Validation Process (identifying are budget shortfalls). Vacancy and procurement review panels. Monthly Health Records finance review meetings. Annual staffing review process. Savings proposals review. IMTP proposals.	Finance inc. claims	6	5	4	20	Annual Health Records Staffing Review.	Bennett, Mr Steven	Completed	Staffing review completed for 2018/2019 has been completed by the Deputy Health Records Managers and the departmental supervisors. All vacancies reviewed and recruitment plan agreed.	Finance Committee	2	2	4	02/04/2019
													Monthly Health Records Vacancy Review Process.	Bennett, Mr Steven	Completed	Monthly vacancy review meeting between Health Records Manager and Deputy Health Records Managers fully implemented.					
													Implementation of quarterly budget review and expenditure management meetings.	Bennett, Mr Steven	Completed	Dates agreed for quarterly finance meetings reviewing budget and staffing levels. The first meeting was completed on 24th July 2018.					
													Identify any additional or non funded costs for the 2019/20 Health Records Budget.	Bennett, Mr Steven	Completed	All non funded budget elements and additional costs have been identified within the Health Records service and have been forwarded to the Deputy Director of operations for discussion with the finance team in preparation for budget setting in 2019/20.					
													Complete a savings review proposal identifying any potential cost savings or efficiencies within the Health Records service or Health Board.	Bennett, Mr Steven	Completed	Savings proposal and PID documentation submitted to the Deputy Director of Operations for discussions with the Executive Team.					
													Complete an IMTP plan for the Health Records service identifying potential cost savings and efficiencies.	Bennett, Mr Steven	Completed	IMTP submitted to Assistant Director of Strategic Planning					
													Complete a Health Records staffing review for 2019/2020.	Bennett, Mr Steven	31/05/2019	Meeting scheduled to discuss staffing resource with Deputy Health Records Managers in first week of May 2019.					
672	cally Effective Care	LTC: Primary Care	Bond, Rhian	Huggins, Tracey	26/11/2018	There is a risk of increased cost of delivering safe and effective general medical services through Managed Practices. This is caused by GP practices terminating their contracts and no other feasible mechanism in place to provide general medical services to the	Options to return managed practices back to independent contractor status being considered for two current managed practices.	Finance inc. claims	6	4	4	16	Implementation of a Health Board agreed locum cap to reduce the costs associated with GP cover.	Huggins, Tracey	31/01/2019	Paper drafted for Executive consideration.	nce Assurance Sub Committee	2	4	8	25/01/2019

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	Standard 3.1 Safe and Clini	P,C				registered population. This will lead to an impact/affect on budgets as well as the potential to impact on patient care. Risk location, Health Board wide.							Appointment of salaried GPs wherever possible to reduce costs associated with delivering locum led services.	Huggins, Tracey	31/01/2019	Rolling advert on NHS jobs.	Operational Quality, Safety & Experie				
													Seek opportunities to return managed practices back into independent contractor status.	Bond, Rhian	30/04/2019	Plans in place for Goodwick and discussions ongoing regarding Tenby.					
													Development of trading accounts for managed practices to enable them to manage within a defined budget and to demonstrate they are viable businesses when returning to independent contractor status.	Bond, Rhian	30/04/2019	Meeting to be arranged with Finance to progress.					
559		3 Counties: Carmarthenshire	Dawson, Rhian	Rees, Craig	23/10/2014	There is a risk of community services and managed practices estate is not fit for purpose and a lack of community equipment required to deliver a safe and high quality patient 'care closer to home' service. This is caused by a lack of investment in primary and community facilities and infrastructure (IT and equipment) over a number of years which has been exacerbated by inadequate programmes of routine maintenance. This will lead to an impact/affect on the ability to deliver services closer to home which will put increased pressure on acute services. This will lead to increases in costs when renting accommodation or hiring equipment to provide safe services, e.g. leg ulcer clinics and community equipment. Risk location, Amman Valley Hospital, Cross Hands Health Centre, Meddygfa Minafon - (Kidwelly, Trimsaran & Ferryside), Meddygfa Teifi, Llandysul, Meddygfaâ€™r Sarn, Pontyates, Pond Street Clinic, The Surgery, Carmarthen.	Limiting clinical activity within the current accommodation. Annual Health and Safety workplace assessments. Reporting on specific issues to estates as and when required. Business continuity plans. Discuss in Local Health and Safety meetings within local partnership forums. Priorities within A Regional Collaboration for Health (ARCH), Mid and West Wales Collaborative and Public Services Board (PSB) in each county. Bespoke premises meeting set up every 2 months with Heads of Service and Estates, Fire Security and Health & Safety. The risk is updated in the Carmarthenshire Heads of Service meeting and submitted to County Management team meeting for approval.	Quality/Complaints/Audit	8	4	4	16	Review and rationalise the Health Board estate. Identify future developments with Capital Planning Process.	Rees, Craig	~~12/03/2017~~ 30/04/2020	Reviews continue on individual county and site basis. Capital schemes being progressed at different stages to reflect differing priorities and funding streams. Pond street relocating to Penlan in 2020.	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	07/03/2019
													Seek investment and utilisation of technological developments in the delivery of community services.	Rees, Craig	~~01/03/2017~~ 30/04/2019	Welsh Government Funding secured awaiting allocation through the capital program. Amman Valley Hospital received 2 refurbishments, 1st floor and ward area. New bid in for clinical drug area.					
													Develop opportunities with Social Care partner organisations.	Rees, Craig	~~01/03/2017~~ 30/04/2019	These are being developed but come with a cost. Reported through County Management Team. Reduced cost of building occupancy in Eastgate costs increased due to staff relocated to other sites. new options being considered, relocation to either Llangenech or Felinfoel site or Ashgrove managed practice.					
													Link with proposed acute services and partners to consider flexible ways of providing services.	Rees, Craig	~~01/03/2017~~ 31/03/2020	Opportunities for Community Clinics, e.g. leg ulcer, continence. Options continuing to be explored, joint venture with Ceredigion to support staff and patients in Teifi GP practice. Further scoping exercise being undertaken results due in June 2019.					

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63		Central Operations: Private Patients	Rees, Gareth	Campbell, Michelle	27/06/2016	There is a risk of avoidable commercial risk to the Health Board arising from its private patient work. This is caused by a lack of proper and adequate clear process. Added to this the absence of bespoke administrative resources necessary to support good governance together with forensic billing reviews where private patient activity is concerned is a further causation. This will lead to an impact/affect on financial loss, statutory duty compliance and reputational harm along with possible migration on the part of consultants and medical staff in the event that the Health Board is not allowed to continue to offer private pathways. The risk is considered to be Health Board wide and predominates at acute centres. Risk location, Health Board wide.	Short term measures included in a paper put to the Executive Team in February 2017 have been enacted and include; suspension of selected elective private work; prior authorisation by the Clinical Director (Scheduled Care) ahead of any day case or outpatient private work that can still be provided without adverse affect on RTT and waiting times.	Business objectives/projects	6	4	4	16	Implement medium term measures included in the Feb-17 Executive Team paper which include issuing to tender the general administration of the Health Board's private practice work.	Rees, Gareth	Completed	SBAR completed and to be reviewed at next ET meeting for final decision on which option to outsource.	Business Planning and Performance Assurance Committee	2	4	8	29/03/2018
													Executive Team decision support requested to proceed with proposal A to ensure each internal audit recommendation could be properly implemented.	Campbell, Michelle	Completed	Executive Team approved the expenditure. The exception being the expenditure related to in-house costs and that £100k savings should be returned in year. For this reason, it was impossible to continue negotiations with the preferred partner.					
													Request ARAC support on the revised negotiations undertaken through July and August 2018.	Campbell, Michelle	Completed	ARAC support given on 21st August					
													Further to the Oracle order progressed in September 2018 and initial set up meeting with TPW, work to commence.	Campbell, Michelle	Completed	Due to preferred partner ill health, work should commence early 2019.					
													TPW team arrived on site on 16th January 2019 to discuss implementation plan and an initial meting was held with the Clinical Director also on this date.	Campbell, Michelle	Completed	TPW Team are on site again on 28th & 29th January. Contacts are being made with teams (sites) along with attending a task and finish group.					
													Second PP set up meeting scheduled for 26th Feb'19 to review progress to date in respect of Forensic billing; development of policy & procedures, tariff, training.	Campbell, Michelle	Completed	meeting date reset					
													Two meetings to be held with Medical Director and Asst. Director of Finance. These are to discuss the setting of a Group to manage oversee the governance of PP and getting the developed tariff adopted	Campbell, Michelle	Completed	Meetings held					

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													Tariff to be approved by Finance Committee	Campbell, Michelle	31/05/2019	New action					
													Consultancy company to develop policies and procedures	Campbell, Michelle	30/06/2019	New action					
													Training of staff in respect of new polices and procedures	Campbell, Michelle	30/09/2019	New action					
													Consultancy company to liaise with top 5 insurance companies	Campbell, Michelle	31/05/2019	New action					
													Consultancy company to attend medical staffing committee's or alternative to raise awareness	Campbell, Michelle	31/05/2019	New action					
724	Standard 2.1 Managing Risk and Promoting Health and Safety	USC: PPH	Denning, Brett	Denning, Brett	09/04/2019	There is a risk of patients being located within inappropriate areas resulting in a delay in patient assessment and treatment. This is caused by insufficient clinical space due to increased medical inpatient activity and admissions. This will lead to an impact/affect on patient outcomes and quality of care, poor patient experience with potential concerns and claims as a result. Staff having to work in crowded and challenging environment due to patient group and poor co-ordination of care. Risk location, Prince Philip Hospital.	There is a Navigator and triage system currently in place.	Safety - Patient, Staff or Public	6	4	4	16					Board	2	3	6	26/04/2019

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107		USC: Cardiology	Perry, Sarah	Bowen, Caryl	21/04/2017	There is a risk of significant patient harm due to IT errors and inefficiencies. This is caused by an ageing McKesson IT system (picture archiving and communication system (PACS). Lack of financial resource to replace McKesson archive system. This will lead to an impact/affect on the efficiency of co-ordinating patient care and ability to monitor patients along the cardiac pathway. Ability to integrate with the All Wales cardiac informatics solution. Catastrophic failure of the McKesson archive carries immediate and significant impact on patient safety. Inability to store diagnostic images and reports, inability to report electronically. Ability to realise efficiencies through the use of technology. Risk location, Health Board wide.	Continued use of existing systems. Image archives: Capital bid has been developed and to go to Capital Meeting November 2017 (submitted). Capital bid approved STA signed awaiting confirmation of delivery date and installation	Safety - Patient, Staff or Public	6	4	4	16	Cardiac IT specialist post identified in cardiology strategy.	Perry, Sarah	31/12/2017	Cardiology Integrated Medium Term Plan (IMTP).	Operational Quality, Safety & Experience Assurance Sub Committee	1	4	4	30/01/2019
													Replace McKesson archive.	Perry, Sarah	**Completed**	Risk highlighted, IT submitted Capital bid 17/18. Cardio physiology to develop capital bid to support McKesson upgrade - @ £500K Dec 2017.					
525	Standard 7.1 Workforce	Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	18/06/2018	There is a risk of financial pressure for the department through both payments and the requirement for an increased nursing and Operating Department Practitioners (ODP) workforce to provide safe staffing levels. This is caused by the site specific policy for compensatory rest following on-call weekend shifts. This will lead to an impact/affect on the financial sustainability of the service. Safe staffing levels through pressure to recruit a larger workforce. Risk location, Bronglais General Hospital.	Maintenance of current model of compensatory rest, which contradicts Agenda for Change agreements as identified by the Internal Audit review of theatres. New roster to commence 29/04/2019	Finance inc. claims	6	4	4	16	SBAR for removal of compensatory rest has been submitted for review by the Nursing Directorate.	Knight, Diane	**Completed**	Subsequent request for Executive Team paper.	Finance Committee	1	4	4	27/03/2019

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													Implementation plan following the Executive decision to be drafted and agreed with the BGH Theatre team and TU reps..	Nichols-Davies, Mandy	Completed	Discussed at Executive Team meeting 2/5/18; 25/7/18. To be considered again 15/8/18. No agreemtn with SCRUB team on changes OCP begining on the 16/1/19 for 90 days to support changes to Terms of Conditions. Awaiting decision OCP has been concluded					
716	Standard 2.6 Medicines Management	P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Simons, Delyth	01/01/2019	There is a risk of considerable additional cost for the provision of aseptic products including chemotherapy to the patients of HDdUHB due to the fragility of the Aseptic Services within HHdUHB This is caused by increased costs of the products when they are out-sourced to other manufacturing units. This will lead to an impact/affect on the cost of the total chemotherapy service leading to increased pressure on the finances of the HDdUHB Risk location, Health Board wide.	Units in BGH and WGH supporting the provision of Chemotherapy to GGH and PPH patients. Review of out-sourced products to ensure best value between manufacture and out-sourcing.	Finance inc. claims	8	5	3	15					Medicines Management Group	2	4	8	01/04/2019
692	Standard 3.1 Safe and Clinically Effective Care	USC: WGH	Cole-Williams, Janice	Andrews, Bethan	03/09/2018	There is a risk of complex medical conditions not being recognised and not treated in a timely manner in elderly, frail patients. This is caused by delay of identifying clinical deterioration of these patients. The medical and nursing teams not recognising the complexity of the medical conditions of frail, elderly patients This will lead to an impact/affect on resulted in significant harm to the patients including death. Risk location, Withybush General Hospital.	Local orthopaedic Governance group set up to monitor implementation of agreed action plan. Action plan has been developed and agreed by Service alongside ASI team. Training programme developed for medical and nursing staff. Medical training has been incorporated into weekly medical training sessions. Workshops planned for April 19' for nursing staff. All R/N will have been updated in AKI/ILS. Bed base has been reconfigured resulting in reduction of beds to mitigate the impact of increased R/N vacancies.	Safety - Patient, Staff or Public	6	3	5	15	Training programme developed for medical and nursing staff. Medical training has been incorporated into weekly medical training sessions. Workshops planned for April 19' for nursing staff. All R/N will have been updated in AKI/ILS	Hawkings, David	30/04/2019	Training programming developed and will be delivered in April 2019	Operational Quality, Safety & Experience Assurance Sub Committee	2	3	6	21/03/2019
													Action plan has been developed and agreed by Service alongside ASI team.	Burns, Mr Andrew	30/08/2019	Action plan in draft, Local Governance Group meeting monthly to monitor risk					

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424		USC: BGH	Davies, Hazel	Davies, Claire	24/04/2018	There is a risk of avoidable harm to patients through unwarranted pressure damage. This is caused by the current stock of air mattresses has exceeded its life expectancy. There are various models of air mattress in service which are no longer supported by their manufacturers. This results in increasing difficulties in sourcing the necessary spare parts. This will lead to an impact/affect on patient safety, patient quality and increased incidence of pressure sores and or damage. Risk location, Bronglais General Hospital.	Repairing mattresses as often as possible and attempting to keep as many air mattresses operational as is possible, but when parts cannot be obtained then there is little alternative but to remove from service.	Safety - Patient, Staff or Public	6	5	3	15	Funding for new air mattresses	Jones, Dawn	06/11/2018	The Clinical trial has been completed and the company awarded a contract to provide air mattresses. Funding is still being sought for implementation. I think the initial plan is to replace any current lease with the new lease to the awarded company. BGH is on the list for replacement of some in this financial year, but will be involved in phase 2 of the HB implementation plan.	Operational Quality, Safety & Experience Assurance Sub Committee	2	3	6	25/03/2019
251	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Central Operations: HSDU	Rees, Gareth	Flear, Philip	07/04/2017	There is a risk of avoidable loss of Joint Advisor Group (JAG) accreditation, which is essential to support the provision of clinical services within endoscopy units as required by Welsh Government. This is caused by due to a strong and intrusive smell of Peracetic Acid within the decontamination area of the endoscopy unit. This will lead to an impact/affect on loss of JAG accreditation which results in non-compliance with Welsh Government's requirements for endoscopy and a consequential impact on the Health Board's ability to attract junior doctors to fulfil placements within the unit. Risk location, Bronglais General Hospital.	SMTL have carried out gas analysis testing within the clean and dirty areas, which were below the acceptable exposure limit. A contract has been set up to monitor gas exposure on a quarterly basis. Paracetic Acid containers are stored in a carbon filtered COSHH cupboard. Endoscopy staff receive annual COSHH training.	Business objectives/projects	6	3	5	15	Prepare SBAR outlining option appraisals to take endoscope decontamination forward.	Flear, Philip	**Completed**	SBAR Completed.13/06/18 - SBAR submitted no further action can be taken until capital funding is secured which is estimated in 2019/2020 financial year. No further update 13.08.18. No further update control measures have been reviewed with no change. 14.09.18 Update 26.10.18 Control measures reviewed and continue to be effective. 30.11.18 No further update. Update 27.12 18 No further update. No further update 27.02.19	Estates and IM&T Sub Committee Capital,	1	5	5	27/02/2018
													Procure Paracetic Monitors for the clean and dirty areas of the endoscope decontamination unit.	Flear, Philip	**Completed**	Capital bid submitted, funding approved. Awaiting delivery of Peracetic monitors. Update 13.08.19 Monitors received and have been installed for use. 14.09.18 Update 14.09.18 Peracetic monitors received and identified to be faulty - replacement monitor received 12.09.18 will continue to monitor closely and review in a months time. 26.10.18 Continuing to work effectively being monitored on a regular basis. 30.11.18 The paracetic monitor is working effectively no further action needs to be on this action.					

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													Obtain updated quotation for replacement of air handling unit.	Griffiths, Jill	Completed	Quotation received.Update 13.08.19 Looking at re locating the decontamination service into HSDU 2019/20. No further update 14.09.18 26.10.18 - No further update on the centralisation of decon into HSDU however whilst this remains a priority the endoscopy washers at PPH are problematic causing cycles failures on a regular basis and will therefore need addressing prior to BGH. 30.11.18 No further update. Update 27.12.18					
681	Standard 2.6 Medicines Management	P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Simons, Delyth	03/12/2018	There is a risk of harm to patients receiving intra-venous drug administration via infusion pumps, where there is a delay in updating the drug library associated with the pumps. This is caused by the current manual process and the lack of equipment (battery pack) to enable Wi-Fi connectivity of the pumps to instantly update. This will lead to an impact/affect on the safety of patients where any change in administration instruction or change in formulation of the drug, results in the administration of the intra-venous medicine at the incorrect rate and or volume. New drugs need to be added and tend to be higher risk as they require increased monitoring (black triangle)and are less familiar to the services. Risk location, Health Board wide.	Review of each medicine in the drug library on an annual basis. Manual process in place for the updating of the Adult Drug Library, Paediatric Drug Library and the Neo-Natal Drug Library. Review is undertaken by two Medicines Information trained Pharmacists. Training undertaken in all Clinical areas undertaking IV administration.	Safety - Patient, Staff or Public	6	3	5	15	Obtain information regarding the cost of installing wi-fi connectivity to the pumps.	Solloway, Paul	29/03/2019	For all the pumps across the Health Board there is a cost of £300,000 (£250 per pump). Discussion regarding the pump connectivity and the Wi-Fi access across sites have been underway with IT.	Medicines Management Group	1	3	3	03/04/2019
													Further discussion needs to be undertaken to establish funding stream.	Pugh-Jones, Jenny	29/03/2019 30/08/2019	No concrete progress made overall, however some pump batteries are being replaced as they become defunct and replaced with Wi-Fi batteries.					

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550		E&F: Property Performance	Elliott, Rob	Williams, Paul -	22/12/2017	There is a risk of the Health Board failing to meet carbon reduction targets as outlined by Welsh Government in line with international aspirations. This is caused by the challenges facing the organisation e.g. the poor condition of the estate, a lack of required resources and not undertaking sufficient opportunities to embed decarbonisation into decision making processes. This will lead to an impact/affect on legal compliance with the Environment Act and Wellbeing of Future Generations Act, financial pressures as being reactive, at a later date, will be more disruptive and costly, poor operational performance and non achievement of cost improvement plans (CIPs) as well as reputational damage because, as a public sector body, the UHB should be leading the way in proactive and progressive behaviour. Risk location, Health Board wide.	Development of an Estate Strategy to support the Transforming Clinical Services (TCS) agenda. The TCS will inform the Estate Strategy and the decarbonisation recommendations within it.	Statutory duty/inspections	8	4	3	12	Commission Carbon Trust to develop a long term decarbonisation plan to focus on energy supply and building fabric and operations in TCS outcomes.	Williams, Paul -	20/12/2019	A meeting was held with the Carbon Trust (on behalf of WG) to outline the current position and action required to meet the 2030 target. AM also identifying baseline and levels of reduction expected for HDUHB.	Capital, Estates and IM&T Sub Committee	3	3	9	07/03/2019
													Delivery of energy efficiency schemes namely steam traps surveys and replacements and insulation lagging at GGH.	Corcoran, Rhian	**Completed**	Action transferred to risk 549.					
													Identify how best to approach the Welsh Government and Environmental Act target to reduce carbon emissions. Present SBAR Strategy to CEIM&TSC to facilitate discussion on wider Health Board implications linked to Procurement, Transport, IM&T, Environment and service delivery. This also links to work being undertaken for Wellbeing of Future Generations Act and TCS.	Williams, Paul -	~~30/11/2018~~ 31/10/2019	Need to commence a carbon management group under the direction of the CEIM&T or an equivalent group e.g. exec team. To be lead by the new SEO following commencement. Change delivery date to 01.10.19					
549		E&F: Property Performance	Elliott, Rob	Williams, Paul -	22/12/2017	There is a risk of escalating utility consumption and associated costs resulting in financial and reputational risks. This is caused by an increase in cost of fossil fuels, the complexity of energy markets, failure of buildings and infrastructure, no investment in onsite generation and renewables. Main efficiency barriers are funding, awaiting long term service plans and not enough resource or time to deliver sustained improvement. This will lead to an impact/affect on [illegible]	Verification of invoices including monthly and quarterly readings referencing the energy monitoring system (Medic). There are discussions with Operational staff and comparisons against previous years' consumption. Work with specialists from the Carbon Trust and Green Growth Wales to undertake reviews and feasibilities to identify opportunities to reduce consumption and cost e.g. a solar farm at Hywel Dda, rooftop photovoltaic (PV) system and [illegible]	Finance inc. claims	6	3	4	12	Determine suitably of additional resource options, external support, consultancy or additional resource within the Environmental and wider Facilities function.	Williams, Paul -	~~19/09/2018~~ 31/09/2019	Part completed. 2 of 4 team member leaving May 2019, need to assessed with new SEO on support option as part of future development of the function. Aqua Fund and CAFM are both underway and their impact needs to be account for	Estates and IM&T Sub Committee	2	4	8	07/03/2019

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						This will lead to an impact/affect on higher levels of expected spend and high levels of unnecessary spend. Failure to contribute to statutory obligations e.g. the Environment Act and Wellbeing of Future Generations, etc. Risk location, Health Board wide.	decarbonising GGH. Low cost spend to save actions within the annual capital allowance e.g. steam trap efficiencies and pipework insulation projects. Phase II energy and carbon saving project has been approved in principle by Welsh Government but no funding is available to progress via central capital. Welsh Government spend to save projects focussing on PV systems on roofs, LED lighting and controls. Building Energy Management systems are in place to monitor and control building environments. Energy Awareness Campaign. Control of energy costs via an All Wales contract and managed via the energy price risk management group.						Delivery of energy efficiency schemes namely steam traps surveys and replacements and insulation lagging at GGH.	Corcoran, Rhian	**Completed**	All orders placed and additional improvement schemes identified and incorporated. Mini tender undertaken. Work underway with completion by End of Mar 19	Capital,				
													Review & agree responsibilities within site based maintenance teams to focus on a sustained approach to energy best practice. Identify issues and where possible take action to minimise energy use as part of current roles. Delivery through best practice implementation of site based systems e.g. Building Energy Management, assigning priority to energy related Planned Preventative Maintenance systems	Williams, Paul -	~~28/09/2018~~ 30/09/2019	Monthly performance with Director of Estates have been on going to review and monitor consumption. Some embedding of process has occurred but further work needed for this to be fully established on all sites. Procedure on roles and responsibilities need to be formally adopted.					
													Consult with the Turnaround Teams, in the development of a energy awareness campaign and the Communication team to identify and communicate key messages across the Health Board.	Corcoran, Rhian	**Completed**	Resource restrictions meant that this campaign could not be prioritised. Will consider for next financial year. Action to be closed, and new action will be raised when capacity available					
381		P,C,LTC: Long Term Care	Paterson, Jill	Broad, Vicki	12/02/2018	There is a risk of domiciliary care providers ceasing to operate within the Hywel Dda University Health Board region. This is caused by workforce and financial complexities of operating domiciliary care agencies at a viable and profitable level. This will lead to an impact/affect on Delayed Transfers of Care numbers within the Health Board and an increased risk of increased emergency admissions to hospital or Care homes if there is insufficient capacity to provide care locally to patients already in receipt of Continuing NHS Funding within their own homes. This will also lead to additional pressure to find capacity within the NHS to absorb patients if care provision ceases to be available. Risk location, Carmarthenshire, Health Board wide, Pembrokeshire.	In house teams are in place in Carmarthenshire, Ceredigion and Pembrokeshire along with 3rd Sector Palliative Care Provision. All Wales and Health Board Wide Contingency Planning Group was set up following on from the Allied entering insolvency. All community packages have a contingency plan. All Allied service users were transferred to in house services or alternative providers. Work on-going in partnership with the Local Authorities within the Health Board footprint to minimise and mitigate the risk across the Health Board service area in the event that another agency ceases to trade. Risks around the stability of the market has been escalated and discussed at Community Health Council (CHC) CIP meetings,Turn around meetings and joint meetings with Local Authority. Established working relationships with Local Authority has enabled improved intelligence and information sharing of the sector. Where providers have ceased trading, the Health Board has been able to secure alternative provision from in	Safety - Patient, Staff or Public	6	3	4	12	Strengthen in-house provision.	Paterson, Jill	**Completed**	This work is being delivered and led by County Teams. Additional Posts have been agreed through the Turnaround Process, staff were to be in place in Carmarthenshire and Pembrokeshire by April 2018, however delays in recruitment processes etc delayed this commencement date. Carmarthenshire staff are largely in place. Pembrokeshire and Ceredigion progressing with appointments. Slippage on dates in Ceredigion has led to a revised timescale of September 2018 of staff in post. To be reviewed against revised timescales.	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	31/01/2019
													Review and benchmark agencies, capacity and tariffs across the Health Board footprint.	Bingham, Heledd	**Completed**	Work to be undertaken during the 2018/19 financial year.					

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							house team and other agencies where there has been capacity. Work is on-going in this area.						Review capacity and activity within in-house CHC delivery Teams.	Broad, Vicki	Completed	Work will be progressed during 2018/19, in line with the timescales of joint working group arrangements and integrated partnership work.					
													Ensure that packages of care for CHC that are agreed for delivery at home are sustainable into the future.	Broad, Vicki	Completed	This will be reviewed through the Expert Officer project and will ensure that the principles of the All Wales Sustainable Care Planning is followed to ensure that packages of care prescribed are affordable and proportionate to need and sustainable in terms of continuity of service in the event of reducing in the number of available care agencies locally. Additional work has been undertaken following on from the financial issues with Allied Healthcare.As part of the Hywel Dda Contingency plan, a revised Risk Assessment and contingency agreement has been implemented. Currently being rolled out					
													Update of current position and recommendations.	Broad, Vicki	~~31/03/2018~~ 29/03/2019	SBAR Paper drafted by Head of Long Term Care for the Executive Team for discussion. This has been completed. Awaiting Exec approval.					
													Continue to partake in the All Wales NHS Conference Call and provide updates and information in line with the requirements of the group.	Broad, Vicki	Completed	Head of Long Term Care is leading on the Allied position on behalf of the Health Board. Head of Long Term Care is part of the All Wales Conference Call meetings.					

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													Contingency plans for Children's packages and Adult packages currently being provided by Allied.	Broad, Vicki	Completed	Contingency planning is well advanced. Local Authorities have advised of their intention to TUPE Allied staff over to their in house teams. Plans are in place for the Local Authority in Carmarthenshire and Pembrokeshire to take over the joint packages of care (Adult's). This will take place from the 12th December 2018. Work is on-going on ensuring that there is sufficient capacity within in-house teams and other providers to take over the fully funded packages of care. Discussions are on-going between Children's services and other agencies with the view taking over the packages of care					
													Develop plans for the eventuality that alternative packages of care will not be able to be sourced.	Broad, Vicki	Completed	Carmarthenshire In house team will be taking on 2 packages from Allied. Currently unable to source care for 1 large package due to no capacity within in house teams and other providers. Patient is currently in respite care and this placement will continue to be funded until alternative arrangements can be made. Pembrokeshire County Team is currently reviewing options and trying to source packages. There is no identified capacity to take on packages in Pembrokeshire.In the short term the Care at Home Team and ART will provide an element of care, with families providing support in the interim.					

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238		USC: BGH	Davies, Hazel	Davies, Claire	30/05/2017	There is a risk of The ability of the BGH site to meet its financial savings target remains a risk due to the impact of nurse recruitment and the need to incur the cost of agency premium. This is caused by Inability to easily recruit nurses due to rurality and relative isolation. Significant success however has been achieved in reducing variable pay cost for doctors and removal of all agency premium This will lead to an impact/affect on The nursing deficit (approx. 40%) impacts significantly on the site's financial delivery and ability to achieve turnaround. Other risks inherent describe all efforts to improve this position including a 1-5 year nursing workforce strategy. Risk location, Bronglais General Hospital.	The clinical strategy for Bronglais which recognises its place within Mid Wales is now well understood and sits within the wider Health Board TCS strategy. This is now supported by a developed 5 year Nursing Workforce strategy which will drive local nurse education and enable the growth of our own local workforce. The senior team are working closely with Swansea and Aberystwyth Universities to achieve this. Short term actions - driving down unit price for nurse agency Financial recovery plan which accounts for actions to improve HCSW and Band 4 role development (2 year plan) Incentivised bank - awaiting approval for second launch Bronglais Summit - held in November to ensure executive colleagues are sighted on the risks and supportive of all actions to improve	Finance inc. claims	6	3	4	12	Develop A clinical strategy for Bronglais General Hospital and agree key themes.	Davies, Hazel	Completed	Clinical strategy for Bronglais General Hospital will be informed by the current improvement programme of transforming clinical strategy scheduled for public consultation Summer 2018. Regular bronglais specific strategy meetings are held with a final agreement due August 2018. Capita are due to complete a workforce strategy ready to present to the Health Board in November 2018.	Finance Committee	4	2	8	25/02/2019
													Develop a Complimentary workforce strategy which takes account of other non traditional workforce options.	Davies, Hazel	Completed	New ANP posts are currently being advertised to support our clinical model with an ANP in cardiology commenced in post. We have also recently appointed an ANP in COTE and frailty. We have also recently appointed three Physician Associates, with two starting in September 2018 and one due to start in December 2018.					

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													Explore ALL options to reduce agency in nursing and medics - including roster improvement to increase utilisation of our own existing staff (links to nursing plan above).	Davies, Hazel	Completed	We have two high cost medics in post, one agency (capped rate) and one NHS (enhanced rate). Both of these will be displaced when the medics recruited are in post. We have successfully recruited doctors to fill the deanery vacancies on our junior medical rota and reduced the number of zero hours locum doctors. We have recruited four staff grade doctors who are due to be in post September 2018. Workforce panel approval is needed for any agency staff appointed and agency and locum cap rates have been introduced which limits the amount we can pay locum staff.					
													Agree a clinical model for colorectal cancer surgery at Bronglais General Hospital. 1 colorectal consultant starts January 2019 2nd consultant awaiting start date CRC model intrinsically linked to the timeline for opening of new theatres at BGH (Scheduled care plan)	Davies, Hazel	30/03/2019	Subject to start date of second CRC surgeon and opening of new theatres, the colorectal model will be able to go live at BGH					

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695	Standard 2.1 Managing Risk and Promoting Health and Safety	P,C,LTC: Long Term Care	Paterson, Jill	Broad, Vicki	05/02/2019	There is a risk of the closure and de-registration of Nursing and Nursing EMI care home beds within the Hywel Dda Footprint. This is caused by financial, operational and service issues within a number of care homes across the Hywel Dda University health Board. This will lead to an impact/affect on a lack of on-going nursing home bed provision locally, risk of admission of residents to hospital, increased risk of DTOC (both from LA and Health)and on going capacity issues within the sector. Risk location, Carmarthenshire, Ceredigion, Health Board wide, Pembrokeshire.	Homes identified through current Joint processes in place. Process is managed through the Escalating Controls Protocol. The Long term Care service monitors the care and support delivered to residents placed in health commissioned beds. Where care delivery is noted to be of poor quality, the care providers is closely monitored and supported to improve. Where improvement is not sustained it may be necessary to commence formal joint health and social care Escalating concerns process. Currently across the Hywel Dda footprint there are a number of homes subject to the Escalating Concerns process. 3 homes are subject to an embargo. Where a Care Home is subject to formal Escalating concerns, the relevant Local Authority will arrange regular Joint Inter-Agency Monitoring Panel Meetings (JIMP). The JIMP meeting will include all agencies involved in the monitoring of care homes; Health Board, Local Authority ties, CIW and Police where necessary. The provider is also invited to attend and a corrective action plan is developed, agreed and monitored. Between the JIMP meetings, heightened monitoring of care delivery will be undertaken by the Long Term Care Teams' LTC Specialist Nurses and the Local Authority Social Workers. Reports are completed and fed subsequent JIMP meetings. Where improvement and requirements are not met, commissioners are required to establish a Home Operational Support Group (HOSG) to directly manage either voluntary or enforced care home closures. All residents would have their health and social care needs reassessed and a transfer of care impact assessment would be completed.	Safety - Patient, Staff or Public	6	3	4	12	Head of Long Term Care to continue to attend HOSG and JIMP meetings and to escalate to the Executive team updates on the outcome of meetings and likelihood of homes to continue under escalating concerns/ cease to trade.	Broad, Vicki	Completed	HoLTC attends the meetings and has carried out a number of unannounced visits where care homes are subject to an Embargo. HoLTC is leading on this matter on behalf of the Health Board.	Quality, Safety and Experience Assurance Committee	2	4	8	11/02/2019
													Contingency plans to be developed in the event of home closures	Broad, Vicki	28/02/2019	This is being progressed through the formal escalating concerns process. Provider and all interested parties are involved in this work.					
													Increased monitoring of homes subject to the Escalating Concerns process is required by the Long Term Care Team.	Broad, Vicki	28/02/2019	Increased monitoring has taken place at all homes subject to the formal Escalating Concerns process. Head of Long Term Care has carried out a number of unannounced visits and been central to the identification of issues and required improvements in identified homes. The Long Term Care specialist nurses have increased the monitoring at homes subject to the escalating Concerns process. Improvement plans are in place and are monitored.					

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													Development of a long term market strategy through the Pooled Funds working groups.	Broad, Vicki	30/09/2019	Initial meetings have been held with providers. Discussions have commenced on the need to shape the market into the future to ensure the development of a sustainable, effective and safe service which will meet the on-going needs of the population Area plans are being developed in line with Welsh Government requirement as part of the Social Care and Well Being Act. This is being led by the Mid and West Wales Partnership Board.					
180	Standard 3.1 Safe and Clinically Effective Care	Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	05/11/2015	There is a risk of avoidable harm to patients' sight due to Glaucoma and Age related Macular Degeneration (AMD) as a result of patients not receiving timely care. This is caused by capacity not meeting demand currently. The 14-day pathway for AMD appointments currently experiences delays which impacts on patients being seen and treated appropriately. This will lead to an impact/affect on the potential sight of patients and longer term impacts on future lifestyle. Inability to meet Referral to Treatment (RTT) targets. Risk location, Amman Valley Hospital, Bronglais General Hospital, Crymych Health Care Centre, Crymych, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	A 12-step action programme led by the Health Board Executive Eye Board to improve patient access to follow ups for Macular Degeneration and AMD. Transfer of patients to community optometrists. Capacity and demand training. Clinical validation with established Consultant through waiting list sessions to validate clinical notes and take a decision on the need for treatment.	Safety - Patient, Staff or Public	6	3	4	12	Management of follow-up waiting list.	Wragg, Gordon	**Completed**	Reporting - ensuring that any patient identified as being harmed by a delayed follow up is reported and lessons learned as part of the process of work. Demand and capacity plans completed. 12 step action programme monitored by the Eye Care Group.	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	11/04/2019
													Admin validation approved.	Wragg, Gordon	**Completed**	Admin validation has begun.					
													Clinicians have identified patients on follow up lists who many be at risk.	Wragg, Gordon	**Completed**	Engaged clinical leads in the prioritisation if their patients and the identification of those most at risk of harm.					
													Report to QSEAC + BPPAC in Febraury 2018 to outline updated actions and risks around services	Mills, Caroline	**Completed**	Papers submitted COMPLETED					
													Agreement to be sought for Community Optometrists to review high risk Glaucoma patients in order to assess follow-up requirements.	Wragg, Gordon	**Completed**	Plan in place for the clinical review of 1200 patients by Community Teams. Start date to be confirmed					
													Wet AMD pathway to be reviewed to ensure that appropriate safeguards are in place to bring patients in for appropriate review	Wragg, Gordon	~~31/10/2018~~ 31/03/2019	In progress by Clinical Lead. All pathways and staffing are under review (financial, safety, mangerial, clinical) as part of the Eye Care Plan development.					

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													Wet AMD SBAR update to be submitted to Joe Teape.	Wragg, Gordon	Completed	Paper in draft					
													Joint community / HES workforce planning to be undertaken to understand service development and capacity for managing patients in the community.	Wragg, Gordon	Completed	Meeting booked for 26/9/18					
551		E&F: Property Performance	Elliott, Rob	Williams, Paul -	22/12/2017	There is a risk of potential pollution, a risk to human health through incorrect handling of sharp and infectious waste, fines, inefficient disposal and negative public perception, e.g. poor reuse and recycling. This is caused by the potentially harmful nature of waste, the level of regulatory control, obligations and Welsh Governments aspirations for long term sustainable waste management, costs associated with waste disposal and poor resource efficiency. This will lead to an impact/affect on staff, patients and visitors through incorrect handling and storage, negative publicity through wasteful practices, unnecessary spend through inefficient waste segregation and purchasing practices and regulatory fines for not meeting legal requirements. Risk location, Health Board wide.	The Waste Management Policy (V2 2017) is in place. Departmental waste procedures are in place in, for example, labs, Hotel Services and Pharmacy. Legal compliance monitoring as part of ISO 14001 standard. Auditing as part of ISO 14001 including operational audits of storage and transport and internal audits of training, segregation, etc. A Waste Management Strategy is in place. Delivery of segregation projects in line with Welsh Government and statutory targets and requirements. Training programmes have been developed. Clinical waste training is also included in Infection Control induction basic level 1 and 2.	Statutory duty/inspections	8	3	4	12	Environmental Team to collate and review departmental procedures for hotel services, Pathology, Pharmacy, Theatres, Maintenance and provide feedback as required.	Corcoran, Rhian	~~21/12/2018~~ 31/05/2019	Delivery still impacted by resource, date to be delayed to end of May 2019	Capital, Estates and IM&T Sub Committee	2	4	8	07/03/2019
													Ensure all sites have appropriate waste paper work files, given the move towards e-consignment notes. Environmental team to audit as part of ISO 14001 audit schedule.	Corcoran, Rhian	~~31/10/2018~~ 31/08/2019	Delayed slightly more due to reduced resource, new target in line with ISO 14001 (2015) standard implementation programme following commencement of new Senior Environmental Officer.					
													Investigate options to have a wider staff base to undertake waste segregation audits e.g. facilities, link Nurses and Infection Control teams.	Corcoran, Rhian	30/11/2018	Attend meetings with associated teams over summer 2018.					
													Update waste management strategy.	Corcoran, Rhian	~~28/09/2018~~ 28/09/2019	Update to strategy has commenced but not completed due to competing priorities. Target date amended due to resource changes within the environment team, expect the document to be completed within 6 months of the new senior environmental officer starting.					
													Deliver waste segregation project at Prince Philip and Withybush hospitals in line with Welsh Government requirements.	Corcoran, Rhian	29/03/2019	Work plan for Prince Philip complete and quotes being obtained to purchase bins.					

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													Develop training schedule to complete waste paper work training and waste portering training. Waste training for staff will be undertaken in line with the roll out of waste segregation projects.	Corcoran, Rhian	29/03/2019	Portering training undertaken at Bronglais hospital. Need to schedule for other sites.					
132		USC: PPH	Denning, Brett	Jones, Alex	19/01/2017	There is a risk of It is proving difficult to deliver services in PPH within the allocated budget due to increased patient activity. This is caused by multiple risks to savings plans due to variation in demand and inter-dependencies with other services that are also under pressure. This will lead to an impact/affect on ability to deliver service and health board overall over spend. Risk location, Prince Philip Hospital.	Oracle. Quick View. Variable pay controls. Finance reports. Finance meetings with triumvirate. Finance appointment of business partner complete.	Finance inc. claims	6	3	4	12	Undertake a PPH budget allocation review.	Denning, Brett	**Completed**	Being undertaken with budget holders.	Finance Committee	2	4	8	29/03/2019
													Delivery of savings plans for 2017/18.	Denning, Brett	**Completed**	Complete.					
													PPH participating in the turnaround process.	Denning, Brett	~~31/12/2017~~ 31/12/2018	In process and on-going.					
													Delivering 2018/19 financial plans which has been agreed at exective level.	Denning, Brett	**Completed**	Review with the Triumvirant team on a timely basis to ensure plans are being monitored. Business partner has now been appointed.					
689	Standard 3.5 Record Keeping	MD: Revalidation & Appraisal	Evans, John	Williams, Helen	28/01/2019	There is a risk of compromised patient safety. This is caused by improper completion or organisation of medical records and non-conformity to agreed best practices and standards. This will lead to an impact/affect on unnecessary delay, frustration, clinical misadventure and litigation. Risk location, Health Board wide.	Regular audits are being undertaken to monitor standards of record keeping. Concerns highlighted relating to individual and or Team record keeping performance are addressed through signposting to relevant courses based on required record keeping standards. Concerns highlighted relating to individual and or Team record keeping performance are reflected upon at appraisal and evidence of remediation included as part of the appraisal information. Doctors are being reminded of the importance of good record keeping on a regular basis by the Medical Director through email and letter communication.	Quality/Complaints/Audit	8	3	4	12	Medical Director to increase communications regarding the importance of good record keeping and send regular bimonthly updates with details of relevant courses.	Evans, John	**Completed**	Letter was sent out on 10th July 2018. Further correspondence to follow and important of good record keeping to be added to MD newsletter.	Quality, Safety and Experience Assurance Committee	2	4	8	28/01/2019
													Medical Appraisers to reinforce the importance of good record keeping during appraisal and signpost to relevant courses where applicable.	Williams, Helen	28/06/2019	To be included on agenda for next Appraiser meeting.					
													Health Board e-learning module relating to good record keeping is in the process of being developed and will be complete by the end of April 2019.	Williams, Helen	30/04/2019	The e-learning module is in the process of being developed.					

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388		Central Operations: EBME	Rees, Gareth	Burns, Mike	23/09/2017	There is a risk of avoidable harm to patients and staff arising when medical equipment is used on patients not in accordance with its design and manufacture. This is caused by inadequate staff training and general awareness of the safety and legal issues. This will lead to an impact/affect on potential injury of patients and staff, delayed care and potential enforcement action. Risk location, Health Board wide.	Recruitment of a medical device trainer in March 2018. Review of staff training to identify categories required for each staff group. Medical Devices Training Sub-Group established reporting to the Medical Devices Sub-Committee.	Statutory duty/inspections	8	3	4	12	Establish a Medical Device Training Sub-Group. Develop a training record of users of medical devices showing that users know how to use the device safely and have received the relevant training. Develop a sustainable governance model for Medical Device Training.	Oliver, Angie (Inactive User)	06/01/2018	Medical Device Training Sub-Group established. Work ongoing to Develop a training record of users of medical devices showing that users know how to use the device safely and have received the relevant training and develop a sustainable governance model for Medical Device Training.	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	01/05/2019
527		Scheduled Care	Hire, Stephanie	Hire, Stephanie	18/06/2018	There is a risk of non-compliance with financial plans. This is caused by the challenge of providing efficiency and productivity savings whilst maintaining clinical standards. This will lead to an impact/affect on the ability to achieve financial stability and reduce departmental overspend. Risk location, Amman Valley Hospital, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Financial forecasting for 2018/19 undertaken. Directorate structure for monthly oversight of spend in place with finance team partners. Efficiency & Productivity forecasting established, with monitoring forums in place to scrutinise and escalate issues.	Finance inc. claims	6	3	4	12	Mapping of efficiency & productivity profile for 2018/19 by all teams.	Hire, Stephanie	Completed	In conjunction with Efficiency & Productivity Holding to Account meetings	Finance Committee	2	4	8	11/04/2019
													Review of progress to be undertaken for Month 5 delivery.	Hire, Stephanie	Completed	Meeting established. Awaiting month 5 information. December update: - 1 x new list established. Wider implementation plan in place to support development					
													2019/20 programme of efficiencies monitoring process in development.	Hire, Stephanie	31/05/2019	In development with Business Partner					

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542		Estates & Facilities	Elliott, Rob	Evans, Paul	27/06/2018	There is a risk of an inability to fully adhere to the principles stated within the recent Accountability Agreement form as issued to the Chief Executive Officer (CEO) on 16th of May 2018. This is caused by financial pressures created by the demands of the Facilities services which are not currently funded within the budget. These include escalation in utilities, supporting additional services required by clinical teams and staffing additional ward areas etc. without associated revenue. This will lead to an impact/affect on the overall financial deficit of the organisation and targeted intervention. Risk location, Health Board wide.	The Director of Facilities is fully aware of the requirements laid out in the Standard Financial Instructions and Accountability Agreement Statement. The Director of Facilities has communicated this key issue to all responsible budget holders to enable concerns and issues to be addressed promptly. The Director of Facilities reviews budgets on a monthly basis with the assistance of financial colleagues and staff. The Director of Facilities is fully aware not to incur expenditure where there is insufficient funding and budgets. Detailed discussions are being held regularly with lead managers to bring expenditure in line with budget levels. The Director of Facilities is fully aware not to recruit over funded establishment. The Director of Facilities will confirm and escalate any urgent or temporary staffing requirements required to the Deputy CEO. The Director of Facilities has set a forecasted savings plan for the facilities directorate for 2018-19 and monitors the efficiency and delivery of this regularly with accountable budget holders.	Finance inc. claims	6	3	4	12					Finance Committee	2	4	8	15/02/2019
270	Standard 3.4 Information Governance and Communications Technology	PP&C: Informatics - Clinical Systems & Informatics Programmes	Tracey, Anthony	Smart, Richard	05/10/2017	There is a risk of the implementation of Welsh Community Care Information Solution (WCCIS) not being cost neutral. This is caused by the complexity of the implementation, the numbers of service resources needed and the reliance on NWIS and the supplier to deliver functionality. This will lead to an impact/affect on increased costs incurred by the Health Board. Risk location, Health Board wide.	Regional Project Board in place which covers Health and Social Care. Work is progressing within the Health Board to identify potential resources from efficiencies, for example, travel costs for district nurses returning to base to enter information into the system.	Business objectives/projects	6	3	4	12	Implementation of business case to be developed ready for March 2018 and signing of deployment order.	Smart, Richard	Completed	A business justification case has been presented to the Board for socialisation, which outlined the benefits and associated costs for WCCIS. Further work has been requested which is due to be presented to BPPAC (27th Feb) which details the possible funding solutions available. Notwithstanding this, there is a significant capital and revenue investment required, circa £7.4m	Business Planning and Performance Assurance Committee	2	4	8	25/03/2019
													Appoint WCCIS Project Manager to replace previous PM.	Smart, Richard	Completed	ICF funding agreed. Interviews undertaken, provisional offer made. going through the employment checks. 2nd post approved by workforce panel. Both posts going through employment checks. Waiting for references, start dates agreed for early Oct 18.					

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	0)												Prepare briefing paper and arrange meeting to progress PM's work plans.	Smart, Richard	Completed	new action. meeting held to prepare plans. Briefing paper has been superseded by separate action.					
													Prepare exec paper regarding proposed new approach.	Smart, Richard	Completed	Initial draft prepared. paper to be available for review by 22/11/18 for mtg 30/11/18. Paper being represented 29/11/18.					
													Review risk after feedback from Executives.		Completed	Paper being presented to execs 29/11/18. Requested to take paper, draft deployment order and legal comment to BPPAC.					
													Update paper to go to BPPAC in January 2019	Smart, Richard	Completed	Draft of paper prepared. If revised approach is agreed risk can be closed as a managed risk. paper submitted. outcome will determine next step					
													Updated Deployment Order to be prepared and submitted - to include the changes requested	Smart, Richard	~~28/02/2019~~ 04/04/2019	DO Drafted - awaiting feedback from WCCIS commercial group. Feedback received. documents to be further updated					
383		Central Operations: EBME	Rees, Gareth	Burns, Mike	23/09/2017	There is a risk of avoidable interruption to service provision arising from a limited availability of medical devices. This is caused by not replacing medical devices in a timely manner. This will lead to an impact/affect on harm to patients with associated detriment to timely care. Risk location, Health Board wide.	A rapid assessment programme is in place which is focused on higher risk devices in the first instance.	Service/Business interruption/disruption	6	3	4	12	Set out an implementation plan to operationalise the policy guidance.	Oliver, Will	Completed	Review and renew organisational structures. Review the entirety of medical device resources and make necessary adjustments to provide a single medical devices function providing a holistic approach to managing risk. The PLAN was established by 30/06/2018. Standard operating procedures and associated communications are being delivered.	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	01/05/2019
387		Central Operations: EBME	Rees, Gareth	Burns, Mike	23/09/2017	There is a risk of avoidable harm to patients resulting from equipment in service with known issues which compromise its safety. This is caused by inadequate management of information and a lack of a robust alert system. This will lead to an impact/affect on harm to patients, enforcement action and incorrect capital purchases. Risk location, Health Board wide.	Review and evaluation of potential systems to mitigate the risk.	Safety - Patient, Staff or Public	6	3	4	12	Review the processes for effective safety notice receipt, distribution and closure. Procure or develop a suitable externally maintained safety notice repository.	Rayani, Mandy	04/01/2018	Discussion taking place between Deputy CEO and Nurse Director on funding.	Operational Quality, Safety & Experience Assurance Sub	2	4	8	01/05/2019

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233		USC: WGH	Cole-Williams, Janice	Mansfield, Simon	28/10/2014	There is a risk of poorer outcomes and increased mortality for stroke patients. This is caused by insufficient nursing staff to patient ratio. Insufficient stroke therapy staff and lack of 7 day consultant cover. This will lead to an impact/affect on delayed assessments and treatments of patients. Increased length of stay due to insufficient therapy treatment. Failure to meet National Stroke Standards. Non compliance of Tier 1 targets, Stroke performance. Evidence, Delays in admission to Stroke unit. Untimely care. Mortality reviews. Risk location, Health Board wide.	Compliance with agreed levels of treatment/therapy monitored annually via Royal College of Physician audit and monthly via Quality Improvement Meetings (QIMs) with appropriate action taken as follows. Active recruitment for all vacancies. Allied Health Professional leads allocate staff to ensure staffing is as equitable and safe as possible. Weekly stroke review meetings to monitor progress against national stroke targets. Monthly Health Board stroke committee meetings.	Quality/Complaints/Audit	8	3	4	12	Review staffing levels and deficits as identified against national stroke standards.	Mansfield, Simon	~~30/04/2018~~ 31/12/2018	Staffing deficits identified in Stroke plan, presented to QSEAC in August 2017. No further staffing up lift has been secured (part of the HB stroke plan)	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	21/03/2019
													Stroke delivery reviewed by QSEAC and the Health Board Stroke Steering Group and investment priorities identified.	Mansfield, Simon	**Completed**	Tier 1 target for classification of stroke consultant changed, therefore compliance is likely to improve from August 2017.					
													Scoping work being undertaken to develop a Hyperacute stroke unit in conjunction with ABMU as part of the ARCH programme.	Mansfield, Simon	~~01/04/2018~~ 31.12.18	Scoping discussions held with ARCH and current service data being collated. Assistance being provided by the Delivery Unit to model the requirements of a Hyperacute Stroke Unit in Morriston Hospital. HB still in full discussion with ARCH. Now must include the TCS process with the scoping work been under taken. Public consultation now closed.					
140	Standard 5.1 Timely Access	MH&LD	Carroll, Mrs Liz	Amner, Karen	16/10/2014	There is a risk of avoidable detriment to the quality of patient care. This is caused by an increasing demand for diagnostic services to individuals (children and adults) requiring assessment for Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). This will lead to an impact/affect on clients who require services are not being provided with timely assessments and interventions. Risk location, Health Board wide.	Waiting List initiative agreed. Service available for individuals up to the age of 18 years. Diagnostic only service available to adults known to services. Cross service and organisational working group established to support the needs of this client group in a co-ordinated and individualised way, maximising resources available. Waiting list reporting system in place.	Safety - Patient, Staff or Public	6	3	4	12	Development of a business case for a service as detailed in the Three Year Integrated Medium Term Plan.	Carroll, Mrs Liz	**Completed**	Additional Welsh Government funding has been received and recruitment is underway.	Quality, Safety & Experience Sub Committee	2	3	6	12/04/2019

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													Waiting list reviewed and reported on a monthly basis to monitor progress and improvement. Service specification to be worked up to be submitted to Welsh Government to draw on Integrated Care Fund for new funding (July 17). Recruitment and implementation of new model (Jan 18).	Carroll, Mrs Liz	**Completed**	Recruitment to Team Leader has been completed. Since November 2017 ADHD targets have become reportable to Welsh Government for those under the age of 18. The Health Board are therefore now required to provide monthly data on both ASD and ADHD waiting times. The waiting times remain of concern due to fixed term appointments and national demand for some healthcare professionals involved in the service.	Mental Health and Learning Disabilities				
													Meeting arranged with Informatics and Performance colleagues to analyse referral rates and look at trajectories as it is evident that referrals are increasing and there is limited capacity within the service to meet demand.	Carroll, Mrs Liz	~~31/01/2019~~ 01/04/2019	Data reporting to commence from 1st April 2019.					
													Delivery Unit are due to meet with the Directorate to look at a model for demand and capacity in order that we can understand what resource is required to provide assessments in a more timely manner.	Carroll, Mrs Liz	06/12/2019	Delivery Unit due to meet on the 7th of May.					
561	Standard 2.2 Preventing Pressure and Tissue Damage	3 Counties: Carmarthenshire	Dawson, Rhian	Rees, Craig	01/11/2015	There is a risk of avoidable harm to patients in the community, manifesting through pressure damage when attending A&E departments. This is caused by an increased aging population with high levels of frailty being cared for at home or in a care home. These patients are often not known to community services before they present at A&E departments. This will lead to an impact/affect on potential to result in increasing numbers of emergency medical admissions, patients' discomfort, pain and loss of independence. Risk location, Health Board wide.	Safeguarding Policy in place. All pressure damage serious incidents are reported into the Strategic Safeguarding Sub Committee. Triage and assessment process in situ for all admissions. Review Datix reports and take immediate action to investigate, including referral to Safeguarding when appropriate. The risk is updated in the Carmarthenshire Heads of Service meeting and submitted to County Management team meeting for approval.	Safety - Patient, Staff or Public	6	4	3	12	Training workshops to be undertaken in each County with representation from Datix, Tissue Viability and Safeguarding Teams.	Rees, Craig	~~01/07/2017~~ 31/08/2019	Training commenced, 3 specific Lead staff trained and 3 more required to complete.	Operational Quality, Safety & Experience Assurance Sub Committee	2	3	6	18/03/2019
													Community flowchart (for process) to be implemented.	Rees, Craig	**Completed**	Carmarthen completed. To be monitored by integrated dashboards within each Carmarthenshire County Management meeting.					

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556		MD: Research & Development	Evans, John	Tattersall, Chris	07/08/2018	There is a risk of failure to meet Key Performance Indicator (KPI) 'C' set by Health and Care Research Wales (HCRW) to increase the quantity of high quality research being undertaken in NHS Wales. This is caused by a failure to increase the number of portfolio studies by 10% per year and commercial studies by 5% per year. This will lead to an impact/affect on a reduction of the amount of studies available to patients and possibly reduced income available for Research & Development to reinvest in further research and research posts. Risk location, Health Board wide.	Close working relationships with the Research Delivery Manager to maintain staff in crucial nursing roles. Monitoring of the situation at a monthly Research & Development (R&D) Operational Team meeting and escalated as needed. Managing the R&D funding allocation to provide sustainable research posts to ensure compliance with the Key Performance Indicators.	Quality/Complaints/Audit	8	4	3	12	Monitor the new KPI at the monthly Operational and Senior team meetings. Delivery staff leads to report to these groups.	Tattersall, Chris	~~04/12/2018~~ 29/01/2020	Revised KPIs are an agenda item on forthcoming Operational team meetings. On target to achieve this, currently at 51% of target at end of Q2. 29.1.19 Performance Indicator remains under review at Operation and senior team meetings. 29.3.19 Portfolio target met, commercial target not met. The target of 6 studies was archived but not in time to recruit into them. Two studies are not recruiting due to sponsor issues out of the control of the HB.	Research & Development Sub Committee	2	3	6	29/03/2019
557		MD: Research & Development	Evans, John	Tattersall, Chris	07/08/2018	There is a risk of failure to meet Key Performance Indicator 'D' set by HCRW to increase the opportunity for NHS patients to participate in, and benefit from, clinical trials and other well designed studies. This is caused by a failure to increase the number of patients recruited to portfolio studies by 10% per year and to commercial studies by 5% per year. This will lead to an impact/affect on a reduction of the amount of patients being offered for the newest treatments and possibly a reduced income available for Research & Development (R&D) to reinvest in further research and research posts. Risk location, Health Board wide.	Close working relationships with Research Delivery teams to maintain staff in crucial nursing roles. Monitoring the situation at a monthly Operational Team meeting and updating as needed in weekly staff meetings, escalating to the R&D Senior Team. Managing the R&D allocation to ensure personnel are in place to ensure compliance with the Key Performance Indicators.	Quality/Complaints/Audit	8	4	3	12	Monitor the new KPI at the monthly Operational and Senior team meetings. Delivery staff leads to report to these groups.	Tattersall, Chris	~~04/12/2018~~ 29/01/2020	29.3.19 remains under review at Operation and senior team meetings. Portfolio target met, commercial target not met. The target of 6 studies was archived but not in time to recruit into them. Two studies are not recruiting due to sponsor issues out of the control of the HB.	Research & Development Sub Committee	2	3	6	29/03/2019
531	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Central Operations: HSDU	Rees, Gareth	Flear, Philip	20/06/2018	There is a risk of failure to break even on delgated year end budget. This is caused by additional dental and podiatry community workload being returned to HSDU for decontamiantion with no additonal funding for the HSDU service. This will lead to an impact/affect on the year end delegated budget due to increased staffing and consumables cost. Risk location, Health Board wide.	Overtime incurred when absolutely necessary. Consumable costs reviewed for potential cost improvement plan.	Finance inc. claims	6	4	3	12	Organsie meeting with community teams to adress the funding concern	Flear, Philip	31/12/2018	Date to be scheduled. Update 23.08.18 Meeting held 20.08.18 a paper to be written and submitted to the decontamination meeting for discussion.26.10.18 The paper was written and presented to the decontamination group meeting 15.10.18. The additional dental workload is causing backlog and delays in the re processing of surgical instruments. Update 27.12.18 Situation is still the same no further update. Update 27.02.19 No further update.	Finance Committee	2	3	6	27/02/2018

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254	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Central Operations: HSDU	Rees, Gareth	Flear, Philip	08/01/2015	There is a risk of avoidable delays to the supply of sterilised equipment to theatres at WGH. This is caused by the reliability of the existing four sterilisers which, being over 10 years old, are 1 year beyond their maximum replacement date and are often out of service due to breakdowns or other failed sterilisation cycles; spare parts are often difficult to source (41 days downtime in 8 months). This will lead to an impact/affect on interruption to both planned and emergency theatre sessions, and delays to patient recovery times following surgery. Delays in emergency cases can also present more significant impacts, which will have an impact on the Referral to Treatment (RTT) times. Risk location, Withybush General Hospital.	A contingency plan to be implemented if necessary, when sterilisers are out of action. Daily checks by Hospital Sterilisation & Decontamination Unit (HSDU) staff help with failure prediction. Ongoing monitoring of each cycle. Recording of each cycle failure, which forms part of the Quality Management System Key Performance Indicators (KPIs). Failed Steriliser cycle Standard Operating Procedures (SOPs) are in place, which are routinely audited. Weekly preventative maintenance checks are carried out by qualified estates staff and these pick up imminent failures, which are addressed when least likely to impact on productive time. Quarterly maintenance is carried out by qualified estates staff, which assists in preventing unforeseeable breakdowns. Each item unloaded from the steriliser is checked by HSDU staff prior to dispatch to the customer, which helps pinpoint loads that might be returned before they arrive at theatres. Time steam and temperature indicators are	Service/Business interruption/disruption	6	3	4	12	Develop and submit a capital bid with the view of replacing.	Flear, Philip	~~31/12/2018~~ 26/02/2021	To be completed at a later date. Update 23.08.18 Following of further review and training it is anticipated that the sterilisers will not be replaced providing they are maintained effectively. It is therefore be anticipated that a capital bid will now be submitted with a view of replacing in 2022/2023 financial year. This will be a managed risk and will be regularly monitored.26.10.18 Control measures reviewed and remain satisfactory. Update 27.1	Capital, Estates and IM&T Sub Committee	1	4	4	27/02/2018
135	Standard 3.1 Safe and Clinically Effective Care	MH&LD	Carroll, Mrs Liz	Rees, Sara	16/10/2014	There is a risk of avoidable detriment to the quality of patient care. This is caused by the current configuration of inpatient services and functions of wards due to isolation of units, no clear model and alternatives to hospital beds. A historic skill mix, variable across the service which leaves inpatient services with more novice professionals working with very complex patients. This will lead to an impact/affect on potential increase in adverse incidents of risk within inpatient services due to high levels of novice professionals and their capacity for complex decision making. Patients in hospital who could with appropriate alternatives available be supported in community settings which would enable independence to be maintained which in turn reduces long term health risks and increases personal resilience. Risk location, Health Board wide.	Mental Health Programme Group (MHPG) is now an implementation group. Multi-agency group including service users and carers reports directly to the Capital, Estates and Information Management and Technology Sub Committee. Management structures have been revised that have enabled greater clinical presence and support for inpatient services. Medical lead sessions are in place to support specialities including adult and older adult inpatient services. Psychological interventions access is in place across inpatient services to enhance therapeutic engagement. Five Psychology Assistants have been appointed to work within adult and older adult MH services.	Safety - Patient, Staff or Public	6	3	4	12	Review of third sector grants to explore opportunities for alternative community bed provision. Develop a formal framework for commissioning of services. Formal consultation on alternative model complete. Independent evaluation completed.	Carroll, Mrs Liz	~~01/03/2017~~ 01/04/2021	The transforming Mental Health Implementation Group has been established under the Chairmanship of Director of Operations. The Implementation Group has established a risk register and will update accordingly.	Mental Health and Learning Disabilities Quality, Safety & Experience Sub Committee	1	4	4	12/04/2019

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520		Central Operations: EBME	Rees, Gareth	Hopkins, Mr Chris	15/06/2018	There is a risk of interruptions to business continuity arising from overdue replacement of medical equipment. This is caused by Discretionary Capital Program (DCP) allocations falling well short of quantified replacement requirements annually. This will lead to an impact/affect on patient services being interrupted or lease options having to be taken out with consequential overheating of revenue budgets. Risk location, Health Board wide.	Equipment replacement priorities are constantly reviewed. DCP allocations reviewed. Equipment due for replacement is pushed back if the replacement is not deemed critical at any time.	Service/Business interruption/disruption	6	3	4	12	Continue representation to Welsh Government on limited DCP allocation.	Williams, Paul	31/12/2018	Update due from the risk owner.	Capital, Estates and IM&T Sub Committee	1	4	4	01/05/2019
													Continued review of replacement plans moving back what is deemed non urgent.	Hopkins, Mr Chris	**Completed**	Inventory work is ongoing and due to complete on 22nd June 2018. Once the inventory work is complete we can examine the replacement needs and forward to the Prioritisation meetings arranged.					
639		P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Simons, Delyth	05/11/2018	There is a risk of disruption and delays to the supply of Radiopharmaceuticals. This is caused by no Deal Brexit, resulting in inability or delays in transition, and importation arrangements on leaving E.U. Inability to stock pile Radiopharmaceuticals due to short lifespan. This will lead to an impact/affect on disruption, delays or inability to provide treatment, clinical trials and routine clinical care due to lack of radio pharmaceuticals. May result in increase in patient distress. Increased financial costs. Increased staff resources required to manage shortages. Risk location, Health Board wide.	Pharmacy Staff already deal with disruptions to the supply of and shortages of medicines, including sourcing alternative suppliers and advising on the use alternative medicines which are available.	Quality/Complaints/Audit	8	3	4	12	Monitor for any WG correspondence	Pugh-Jones, Jenny	31/03/2019	All correspondence from WG to be assessed for impact and required action	Medicines Management Group	1	4	4	03/04/2019
183		Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	01/09/2016	There is a risk of avoidable harm to patients attending North Road Eye Clinic due to the condition and function of the internal environment. This is caused by the ground floor of building being too small to accommodate patients attending clinics on a daily basis in a space shared by Ophthalmology and GUM. The corridor is used as both a waiting room and equipment store. All calls and discussions at the clinic reception can be overheard by others in the area. This will lead to an impact/affect on the health and safety of patients, staff and visitors in terms of slips trips and falls, breaches of patient	Reduction in clinic size and alternating pre-assessment clinic with Optical Coherence Tomography (OCT) clinics. Music played in waiting area to mask conversations from reception and consultation rooms. Where possible, transfer patients requiring confidential discussions to another area. Environmental monitoring in place. Programme of minor improvements undertaken (improvements made to treatment room, additional waiting room, flooring replacement).	Safety - Patient, Staff or Public	6	4	3	12	Relocate GUM and dental services elsewhere in the Health Board and reconfigure internal building to acceptable safe standards.	Mills, Caroline	**Completed**	Task and finish group set up in Ceredigion led by County Director with estates representation. Update being sought on options available Referred to Rob Elliott for inclusion on Estates Risk Register and action.	Safety and Experience Assurance Committee	1	4	4	18/04/2019
													Project plan to be confirmed for North Road site.	Wragg, Gordon	**Completed**	Currently working on options with the estates teams.					

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						of slips trips and falls, breaches of patient confidentiality, compromise of patient treatment in the event of a medical emergency or fire, and impact the ability of the service to increase capacity to meet current and future demand. Risk location, North Road Clinic.	Occupational Health involvement.						Project plan to be confirmed for North Road site.	Wragg, Gordon	~~30/11/2018~~ 31/01/2019	Working project group established to ensure phase 1 (minor works) are planned for short term improvements and phase 2 (replacement). Project plan has been requested. Timescales + costs are being established	Quality,				
264		3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	01/04/2016	There is a risk of avoidable harm to patients and staff arising from inherent building and engineering hazards at Aberaeron hospital. This is caused by widespread Health and Safety issues, deteriorating condition, lack of disability access, etc. This will lead to an impact/affect on injury to patients and staff, or a need to limit activity on site. Expectation of the public is that there will be a capital solution currently has commenced. Risk location, Aberaeron Hospital.	Welsh Government approval of Business case for redevelopment and relocation of services fit for purpose. Scoping exercise of the options has been completed. Process in place to monitor the condition and respond to the works required to maintain a safe environment. Stakeholder group implemented to fully engage the public.	Safety - Patient, Staff or Public	6	3	4	12	Community and Primary Care Project Board established to provide services in a fit for purpose facility. Recent acquisition of building within Aberaeron will enable reprovision of services from the old facility.	Hawkes, Jina	~~03/09/2018~~ 28/09/2019	Good progress is being made with this project. Work streams are established. Consultation event with Public completed. developers are on site.	Operational Quality, Safety & Experience Assurance Sub Committee	1	4	4	15/04/2019
													Reporting of current unsafe environmental issues to the estates department.	Evans, Tracey -	**Completed**	Regular communications with maintenance					
													Undertake a risk assessment and develop a mitigation plan.	Jones, Elfyn	**Completed**	Incidents have been communicated from Aberaeron Hospital. Independent estates survey has been undertaken. Estates have visited the site and supplied de-humidifier.					
													There is a lack of communication from the IT department in forming the overall project scheme, which raises risks as IT is fundamental to the agile working programme.	Skitt, Peter	**Completed**	The risk has been raised and noted at the Aberaeron Integrated Care Centre Board meeting. Workshops with IT will be held in May 2019 for staff to engage					

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577		3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	23/10/2014	There is a risk of avoidable harm to patients and staff arising from inherent building and engineering hazards at Cardigan hospital. This is caused by widespread Health and Safety issues, deteriorating condition, lack of disability access, etc. This will lead to an impact/affect on injury to patients and staff, or a need to limit activity on site. Expectation of the public is that there will be a capital solution currently has commenced. Risk location, Cardigan Memorial Hospital.	Welsh Government approval for a Business Case for the construction of a fit for purpose new build. Scoping exercise of the options has been completed. Process in place to monitor the condition and respond to the works required to maintain a safe environment. Stakeholder group implemented to fully engage the public.	Safety - Patient, Staff or Public	6	3	4	12	Implementation of the new build scheme.	Skitt, Peter	31/12/2019	Scheme running within contingencies of plan.	Operational Quality, Safety & Experience Assurance Sub Committee	1	4	4	15/04/2019
709		Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	20/12/2018	There is a risk of avoidable patient harm, disruption to service delivery due to potential for Operating tables to fail due to their age. This is caused by 24 of the operating tables being used within the Health Board are between 10 & 29 years old and are in need of being replaced. A number of out of support with the manufacturers and some have been condemned. This will lead to an impact/affect on service delivery, increased RTT, patient dissatisfaction, complaints, adverse publicity Risk location, Health Board wide.	Regular servicing of operating tables and repair where parts are available.	Service/Business interruption/disruption	6	4	3	12	Undertake trial of operating tables to identify preferred replacement	Knight, Diane	**Completed**	Trial completed and preferred option chosen	Operational Quality, Safety & Experience Assurance Sub Committee	2	2	4	27/03/2019
													Prepare capital bid for replacement of operating tables	James, David	**Completed**	Capital bid submitted					
719	Standard 2.1 Managing Risk and Promoting Health and Safety	USC: Pathology	Perry, Sarah	Stiens, Andrea	01/03/2019	There is a risk of that staff (mortuary staff, porters and Funeral Directors and deceased patients) could be injured and failure to ensure dignity and respect of deceased patients. This is caused by the body store installed in 2000 is no longer fit for purpose. Due to insufficient body storage capacity, door apertures are not sufficiently wide enough to accommodate the increasing numbers of larger deceased patients the rollers are less efficient due to age of equipment unable to repair. This will lead to an impact/affect on potential for injury to staff and lack of dignity for deceased patients. Reputational impact for the Health Board due to relatives complaints and claims. Risk location, Prince Philip Hospital.	Standard operating procedures. Staff training and education - staff are required to undertake manual handling training. Process in place when capacity is reached - transfer to GGH Mortuary. Process for dealing with bariatric patients - blankets available.	Safety - Patient, Staff or Public	6	3	4	12	Develop a capital bid for funding to replace existing body store.	Stiens, Andrea	**Completed**	Capital funding allocated for 2019/20.	Capital, Estates and IM&T Sub Committee	1	4	4	17/04/2019
													Identify a supplier to design and complete works.	Thomas, Helen	30/08/2019	New action start of process.					

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710		Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	20/12/2018	There is a risk of the Stryker System 5 power tools being used in theatres in Bronglais General Hospital are failing. 2 sets cannot be used as they are missing sagittal saws. This is caused by the system 5 power tools are no longer being supported by the manufacturer. This will lead to an impact/affect on service delivery, RTT, patient dissatisfaction, complaints. Risk location, Bronglais General Hospital.	Where possible minimise the use of the system 5 power tools.	Service/Business interruption/disruption	6	4	3	12	Prepare capital bid for replacement.	James, David	Completed	Capital bid submitted.	Operational Quality, Safety & Experience Assurance Sub Committee	2	2	4	27/03/2019
711		Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	20/12/2018	There is a risk of insufficient numbers of power tools in Prince Philip Theatres. 2 sets of power tools and 2 sets of cordless drivers required to allow sufficient turn around between cases. This is caused by the increased orthopaedic workload in PPH (7 days a week at times) due to waiting list initiatives. This will lead to an impact/affect on service delivery, RTT. Risk location, Prince Philip Hospital.	Staff liaise with HSDU to arrange a quick turnaround of used power tools.	Service/Business interruption/disruption	6	4	3	12	Prepare capital bid for additional tools.	James, David	Completed	Capital bid submitted.	Operational Quality, Safety & Experience Assurance Sub Committee	2	2	4	27/03/2019
712		Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	22/01/2019	There is a risk of failure of Camera (stack)systems. This is caused by the age of the stack systems currently in use within the health Board. 8 stack systems are now out of support by the manufacturer. 9 more stack systems will be obsolete within the next 2 - 3 years. This will lead to an impact/affect on delays in patients receiving treatment, service delivery, complaint, organisational reputation. Risk location, Health Board wide.	Regular servicing of stack systems and repair where parts are available.	Service/Business interruption/disruption	6	4	3	12	Arrange demonstration of latest stack systems in order to identify required replacements according to clinical need.	James, David	30/04/2019	One demonstration has been held in BGH. Awaiting further dates from the manufacturer.	Operational Quality, Safety & Experience Assurance Sub Committee	2	2	4	27/03/2019
													Prepare capital bid for replacement of stack systems.	James, David	28/06/2019	Awaiting results of feedback from demonstration days.					

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640	Standard 2.6 Medicines Management	P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Simons, Delyth	05/11/2018	There is a risk of disruption and delays to the supply of medicines. This is caused by no Deal Brexit, resulting in inability or delays in transition and importation arrangements on leaving E.U. This will lead to an impact/affect on disruption, delays or inability to provide treatment, clinical trials and routine clinical patients. May result in increase in patient distress. Increased financial costs. Risk location, Health Board wide.	Department of Health & Social Care & UK Government arrangements will be in place, suppliers will be asked to stockpile and additional 6 weeks supply of medicines within the UK. Air freight those medicines with a short shelf-life.	Safety - Patient, Staff or Public	6	3	4	12	Ensure that Medicines Management Service is kept updated with any developments. No developments currently	Simons, Delyth	~~30/11/2018~~ 30/03/2019	Attend All- Wales meeting	Medicines Management Group	1	4	4	03/04/2019
526		Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	18/06/2018	There is a risk of financial pressure to the service to continue to provide the current Age related Macular Degeneration(AMD)treatments of Lucentis and Eylea drugs. This is caused by the cost of on-going high cost drug treatment becoming a departmental cost pressure following the ending of pilot funding from Welsh Government in 2017. This will lead to an impact/affect on the ability of the service to provide assurance for financial prudence. Risk location, Amman Valley Hospital, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Review of medication usage. Review of Ophthalmology patient pathway. Flagging of cost pressure through budget setting.	Finance inc. claims	6	4	3	12	New drug (Avastin) has been identified as providing good outcomes for patients with AMD. The drug was primarily licensed for use on Diabetic retinopathy, but was found to be effective for AMD. It has been adopted by NHS England, but is subject to a judicial review regarding medical licensing. Decision on use is with Welsh NHS.	Wragg, Gordon	~~31/01/2019~~ 31/01/2019	Health Board Clinicians are examining the potential use of the drug for effectiveness vs other treatments. If suitable for adoption may reduce drug costs up to £500K. Awaiting response to Judicial Review SBAR drafted in Sept 2018 Awaiting Welsh NHS decision on licensing.	Finance Committee	1	3	3	12/04/2019
523		Scheduled Care: General Surgery	Hire, Stephanie	Lewis, Caroline	18/06/2018	There is a risk of financial cost pressure. This is caused by the requirement to engage locum clinicians to provide cover for staff currently not in work as a result of employee relation issues. This will lead to an impact/affect on the ability to provide care within the departmental budget. The ability to provide continuity of care to patients. The moral and motivation of the clinical teams involved. Risk location, Glangwili General Hospital, Withybush General Hospital.	Probity on the locum contracts being agreed to ensure continuity of service. Adherence to Health Board HR Policies in the management of cases.	Finance inc. claims	6	4	3	12	Develop management plans for continued locum payments to cover GGH consultant off work due to employment relation issues to be specified, including time line for likely conclusion of situation.	Lewis, Caroline	**Completed**	In progress.	Finance Committee	1	3	3	11/04/2019
													Develop a management plan for continued locum payments to cover WGH consultant off work due to long term sickness, including time line for likely conclusion of situation.	Lewis, Caroline	~~13/08/2018~~ 30/06/2019	HR strategy to bring a solution to issues in development in conjunction with Medical HR.					
													Develop management plans for continued locum payments to cover WGH middle grade covering a consultant off work due to employment relation issues to be specified, including time line for likely conclusion of situation.	Lewis, Caroline	**Completed**	In progress.					

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128	Standard 2.6 Medicines Management	Central Operations: Out of Hours	Rees, Gareth	Davies, Nick	01/09/2016	There is a risk of delays to patients receiving treatment, administration or availability of control drugs and medication due to stock levels and of "Just in Case" or appropriate care planning. This is caused by a lack of a coordinated approach for pharmacy supervision of stock levels as well as restrictions in conveyance of controlled medications by GPs whilst on duty.There is also an issue involving day time practitioners who do not always complete care plans resulting in avoidable visits to OOH services. This will lead to an impact/affect on Out of Hours services having to attend to avoidable calls. In turn, patients may face delays in receiving timely care. Journey times and distances travelled by clinicians also increase as they need to return to base to collect required medication for certain calls. Risk location, Health Board wide.	GPs ensure that they carry sufficient drug stocks in the vehicles during home visits. If attending to palliative care calls, GPs are to give consideration to obtaining controlled drugs prior to attending. Close working with practices and Palliative Care Teams, and Paul Sartori Foundation and Macmillan Cancer Support, etc. to ensure that where appropriate 'Just In Case Boxes' are available in the patients home. Special notes should be made available on Adastra to indicate those patients. Close collaboration with Acute Response Teams allow the most appropriate clinician to respond to the call.	Quality/Complaints/Audit	8	4	3	12	Discussions have been held with Pharmacy regarding increasing pharmacy provision throughout Carmarthenshire and Pembrokeshire in line with the Ceredigion model. Costings and plan are awaited.	Pugh-Jones, Jenny	~~02/04/2018~~ 31/03/2019	19/11/18 On-going discussions with pharmacy leads continue with a policy and procedure being prepared in order to increase availability of controlled drugs to the OOH service.	Medicines Management Group	1	3	3	06/02/2019
93		USC: Pathology	Perry, Sarah	Bowen, Caryl	01/10/2014	There is a risk of avoidable harm to staff and others by contact, ingestion or inhalation of hazardous substances. This is caused by ineffective segregation of formaldehyde which is now a category 1 carcinogen. This will lead to an impact/affect on serious harm to staff from exposure to formaldehyde leading to sensitisation and lasting health issues. Criminal prosecution under Health & Safety law. Risk location, Glangwili General Hospital.	Risk assessments completed March 2015. Formaldehyde environmental monitoring in place. Levels are below recommended safety levels. Staff who display symptoms are referred to Occupational Health for advice and on-going monitoring.	Safety - Patient, Staff or Public	6	2	5	10	Estates review of relocation of tissue processors into a separate room with adequate ventilation - no available space within Pathology GGH footprint - would need to relocate staff from adjacent rooms. Application for additional space in Teilo to decant Consultant Cellular Pathologists was unsuccessful.	Stiens, Andrea	**Completed**	Cost of this option has been deemed to high. Estates team are now costing a modular solution. Modular solution also too expensive.	Quality, Safety & Experience Assurance Sub Committee	1	5	5	04/04/2019

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													Feasibility study to assess potential relocation of either Microbiology or Cellular Pathology from GGH location to Science Block in National Botanical Garden of Wales.	Stiens, Andrea	Completed	All Wales bid via Efficiency Through Technology Fund (ETTF)bid submitted - Unsuccessful. Cost for HDUHB per annum Year 1 to 3 60K, Year 3 onwards 35K. All Wales bid has been resubmitted to ETTF September 2017. Bid has been unsuccessful. NBGOW option too expensive. Option to build additional offices to relaease space adjacent to lab, costs can be reduced if team can be relocated to space released by Finance at GGH - refer to separate action.	Operational				
													Exploring the option of modular laboratories as an interim solution.	Stiens, Andrea	Completed	Cost of this option has been deemed to high, Estates team are now costing a modular solution. Cost of modular solution also too expensive.					
													Option identified to build 3 Consultant offices above current flammable stores structure adjacent to Pathology, which would release space adjacent to current cellular pathology laboratory for reconfiguration to house tissue processors etc. this reduces the health and safety risks.	Stiens, Andrea	Completed	Fully costed SBAR has been submitted to the capital Health and Safety group. Joe teape has requested a review of options to identify if the project can be segregated into smaller projects to aid resolution. Refer to remaining actions.					
													Relocation of Consultant Cellular Pathologists and Medical secretarial team to vacant space created by moving back office functions off site. This has been flagged with Sarah Perry GM for GGH site.	Perry, Sarah	Completed	Awaiting movement of back office functions to release space.Due to take place July 2018. Capital Funding to make estate changes agreed July 2018. relocation to this space is no longer the preferred choice due to distance from the Cellular pathology laboratory.					

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													Reconfigure released Consultant Cellular pathologist office space adjacent to Cellular pathology cut up room to include ventilation to house tissue processor analysers.	Elliott, Rob	28/12/2018	This action cannot progress until space is released and capital is agreed					
													Alternative space to house Consultant Cellular pathologist team and medical Secretary staff is being explored - two options in the main hospital corridor are being explored and assessed - this is being taken forward via the GGH Accommodation Group	Perry, Sarah	31/05/2019	Current two options are being assessed					
365		Central Operations: EBME	Rees, Gareth	Burns, Mike	23/09/2017	There is a risk of avoidable risk of harm to patients due to an inadequate equipment inventory and out of date schedules. This is caused by an inadequate equipment inventory which gives rise to inaccurate maintenance schedules resulting in devices in clinical service not having adequate maintenance arrangements in place. This will lead to an impact/affect on risk of harm to patients and Health and Safety Executive (HSE) enforcement. Non-Compliance with: Medicines and Healthcare products Regulatory Agency (MHRA) recommendations based on Provision and Use of Work Equipment Regulations (PUWER) regulations. Risk location, Health Board wide.	A programme of intelligence gathering is in being and is incrementally reducing the risk through the Medical and Non-Medical Devices Control Group. Management information included in regular reports to the Control Group. Identification of existing decisions and practices is taking place without any formal recognition of the governance and risk management requirements. Preparation of an executive proposal setting out a safe and fit for purpose arrangement for medical devices management across the Health Board.	Safety - Patient, Staff or Public	6	2	5	10	Cleanse, standardise and validate the inventory across all sites.	Burns, Mike	**Completed**	Reported to the Medical and Non Medical Equipment Control Group.	Operational Quality, Safety & Experience Assurance Sub Committee	1	5	5	01/05/2019
671	Standard 3.1 Safe and Clinically Effective Care	MH&LD: Substance Misuse	Carroll, Mrs Liz	Hughes, Geraint	26/11/2018	There is a risk of individuals being unable to access timely opiate substitute therapy. This is caused by a lack of specialist prescribers, primarily in Llanelli. This will lead to an impact/affect on clients of the Community Drug & Alcohol Team (CDAT) being unable to access prescribing, putting them at greater risk of overdose. This could lead to an increase in Drug Related Deaths and reputational risks to the Health Board if it is unable to meet its Key Performance Indicators. Risk location, Health Board wide.	Case management processes are in place to ensure gaps in prescribing are identified early. Policies/procedures. Medical Services Meeting. Quality Performance Planning Meeting (QPP. Quarterly Performance Reports to Area Planning Board Commissioners.	Safety - Patient, Staff or Public	6	2	5	10	to meet with APB Commissioners to identify finance to enable the development of Non Medical prescribing and the establish a Specialist Prescribing Service (SPS) in Llanelli.	Jones, Richard	**Completed**	have met with APB Commissioners and identified funding from 01.11.18-31.03.19 to implement Non Medical prescribing Pembrokeshire, further develop Non-Medical Prescribing in Ceredigion and to establish a Specialist Prescribing Service (SPS) in Llanelli.	Quality, Safety & Experience Assurance Sub Committee	1	5	5	31/01/2019
													To recruit into Non-Medical Prescribing post in Pembrokeshire.	Hughes, Geraint	02/01/2019	Vacancy to be approved by Directorate and Health Board panel.Work ongoing. Appointed temporarily whilst funding is confirmed for 2019-2020.					

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													To revised the management structure in CDAT Ceredigion locality to enable additional Non-Medical Prescribing resource.	Hughes, Geraint	**Completed**	Vacancy to be approved by Directorate and Health Board panel.	Operational				
													To establish a Specialist Prescribing Service (SPS) in Llanelli.	Hughes, Geraint	**Completed**	Meeting Prescribers and Commissioners on 26.11.18 to agree implementation.					
459		P,C,LTC: Primary Care	Bond, Rhian	Huggins, Tracey	01/08/2017	There is a risk of the IR35 tax ruling impacting on ability to secure locums/salaried GPs in Health Board Managed Practices and the associated increased costs. This is caused by Implementation of IR35 tax ruling in 2017. This will lead to an impact/affect on patients, as could lead to the loss of GMS medical cover and the risk of having to redirect paitents to A&E/MIU. Risk location, Health Board wide.	HDUHB must assess the IR35 status of the worker and if necessary take the appopriate actions. BMA guidance to locums suggest that blanket policies by engagers do not apply and each engagement should be assessed separately. In some cases locums have completed their own assessment using HMRC toolkit and the employment outcome has been "self employed".	Service/Business interruption/disruption	8	3	3	9	Paper regarding Locums in Managed Practices and IR35 to be presented to the Executive team and the paper is ready but the CEO specifically requested that the OOH position was included. TH is waiting on that information from OOH, once received the paper will be submitted to Exec Team as requested	Huggins, Tracey	~~31/10/2018~~ 31/01/2019	Paper regarding IR35 and Locums in managed practices going to Excutive team for discussion and escalation. OOH View received and included in the paper which will be completed on 26.11.18	Operational Quality, Safety & Experience Assurance Sub Committee	3	3	9	23/11/2018
593		3 Counties: Pembrokeshire	Lorton, Elaine	Hay, Sonia	03/09/2018	There is a risk of ICF funding for existing services will be discontinued or cease. This is caused by by the Integrated Care Fund (ICF) ceasing in March 2020. This will lead to an impact/affect on Financial pressure to county operational revenue budgets through unfunded posts. Staff & cause uncertainty in relation to role & employment. Patients physical and mental health may decline due to a reduction or cease of current service provision, eg, loss of functional ability & deconditioning due to a reduction in rehabilitation funded posts. Timely discharge from acute & community hospitals due to lack of service provision. Risk location, Pembrokeshire.	Existing community services funded by ICF are regularly reviewed. Welsh Government made aware by quarterly reporting of outcomes and impacts of services funded. Position paper highlighting potential impact and risk was shared in SBAR to BPAC in October 2017.	Workforce/OD	8	3	3	9	Ensure all ICF funded projects and services have clear exit strategies.	Hay, Sonia	01/12/2018	Ongoing	Finance Committee	2	3	6	16/04/2019
													Review all vacancies in line with potential ICF posts.	Hay, Sonia	**Completed**	Completed					
													Ensure the potential risk of ICF funding is highlighted on Operational Business Team Meeting for monitoring impact on wider services.	Hay, Sonia	~~25/01/2019~~ 11/06/2019	Ongoing as part of IMTP					

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528	Standard 2.6 Medicines Management	Scheduled Care: Rheumatology	Hire, Stephanie	jones, Donna	18/06/2018	There is a risk of financial pressure through the prescription of high cost medication. This is caused by the exclusive license for Humira (Adalinamab) creates a cost pressure for this drug, which is only able to be prescribed from a Hospital Setting. In 2018-19 the patent expires which allows for the prescribing of bio-similar medications. This will lead to an impact/affect on a cost saving per patient with an expected 40% saving on medication costs, resulting in a £250k whole year saving. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Clinical teams are prepared for change over once possible.	Finance inc. claims	6	3	3	9	Transition plan required for patients to map time frame for change over of prescription.	Harry, Debora	Completed	Forecasting underway - clinical team mapping the number of patients and how they can be clinically reviewed and transitioned to new drugs.	Finance Committee	2	3	6	11/04/2019
													Transition plan being deployed with expected impact to be felt from M6 2019/20	Harry, Debora	30/09/2019	PID has been developed to support transition and identify potential cost reduction					
664	Standard 3.1 Safe and Clinically Effective Care	Women & Children's: Community Children's Services	Jones, Keith	Devonald-Morris, Margaret	09/11/2018	There is a risk of unsustainable care delivery for children and young people who have continuing care packages delivered by two 3rd sector providers. This is caused by one of the three third sector providers giving notice to cease delivery with the transfer of packages across to the two remaining providers, one provider covers Carmarthenshire and the other covers Ceredigion and Pembrokeshire. This will lead to an impact/affect on on potential increase to hourly rate due to lack of competition. Furthermore, remaining provider in Pembrokeshire has had issues with one package where family dynamics/expectations has been a contributing factor in retaining and recruiting care staff. This can lead to increased admissions to secondary care. Risk location, Health Board wide, Pembrokeshire.	Implemented impact assessments and contingency plans for all care packages HB wide. Children's Community Nursing Service working with Health & Safety and Social Care to address the family's dynamics and expectations. Use of HB bank staff to cover packages of care to avoid admission to secondary care.	Workforce/OD	8	3	3	9	Liaise with providers, Service Delivery Manager (SDM)/Senior Nurse (SN) Community, Children's Community Nurse Team Leader and Nurse Assessor to ensure the lease disruption to transfer of care delivery from one provider to another.	Devonald-Morris, Margaret	02/08/2019	Children's Community Nursing Team Leader and Nurse Assessor to undertake weekly monitoring of care,identify gaps in service and implement action plan to address.	Operational Quality, Safety & Experience Assurance Sub Committee	2	3	6	07/02/2018
													SDM/SN Community to work with Finance team to explore increase in nursing resource to develop 'in-house home care team' funded via the Continuing Care Budget.	Devonald-Morris, Margaret	31/03/2019	SDM/SN Community liaising with finance lead. Establishment for Continuing car packages identified on IMTP.					

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673	Standard 3.1 Safe and Clinically Effective Care	P,C,LTC: Primary Care	Bond, Rhian	Huggins, Tracey	26/11/2018	There is a risk of cost pressure to the General Medical Services(GMS)budget. This is caused by national agreements on Directed Enhanced Services with no additional funding. This will lead to an impact/affect on overall budget position unless other enhanced services are decommissioned to meet the cost pressure. Risk location, Health Board wide.	No controls currently in place as information on new DES awaited from Welsh Government (WG)as part of their contract negotiations.	Finance inc. claims	6	3	3	9	Review of risk once detail of Directed Enhanced Services are known and the associated financial impact.	Bond, Rhian	04/01/2019	Further information requested from Welsh Government.	Operational Quality, Safety & Experience Assurance Sub Committee	3	1	3	28/01/2019
278		Women & Children's: Community Children's Services	Jones, Keith	Devonald-Morris, Margaret	20/02/2015	There is a risk of delayed and sub-optimal care of paediatric diabetic patients as a result of current non-compliance with Diabetes Peer Review standards. This is caused by insufficient staff funding. Paediatric Dietetic time is managed by County teams. This will lead to an impact/affect on the timing of patient reviews and advice resulting in the subsequent risk of increased long-term diabetes-related morbidity and mortality, with deteriorating HbA1c. Risk location, Health Board wide.	Paediatric Diabetes nurse capacity combined across the Health Board to maximise availability of current resource to each county. Deficits in Dietetic resource has been highlighted via monitoring reports to Quality, Safety & Experience Assurance Committee (QSEAC) and prioritised with Pembrokeshire County Integrated Medium Term Plan (IMTP) submission 2016/17 and again for 2017/18. Paediatric team prioritise patient access and reviews according to known clinical priority. Presented SBAR to the Quality & Safety (Q&S) meeting 26/04/2017. Funding agreed for dietetic support on October 2018	Safety - Patient, Staff or Public	6	3	3	9	Dietetic service to progress recruitment of additional Dietetic time via IMTP plans.	Devonald-Morris, Margaret	~~01/12/2017~~ 13/08/2018 13/10/2018 13/12/18	Dietetic Service further reviewing plans for additional dietetic team resource. In the meantime triage of all referrals and prioritisation of cases. Status remains the same with regards to resource in addition a recent vacancy based at BGH has not been recruited to but have been permitted to seek a period of locum cover. Directorate unable to progress until 18/19 financial balance achieved. 26/11/18, Instruction from Executive board to fund 0.6 WTE band 6 from acute budget. finance instructed.	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	07/02/2019
													Senior Nurse Community Paediatrics to undertake further assessment of Paediatric Diabetes Specialist Nurse(PDSN) Workforce.	Devonald-Morris, Margaret	~~01/12/2017~~ 28/12/2018	Directorate unable to further progress within available funding. Issue to be further highlighted via IMTP proposals. Revision and reallocation of caseloads.					

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													Identify appropriate funding to support PDSN bank staff. Develop a local management arrangement between paediatric ward staff and PDSN.	Devonald-Morris, Margaret	~~01/12/2017~~ 13/08/2018 13/10/2018 31/03/19	PDSN bank is being used to support nursing services. Local management arrangements in place and review for periods of leave. Recruited 0.8 WTE to 1.0 WTE post, commencement date end July 2018. 0.2 WTE vacancy currently funding bank hours. 0.8 WTE PDSN increased to 0.91WTE and 0.6 WTE increased to 0.69 WTE					
294		Women & Children's: Community Children's Services	Jones, Keith	Devonald-Morris, Margaret	24/04/2017	There is a risk of delayed and sub-optimal care of paediatric patients requiring community nursing and a holistic approach to palliative care needs in line with NICE Guidance 61 End of Life care for infants. This is caused by non-compliance with Royal College of Nursing Standards re ratio of nursing to child or young people population. In addition, the Royal College of Paediatric and Child Health recommendation of increasing community nursing capacity all, which are dependent on funding. This will lead to an impact/affect on timely interventions and clinical outcome, for children and families coming to terms with the prognosis. Risk location, Health Board wide.	One Hywel Dda children's community nursing team in place. Traffic Light System in place to ensure a safe and sustainable Children's Community Nursing Service that has the flexibility to meet the holistic nursing needs of current caseload. Recruitment of 47.5 hours Band 5 to replace a Band 7 to support maximising nursing capacity. Paediatric Palliative Care draft service specification and the provision of 24/7 advice service from the All Wales Clinical Network for Paediatric Palliative Care in place. Health Board adult and Paediatric Delivery Action Plan in place. All Wales Paediatric Advanced Care Plan in place.	Quality/Complaints/Audit	8	3	3	9	Existing caseload to be monitored, referrals to be reviewed against the traffic light framework to ensure a safe, sustainable service delivery.	Devonald-Morris, Margaret	~~31/01/2018~~ 30/06/2019	Ongoing appraisal of case load and referrals monitored.	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	07/02/2019
													Ensure investment into the Service Delivery is included in the Delivery action plan for 2018 onwards.	Devonald-Morris, Margaret	~~31/01/2018~~ 30/06/2018	SBAR developed for Community Nursing Services for budget setting 2018/19 submitted, no investment to date. Investment for 2019-2021 included in IMTP.					
													Develop a paediatric action & delivery plan in line with NICE guidance self assessment.	Devonald-Morris, Margaret	**Completed**	Email sent to palliative care lead consultant and nurse to arrange a date to develop. This meeting was postponed, to rearrange.					
													Develop an additional SBAR which includes nursing and medical staffing as an action from the Paediatric Task and finish Group.	Devonald-Morris, Margaret	31/12/2018	Draft SBAR completed and presented to Paediatric Task and finish group, ammendments required. 21/11/18 Paediatric Task & finish Group, Presentation by General Manager re: Withybush Paediatric Assessment Care Unit and Acute Model, elective and planned surgery and investment for community.					

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102		USC: Pathology	Perry, Sarah	Bowen, Caryl	08/09/2016	There is a risk of failure of the Blood Bank Issue room fridge leading to delay in access to blood products and an impact on patient safety. This is caused by lack of air conditioning and temperature control in the Blood Bank Issue room. This will lead to an impact/affect on the >10 year old Blood issue fridge is over compensating to maintain safe temperature for storage of blood stocks. Risking failure of this fridge which will result in wastage of blood products and possible life threatening delay to patients requiring emergency blood transfusions. Blood inappropriately stored can become contaminated with bacteria and if given to patients can result in adverse transfusion reaction. Risk location, Withybush General Hospital.	Maintenance contract in place for Blood Issue fridge. Contingency plans in place should fridge fail.	Safety - Patient, Staff or Public	6	3	3	9	Capital Bid submitted for consideration in the 2017/18 capital allocation process.	Stiens, Andrea	**Completed**	Await outcome of the allocation of HB capital. No capital funding identified in 2017/18.	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	04/04/2019
													Submit capital bid to 2019/20 capital programme	Jones*, Dylan	22/04/2019	No progress to date					
101		USC: Pathology	Perry, Sarah	Bowen, Caryl	08/09/2016	There is a risk of delay in blood transfusion and impact on patient safety. This is caused by blood Issue Fridge and Blood Stock Fridge being over 17 years old and maintaining required temperatures is an issue. This will lead to an impact/affect on cross matched blood and also the emergency issue blood would have to be moved to the Blood Stock fridge within blood transfusion. This would impact on patient safety as emergency blood would not be available as quickly. Blood Stock fridge does not have the capacity for holding large amounts of issue blood, there would be an increased potential for incorrect unit selected for patients resulting in transfusion reactions. Risk location, Withybush General Hospital.	Maintenance contract in place for Blood Issue fridge and Blood stock Fridge. Contingency plans in place should fridge fail.	Safety - Patient, Staff or Public	6	3	3	9	Capital Bid submitted for consideration in the 2017/18 capital allocation process.	Stiens, Andrea	**Completed**	Await outcome of the allocation of HB capital. Stock fridge 15K. Issue fridge 15K. No capital funding identified in 2017/18.	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	04/04/2019
													Submit capital bid to 2019/20 capital programme	Jones*, Dylan	22/04/2019	No progress to date					

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103		USC: Pathology	Perry, Sarah	Bowen, Caryl	08/09/2016	There is a risk of delay in blood transfusion and an impact on patient safety. This is caused by no back up platelet incubator being available. This will lead to an impact/affect on unable to store platelets causing delay to blood transfusion service provision. Platelets would have to be arranged for daily delivery from Welsh Blood Service increasing cost of transportation and delay to patient flow and discharge. Risk location, Withybush General Hospital.	Maintenance contract in place for Platelet Incubator. Contingency plans in place should fridge fail.	Safety - Patient, Staff or Public	6	3	3	9	Capital Bid submitted for consideration in the 2017/18 capital allocation process.	Stiens, Andrea	Completed	Await outcome of the allocation of HB capital £10k. No capital funding identified in 2017/18. Capital bid not approved in 2017/18	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	04/04/2019
													Capital bid to be submitted to the 2019/20 programme	Jones*, Dylan	22/04/2019	No progress to date					
318		Women & Children's: Gynaecology	Jones, Keith	Humphrey, Lisa	11/05/2017	There is a risk of avoidable detriment to the quality of patient care and experience for patients with early pregnancy complications. This is caused by insufficient trained Sonographer staffing during weekdays to guarantee access within 24 hrs and a lack of weekend service provision. This will lead to an impact/affect on disruption and closure of services during staff absence and increased presentation of patients in A&E, delay in diagnosis due to access to ultrasound. Failure to comply with National Institute for Health and Care Excellence (NICE) guidelines to provide appointment within 24 hours of referral. Risk location, Health Board wide.	One Specialist Nurse Sonographer in post in GGH. Backfill provided by Senior Nurse Managers for limited service only. Band 7 early pregnancy nurse post on TRAC for Withybush to provide backfill for Glangwilli early pregnancy. BJC due for submission to workforce panel.	Safety - Patient, Staff or Public	6	3	3	9	Planning in place for additional nurse Sonographers to be trained to provide sustainable weekday service.	Humphrey, Lisa	Completed	Training completed July 2017.	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	13/03/2019
													SBAR to be submitted to Health Board IMTP 17-18 for funding to support re-banding of staff.	Humphrey, Lisa	Completed	Full service report completed, SBAR and National Institute for Clinical Excellence (NICE) baseline assessment submitted to next Directorate Quality and Safety group.					
													New band 7 WTE 1.0 specialist EPAU nurse post to be placed on TRAC with business case.	Rees, Sarah	~~13/03/2019~~ 30/06/2019	Meeting to be arranged with Lisa Humphrey and Keith Jones to discuss funding.					
516		Finance	Thomas, Huw	Hayes, Rebecca	27/05/2016	There is a risk of the Health Board recovering an incorrect amount of VAT on advice given on historic and incomplete Design for Life Schemes. This is caused by difficulty in obtaining VAT advice from D4L nominated VAT advisor. This will lead to an impact/affect on the capital program with any incorrect or blocked VAT claims needing to be repaid. This may increase as final reviews are undertaken. Risk location, Health Board wide.	This contract is managed by NHS Shared Services on behalf of Welsh Government. Welsh Government are informed through Capital Review Meetings. It is likely any issues will be funded by Welsh Government as they arise from an all Wales VAT advice contract.	Finance inc. claims	6	4	2	8	Identify a provider for VAT advice.	Eve, David (Inactive User)	Completed	For new D4L schemes the VAT advisory work will be undertaken by the HB current VAT advisors. The issue for new D4L schemes is resolved.	Finance Committee	4	2	8	29/11/2018

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													Work with Shared Services and Deloitte's to resolve the older D4L schemes.	Thomas, Huw	~~30/09/2017~~ 31/01/2019	2 schemes are currently with HMRC for closure, another 3 schemes remain outstanding and 1 scheme is on-going. Work continues to resolve the older schemes. Deloitte are supporting the HB with current HMRC queries and correspondence. Discussions between HMRC Policy Team and Deloitte took place in December 2017, with internal HMRC discussions following in January 2018. HMRC visited the HB in July 2018 and reviewed all of the schemes in detail. As a result, Deloitte have prepared revised work in respect of final account assessment; this is being submitted to HMRC in October 2018 for feedback.					
73		Central Operations: Out of Hours	Rees, Gareth	Davies, Nick	01/10/2010	There is a risk of avoidable harm to paediatric patients as a result of no dedicated paediatric service during Out of Hours (OOH) operational times. This is caused by no dedicated paediatric service being available. This will lead to an impact/affect on GPs having to manage medically compromised children with insufficient specialist paediatric support on site. Experience of the receiving service in GGH not able to accept a sick child. Potential significant harm to sick children with large claims and reputational damage to the organisation. Risk location, Llynyfran Surgery, Llandysul, Prince Philip Hospital, Withybush General Hospital.	Guidelines on the management of paediatric patients are circulated to all staff. A triage and transfer model is in place. On-going liaison with the Women and Children's Directorate. Guidance has been received with regards to direct admission to GGH in the OOH period.	Safety - Patient, Staff or Public	6	2	4	8	Develop a link with the Women and Children Directorate, and liaise between the clinical lead.	Davies, Nick	**Completed**	The OOH service has been included in the Paediatric Task and Finish Group assessing the provision in Pembrokeshire.	Operational Quality, Safety & Experience Assurance Sub Committee	2	4	8	06/02/2019
													Identify dedicated ambulance transport.	Davies, Nick	**Completed**	Dedicated Ambulance Vehicle (DAV) transport is to continue for the foreseeable future.					
													Establish and provide clear guidelines and protocols and promote and encourage Incident Reporting where deficits in protocols are identified and incidents occur.	Davies, Nick	**Completed**	Established guidelines and incident reporting are in place and under frequent review.					
444		Information and Communication Technology	Tracey, Anthony	Solloway, Paul	01/06/2014	There is a risk of increased costs could be incurred by the Health Board and inefficiencies in software licensing. This is caused by lack of defined software asseting procedures and tools. This will lead to an impact/affect on audits being undertaken by software vendors to identify if the	Software installations are closely monitored to ensure compliance.	Finance inc. claims	6	2	4	8	Review Asset Management Procedures.	Solloway, Paul	**Completed**	Benchmarking exercise completed by Microsoft license specialist.	States and IM&T Sub Committee	3	2	6	06/01/2019

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		PP&C: Informatics				Health Board is correctly licensed for the software it uses. Any shortfalls could have financial implications for the Health Board. Risk location, Health Board wide.							Update procedures and communicate to all IT department.	Solloway, Paul	~~30/11/2017~~ 31/12/2018	Procedures being updated in line with best practice, date delayed due to lack of resources.	Capital, E				
													Provide regular reports on software assets.	Solloway, Paul	~~31/03/2018~~ 31/12/2018	No progress to date, date delayed due to lack of resources.					
134	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Central Operations: HSDU	Rees, Gareth	Flear, Philip	08/01/2015	There is a risk of needing to destroy large numbers of surgical instruments following suspected prion contamination arising during invasive procedures. This is caused by the inability to be able to mark individual instruments to enable them to be tracked and traced through the decontamination processes as there is no instinctually reliable system available on the market. This will lead to an impact/affect on an inability to trace instruments should a look back exercise be required e.g. possible patient infection. Unable to defend possible litigation claims. In the event of detected contamination all similar instruments will need to be destroyed with consequential financial impacts. Risk location, Health Board wide.	Supplementary instruments are colour coded to allow the surgical speciality to be identified. Where the same supplementary instrument is used for the same procedure, these have been added to the relevant instrument sets. Stock of supplementary instruments within theatres have been reduced and continue to be monitored with the aim of reducing further. Single use instruments are used where available.	Finance inc. claims	6	2	4	8	HSDU management to continue reviewing new technologies which could possible mitigate this risk.	Flear, Philip	~~13/06/2018~~ 31/01/2019	Unable to progress. This is due to systems not being within current knowledge and invention to do so safely. 13/06/18 No further update. 23/10/18 No further update. Update 27.12.18 Visit took place system on trial in enabling health board will review results in 3 months time. Update 27.02.19 Awaiting response from other health boards.	Capital, Estates and IM&T Sub Committee	2	3	6	27/02/2018
													Discuss with other Health Boards in England to establish how others are approaching this challenge. Continue to review technology for an acceptable resolution.	Flear, Philip	Completed	Discussed with other health boards and with Hospital Sterilisation and Decontamination Unit (HSDU) management from Derriford, who have etch marked their single instruments. However this is against manufacturer's warranty procedures. No suitable system in place to mitigate this risk as at August 2017. Update 13.08.18 - No further update. 23.10.18 Intend visiting to view a system to be updated in December of any progress. Update 27.12.18 Visit took place system on trial in enabling health board will review results in 3 months time.					

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677	Standard 3.3 Quality Improvement, Research and Innovation	MH&LD: Older Adult Mental Health Services	Carroll, Mrs Liz	Evans, Melanie	02/04/2018	There is a risk of avoidable detriment to financial robustness and performance. This is caused by inefficient use of staff resources on Enlli Ward as it is a 7 bedded unit with a nursing staff compliment of 24.39 WTE. Other units providing a similar function have 25 WTE to manage 15 beds. This will lead to an impact/affect on avoidable detriment to financial robustness and performance. Risk location, Bronglais General Hospital.	Ensuring rosters are efficient with annual leave and study leave proportioned within the headroom to avoid the unnecessary need to incur any variable pay costs. Sickness absence monitoring is in place. PADRs 90.91%	Finance inc. claims	6	2	4	8	Plans are being developed to ensure a more efficient use of staff resource which will also provide an enhanced service for patients.	Carroll, Mrs Liz	04/01/2019	Capital bid has been developed and detailed floor plan and specification being developed.	Capital, Estates and IM&T Sub Committee	3	2	6	14/02/2019
226		Estates & Facilities	Elliott, Rob	Harrison, Tim	01/02/2018	There is a risk of avoidable incidence of patients suffering severe burns from coming into contact with hot surfaces, i.e. radiators, located throughout in-patient wards and side rooms at WGH. This is caused by unprotected cast iron radiators situated throughout clinical areas including side rooms. Prolonged contact often occurs because people have fallen and are unable to move away from the heat source. This will lead to an impact/affect on patients health resulting in burns and potential for loss of limb or death. This would also lead to HSE prosecution if this were to occur. Risk location, Withybush General Hospital.	Radiator thermostats fitted. Communal ward locations are lower risk as radiator tends to be positioned centrally. Risks highlighted at Managers Passport Training. Site Operations Manager looking into appropriate radiator covers.	Safety - Patient, Staff or Public	6	2	4	8					Emergency Planning and Health and Safety Sub Committee	1	4	4	20/06/2018

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563		3 Counties: Carmarthenshire	Dawson, Rhian	Rees, Craig	04/10/2017	There is a risk of avoidable patient harm and increased admissions to the acute sector GGH and PPH. This is caused by the potential for the Integrated Care Fund (ICF) to cease in March 2020 and a requirement to fund services from current budgets which may not be possible, therefore newly established services brought to reality by the ICF may cease. This will lead to an impact/affect on services to patients' may be delayed resulting in delayed transfers of care, risk of hospital acquired infection along with loss of capacity to keep care for patients at their own homes, or a negative financial impact on Health Board finances. Risk location, Amman Valley Hospital, Glangwili General Hospital, Llandovery Cottage Hospital, Prince Philip Hospital.	Position paper set out in an SBAR to the Business Planning and Performance Assurance Committee on October 2017. Welsh Government been made aware via quarterly reports. Regional Board and County Boards will highlight any issues as they arise. The risk will be updated after the Carmarthenshire County Management Team meeting.	Safety - Patient, Staff or Public	6	2	4	8	Seek clarity on funding agreement between Welsh Government and the Health Board.	Dawson, Rhian	~~31/12/2018~~ 30/04/2019	Continue to review with the west wales care partnership and Welsh Government. ICF funding bids have been submitted to Welsh Government awaiting outcome.	Operational Quality, Safety & Experience Assurance Sub Committee	1	4	4	18/03/2019
575		3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	04/10/2017	There is a risk of avoidable patient harm and increased admissions to the acute sector. This is caused by the Integrated Care Fund (ICF) ceasing in March 2020 and a requirement to fund services from current budgets which may not be possible, therefore newly established services brought to reality by the ICF may cease. This will lead to an impact/affect on patients' loss of functional ability, delayed transfers of care, risk of hospital acquired infection along with loss of capacity to keep care for patients at their own homes, or a negative financial impact on Health Board finances. Risk location, Health Board wide.	Position paper set out in an SBAR to the Business Planning and Performance Assurance Committee on October 2017. Welsh Government been made aware via quarterly reports. Regional Board and County Boards will highlight any issues as they arise.	Safety - Patient, Staff or Public	6	2	4	8	Create an SBAR to demonstrate the risk and any mitigations in place.	Hawkes, Jina	**Completed**	SBAR Created	Operational Quality, Safety & Experience Assurance Sub Committee	1	4	4	15/04/2019
													Assurance is required with regards to Regional Governance arrangements and guidance to engage with the Regional process.	Hawkes, Jina	**Completed**	Regional Governance arrangements have been raised with the Regional Team. Regional Governance arrangements have been raised with Sarah Jennings who is a West Wales Board Member					
													Awaiting feedback from Sarah Jennings	Hawkes, Jina	04/01/2019	Review of current Regional Governance arrangements is underway General feedback is still being discussed (18/3/19)					
													Exploring next steps with roles who are currently funded by ICF, including re-deployment, redundancy etc	Hawkes, Jina	17/06/2019	Met with HR to start next steps					

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518		E&F: Property Performance	Elliott, Rob	Williams, Paul -	04/12/2017	There is a risk of pollution incidents, disruption to continuity of supply and quality of fuel oil, leading to an increased revenue spend. This is caused by a failure in fuel oil containment due to age, condition and procedures, linked to a failure to comply with Water Resources (Control of Pollution Oil Storage) Regs 2016. Also, diminished supply (especially Heavy Fuel Oil), linked to EU legislation / volatility of global energy markets. This will lead to an impact/affect on ground or surface water pollution leading to costly remedial work, potential fines or enforcement action depending on severity of environmental impact. Also interruption to heating and hot water from some primary (GGH) but mainly secondary supplies, negative publicity. Escalating revenue costs by not moving away from oil use. Risk location, Aberaeron Hospital, Cardigan Memorial Hospital, Cross Hands Health Centre, Glangwili General Hospital, Hafan Derwen, Minaeron, Tregaron Hospital, Ty Myddfai - Psychotherapy, Withybush General Hospital.	1)Planned Preventative Maintenance(PPMs) and procedure in place covering the delivery and storage of oil. 2)ISO 14001 audits review action taken inline with legal compliance and operational procedures, highlighting areas of non conformance for improvement. 3)External assessments by suitably qualified contractors undertaken to tanks, bunds and pipework agaist the oil storage regulations. Minimum and best practice recommendations provided. 4)Capital investment in high priority recommendations to ensure compliance with oil storage regulations. 5)Internal assessment undertaken to replace oil at Hafan Hedd and Minaeron with LPG. 6)External feasibility undertaken to determine short and long term energy use at GGH, to move away from Heavy Fuel Oil use. Includes the assessment on the cleaning vs replacement of existing oil tanks. 7)Internal assessment of WGH oil storage condition and contingency requirement to develop scheme for capital funding. 8)Decommissioning of Aberaeron Oil tank in line with property disposal timescales. 9)Energy Price Risk Management Group (EPRMG) meet quarterly to assess energy price trends and support forward planning. 10)All Wales contract in place covering the supply of oil.	Statutory duty/inspections	8	2	4	8	Update operations procedures in line with pollution prevention / ISO recommendations	Corcoran, Rhian	~~10/08/2018~~ 30/06/2019	To be done by the end of June 2019 (delays due to resource change)	Capital, Estates and IM&T Sub Committee	1	4	4	07/03/2019
													Upgrade PPMs to reflect new procedures. Provide awareness sessions to maintenance staff on new requirements.	Corcoran, Rhian	~~28/09/2018~~ 30/06/2019	To be done by the end of June 2019 (delays due to resource change)team - months change to November and December.					
													Ensure audits are undertaken in line with ISO 14001 audit schedule, and any non conformances are actioned within appropriate timescales.	Corcoran, Rhian	~~21/12/2018~~ 31/05/2019	4 acute site audits scheduled for April. Community sites scheduled for May. Report on progress against Non Conformances in M6 ISO 14001 Review at CEIM&T in October 2018.					
													Review and fund priority compliance works in line with Oil Storage Regulations	Corcoran, Rhian	~~29/03/2019~~ 31/08/2019	Delayed in line with WGH project delivery					
													To identify and develop a scheme proposal to manage short and medium term risks associated with oil use and storage at GGH and WGH.	Williams, Paul -	~~26/10/2018~~ 31/08/2019	WGH: scheme not yet agreed but must be completed by August 2019 (ISO compliance) Official design scheme must be finalised with site ops by May 2019 . GGH - scheme approved and will be completed by July 2019					
													Obtain quotes for cleaning of tanks / replacement of pipework etc at GGH and WGH to aid delivery of the design scheme.	Corcoran, Rhian	**Completed**	Quotes sought, awaiting final submissions Quotes provided to design team as part of evidence base to deliver scheme.					
													Deliver capital scheme upgrading oil (or alternative) storage solutions at GGH and WGH.	Williams, Paul -	27/09/2019	07.03.19 - On target					

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156	Standard 2.1 Managing Risk and Promoting Health and Safety	MD: Medical Education & Knowledge	Evans, John	Noble, Jayne	25/05/2016	There is a risk of the Health Board having reduced SIFT (Service Increment for Teaching) income if medical student numbers are reduced or removed. This is caused by failure to meet the Welsh Government standards on accommodation and associated facilities set for Health Boards or failure to find external accommodation that meets the student placement requirements. This will lead to an impact/affect on the Health Board contributing more to the recurring costs and reducing the opportunity to recruit Foundation Doctors to work in our hospitals. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Inceased use of external accommodation due to increased student numbers and an increase in locum doctors and agency nurses. Students are asked to report problems early to their local Medical Education team. End of Placement evaluations that highlight problems are acted on before the next students arrive. Medical School Evaluations.	Finance inc. claims	6	2	4	8	BGH is experiencing problems with their student only block, being used by agency nurses and F1 doctors due to poor standards in the F1 block. Very poor accommodation standards have been reported across the Health Board, but are worse in BGH.	Noble, Jayne	Completed	Work with Hotel Facilities to reduce the numbers of agency nurses using the student block in BGH. New process in place to secure student accommodation and not release rooms to locums External accommodation for Mental Health students identified in Trinity College for the Carmarthen area T&FG in place to review all accommodation and Action Plan produced. Requesting discretionary capital to undertake worst affecting accommodation, particularly in BGH and WGH	Capital, Estates and IM&T Sub Committee	1	4	4	05/02/2019
													Continue to use medical school feedback to make improvements.	Noble, Jayne	Completed	The Undergraduate Annual Review highlights the need for improvements. T&F Group in place with Action Plan. Continue to monitor Medical School feedback to feed into the T&F Group					
													Improvements in Wi-Fi access.	Noble, Jayne	Completed	Wi-Fi problems are being reported by students. BT are increasing bandwidth in the residences. SIFT is to contribute to this through existing accommodation funding in BGH, GGH and PPH and new funding received from WGH and Mental Health.					
													An Accommodation Task and Finish Group has been set up reporting to the Capital, Estates and Information Management and Technology (CE&IMT) Sub-Committee.	Preece, Karen	Completed	A scoping exercise has been carried out to ascertain conditions against standards and reviewing the level of discretionary capital required for short and long term improvements. Capital now identified for 2018-2019. Quality control systems are in place to ensure the cleanliness of rooms and protection of prepared rooms for student occupancy.					

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													Year 1 Works programme in place on each site, utilising £200K of discretionary capital. Due to finish by end of March 2019. T&F Group to begin plans for Year 2 bid for capital.	Noble, Jayne	28/02/2019	Next Accommodation T&F Group Meeting scheduled for 28th February to discuss Year 2 works bid					
374		P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Simons, Delyth	03/02/2011	There is a risk of disruption of services to patients. This is caused by by non-compliance with national standards. This will lead to an impact/affect on services to patients resulting due to the closure of the aseptic units. Risk location, Bronglais General Hospital, Withybush General Hospital.	Standard operating procedures, monitoring on-going audit and Quality Control with regular input of Quality Assurance/Quality Control lead. Additional 0.5 Whole Time Equivalent (WTE) Assistant Technical Officer approved for all sites to enable the Health Board to remain compliant with Medicines and Healthcare Products Regulating Agency (MHRA) standards. The Unit in GGH has been shut down due to water ingress on 4 occasions into the isolators External audit of WGH and BGH units have been undertaken and action plans in place. Rationalisation of out-sourced products 1wte Technician transferred from GGH to WGH Out-sourcing of products as appropriate	Quality/Complaints/Audit	8	2	4	8	Continue to progress work of Project Group	Simons, Delyth	**Completed**	Monthly project group meetings in place	Medicines Management Group	1	4	4	01/04/2019
													Business Justification Case to be submitted to Welsh Government following confirmation of appropriate process from WG	Williams, Paul	28/09/2018	On-going communication with WG Technical specification completed					
													Task and finish group to prepare BJC for presentation to Welsh Government. Plans to be developed for a new unit in WGH to support Chemotherapy and Radio-Therapy	Pugh-Jones, Jenny	~~31/12/2018~~ 31/01/2019	Medicines Management working with planning and estates department to ensure plans are presented to WG					
588	Standard 3.1 Safe and Clinically Effective Care	erapies & Health Science: Podiatry & Surgical Appliances	Vanderlinden, Natalie	Mulroy, Mike	30/12/2016	There is a risk of failure to meet clinical standards Putting Feet First (Feb 2013), NICE Clinical Guideline 19, Prudent Health Diabetic Foot Pathway (All Wales DBM Foot Group 2017) This is caused by insufficient investment in new specialized services and inadequate clinical accommodation. Also a lack of recognised MDT in high risk and acute diabetic foot disease across 4 hospital sites. This will lead to an impact/affect on patient outcomes due to delay in accessing podiatry high risk (casting), vascular and CMATS podiatry services delayed surgical opportunity to reduce the requirement of amputation	No lab facilities available in Ceredigion for cast offloading insole manufacture and minor adjustments on modular/stock orthotics. Podiatrists travelling to Carmarthen to use lab facilities. Patients offered access to CARMS specialist services, i.e. Glangwili and PPH vascular, CMATS podiatry and casting clinics if patients willing/able to travel. CMATS Podiatry clinic started in Lampeter. Vascular clinic held once monthly in BGH.	Quality/Complaints/Audit	6	2	4	8	Accomodation shortfall at BGH site delaying start of casting clinics to offload foot ulcers as per NICE Guidance and All Wales Offloading document. Discuss room use with physiotherapists as plaster techs have no designated plaster room and have to use shared room on OPD with limited access. Further training identified but limited access to room has delayed training to date.	Mulroy, Mike	30/09/2019	Casting room identified in BGH OPD but limited availability. Awaiting discussion with physiotherapy for access to suit podiatry high risk clinic for removal of cast, debridement of diabetic foot ulcers and reapplication of cast. Further training to be completed. Discussion with Physio re room availability - no problem. Orthotic manager to enquire re further training of plaster techs.	Quality, Safety & Experience Assurance Sub Committee	1	4	4	02/04/2019

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		The				~~requirement of amputation~~ poor delivery of key existing and future services as identified in IMTP; HB's performance due to non compliance with clinical standards and legislation equity of service delivery across the Health Board Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.							Start CMATS Podiatry clinic in BGH Leri Day Unit clinic room.	James, Enfys	**Completed**	CMATS podiatrist from Carmarthen will attend clinics in March 2019.	Operational				
													Explore possible provision of lab in BGH Leri Day Unit and identify need on future accommodation plan. Lab identified in Cardigan New Build.	James, Enfys	~~28/06/2019~~ 31/12/2022	Some requirements submitted to therapy lead. Planned refurbishment of Leri Day Unit for 2020. Existing services and wishlist submitted to estates. Ongoing meetings attended by Podiatry Lead. New facility anticipated to be complete in 2022.					
													MDT pilot in PPH to establish business plan and training requirements for ward staff pre and post operatively. Dedicated anaesthetist pre op session to be arranged and support by DBM consultant.	Morris, Joanne	~~31/03/2019~~ 25/06/2019	Ongoing meetings with Exec level. Some staffing shortfall identified.					
721	Standard 3.1 Safe and Clinically Effective Care	MD: Effective Clinical Practice	Evans, John	Eden, Ingaret	08/03/2019	There is a risk of NICE guidance not being disseminated to appropriate staff in a timely manner. This is caused by resources being limited to a staff of 0.4 WTE Band 7 and 0.4 WTE band 5. This will lead to an impact/affect on the possibility that services will not be fully aware of their responsibilities in relation to NICE guidance. The Health Board is expected to ensure that provision is made to enable healthcare staff to implement NICE guidance as expected by the Welsh Government. Risk location, Health Board wide.	NICE policy. Staff of 0.4 WTE Band 7; 0.4 WTE Band 5. Robust system for dissemination and collection of baseline information.	Quality/Complaints/Audit	8	4	2	8	Directorate lead to identify further resources and with Co-ordinator to identify new ways of working.	Eden, Ingaret	31/10/2019	New action.	Effective Clinical Practice Sub Committee	2	2	4	18/04/2019
667	Standard 3.2 Managing Risk and Promoting Health and Safety	Health Science: Podiatry & Surgical Appliances	Vanderlinden, Natalie	Mulroy, Mike	20/11/2018	There is a risk of harm to patients. This is caused by potential delay in fitting spinal bracing to unstable spinal fractures. This will lead to an impact/affect on patient having to be immobilised unecessarily with associated risks (DVT, PE, hypotension, muscle atrophy; delayed transfer of care and increased bed occupancy). patient risk of permanent disability if fracture dislocates. ward staffing - severely compromised when patient needs to be moved, fed, etc as it takes 5 ~~members of staff to do this~~	Contracted Orthotist on site every Friday and alternate Mondays. In house orthotist has trained plaster technicians, physiotherapy, T&O specialist nurses in stable fracture bracing but they are unwilling to manage unstable fractures.	Safety - Patient, Staff or Public	6	2	4	8	SBAR to identify further investment to provide mid week orthotist hours	Mulroy, Mike	**Completed**	SBAR submitted 8/2/19. Awaiting comments.	Safety & Experience Assurance Sub Committee	1	4	4	02/04/2019

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	Standard 2.1 Ma	Therapies & H				members of staff to do this. cancellation of clinics resulting in delayed care affecting patient outcomes Risk location, Bronglais General Hospital, Glangwili General Hospital, Withybush General Hospital.							Referral for bracing for T4 unstable fracture in Bronglais Hospital resulted in cancellation of clinic sessions for urgent measures and fitting of bespoke brace. Complexity of orthotic management required 3 sessions of orthotist and assistant time and ongoing monitoring.	James, Enfys	**Completed**	Brace fitted. Patients re-appointed within 8 weeks of cancellation.	Operational Quality, Sa				
513		Finance	Thomas, Huw	Hayes, Rebecca	01/05/2016	There is a risk of lack of modernisation of the Finance Directorate. This is caused by withdrawal of the earlier Organisational Change Plan OCP. This will lead to an impact/affect on the level of financial support will be less than optimal. Risk location, Health Board wide.	The Director of Finance is in close liaison with the Senior Finance Team on budget performance, the underlying run-rate and Savings profiles. Temporary agency staff are filling some of the vacancies, until permanent recruitment is made, within the department and this will be retained until permanent solutions are concluded as part of the consultation.	Finance inc. claims	6	4	2	8	Recruit finance staff for vacant positions.	Thomas, Huw	~~29/05/2018~~ 31/03/2019	Director appointment in December 2017. Deputy Director appointed April 2018. OCP commenced its implementation in July 2018 and is on-going; Assistant Directors appointed July 2018 and Senior Finance Business Partners appointed September 2018. Finance Business Partners appointed November 2018. Next tier of slotting in and vacancy advertisement implemented in December 2018.	Finance Committee	1	2	2	29/11/2018
522		Scheduled Care: Anaesthetics	Hire, Stephanie	Knight, Diane	18/06/2018	There is a risk of financial overspend for Anaesthetics. This is caused by the inability to reduce the number of Supporting Professional Activity (SPA) sessions across the consultant body to draw in line with advice from the Medical Director. This will lead to an impact/affect on the financial sustainability of the department. Ability to provide 21 more funded direct clinical care sessions from within the established consultant body. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Job planning in place in line with Medical Directors instructions.	Finance inc. claims	6	4	2	8	Job planning dates to be established for all Consultant Anaesthetists	Knight, Diane	**Completed**	complete	Finance Committee	1	2	2	27/03/2019
													Full review of workload commitments	Knight, Diane	~~30/11/2018~~ 31/03/2019	Being addressed through the electronic job planning process.					

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161	Standard 2.1 Managing Risk and Promoting Health and Safety	MD: Medical Education & Knowledge	Evans, John	Noble, Jayne	25/05/2016	There is a risk of the Health Board losing funding to run our L&KS Service. This is caused by reduced Deanery funding due to budget changes with the new HEIW Body. Also reduced Deanery funding if Junior Doctors numbers are reduced in Hywel Dda or moved to less sites. This will lead to an impact/affect on the Health Board to provide the funding lost from the external source. Risk location, Health Board wide.	HEIW to commence in April 2018, first six months there will be a shadowing period.	Finance inc. claims	6	2	3	6	Awaiting implementation of the Health Education Wales (HEIW), an integrated body for health training investment, in April 2018. Expect no changes until this time.	Noble, Jayne	Completed	HEIW commenced 1st October. HEIW investing in All Wales Libraries, still awaiting any news on local budgets	Workforce and OD Sub Committee	2	3	6	05/02/2019
390		Central Operations: EBME	Rees, Gareth	Burns, Mike	15/03/2018	There is a risk of avoidable harm to patients arising from poorly governed CPAP equipment within community settings. This is caused by a lack of systematic management of the proliferation of CPAP equipment, lack of corresponding resource and poorly maintained equipment. This will lead to an impact/affect on harm and inappropriate treatment of patients due to ineffective use and management of equipment. Risk location, Health Board wide.	Reporting to Medical and Non Medical Equipment Control Group. Paper to QSEAC. Baseline assessment undertaken. Work on-going to identify maintenance requirements. EBME staff being sent away on technical training in order to maintain these devices in-house.	Safety - Patient, Staff or Public	6	2	3	6	Review all Non Invasive CPAP equipment and complete a baseline assessment Complete an inventory Develop a sustainable governance model for CPAP equipment Undertake a PDSA cycle on all CPAP equipment Develop an ongoing maintenance plan for all CPAP equipment in Community.	Burns, Mike	Completed	Review all Non Invasive CPAP equipment and complete a baseline assessment - complete Complete an inventory - complete Develop a sustainable governance model for CPAP equipment - complete Undertake a PDSA cycle on all CPAP equipment - complete Develop an ongoing maintenance plan for all CPAP equipment in Community - awaiting completion of technical training.	Operational Quality, Safety & Experience Assurance Sub Committee	2	3	6	01/05/2019
385		Central Operations: EBME	Rees, Gareth	Burns, Mike	23/09/2017	There is a risk of avoidable harm to patients arising from poorly governed ultrasound equipment. This is caused by a lack of systematic management of the proliferation of ultrasound equipment, lack of corresponding resource, absence of adequate training and poorly maintained equipment. NB: incident at BGH May-18. This will lead to an impact/affect on harm and inappropriate diagnosis of patients due to ineffective use and management. Potential recall of large numbers of patients and potential adverse publicity. Risk location, Health Board wide.	Medical and Non Medical Equipment Control Group.	Safety - Patient, Staff or Public	6	2	3	6	Develop a sustainable governance model for ultrasound through establishment of an Ultrasound Governance Group.	Oliver, Will	Completed	Governance model being discussed as part of QSEAC workshop. The all Wales Governance standards for US governance form the basis of the Governance model. The initial meeting of the US Governance group is set for the 27th of September 2018. Amanda Evans, Head of Radiology services is leading on this and Chairing. The group will report directly to the operational QESAC	Quality, Safety & Experience Assurance Sub Committee	2	3	6	01/05/2019

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													Allocate responsibility to appropriate officers for tasks, training and safe device operation.	Oliver, Will	Completed	Training responsibility has been assigned to Angie Oliver. Assistant Director of Workforce and OD, who has established a Medical Devices Training Group reporting to MDGAG. We are still considering the other 2 responsibilities	Operational Q				
													Develop a training plan for the use of ultrasound.	Oliver, Will	Completed	Action has been picked up through the Ultrasound Governance Group.					
376		P,C,LTC: Long Term Care	Paterson, Jill	Broad, Vicki	04/06/2013	There is a risk of financial implications to the Health Board following the Supreme Court judgement on FNC (NHS-funded Nursing Care) and Nursing responsibilities. This is caused by Local Authorities in Wales appealing the decision of the High Court Appeal in the Supreme Court. This will lead to an impact/affect on changes in the funding arrangements around the nursing provision in a care home environment and have a significant financial effect both retrospectively (back to 2014) and going forward. Risk location, Health Board wide.	Established All Wales working Group and Board - Director level member chairs Board. Risk has been communicated to the Executive Team and The Board through All Wales Directors of Finance Group. Financial impact to the organisation established - both from retrospective FNC reimbursement and potential cost implications for 2018-19 and onwards. Work is on-going both at a National and Local level. Director of Primary care and long term care Chairs the All Wales Technical Group. Head of Long Term Care attends the Heads of Complex Care Meetings and the Assistant Director of Finance attends the All Wales Finance meetings. Internal Health Board meetings have taken place between Finance and Long Term Care to develop a clear plan around ensuring that the Health Board is compliant with guidance issued by the All Wales Steering group.	Finance inc. claims	6	2	3	6	Finance team are reviewing the financial impact (retrospective impact and impact in 2018/19).	Bingham, Heledd	Completed	No update.	Finance Committee	2	2	4	27/03/2018
													Legal advice being sought on an All Wales basis by the CHC Lead on potential liabilities around back payment of Continuing Health Care fees.	Paterson, Jill	~~27/07/2018~~ 30/06/2019	Awaiting further feedback from Welsh Government and Care Forum Wales. CHC will be reviewed once further information has been received and assessment can be made on the known and associated risks.					
													Agreement with Local Authorities regarding the payment process of the 2014 - 2017 element and agreement of on going uplifts to the Local Authority element of the FNC payment.	Broad, Vicki	Completed	Agreement has been reached on the back-pay element. This is completed. Local Authorities are still considering the 2018/19 update.					
													Accrual of self funder costs into 2018/19	Davies, Rhian	Completed	Based on recent guidance from Welsh Government					
													Identification of short fall in funding from Welsh Government	Davies, Rhian	Completed	completed					
													Decision by CEOs regarding uplift model for 2019/20	Broad, Vicki	~~29/03/2019~~ 30/04/2019	Options paper has been drafted by the NHS lead. CEOs to discuss in their February meeting. The CEO meeting was deferred. Awaiting a decision early in the 2019/20 financial year.					

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377		Women & Children's: Midwifery/Maternity	Jones, Keith	Jenkins, Mrs Julie	01/03/2016	There is a risk of patient safety and delivery of timely antenatal care and diagnosis. This is caused by absence of scanning facilities, staff with appropriate training, limited sonographers resulting in insufficient appointments and non compliance with ASW standards. Obstetrician's facilitating departmental scans not linked to PACS and scan equipment outside Antenatal Screening Wales standards. This will lead to an impact/affect on quality and continuity of Consultant led antenatal care and timely patient referral inline with Antenatal Screening Wales and Royal College of Obstetricians and Gynaecologists (RCOG) Standards. Quality of patient experience as patients attend additional appointments in other sites to access scans. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Alternative scanner has been sourced to ensure a quality safe service Provision at BGH. Service delivery manager and Lead for gynaecology reviewing compliance for minimum standards for scanning proficiency. Meetings held with radiology department to assess current non compliance and potential measures to mitigate risk. Midwife sonograms facilitating some sessions to assist with capacity. Paper presented to MDT Obs and Gynae team. GM to present to Executive Board for consideration of options paper.	Safety - Patient, Staff or Public	6	3	2	6					Operational Quality, Safety & Experience Assurance Sub Committee	2	2	4	07/02/2019
547		E&F: Property Performance	Elliott, Rob	Williams, Paul -	31/03/2017	There is a risk of failing to meet a mandatory Welsh Government requirement to operate an environmental management system (EMS) certified to the 2015 ISO 14001 standard, externally audited by a UKAS approved auditor. This is caused by insufficient resources and enablers, e.g. within the environment team and supporting teams and the wider staff base. Inherent difficulties are associated with behavioural change, engagement, leadership and limited funding for improvement projects, and the cost of assessment and consultancy. This will lead to an impact/affect on the organisation's ability to achieve or maintain the ISO 14001 standard, which is also the principal means through which environmental and resource efficiency performance and continual improvement is delivered and measured. Risk location, Health Board wide.	The 2006 ISO 14001 standard, 3 year UKAS (United Kingdom Accreditation Service) certification, was achieved in 2012 and continued to maintain key systems reviewed by external auditors. Utilised consultancy support to update system documentation to the 2015 standard during 2017/18. Key ISO 14001 requirements have been integrated into Health Board systems e.g. governance objectives and targets and management review via the Capital, Estates and Information Management & Technology (CEIM&T) committee and risks via Datix Risk Assessment Forms.	Statutory duty/inspections	8	2	3	6	Arrange a tender to appoint a new contractor to undertake UKAS audits of the EMS to the 2015 ISO 14001 standard.	Williams, Paul -	31/05/2019	Tender documentation to be prepared in April, give 3 weeks for companies to bid. Need to award by end of May. 07.03.19 update - on target.	Capital, Estates and IM&T Sub Committee	1	3	3	07/03/2019
													Complete all remaining training packages (environment / waste segregation / waste paperwork / oil deliveries) and begin training programme.	Corcoran, Rhian	~~29/03/2019~~ 31/05/2019	This has been progressed, but will not be completed until May 2019 due to temporary reduced resource in the team.					
													Complete updates of operational controls i.e. 3 maintenance procedures, utilities work instructions, waste procedures.	Corcoran, Rhian	~~29/03/2019~~ 30/06/2019	This has been progressed, but will not be completed until June 2019 due to temporary reduced resource in the team					
													Complete and receive approval for annual environmental Objectives and Targets.	Williams, Paul -	~~29/03/2019~~ 31/05/2019	This will be decided with the new SEO who commences April 2019. Aim for papers to be submitted to the May CEIM&T committee					
													Complete EMS documentation updates to reflect the new 2015 standard.	Corcoran, Rhian	~~29/03/2019~~ 30/06/2019	Some have been completed, the remainder need to be completed with new SEO. Planned for end of June 2019					

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													Focus action on the new standard requirement for evidencing organisational leadership on environmental management. this will include completing briefing note, attendance of exec team, ops board and other meetings, one on ones with key staff e.g. CE and chair, procurement, etc	Williams, Paul -	31/07/2019	To be commenced and planned by the new Senior Environmental Officer following their appointment in March 2019. 07.03.19 update - on target.					
													Undertake the annual management review	Williams, Paul -	31/07/2019	Complete review document alongside completion of the annual sustainability report. Present at July CEIM&T committee. 07.03.19 update - on target.					
													Be externally audited against the 2015 ISO 14001 standard	Williams, Paul -	29/11/2019	Follow tender, aim to have a Phase 1 audit in July / August and then the main audit in November. Further actions to be documented following the Phase 1 audit. 07.03.19 update - on target.					
151	Standard 2.1 Managing Risk and Promoting Health and Safety	MD: Medical Education & Knowledge	Evans, John	Noble, Jayne	23/05/2016	There is a risk of service provision implacted if Junior Doctor posts are removed. This is caused by the failure to deliver the GMC Standards for training and failing to deliver the specialty curriculum. This will lead to an impact/affect on the Health Boards ability to recruit or retain medical staff due to poor training resources/facilities. Risk location, Health Board wide.	Review of physical space to deliver clinical skills/simulation and review of Educators across the Health Board. Review to be complete by end of February 2018. Clinical Skills Hub set up, first meeting held on 11th Jan. Clinical Skills/Simulation Faculty to be organised - first meeting to be held by March 2018. Monitor Educational Contract adherence. Work with College Tutors. Monitor education contract components through the ECAS system for all Specialties from August 2017. Raise issues early if any deterioration.	Service/Business interruption/disruption	6	2	3	6	Lack of physical space to delivery clinical skills/simulation in BGH. Review Clinical Skills Educators in PPH. T&FG to be organised to review resources for Clinical Skills across the Health Board. Highlight lack of space in the L&KS Service (Library and Knowledge Services) for GGH.	Noble, Jayne	**Completed**	Collaborative review teaching rooms in BGH awaited, progress reliant on other Services. Review of all Wales consortium for Library purchases awaited. Clinical Skills/Faculty sub group, Clinical Skills Hub working to collate all equipment and personell available to feed into the main Clinical Skills Faculty, ready for early March Raised opportunity to merge GGH and Hafan Derwen Library in a new Unit on the GGH site with Planning.	Workforce and OD Sub Committee	1	3	3	27/09/2018
													Monitor educational contract, adopting 'live' system from the Wales Deanery.	Noble, Jayne	**Completed**	Deanery to continue monitoring educational contracts and provide Health Board with exception reports from August 2017 through to July 2018.					

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													Work with College Tutors if deterioration occurs.	Noble, Jayne	**Completed**	Implement reporting system for College Tutors through the Medical Education Board.					
													Deanery Exception report tool (ECERT) available from September 2018, replacing ECAS. Trainees encouraged to report exceptions when they cannot fulfil the Education Contract due to service pressures, etc.	Noble, Jayne	27/09/2018	Trainees encouraged to use ECERT to provide early warning that training is not being met					
511		Finance	Thomas, Huw	Hayes, Rebecca	01/05/2016	There is a risk of operational problems in delivering adequate payment systems within NHS Wales Shared Services. This is caused by duplicate & incorrect payments, with no confidence that all incorrect or duplicates are recovered. Delayed payments, lost invoices, suppliers placing Health Board on hold, loss of reputation, failed Public Sector Payment Performance (PSPP)target, in excess of £3m of invoices on hold. This will lead to an impact/affect on reputational damage, service continuity issues and failure to meet Welsh Government(WG)targets for the prompt payment of suppliers. Risk location, Health Board wide.	Additional control measures have been implemented both within procurement and financial accounting in order to attempt to mitigate the current issues. Additional resources have been secured in order to deliver plan. Shared services have attended the Audit Risk and Assurance Committee (ARAC) in order to provide assurance that remedial action will be taken to put the action plan back on track. Regular updates have been provided to ARAC.	Service/Business interruption/disruption	6	2	3	6	Improve the current performance and engagement in the payments process. Monitored to maintain progress within NHS Wales Shared Services Procurement NWSSP.	Thomas, Huw	~~30/09/2017~~ 30/08/2018	Monitoring and engagement in place. System enhancements (Oxygen) fully implemented in 2018 by Shared Services; contributing to compliance with the Health Board's prompt payment policy. The Health Board reported 96.7% compliance with the policy for Quarter 1 2018/19. This will however continue to be an on-going risk to monitor.	Finance Committee	1	3	3	04/10/2018
170	Standard 2.1 Managing Risk and Promoting Health and Safety	MD: Medical Education & Knowledge	Evans, John	Noble, Jayne	09/12/2016	There is a risk of reduction of SIFT to the Health Board if student numbers drop. This is caused by reduction in medical student numbers due to changes in the curriculum which the Health Board cannot provide and increased student numbers requiring the need to find external accommodation. This will lead to an impact/affect on the reduction of SIFT funding and an increased reliance on Health Board funding to cover recurring costs. Increasing student numbers has impact on hospital accommodation and requirements for external accommodation. Risk location, Health Board wide.	Increased student numbers from both Swansea and Cardiff Medical Schools. Pockets of difficulties delivering the curriculum, working with the Service to find ways to deliver the training required.	Finance inc. claims	6	2	3	6	Student numbers increased for 2017/2018. New Chronic Disease Block has gone ahead but Consultant staffing issues in Rheumatology and Dermatology may result in block being cancelled or numbers reduced due to in ability to cover the placement curriculum. Increasing consultant staffing problems across GGH, PPH and WGH for 2018-2019 academic year.	Noble, Jayne	**Completed**	Increased student weeks for 2017/2018, recurring into 2018-2019. Appropriate external accommodation identified to house extra student numbers. Discussions with Honorary Senior Lecturers to decide on student numbers for 2018-2019. Consultant appointments have improved for GGH and PPH in relation to the CD2 placements, however, this has worsened in WGH. Looking at working with GPs with special interest in Dermatology.	Workforce and OD Sub Committee	1	3	3	27/09/2018
													Requirement for external accommodation, resulting in pressures for Mental Health.	Noble, Jayne	**Completed**	External accommodation found for Carmarthen students in Trinity College if needed.					

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													Student feedback poor in the Woman, Child and Family block. Unhappy with the exposure available in WGH. Local meeting to discuss issues with Consultant link tutors	Noble, Jayne	**Completed**	Await outcome of local meeting and contact Cardiff Medical School with our findings Paeds students from Cardiff Medical School removed from Withybush due to lack of acute exposure. Review taking extra students from the Primary Care Academy (Swansea Medical School)					
584	Standard 3.1 Safe and Clinically Effective Care	Therapies & Health Science: Podiatry & Surgical Appliances	Vanderlinden, Natalie	Mulroy, Mike	30/12/2016	There is a risk of avoidable detriment to the quality of patient care This is caused by a delay in the provision of orthotic products exacerbated by an increase in demand for certain products without accompanying budget, i.e.CMATS service has increased demand for surgical appliances as well as new advanced posts in podiatry, physiotherapy and OT MSK services. This will lead to an impact/affect on on patients' health, mobility, pain and quality of life, and may cause an increase in hospital stays. Risk location, Health Board wide.	Wales Product Formulary providing best product at best price. Monitor number of non-formulary items issued. Restriction of appliances where patients able to purchase own commercially. Issue and fit of orthotic items by other professionals where governance controls in place. Ensure inclusion in future initiatives as stakeholders to ensure adequate provision of funding.	Safety - Patient, Staff or Public	6	2	3	6	Implement new Orthotist contracts to deliver further savings - Bespoke contract and Orthotist only contract due to start 2019.	Mulroy, Mike	~~31/03/2019~~ 31/10/2019	Training needs identified. No adequate storage for consumables in BGH Leri Day Unit or lab facilities to enable adjustment for fit identified and addressed in risk 588. Orthotist contract agreed and starting 2019.	Operational Quality, Safety & Experience Assurance Sub Committee	1	3	3	02/04/2019
													Attend Stroke Pathway Redesign Steering Group meetings to ensure inclusion in adequate planning and provision of orthotic products during acute and long term rehab; and podiatry need as prevention and during rehab.	Mulroy, Mike	~~31/03/2019~~ 31/12/2019	Meeting 27/3/19 identified actions for all departments to identify forward plan and new integrated ways of working. Ongoing meetings to be planned.					
234		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	01/11/2011	There is a risk of breach of the General Data Protection Regulations 2018 (GDPR) and Data Protection Act 2018. This is caused by inappropriate release and disclosure of patient information and confidential documentation. This will lead to an impact/affect on the Health Board through possible litigation or legal proceedings following inappropriate disclosure of confidential information. A review or audit by the Information Commissioner's Office (ICO). Imposed fine up to £500,000. Public and political embarrassment. Risk location, Health Board wide.	Health Board Corporate induction programme, training and e-learning. Staff job descriptions and contracts of employment. Approved Corporate Data Protection, Confidentiality, and Information security policies. Agreed and approved Health Records strategies, policies and procedures. Information Governance Framework. Health Records standard operating procedures (SOP) for medico legal and subject access requests with escalation process and consultant authorisation	Statutory duty/inspections	8	2	3	6	Completion of actions identified within Health Records Security Audit.	Bennett, Mr Steven	**Completed**	All Staff have completed the relevant mandatory Information Governance Training as identified within the security Audit.	Information Governance Sub Committee	1	3	3	23/01/2019
													Full staff compliance with mandatory e-learning.	Bennett, Mr Steven	~~31/12/2018~~ 31/01/2019	The Health Records service is fully compliant with the mandatory e-learning target with a service performance level of 96.61%. Only the contact centre remains below the target at 87.5% and this will be over 90% by the end of January ensure all staff have achieved the agreed target.					

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							~~authorisation.~~ Health Records standard operating procedures for general departmental enquiries. The National Intelligent Integrated Audit Solution (NIIAS) audit system. NIIAS Training Sessions. Internal security audit reviews. Datix Incident reporting system. Staff Meetings and Team Brief. Monthly Ward Clerk meetings at Glangwili Hospital.						Implementation of informal Information Governance (IG) and Health Records training sessions for ward clerks and secretaries.	Bennett, Mr Steven	~~31/07/2018~~ 30/03/2019	Health Records training sessions have been completed for secretaries and ward clerks at WGH, PPH and GGH however the ward clerks at BGH remain outstanding. Initial discussions have been completed with the Head of Information Governance to consider the possibility of joint Health Records/IG training. Pending further discussions a more formal decision will be made if this action is achievable.					
													Develop a Health Records e-learning package.	Bennett, Mr Steven	**Completed**	Discussions have confirmed that a provision of a health records e-learning training package would require national development and agreement. This would have to be agreed with both NWIS and other Heath Boards and delivery is currently unachievable specifically within Hywel Dda. The issue will be raised at the Health Records Management Advisory Group for consideration and possible development but the action will be closed within Hywel Dda.					
255		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	01/12/2011	There is a risk of avoidable harm or injury to staff working in the Health Records service through undertaking routine daily activities. This is caused by poor working and unsafe environments, specifically with insufficient storage capacity for patient records and the lack of investment in electronic systems to deliver a sustainable position. This will lead to an impact/affect on staff injury including trips, slips or falls. Increased complaints and possible litigation. Short and long term staff sickness. Increased costs associated with overtime to cover services. Short term service disruption. ~~Risk location: Health Board wide~~	Health Board Corporate Induction Programme and Manual Handling Training. Health Records Training and departmental Induction. Corporate Policies, Manual handling policy, Health & Safety Policy, Risk Management Policy. Annual weeding and destruction programme agreed and facilitated accordingly across the Health Board. Scanning of deceased patient records. Alteration to current racking and purchase of ~~additional racking at Glangwili General Hospital~~	Safety - Patient, Staff or Public	6	2	3	6	Implementation of the weeding and destruction plan in 2017/2018.	Bennett, Mr Steven	**Completed**	The weeding plan for 2017/2018 was agreed and the plan was implemented in priority order. The plan has now been completed for all hospital localities removing and relocating all non-current records from 2015.	Information Governance Sub Committee	1	3	3	23/11/2018

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						Risk location, Health Board wide.	additional racking at Glangwili General Hospital (GGH). Resourcing of additional racking for the offsite facility. Datix incident reporting is utilised within the Health Records service so we can identify any themes or trends around staff injury or impact on service delivery through lack of storage capacity. Provision of equipment, kick stools, ladders, trolleys. Health & Safety Inspections. Internal audit reviews.						Develop a business case for the implementation of a scanning solution.	Rees, Gareth	29/03/2019	Agreement at the Dec18 Executive Team was reached on identifying Senior Responsible Officer for the project (Mr Joe Teape) and a accurate delivery plan will need to be discussed at an early meeting in order to determine timescales and budgets to deliver. This is likely to require WG capital support to deliver therefore it is estimated that the Business Case will take approximately 18 months to develop.					
													Implementation of the weeding plan for 2018/2019		31/03/2019	The weeding plan has been fully implemented and all 2016 records have been relocated from Glangwili and Prince Philip. The 2016 records from Bronglais and Withybush should be relocated by the end of the financial year.					
380		P,C,LTC: Long Term Care	Paterson, Jill	Broad, Vicki	12/02/2018	There is a risk of less frequent scrutiny and monitoring of cost and activity once pooled funds for Older Adults in Care Homes has been implemented. This is caused by the potential that the lead commissioner, pooled fund manager role will be carried out by Local Authority partners and that financial reporting will be aligned to their own reporting timescales. This will lead to an impact/affect on the Health Board's ability to produce early, frequent and accurate financial forecasts and may as a consequence result in financial risks to the organisation. It will also reduce our on-going ability to apply efficiency targets on the budget areas that are within scope of the Pooled Fund agreement. Risk location, Health Board wide.	Governance Structure has been agreed at Board level. Arrangements for reporting and frequency of reporting to be agreed via the Governance. Steering Group in place and shadow Board meeting arrangements (attended by lead Directors of the 4 organisations). Agreement reached that Pooled Funds in 2018/19 will be operated through a "virtual agreement" therefore financial grip and reporting will continue to be with the Health Board for 2018/19. These arrangements are to continue during 2019/20 therefore financial risk is lower that inherent position. Work is on-going through the Pooled Funds Working and Sub Group structures to work through the requirements of all organisations around reporting and financial aspects of pooled funds going forward from April 2019. This work has not been concluded and will continue during 2019/20. Operational Sub Group has drafted an Operations agreement for admission and the process of funding placements. Commissioning Sub Group is drafting and agreeing care home pre placement agreements and contracts. currently awaiting final version ,	Finance inc. claims	6	2	3	6	Health Board and Executive Team engaged on risks associated with Pooled funds arrangements, especially around financial implications.	Paterson, Jill	Completed	Paper was taken to Board in March 2018 along with the Joint Partnership Agreement, and Board were updated accordingly. Therefore this action has been completed to date but will require on-going updates on the on-going risks associated with the Pooled funds agreements.	Finance Committee	1	3	3	27/03/2019
													Director of Finance updated on All Financial recommendations and risks.	Paterson, Jill	Completed	Director of Finance lead meetings have taken place and further scheduled to take place. Director of Finance meetings includes representation from the Health Board. Finance Staff are on the Finance sub group and have developed the recommendations with their Local Authority Colleagues. This has been actioned and completed , however, this will now apply to the work going forward across the Region during the 2018/19 financial year and therefore this will need to be actioned further.					

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							prior to consultation with the sector. Meetings have been held between the legal representatives of the 4 organisation to revise the draft Pooled Funds Agreement. A final draft is awaited. Director of Finance meetings and meetings between the 3 LA Directors of Social Care and HB Director of Primary Care, Community and Long Term Care and Director of Strategic Partnerships continue to take place.						Partnership agreement signed off by 31/3/18.	Paterson, Jill	**Completed**	Partnership Agreement for Pooled funds - Older Adults has been signed off by all 4 organisations and is now going through the process of applying official seals to it. The Agreement was discussed at the Health Board's March Board Meeting on the 29th March 2018.					
													Sign off of the Pre Placement Agreement and supporting documents.	Broad, Vicki	~~29/03/2019~~ 29/06/2019	by the Head of Corporate Office (Health Board). Further discussions are on-going. Legal to legal meetings have taken place. Schedules are being completed through various work stream groups. Next steps will be to engage with the Care Home Sector and their legal representatives. Work is being led by Pembrokeshire County Council and therefore the Health Board has limited scope in respect of timescales.					
305		PP&C: Informatics - Clinical Systems & Informatics Programmes	Tracey, Anthony	Smart, Richard	01/09/2010	There is a risk of currently funded systems staff being lost. This is caused by a lack of funding for staff. Where staff are funded from NWIS provided project funding. This will lead to an impact/affect on the delay of planned implementation of projects, such as MTeD, Welsh Clinical Communications Gateway (WCCG), and other national projects. Risk location, Health Board wide.	Continued communication with NWIS over the resourcing of national projects. Where there is anticipated end of funding then remedial plans have been designed to ensure rollout but with a longer timeframe. Funding letters arrive far to late in financial year to recruit.	Business objectives/projects	6	3	2	6	Raise timing of funding letter with NWIS	Smart, Richard	20/03/2019	Discussed at meeting with NWIS 14/02/19. David Sheard has assured programme leads that letter of funding to HBs for 2019/20 will be provided soon	Capital, Estates and IM&T Sub Committee	1	1	1	25/03/2019

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676	Standard 2.1 Managing Risk and Promoting Health and Safety	Women & Children's: Midwifery/Maternity	Jones, Keith	Owen, Lesley	29/11/2018	There is a risk of misinterpretation and lack of consistency of foetal heart rate monitoring. Health Board Guidelines need updating in line with National Guidelines and an All Wales Maternity Standard. This is caused by the need for current Guideline update following introduction of All Wales Foetal Monitoring guidelines which advocates Federation Internationale of Gynaecologists and Obstetricians (FIGO)in contradiction to current NICE Guidelines. This will lead to an impact/affect on all women receiving electronic Cardiotograph (CTG) fetal monitoring with the potential impact of adverse perinatal outcome and the need for delivery by caesarean section Risk location, Health Board wide.	Mandatory training annually for the MDT team. Use of pre-existing guidelines to ensure consistency. All unexpected poor outcomes are reviewed by Clinical Risk Manager. Hourly 'Fresh Eyes' review of fetal heart monitoring (CTG) recordings 2 hourly senior midwifery review of all high risk intrapartum cases.	Safety - Patient, Staff or Public	6	1	5	5					Operational Quality, Safety & Experience Assurance Sub Committee	1	5	5	12/03/2019
436		PP&C: Informatics - Information and Communication Technology	Tracey, Anthony	Solloway, Paul	01/04/2014	There is a risk of inefficient printing practices are operating across the organisation. This is caused by the lack of a defined printing strategy for Hywel Dda where we have:- Lack of visibility of printing costs, Inefficient printing models, Not leveraging latest technologies and no defined replacement scheme. This will lead to an impact/affect on increased costs to the organisation of its printing estate. Risk location, Health Board wide.	None.	Finance inc. claims	6	5	1	5	Create tender document to engage with third party to audit, assess and provide recommendations on printing estate.	Solloway, Paul		No progress to date as not on Informatics Operational Plan	Capital, Estates and IM&T Sub Committee	2	1	2	08/12/2018

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277		Women & Children's: Paediatrics & Neonates	Jones, Keith	Morrissey, Mr David	01/01/2012	There is a risk of compromise in the care of infants born at Bronglais General Hospital who subsequently need to be transferred for special care to a neonatal unit. This is caused by the absence of a neonatal transport service and retrieval service 24hours a day. Infants who require neonatal care have to be transported from Bronglais General Hospital to a Special Care Baby Unit when their condition may suddenly deteriorate. This will lead to an impact/affect on the potential timeliness of neonatal care provided with potential adverse clinical outcomes. Risk location, Bronglais General Hospital.	Existing All Wales Neonatal retrieval service (CHANTS) available only for 12 hours per day. Paediatrics and Obstetrics work together to identify at risk pregnancies which can be transferred prior to delivery. Wherever possible, the mother is transported to be with the infant as soon as possible. A patient risk identification programme in place to identify any women likely to require neonatal support so that care can be transferred to appropriate closest available maternity bed pre-delivery. Pending arrival of retrieval teams, babies are cared for by the Paediatric team (with support of on-site paediatrics nurses and midwives) with telephone access to the Neonatal Units at GGH, Singleton/Cardiff and the en-route retrieval team.	Safety - Patient, Staff or Public	6	1	4	4	Highlight and report any adverse effects due to the lack of 24 hour provision	Morrissey, Mr David	~~31/03/2018~~ 31/03/2019	Likelihood of occurrence has significantly reduced as a result of control measures identified. Risk severity not expected to reduce further due to the consequential impact on the neonate's health which could be death or disability. To be reviewed annually.	Operational Quality, Safety & Experience Assurance Sub Committee	1	4	4	07/02/2019
152		MD: Research & Development	Evans, John	Tattersall, Chris	26/05/2016	There is a risk of failure to meet targets set by Welsh Government on the Key Performance Indicators 'B' (Manage appropriate use of R&D income). This is caused by failure to adopt and roll out the new All Wales R&D finance policy in a timely manner and having sufficient staff in place to oversee invoicing processes. This will lead to an impact/affect on R&D would be unsustainable with both research support posts and ultimately trial patients put at risk. Risk location, Health Board wide.	In conjunction with Health & Care Research Wales develop and accept the Wales-wide Finance Policy). Approved at the November R&D sub-committee). Use of national costing templates and guidance. Staff education sessions by R&D and finance teams.	Finance inc. claims	6	1	4	4	Local R&D to retain membership of national working groups developing processes and guidance on research income and costings.	Tattersall, Chris	~~31/03/2018~~ 31/03/2019	Active representation from HDUHB's R&D Department continues on various Health and Care Research Wales working groups, and relevant progress is reported at monthly R&D Operational Team meetings, at quarterly R&D Sub-Committee meetings and twice a year to the University Partnership Board (via KPI data reports). To continue until national system in place.	Research & Development Sub Committee	1	4	4	29/01/2019
													Further development of cost recovery processes.	Tattersall, Chris	~~31/03/2018~~ 31/03/2020	Tracking of cost recovery processes improved and staff educated in the raising of invoices. 16.10.18: Process in place, therefore to assess this process alongside HCRW performance monitoring. 29.1.19 development of RRB processing following R&D / finance meeting in January. R&D to promote new process in RN meeting in February.					

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97		USC: Pathology	Perry, Sarah	Bowen, Caryl	09/12/2015	There is a risk of compromising the dignity and respect of bariatric deceased patients, avoidable detriment to the quality of patient care, non compliance of regulations and detriment to organisational reputation. This is caused by a lack of bariatric storage facilities within the Mortuary Body Store and a change in Bariatric ward bed width which has compromised the ability to utilise the bariatric fridges at GGH. This will lead to an impact/affect on loss of public confidence, non compliance of legislation, transfer of bariatric deceased patients to the GGH Mortuary and families being unable to undertake a viewing locally. Risk location, Health Board wide.	Bariatric patients will be transferred to the GGH facility.	Quality/Complaints/Audit	8	2	2	4	Plan space for Bariatric storage when current Body Stores are replaced. Requirement of Human Tissue Authority (HTA) to log on risk register.	Stiens, Andrea	~~30/03/2018~~ 30/11/2018	Bid submitted in September 2016. Refreshed capital bids have been submitted for 2017/18 capital equipment cycle £50k. No capital funding has been identified in 2017/18.	Operational Quality, Safety & Experience Assurance Sub Committee	1	2	2	08/02/2019
													Purchase via charitable funds one bariatric blanket for each hospital site.	Stiens, Andrea	**Completed**	Approval has been secured for BGH and WGH. Awaiting outcome of discussions with PPH and GGH. A bariatric blanket is now available in every mortuary.					
515		Finance	Thomas, Huw	Hayes, Rebecca	27/05/2016	There is a risk of the Health Board is failing to comply with HMRC (IR35) regulations, in relation to Off payroll arrangements. This is caused by a request to identify individuals that are paid on average £220 per day over a 6 month period and seek assurance from these individuals, that they comply with UK Revenue and Tax obligations. As identified via a directive from Welsh Government (WG). This will lead to an impact/affect on the health board may be subject to a fine of over £1m. Risk location, Health Board wide.	Medical staffing contact all doctors based on information received from Medacs and Staff Flow to seek assurance of compliance.	Finance inc. claims	6	2	2	4	The Director of Finance is to link with HR to establish a Health Board task and finish group to look at developing a work plan to ensure that compliance is achieved.	Thomas, Huw	09/01/2017	New compliant system is now in place.	Finance Committee	1	2	2	29/11/2018

Risk Ref	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Date Reviewed
38		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	01/03/2012	There is a risk of significant service disruption across the Health Board to outpatient and inpatient services due to unavailable electronic facilities. This is caused by IT system failure (Myrddin). This will lead to an impact/affect on the ability to record patient information and medical history. Inability to track or locate patient records. Inability to order or review tests and investigations. Inability to process patient information, record clinical outcomes or arrange appointments. Cancelled appointments and inpatient admissions, increasing waiting times. Poor service provision to staff and patients. Increase in complaints. Risk location, Health Board wide.	I.T. backup systems and processes. Primary & Secondary database contingency processes. Health Records Business Continuity Plan. Health Records Standard Operating Processes.	Service/Business interruption/disruption	6	2	2	4	Communicate business continuity procedures to relevant staff groups.	Bennett, Mr Steven	~~31/12/2017~~ 31/03/2019	Following the completion of the initial briefing document outlining the relevant procedures to follow to ensure business continuity it has been agreed a more detailed document is required to support services and staff groups. Work has commenced and will be completed by March 2019.	Information Governance Sub Committee	1	2	2	23/01/2019
326		P,C,LTC: Low Vision	Paterson, Jill	Martin, Donna	01/03/2016	There is a risk of possible reductions in the quality and range of low vision aids available to Low Vision Service Wales (LVSW) patients through this service due to the way the procurement process works. This is caused by the inability at present to resolve the NHS Wales Shared Services Partnership (NWSSP) procurement services requirements which require a clinical specification for each item on the LVSW aids contract which if not correctly identified could allow for inferior items becoming part of the LVSW catalogue. This will lead to an impact/affect on the Health Board prescribing products that may not stand up to use and will need to be replaced multiple times at a cost to the Host Health Board. There could be damage to service reputation and an impact on patients with inferior products being more difficult for patients to use and therefore creating much less positive outcomes for patients. Risk location, .	Shared Services Partnership (SSP) Procurement are currently working up the contract specification.	Safety - Patient, Staff or Public	6	2	2	4	SSP are to address the new contract and devise a feasible way to progress when SSP have resource. Ongoing discussions have resulted in SSP declaring that Clinical Specifications of different types of clinical low vision aids for patients must be drawn up in order to inform the tender process.	Martin, Donna	~~30/11/2017~~ 17/09/2018	The Service Manager has been informed that legal advice has now been clarified by NWSSP Procurement and a way ahead which ensures that popular prescribing items are specified has been identified to take this forward. The LVSW clinical lead has put together an expert panel to support the creation of technical specifications of items that need to be included in the tender process for the new supplier to the LVSW. The panel has met a number of times and NWSSP are now responsible for taking this forward.	Operational Quality, Safety & Experience Assurance Sub Committee	1	2	2	02/01/2019
553		Medicines Management	Pugh-Jones, Jenny	Simons, Delyth	01/08/2018	There is a risk of non-compliance with the European Union's Council Directive 2011/62/EU. This is caused by the regulation requiring those supplying medication to patients to verify the authenticity of a drug using an unique identifier barcode and checking an anti-tamper device. This will lead to an impact/affect on on patient	Attendance at All Wales workshops to understand the full implications. Capital Pro-forma submitted for funding. Working at All-Wales level with NWIS. Scanners on all sites	Statutory duty/inspections	8	1	4	4	Submit brief to the Executive Team (ET).	Pugh-Jones, Jenny	**Completed**	Writing brief for the ET meeting in August.	Medicines Management Group	1	1	1	03/04/2019

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		P,C,LTC				safety and could lead to patient harm through the supply of falsified medicines.Financial penalties for non-compliance with EU law could lead to restrictions in access to medicines and inability to supply medication to patients leading to major service implications i.e no medication could be supplied to wards or patients from hospital pharmacies. Risk location, Health Board wide.	Working SOPs in place and staff raining undertaken Working draft SOPs in place and staff training undertaken						Meet with the local IT lead to raise awareness of the NHS Wales Informatics Service (NWIS) workstream.	Pugh-Jones, Jenny	**Completed**	The meeting is to be arranged.	Medic				
													Attendance at All-Wales update meetings to ensure updated with All-Wales position		**Completed**	Awaiting dates of meetings					
													All scanners ordered and delivered to sites. Need configuration to ensure working correctly. SOP's need to be in place to ensure correct and consistent operation	Simons, Delyth	**Completed**	Awaiting commissioning of scaners					
													Finalise SOPs	Simons, Delyth	~~31/05/2019~~ 31/052019	Working SOPs to be ratified					
237		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	01/03/2012	There is a risk of avoidable short term service disruption in Health Records service with the inability to deliver the daily core activities and responsibilities for out and inpatient and day case attendances. This is caused by inappropriate staffing levels (Health Records Service). This will lead to an impact/affect on the ability to complete all daily duties. Cancellations of outpatient appointments and inpatient admissions, increasing waiting times. Non compliance with National targets and reduced funding allocation. Poor service to both staff and patients with increased complaints. Increased sickness levels within the service. Increased costs associated with overtime to cover services. Low staff morale. Risk location, Health Board wide.	Annual review of staffing levels and workloads. Standardised working processes. Sickness levels monitored and managed in line with the Health Board's sickness & absence policy. Recruitment of bank staff within all health records departments. Use of overtime to cover necessary duties. Costing process for all new or additional clinic sessions. Â–Â–Weekly service sickness updates. □ Monthly sickness audit reviews. Â–Health Records sickness pathway chart.□ Health Records Monthly budget review meetings.	Service/Business interruption/disruption	6	1	3	3	Development of a Health Records Service Document.	Bennett, Mr Steven	~~31/01/2019~~ 30/03/2019	Work has commenced on the service document whilst the costs are being finalised. All day to day responsibilities have been identified and are being agreed with the Health Records supervisors. All information will be distributed to the relevant staff groups once the document has been completed.	Workforce and OD Sub Committee	1	3	3	24/01/2019

Risk Ref	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Date Reviewed
147		MD: Research & Development	Evans, John	Seale, Lisa	26/05/2016	There is a risk of principal investigators' research fund balances reducing to zero. This is caused by insufficient funding income being secured, which may be due to a failure to carry out new research studies or a failure to recruit research subjects to existing studies. This will lead to an impact/affect on researcher account balances could become insufficient to sustain the employment of research staff whose posts are dependent upon continued research income. Risk location, Health Board wide.	Options to help support active researchers from the R&D funding allocation discussed regularly. Quarterly meetings between R&D and Finance to consider the Investigator accounts. Monthly statements of Investigator Research account balances issued to Principal Investigators, and prior warnings issued where account balances appear to be reducing over time with no income to offset expenditure. Investigator Research Accounts Terms and Conditions (Version 2, January 2017 approved by R&D Sub-Committee on 13/02/17).	Finance inc. claims	6	1	3	3	In conjunction with Health & Care Research Wales develop and accept the Wales-wide Finance Policy to include terms and conditions of Investigator Accounts. Disseminate/promote terms and conditions document to investigators.	Tattersall, Chris	~~31/03/2018~~ 28/01/2020	Localised finance policy discussed with Health and Care Research Wales on 15/09/17. Local R&D Finance Policy approved at R&D Sub-Committee (20/11/17). 16.10.18: Assessment of compliance with the policy with HCRW during 2018/19 to be undertaken, initial meeting held on 26.09.2018. 29.1.19 Investigator accounts now reported to investigators by finance. Recording and tracking of income / RRB process development on-going between R&D and finance.	Research & Development Sub Committee	1	3	3	29/01/2019
247		Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	02/01/2012	There is a risk of potential for avoidable harm or injury to staff within the Health Records department at Bronglais General Hospital. This is caused by lone working on unusual occasions. This will lead to an impact/affect on staff with potential injury including trips, slips or falls. Increased complaints and possible litigation. Short and long term staff sickness and increased costs associated with overtime to cover services. Risk location, Bronglais General Hospital.	Corporate policies, Lone Working Policy, Health & Safety Policy, Manual Handling Policy and Risk Management Policy. Restricted library access for authorised personnel only. Security arrangements, key codes, swipe access, lockable doors. Health Records Training and departmental Induction. Staff reporting on and off duty process. Internal Security audit process. Provision of equipment, kick stools, ladders and trolleys.	Finance inc. claims	6	1	3	3	Completion of actions identified within the Health Records Security Audit.	Bennett, Mr Steven	**Completed**	All Staff have completed the relevant mandatory Information Governance Training as identified within the security Audit.	Emergency Planning and Health and Safety Sub Committee	1	3	3	24/01/2019

Risk Ref	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Date Reviewed
512		Finance	Thomas, Huw	Hayes, Rebecca	01/05/2016	There is a risk of Her Majesty's Revenue and Customs (HMRC), querying on an All-Wales basis the operation of the Out Of Hours GP scheme, would rule that payments should be made net of tax and National Insurance (NI). This is caused by discussions with HMRC and Deloitte's advising Local Health Boards and Boards whereby Health Boards have agreed to bring General Practitioners (GP's) Out of Hours (OOH) doctors within tax and NI deduction at source from 1st November 2017. This will lead to an impact/affect on the stability of the OOH service which the Operations Directorate are working to mitigate. The remaining risk with HMRC relates to the backdating of Tax and NI liability to 6th April 2017 at significant cost. Risk location, Health Board wide.	Hywel Dda has commissioned Deloitte LLP to provide advice. Links have also been made with other Health Boards in Wales in order to ensure that a consistent approach is being adopted. Deloitte LLP are providing Tax advice to the Health Board on this issue. The HMRC have accepted that there will be no backdating of reclaim before 31/03/2017. From November 2017 all ad hoc OOH GPs have been processed through payroll in accordance with IR35 requirements.	Service/Business interruption/disruption	6	3	1	3	HMRC have confirmed that OOH is within the scope of IR35. HMRC have accepted there will be no backdating of reclaim before 31/03/17; the period under risk is April - November 2017 in relation to the PAYE, Employee's and Employer's NIC. Professional advice from Deloitte is required.	Thomas, Huw	~~30/09/2017~~ 31/01/2019	Deloitte are co-ordinating the process in relation to the PAYE, Employee's and Employer's NIC for the period April - November 2017 on behalf of Health Boards in Wales to reach satisfactory settlement with HMRC. The maximum liability has now been confirmed by HMRC, and sufficient provision was made in 2017/18 to cover this maximum value. Negotiations are still on-going between HMRC and Deloitte. From November 2017, all ad hoc OOH GPs have been processed through payroll in accordance with IR35 requirements.	Finance Committee	3	1	3	12/11/2018
605	Standard 5.1 Timely Access	Therapies & Health Science: Physiotherapy	Vanderlinden, Natalie	Annandale, Helen	02/04/2018	There is a risk of patient harm due to potential staffing reduction. This is caused by additional CIPs on service due to variable pay recurring target, unfunded CMAT regrading and recurring income target. No identified long term plan to deliver recurringly in 2019/20 unless significantly decrease in core staffing levels. This will lead to an impact/affect on decrease core staffing of 15.36 whole time equivalent (WTE) will result in ceasing a core service. e.g. No community paediatric service across the Health Board or No physiotherapy service in the 4 stroke units, elective orthopaedic & trauma units or No CMATS clinical service within the Health Board. Risk location, Health Board wide.	Financial and service delivery plan submitted to Executive Directors Team. Utilise current vacancies to manage risk for 18/19 and underspend within other services within directorate to balance directorate budget at year end 2018/19.	Finance inc. claims	6	1	3	3	Submit cost pressures as part of validation Submission to Execs regarding requirement of CIP for 19/20 & service risks	Annandale, Helen Annandale, Helen	15/02/2019 30/04/2019	Submitted cost pressures as part of directorate submission .	Operational Quality, Safety & Experience Assurance Sub Committee	1	2	2	25/04/2019

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Winter Monies Allocation 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations/Deputy Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gareth Rees, Deputy Director of Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper sets out details of additional funding provisions, made available to Hywel Dda University Health Board (HDdUHB) by Welsh Government (WG), to facilitate added unscheduled care system resilience over the winter period which spanned November 2018 to March 2019. The paper outlines how the allocation was distributed and the monitoring and review processes that were put in place to facilitate rapid response to variations as the season progressed.

It is not the intent that this report should be taken as a comprehensive winter review document given broader winter planning information, feedback and learning is being provided as part of a separate paper to be presented to Board on 30th May 2019.

The report is provided to the Finance Committee for discussion purposes.

Cefndir / Background

HDdUHB's winter preparations started in earnest in June 2018 following the population and analysis of outcome information from the previous winter's experiences (2017/18). This period was considered across the principality to be the most particularly challenging period for some time.

Whilst the focus during the first few months of planning was centred on the closure of a calculated gap of 150 beds, with either additional beds or measures in substitution of, it was not until 8 November 2018 that any targeted central support was confirmed.

HDdUHB's early planning work had however taken a two pronged approach in terms of the assumption that there was no centrally targeted support confirmed at that time. Therefore, planning was developed around no extra money as well as forthcoming support. This approach placed the Health Board in a relatively advanced position when central financial support was announced by the Cabinet Secretary for Health and Social Services on 25 October 2018.

HDdUHB's initial allocation, confirmed in November 2018, amounted to £1.941 million. This formed part of a broader NHS Wales allocation of £20 million and was determined based on a direct needs formula applied by Welsh Government. Of the £20 million, a sum amounting to £4

million was top sliced from the allocation and directed to nationally agreed priorities promoted by the National Programme for Unscheduled Care, following engagement with local leads. Typically, these initiatives included a pilot of 'Emergency Department Enhancement and Assisted Discharge Support' commissioned from British Red Cross, a pilot of 'Hospital to Home' support commissioned from 'Care and Repair', and a trial of pharmacists working as part of a multi-disciplinary team in emergency departments. HDdUHB's benefit from these initiatives was valued at £356,740.50. Further gains arose from a number of schemes, funded from the £4m allocation, in relation to broader Welsh Ambulance Services initiatives and included additional control centre resources and additional falls response vehicles.

By 6th February 2019, further sums had been allocated to HDdUHB. This was as a result of discussions held at winter summit meetings with Welsh Government, highlighting targeted schemes that HDdUHB wished to progress but were unable to because of the need to remain within allocations. These included a broad range of schemes such as community capacity in various forms, additional therapies and pharmacy capacity, 111/OOHs support, community equipment, and extended British Red Cross support. The schemes were all aimed at supporting both admission avoidance and more effective discharge processes. The additional £347,662 brought HDdUHB's total winter support package to £2,645,402.50.

Asesiad / Assessment

The plan for winter 2018/19 was developed in the true spirit of partnership with local authority and Welsh Ambulance Services NHS Trust (WAST) partner organisations. For the first time in the Health Board's history, the winter plan was published and owned by HDdUHB and its strategic partner organisations. Inherently, the plan had a significantly greater emphasis on admission prevention and supported discharge; all decisions taken, where the allocation of financial support was concerned, were undertaken in true collaboration with strategic partners.

As noted earlier in this paper, the approach to demand and capacity centred around a baseline bed model which had been ascertained empirically from the actual bed position taken at January 2018. From the work undertaken in the planning workshops between June and September 2018, the starting deficit of 150 beds was mitigated by 77 beds (assumed benefit from improvement work and tolerable levels of outliers and ED lodging) leaving a 73 bed residual gap. Being a significant proportion of the starting position, and with the easy gains already included in the plan, the planning team were left with a challenging proposition.

Given the 73 medical bed equivalent capacity gap, there was agreement to suspend bed closure plans designed into HDdUHB's annual plan and to direct an equivalent amount of money, which would have been gained from activating bed closure plans, from the winter allocation into the bottom line. This figure amounted to £1 million. This decision was much debated within HDdUHB and shared with the Board in November 2018 before being put to Welsh Government ahead of it being activated.

The key benefit in exercising this option was that the capacity identified as being needed (45 medical beds) would be guaranteed. With hindsight, and in the interest of patient safety, this proved to be the correct decision. The balance of resources available for winter initiatives enabled the medical bed gap to be further mitigated by an estimated 64 beds; leaving a residual gap of 9 beds.

The residual 9-bed deficit was seen to be within a reasonable tolerance it could be managed operationally on a day-to-day basis.

For the remaining winter support monies, a series of check and challenge sessions were held with Executive Directors; the product of which was a plan which delivered a reasonable capacity model in the context of expected demand.

The key planning themes against which money was allocated and expenditure tracked were as follows:

Theme	Plan	Outturn
Corporate schemes	£665,065.00	£406,646.40
Community flow improvements	£549,429.00	£367,065.00
Acute flow improvements	£201,961.50	£162,243.28
Acute bed capacity	£1,228,947.00	£1,709,447.82
Totals	**£2,645,402.50**	**£2,645,402.50**

It is also worth noting the process of monitoring and variation control that was instituted immediately after the Christmas/ New Year holiday and remained a constant feature of Monday morning SITREP meetings until the end of March 2019. These discussions were led by the Deputy CEO/Director of Operations and supported by an Assistant Director of Finance. They included site general managers and county directors, or their deputies, and proved a reliable forum around which to monitor expenditure against plan and discuss/approve variations as they arose. The result was an outturn that broke even against the plan after some adjustments across themes were accommodated, which mainly featured in the unexpected levels of surge bed capacity.

The investment in community service support is one area that could possibly be considered as falling short of expectation as the consequence of spending on surge beds far exceeded expectation with an outturn of £480,500. This further underlines the appropriateness of the decision to defer the bed closure programme, whereas the decision not to defer could have resulted in a further unplanned surge with even higher outturn costs.

There has been much to take from the approach and processes developed in planning and navigating safe passage through winter 2018/19. The headlines include:

- Creating a reliable bed model upon which to plan
- Abridging the plan to the most essential components only (plan on a page)
- Planning on the basis of what resources are known, as well as what might be, to take good advantage from opportunity monies
- Adopting pragmatic approaches to addressing bed gaps
- Early confirmation of support funding which in turn facilitates early bookings of agency/locum staff and care home beds securing best value services
- Institution of regular but short review and cost monitoring sessions

These lessons will be embedded into the planning process for winter 2019/20, together with the detailed learning that will emerge over the coming weeks as the evaluation process is completed. This will continue to lead to the planning cycle which will commence June 2019 for activation by November 2019.

Argymhelliad / Recommendation

The Finance Committee is asked to receive and note the content of this report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.1 To scrutinise and provide oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer-term sustainability).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 2.9 Medical Devices, Equipment and Diagnostic Systems 3.3 Quality Improvement, Research and Innovation
Amcanion Strategol y BIP: UHB Strategic Objectives:	9. To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives:	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the report
Rhestr Termau: Glossary of Terms:	SITREP – Situation Report WAST – Welsh Ambulance Services NHS Trust
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Executive Team Public Board Unscheduled Care Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial impacts and considerations are inherent in the report.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Robust winter plans ensure patient care continues to be provided throughout the winter period.
Gweithlu: **Workforce:**	Use of agency resources to mitigate internal human resource capacity limitations details are contained within the winter plans.
Risg: **Risk:**	The winter period presents heightened risk to HDdUHB with increased demand across the unscheduled care system. The risk issues associated with the unscheduled care system and across winter are recorded on existing risk registers.
Cyfreithiol: **Legal:**	Not Applicable

Enw Da: **Reputational:**	There could be significant reputational risks for HDdUHB and partners in the event of major incident.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Bespoke winter plans are in place for the three counties which reflect the needs of the population within each of these counties.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Medicines Management Finance Committee Monday 20th May

Jenny Pugh-Jones
Clinical Director Pharmacy and Medicines Management

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Addressing

- Horizon Scanning & NICE/HCD Modelling
  - Review
  - 2019-20 allocation
- NCSO (No cheaper stock obtainable)
  - Financial Impact
  - Mitigation
- Medicines Management CIP 19-20 (Primary Care)
  - Financial Impact
  - Mitigation
- Aseptic Services
  - Financial Impact
  - Discretionary Capital
  - Long Term Resolution

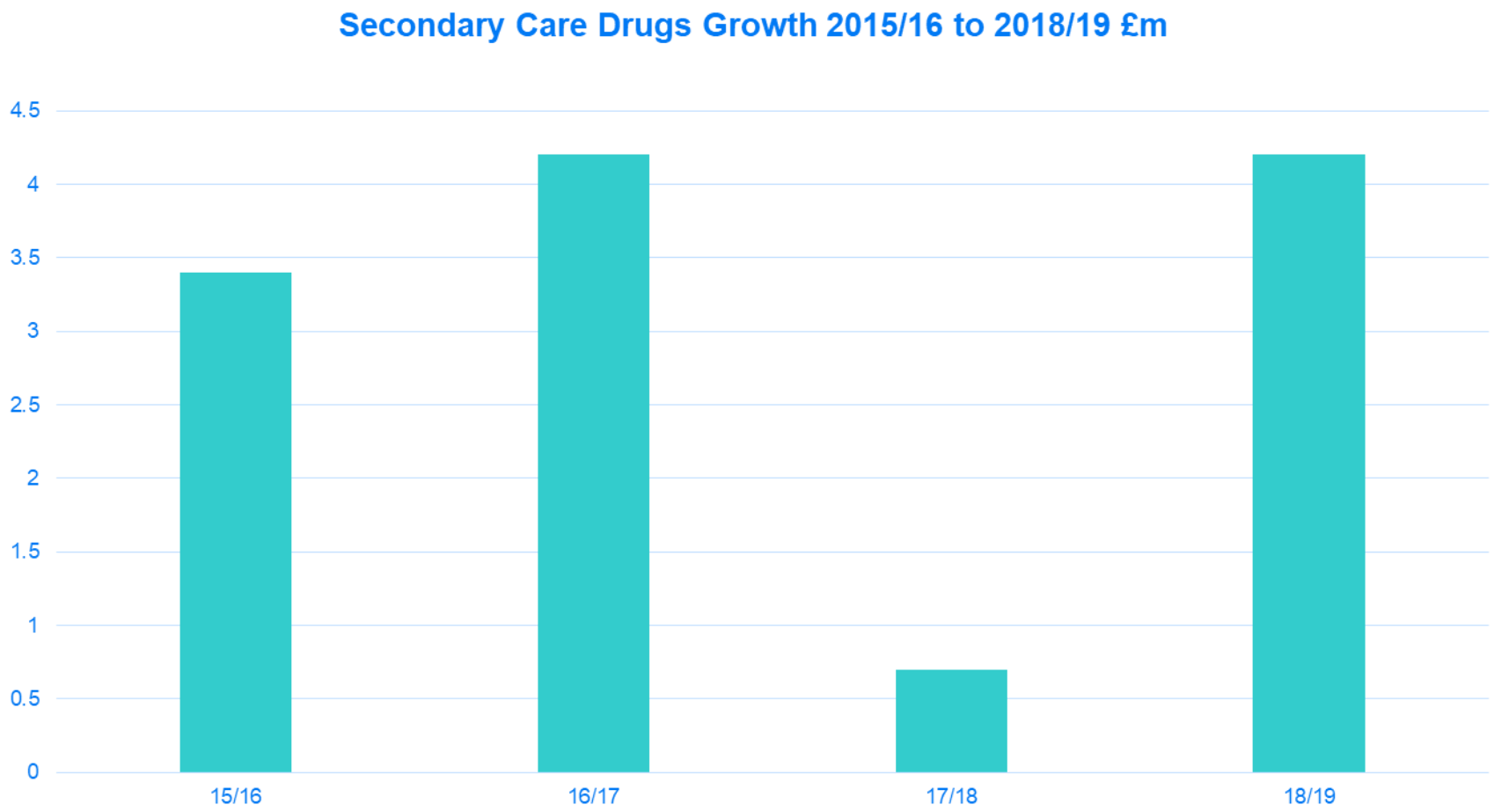
1. Horizon Scanning & NICE/HCD Modelling

How its done:

- Public Health Horizon Scanning(per 100,000 population)
- AWTCC horizon scanning and planning
- NICE/AWMSG appraisal programme
- Local intelligence to inform numbers

- Legal Position: Implementation within 3 months of publication of NICE/AWMSG
- Superseded by New Treatment Fund (NTF) – must be available within 60 days of publication of the Final Appraisal Document (FAD) so brings forward implementation around 4-5 months
  - Tier 1 Target
  - Allocation of £1.8M to support – not just medicines but service infrastructure

Growth


Secondary Care Drugs Growth 2015/16 to 2018/19 £m
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
15/16
16/17
17/18
18/19

2019-20

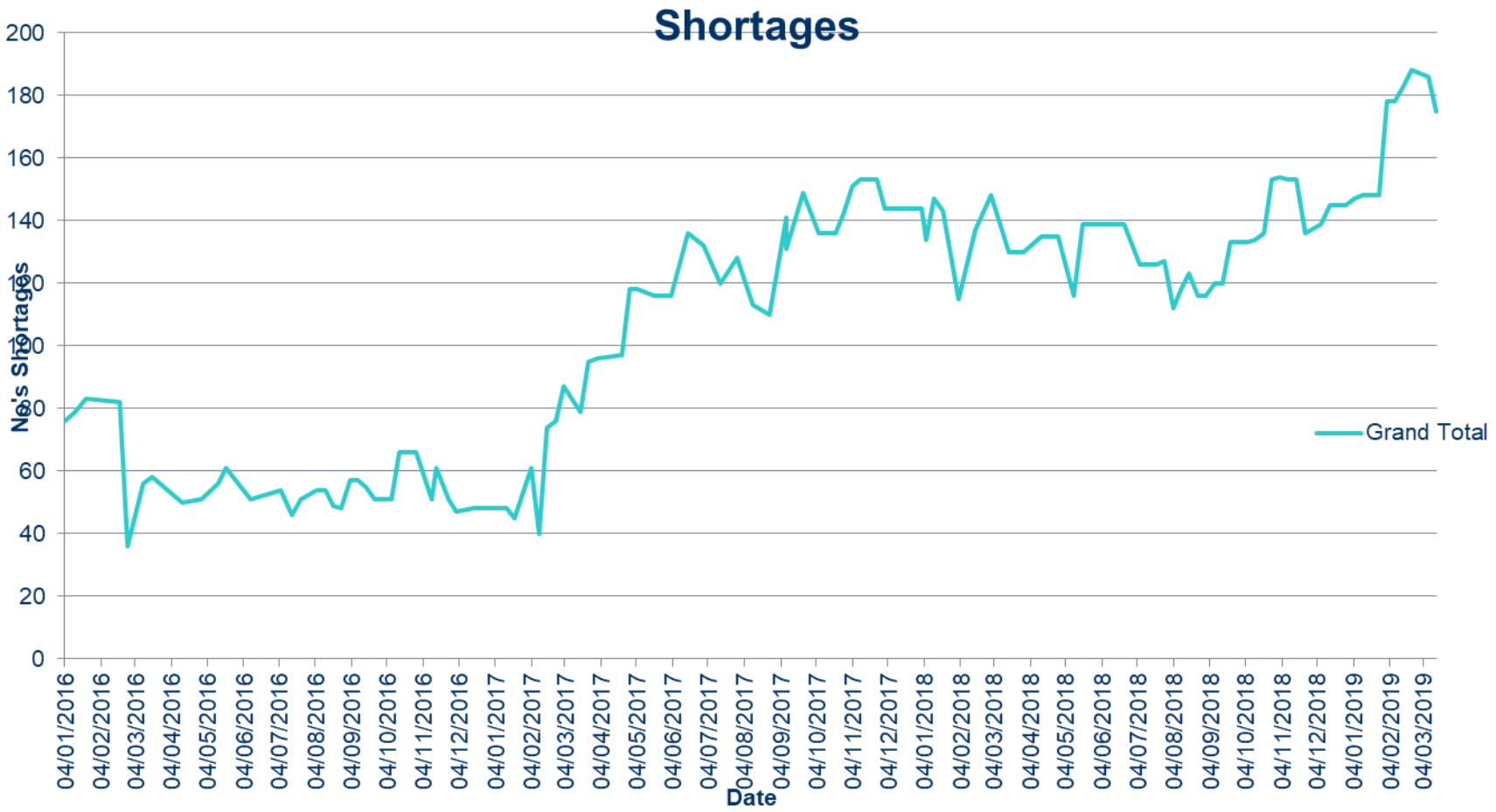
- Allocation of £2.6M for secondary care
- Prediction of £3.8M
- Shortfall of £1.2M

- Allocated mainly oncology and haematology
- Horizon Scanning and Finance Group reporting to MMSC

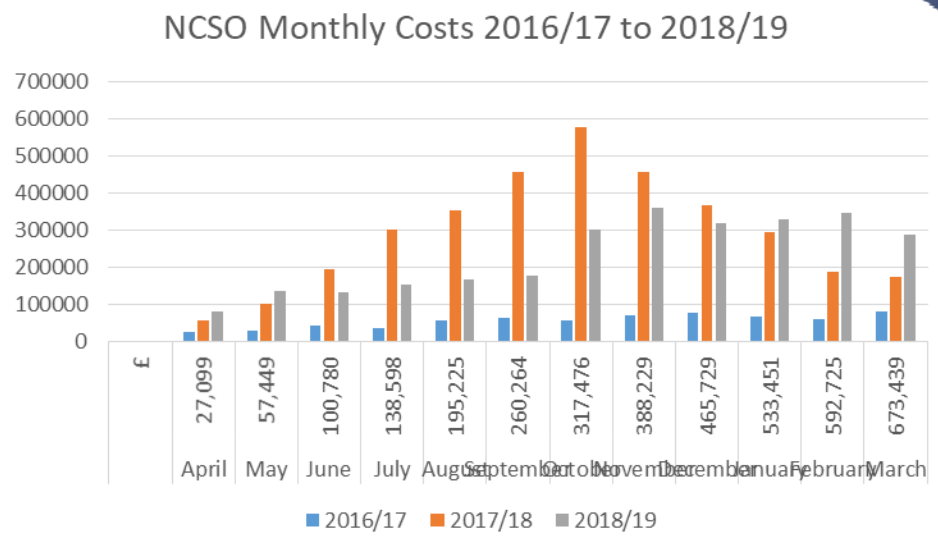
2.No Cheaper Stock Obtainable

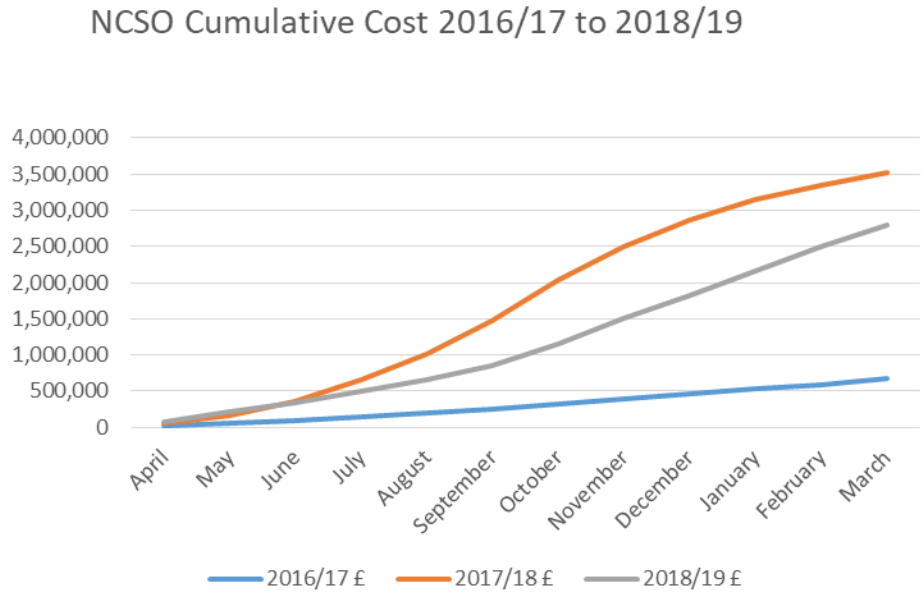
- Stock shortages are increasing month on month since March 2017. The impact is significant both in costs and workload dealing with these shortages to ensure consistent patient access
- NCSO- Costs from £27K per month to £325K per month
- Cost pressure in 2018-19 of £2.5M (over an above expenditure form 2016-17)

Shortages (number of lines)



Monthly costs increase from £80k- £346k pm in year 2018-19





NCSO reduced overall in 18-19 due to early reductions in early part of the year, by Jan 2019 increased to £330K pm, £346K in Feb.
1st 6/12- £844K , 2nd 6/12 £1.9M

Mitigation

- Challenging- would have ended year (2018-19) at £1.8M under if NCSO was at pre-2017 level
- Unable to switch easily from one drug/formulation to another due to:
    - Significant work required and may change back next month
    - Disruptive for patients
    - Switching then causes shortages in other areas
- Brexit- DoH legislation passed to allow (following due process) changing from one drug to another by Community Pharmacy without the need to send patient back to practice.
- Health Board has approved policy to support shortages process
- Assess any switches and NCSO on individual basis
- Remains a significant and unpredictable cost pressure

3. Medicines Management CIP 2019-20

- Target for Pharmacy and MM = £2.9M
- Non-recurring will be achieved in staffing due to turnover and delays in recruitment (100K)
- Prescribing £1.5M identified and set up to monitor and review
- £1.4M unidentified as individual schemes , however the repeat prescribing/dispensing process is being targeted as a whole system.

Prescription Growth

- Growth in items dispensed has increased year on year by 1-2% for the last 5 years, with the exception of 2018-19 where a decrease has been demonstrated.
- 10,000,000 items dispensed each year- two pronged approach:
  - Polypharmacy review- requires pharmacist/dedicated GP time review best as MDT with patient
  - Process mapping and review of the repeat prescription process

Repeat Prescriptions

- 1000 Lives support – workshops targeted at practices (HD with a number of practices attending in April 2019)
- AWTTC collating best practice across NHS Wales
- HB Actions- Targeted 5 practices- demonstrating a Process Mapping
  - Linking with Community Pharmacies and GPs
  - My Health Online encouraged
  - Repeat prescribing policies (number of re-authorisations, quantity, repeats vs acute)
  - Patients taking control

Potential Efficiencies

- Based on 10M items @ £6.50 each
- 1% reduction relates to 650Kpa.
- In the 5 practices initially targeted comparing Sep 18 – Feb 19 with Sep 17 to Feb 18 of total across these practices has shown a reduction equating to £47K in 5 months reduction in costs (7235 items - 1.68%). Replicating this across further practices has potential to reduce costs in the region of £1.09M
- **This is highly dependent on Cat M, NCSO and capacity**

Currently Developing Short and Long Term Plan to address and sustain

Short Term;

- Tool kit for practices being developed for repeats
- Training for reception staff
- Repeat prescribing policies- reviewed and updated
- Audits and process mapping to identify areas to be targeted
- Working with Community Pharmacies and practices to support new ways of working
- Requires greater capacity- QI/Technical and practices

Longer Term:

- Maintain work completed above
- Polypharmacy reviews for all patients
- Requires capacity

4. Provision of Aseptic Technical Services

- Fragile units with limited investment over many years (similar across Wales and UK)
- Standards have been increased over the years
- 3 units no longer meeting critical criteria – 1 closed Dec 2018 , 2 remaining requiring immediate refurbishment to support delivery for a further 24-36 months.
- New build standalone unit as a long term solution aligned with Transforming Access to Medicines (TRAMS)

Efficiencies of In-House Production

- Out-sourcing increases costs in the region of 25-30% per item
- Monthly increase for GGH closure is estimated at £30K per month.
- Closure of WGH and BGH would increase this to in the region of £90K per month (>£1M pa)
- Radio-pharmacy is a **high clinical risk-** closure of the unit in WGH would result in patients being diverted to Singleton which is already at capacity- implications for Single Cancer Pathway

Short Term Solution

- Refurbishment of WGH (£153K) and BGH (£45K) will ensure units are acceptable to continue to provide cover for the next 24-36 months providing a long term solution is in place.
- **This includes radio pharmacy where closure would have significant impact on patient care.**
- Quality Management Systems to be embedded- training in place and already increase in usage (Q-Pulse)
- Limited QA cover needs to be addressed- Band 6 QA technician (also QA covers medical gas testing which if out-sourced would cost and additional £15K - £20K pa)
- With the above in place, this will allow currently out-sourcing to be repatriated reducing cost pressures by around £30K per month.
- Timeline for completion of above: Sept/Oct 2019

Long Term Resolution- National Strategic Direction

- National Project: Transforming Access to Medicines (TRAMS) has identified the preferred model of:
  - 3 Production Units providing cover for NHS Wales (currently around £100M is out-sourced to England)
  - With 3-6 licensed (with MHRA) satellite units to support, one of which should be west of Swansea.
- A single , standalone unit will:
  - Maximise efficiencies- both at national and local levels
  - Repatriation of out-sourcing
  - Licensed unit will allow greater flexibility in life span of products (reduced waste)
  - Greater resilience

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Current Progress

Activity	Comments	Timeline
Recruit Business Justification Writers	Need to refresh and review draft BJC. Confirmed with WG this is the preferred route	Completed
First Option Appraisal of Sites	Long list of 14 reduced to 6 (including do nothing)	Completed
Final Non-Financial Option Appraisal	Short list of 6 – two options closely scored	Completed
Financial Appraisal for Options	Options to be weighted and financial implications assessed.	In progress (Due end of May 2019)
ET approval of final option		
Completion of draft BJC (awaiting final costings)		
Procurement Process to be completed		
Submission of BJC to WG and approval		Q3 2019- approval Q3/Q4
Anticipated commencement of project		April 2020
Anticipated completion of building		Feb 2021
Anticipated Full recommissioning		June 2021

Stand Alone Unit

- Capital investment is required- fully linked in with both TRAMS and WG (est. £5M)
- Initial efficiencies will be required to be invested back into service to develop a fully sustainable service- currently capacity planning and workforce mapping in being undertaken at national level
- Benefits are a **robust** and **resilient** high quality service provision for patients across HD and NHS Wales

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Draft Annual Accounts 2018/19
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The draft Statutory Annual Accounts have been prepared in accordance with the Welsh Government timetable and guidelines. The Finance Committee is asked to review and discuss the draft Accounts.

The draft Accounts was submitted to Welsh Government on 26th April 2019. The Accounts are now being scrutinised by Wales Audit Office, and the Final Accounts will be presented to Audit and Risk Assurance Committee (ARAC) on 29th May 2019 in readiness to send to Welsh Government by 31st May 2019.

The draft Statutory Accounts was presented to ARAC on 7th May 2019.

Cefndir / Background

Under the National Health Service Act (Wales) 2006 the Health Board is required to prepare accounts for each financial year.

The Accounts must comply with the accounting guidance of the Government Reporting Manual (FReM) which is in force for the financial year in which the accounts are prepared and has been applied by Welsh Government and detailed in the NHS Wales Local Health Board Manual of Accounts.

In preparing the accounts Directors are required to apply, on a consistent basis, the accounting principles laid down by Welsh Ministers, make judgements and estimates which are responsible and prudent, and state whether applicable accounting standards have been followed.

Asesiad / Assessment

The Draft Annual Accounts is attached at Appendix 1 for discussion.
Argymhelliad / Recommendation The Finance Committee is asked to discuss the draft annual accounts.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.4 The Committee's principle duties encompass the following: 4.4.2 Maintain an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control. 5.13 Approve the writing off of losses or the making of special payments within delegated limits. 5.15 Receive a report on all Single Tender Actions and extensions of contracts.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF S09-PR20 BAF SO10-PR33
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system, activity recorded in the procurement Bravo system.
Rhestr Termau: Glossary of Terms:	AP-Accounts Payable AR –Accounts Receivable CF –Counter Fraud COS-Contracted Out Service VAT

	ECN- Error Correction Notice EOY – End Of Year ERs NI-Employers National Insurance HMRC-Her Majesty's Revenue and Customs HOLD- Invoices that cannot be paid, as there is a query with the price or quantity or validity NWSSP-NHS Wales Shared Services Partnership NIC-National Insurance Contribution PID –Patient identifiable data PO –Purchase Order PSPP-Public Sector Payment Policy RTI-Real Time Information(transmitted to HMRC from the Payroll system) STA-Single Tender Action VAT-Value Added Tax
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	UHB's Finance Team UHB's Management Team Executive Team Finance Committee

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial implications are inherent within the report
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Risk to our financial position affects our ability to discharge timely and effective care to patients
Gweithlu: **Workforce:**	Overpayments are reported within this report.
Risg: **Risk:**	Financial risks are detailed in the report.
Cyfreithiol: **Legal:**	The UHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.

Enw Da: **Reputational:**	Adverse variance against the UHB's financial plan will affect our reputation with Welsh Government, the Wales Audit Office, and with external stakeholders
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

HYWEL DDA UNIVERSITY HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st June 2009 and became operational on 1st October 2009 and comprises the former organisations of Hywel Dda NHS Trust and Carmarthenshire, Ceredigion and Pembrokeshire Local Health Boards.

Performance Management and Financial Results

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Expenditure on Primary Healthcare Services	3.1	**185,316**	183,962
Expenditure on healthcare from other providers	3.2	**200,169**	197,462
Expenditure on Hospital and Community Health Services	3.3	**534,120**	506,430
		919,605	887,854
Less: Miscellaneous Income	4	**(57,187)**	(54,345)
LHB net operating costs before interest and other gains and losses		**862,418**	833,509
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**(13)**	(11)
Finance costs	7	**9**	3
Net operating costs for the financial year		**862,414**	833,501

See note 2 on page 22 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 65a form part of these accounts

Other Comprehensive Net Expenditure

	2018-19 £'000	2017-18 £'000
Net (gain) / loss on revaluation of property, plant and equipment	**1,185**	14,435
Net (gain) / (loss) on revaluation of intangibles	**0**	0
Net (gain) / loss on revaluation of available for sale financial assets	**0**	0
(Gain) / loss on other reserves	**0**	0
Impairment and reversals	**0**	(1,053)
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Other comprehensive net expenditure for the year	**1,185**	13,382
Total comprehensive net expenditure for the year	**861,229**	820,119

Statement of Financial Position as at 31 March 2019

	Notes	31 March 2019 £'000	31 March 2018 £'000
Non-current assets			
Property, plant and equipment	11	**266,222**	254,395
Intangible assets	12	**1,621**	1,045
Trade and other receivables	15	**43,183**	14,697
Other financial assets	16	**0**	0
Total non-current assets		**311,026**	270,137
Current assets			
Inventories	14	**8,084**	7,875
Trade and other receivables	15	**34,330**	39,598
Other financial assets	16	**0**	305
Cash and cash equivalents	17	**1,460**	1,528
		43,874	49,306
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**43,874**	49,306
Total assets		**354,900**	319,443
Current liabilities			
Trade and other payables	18	**(93,484)**	(95,090)
Other financial liabilities	19	**0**	0
Provisions	20	**(23,541)**	(27,764)
Total current liabilities		**(117,025)**	(122,854)
Net current assets/ (liabilities)		**(73,151)**	(73,548)
Non-current liabilities			
Trade and other payables	18	**0**	0
Other financial liabilities	19	**0**	0
Provisions	20	**(43,497)**	(14,971)
Total non-current liabilities		**(43,497)**	(14,971)
Total assets employed		**194,378**	181,618
Financed by :			
Taxpayers' equity			
General Fund		**167,572**	154,822
Revaluation reserve		**26,806**	26,796
Total taxpayers' equity		**194,378**	181,618

The financial statements on pages 2 to 7 were approved by the Board on 30th May 2019 and signed on its behalf by:

On Behalf of the Chief Executive and Accountable Officer ……..

30th May 2019

The notes on pages 8 to 65a form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2019

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2018-19			
Balance as at 31 March 2018	154,822	26,796	**181,618**
Adjustment for Implementation of IFRS 9	-82	0	**-82**
Balance at 1 April 2018	154,740	26,796	181,536
Net operating cost for the year	(862,414)		**(862,414)**
Net gain/(loss) on revaluation of property, plant and equipment	0	1,185	**1,185**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Movements in other reserves	0	0	**0**
Transfers between reserves	1,175	(1,175)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2018-19	(861,239)	10	**(861,229)**
Net Welsh Government funding	874,071		**874,071**
Balance at 31 March 2019	167,572	26,806	**194,378**

The notes on pages 8 to 65a form part of these accounts

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2018

	General Fund £000s	Revaluation Reserve £000s	Total Reserves £000s
Changes in taxpayers' equity for 2017-18			
Balance at 31 March 2017	157,520	16,183	**173,703**
Net operating cost for the year	(833,501)		**(833,501)**
Net gain/(loss) on revaluation of property, plant and equipment	0	14,435	**14,435**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	(1,053)	**(1,053)**
Movements in other reserves	0	0	**0**
Transfers between reserves	2,769	(2,769)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from (please specify)	0	0	**0**
Total recognised income and expense for 2017-18	(830,732)	10,613	**(820,119)**
Net Welsh Government funding	828,034		**828,034**
Balance at 31 March 2018	154,822	26,796	**181,618**

The notes on pages 8 to 65a form part of these accounts

Statement of Cash Flows for year ended 31 March 2019

		2018-19	2017-18
		£'000	£'000
Cash Flows from operating activities	notes		
Net operating cost for the financial year		**(862,414)**	(833,501)
Movements in Working Capital	27	**(27,602)**	6,595
Other cash flow adjustments	28	**56,848**	24,150
Provisions utilised	20	**(12,908)**	(8,194)
Net cash outflow from operating activities		**(846,076)**	(810,950)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(28,082)**	(17,373)
Proceeds from disposal of property, plant and equipment		**12**	276
Purchase of intangible assets		**(945)**	(229)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	(365)
Proceeds from disposal of other financial assets		**0**	289
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(29,015)**	(17,402)
Net cash inflow/(outflow) before financing		**(875,091)**	(828,352)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**874,071**	828,034
Capital receipts surrendered		**0**	0
Capital grants received		**952**	634
Capital element of payments in respect of finance leases and on-SoFP		**0**	0
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**875,023**	828,668
Net increase/(decrease) in cash and cash equivalents		**(68)**	316
Cash and cash equivalents (and bank overdrafts) at 1 April 2018		**1,528**	1,212
Cash and cash equivalents (and bank overdrafts) at 31 March 2019		**1,460**	1,528

The notes on pages 8 to 65a form part of these accounts

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2018-19 Manual for Accounts. The accounting policies contained in that manual follow the European Union version of the International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Income and funding

The main source of funding for the Local Health Boards (LHBs) are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the Local Health Board. Welsh Government funding is recognised in the financial period in which the cash is received.

Non discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.
Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers is applied, as interpreted and adapted for the public sector, in the Financial Reporting Manual (FReM). It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. Upon transition the accounting policy to retrospectively restate in accordance with IAS 8 has been withdrawn. All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.
A review consistent with the portfolio approach was undertaken by the NHS Technical Accounting Group members, which

- identified that the only material income that would potentially require adjustment under IFRS 15 was that for patient care provided under Long term Agreements (LTAs) for episodes of care which had started but not concluded as at the end of the financial period;
- demonstrated that the potential amendments to NHS Wales NHS Trust and Local Health Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels.

Under the Conceptual IFRS Framework due consideration must be given to the users of the accounts and the cost restraint of compliance and reporting and production of financial reporting. Given the income for LTA activity is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales it was considered reasonable to continue recognising in accordance with those established terms on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.
Only non-NHS income may be deferred.

1.4 Employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the LHB commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the LHBs accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme
The LHB has to offer an alternative pensions scheme for employees not eligible to join the NHS Pensions scheme. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses
Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment
Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the LHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the LHBs services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales bodies have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2017-18 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure.

From 2015-16, the LHB must comply with IFRS 13 Fair Value Measurement in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the entity or the asset which would prevent access to the market at the reporting date. If the LHB could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current
value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, NHS bodies are required to get all All Wales Capital Schemes that are completed in a financial year revalued during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the LHBs business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the LHB; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the LHB expects to obtain economic benefits or service potential from the asset. This is specific to the LHB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the LHB checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9 Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The Local Health Board as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Net Expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2 The Local Health Board as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Inventories
Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

.1.13 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions
Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs
The Welsh Risk Pool (WRP) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was not implemented in 2018-19. The WRP is hosted by Velindre NHS Trust.

1.15 Financial Instruments

From 2018-19 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales bodies, will be to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM shall recognise the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that includes the date of initial application in the opening general fund within Taxpayer's equity.

1.16 Financial assets
Financial assets are recognised on the Statement of Financial Position when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease

receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.
NHS Wales Technical Accounting Group members reviewed the IFRS 9 requirements and determined a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value
Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCNE
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5 Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
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For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 Financial liabilities are initially recognised at fair value
Financial liabilities are classified as either financial liabilities at fair value through the Statement of Comprehensive Net Expenditure or other financial liabilities.

1.17.2 Financial liabilities at fair value through the Statement of Comprehensive Net Expenditure
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax
Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies
Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the LHB has no beneficial interest in them. Details of third party assets are given in Note 29 to the accounts.

1.21 Losses and Special Payments
Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had LHBs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP). The LHB accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is below 50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget
The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in Note 32.

The pool is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty
In the application of the LHB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Provisions
The Health Board provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the Health Board or Trust, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision Contingent Liability for all other estimated expenditure.
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of -0.75%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

1.25 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHBs approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHBs criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the LHB to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs Statement of Financial Position.

Other assets contributed by the LHB to the operator
Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the LHB through the asset being made available to third party users.

1.26 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.
Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.27 Carbon Reduction Commitment Scheme
Carbon Reduction Commitment Scheme allowances are accounted for as government grant funded intangible assets if they are not realised within twelve months and otherwise as current assets. The asset should be measured initially at cost. Scheme assets in respect of allowances shall be valued at fair value where there is evidence of an active market.

1.28 Absorption accounting
Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.
Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29 Accounting standards that have been issued but not yet been adopted
The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts (The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.), IFRS 16 Leases, HMT have confirmed that IFRS 16 Leases, as interpreted and adapted by the FReM is to be effective from 1st April 2020.
IFRS 17 Insurance Contracts,
IFRIC 23 Uncertainty over Income Tax Treatment.

1.30 Accounting standards issued that have been adopted early
During 2018-19 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31 Charities
Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as the LHB is the corporate trustee of the linked NHS Charity (Hywel Dda Charities), it is considered for accounting standards compliance to have control of Hywel Dda Health Charities as a subsidiary and therefore is required to consolidate the results of Hywel Dda Health Charities within the statutory accounts of the LHB.

The determination of control is an accounting standard test of control and there has been no change to the operation of Hywel Dda Charities or its independence in its management of charitable funds.

However, the LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will [consolidate/disclose] the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is reponsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Net operating costs for the year	809,895	833,501	**862,414**	**2,505,810**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,086	1,956	**1,722**	**4,764**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	**0**	**0**
Total operating expenses	810,981	835,457	864,136	**2,510,574**
Revenue Resource Allocation	761,368	766,027	**828,698**	**2,356,093**
Under /(over) spend against Allocation	(49,613)	(69,430)	**(35,438)**	**(154,481)**

Hywel Dda UHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2016-17 to 2018-19.

The Health Board did not receive any repayable brokerage during the year.
The Health Board received £31.3 million repayable cash only support in 2018-19. The accumulated cash only support provided to the Health Board by the Welsh Government is £160.964 million as at 31 March 2019. The cash only support is provided to assist the Health Board with ensuring payments to staff and suppliers, there is no interest payable on cash only support. Repayment of this cash assistance will be in accordance with the Health Board's future Integrated Medium Term Plan submissions.

2.2 Capital Resource Performance

	2016-17	2017-18	2018-19	**Total**
	£'000	£'000	£'000	**£'000**
Gross capital expenditure	18,970	18,474	**31,820**	**69,264**
Add: Losses on disposal of donated assets	0	0	**0**	**0**
Less: NBV of property, plant and equipment and intangible assets disposed	(258)	(265)	**0**	**(523)**
Less: capital grants received	(9)	(11)	**0**	**(20)**
Less: donations received	(1,159)	(623)	**(952)**	**(2,734)**
Charge against Capital Resource Allocation	17,544	17,575	**30,868**	**65,987**
Capital Resource Allocation	17,574	17,613	**30,893**	**66,080**
(Over) / Underspend against Capital Resource Allocation	30	38	**25**	**93**

The LHB met its financial duty to break-even against its Capital Resource Limit over the 3 years 2016-17 to 2018-19.

2.3 Duty to prepare a 3 year plan

The NHS Wales Planning Framework for the period 2018-19 to 2020-21 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans (IMTP) to the Welsh Government.

Following discussion between Hywel Dda University Health Board and Welsh Government, the Health Board acknowledged that it was not in a position to submit an IMTP for the period 2018-19 to 2020-21 given the status of the Transforming Clinical Services and Turnaround Programmes. In the absence of an IMTP, the Health Board developed an Annual Plan that was submitted to Welsh Government by the Board on 29th March 2018.

The statutory financial duty under section 175 (2A) of the National Health Services (Wales) Act 2006 to prepare a three year plan was therefore not met.

	2018-19 to 2020-21
The Minister for Health and Social Services approval status	**Not Approved**

The LHB **has not** therefore met its statutory duty to have an approved financial plan for the period 2018-19 to 2020-21.

The LHB prepared an Annual Plan for 2017-18 therefore there **was not** an approved Integrated Medium Term Plan in 2017-18.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited	Non-cash limited	2018-19 Total	2017-18
	£'000	£'000	£'000	£'000
General Medical Services	71,645		**71,645**	69,407
Pharmaceutical Services	19,453	(5,821)	**13,632**	13,354
General Dental Services	19,925		**19,925**	20,002
General Ophthalmic Services	1,238	4,099	**5,337**	4,983
Other Primary Health Care expenditure	3,943		**3,943**	4,806
Prescribed drugs and appliances	70,834		**70,834**	71,410
Total	**187,038**	**-1,722**	**185,316**	183,962

Staff Costs of £4.75m paid by the Health Board are included in General Medical Services (£4.93m 2017-18)

3.2 Expenditure on healthcare from other providers

	2018-19	2017-18
	£'000	£'000
Goods and services from other NHS Wales Health Boards	**38,754**	38,946
Goods and services from other NHS Wales Trusts	**7,324**	6,878
Goods and services from Health Education and Improvement Wales (HEIW)	**0**	0
Goods and services from other non Welsh NHS bodies	**1,189**	3,000
Goods and services from WHSSC / EASC	**85,495**	79,714
Local Authorities	**9,331**	9,179
Voluntary organisations	**1,970**	1,819
NHS Funded Nursing Care	**3,125**	3,744
Continuing Care	**47,012**	47,599
Private providers	**5,790**	6,430
Specific projects funded by the Welsh Government	**0**	0
Other	**179**	153
Total	**200,169**	197,462

Expenditure with Local Authorities in Note 3.2 includes expenditure on pooled budgets as reported in note 32.

3.3 Expenditure on Hospital and Community Health Services

	2018-19 £'000	2017-18 £'000
Directors' costs	2,451	2,212
Staff costs	400,701	385,248
Supplies and services - clinical	74,317	67,363
Supplies and services - general	5,547	5,672
Consultancy Services	1,691	993
Establishment	8,554	8,357
Transport	1,539	1,245
Premises	15,638	13,653
External Contractors	371	1,646
Depreciation	15,255	15,347
Amortisation	369	352
Fixed asset impairments and reversals (Property, plant & equipment)	4,979	1,139
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	392	387
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	1,856	1,648
Research and Development	0	0
Other operating expenses	460	1,168
Total	**534,120**	506,430

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	**2018-19 £'000**	2017-18 £'000
Clinical negligence	33,970	5,289
Personal injury	368	(207)
All other losses and special payments	167	337
Defence legal fees and other administrative costs	707	267
Gross increase/(decrease) in provision for future payments	**35,212**	**5,686**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	99	38
Less: income received/due from Welsh Risk Pool	(33,455)	(4,076)
Total	**1,856**	**1,648**

Personal injury includes £20k (2017-18 £143k) in respect of permanent injury benefits.
Clinical Redress expenditure during the year was £352k in respect of 62 cases (2017-18 £225k re 93 cases).

4. Miscellaneous Income

	2018-19	2017-18
	£'000	£'000
Local Health Boards	**18,730**	18,103
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**2,152**	2,071
NHS trusts	**3,837**	3,206
Health Education and Improvement Wales (HEIW)	**659**	0
Other NHS England bodies	**4,342**	4,503
Foundation Trusts	**0**	0
Local authorities	**4,535**	4,954
Welsh Government	**2,963**	1,706
Non NHS:		
Prescription charge income	**7**	6
Dental fee income	**3,276**	3,240
Private patient income	**15**	97
Overseas patients (non-reciprocal)	**334**	349
Injury Costs Recovery (ICR) Scheme	**1,272**	1,129
Other income from activities	**536**	556
Patient transport services	**0**	0
Education, training and research	**7,151**	8,087
Charitable and other contributions to expenditure	**779**	833
Receipt of donated assets	**952**	623
Receipt of Government granted assets	**0**	11
Non-patient care income generation schemes	**481**	399
NHS Wales Shared Services Partnership (NWSSP)	**0**	0
Deferred income released to revenue	**399**	371
Contingent rental income from finance leases	**0**	0
Rental income from operating leases	**356**	0
Other income:		
Provision of laundry, pathology, payroll services	**127**	78
Accommodation and catering charges	**1,459**	1,688
Mortuary fees	**145**	164
Staff payments for use of cars	**243**	251
Business Unit	**0**	0
Other	**2,437**	1,920
Total	**57,187**	54,345

Injury Cost Recovery (ICR) Scheme income is subject to a provision for impairment of **21.89%** re personal injury claims

5. Investment Revenue

	2018-19	2017-18
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	**0**	0

6. Other gains and losses

	2018-19	2017-18
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	13	11
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	**13**	11

7. Finance costs

	2018-19	2017-18
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts		
main finance cost	0	0
contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	**0**	0
Provisions unwinding of discount	9	3
Other finance costs	0	0
Total	**9**	3

8. Operating leases

LHB as lessee

As at 31st March 2019 the LHB had 24 operating leases agreements in place for the leases of premises, 209 arrangement in respect of equipment and 201 in respect of vehicles, with 1 premises, 10 equipment and no vehicle leases having expired in year. The periods in which the remaining 434 agreements expire are shown below:

Payments recognised as an expense	**2018-19**	2017-18
	£000	£000
Minimum lease payments	**3,247**	1,663
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**3,247**	1,663

Total future minimum lease payments	
Payable	**£000**	£000
Not later than one year	**1,197**	611
Between one and five years	**2,135**	297
After 5 years	**2,909**	0
Total	**6,241**	908

Number of operating leases expiring	**Land & Buildings**	**Vehicles**	**Equipment**	**Total**
Not later than one year	**3**	**59**	**12**	**74**
Between one and five years	**7**	**142**	**197**	**346**
After 5 years	**14**	**0**	**0**	**14**
Total	24	201	209	**434**
Charged to the income statement (£000)	**0**	**3,006**	**241**	**3,247**

There are no future sublease payments expected to be received

LHB as lessor

Rental revenue	**£000**	£000
Rent	**304**	0
Contingent rents	**0**	0
Total revenue rental	**304**	0

Total future minimum lease payments	
Receivable	**£000**	£000
Not later than one year	**303**	0
Between one and five years	**1,210**	0
After 5 years	**2,019**	0
Total	**3,532**	0

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	£000	£000	£000	£000	£000	£000
Salaries and wages	320,784	3,743	15,009	4,999	**344,535**	332,172
Social security costs	31,219	0	0	274	**31,493**	30,077
Employer contributions to NHS Pension Scheme	38,566	0	0	11	**38,577**	36,677
Other pension costs	94	0	0	0	**94**	38
Other employment benefits	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	**0**	0
Total	390,663	3,743	15,009	5,284	**414,699**	398,964
Charged to capital					**464**	388
Charged to revenue					**414,235**	398,576
					414,699	398,964
Net movement in accrued employee benefits (untaken staff leave accrual included above)					(351)	7

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Other Staff	Total 2018-19	2017-18
	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	1,545	35	3	0	**1,583**	1,498
Medical and dental	678	20	1	70	**769**	733
Nursing, midwifery registered	2,652	2	202	0	**2,856**	2,860
Professional, Scientific, and technical staff	306	0	0	0	**306**	281
Additional Clinical Services	1,692	0	3	0	**1,695**	1,675
Allied Health Professions	523	1	0	18	**542**	531
Healthcare Scientists	166	0	1	0	**167**	157
Estates and Ancilliary	782	0	0	0	**782**	793
Students	11	0	0	0	**11**	16
Total	**8,355**	**58**	**210**	**88**	**8,711**	8,544

9.3. Retirements due to ill-health

During 2018-19 there were 15 early retirements from the LHB agreed on the grounds of ill-health (13 in 2017-18 - £597,853). The estimated additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) will be £567,507.

9.4 Employee benefits

The LHB does not have an employee benefit scheme.

Included in permanent staff in Note 9.2 above there are 577 (522, 2017-18) who are on Fixed Term temporary contracts of which 305 (261, 2017-18) are Medical and Dental

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2018-19 Number of compulsory redundancies	2018-19 Number of other departures	2018-19 Total number of exit packages	2018-19 Number of departures where special payments have been made	2017-18 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	1	**1**	0	0
£10,000 to £25,000	0	0	**0**	0	0
£25,000 to £50,000	0	0	**0**	0	0
£50,000 to £100,000	0	0	**0**	0	1
£100,000 to £150,000	0	0	**0**	0	0
£150,000 to £200,000	0	0	**0**	0	0
more than £200,000	0	0	**0**	0	0
Total	**0**	**1**	**1**	**0**	**1**

Exit packages cost band (including any special payment element)	2018-19 Cost of compulsory redundancies	2018-19 Cost of other departures	2018-19 Total cost of exit packages	2018-19 Cost of special element included in exit packages	2017-18 Total cost of exit packages
	£'s	£'s	£'s	£'s	£'s
less than £10,000	0	6,180	**6,180**	0	0
£10,000 to £25,000	0	0	**0**	0	0
£25,000 to £50,000	0	0	**0**	0	0
£50,000 to £100,000	0	0	**0**	0	76,203
£100,000 to £150,000	0	0	**0**	0	0
£150,000 to £200,000	0	0	**0**	0	0
more than £200,000	0	0	**0**	0	0
Total	**0**	**6,180**	**6,180**	**0**	**76,203**

Redundancy costs have been paid in accordance with the NHS Redundancy provisions, other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

9.6 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the LHB in the financial year 2018-19 was £180,000-£185,000 (2017-18, £175,000 - £180,000). This was 7 times (2017-18, 7) the median remuneration of the workforce, which was £28,330 (2017-18, £26,624).

In 2018-19, 34 (2017-18, 39) employees received remuneration in excess of the highest-paid director. Remuneration for staff ranged from £17,460 to £307,299 (2017-18 £15,404 to £295,365).

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

9.7 Pension costs

PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 5% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 2% of this. The legal minimum level of contribution level is due to increase to 8% in April 2019.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,032 and £46,350 for the 2018-19 tax year (2017-18 £5,876 and £45,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2018-19	**2018-19**	2017-18	2017-18
NHS	**Number**	**£000**	Number	£000
Total bills paid	**3,748**	**230,575**	3,908	219,791
Total bills paid within target	**3,451**	**227,570**	3,504	217,250
Percentage of bills paid within target	**92.1%**	**98.7%**	89.7%	98.8%
Non-NHS				
Total bills paid	**186,631**	**334,724**	177,339	315,875
Total bills paid within target	**179,436**	**326,310**	170,221	305,520
Percentage of bills paid within target	**96.1%**	**97.5%**	96.0%	96.7%
Total				
Total bills paid	**190,379**	**565,299**	181,247	535,666
Total bills paid within target	**182,887**	**553,880**	173,725	522,770
Percentage of bills paid within target	**96.1%**	**98.0%**	95.8%	97.6%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2018-19	2017-18
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2018	25,661	196,113	7,494	10,771	65,016	245	22,810	5,821	**333,931**
Indexation	308	837	75	0	0	0	0	0	**1,220**
Additions									
- purchased	35	1,833	0	20,926	3,972	0	2,934	222	**29,922**
- donated	0	576	0	11	200	0	67	98	**952**
- government granted	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	9,632	0	(9,632)	0	0	0	0	**0**
Revaluations	0		0	0	0	0	0	0	**0**
Reversal of impairments	205	1,122	0	0	0	0	0	0	**1,327**
Impairments	0	(7,033)	0	0	0	0	0	0	**(7,033)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(1,494)	(5)	(4,950)	0	**(6,449)**
At 31 March 2019	26,209	203,080	7,569	22,076	67,694	240	20,861	6,141	**353,870**
Depreciation at 1 April 2018	0	7,511	343	0	51,822	244	15,092	4,524	**79,536**
Indexation	0	32	3	0	0	0	0	0	**35**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	44	0	0	0	0	0	0	**44**
Impairments	0	(771)	0	0	0	0	0	0	**(771)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(1,496)	(5)	(4,950)	0	**(6,451)**
Provided during the year	0	7,674	343	0	4,543	1	2,188	506	**15,255**
At 31 March 2019	0	14,490	689	0	54,869	240	12,330	5,030	**87,648**
Net book value at 1 April 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Net book value at 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Net book value at 31 March 2019 comprises :									
Purchased	25,954	184,872	6,880	22,076	11,819	0	8,398	893	**260,892**
Donated	255	3,718	0	0	1,006	0	107	215	**5,301**
Government Granted	0	0	0	0	0	0	26	3	**29**
At 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Asset financing :									
Owned	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2019	26,209	188,590	6,880	22,076	12,825	0	8,531	1,111	**266,222**

The net book value of land, buildings and dwellings at 31 March 2019 comprises :

	£000
Freehold	**219,938**
Long Leasehold	**1,741**
Short Leasehold	**0**
	221,679

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institute of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for whih as asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	25,285	200,937	8,120	9,244	65,631	245	19,811	5,593	**334,866**
Indexation	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	0	1,711	0	10,217	2,510	0	2,983	190	**17,611**
- donated	0	204	0	0	376	0	5	38	**623**
- government granted	0	0	0	0	0	0	11	0	**11**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	842	3,746	0	(4,577)	(11)	0	0	0	**0**
Revaluations	657	397	(538)	0	0	0	0	0	**516**
Reversal of impairments	5	(4,857)	47	0	0	0	0	0	**(4,805)**
Impairments	(1,128)	(6,017)	(135)	(4,113)	0	0	0	0	**(11,393)**
Reclassified as held for sale	0	(8)	0	0	0	0	0	0	**(8)**
Disposals	0	0	0	0	(3,490)	0	0	0	**(3,490)**
At 31 March 2018	25,661	196,113	7,494	10,771	65,016	245	22,810	5,821	**333,931**
Depreciation at 1 April 2017	0	26,411	1,547	0	50,170	243	13,240	3,941	**95,552**
Indexation	0	0	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(12,391)	(1,528)	0	0	0	0	0	**(13,919)**
Reversal of impairments	0	(12,250)	4	0	0	0	0	0	**(12,246)**
Impairments	0	(1,764)	(19)	0	0	0	0	0	**(1,783)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(3,415)	0	0	0	**(3,415)**
Provided during the year	0	7,505	339	0	5,067	1	1,852	583	**15,347**
At 31 March 2018	0	7,511	343	0	51,822	244	15,092	4,524	**79,536**
Net book value at 1 April 2017	25,285	174,526	6,573	9,244	15,461	2	6,571	1,652	**239,314**
Net book value at 31 March 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Net book value at 31 March 2018 comprises :									
Purchased	25,411	185,355	7,151	10,771	12,053	1	7,604	1,139	**249,485**
Donated	250	3,247	0	0	1,141	0	73	153	**4,864**
Government Granted	0	0	0	0	0	0	41	5	**46**
At 31 March 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Asset financing :									
Owned	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2018	25,661	188,602	7,151	10,771	13,194	1	7,718	1,297	**254,395**

The net book value of land, buildings and dwellings at 31 March 2018 comprises :

	£000
Freehold	**219,602**
Long Leasehold	**1,812**
Short Leasehold	**0**
	221,414

11. Property, plant and equipment (continued)

i) Acquisitions shown as donated assets within Note 11 were bought using monies donated by the public into the Hywel Dda Charities and contributions from Ty Bryngwyn Hospice, League of Friends and other charities and organisations.

During 2018-19 fixed assets purchased to the following value were funded by the following:

Hywel Dda General Fund Charity (1147863) Plant and Machinery	£154,528
Hywel Dda General Fund Charity (1147863) Furniture and Fittings	£ 98,112
Hywel Dda General Fund Charity (1147863) Bulidings	£ 38,368
Hywel Dda General Fund Charity (1147863) Information Technology	£ 58,344
Ty Bryngwyn Hospice Committee	£547,482
League of Friends & Other Contributions	£54,952
Total Donated Assets	**£951,786**

Other Disclosures

i) The LHB is not carrying any temporary idle assets.
Gross carrying amount of all fully depreciated assets still in use as at 31st March 2019 is £52,203,495

IFRS 13 - Fair Value Measurement

AS at 31st March 2019, the Health Board does not hold any fixed assets at fair value as defined by IFRS 13.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2018	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2019	0	0	0	0	0	**0**
Balance brought forward 1 April 2017	205	0	0	0	0	**205**
Plus assets classified as held for sale in the year	8	0	0	0	0	**8**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	(190)	0	0	0	0	**(190)**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	(23)	0	0	0	0	**(23)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2018	0	0	0	0	0	**0**

Assets sold in the period

Assets classified as held for sale during the year

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	2,548	0	79	0	0	0	**2,627**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- purchased	**945**	**0**	**0**	**0**	**0**	**0**	**945**
Additions- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers		**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(134)**	**0**	**(2)**	**0**	**0**	**0**	**(136)**
Gross cost at 31 March 2019	**3,359**	**0**	**77**	**0**	**0**	**0**	**3,436**
Amortisation at 1 April 2018	1,511	0	71	0	0	0	**1,582**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	**361**	**0**	**8**	**0**	**0**	**0**	**369**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(134)**	**0**	**(2)**	**0**	**0**	**0**	**(136)**
Amortisation at 31 March 2019	**1,738**	**0**	**77**	**0**	**0**	**0**	**1,815**
Net book value at 1 April 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**
Net book value at 31 March 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**
At 31 March 2019							
Purchased	**1,613**	**0**	**0**	**0**	**0**	**0**	**1,613**
Donated	**8**	**0**	**0**	**0**	**0**	**0**	**8**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2019	**1,621**	**0**	**0**	**0**	**0**	**0**	**1,621**

12. Intangible non-current assets

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Carbon Reduction Commitments	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	2,319	0	79	0	0	0	**2,398**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	229	0	0	0	0	0	**229**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Gross cost at 31 March 2018	**2,548**	**0**	**79**	**0**	**0**	**0**	**2,627**
Amortisation at 1 April 2017	1,172	0	58	0	0	0	**1,230**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	339	0	13	0	0	0	**352**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Amortisation at 31 March 2018	**1,511**	**0**	**71**	**0**	**0**	**0**	**1,582**
Net book value at 1 April 2017	**1,147**	**0**	**21**	**0**	**0**	**0**	**1,168**
Net book value at 31 March 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**
At 31 March 2018							
Purchased	1,026	0	8	0	0	0	**1,034**
Donated	10	0	0	0	0	0	**10**
Government Granted	1	0	0	0	0	0	**1**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2018	**1,037**	**0**	**8**	**0**	**0**	**0**	**1,045**

Additional disclosures re Intangible Assets

Computer Software & Licences are capitalised at their purchased price.

Computer Software & Licences are not indexed as IT assets are not subject to indexation.

The assets are amortised monthly over their expected life.

The gross carrying amount of fully amortised intangible assets still in use as at 31 March 2019 was £964,805.

13 . Impairments

	2018-19 Property, plant & equipment £000	2018-19 Intangible assets £000	2017-18 Property, plant & equipment £000	2017-18 Intangible assets £000
Impairments arising from :				
Loss or damage from normal operations	**0**	**0**	0	0
Abandonment in the course of construction	**0**	**0**	0	0
Over specification of assets (Gold Plating)	**0**	**0**	0	0
Loss as a result of a catastrophe	**0**	**0**	0	0
Unforeseen obsolescence	**0**	**0**	0	0
Changes in market price	**0**	**0**	0	0
Others (specify)	**(6,262)**	**0**	(9,633)	0
Reversal of impairments	**1,283**	**0**	7,441	0
Total of all impairments	**(4,979)**	**0**	(2,192)	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	**(4,979)**	**0**	(1,139)	0
Charged to Revaluation Reserve	**0**	**0**	(1,053)	0
	(4,979)	**0**	(2,192)	0

14.1 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	**3,776**	3,531
Consumables	**4,096**	4,153
Energy	**212**	191
Work in progress	**0**	0
Other	**0**	0
Total	**8,084**	7,875
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2019	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	**31 March 2019 £000**	31 March 2018 £000
Welsh Government	**1,679**	**1,222**
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**95**	**450**
Welsh Health Boards	**1,403**	**1,183**
Welsh NHS Trusts	**910**	**404**
Health Education and Improvement Wales (HEIW)	**96**	**0**
Non - Welsh Trusts	**1**	**2**
Other NHS	**682**	**618**
Welsh Risk Pool	**21,892**	**27,639**
Local Authorities	**1,157**	**2,010**
Capital debtors	**0**	**0**
Other debtors	**5,499**	**5,299**
Provision for irrecoverable debts	**(1,053)**	**(872)**
Pension Prepayments	**0**	**0**
Other prepayments	**1,969**	**1,643**
Other accrued income	**0**	**0**
Sub total	**34,330**	39,598
Non-current		
Welsh Government	**0**	0
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Health Education and Improvement Wales (HEIW)	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
Welsh Risk Pool	**43,183**	14,697
Local Authorities	**0**	0
Capital debtors	**0**	0
Other debtors	**0**	0
Provision for irrecoverable debts	**0**	0
Pension Prepayments	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**43,183**	14,697
Total	**77,513**	54,295
Receivables past their due date but not impaired		
By up to three months	**279**	339
By three to six months	**71**	71
By more than six months	**30**	68
	380	478

Expected Credit Losses (ECL) / Provision for impairment of receivables		
Balance at 31 March 2018	(872)	
Adjustment for Implementation of IFRS 9	**(82)**	
Balance at 1 April 2018	(954)	(834)
Transfer to other NHS Wales body	**0**	**0**
Amount written off during the year	**55**	**5**
Amount recovered during the year	**0**	**0**
(Increase) / decrease in receivables impaired	**(154)**	**(43)**
Bad debts recovered during year	**0**	**0**
Balance at 31 March	**(1,053)**	(872)

In determining whether a debt is impaired consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT		
Trade receivables	**582**	613
Other	**0**	0
Total	**582**	613

16. Other Financial Assets

	Current		Non-current	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	305	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**305**	**0**	**0**

17. Cash and cash equivalents

	2018-19	2017-18
	£000	£000
Balance at 1 April	**1,528**	1,212
Net change in cash and cash equivalent balances	**(68)**	316
Balance at 31 March	**1,460**	1,528
Made up of:		
Cash held at GBS	**1,347**	1,708
Commercial banks	**88**	(202)
Cash in hand	**25**	22
Current Investments	**0**	0
Cash and cash equivalents as in Statement of Financial Position	**1,460**	1,528
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**1,460**	1,528

The movement relates to cash, no comparative information is required by IAS 7 in 2018-19.

18. Trade and other payables

Current	**31 March 2019 £000**	31 March 2018 £000
Welsh Government	**4**	**1**
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**1,148**	**133**
Welsh Health Boards	**1,113**	**1,318**
Welsh NHS Trusts	**1,345**	**790**
Health Education and Improvement Wales (HEIW)	**0**	**0**
Other NHS	**9,182**	**10,151**
Taxation and social security payable / refunds	**1,008**	**3,784**
Refunds of taxation by HMRC	**0**	**0**
VAT payable to HMRC	**0**	**0**
Other taxes payable to HMRC	**0**	**0**
NI contributions payable to HMRC	**1,317**	**4,550**
Non-NHS creditors	**6,157**	**4,283**
Local Authorities	**2,995**	**6,064**
Capital Creditors	**8,068**	**5,276**
Overdraft	**0**	**0**
Rentals due under operating leases	**0**	**0**
Obligations under finance leases, HP contracts	**0**	**0**
Imputed finance lease element of on SoFP PFI contracts	**0**	**0**
Pensions: staff	**0**	**0**
Accruals	**54,373**	**51,084**
Deferred Income:		
Deferred Income brought forward	**399**	**385**
Deferred Income Additions	**418**	**385**
Transfer to / from current/non current deferred income	**0**	**0**
Released to SoCNE	**(399)**	**(371)**
Other creditors	**6,356**	**7,257**
PFI assets –deferred credits	**0**	**0**
Payments on account	**0**	0
Total	**93,484**	95,090

Non-current		
Welsh Government	**0**	0
Welsh Health Specialised Services Committee (WHSSC) / Emergency Ambulance Services Committee (EASC)	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Health Education and Improvement Wales (HEIW)	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS creditors	**0**	0
Local Authorities	**0**	0
Capital Creditors	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**0**	0
Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Total	**0**	0

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

Amounts falling due more than one year are expected to be settled as follows:	**31-Mar-19 £000**	**31-Mar-18 £000**
Between one and two years	0	0
Between two and five years	0	0
In five years or more	0	0
Sub-total	0	0

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	**31 March 2019 £000**	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2018	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2019
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	**22,286**	0	0	2,185	11,453	(9,094)	(9,225)	0	**17,605**
Personal injury	**3,299**	0	0	0	592	(530)	(224)	9	**3,146**
All other losses and special payments	**0**	0	0	0	167	(167)	0	0	**0**
Defence legal fees and other administration	**545**	0	0	129	827	(345)	(463)		**693**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**46**			0	13	(22)	0	0	**37**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**1,588**		0	0	2,391	(1,505)	(414)		**2,060**
Total	**27,764**	**0**	**0**	2,314	15,443	(11,663)	(10,326)	**9**	**23,541**
Non Current									
Clinical negligence	**14,614**	0	0	(2,185)	32,186	(1,123)	(444)	0	**43,048**
Personal injury	**0**	0	0	0	0	0	0	0	**0**
All other losses and special payments	**0**	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	**357**	0	0	(129)	376	(122)	(33)		**449**
Pensions relating to former directors	**0**			0	0	0	0	0	**0**
Pensions relating to other staff	**0**			0	0	0	0	0	**0**
Restructuring	**0**			0	0	0	0	0	**0**
Other	**0**		0	0	0	0	0		**0**
Total	**14,971**	**0**	**0**	**(2,314)**	**32,562**	**(1,245)**	**(477)**	**0**	**43,497**
TOTAL									
Clinical negligence	**36,900**	**0**	**0**	**0**	**43,639**	**(10,217)**	**(9,669)**	**0**	**60,653**
Personal injury	**3,299**	**0**	**0**	**0**	**592**	**(530)**	**(224)**	**9**	**3,146**
All other losses and special payments	**0**	**0**	**0**	**0**	**167**	**(167)**	**0**	**0**	**0**
Defence legal fees and other administration	**902**	**0**	**0**	**0**	**1,203**	**(467)**	**(496)**		**1,142**
Pensions relating to former directors	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Pensions relating to other staff	**46**			**0**	**13**	**(22)**	**0**	**0**	**37**
Restructuring	**0**			**0**	**0**	**0**	**0**	**0**	**0**
Other	**1,588**		**0**	**0**	**2,391**	**(1,505)**	**(414)**		**2,060**
Total	**42,735**	**0**	**0**	**0**	**48,005**	**(12,908)**	**(10,803)**	**9**	**67,038**

Expected timing of cash flows:

	In year to 31 March 2020	Between 1 April 2020 31 March 2024	Thereafter	Total
				£000
Clinical negligence	17,605	43,048	0	**60,653**
Personal injury	3,146	0	0	**3,146**
All other losses and special payments	0	0	0	**0**
Defence legal fees and other administration	693	449	0	**1,142**
Pensions relating to former directors	0	0	0	**0**
Pensions relating to other staff	37	0	0	**37**
Restructuring	0	0	0	**0**
Other	2,060	0	0	**2,060**
Total	**23,541**	**43,497**	**0**	**67,038**

20. Provisions (continued)

	At 1 April 2017	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2018
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence	14,119	0	0	9,206	8,723	(5,802)	(3,960)	0	**22,286**
Personal injury	4,131	0	0	0	356	(628)	(563)	3	**3,299**
All other losses and special payments	0	0	0	0	340	(337)	(3)	0	**0**
Defence legal fees and other administration	495	0	0	134	597	(268)	(413)		**545**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	53			0	14	(21)	0	0	**46**
Restructuring	0			0	0	0	0	0	**0**
Other	217		0	0	2,289	(883)	(35)		**1,588**
Total	**19,015**	**0**	**0**	**9,340**	**12,319**	**(7,939)**	**(4,974)**	**3**	**27,764**
Non Current									
Clinical negligence	23,525	0	0	(9,206)	1,011	(231)	(485)	0	**14,614**
Personal injury	0	0	0	0	0	0	0	0	**0**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	432	0	0	(134)	84	(24)	(1)		**357**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**23,957**	**0**	**0**	**(9,340)**	**1,095**	**(255)**	**(486)**	**0**	**14,971**
TOTAL									
Clinical negligence	37,644	0	0	0	9,734	(6,033)	(4,445)	0	**36,900**
Personal injury	4,131	0	0	0	356	(628)	(563)	3	**3,299**
All other losses and special payments	0	0	0	0	340	(337)	(3)	0	**0**
Defence legal fees and other administration	927	0	0	0	681	(292)	(414)		**902**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	53			0	14	(21)	0	0	**46**
Restructuring	0			0	0	0	0	0	**0**
Other	217		0	0	2,289	(883)	(35)		**1,588**
Total	**42,972**	**0**	**0**	**0**	**13,414**	**(8,194)**	**(5,460)**	**3**	**42,735**

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2018-19 £'000**	2017-18 £'000
Legal claims for alleged medical or employer negligence	**61,482**	53,939
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**1,691**	1,655
Continuing Health Care costs	**6,925**	13,600
Other	**0**	0
Total value of disputed claims	**70,098**	69,194
Amounts (recovered) in the event of claims being successful	**(59,534)**	(51,750)
Net contingent liability	**10,564**	**17,444**

21.2 Remote Contingent liabilities

	2018-19 £'000	2017-18 £'000
Guarantees	0	0
Indemnities	536	266
Letters of Comfort	0	0
Total	**536**	**266**

21.3 Contingent assets

	2018-19 £'000	2017-18 £'000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2018-19 £'000	2017-18 £'000
Property, plant and equipment	28,124	16,100
Intangible assets	0	0
Total	**28,124**	16,100

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out or written-off during the financial year

	Amounts paid out during period to 31 March 2019		Approved to write-off to 31 March 2019	
	Number	**£**	**Number**	**£**
Clinical negligence	124	10,216,769	98	8,658,580
Personal injury	40	530,385	14	237,375
All other losses and special payments	295	167,037	295	167,037
Total	459	10,914,191	407	9,062,992

Analysis of cases which exceed £300,000 and all other cases

Cases exceeding £300,000	Case type	**Amounts paid out in year** £	**Cumulative amount** £	**Approved to write-off in year** £
07RR6MN0006	MN	1,394,905	1,578,905	0
09RYNMN0061	MN	35,000	665,000	0
12RYNMN0077	MN	1,300,000	1,615,021	0
13RYNMN0032	MN	650,000	980,000	0
13RYNMN0074	MN	0	819,000	819,000
14RYNMN0005	MN	680,000	695,000	695,000
14RYNMN0069	MN	2,280,000	2,810,000	2,810,000
14RYNMN0105	MN	0	850,000	850,000
15RYNMN0026	MN	0	362,698	362,698
15RYNMN0034	MN	323,345	573,345	0
16RYNMN0063	MN	100,000	310,000	0
18RYNMN0084	MN	422,000	423,920	0
19RYNMN0007	MN	370,950	370,950	0
Sub-total		**7,556,200**	**12,053,839**	**5,536,698**
All other cases		3,357,991	8,165,392	3,526,294
Total cases		**10,914,191**	**20,219,231**	**9,062,992**

24. Finance leases

24.1 Finance leases obligations (as lessee)

Amounts payable under finance leases:

Land	**31 March 2019 £000**	31 March 2018 £000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.1 Finance leases obligations (as lessee) continue

Amounts payable under finance leases:

Buildings	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

Other	**31 March 2019**	31 March 2018
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.2 Finance leases obligations (as lessor) continued

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under finance leases:

	31 March 2019	31 March 2018
Gross Investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has no PFI schemes which are deemed to be off-statement of financial position

Commitments under off-SoFP PFI contracts	Off-SoFP PFI contracts	Off-SoFP PFI contracts
	31 March 2019	31 March 2018
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element	**On SoFP PFI Imputed interest**	**On SoFP PFI Service charges**
	31 March 2019	**31 March 2019**	**31 March 2019**
	£000	**£000**	**£000**
Total payments due within one year	**0**	**0**	**0**
Total payments due between 1 and 5 years	**0**	**0**	**0**
Total payments due thereafter	**0**	**0**	**0**
Total future payments in relation to PFI contracts	**0**	**0**	**0**

	On SoFP PFI Capital element	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2018	31 March 2018	31 March 2018
	£000	£000	£000
Total payments due within one year	0	0	0
Total payments due between 1 and 5 years	0	0	0
Total payments due thereafter	0	0	0
Total future payments in relation to PFI contracts	0	0	0

Total present value of obligations for on-SoFP PFI contracts **£0m**

25.3 Charges to expenditure	2018-19	2017-18
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

PFI scheme expiry date:	31 March 2019 £000	31 March 2018 £000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2018-19	2017-18
	£000	£000
(Increase)/decrease in inventories	**(209)**	201
(Increase)/decrease in trade and other receivables - non-current	**(28,486)**	8,888
(Increase)/decrease in trade and other receivables - current	**5,573**	(11,747)
Increase/(decrease) in trade and other payables - non-current	**0**	0
Increase/(decrease) in trade and other payables - current	**(1,606)**	10,125
Total	**(24,728)**	7,467
Adjustment for accrual movements in fixed assets - creditors	**(2,792)**	(872)
Adjustment for accrual movements in fixed assets - debtors	**0**	0
Other adjustments	**(82)**	0
	(27,602)	6,595

28. Other cash flow adjustments

	2018-19	2017-18
	£000	£000
Depreciation	**15,255**	15,347
Amortisation	**369**	352
(Gains)/Loss on Disposal	**(13)**	(11)
Impairments and reversals	**4,979**	1,139
Release of PFI deferred credits	**0**	0
Donated assets received credited to revenue but non-cash	**(952)**	(623)
Government Grant assets received credited to revenue but non-cash	**0**	(11)
Non-cash movements in provisions	**37,210**	7,957
Total	**56,848**	24,150

29. Third Party assets

Hywel Dda University Health Board held £1,400,694 cash at bank and in hand at 31 March 2019 (31 March 2018, £1,178,113) which relates to monies held by the Health Board on behalf of patients. Cash held in Patient's Investment Accounts amounted to £666,248 at 31 March 2019 (31 March 2018, £664,921). This has been excluded from the Cash and Cash equivalents figure reported in the Accounts.

30. Events after the Reporting Period

The LHB **has not** experienced any events having a material effect on the accounts, between the date of the statement of financial position and the date on which these accounts were approved by its Board.

31. Related Party Transactions

Total value of transactions with Board members and key senior staff in 2018-19

	Payments to related party	from related party	Amounts owed to related party	Amounts due party
	£000	£	£	£
Age Concern Pembrokeshire	85	0	0	0
Blackpool Teaching Hospitals Foundation Trust	16	0	0	0
Carmarthenshire County Council	12,963	1,983	1,015	765
HMRC	2,325	0	37,507	0
Mencap	95	0	0	0
National Botanic Gardens of Wales	8	0	0	0
Pembrokeshire County Council	5,080	2,812	1,452	223
Public Health England	15	0	0	0
Spice Innovations Ltd	54	0	0	0
Swansea University	571	2	1,378	2
University of Wales Trinity St David	20	0	2	0

The Welsh Government is regarded as a related party. During the accounting period the Hywel Dda University Health Board has had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body:

	Debtor @ 31 -Mar 19	Creditor @ 31-Mar-19	Income @ 31-Mar-19	Expenditure @ 31-Mar-19
	£'000s	£'000s	£'000s	£'000s
Welsh Government	1,679	4	880,945	5
Abertawe Bro Morgannwg University Health Board	406	433	4,150	35,335
Aneurin Bevan University Health Board	23	74	762	808
Betsi Cadwaladr University Health Board	237	27	4,522	410
Cardiff & Vale University Health Board	187	165	553	6,359
Cwm Taf University Health Board	87	76	445	529
Powys Local Health Board	463	339	8,299	580
Public Health Wales NHS Trust	60	225	2,067	2,078
Velindre University NHS Trust	5,061	1,107	2,157	12,051
Welsh Ambulance Services Trust	40	12	178	3,093
Welsh Health Specialised Services Committee	95	1,148	2,152	85,495
Health Education and Improvement Wales (HEIW)	96	0	3,187	0
Total £'000s	8,434	3,611	909,417	146,743

A number of the LHB's Board members have interests in related parties as follows:

Name	Details	Interests	
Anna Lewis	Independent Member	Board Trustee	Spice Innovations Ltd
		Visiting Senior Lecturer	Swansea University
Julie James	Independent Member	Health Assessor	Welsh Government Health and Wellbeing at Work Corporate Standard
		Trustee	National Botanic Garden of Wales
		Member of Court	Swansea University
		Non-Executive Director	Welsh Government Dept for Education and Local Government & Communities
		External Voting Member	Carmarthenshire County Council Audit Committee
		Member	Carmarthenshire County Council's Standards Committee
Michael Hearty	Associate Member	Finance Advisor	Betsi Cadwaladr Health Board
		Non-Executive Director	HMRC
		Non-Executive Director	Blackpool Teaching Hospital Foundation Trust
		Non-Executive Director	Public Health England
Philip Kloer	Medical Director	Honorary Professor	Swansea University
Simon Hancock	Independent Member	Treasurer	Age Concern
		Member	Mencap
		Vice Chair	Pembrokeshire County Council
		Member of Court	Swansea University
Steve Moore	Chief Executive	Honorary Professor	University of Wales Trinity St David

32. Pooled budgets

Hywel Dda University Health Board has entered into a pooled budget with Ceredigion County Council on the 1st April 2009. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store. The pool is hosted by Ceredigion County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Ceredigion County Council and the Health Board. Payments for services provided by Ceredigion County Council in the sum of £306,000 are accounted for as expenditure in the accounts of the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Hywel Dda University Health Board has entered into a pooled budget with Carmarthenshire County Council on the 1st October 2009. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store. The pool is hosted by Carmarthenshire County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Carmarthenshire County Council and the Health Board. Payments for services provided by Carmarthenshire County Council in the sum of £381,960 are accounted for as expenditure in the accounts of the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Hywel Dda University Health Board has entered into an agreement with Carmarthenshire County Council on the 31st March 2011 under section 33 of the NHS (Wales) Act 2006 for the provision of Carmarthenshire Community Health and Social Care services. The section 33 agreement itself will initially only provide the framework for taking forward future schedules and therefore references all community based health, social care (adults & children) and related housing and public protection services so that if any future developments are considered a separate agreement will not have to be prepared. There are currently no pooled budgets related to this agreement.

Hywel Dda University Health Board has entered into an agreement with Pembrokeshire County Council on the 31st March 2011 under section 33 of the NHS (Wales) Act 2006 for the provision of an integrated community joint equipment store and from 1st October 2012 the agreement has operated as a pooled fund. The pool is hosted by Pembrokeshire County Council and a memorandum note to the final accounts will provide details of the joint income and expenditure. The financial operation of the pool is governed by a pooled budget agreement between Pembrokeshire County Council and the Health Board. Hywel Dda University Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement and the sum of £ £310,781 has been accounted for as expenditure in the accounts of the Health Board.

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

The Hywel Dda University Health Board has identified the organisations full Board as the Chief Operating Decision Maker (CODM) under IFRS 8. Only the full Board can allocate resources to the various services. The organisation is constituted as an integrated Local Health Board with seamless service delivery.

The management and reporting for the operations of Hywel Dda University Health Board to the CODM is through Acute Care and Counties. Whilst these may be seen as segments they each provide the same spectrum of integrated services and therefore the Local Health Board has aggregated them into one healthcare segment as provided for under IFRS 8. The Local Health Board has no non healthcare activities.

34. Other Information

IFRS15

Work was undertaken by the TAG IFRS sub group, consistent with the 'portfolio' approach allowed by the standard. Each income line in the notes from a previous year's annual accounts (either 2016/17 or 2017/18) was considered to determine how it would be affected by the implementation of IFRS 15. It was determined that the following types of consideration received from customers for goods and services (hereon referred to as income) fell outside the scope of the standard, as the body providing the income does not contract with the body to receive any direct goods or services in return for the income flow.

- Charitable Income and other contributions to Expenditure.
- Receipt of Donated Assets.
- WG Funding without direct performance obligation (e.g. SIFT/SIFT®/Junior Doctors & PDGME Funding).

Income that fell wholly or partially within the scope of the standard included:

- Welsh LHB & WHSCC LTA Income;
- Non Welsh Commissioner Income;
- NHS Trust Income;
- Foundation Trust Income;
- Other WG Income;
- Local Authority Income;
- ICR Income ;
- Training & Education income ;
- Accommodation & Catering income

It was identified that the only material income flows likely to require adjustment for compliance with IFRS15 was that for patient care provided under Long Term Agreements (LTA's). The adjustment being, for episodes of patient care which had started but not concluded (FCE's), as at period end, e.g. 31 March.

When calculating the income generated from these episodes, it was determined that it was appropriate to use length of stay as the best proxy for the attributable Work In Progress (WIP) value. In theory, as soon as an episode is opened, income is due. Under the terms and conditions of the contract this will only ever be realised on episode closure so the average length of stay would be the accepted normal proxy for the work in progress value.

For Hywel Dda University Health Board, the summary assessment of the impact of IFRS 15 is below -

Annual Accounts year looked at: 2016/17

Total Income per Accounts in the year 2016/17 :	£52.934m
Total Income looked at as part of the exercise:	£29.595m
Total Income looked at considered to be outside the scope of IFRS 15:	£ 3.873m
Total Income looked at that is inside the scope of IFRS 15	£25.722m
Total Income looked at that is inside the scope of IFRS 15 and potentially requires adjustment for incomplete service provision episodes	£15.014m
Total estimated adjustment required under IFRS 15	£ 0.059m

34. Other Information (continued)

IFRS 9

For consistency across Wales, the practical expedient provision matrix was used to estimate expected credit losses (ECLs) based on the 'age' of receivables as follows:

- Receivables were segregated into appropriate groups

- Each group, was analysed:

a) age-bands

1-30 days (including current)
31-60 days
61-90 days
91-180 days
181- 365 days
> 1 year

b) at historical back-testing dates (data points)

- For each age-band, at each back-testing date the following were determined:
  a) the gross receivables
  b) the amounts ultimately collected/written-off. If material, adjustments should be made to exclude the effect of non-collections for reasons other than credit loss (e.g. credit notes issued for returns, short-deliveries or as a commercial price concession)

The average historical loss rate by age-band was calculated, and adjusted where necessary e.g. to take account of changes in:
a) economic conditions
b) types of customer
c) credit management practices

Consideration was given as to whether ECLs should be estimated individually for any period-end receivables, e.g. because information was available specific debtors.

Loss rate estimates were applied to each age-band for the other receivables.

The percentages calculated have been applied to those invoices outstanding as at 31st March 2018 (which don't already have a specific provision against them) to recalculate the value of the HB/Trust non-specific provision under IFRS9.

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009

Annual Accounts 2018/19

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Statement of Comprehensive Net Expenditure For the year ended 31 March 2019

	2018-19 £'m	2017-18 £'m	Change £'m	Change %	
Expenditure on Primary Healthcare Services	**185.3**	**184.0**	1.4	1%	
Expenditure on healthcare from other providers	**200.2**	197.5	2.7	1%	
Expenditure on Hospital and Community Health Services	**534.1**	506.4	27.7	5%	Movement predominately due to £15m pay award, £4m increase in drugs spend and £4m additional impairment cost in relation to 2 major schemes
	919.6	887.9	31.8	4%	
Less: Miscellaneous Income	**(57.2)**	(54.3)	2.8	5%	
LHB net operating costs before interest and other gains and losses	**862.4**	833.5	28.9	3%	
Other (Gains) / Losses	**(0.0)**	(0.0)	(0.0)		
Finance costs	**0.0**	0.0	0.0		
Net operating costs for the financial year	**862.4**	833.5	28.9	3%	
			-		
General ophthalmic services expenditure and other non-cash limited expe	**1.7**	2.0	(0.2)		
Total operating expenses	**864.1**	**835.5**	**28.7**		
Revenue Resource Allocation	828.7	766.0	62.7	8%	
(Over) spend against allocation	**(35.4)**	**(69.4)**	**34.0**	**-49%**	

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Statement of the Financial Position as at 31 March 2019

	31 March 2019 £'m	31 March 2018 £'m	Change £'m	Change %	
Non-current assets					
Property, plant and equipment	**266.2**	254.4	11.8	5%	Movement driven by fixed assets acquired in year offset by depreciation and impairments charges.
Intangible assets	**1.6**	1.0	0.6	55%	
Trade and other receivables	**43.2**	14.7	28.5	194%	Increase relates to Welsh Risk Pool, corresponding liability in Provisions
Total non-current assets	**311.0**	270.1	40.9	15%	
Current assets					
Inventories	**8.1**	7.9	0.2	3%	
Trade and other receivables	**34.3**	39.6	(5.3)	-13%	£6m movement relates to reduction in Welsh Risk Pool asset held in Short-term
Other financial assets	**-**	0.3	(0.3)	-100%	
Cash and cash equivalents	**1.5**	1.5	(0.1)	-4%	
Total current assets	**43.9**	49.3	(5.4)	-11%	
Total assets	**354.9**	319.4	35.5	11%	
Current liabilities					
Trade and other payables	**(93.5)**	(95.1)	1.6	-2%	
Provisions	**(23.5)**	(27.8)	4.2	-15%	Increase relates to Welsh Risk Pool, corresponding asset in Long-term Trade and other receivables
Total current liabilities	**(117.0)**	(122.9)	5.8	-5%	
Net current assets/ (liabilities)	**(73.2)**	(73.5)	0.4	-1%	
Non-current liabilities					
Provisions	**(43.5)**	(15.0)	(28.5)	191%	Increase relates to Welsh Risk Pool, corresponding asset in Long-term Trade and other receivables
Total non-current liabilities	**(43.5)**	(15.0)	(28.5)	191%	
Total assets employed	**194.4**	181.6	12.8	7%	
Financed by :					
Taxpayers' equity					
General Fund	**167.6**	154.8	12.8	8%	
Revaluation reserve	**26.8**	26.8	0.0		
Total taxpayers' equity	**194.4**	181.6	12.8	7%	

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Statement of Cash Flows for year ended 31 March 2019

	2018-19 £'m	2017-18 £'m	
Cash Flows from operating activities			
Net operating cost for the financial year	**(862.4)**	(833.5)	
Movements in Working Capital	**(27.6)**	6.6	Movement of £23m in year relates to Welsh Risk Pool Balances
Other cash flow adjustments	**56.8**	24.2	Non cash adjustments relating to depreciation and amortisation (£21m) and provisions for Welsh Risk Pool (£37m)
Provisions utilised	**(12.9)**	(8.2)	Welsh Risk Pool utilisation
Net cash outflow from operating activities	**(846.1)**	(811.0)	
Cash Flows from investing activities			
Purchase of property, plant and equipment	**(28.1)**	(17.4)	
Proceeds from disposal of property, plant and equipment	**0.0**	0.3	
Purchase of intangible assets	**(0.9)**	(0.2)	
Payment for other financial assets	**-**	(0.4)	
Proceeds from disposal of other financial assets	**-**	0.3	
Net cash inflow/(outflow) from investing activities	**(29.0)**	(17.4)	
Net cash inflow/(outflow) before financing	**(875.1)**	(828.4)	
Cash Flows from financing activities			
Welsh Government funding (including capital)	**874.1**	828.0	
Capital grants received	**1.0**	0.6	
Net financing	**875.0**	828.7	
Net increase/(decrease) in cash and cash equivalents	**(0.1)**	0.3	
Cash and cash equivalents (and bank overdrafts) at 1 April 2018	**1.5**	1.2	
Cash and cash equivalents (and bank overdrafts) at 31 March 2019	**1.5**	1.5	

Key Judgemental Areas

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Provisions

- Provisions, long term and short tem, total £67m as at 31 March 2019. Of this £65m relates to clinical negligence and personal injury claims. The £2m balance relates to CHC retrospective claims.
- This liability is offset by the Welsh Risk Pool asset held in long term and short term assets.
- For a provisions to be recognised in the accounts there must :
  - be a legal or constructive obligation as a result of a past event
  - it is probable that the obligation will be settled
  - a reliable estimate can be made of the obligation

Provisions as at 31 March 2019

£m's

	Opening Balance	Arising during year	Utilised during year	Reverese d unused	Transfer	Closing Balance
Short term	27.8	15.4	(11.7)	(10.3)	2.3	23.5
Long term	15.0	32.5	(1.2)	(0.5)	(2.3)	43.5
Total	**42.8**	**47.9**	**(12.9)**	**(10.8)**	**-**	**67.0**

CHC

- CHC Retrospective review claims provision of £2m is included within the overall provisions balance.
- The provision relates to care home fees that have been paid by individuals where the fee should have been paid by the NHS.
- Where the value of the claim is known, but payment has not yet been made, these are recorded within accruals.
- Where the actual settlement value is not yet known, an estimate based on the average value of claims processed, is made and recorded within provisions.

CHC Provisions - included within overall provisions figure

£m's

	Opening Balance	Arising during year	Utilised during year	Closing Balance
Short term	0.2	2.3	(0.9)	1.6
Total	**0.2**	**2.3**	**(0.9)**	**1.6**

Fixed Assets

- Fixed assets are measured initially at cost.
- Land and buildings are stated at their revalued amounts, being fair value at the date of revaluation. Revaluations are carried out every 5 years as part of the all Wales review.
- Plant and equipment are assessed every 3 years for impairment.
- Fixed assets are depreciated over their useful economic lives.

  Depreciations rates are as follows:

Land	Not depreciated
Buildings	35 years
Plant & machinery, furniture & fittings, IT	5 years

- Fixed assets are only recognised if
  - It is to be used to deliver services or for administrative purposes
  - It is probable that the economic benefit will flow to the HB
  - It is expected to be used for more than one year
  - Its cost can be measured reliably

Fixed Assets as at 31 March 2019

£m's

	Land	Buildings	Assets under construction	Plant & machinery	IT	Furniture & fittings	Total
Carrying value	26.2	195.5	22.1	12.8	8.5	1.1	266.2

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Implementation of International Financial Reporting Standard (IFRS) 16 Leases Accounting Standard
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas – Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rhian Davies – Assistant Director of Finance (Corporate Finance) / Eldeg Rosser – Senior Business Partner (Major Projects and Planning)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The report attached updates the Finance Committee on the steps being taken to prepare for the implementation of the International Financial Reporting Standard (IFRS) 16 Leases accounting standard.

The Finance Committee is requested to note the work being undertaken.

Cefndir / Background

IFRS 16 is a new accounting standard which will be effective from 1st April 2020.
It sets out the principles for the recognition, measurement, presentation and disclosure of leases and replaces previous accounting standards related to leases.

Under IFRS 16 items currently being leased and classed as revenue expenditure, which are not required to be disclosed on the balance sheet, will in future have to be classed as capital assets and accounted for on this basis.

Significant work is required to identify relevant contracts/regular financial payments in order for an assessment to be made as to whether they would be classified as capital items and placed on the balance sheet.

A task and finish group has been set up, in conjunction with key internal stakeholders, to monitor progress against an action plan.

Welsh Government will require Hywel Dda University Health Board's assessment of the impact of IFRS 16 by early August 2019 in order to understand the impact on capital expenditure and depreciation for 2020/21.

Asesiad / Assessment

An assessment has been completed to determine the work required to ensure the successful implementation of IFRS 16. A detailed action plan has been completed with responsibilities assigned against key individuals.

Currently, there is uncertainty around how the implementation of IFSR 16 will impact upon the Health Board Capital Resource Limit for 2020/21. Further work on the impact of IFRS 16 is being co-ordinated at an All Wales level by the Capital Technical Accounting Group.

Argymhelliad / Recommendation

The Finance Committee is requested to note the work being undertaken.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5 The Finance Committee will provide assurance, raising appropriate concerns and make recommendations to the Board as a consequence of the Committee's role in relation to short term focus, medium term focus and improving financial management
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	IFRS Publications Financial Reporting Advisory Board (FRAB) – guidance and publications
Rhestr Termau: Glossary of Terms:	IFRS – International Financial Reporting Standards
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Not Applicable

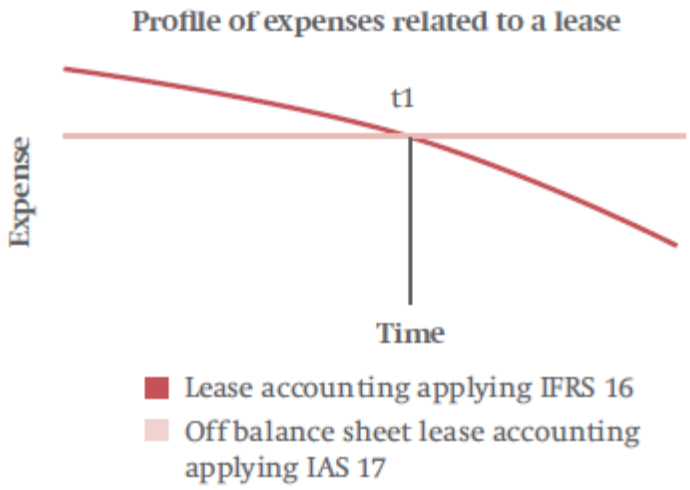
Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial impact of standard not yet identified.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not Applicable
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Implementation of IFRS 16 (Leases) accounting standard

Background

IFRS 16 is being applied by HM Treasury in the Government Financial Reporting Manual (FReM) from 1st April 2020.
IFRS 16 introduces a single lessee accounting model that results in more faithful representation of a lessee's assets and liabilities and, together with enhanced disclosures, will provide greater transparency of a lessee's financial leverage and capital employed.
IFRS 16 requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value.
Leases which were previously recognised as operating leases with a term greater than 12 months and not of low value e.g. the leasing of an item of equipment for 4 years at a fixed rate per annum will need to be recognised as a right of use asset on the Balance Sheet and will be depreciated on a straight line basis for the life of the lease term.
There will also be a lease liability. The reduction of the liability will be in two elements, interest and principal with the interest payment being front loaded. The impact of this is that the expense is higher at the start of the lease term, reducing as the lease term progresses, as opposed to a straight line expense currently.
The below diagram illustrates this impact:-



IFRS 16 does not provide a numerical threshold for what constitutes low value, however examples provided are:-

- Tablets and personal computers,
- Small items of Office furniture,
- Telephones.

Leases will need to be judged on a lease by lease basis, dependent on the individual value of the equipment and not the overall value of the contract. Even where the accounting treatment does not change they will still need to be captured on the lease registers with disclosures made.

Work required

1. Identify what records are currently in existence – lease registers and what information are recorded within them.
2. Review contracts to identify whether they contain a lease. Key questions to ask:
    a. Does a contract exist?
    b. Are you able to identify an asset? You will need to look beyond terms of contract to see if rights of use would ever be used.
    c. The right to obtain substantially all of its economic benefits – will need to look at length of lease not life of use
    d. Do you have right to direct its use?
3. Where contracts contain a lease the following information will need to be recorded if applicable:
    a. what is being leased – then identify if low value or not?
    b. length of lease period
    c. any fixed Payments associated with lease
    d. any incentives receivable
    e. any variance lease payments
    f. amounts payable under residual value guaranteed
    g. purpose Option
    h. penalties for termination
    i. lease modifications
    j. lease and service components of a lease – if clearly stated. Can opt to combine service and lease elements if too onerous (however this needs to be for a class of assets not on and individual asset basis).
4. Contracts may not be in existence for all leases, therefore it is suggested that a review is undertaken of regular transactions (for example monthly and quarterly payments.
5. Document and agree list of low value lease items. Decision to apply the exemption for low value assets is made on a “lease by lease” basis. The decision is based on the value of the individual asset and not the value of the lease contract –a lease of lots of low assets may be material but can be excluded under this exemption because each of the individual assets is of low value. It can only be of low value if it can be used on its own and it is not highly dependent or highly interrelated with other assets.
6. Brief non-finance stakeholders as to the upcoming change.
7. Undertake calculations which will enable you to work through the impact on the financial position. Discount Rate will need to be applied to the present value calculation (present value of lease payments plus present value of expected payments at the end of the lease). When unable to determine a discount rate, HM treasury will develop a central internal rate of borrowing for NHS bodies to apply. NHS bodies will be reliant on HM Treasury for the publication of the rates which may impact on understanding the full impact of a lease arrangement.

Proposed Action Plan

Number	Action	Key Responsible Person	Status	Start	End	Progress Update
1	Identify current lease registers and examine records held	Eldeg Rosser, Finance	Complete	March 2019	May 2019	Lease registers identified for Estates, Photocopiers and lease cars
2	Set up new lease register in required format	Eldeg Rosser, Finance	In Progress	01/05/19	15/05/19	
3	Review contracts, identify leases and record leases in lease register	Procurement / Estates	In Progress	May 2019	June 2019	
4	Identify relevant subjective codes to review payments / orders.	Eldeg Rosser, Finance	In Progress	May 2019	June 2019	
5	Engagement with Wales Audit Office regarding process undertaken and agreement of classification of low value items	Eldeg Rosser, Finance	Not yet started	July 2019	July 2019	
6	Review impact of IFRS 16 on financial position. Includes impact regarding Financial Plan and Discretionary Capital Programme.	Eldeg Rosser, Finance	Not yet started	July 2019	July 2019	
7	Calculate the DEL and AME (including IFRS 16 impacts)	Eldeg Rosser, Finance	Not yet started	August 2019	August 2019	
8	Brief non finance stakeholders as to the upcoming change	Finance Business Partners	Not yet started	September 2019	November 2019	
9	Review Impact on Financial Statements – SOCNE and Cashflow statement	Jennifer Thomas, Finance	Not yet started			
10	Review disclosure requirements for 2019/20 Statement of Accounts	Jennifer Thomas, Finance	Not yet started			

Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person

Defining Value-based Healthcare in the NHS

Centre for Evidence-Based Medicine Report 2019/04

Defining Value-based Healthcare in the NHS

Hurst L, Mahtani K, Pluddemann A, Lewis S, Harvey K, Briggs A, Boylan A-M, Bajwa R, Haire K, Entwistle A, Handa A and Heneghan C

CEBM, University of Oxford

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Foreword

Evidence-based medicine describes the need for *"the more thoughtful identification and compassionate use of individual patient's predicaments, rights, and preferences in making clinical decisions about their care."* [1] 1997 saw the Centre for Evidence-based Medicine publish both *Evidence-based Medicine, How To Practice and Teach It* [2] and *Evidence-based Healthcare, How To Make Health Policy and Management Decisions.* [3] The latter used the term ***value based healthcare*** for the first time in its second edition in 2001, [4] emphasising *"those who pay for healthcare will require that interventions are provided only when their outcomes give greater benefits than any other alternative use of resources."*

The Centre has, over the years, demonstrated and advocated against the potential harms of "too much medicine" [5] and poor regulation of treatments [6] and research. [7] It has used evidence to show where healthcare resources may be wasted (e.g., Tamiflu [8]) and costs could be saved (e.g. open prescribing [9]). All of these examples show how evidence can be used to increase value in the use of healthcare resources.

Shortly after the Centre was established, the election of the Tony Blair government in 1997 led to a decade of unprecedented growth in NHS investment. Decision makers found all the pressure was off. It was not until the culture change induced by the Lehman Brothers collapse in 2008 that population value became an explicit element in decision making.

Today, "*up-to-date decision-making in health care around the world*" must consider value as well as evidence. Evidence-based medicine and evidence-based healthcare have been two sides of the same coin for twenty years. So, too, are personal value and population value. Value for a population is determined by both the allocation and the use of resources to optimise health and minimise inequity. This report explores the key issues and brings together both evidence and value in decision making.

Sir Muir Gray
University of Oxford
2019

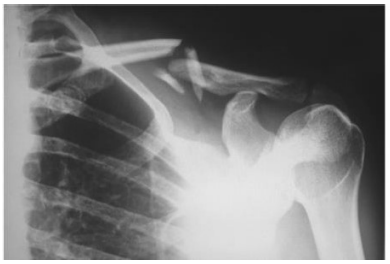
Table of Contents

Summary

'Value' is gaining prominence in healthcare systems facing increased demand for services with limited resources. However, value-based healthcare has not yet been embraced as part of the everyday language and business of the NHS in the way that evidence-based healthcare has.

The absence of an agreed definition of 'value-based healthcare' in the NHS, the lack of skills required to deliver value-based healthcare and a clear understanding of the barriers to effective development and implementation inhibits the health system in addressing problems such as overdiagnosis, too much medicine, poor allocation of resources and the introduction of inadequately evidenced technologies

This report sets out a route to defining value-based healthcare in the NHS, an assessment of the barriers to its development, and an understanding of what skills and training would support implementation. A stakeholder workshop informs the report with patients and leaders across the NHS and value sector.



Definition: Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person.

Seven Key recommendations

For patients and professionals in the NHS who are interested in increasing value at a local or national level:

1. Adopt a common terminology so that every person involved in healthcare, including patients, has a shared understanding of what value-based healthcare is.

2. Identify and communicate unwarranted variations in healthcare to every person, ensuring genuine transparency about why value-based healthcare is essential, and why realistic decisions based on the available resources are required.

3. Recognize and develop strategies to overcome barriers to implementing value-based healthcare at the individual, team and organisational level.

4. Build capacity and capability to translate and implement the best available research evidence into effective action to increase value.

5. Develop the necessary skills in value-based healthcare by training staff in how to measure outcomes, patient experience and resource use

6. Ensure programmes to increase value are monitored and evaluated to provide better evidence about what is and isn't effective

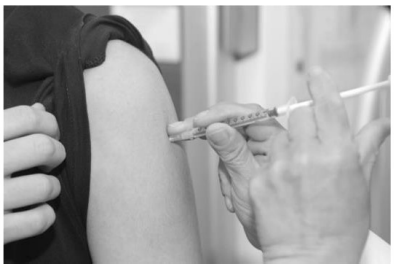
7. Facilitate better communication and dissemination about what works in increasing value at a local and national level.

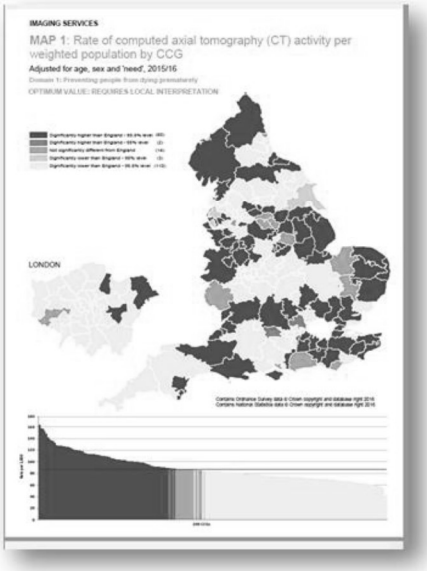
Why we need to consider value in healthcare?

The relationship between the resources used and outcomes achieved in healthcare is under greater scrutiny. Resources are increasingly outstripped by demand for healthcare, [10] driven by changing population demographics, innovation and new technologies, patient expectations and an increase in multi-morbidity [11]. Adding to this pressure to meet ever-increasing demands, the NHS is underfunded [12] and overstretched. [13] Yet, evidence suggested that resources are all too often wasted. [14]

Unwarranted Variations

"Unwarranted Variations" in healthcare describe differences in resource allocation, resource use or outcomes in health that aren't explained by patient preference or illness. [15]

In Clinical Commissioning Groups (CCGs) in England, the rate of CT investigations varied from 34 to 163 per 1,000 weighted population. A **4.6-fold** difference between CCGs.

It is currently not clear what the level of CT activity for a population should be, but both underuse and overuse of CT scanning could be harmful to patients (high doses of radiation are associated with CT scanning).

'The magnitude of variation for many of the indicators in this Atlas may surprise some people. In a context of evidence-based medicine and guidelines, how is it possible that the degree of variation in diagnostic testing is so great?'

The 2nd Atlas of Variation in NHS Diagnostic Services in England

Evidence that unwarranted variations exist in the NHS is set out in the NHS Atlas of Variation [16]]. Unwarranted variations are associated with overuse or underuse of health technologies and care. [17] Underuse and overuse of tests and treatments is a global phenomenon. [18] [19] [20] And while the NHS has mechanisms to protect against this; it is not immune. [21] Unwarranted variations in care exist, persist and affect all aspects of care. Lord Carter's review of the 'operational productivity and performance in English NHS acute hospitals' estimated that if we reduced unwarranted variation at least £5bn of the £55.6bn spent annually by acute hospitals could be saved. [22]

Unwarranted variations show where NHS resources might be wasted, where patients may be harmed through underuse or overuse of care and highlight opportunities to increase value.

CASE STUDY: Openprescribing.net, from the EBM Datalab, monitors patterns of prescribing for doctors, managers and anybody involved in the NHS in England to use. The research has identified that:

- NHS doctors in England are prescribing more and stronger opioids and that there are unwarranted geographical variations in the prescribing patterns of these drugs [23]
- Although doctors are generally prescribing fewer treatments from a list identified as "low value" by NHS England, the overall cost of prescribing them has increased and prescribing varies widely by treatment, geographic area and individual practice [24]
- The extent and speed of implementation of new prescribing guidelines on a group of antibiotics for England (aiming to limit increased antimicrobial resistance) varied across the country, by clinical commissioning group [25]

The Right Thing to Do

The NHS is a tax-funded resource and therefore has a moral obligation to use its resources as efficiently and effectively as possible. A survey of public attitudes found that for people who were dissatisfied with the NHS, the top three reasons given related to access and resourcing - 33 per cent identified waste as a reason. [26]

Furthermore, the NHS must address health inequalities in access and outcomes. And improving outcomes for patients presents opportunities for greater clinical stewardship in the management of resources. [27] Increasing value will reduce waste, improve health outcomes and reduce health inequalities with the available resources.

Why do we need to define value-based healthcare for the NHS?

Interest in value-based healthcare has increased significantly in the NHS with several high profile programmes set up to address unwarranted variations and their causes. For example, "Getting it Right First Time" [28] and "RightCare" in England. [29] "Realistic Medicine" in Scotland [30] and "Prudent Healthcare" in Wales [31] all aim to reduce waste and centre patients in decision making.

'Getting it Right First Time'	"A national programme designed to improve the quality of care within the NHS by reducing unwarranted variations." [32]
'NHS RightCare' in England	"The NHS RightCare delivery methodology is based around three simple principles of working with local systems; • Diagnose the issues and identify opportunities with data, evidence and intelligence • Develop solutions, guidance and innovation • Deliver improvements for patients, populations and systems" [33]
'Realistic Medicine' in Scotland	"Realistic medicine aims to improve care and treatment it offers by: • "Sharing decision making between health professionals and patients • Providing a personalised approach to care • Reducing harmful and wasteful care • Collaborative work between health professionals to avoid duplication and provide a joined up care package that better meets needs and wishes" [34]
'Prudent Healthcare' in Wales	"Healthcare that fits the needs and circumstances of patients and avoids wasteful care". "Any service or individual providing a service should: • Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production • Care for those with the greatest health need first, making the most effective use of all skills and resources • Do only what is needed, no more, no less; and do no harm • Reduce inappropriate variation using evidence-based practices consistently and transparently." [35]

But value-based healthcare is far from fully embedded in the NHS. Evidence suggests that the adoption of programmes to increase value to date has been piecemeal [36] and that their projected impact may have been exaggerated. [37] Case studies show that NHS Trusts seeking to increase value take different approaches which can vary from small innovations to whole scale systemic changes [38].

The NHS Constitution enshrines that 'The NHS is committed to providing best value for taxpayers' money' [39]. Yet, there is no agreed consensus on what defines value in the NHS and what "value-based" healthcare in this context means.

The most well-known definition of value is 'the health outcomes achieved per dollar spent'. [40] but this description has limitations in the context of universal healthcare systems funded through social insurance or taxation. Focusing only on funds spent on each patient's cycle of care does not take account of the available resources and how they are allocated across the whole population.

An essential component of value-based healthcare in the NHS must be the process of making judgements about the allocation and use of resources. At a national level, the NHS has systems of resource allocation in place, such as the National Institute for Health and Care Excellence (NICE) and a national formula to weight the distribution of financial resources. However, decisions about resource allocation are also required at an organisation and individual (patient) level. Daily value decisions are taken by NHS commissioners, managers and by clinicians, although they may not be recognised as such. NHS clinicians incorporate evidence about effectiveness into their decision making but do not yet routinely consider resource allocation and opportunity costs in their decisions. Any definition of value, therefore, must be applicable to, the range of stakeholders active in the system and take into account the role of resource allocation.

To address this, technical, allocative and personal aspects of value in the NHS have been described, [10] but each of these terms require further explanation to be clearly understood.

There are no consistent definitions of value or value-based healthcare in widespread use that are succinct and take into account that "resource use" in the NHS incorporates both the application and the allocation of resources to achieve health outcomes.

Engagement with value-based healthcare has not been as widespread in the NHS and research as might be expected, we believe in part because there is no clarity about what value-based healthcare means and how it applies to decision making. Further, the barriers to value-based healthcare are poorly delineated and understood, and there is a lack of clarity about the knowledge, skills and training required to develop and deliver value-based change.

Our approach

We invited a range of stakeholders with an interest and experience in healthcare value and the NHS (commissioners and providers, academics, patients, thank tanks and a healthcare value social enterprise) to a workshop to address these issues. Emerging themes were captured to answer three core questions:

1. What do we mean by value in the NHS?
2. What are the key challenges and barriers to value-based healthcare in the NHS? and
3. What skills and training are needed to deliver it?

1. Meaning of value in the NHS

"Resource Use" not **"Costs":** The term "costs" can have economic and negative associations. "Resource use" was preferred because not all "costs" are financial. Patient care can require the use of personal, societal and environmental resources. These examples highlight that resource use today, can have implications for future resource availability and demand. Resource use can also prove to be a positive process, for example, NHS staff are a high-value resource and making the best use of their time is more likely to provide job satisfaction and support their well-being.

Personal, societal and environmental resource use associated with healthcare

Personal (patient)	The burden of treatment, discrimination
Societal	Health and social care, the burden of care (for carers), loss of productivity, welfare and pension costs
Environmental	Carbon, pollutants

Focused on **Outcomes** not **Outputs:** Value should focus on outcomes that matter and make a difference to patients. Defining outcomes, reframing services to measure and prioritise outcomes that matter is essential to increasing value. Collecting data about experiences and outcomes has gained currency in the NHS in recent years, but a tendency remains for commissioners and providers to measure structures and processes rather than outcomes. [41] Measuring outcomes, though, comes with new challenges. For example, engaging with patients to identify outcomes that matter to them, and finding the resources to collect and analyse outcomes, which may occur sometime after clinical contact has ended require new ways of working.

Equity: Value in the NHS must take account of the inherent tension between individual patient and population needs. Obtaining value requires being "proportionate", "fair" and "equitable". Attaining value in systems with fixed available resource, therefore, requires judgements about the relative value of different interventions and technologies and their use across the population. Value-based decisions have wider social implications: a view supported by NICE, which describes two types of value judgements - social and scientific. [42]

Value represents a **relationship:** Value is a relationship between resources, outcomes and context. Focusing on only one part of this relationship, such as outcomes, will be insufficient to increase value in the NHS.

What do we mean by value-based healthcare in the NHS?

The value in a universal healthcare system relates the health outcomes and experiences achieved to the resources used in the context of the services provided and the population served. How we define and measure value, therefore, varies depending on the context. The emphasis should, therefore, be to define value-based healthcare and describe its most essential characteristics in a way that is meaningful to everyone, from individual patients to national organisations, and from prevention to end of life care. We propose that:

Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person.

"Equitable, sustainable and transparent"

✓ Resources are used to achieve better outcomes and experiences for every individual in the population in a way that is proportionate and fair. Value-based healthcare takes the wider impact of resource use and allocation into account, recognising that there are opportunity costs to resource use in the NHS and that healthcare has an important role to play in reducing health inequalities.
✓ The available resources are used in a way that will not compromise the availability of resources (financial and environmental) for the future.
✓ Judgements about resource allocation, resource use and about the outcomes and experiences that NHS organisations prioritise and measure are explicit, open and honest throughout the system. Transparency in decision making is part of the NHS constitution. The National Institute for Health and Care Excellence has demonstrated the importance of a transparent approach or "accountability for

reasonableness" in resource allocation decisions [43].

"Use of the available resources"

✓ The allocation and application of the resources that are available to the system, many of which may not be monetised, are defined and measured.
✓ Decision makers recognise that resource use in itself can be a positive outcome, contributing to, for example, staff well-being, the wider community and social and physical environments.
✓ The way that resources are allocated and applied is reported in a meaningful way and fed back into decision-making processes to improve evidence and justify the future investment, or changes to the investment of resources, including opportunity costs.

"Outcomes and experiences for every person"

✓ Definitions of the most important outcomes and experiences are available for the service being delivered.
✓ The most important outcomes and experiences for every person are defined by the needs and preferences of the patients, the public and society using the best available evidence.
✓ Outcomes and experiences are measured, reported in a meaningful way and fed back into decision-making processes to justify the future investment of resources, including opportunity costs.

2. The key challenges and barriers to value-based healthcare in the NHS

1.	**Better data:** The problems of defining, measuring and sharing data about resource use (including staff, patient and carer time) and outcomes and experiences that matter to patients are significant barriers to increasing value. The availability of data and analytical capability to measure both outcomes and resources offered by NHS organisations is currently limited.
2.	**Better evidence:** Understanding what works to increase value requires better evidence about what happens in the real world of the NHS, i.e. effectiveness, not efficacy. Knowing what works provides useful evidence to feed into decision making about resource use and allocation.
3.	**Describing the Journey to Value:** In the absence of whole-scale change, pragmatic approaches to increase value are happening across the NHS without a clear map. A step by step guide for programmes to increase value that is flexible to scale and focus would be helpful.
4.	**Multi-disciplinary Engagement:** Increasing value in practice must be multidisciplinary and involve all stakeholders, especially including patients. Multiple skills are needed, and many professional groups must be engaged. But value means different things to different people/stakeholders, and there are multiple perspectives at any one time.
5.	**A Value-based culture:** There is a need to unify language, culture and behaviour around value to gain currency in the NHS. Language about value is not socialised at board levels as 'normal'. There is a common misconception that programmes to increase value are simply looking for cost-efficiencies. Large-scale action to increase value in the NHS will require system-wide behaviour change, individual clinical behaviour change and culture change.
6.	**A Value-based System:** The culture of the NHS will need to change dramatically to focus on delivering value. Financial constraints, performance targets, staff burnout and competing priorities are identified distractors and barriers to successfully implementing value-based improvements. The absence of accountability, levers and incentives for value in a system with a collective "rescue" culture make it challenging to make value a priority.

CASE STUDY: Increasing Value in COPD Care

Aneurin Bevan University Health Board (ABUHB) has an annual budget of £1.1 billion and serves a population of over 600,000 people in South East Wales. Prevalence rates of Asthma and COPD in this area are similar to the Welsh average.

What was the value problem?

£17.3 million was spent on respiratory drugs in Gwent in 2014/15, of which £16 million was inhaled therapy for Asthma and COPD. 65% of this prescribing spend was on Inhaled Corticosteroids (ICS). Approximately 45% of ICS items were prescribed as high strength products. These patterns of prescribing appeared to be out of step with national guidelines for the management of Asthma and COPD and prescribing costs were disproportionately high. ABUHB still had a higher rate of admissions/ procedures for COPD and Asthma than other parts of Wales.

In 2014/15 Respiratory physicians, general practitioners, pharmacists, patients, third sector and finance colleagues collaborated to examine the available data, identify the main issues, understand the value problem by considering how resources were distributed across the system and develop solutions.

Between 2014/15 and 2016/17 ABUHB reduced respiratory prescribing spend by £1.3M. The proportion of high strength Inhaled corticosteroids prescribed decreased from 39% in 2014 to 23% in 2017.

A significant challenge faced by this project was the availability of data to understand the problem and to demonstrate an improvement in outcomes. For example, it was not possible to distinguish prescribing related to asthma from prescribing related to COPD and, at the end of the project, proxy indicators were used to assess outcomes. ABHUB have subsequently begun a programme to systematically measure patient-reported outcome measures and are now measuring outcomes in about 20 areas. This is only possible with the patient being central in the design and implementation of the systems which support the collection of PROMs.

3. Skills and training needed to deliver value-based healthcare

Common challenge	Skills and Training Gap
Better data:	- The analytical capability to define and measure health outcomes and experiences with patients in the national and local context. - The analytical capability to define and measure resource use in the national and local context. - Communication skills to disseminate information to NHS managers, healthcare workers, patients and the public.
Better evidence:	- Skills and knowledge to translate existing evidence into programmes to increase value, and to evaluate programmes designed to increase value. - Communication skills to disseminate new evidence from programme evaluations.
Describing the Journey to Value:	- The capacity to identify and prioritise 'value problems' (i.e. aspects of care in which value can be improved). - Knowledge synthesis to provide a guide to the process of increasing

	value that could apply at an organizational level or for smaller systems of care.
Multi-disciplinary Engagement:	- Training and skills development in value is needed for a range of different professional groups, from directors to managers to clinicians to finance people. - Effective communication skills to achieve "buy-in" from patients, the public and disparate groups of professionals.
A Value-based culture:	- Training in value-based healthcare, leadership skills, understanding culture, behaviour and the process of culture change to increase value.
A Value-based System	- Skills and knowledge in healthcare systems and their role in increasing value.

Conclusion

Improving health outcomes as a goal in itself is worthy but cannot be achieved at any cost in a health system with a fixed budget. Managing the use of financial resources is essential in a health service with budgetary pressures, but cost efficiencies can be misplaced. The relationship between health outcomes with resource use, resource allocation and context must be understood to make good decisions. A common language to articulate this relationship is needed, if value-based healthcare is to be embraced in the NHS. **We suggest that value-based healthcare is defined as the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences of care for every person.**

Implementing value-based healthcare will require system change and for new behaviours and culture to become the norm in the NHS. From on our analysis, we make the following recommendations for patients and professionals in the NHS who are interested in increasing value at a local or national level:

1. Adopt a common terminology so that every person involved in healthcare, including patients, has a shared understanding of what value-based healthcare is.
2. Identify and communicate unwarranted variations in healthcare to every person, ensuring genuine transparency about why value-based healthcare is essenital, and why realistic decisions based on the available resources are required.
3. Recognize and develop strategies to overcome barriers to implementing value-based healthcare at the individual, team and organisational level.
4. Build capacity and capability to translate and implement the best available research evidence into effective action to increase value.
5. Develop the necessary skills in value-based healthcare by training staff in how to measure outcomes, patient experience and resource use
6. Ensure programmes to increase value are monitored and evaluated to provide better evidence about what is and isn't effective
7. Facilitate better communication and dissemination about what works in increasing value at a local and national level.

The NHS England Long Term Plan, [44] Realistic Medicine in Scotland [30] and Prudent Healthcare [31] in Wales have all encouraged aspects of value-based healthcare in the NHS. However, value-based healthcare has yet to achieve the reach of evidence-based healthcare. Developing a common understanding of the meaning and implications of value-based healthcare, and developing the right skills and knowledge in the workforce will be essential to implementing it and delivering high-quality affordable care.

Declaration of interest:

LH is the module coordinator of a Postgraduate course in Healthcare Value, is developing a postgraduate certificate course in Healthcare Value and is the spouse of the Director of the Evidence-Based Medicine Datalab, used as a case study in this report. AP received grants from NIHR, from NIHR School for Primary Care Research, during the conduct of the report and occasionally receives expenses for teaching Evidence-Based Medicine. SL receives grants and non-financial support from ICHOM, grants from Abbvie, non-financial support from Janssen and non-financial support from ABHI outside the submitted work. AB has co-edited a textbook titled: 'Practising Public Health: A Guide to Examinations and Workplace Application' which includes discussions of principles of public health, such as value. CH has received expenses and fees for his media work, including BBC Inside Health. He holds grant funding from the NIHR, the NIHR School of Primary Care Research Evidence Synthesis Working Group (project 390), The NIHR Oxford BRC, and the WHO. The CEBM jointly runs the EvidenceLive Conference with the BMJ and the Overdiagnosis Conference with some international partners; these are based on a non-profit model. CH is Editor in Chief of BMJ Evidence-Based Medicine and an NIHR Senior Investigator Award.

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Julian Marks - PPI Contributor
Professor Jonathan Michie - President, Research Centre Director and Professor of Innovation & Knowledge Exchange, Kellogg College
Dr Tim Wilson - Managing Director, Oxford Centre for Triple Value Healthcare Ltd and Honorary Fellow, Nuffield Department of Primary Care Health Sciences, University of Oxford
And to
Sir Professor Muir Gray - Founding Director, Oxford Centre for Triple Value Healthcare Ltd and Visiting Professor in the Nuffield Department of Surgical Sciences at the University of Oxford

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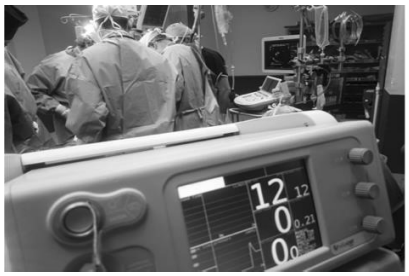
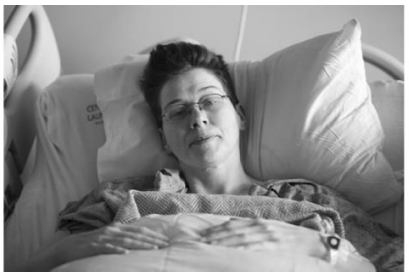


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PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Centre for Evidence Based Medicine Report – Defining Value-Based Healthcare in the NHS (2019)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Bowling, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The conversation around Value Based Healthcare (VBHC), as both a concept and practical way of working, has grown in recent years. Both organisations, including our own, and countries, including Wales, grapple with what this means for their population and services, as well as how to effectively implement.

The Centre for Evidence Based Medicine (CEBM) hosted a discussion, reported in the attached paper, which provided an overview of progress made across the UK. The reportidentifies definitions of key terms, highlights key barriers, and makes seven recommendations to increase Value.

This report is recommended to the Finance Committee as an overview and background of Hywel Dda University Health Board's (HDdUHB) financial role to effectively support the development of VBHC.

Cefndir / Background

The concept of VBHC is based upon the following:

- Bevan Commission: development of prudent healthcare since 2013
- Welsh Government: Healthier Wales: Plan for Health and Social Care 2018; specifically one of the quadruple aims: higher value health and social care
- HDdUHB strategy: A Healthier Mid and West Wales, Our Future Generations Living Well

Asesiad / Assessment

National strategy generates expectation of local and regional progress in implementing VBHC; representing a key organisational risk if progress is not made.

HDdUHB's VBHC strategy was agreed by Executive Board in November 2018. A VBHC Group was then established in January 2019 and chaired by Dr Phil Kloer, Medical Director and Director of Clinical Strategy.–The finance team are represented amongst the membership of this Group. In common with many other organisations, nationally and internationally, HDdUHB is at a relatively early stage in exploring and implementing VBHC.

This paper proposes that terminology, development of capacity and skills, communication throughout healthcare, and ongoing monitoring of effectiveness are all elements of effective VBHC delivery.

Argymhelliad / Recommendation
The Committee is asked to note the content of the report for information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5.2 Receiving assurances in respect of directorate performance against annual budgets, capital plans and the cost improvement programme and innovation and productivity plans.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	A respected institution, foreword by Sir Professor Muir Gray and participant Dr Sally Lewis, National Clinical Lead for Value-Based and Prudent Healthcare (Wales)
Rhestr Termau: Glossary of Terms:	Value-Based Healthcare (VBHC) Centre for Evidence Based Medicine (CEBM) aims to develop, promote and disseminate better evidence for healthcare. It is based in the Nuffield Department of Primary Care Health Sciences at the University of Oxford. [www.cebm.net]
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	As an overview of a key topic, there is no expected separable impact in and of itself
Ansawdd / Gofal Claf: **Quality / Patient Care:**	As an overview of a key topic, there is no expected separable impact in and of itself
Gweithlu: **Workforce:**	As an overview of a key topic, there is no expected separable impact in and of itself
Risg: **Risk:**	As an overview of a key topic, there is no expected separable impact in and of itself
Cyfreithiol: **Legal:**	As an overview of a key topic, there is no expected separable impact in and of itself
Enw Da: **Reputational:**	As an overview of a key topic, there is no expected separable impact in and of itself
Gyfrinachedd: **Privacy:**	As an overview of a key topic, there is no expected separable impact in and of itself
Cydraddoldeb: **Equality:**	As an overview of a key topic, there is no expected separable impact in and of itself

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 May 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update Report – Financial Efficiency Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rhian Davies, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance Committee will be aware that the Director General for Health and Social Care has implemented an Efficiency, Healthcare Value and Improvement Group. This Group has a wide-ranging brief to review and propose changes in practices, to secure better value healthcare, and to support health boards in maximising patient outcomes within the resources available across Wales.

As part of this work the Finance Delivery Unit (FDU) has been tasked with identifying opportunities to improve the efficient use of resources for health board consideration. All health boards – and in the near future Welsh NHS Trusts - are required to engage with this framework and incorporate the outcomes of the framework into their planning processes. The expectation is that better use of business intelligence will identify good practice and areas of variation and promote better use of resources. This will eventually become both an integral and routine part of health board management.

This report contains recommendations for Committee consideration of the work currently underway and the future proposed areas that Hywel Dda University Health Board (HDdUHB) concentrates its efforts upon to maximise the impact of this work.

Cefndir / Background

Colleagues within finance have been working with the FDU and NHS Benchmarking Network to identify opportunities to improve the financial performance of HDdUHB, to highlight variation, and to identify good practice. Members will recall that, earlier this year, a report was drafted which quantified the opportunities available to HDdUHB to improve financial performance. Much of the analysis for that report was subsequently used in the budget setting process; highlighting areas for improvement and catalysing other work to understand the reasons behind variation within and between health boards.

Since then, the FDU has expanded the Efficiency Framework to incorporate further areas of analysis on behalf of Directors of Finance. Procurement activity is now included on the forward

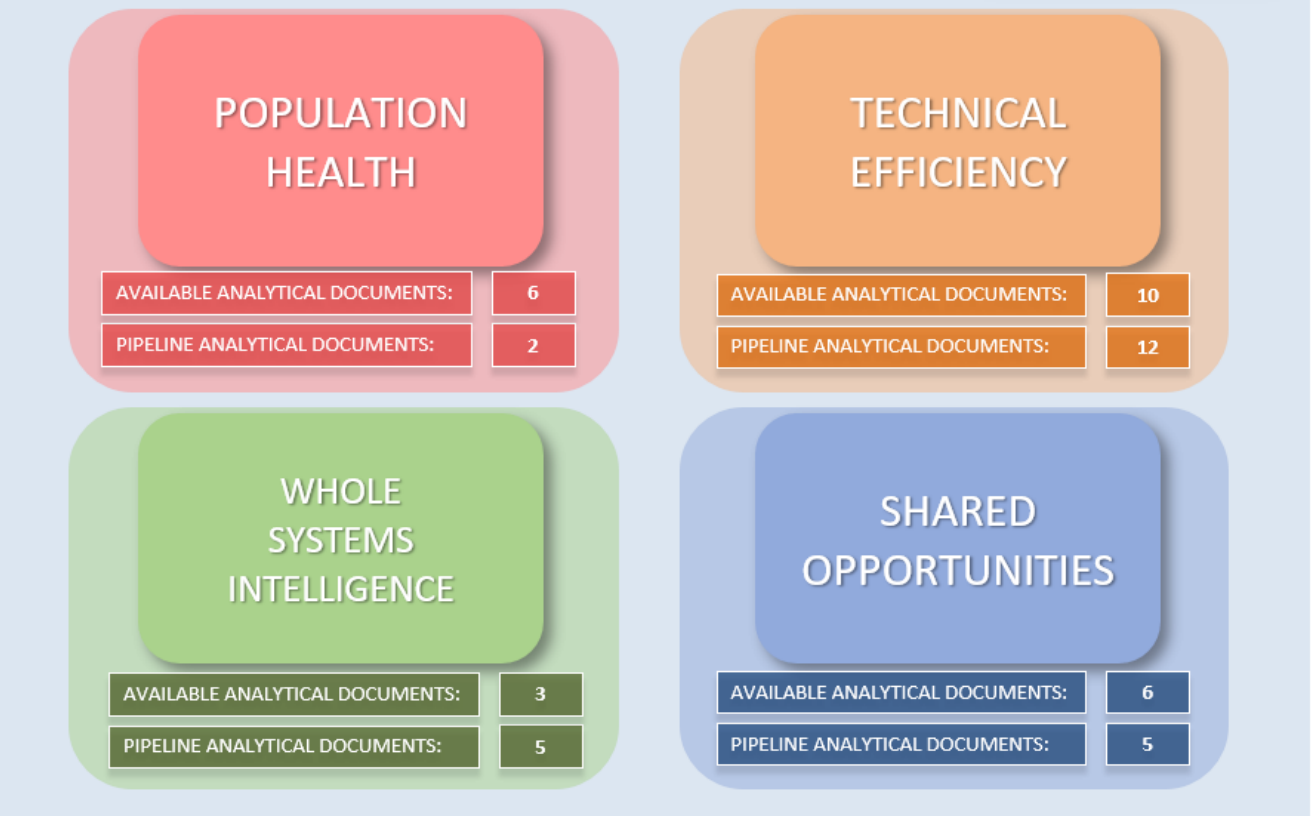
work programme, along with further areas of benchmarking not covered by the NHS Benchmarking Network, sources of strategic financial and technical intelligence, etc. HDdUHB has also developed further intelligence to highlight areas for investigation and improvement. This process will continue to be expanded and refined over the coming months.

Asesiad / Assessment

As noted in the report presented to Finance Committee in January 2019, a number of areas for opportunity were identified in advance of the budget setting process for 2019/20. At that point, opportunities totalling approximately £21m were quantified and scrutinised by Committee. Since then further analysis has been undertaken in a number of areas to supplement the original work.

Appendix 1 illustrates the areas that the FDU have examined since then. The majority of this work is refreshing analysis undertaken late last year and provides an up to date picture of the potential financial and operational efficiencies that were originally identified. To supplement this each health board has received bespoke reports on NHS Benchmarking–led opportunities, comparisons of central data sources such as the CHKS database, and summaries of health board savings plans resulting from the 19/20 planning round.

The themes adopted for further analysis are shown below:



Colleagues within finance are reviewing the updated and expanded data to ensure all opportunities are captured and considered. This work will be completed in Summer 2019 in readiness to inform the planning process for 2020/21 and beyond.

In addition to this analysis work is underway to quantify potential opportunities from the NHS Benchmarking Network. HDdUHB participated in a number of different benchmarking exercises over the last twelve months. Whilst work was undertaken, as a result of each individual benchmarking exercise, a bespoke report setting out key messages has been

commissioned by the FDU. This report greatly simplifies the task of targeting the areas of highest opportunity and the finance team is again working to convert the messages within that report into actionable opportunities for change.

In conclusion, recent changes to the finance team structure and responsibilities has allowed additional capacity to be created to focus on improving value across HDdUHB. Recent work undertaken by the team includes a review of orthopaedic pathways for total knee replacement; ongoing support for a review of respiratory medicine; assistance in reviewing procedures of low clinical value; and a review of activity and pathways within neurological services. It is expected that, as the capacity of the team to create further strategic business intelligence grows, more reviews such as these will be undertaken to support wider health board objectives.

Argymhelliad / Recommendation

- The Finance Committee is asked to discuss the approach adopted and note the work currently underway in advance of the 2020/21 planning round.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5.13 Developing and implementing a financial management improvement agenda across the organisation. 5.6 Subject to the Board's direction and approval, develop and regularly review the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting

	times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Various reports, returns, statistics etc – contact Chris.Williams10@wales.nhs.uk for further information
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct financial impact
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct quality impacts
Gweithlu: Workforce:	No direct workforce impacts
Risg: Risk:	Principal risk is not complying with the requirements of Welsh Government to properly incorporate the efficiency framework within health board policy and working practices.
Cyfreithiol: Legal:	No direct legal impacts

Enw Da: **Reputational:**	No public reputational impacts
Gyfrinachedd: **Privacy:**	No privacy impacts
Cydraddoldeb: **Equality:**	No direct equality impacts

NHS Wales Financial Efficiency Framework - update

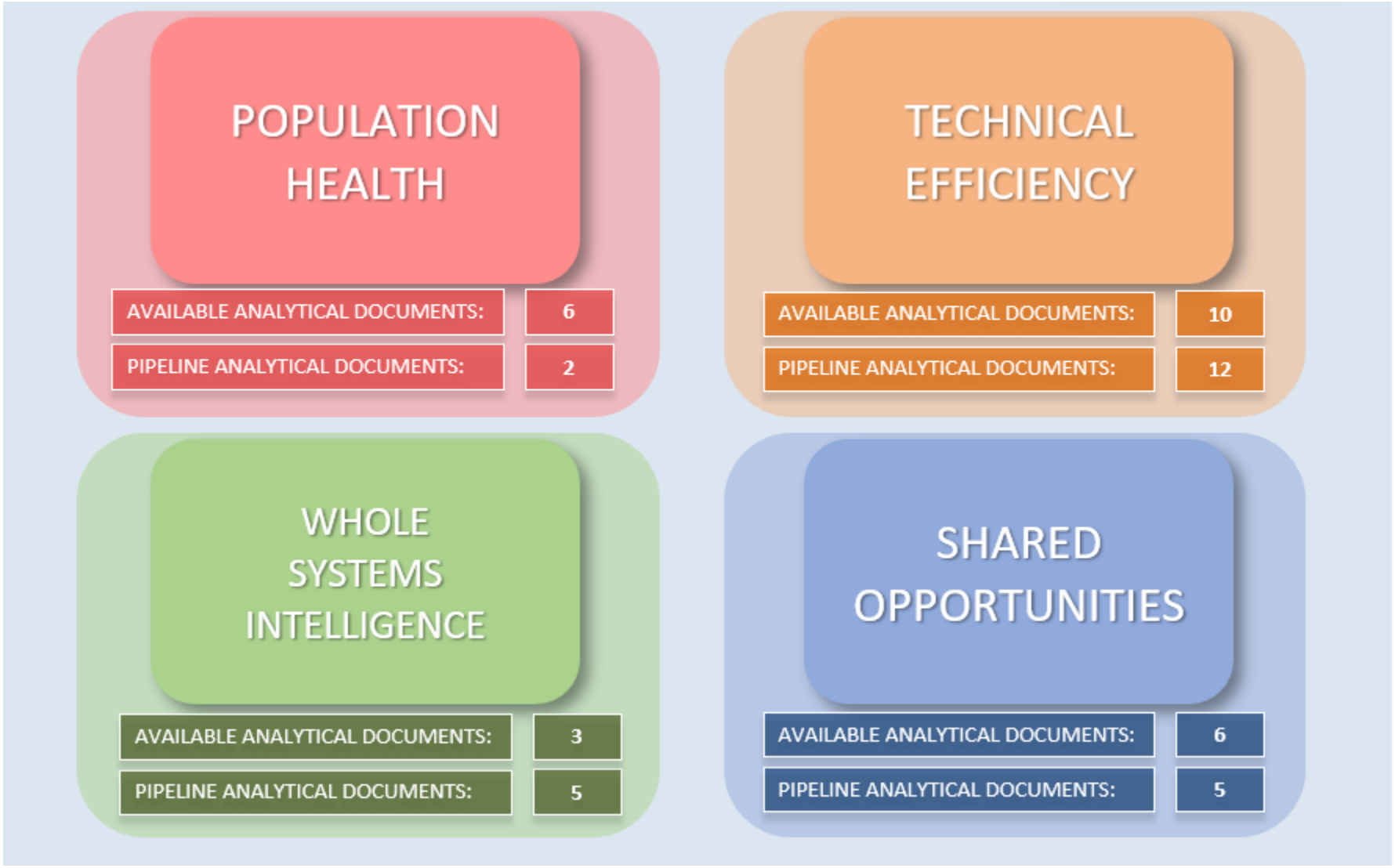
Efficiency, Healthcare Value and Improvement Group

- Established by Director General
- Membership - Directors of Finance
- Facilitated by Finance Delivery Unit
- Remit is to identify variation, share best practice and promote effective use of resources
- Expectation that health boards will consider all outputs from the group with a view to including in planning process

Efficiency, Healthcare Value and Improvement Group

- Original framework reviewed and opportunities identified for 19/20
- Perhaps not yet fully embedded
- Framework refreshed and expanded
- Significant work underway to identify areas of highest opportunity

Four themes


POPULATION HEALTH
AVAILABLE ANALYTICAL DOCUMENTS: 6
PIPELINE ANALYTICAL DOCUMENTS: 2
TECHNICAL EFFICIENCY
AVAILABLE ANALYTICAL DOCUMENTS: 10
PIPELINE ANALYTICAL DOCUMENTS: 12
WHOLE SYSTEMS INTELLIGENCE
AVAILABLE ANALYTICAL DOCUMENTS: 3
PIPELINE ANALYTICAL DOCUMENTS: 5
SHARED OPPORTUNITIES
AVAILABLE ANALYTICAL DOCUMENTS: 6
PIPELINE ANALYTICAL DOCUMENTS: 5

Examples of areas of investigation

Population health

LOW / LIMITED VALUE ACTIVITY	'Do Not Do' activity - identified using the flag developed by NWIS using NICE definitions. Analysis by provider, population, and trends over time.
	INNU activity - identified using OPSC codes. Analysis by provider, population, and trends over time.
RESPIRATORY HEALTH	RHIG Programme - Respiratory Variation Plans (align DDoFs / Efficiency Board)
REFERRAL VARIATION	Secondary Care referrals by specialty, GP practice, GP cluster vs norm
ACCESS VARIATION	ED repeat attendance volumes & variation
ACCESS VARIATION	New / Follow-up referral analysis by residency, GP practice per 1000 popn

Examples of areas of investigation

Technical efficiency

- In total, 49 separate areas
- Some areas still under construction
- Must be able to demonstrate we have fully considered all areas
- Intention to create a full report for Board consideration during planning round

- Additional strategic intelligence
- Based on HB returns, but also English Trusts
- Separate report for each health board setting out further potential improvements
  - 85 separate areas for Hywel Dda
- Highlights quality as well as financial opportunities, patient access etc
- Additional analysis underway to support directorates

NHS Wales Efficiency Healthcare Value & Improvement Group

Efficiency Framework Update

Sponsor:	
Contact:	**Finance Delivery Unit**
Who will present:	**Hywel Jones – Director, Finance Delivery Unit**

1. PURPOSE

1.1. This paper provides an update to the NHS Wales Efficiency Group as a standing item on progress to date with the implementation of the Efficiency Framework which has been developed to support the delivery of the efficiency and productivity improvement agenda within NHS Wales.

1.2. This paper is structured around 3 key themes with the purpose of enabling a discussion for each of these theme components, which are:

i. A progress update on the continued development of the Efficiency Framework over the last quarter, the pipeline of developments, and anticipated future Efficiency Group items.

ii. A progress update on the intended development of strategic financial intelligence and the anticipated work programme in this area, again to inform anticipated future Efficiency Group items.

iii. Detailed themes and headlines of four specific exercises which have been undertaken since the last Efficiency Group which include:

- Corporate Benchmarking
- Mental Health Benchmarking
- Ward Based Nursing Variation
- Procurement

1.3. Group members are asked to note and consider the update given for each of the 3 themes set out above, endorse actions proposed for future development and agree any suggestions for further improvement.

2. PROGRESS UPDATE – FRAMEWORK DEVELOPMENT

2.1 As outlined at the last Efficiency Group meeting the Efficiency Framework is live on the Finance Delivery Unit's share-point site, with access available to users in line with the Access Protocol agreed by Directors of Finance. Usage and access of the Framework itself is in the order of around 100 unique users a month for October and November 2018, with circa 500/600 visits across those users. Communication and awareness sessions and presentations continue to be delivered on an ongoing basis with recent activity including:

NHS Wales Efficiency Healthcare Value & Improvement Group

- Health Board IMTP Events
- HfMA National Conference
- Celtic Nations Conference – sharing best practice across NHS Wales, Scotland, and Northern Ireland
- Engagement with professional peer groups e.g. Directors of Nursing

2.2 Initial indications from engagement meetings indicate that the framework is being used and considered in the development of organisations 2019/20 IMTP's and operational plans. As part of the planning review process consideration will be given to plans developed by organisations, and high value opportunities assessments against opportunity areas within the framework as appropriate.

2.3 An agreed Case Study template approach developed in conjunction with the Finance Academy is now in use, for consistent application to support shared learning and knowledge of good practice delivery of improvement programmes. The spread and capture of case study templates is increasing as a communication and information tool to include areas such as best practice procurement, Bevan Exemplars, successful Invest 2 Save schemes, Celtic Nations best practice etc. Progress is incremental and it is expected that the development of a case study repository will take time however progress is being made.

2.4 Updated framework content which has either been completed since the last meeting of the Efficiency Group, or is in the process of being collated for inclusion in future weeks includes the four areas outlined above in section 1.2, and also includes:

- Updated Savings Plans comparison by organisations as at Q2 of 2017/18
- Completion of signposting to NHS Benchmarking network exercises and output
- Finalising the review of useful references and sign-posts to various evidence bases including NICE, Health Technology Wales etc.

2.5 Current planned activity for future months include:

- A refresh of the all-Wales CHKS report based on 2017/18, expanded for other relevant productivity indicators where appropriate

- Capture and review of the refreshed 2017/18 all Wales Estates and Facilities benchmarking

- Review of NHS Benchmarking Network outputs as exercise complete in 2018/19 including Mental Health, Theatres, Emergency Care, Planned Care

- Early comparison of organisation's savings proposals and plans going into 2019/20

- Clinical Services & HSDU benchmarking in response to a Health Board request

- Capturing and sharing pharmacy and prescribing intelligence and priorities as developed by the joint pharmacy and finance group

- Prioritising pipeline developments as requested by organisations as part of IMTP development moving into 2019/20, with an expected focus on workforce.

The outputs of the exercises described above will be structured for future Efficiency Group agenda items.

3. STRATEGIC FINANCIAL INTELLIGENCE - UPDATE

The Efficiency Group will be aware from previous papers to the Group that the development of financial intelligence to support this agenda would be focussed on two key priorities:

1. Developing a mechanism for capturing and sharing variation and opportunities for improvement, which has been progressed through the development of the Efficiency Framework

2. Developing better strategic financial intelligence through the intended integration of big data sets and macro level analysis of costs at a system, pathway, and population level.

Having established the Efficiency Framework, attention is turning to developing the second of these priorities, which is also an important consideration in the development of the Value Based Healthcare approach across NHS Wales. It is worth noting, that the availability and data capture of intelligence at a patient level and the potential for integrating this data to produce leading edge intelligence and analysis is significant.

Finance teams within organisations in NHS Wales are currently completing costing returns submissions on 2017/18 data. This process has been delayed this year due to the complexity and challenges of implementing a consistent single all Wales system across all Welsh provider organisations. Whilst this has resulted in implementation challenges the future benefits and potential intelligence that can be generated in a consistent manner going forward is significant. This includes the ability to compare to English organisations with greater consistency as costs are being produced in a manner which is consistent with the NHS England Costing Transformation Programme standards.

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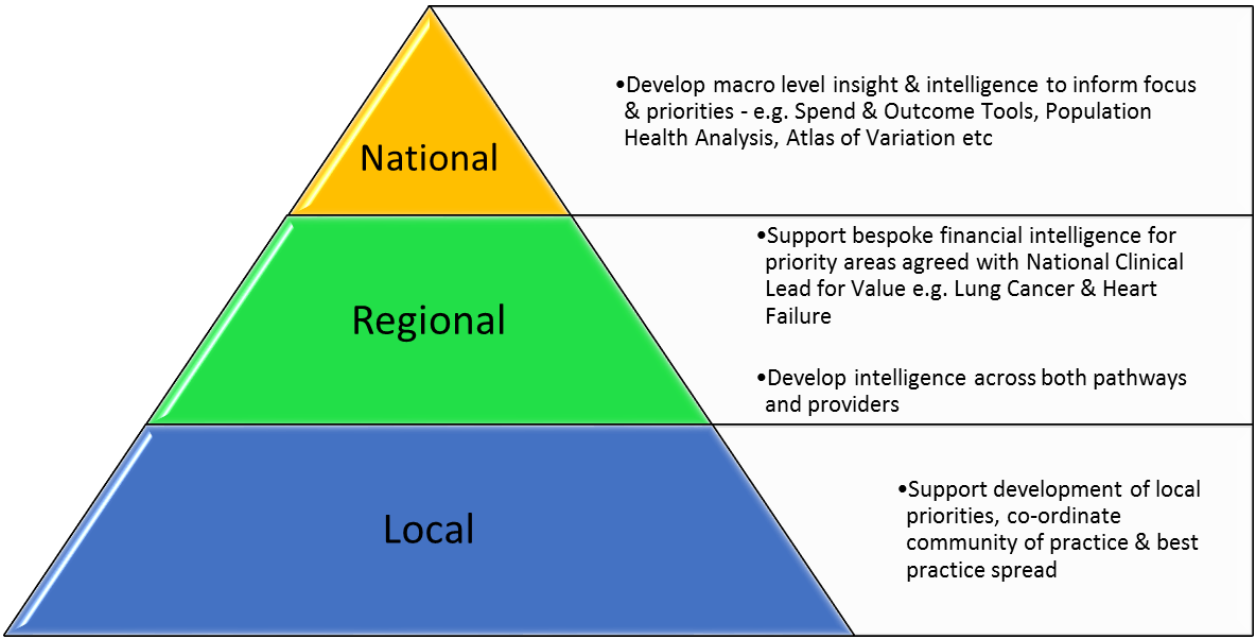
As an approach the development of intelligence is intended to be progressed at three levels as outlined visually below:



The approach to developing this intelligence will centre on:

- Developing intelligence and tools within the Finance Delivery Unit such as a Spend and Outcome Tool

- Continuing to utilise and develop existing intelligence produced on an annual basis through the Welsh Costing returns including programme budgeting, specialty costs, case-mix costs, patient level costing

- Exploring integrating Patient Level Cost data (which will be available across all providers for A&E, Outpatients, and Admitted Patient Care for 2017/18) with NWIS data-sets as a proof of concept as part of the National Data Resource programme to develop wider system intelligence

- Bespoke financial intelligence and support to organisations as the analytical capacity of the Finance Delivery Unit is enhanced.

- Exploring integrating Welsh provider data at a patient level with the NHS England Patient Level Costing Portal for greater comparability and benchmarks on a wider system and provider basis.

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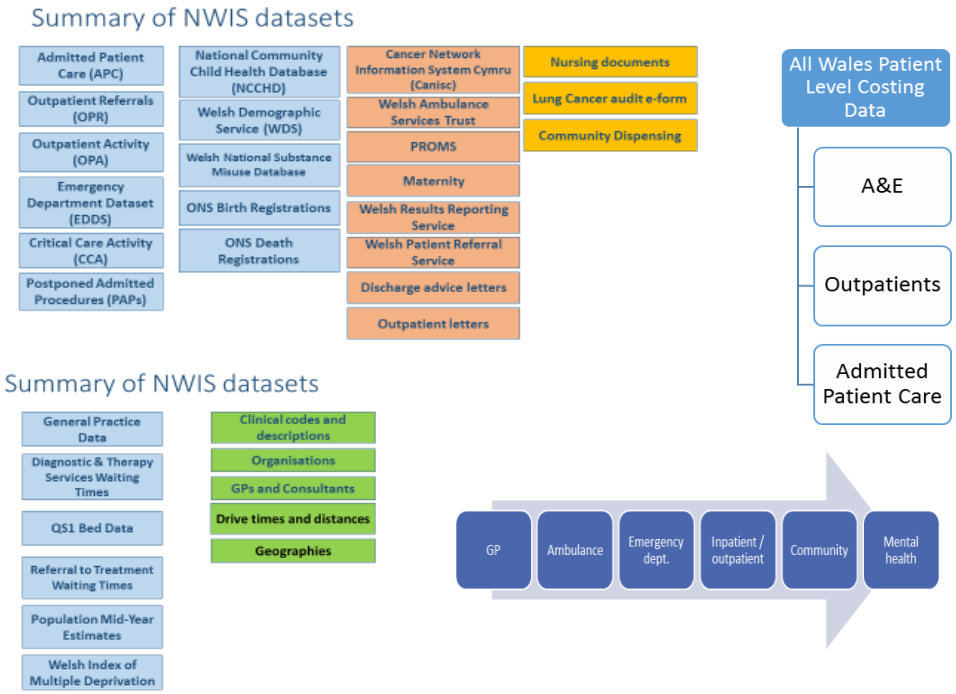
To illustrate, the following diagram outlines all of the potential data-sets that can be integrated to inform financial intelligence and cost variation down to a patient level.



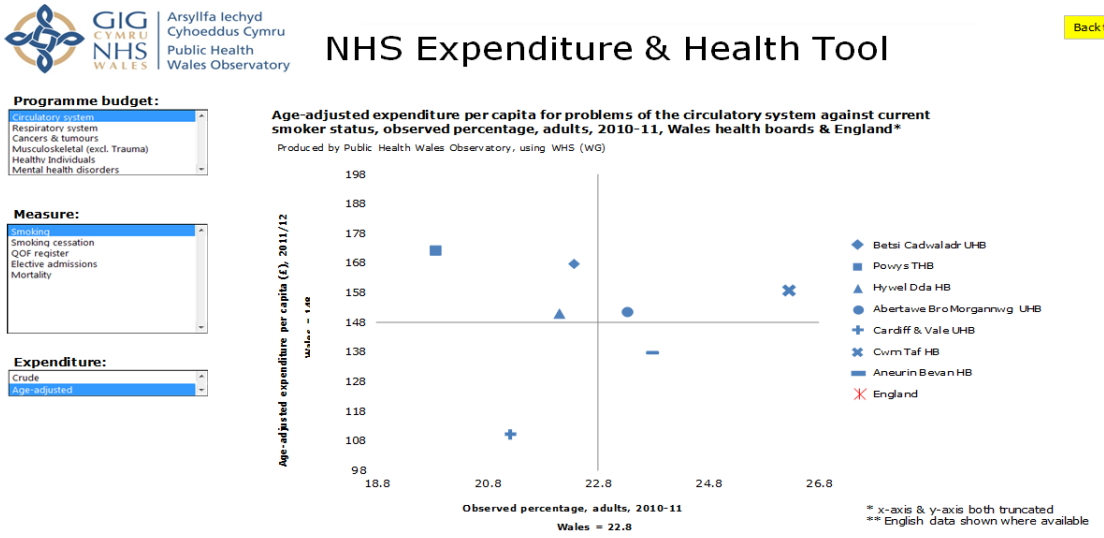
The anticipated financial intelligence that could be produced includes:

- Patient level cost by pathway, provider (across organisations)
- Costs to patient level by disease type, cluster, aligned to deprivation indices
- Alignment of cost and outcome data where captured at patient level
- Potential to align data with other products e.g. WCP, My Health Online
- Variation reports under-pinned by drill-down and evidence

NHS Wales Efficiency Healthcare Value & Improvement Group

As an illustration of the type of spend and outcome tool that can be developed, the chart below is of the NHS Wales Expenditure Tool which was previously produced by Public Health Wales based on 2011/12 data which aligned programme budget expenditure by 6 major disease categories with 43 published indicators and age-weighted population.

This chart as an example is based on 2011/12 data and reflects a system view of age adjusted expenditure per capita for circulatory system problems against current smoker status indicators



Age-adjusted expenditure per capita for problems of the circulatory system with selected indicators, Wales health boards & England

	Age-adjusted expenditure per capita (£)	Current smoker status, adults (1)	% of smokers treated by Stop Smoking Wales (2)	QOF CHD register, % of list size (3)	Elective hospital admissions, any mention of revascularisation (4)	Mortality from circulatory disease, under 75 (5)
Betsi Cadwaladr University	168	22.4	1.1	4.2	64.2	98.2
Powys Teaching	172	19.9	1.3	4.2	73.9	82.0
Hywel Dda	151	22.1	1.5	4.3	50.0	98.4
ABMU	151	23.3	2.3	4.2	51.0	102.1
Cardiff & Vale University	110	21.2	0.6	3.0	30.6	67.2
Cwm Taf	159	26.3	1.1	4.1	39.9	110.9
Aneurin Bevan	137	23.8	1.1	4.1	40.0	96.7
Wales	**148**	**22.8**	**1.3**	**4.0**	**48.9**	**94.3**
England	n/a	n/a	n/a	3.4	n/a	75.0

Source: (1) WHS (WG); (2) SSW, (3) PEDW (NWIS) & MYE (ONS), (4) StatsWales, England data from HSCIC; (5) ADDE (ONS) & MYE (ONS), England data from Mortality statistics & MYE (ONS)

Discussions are ongoing to develop a proposed toolkit and methodology, and the capacity and timescales to deliver those proposals and intelligence.

The Efficiency Group are asked to note and consider this development which will be taken forward by the Finance Delivery Unit and NWIS, in recognition that the successful development of such intelligence and products will then feature as part of future Efficiency Group agenda items once developed.

NHS Wales Efficiency Healthcare Value & Improvement Group

4. EFFICIENCY FRAMEWORK FOCUS AREAS

In recent months as noted in the previous update to the Efficiency Group, priority has been given to specific benchmark and variation exercises which have been requested by Health Boards and are significant areas of expenditure where further intelligence on variation would be beneficial to inform future plans.

The four areas of focus are:

- Corporate Benchmarking
- Mental Health Benchmarking
- Ward Based Nursing Variation
- Procurement

Where the exercise is a new and bespoke area of work, the approach has consistently been as follows:

- Agreeing a clear approach and data-set
- Each organisation completing the data gathering exercise facilitated by the efficiency framework sub-group representative
- Outputs consolidated and shared with organisations for validation
- Output finalised and made available with a product which is easy to use and variation metrics outlined

4.1 Corporate Benchmarking

At the request of a Health Board an exercise has been completed on benchmarking the workforce elements of the corporate functions of Finance, HR, Planning, Performance, and Information & IT.

Organisations who participate in the Efficiency Framework are the 7 Health Boards and WAST, and this exercise therefore is captured for those 8 organisations. Some comparators are focussed on the 6 larger health boards given the effect the relative size of Powys and WAST can have on the analysis.

This exercise was informed by the approach taken to an NHSI benchmarking exercise undertaken across Foundation Trusts in England, but amended for appropriate use within a Welsh context (for example, excluding the benchmarking of services which are delivered within a shared services environment within Wales but by provider organisations within NHS England).

The exercise was based on:

- 2017/18 outturn
- Actual wte for March 2018
- Categorisation of cost and wte by sub-function (e.g. for finance this included financial services, devolved financial management, financial planning, etc.)

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- Excluding Director costs, with £ and wte captured by grade of staff
- An agreed definition and categorisation of the staff and roles that should be categorised in each sub-function to ensure comparability
- For planning & performance the exercise captured corporate functions only, where organisations have fully devolved performance teams in divisional management functions these were not considered

Metrics derived include:

- Cost and WTE per function in absolute terms and as % of turnover
- The equivalent cost and wte by sub-function
- Opportunity value by organisation to quartile and median position – easily identified through a drop-down analysis within the toolkit

At a summary level the exercise indicates:

- Notable variation in spend and wte of staff working in various functions across organisations as a proportion of turnover
- Variation in skill-mix and banding in a number of areas

	AB	ABM	BCU	CT	CV	HD
	£,000	£,000	£,000	£,000	£,000	£,000
Turnover	**1,263,247**	**1,410,608**	**1,693,556**	**763,046**	**1,369,268**	**906,328**
Finance Staff Spend	**£ 5,178**	**£ 4,266**	**£ 5,515**	**£ 2,398**	**£ 4,336**	**£ 3,099**
Finance % of turnover	0.41%	0.30%	0.33%	0.31%	0.32%	0.34%
HR Staff Spend	**£ 4,290**	**£ 3,259**	**£ 4,602**	**£ 4,616**	**£ 3,751**	**£ 5,234**
HR % of turnover	0.34%	0.23%	0.27%	0.60%	0.27%	0.58%
Planning/IT/Performance/Information staff spend	**£ 8,891**	**£ 5,433**	**£ 8,231**	**£ 4,641**	**£ 6,403**	**£ 4,793**
Planning/IT/Performance/Information staff % of turnover	0.70%	0.39%	0.49%	0.61%	0.47%	0.53%
Total Staff Spend of Benchmarked Functions	£ 18,359	£ 12,958	£ 18,348	£ 11,655	£ 14,490	£ 13,126
% of Turnover	**1.45%**	**0.92%**	**1.08%**	**1.53%**	**1.06%**	**1.45%**

High level themes and areas of variation and inquiry by corporate function are as follows:

Finance

- Variation in cost of finance function per £100m turnover across the 6 larger Health Boards ranging from £302k within ABMU to £410k within Aneurin Bevan Health Board

- Variation in WTE / £100m turnover ranging from 6wte within ABMU to 8.4wte within Aneurin Bevan Health Board

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- Notable variation within wte deployment across functions e.g. across central and devolved financial management, as outlined in the table below

Sub Function / Metric		WTE by Sub-Function							
		AB	ABM	BCU	CT	CV	HD	POWYS	WAST
Financial services	*WTE of Sub-Function*	**27.0**	**19.4**	**39.9**	**15.2**	**23.2**	**17.9**	**4.1**	**5.0**
	WTE per 100m Turnover	2.1	1.4	2.4	2.0	1.7	2.0	1.3	2.5
Central financial management	*WTE of Sub-Function*	**12.6**	**23.5**	**13.6**	**10.1**	**6.9**	**2.2**	**1.7**	**3.0**
	WTE per 100m Turnover	1.0	1.7	0.8	1.3	0.5	0.2	0.6	1.5
Devolved financial management	*WTE of Sub-Function*	**39.9**	**21.7**	**54.6**	**10.1**	**39.5**	**25.5**	**11.5**	**9.2**
	WTE per 100m Turnover	3.2	1.5	3.2	1.3	2.9	2.8	3.7	4.7
Financial Improvement	*WTE of Sub-Function*	**7.4**	**9.2**	**6.0**	**5.8**	**3.5**	**7.0**	**3.3**	**0.7**
	WTE per 100m Turnover	0.6	0.7	0.4	0.8	0.3	0.8	1.1	0.3
Commissioning	*WTE of Sub-Function*	**8.2**	**4.0**	**16.8**	**4.7**	**5.3**	**5.0**	**6.9**	**0.0**
	WTE per 100m Turnover	0.6	0.3	1.0	0.6	0.4	0.6	2.2	0.0
Financial Planning	*WTE of Sub-Function*	**6.1**	**4.2**	**0.8**	**7.4**	**9.1**	**5.6**	**0.8**	**0.7**
	WTE per 100m Turnover	0.5	0.3	0.0	1.0	0.7	0.6	0.3	0.3
Capital Planning	*WTE of Sub-Function*	**2.2**	**1.0**	**0.9**	**0.0**	**1.6**	**4.0**	**1.0**	**0.7**
	WTE per 100m Turnover	0.2	0.1	0.1	0.0	0.1	0.4	0.3	0.3
Graduate Trainees	*WTE of Sub-Function*	**3.2**	**2.0**	**2.0**	**1.0**	**2.0**	**1.0**	**0.0**	**1.0**
	WTE per 100m Turnover	0.3	0.1	0.1	0.1	0.1	0.1	0.0	0.5

- Skill mix – Qualified / Total Staff compliment ratio – ranging from 20% within BCU to 54% for Aneurin Bevan

Qualified & Technician Staff		Cost per WTE by Sub-Function							
		AB	ABM	BCU	CT	CV	HD	POWYS	WAST
Qualified	*Headcount*	**61**	**37**	**30**	**25**	**37**	**20**	**11**	**8**
Studying	*Headcount*	14	8	8	4	11	11		4
Unqualified	*Headcount*	**32**	**38**	**81**	**13**	**33**	**26**	**12**	**4**
AAT	*Headcount*	7	2	33	17	17	15	3	7
Total	*Headcount*	**114**	**85**	**152**	**59**	**98**	**72**	**26**	**23**

HR

- Variation in the cost of the function per £100m turnover ranging from £272k BCU to £605k Cwm Taf

- Variation in WTE / £100m turnover ranging from 6.4wte within Aneurin Bevan to 17.3wte within Cwm Taf

- Variation in the average cost per wte ranging from £30k within Cardiff & Vale to £45k within Aneurin Bevan

- The most significant variation in wte by sub-function is within Education & OD functions ranging from 8.8wte within Aneurin Bevan to 63.9wte within Cwm Taf – this needs to be understood further.

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- The table below outlines wte by sub-function by organisation:

Sub Function / Metric		WTE by Sub-Function							
		AB	ABM	BCU	CT	CV	HD	POWYS	WAST
Core HR	*WTE of Sub-Function*	**37.0**	**39.9**	**20.8**	**31.1**	**36.8**	**9.1**	**7.3**	**24.4**
	WTE per 100m Turnover	2.9	2.8	1.2	4.1	2.7	1.0	2.4	12.4
Occupation Health & Wellbeing	*WTE of Sub-Function*	**15.9**	**17.4**	**31.9**	**14.1**	**30.8**	**15.5**	**4.5**	**10.8**
	WTE per 100m Turnover	1.3	1.2	1.9	1.9	2.3	1.7	1.4	5.5
Recruitment	*WTE of Sub-Function*	**21.0**	**1.9**	**3.7**	**6.8**	**5.4**	**35.0**	**2.4**	**0.0**
	WTE per 100m Turnover	1.7	0.1	0.2	0.9	0.4	3.9	0.8	0.0
Workforce & Staffing	*WTE of Sub-Function*	**13.1**	**16.6**	**39.2**	**16.4**	**19.7**	**29.2**	**10.8**	**6.9**
	WTE per 100m Turnover	1.0	1.2	2.3	2.1	1.4	3.2	3.5	3.5
Education & Organisational Development	*WTE of Sub-Function*	**8.8**	**15.0**	**25.6**	**63.9**	**34.2**	**52.5**	**1.0**	**24.8**
	WTE per 100m Turnover	0.7	1.1	1.5	8.4	2.5	5.8	0.3	12.6

Other Corporate Functions

- Notable variation in costs and wte per £100m turnover, recognising however the material impact of non-pay in these areas, and the potential impact of functions within devolved management structures which may be variable across organisations.

- The table below outlines wte by sub-function by organisation for other corporate functions

Sub Function / Metric		WTE by Sub-Function							
		AB	ABM	BCU	CT	CV	HD	POWYS	WAST
Planning	*WTE of Sub-Function*	**14.6**	**30.8**	**32.1**	**14.8**	**27.6**	**9.8**	**6.1**	**3.9**
	WTE per 100m Turnover	1.2	2.2	1.9	1.9	2.0	1.1	2.0	2.0
Performance	*WTE of Sub-Function*	**3.0**	**1.0**	**9.0**	**25.3**	**19.9**	**16.8**	**1.0**	**5.6**
	WTE per 100m Turnover	0.2	0.1	0.5	3.3	1.5	1.9	0.3	2.9
Information	*WTE of Sub-Function*	**17.3**	**20.5**	**35.1**	**18.0**	**22.4**	**60.5**	**18.2**	**22.4**
	WTE per 100m Turnover	1.4	1.5	2.1	2.4	1.6	6.7	5.8	11.4
IT	*WTE of Sub-Function*	**109.0**	**66.0**	**116.7**	**44.5**	**56.8**	**58.7**	**5.0**	**22.9**
	WTE per 100m Turnover	8.6	4.7	6.9	5.8	4.1	6.5	1.6	11.6

4.2 Mental Health Benchmarking

At the request of a Health Board an exercise was undertaken on benchmarking Mental Health services. Recognising the data collection for the national Mental Health NHS Benchmarking Network exercise had already been recently undertaken, through the Efficiency Framework Sub-Group all Welsh organisations data across key areas were collated and analysed to identify notable variation in key areas across Welsh Health Boards only.

Since this exercise the NHS Benchmarking exercise has been completed and will allow Health Boards to have a wider comparator outside of a Welsh only context.

From a Welsh perspective there is notable variation across Health Boards in:

NHS Wales Efficiency Healthcare Value & Improvement Group

- Bed capacity per 100k population
- Average length of stay in both adult and older adult services
- Staff resource per adult and older adult in-patient services
- Staff sickness rates for both adult and older adult services.
- Levels of bank and agency usage
- Costs per bed

Of note community contacts is not captured routinely on an All Wales basis which impacts on the potential assessment of system capacity as a whole

For Adult Acute Mental Health services:

Acute Adult						
Metrics	AB	ABM	BC	C&V	CT	HD
Adult Acute Beds per 100,000 registered pop	15.39	16.33	15.28	15.63	16.35	12.94
length of stay excl leave	11.00	23.00	30.00	32.00	21.00	28.00
Adult Acute Nurses per 10 beds	11.01	7.46	8.96	9.98	7.24	8.82
Adult Acute Staff Sickness / Absense	8.0%	8.2%	7.2%	5.0%	12.3%	6.1%
Bank & Agency Spend as % of total staff spend	20.1%	9.0%	20.0%	12.4%	25.5%	11.5%
Cost Per Bed	£ 84,831	£98,107	£118,641	£ 97,267	£89,805	£146,051

- Bed numbers per 100,000 registered population have a variation range of 26%
- Average length of stay excluding leave variation from 11 days to 32 days
- 52% variation in nurse wte per 10 beds
- Notable variation in sickness absence from 5% to 12.3%
- Cost per bed variation from £84k to £146k

For Older Adult Mental Health services:

Older Adult						
Metrics	AB	ABM	BC	C&V	CT	HD
Older Adult Beds per 100,000 registered pop	13.59	14.81	10.86	15.63	11.56	11.40
length of stay excl leave	52	73	90	130	59	83
Older Adult Nurses per 10 beds	8.48	5.13	9.42	7.08	8.28	7.17
Older Adult Staff Sickness / Absense	6.00%	7.45%	10.11%	6.90%	8.02%	7.96%
Bank & Agency Spend as % of total staff spend	17.0%	15.9%	33.5%	17.5%	8.5%	7.3%
Cost Per Bed	£103,415	£56,380	£140,860	£ 108,598	£92,415	£ 96,920

- Bed numbers per 100,000 registered population have a variation range of 43%
- Average length of stay excluding leave variation from 52 days to 130 days
- 84% variation in nurse wte per 10 beds
- Notable variation in sickness absence from 6% to 10.1%
- Cost per bed variation from £56k to £140k

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4.3 Ward Based Nursing

Ward Based Nursing data has been collated from all Health Boards across Wales, with a focus on all hospital based ward areas (excluding Obstetrics/Maternity, A&E, and Assessment Units). At initial collection, this has led to the collection of data from 421 wards across Wales as follows:

Total Wards								
Ward Type	**ABMU**	**C&V**	**Cwm Taf**	**Hywel Dda**	**Powys**	**BCU**	**AB**	**Grand Total**
Community	2		10	4	10	14	15	55
Critical Care - Adult	1		2	3				6
Critical Care - Paeds		2						2
Learning Disabilities	11						7	18
Medical	29	23	12	25		23	18	130
Mental Health	27	20	11	10			13	81
Paediatric	5	2	4	4				15
Surgical	21	18	12	13		18	20	102
Tertiary		12						12
Grand Total	**96**	**77**	**51**	**59**	**10**	**55**	**73**	**421**

The data collection involved the capture of key metrics for each of these ward areas within the Health Boards in Wales, including detail of core Registered nursing hours within rosters, bed numbers, predominant shift patterns and allocated allowances for both Registered Nurses and Health Care Support Workers. The data-set gathered at each individual ward level is as follows:

Ward Based Nursing Exercise Content	
Site	Establishment uplift RGN/HCSW
Ward Type	RGN/HCSW Ratio
Sub-Specialty	Supernumerary levels ward sisters / charge nurses / managers
Bed Numbers	WTE per bed excl. ward manager
Ward / Bed Variation e.g. NIV	Current ward vacancies
Predominant Shift Pattern	
Core Roster Hours	

The initial data collection was summarised, with key themes presented by the Finance Delivery Unit to Directors of Nursing on the 23rd of November. Emerging themes from the draft data includes:

- Variation in the predominant shift patterns rostered by wards and Health Boards
- Variation in allocated uplift for Health Care support workers across Wales
- Site based variation.
- Variation in wte per bed by specialty, and core rostered hours within ward types for 28 bed wards

Next Steps

At the November meeting it was agreed that the data by individual organisation would be shared with Directors of Nursing for final validation. Complete and validated submissions have been agreed to be returned to the Finance Delivery Unit by Friday 7th December 2018.

The validated data will be re-summarised and shared with Directors of Nursing with a follow-up planned for January 2019 to consider key themes and variation highlighted for review.

The next steps in identifying and progressing any variation and opportunities by organisation identified within the data will be for determination by each Health Board.

Further to this initial assessment, other approaches and metrics to support the review and assessment of ward based nursing will be reviewed for consideration and potential use within NHS Wales as appropriate led by Directors of Nursing and supported by the Finance Delivery Unit. For example, this would consider the potential development and metrics such as Care Hours per Patient Day which has been developed in NHS England as a part of the Carter Reviews and work programme.

4.4 Procurement

In recent months the Finance Delivery Unit has been supporting Procurement colleagues in developing a framework for sharing evidence and intelligence for procurement variation and opportunities for improvement.

The agreed structure of the intelligence that will be captured within the Efficiency Framework is to capture:

- Evidence Based Procurement & National Projects

This section of the framework will capture the outputs and opportunities identified from the Evidence Based Procurement Board and central sourcing opportunities

- Traditional Procurement

This section of the framework will capture the outputs and opportunities through all Health Board procurement leads sharing the big ticket procurement savings opportunities being progressed within individual Health Board plans, supported by case studies where appropriate. This will also include opportunities being addressed through collaborative procurement.

- Value Based Procurement

This section of the framework will capture the development and opportunities associated with Value Based Procurement

NHS Wales Efficiency Healthcare Value & Improvement Group

An output for the Evidence Based Procurement & National Projects element has been finalised and agreed with Procurement, and will be made available through the framework. The traditional procurement and Value Based Procurement aspects of the framework remain in development and will be finalised and shared when complete.

The approach described above, will capture known opportunities and improvements in 2018/19 as a start point, and will be updated on an ongoing basis as 2019/20 plans and future opportunities work develops.

Evidence Based Procurement

In relation to Evidence Based Procurement & National Projects, the current evidence and opportunities for improvement are as follows:

Trocars

The opportunity for improvement in relation to the procurement of Trocars has been subject to previous papers to the Efficiency Group. A national review of trocar utilisation and spend was undertaken, which led to the establishment of a new national procurement framework for trocars.

The new framework provides an initial unit cost reduction for organisations that switch to the preferred product and two further saving opportunities of:

- 10% if Wales purchases 60% of its trocars from the preferred supplier
- 20% should the overall purchase increase on an all Wales basis to 70%.

The following table outlines the saving opportunity by organisation based on expenditure over the most recent 12 month period from 1st November 2017 – 31st October 2018

Health Board	Total Spend (£)	Product Switch Saving (£)	Bulk Discount Saving - 10% Opportunity (£)	Bulk Discount Saving - 20% Opportunity (£)	Maximum Saving Opportunity (£)
Aneurin Bevan UHB	**259,052**	134,406	12,465	24,929	159,336
Abertawe Bro Morgannwg ULHB	**225,739**	82,541	14,320	28,640	111,181
Betsi Cadwladr ULHB	**221,897**	30,499	19,140	38,280	68,778
Cardiff and Vale ULHB	**181,174**	37,876	14,330	28,660	66,536
Cwm Taf UHB	**122,551**	14,629	10,792	21,584	36,213
Hywel Dda UHB	**110,132**	8,114	10,202	20,404	28,518
Powys Teaching LHB	**620**	88	53	106	194
Grand Total	**1,121,165**	**308,153**	**81,301**	**162,602**	**470,755**

The two outlying Health Boards not maximising the opportunity through switching are Aneurin Bevan and ABMU Health Boards.

It should be noted that Cardiff & Vale's opportunity gain is off-set by the potential pressure that would be incurred through moving away from the current supplier given the wider organisational contract in place with that supplier.

NHS Wales Efficiency Healthcare Value & Improvement Group

For Hywel Dda and Cwm Taf Health Boards the saving opportunity is largely as a result of the all Wales discount that would be received if ABM & Aneurin Bevan switched in line with the all Wales approach.

Hips

The area of hip replacement continues to pose a challenge in relation to reducing national variation. The situation is complex and concerns variation beyond choice of implants. An update paper on this topic was shared with the Efficiency Group at its meeting of June 2018 outlining the picture remained variable in relation to standardisation across NHS Wales's providers.

An in depth Time Driven Activity Based Costing (TDABC) exercise is being explored to inform the national picture and together with outcome measurement will shape the national strategy in 2019. A high level exercise was conducted to assess the 'size of the prize' available to justify further work in this area based on price comparisons alone and the following table underlines the need for further detailed work.

HEALTH BOARD	POTENTIAL SAVING IF HB STANDARDISED TO LOWEST COST HIP PROSTHESES WITHIN CURRENT HB PORTFOLIO	ADDITIONAL POTENTIAL SAVING PER HB IF STANDARDISED TO LOWEST COST HIP PROSTHESES ON A NATIONAL LEVEL	TOTAL POTENTIAL SAVING PER HEALTH BOARD
ABMU	£106,757	£101,926	£208,683
Aneurin Bevan	£187,026	£149,710	£336,736
BCU	£107,488	£147,219	£254,707
Cardiff & Vale	£31,506	£44,518	£76,023
Cwm Taf	£50,843	£99,174	£150,017
Hywel Dda	£117,523	£54,827	£172,350
TOTALS	**£601,143**	**£597,373**	**£1,198,516**

The HB savings detailed in the above table are based on the lowest prices current available via the All Wales Framework Agreement. The additional 'All Wales' potential savings figures, based on National Standardisation, are based on the lowest prices available in the UK market (researched via the Purchase Price Index Benchmarking tool).

LIPUS

Following the NICE Interventional procedures guidance on Low Intensity Pulsed Ultra-Sound (LIPUS) and a review of current evidence, the Evidenced Based Procurement Board agrees with NICE recommendations that LIPUS should not be used on fresh fractures, and should only be used on delayed-union and non-union fractures as part of an audit or research programme. There is an expectation therefore that usage will be eradicated within NHS Wales unless it is part of a formal research or audit programme. This would result in an expenditure reduction of circa £0.2m per annum based on expenditure in the first 6 months of 2018/19.

NHS Wales Efficiency Healthcare Value & Improvement Group

Health Board	2016/17 £	2017/18 £	6 months 2018/19 £	Forecast 2018/19 £
ABUHB	127,500	-	21,250	42,500
ABM	67,500	42,500	25,000	50,000
BCU	137,686	52,711	19,550	39,100
CT	18,900	35,398	11,875	23,750
C&V	32,040	22,950	16,200	32,400
HD	20,496	12,810	15,372	30,744
Total	**404,122**	**166,369**	**109,247**	**218,494**

Antimicrobial Wound Dressings

An advice statement was issued in October 2018 by Evidence Based Procurement Board in relation to Antimicrobial Wound Dressings following the consideration of a number of Healthcare Technology Assessments and recommendations from the EBPB expert advice group. Evidence Based Procurement Board advice states:

1. Antimicrobial dressings should not routinely be used on non-infected acute and chronic wounds;
2. Antimicrobial dressings should be considered only when there are clinical signs or symptoms of localised infection, or where localised infection is suspected as a cause of non-healing. They should not be used to treat MDRO (multi drug resistant organism) colonised wounds which do not fall into this category;
3. Antimicrobial dressings should only be recommended/prescribed by specialist staff (for example tissue viability nurses or specialist podiatrists) as designated by the Health Board or Trust. Their use requires regular review of the requirement for AWDs by the clinician;
4. To ensure appropriate control and use of antimicrobial dressings, the EBPB *AWD Recommendations and Algorithm* should be adopted by Welsh NHS organisations

There is an expectation that considered and controlled use of AWDs in line with these recommendations will results in significantly reduced spend on unnecessary and ineffective interventions.

The expenditure landscape is complex with expenditure being incurred through direct prescribing, ordering via Oracle, and direct ordering with the company (e.g. ONPOS). Work is ongoing to establish the spend in AWDs through direct ordering, and the expenditure below relates to what is captured through CASPA data (Prescribing) and Oracle only.

NHS Wales Efficiency Healthcare Value & Improvement Group

Expenditure on this basis by organisation, and per head of population, is as outlined below:

Health Board	2013 £	2014 £	2015 £	2016 £	2017 £	2018* £
ABUHB	296,737	343,975	384,369	271,610	149,672	109,650
ABM	427,185	409,736	275,561	218,866	191,215	189,182
BCU	438,063	405,947	361,849	299,652	196,076	124,731
CT	185,906	172,253	171,731	198,069	229,711	181,499
C&V	404,480	453,140	270,915	217,756	195,722	163,779
HD	176,976	163,653	149,473	136,663	157,902	100,717
Powys	44,902	34,380	44,905	38,610	46,322	46,682
Total	**1,974,250**	**1,983,083**	**1,658,803**	**1,381,226**	**1,166,620**	**916,240**

* Expenditure based on calendar years

** 2018 expenditure based on full year projection from actuals to end of September 2018

Health Board	2013 £	2014 £	2015 £	2016 £	2017 £	2018* £
ABUHB	511	593	662	468	258	189
ABM	817	783	527	418	366	362
BCU	631	585	521	432	283	180
CT	628	582	580	669	776	613
C&V	839	940	562	452	406	340
HD	461	426	389	356	411	262
Powys	338	259	338	291	349	352

* Cells highlighted reflect a spend per head increases on prior years

It is clear that significant progress has been made in reducing expenditure in recent years, which is more notable in some Health Boards. This may represent an opportunity for continued improvement for some organisations.

Future Evidence Based Procurement Board Programme

The following list of Topics are either in the current EBPB work programme or are expecting completed Topic Referral Forms in the near future:

- Cardiac Stents
- DACC Coated dressings
- Atraumatic needles for diagnostic lumbar puncture
- TAVI valves
- Spinal implants

The section of the efficiency framework outlining the above detail also includes the relevant topic referral forms, guidance and evidence, and contact details for further information or clarification on any of the above issues.

NHS Wales Efficiency Healthcare Value & Improvement Group

5. SUMMARY

The Efficiency Group is asked to:

- **Note** the further progress made in developing the Efficiency Framework
- **Note and agree** priorities for future months actions, the outputs of which will be timetabled to future months Efficiency Group agenda's
- **Note** the intended progress and outline in developing strategic financial intelligence over future months
- **Consider** and **agree actions** on the specific Efficiency Framework exercises undertaken in recent months in relation to Corporate Benchmarking, Mental Health Benchmarking, Ward Based Nursing, and Procurement

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Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Health Board & Trust Chief Executives

10 January 2019

Dear all

Efficiency, Healthcare Value, and Improvement Group – Efficiency Framework

At the December meeting of the National Efficiency, Healthcare Value, and Improvement Group meeting, the board received an update paper from the Finance Delivery Unit on progress with the development of the Efficiency Framework. You will be aware from the session at NHS Executive Board on 17th July 2018 that the Framework is being developed on behalf of Directors of Finance in supporting the National Efficiency Group and organisations to progress the delivery of this agenda across NHS Wales. I have attached a copy of the Efficiency Board paper to this letter.

Our discussion at the meeting followed the structure of the paper, considering and noting:

- progress to date, and the current efficiency framework work programme;
- the planned development of further strategic intelligence to inform future analysis and insight;
- a review of specific outputs and focus areas of recent months

In the context of "A Healthier Wales", there must now be greater progress in understanding and addressing variation with the consistent application and implementation of best practice across the system. I expect to see a significant increase in the level of consistent engagement and application of the efficiency framework by all organisations going forward, in support of the development and delivery of local plans. It is clear that a significant amount of information and intelligence is available and I am expecting to see this feature within organisations plans for 2019/20 as a minimum, and on a routine basis going forward.

I also expect organisations to use this approach as an opportunity to progress and influence any areas where specific benchmarking through this framework would be useful and beneficial for you to explore in developing new plans going forward. Participating organisations to date are all seven Health Boards and WAST, and I have asked Hywel Jones of the Finance Delivery Unit to liaise with other organisations to now join the framework process and supporting arrangements.

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Specific items were considered at the meeting which require your consideration and action at organisational level. These include:

- Corporate benchmarking – it was recognised that this exercise remained in progress due to the varying level of validation which has taken place across organisations. This exercise will be finalised in January 2019, and the output and relative position of each organisation is for local understanding and application as to how this informs future plans in this area. However, there is an expectation that there will be a greater consistency in how best practice models are implemented across these areas by organisation. Future further reviews in this area will be expected to capture the change in best practice implementation which will have taken place.

- Mental Health – the analysis undertaken through the framework considered Welsh Health Board submissions to the NHS Benchmarking Network exercise and Welsh Health Board only analysis. It is clear that specific Health Boards have some material variation in specific areas. There is an expectation that there is an acceleration in the strategic transformation of services for those organisations to address these opportunities in 2019/20 plans.

- Ward Based Nursing – the Finance Delivery Unit is working with Directors of Nursing to produce a ward based nursing data-set across all hospital based ward areas within NHS Wales and intelligence on key metrics. A final output will be shared and considered with Directors of Nursing at their January peer group meeting. The consistent application of, and compliance with the Nurse Staffing Act by organisation is an essential requirement which is a given as a baseline position. Any material variation identified through this exercise therefore needs to be understood locally, and any improvement potential taken forward as appropriate through 2019/20 plans within that context.

- Procurement – four specific areas and issues with an opportunity value to NHS Wales of circa £2m were considered as follows:

  Trocars – There remains a £0.5m opportunity to NHS Wales in relation to the procurement of Trocars under the national procurement framework. This was a source of frustration to the group that this opportunity remained available given previous work and correspondence in this area. The two outlying Health Boards not maximising this opportunity through switching currently are ABMU, and Aneurin Bevan Health Boards. It should be noted that part of this opportunity relates to a further price discount which would benefit all organisations once the all Wales purchase in totality is greater than 70% on an all Wales basis. I expect to see this issue addressed now as part of 2019/20 plans. If this cannot be achieved, I'm expecting a response outlining the issues by 31st January 2019.

  Hips – There remains a £1.2m opportunity based on lowest prices available via the All Wales Framework agreement. It is expected that progress is made in this area as part of 2019/20 plans, which includes further progress in implementing the agreed Hip Prosthesis guidance agreed on an all Wales basis and maximising the opportunity in this area.

  LIPUS – The Evidence Based Procurement Board has reviewed and considered this area and supports the NICE recommendation as outlined in the paper considered at the meeting. There is an expectation therefore that usage will be eradicated within NHS Wales unless it is part of a formal research or audit programme as part of 2019/20 plans.

Anti-microbial dressing – Advice has been issued in October 2018 by the Evidence Based Procurement Board in relation to Antimicrobial Wound Dressings following consideration of expert advice. There is an expectation that considered and controlled use of Anti-microbial dressings in line with these recommendations will result in reduced expenditure on unnecessary and ineffective interventions. Where some progress has been made in some organisations, it is anticipated that should this remain an opportunity for improvement that this is progressed through 2019/20 plans.

The Efficiency Framework is a useful toolkit to identify variation and opportunities for improvement which need to be maximised in the context set out above. If there are any reasons why any of these issues and areas highlighted above cannot be progressed then please let me know.

In addition to expecting to see progress on the specific areas identified in this letter, I have asked Hywel Jones for a regular update on these actions, and more broadly for the Finance Delivery Unit to bring a detailed update to each Efficiency, Healthcare Value, and Improvement Group meeting on a quarterly basis of both the specific focus themes to allow consideration of the improvement potential in theme areas, and also to more broadly consider the most significant top 5 areas of improvement potential by organisation and as a whole system. I will write to you following each meeting going forward with any specific issues to take forward in this manner on an ongoing basis.

Yours sincerely

Dr Andrew Goodall CBE

Copied to:
Alan Brace, Director of Finance HSS, Welsh Government
Hywel Jones, Director, Finance Delivery Unit
Simon Dean, Deputy Chief Executive, NHS Wales,
Mark Roscrow, Director, NWSSP

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Health Board & Trust Chief Executives

Our Ref: AG/HJ/SB

5 April 2019

Dear Colleagues

Efficiency, Healthcare Value, and Improvement Group – 15th March 2019

I wrote to you in January 2019 outlining my expectations in relation to the National Efficiency, Value, and Improvement Group going forward, both in terms of the level of engagement with the Efficiency Framework by organisations, and also how the national group would continue to support this agenda. It has been helpful to receive some correspondence from Swansea Bay University Health Board outlining their local arrangements which mirror the national arrangements, and some of the deliverables which have been achieved in 2018/19 through this approach, which may be a useful blueprint for other organisations to follow.

The agenda and papers for the recent March 2019 meeting of the National Group are attached for information. Our discussion and agreed actions against each of the agenda items reflected the following:

On the Ground Educator Programme Lymphedema - You will be aware of my expectation that the system would proactively own and implement this development which is an excellent example of best practice, with the potential to deliver quality improvement, and financial savings across the system. As a result it is expected that this features as part of Health Board's 2019/20 plans. If Health Boards cannot demonstrate progress locally with this development I was clear in my expectation that this would be something that I would fund centrally to ensure we make progress, and this would be funded through the top-slicing and subsequent retention of savings delivered through implementation. I would rather organisations locally own this development. Gary Doherty as the CEO representative on the Group agreed to follow up with CEOs for clarity on the agreed Health Board approach for 2019/20, and I look forward to receiving confirmation of the outcome of those discussions.

CHKS Productivity & Efficiency Improvement - We received the report from CHKS which was commissioned by Welsh Government in conjunction with the Finance Delivery Unit on the 2017/18 performance position on a number of productivity and efficiency indicators across Health Boards, in comparison to English peer groups. It is clear as outlined in the reports that there continue to be a number of significant areas for improvement, and the clear expectation is that organisations make progress with these opportunities in the development of 2019/20 plans. Opportunities for addressing

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variation are clear from a patient experience, quality, safety, and financial perspective. Material opportunity values by organisation, and the progress being made against these, will feature as part of future organisational planning and delivery discussions.

The group also noted that the variation in performance by Health Boards in clinical coding completeness of Admitted Patient Care records resulted in a delay in the timeliness of this report. The lack of progress in some Health Boards with the minimum requirements for coding completeness is a concern, and improvement is expected in 2019/20 to support improvements in the timeliness in this type of assessment going forward.

Estates & Facilities Benchmarking - A report on the outputs of the Estates & Facilities Benchmarking exercise for 2017/18 was received from Shared Services, highlighting a wide variation across Health Boards and service area. However, this needs to be seen in the context of a requirement for a clear local estates strategy, improvement and maintenance plans, and the correlation in areas of investment and increased expenditure with other quality issues e.g cleaning standards and delivering improvements in infection control. Whilst some variations are understood on this basis, there are other areas which require clear understanding and attention by Health Boards on a local basis. This exercise is undertaken on an annual basis, with potential for wider benchmarking with NHS England, therefore this area requires attention on an ongoing basis to maximise the benefit of this approach.

Postponed Procedures - There is a significant opportunity to deliver improvements in patient experience, reduced elective waiting times, and financial improvement through improved management of postponed procedures across our system. Whilst acknowledging that not all postponed procedures would result in a missed theatre slot, the group focussed on the significant opportunity to improve short notice postponements, which equated to 2,797 procedures in the month of December 2018 alone. There are a range of reasons for postponement, and whilst this requires understanding and progress at specialty and local health board level, I have asked Andrew Sallows to lead a central Task & Finish Group to explore best practice and opportunities for improvement in this area to determine the range of actions which can be taken to deliver a significant improvement in this area prospectively. Addressing the reasons and level of postponement can support better care, capacity for RTT and avoid additional financial spend.

All Wales Catering System Review – You will be aware that this area has been subject to previous scrutiny by the Public Accounts Committee, as an area of strategic improvement for NHS Wales. There is good evidence from NHS Scotland on a standardised system being implemented nationally with demonstrable benefits to patient experience and savings. An All Wales framework has been developed, with a range of financial opportunity across organisations. I expect that organisations that have a material saving opportunity will be taking this forward, if this is not being progressed I need confirmation of why that is the case.

Lung Cancer Outcome Dashboard - Dr Sally Lewis presented an output of the recently developed Lung Cancer Outcome dashboard for NHS Wales, developed from a wide range of data sources as a proof of concept using a Microsoft Power BI reporting dashboard. The dashboard will become available in the near future and organisations are expected to engage in the rich data and insight this intelligence tool will provide. Future developments include integrating cost and outcome data, and developing the same approach to a small number of key clinical specialties. The work being progressed on a national basis to support the Value Based Healthcare agenda has the potential to make a significant difference to the system, and is an area where NHS Wales is at the forefront of this agenda on an international basis. We need to capitalise on this opportunity as a real point of difference for NHS Wales and I encourage you to engage directly with this work programme, and ensure outcome capture is a key priority for each Health Board in 2019/20.

I am expecting the opportunities for improvement which are highlighted within these items to be progressed and maximised by individual health boards, and system wide opportunities such as the On the Ground Educator Programme for Lymphedema to feature consistently as part of agreed system wide plans in 2019/20. If there are any reasons why any of these issues cannot be progressed then please let me know.

Yours sincerely

Dr Andrew Goodall CBE

cc: Alan Brace, Director of Finance HSS, Welsh Government
Hywel Jones, Director, Finance Delivery Unit
Simon Dean, Deputy Chief Executive, NHS Wales,
Andrew Sallows, Delivery Programme Director

Enw'r Pwyllgor / Name of Committee	Finance Committee
Cadeirydd y Pwyllgor/ Chair of Committee:	Michael Hearty, Associate Member
Cyfnod Adrodd/ Reporting Period:	Meeting held on 25th April 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

The Finance Committee has been established to advise the Board on all aspects of finance and the revenue implications of investment decisions. Hywel Dda University Health Board's (HDdUHB's) Finance Committee's primary role is, as such, to provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation.

This report summarises the work of the Finance Committee at its meeting held on 25th April 2019, with the following highlighted:

- **Finance Report Month 12** – the Month 12 Finance Report was presented to Committee. The Committee was advised that the Health Board's financial position at the end of Month 12 stood at £35.4m, an improvement on the year-end forecast of £35.5m. The Health Board also over-achieved on the expected savings delivery position by £0.2m in March.

- **Turnaround Report Month 12** – the Month 12 Turnaround Report was presented to Committee. The Committee took an assurance from the Holding to Account (HTA) scrutiny processes in place to recognise any non-recurrent and savings efficiencies. The Committee noted that receipt of the accountability letters and noted the organisations growing maturity in dealing with the risks involved and The Committee was assured that where risks are identified, mitigating actions must be articulated.

- **Finance Committee Annual Report 2018/19** – the Finance Committee Annual Report was presented to the Committee. The Committee endorsed the Finance Committee's Annual Report 2018/19, for onward submission to the Board on 29th May 2019 for approval.

- **Establishment Control** – The Establishment Control report was presented to Committee. The Committee was informed of the detail of the roll-out plan with confirmation received that the data collected is being actively reviewed by the Director of Workforce & OD, the Director of Nursing, Quality and Patient Experience and the finance team. Additionally, the data presented relating to rosters provides a forward look at the status at a ward and shift level, which is useful to identify any areas of concern or particular hotspots. The Committee was assured that that information will form part of the performance management framework where, for example, areas of high level sickness are scrutinised and subsequently targeted by the workforce team.

- **Capital Financial Management** – the Capital Financial Management report was presented to Committee. The Committee was assured that the Health Board met its capital expenditure limit at year end. The Committee was assured that the capital programme for 2019/20 was profiled to be spent more evenly throughout this year.

- **Savings Plan 2019/20 –** the Savings Plan 2019/20 was presented to Committee. The Committee was advised that savings of £24m are required in order to meet the year end position of a £29.8m deficit, although this figure may vary as a result of work being undertaken on Referral to Treatment Time (RTT). The Committee was further advised of the change in control total set by Welsh Government with a further £5m added pressure on this year. The Committee articulated its apprehensiveness in the organisation's ability to meet the savings plan challenge given the lack of assurance that could be provided at this point in time. However, the Committee was assured that all schemes now have Project Initiation Documents (PIDs) in place to provide greater assurance that plans are robust and can be managed effectively. Further work is being currently undertaken to meet the challenge.

- **Draft Financial Plan Implementation 2019/20 –** the Draft Financial Plan Implementation 2019/20 was presented to Committee. The Committee was advised the control total for 2019/20 stands at £25m. Current assessment against the control total identifies a £5.5 m resource requirement for RTT and identifies non-recurrent resources to manage the gap. The Committee was advised of the £10m risk associated with the Red and Amber rated schemes in delivering the £25 million control total, which poses a significant risk in addition to the gap, however acknowledged that the focus of the upcoming HTA meetings will be to de-risk these schemes. The number of signed accountability letters received to date was shared with the Committee, together with the assurance that any outstanding would be addressed via the HTA process and escalated accordingly if necessary.

- **Referral to Treatment Time (RTT) Month 12 Report –** the Referral to Treatment Time (RTT) Month 12 Report was presented to Committee. The Committee was advised that performance in respect of RTT, Diagnostics and Therapies targets is positive and delivered a £1.2m under-commitment with the avoidance of any resultant funding clawback. The Committee was advised of activity and capacity within Therapy services and the further work needed to address the current system of manual tracking as opposed to the electronic tracking of patients.

- **RTT Plan 2019/20 –** the RTT Plan 2109/20 was reported to Committee. The Committee was advised that the forecast of the delivery requirement for 2019/20 stands at £5.5m.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /
Matters Requiring Board Level Consideration or Approval:

- The Board, at its meeting on 29th May 2019, is asked to approve the Finance Committee Annual Report 2018/19

Risgiau Allweddol a Materion Pryder /
Key Risks and Issues/ Matters of Concern:

- Continuing issues with the Aseptic Unit in Glangwili General Hospital which represents an overall risk to the Health Board's Financial Plan.
- Delivery of the 2019/20 Savings Plan

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /
Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

In addition to the standing agenda items, the next Finance Committee meeting will include reports relating to the Finance Committee Outcome of Self-assessment of Performance 2018/19, Corporate Risks, Financial Operational Risks, Winter Planning 2019/20, Deep-dive into Medicines Management & Aseptic Unit, Deep-dive into CHC, and Draft Annual Accounts 2018/19 Review of Risks Arising from HTA Process, Debrief exercise from recent cycle of meetings.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

20th May 2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Scheme of Financial Delegation
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Fiona Powell, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide the Committee with a summarised Scheme of Financial Delegation which sets out the financial accountability and limits for the Health Board Executive Directors and delegated officers.

Cefndir / Background

Executive Director responsibilities and accountabilities form part of Hywel Dda University Health Board's (HDdUHB) Scheme of Delegation - Directors' roles and responsibilities, which itself forms part of the Health Board's Standing Orders.

The Scheme of Delegation is an integral element of the HDdUHB's Governance and Assurance Framework.

To supplement the Scheme of Delegation, a Corporate Scheme of Financial Delegation will provide clarity for HDdUHB on financial limits and approvals.

Asesiad / Assessment

A sound system of internal control will ensure that any risks to the achievement of the HDdUHB's objectives are identified, assessed, managed and mitigated against.

By formalising and summarising the financial scheme of delegated responsibility within HDdUHB the Committee can obtain the necessary assurance that operational responsibility for implementing and maintaining internal financial control is robust and clear.

Appendix 1 – The Corporate Scheme of Financial Delegation sets out the current approval limits covering the following areas –

- Budget changes
- General expenditure
- Capital expenditure
- Healthcare agreements

- Capital expenditure
- Specialist expenditure areas
- Charitable funds
- Single tender action
- Staffing

The approval limits agree with those set out in HDdUHB's current Scheme of Delegation.

It is proposed that the limits for the Director of Finance under Charitable Funds be increased from £5,000 to £25,000 in line with the limits assigned to Executive Directors currently

Argymhelliad / Recommendation

The Finance Committee is asked to discuss and recommend the proposed change to the Corporate Scheme of Financial Delegation to the Board.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.6 Subject to the Board's direction and approval, develop and regularly review the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible. 5.7 Review and approve financial procedures on behalf of the Health Board. 5.8 Agree issues to be escalated to the Board with recommendations for action.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Organisational Financial risk included on HB Risk register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Model Standing Orders and Standing Financial Instructions
Rhestr Termau: Glossary of Terms:	Glossary of Terms: Incorporated within the main body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to Finance Committee:	Links with Wales Audit Office Structured Assessment process.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of internal control enacts robust financial control, safeguards public funds and the Health Board's assets. Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed.

Cyfreithiol: **Legal:**	A sound system of internal control ensures that any legal risks to the achievement of the Health Board's objectives are identified, assessed and managed.
Enw Da: **Reputational:**	Sound financial control is essential for the reputation of the Health Board.
Gyfrinachedd: **Privacy:**	No personally identifiable information included
Cydraddoldeb: **Equality:**	The model SOs and SFIs have been subject to an Equality Impact Assessment as part of the NHS Reform Programme, and the revised SOs were subject to an in house EqIA screening in September 2012, the outcome of which indicated no negative impact in relation to the Health Board's duties under the Equality Act 2010.

Hywel Dda University Health Board
Corporate Scheme of Financial Delegation

Approval	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Single Tender Actions	Staffing	
	Any expenditure approval must be within funding limits of approved budgets. **Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.** **Executive Directors to determine the scheme of delegation within their structures.**														
	Budget transfers between budget managers	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and private sector, annual value) (Primary care contracts approved by Board)	Building and engineering orders; related consultancy support (individual contract commitment)	Medical devices; plant; machinery; related consultancy support (individual contract commitment)	IM&T; telecoms; systems; software; related consultancy (individual contract commitment)	Property or equipment leases (granting or terminating leases; annual value)	External consultancy support (total contract value for duration of service)	Losses/special payments (Terminations approved by Director of W&OD, VERS by RATS Committee)	New drugs if more expensive than the current alternative (value based on annual costs)	Locally held funds (total bid value)	General funds (total bid value)	All values	New posts (increase establishment)	Agency and waiting list initiatives (all values)
WG (in advance of contract)	No requirement	£1m plus	£1m plus (Private Sector)	£1m plus	£1m plus	£1m plus		£1m plus	See Manual for guidance as special rules apply for certain losses and ex gratia payments						
Board following CEO approval	£1m plus	£1m plus	NHS: Over £10m approved in advanced, below £10m retrospectively reported. Private: Over £1m in advance.	£1m plus	£1m plus	£1m plus	£0.5m plus any which need signing under seal (Reservation of power)	£25k plus		£1m plus					
Audit Committee													Retrospective reporting		
Charitable Funds Committee											Over £50k	Over £50k			
Charitable Funds Sub Committee											Over £5k	Over £5k			
Capital, Estates and IM&T Sub Committee				Capital projects/schemes must be approved by the Committee before sign off via the Scheme of Delegation and in some cases capital expenditure limits (noted on the Oracle approval hierarchy) may be in excess of the scheme of delegation limits											
CEO through ET	£0.5m to £1m	£0.5m to £1m	NHS: New or variation to £10m Private: £0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£25k plus	£0.5m to £1m	£0.5m to £1m			As escalated by DoF	Can approve new posts across LHB	
Any 2 of CEO, COO and DoF (must incl DoF)		Up to £1m	NHS: New or variation to £5m Private: to £0.5m					Up to £25k		Up to £0.5m			As escalated by DoF		
DoF	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £25k	Up to £0.5m		Up to £5k	Up to £5k	As escalated by Board Secretary or DDoF	Can approve new posts within own structure	Must approve in advance in own structure
Executive Directors (unless noted below)		Up to £100k						Up to £25k			Up to £25k	Up to £25k	Waivers must be approved by Board Secretary or DDoF		
COO		Up to £100k	Up to £100k	Up to £100k	Up to £100k		Up to £100k	Up to £25k							
Director of Planning		Up to £100k	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £100k	Up to £25k							
Medical Director		Up to £100k						Up to £25k							
Director of W&OD		Up to £100k						Up to £25k	Terminations to £50k (beyond which to WG)						
Deputy COO		Up to £100k	Up to £100k		Up to £100k	Up to £100k									
Director of Estates		Up to £75k		Up to £75k		Up to £75k									
County Directors		As delegated by the respective Exec Director									Up to £5k				
General Managers		As delegated by the respective Exec Director									Up to £5k				
Claims/Redress Manager									Up to £5k						
Authorised fund holder		As delegated by the respective Exec Director									Up to £5k				

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HYWEL DDA UNIVERSITY HEALTH BOARD – FINANCE COMMITTEE

The Committee meets on a monthly basis. The following table sets out the Committee's business for the remainder of 2019/20, including standing agenda items (denoted by *).

Agenda Item/Issue	Lead	25th April 2019	20th May 2019	25th June 2019	22nd July 2019	22nd Aug 2019	24th Sept 2019	23rd Oct 2019	26th Nov 2019	19th Dec 2019	28th Jan 2020	27th Feb 2020	24th March 2020
GOVERNANCE													
Apologies*	MH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interests*	All	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes from previous meeting*	MH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising and Table of Actions*	MH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual Review of TORs/membership	MH	✓											
Finance Committee Outcome of Self-Assessment of Performance	MH		✓										
Finance Committee Annual Report	MH	✓											
Reflective Summary	HT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
FOR DISCUSSION													
Finance Report Month*	FP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial Projections Report	HT		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial plan development and draft financial plan	HT						✓	✓	✓	✓	✓	✓	✓
Turnaround Report/ Savings Plan Month*	AC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
RTT Month*	KJ	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

HYWEL DDA UNIVERSITY HEALTH BOARD – FINANCE COMMITTEE

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Establishment Control*	LG	✓	✓	✓	✓	✓	✓						
Capital Financial Management	HT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Contracting Update	HT			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Finance Team Strategy	HT			✓									
External Finance Review*	HT		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Year End Debrief	HT		✓										
Addressing Recommendations from the Deloitte ZBR	HT		✓										
ASSURANCE													
Corporate Risks	HT		✓		✓		✓		✓		✓		✓
Finance Operational Risks	HT		✓			✓			✓			✓	
Winter Planning 2019/20	JT		✓										
Deep-dive into Medicines Management/Aseptic Unit	JPJ		✓										
Deep-dive into CHC	HT				✓								
FOR APPROVAL													
Annual Financial Plan/Enabling Plan	HT									✓			
FOR INFORMATION													
Scheme of Delegation	HT		✓					✓					
Finance Committee Annual Workplan*	MH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Update Reports to Board*	MH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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Draft Annual Accounts 2018/19	HT		✓										
Any Other Business*													
ADMINISTRATION													
Agenda setting meeting with Chair & Exec Lead (at least 4 weeks before the meeting)	SB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team prior to issue	SB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	SB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda & papers 7 days prior to the meeting	SB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	SB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Chair: Michael Hearty
Vice-Chair: Mike Lewis
Lead Executive: Huw Thomas
Committee Secretary: Sarah Bevan

MH – Michael Hearty	**JT – Joe Teape**
HT – Huw Thomas	**LG – Lisa Gostling**
FP – Fiona Powell	**KJ – Keith Jones**
AC – Andrew Carruthers	**SB – Sarah Bevan**