



## PWYLLGOR ADNODDAU CYNALIADWY SUSTAINABLE RESOURCES COMMITTEE

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	20 December 2022
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	KPMG Retrospective
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Huw Thomas, Director of Finance
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	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

Hywel Dda University Health Board (HDdUHB) has been placed in Targeted Intervention by Welsh Government (WG) for finance and planning. The conditions for de-escalation include preparing a credible approvable plan and an improvement in the financial position. To help this the Health Board has reviewed the recommendations from the review of finances undertaken by KPMG in 2019.

The Sustainable Resources Committee is requested to discuss the current status on recommendations from the KPMG review and planned future actions.

##### Cefndir / Background

KPMG were commissioned by WG to undertake a review of finances in HDdUHB during 2019. Four separate reports were compiled and initially presented to the Finance Committee in December 2019. The Health Board's response to the recommendations was presented to the Finance Committee in March 2020 prior to the COVID-19 pandemic.

The reports covered include:

- Grip and control, attached at Appendix 1
- Delivery Framework including a Budget Holder Survey, attached at Appendix 2
- Recovery Plan, attached at Appendix 3
- Assessment of 2019/20 Financial Plan, attached at Appendix 4

##### Asesiad / Assessment

The KPMG reports reference the processes and governance structures in place at the time of the review, e.g. Holding to Account and Finance Committee. Whilst several changes have happened in the intervening period, some of the key themes from the recommendations remain relevant.

The Health Board's current status against the recommendations is summarised in the report, attached at Appendix 5. The status as reported in March 2020 is also included for completeness.

Some areas have been fully implemented, although delivery may be challenging. Other areas are on-going or no longer relevant. The report covering the Assessment of the 2019/20 Financial Plan can be discounted as the items have been covered elsewhere.

### **Argymhelliad / Recommendation**

The Sustainable Resources Committee is requested to discuss the current status on recommendations from the KPMG review and planned future actions.

<b>Amcanion: (rhaid cwblhau) Objectives: (must be completed)</b>	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, give early warning of potential performance issues, 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.
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:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	6K_22 workforce, clinical service and financial sustainability
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019</a>	9. All HDdUHB Well-being Objectives apply

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	KPMG Reports 2019
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Targeted Intervention Working Group/Executive Team

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	The recommendations from the KPMG reports were targeted to improve the Health Board's financial position.
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Not applicable
<b>Gweithlu: Workforce:</b>	Not applicable
<b>Risg: Risk:</b>	The recommendations from the KPMG reports were targeted to improve the Health Board's financial position and reduce the level of financial risk.
<b>Cyfreithiol: Legal:</b>	Not applicable
<b>Enw Da: Reputational:</b>	Not applicable
<b>Gyfrinachedd: Privacy:</b>	Not applicable
<b>Cydraddoldeb: Equality:</b>	Not applicable





# Financial Grip & Control

06 December 2019



# Important notice

This report ('the Report') has been prepared for Welsh Government ('WG') on the basis set out in the call off order signed 31 July 2019 ('Letter of Appointment'). This Report is for the benefit of Welsh Government only, and has been released to them on the basis that it shall not be copied, referred to or disclosed, in whole or in part, without our prior written consent. Any disclosure of this Report beyond what is permitted under the Letter of Appointment will prejudice substantially this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If Welsh Government receive a request for disclosure of the product of our work or this Report under the Freedom of Information Act 2000 or the Freedom of Information (Scotland) Act 2002, having regard to these actionable disclosure restrictions, Welsh Government should let us know and should not make a disclosure in response to any such request without first consulting KPMG LLP and taking into account any representations that KPMG LLP might make.

This Report is not suitable to be relied on by any party wishing to acquire rights against KPMG (other than WG) for any purpose or in any context. Any party, other than the WG, that obtains access to this Report or a copy (under the Freedom of Information Act 2000 or otherwise) and chooses to rely on this Report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG does not assume any responsibility and will not accept any liability in respect of this Report to any party other than WG.

The fieldwork commenced on 29 July 2019 and was completed on 31 October 2019. We have not undertaken to update our report for events or circumstances arising after that date.

In preparing this Report, the primary source of information has been obtained from HDUHB. KPMG does not accept responsibility for such information which remains the responsibility of the HDUHB. We have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information which was made available to us in the course of our work in accordance with the terms of the Letter of Appointment. We have not, however, sought to establish the reliability of the sources by reference to other evidence.

This engagement is not an assurance engagement conducted in accordance with any generally accepted assurance standards and consequently no assurance opinion is expressed. Nothing in this Report constitutes a valuation or legal advice.

KPMG emphasises that the realisation of the prospective quality and performance and other information set out within the Report is dependent on the continuing validity of the assumptions on which it is based. The assumptions will need to be reviewed and revised to reflect such changes in service/delivery trends, workforce, cost structures or the strategic intentions of existing services as they emerge. KPMG accepts no responsibility for the realisation of the prospective quality and performance and financial information. Actual results are likely to be different from those shown in the prospective financial information because events and circumstances frequently do not occur as expected, and the differences may be material.

The contents of our Report have yet to be reviewed in detail by the directors of HDUHB for the purposes of factual accuracy. All recommendations made are subject to Health Board governance processes (including QIA) and the responsibility for quality, safety and patient experience rests with the Health Board

# Executive summary

Area	Findings
<b>Grip and Control</b>	<p>An experienced turnaround and financial governance team from KPMG reviewed the standard financial improvement controls across Hywel Dda University Health Board. During the course of this review a number of areas of concern were identified relating to both design and deployment of the controls environment as well as compliance with established controls, specifically:</p> <ul style="list-style-type: none"> <li>— There are significant areas of enhancement within pay controls which we would expect to have a substantial impact on financial performance.</li> <li>— Although there could be improvements in non-pay controls, for example we would always suggest a 'discretionary spend' challenge the financial impact will be smaller, due to lower levels of addressable spend.</li> <li>— There are improvements required to the planning process (which HDUHB is aware of and working towards implementing).</li> <li>— Improvements to financial recovery governance have been identified will be covered in a separate pack (Delivery Framework).</li> </ul> <p>We have identified 13 direct actions (and a series of enabling/driver actions) which should enable the Health Board to deliver the equivalent of £1.0M-£2.0M of financial run rate improvements (albeit the impact will be seasonal, rather than on a flat monthly basis). These 13 actions are summarised on the next page.</p> <p>The pay opportunities represent £8-16M (which is between 2-4% of addressable spend), this is to be achieved through changes to processes, technological solutions enhancing/changing some existing processes and controls, reporting and compliance testing.</p> <p>The balance being non pay (delivered through tighter financial performance management in month 12 and targeting reduction against a series of discretionary spend areas through education, control, reducing options to spend and financial reporting.</p> <p>Note: these savings may contain double-counts with CIPs and are subject to PIDs, QIA and formal sign off by the Health Board.</p>
<b>Observations</b>	<p>The University Health Board does have evidence of policies, standard operating procedures (SOPs) and controls that in some cases are necessary and sufficient to provide assurance. Through the course of the review it was apparent that this was not universally consistent and as a consequence there are opportunities to strengthen the controls environment to provide much greater potential for financial grip. Each instance has been discussed with the Health Board and an immediate remedial action list documented in this paper.</p> <p>Where the pre-existing controls were sufficiently tight and would be sufficient, the review identified areas of sub-optimal compliance with the control, with 'custom and practice' appearing to be outside of the documented control. Again this provides scope to strengthen the compliance environment within the Health Board and as a consequence deliver a positive financial contribution in the remainder of the year.</p>
<b>Next Steps</b>	<p>The UHB Executive Leadership to work with KPMG to sign-off remedial actions that will drive the necessary augmentation in both the environment and compliance framework where current deficiencies make controlling expenditure more difficult.</p>

# Executive summary – actions with financial quantifications

Control	Description of changes proposed	Annualised financial impact (£M)	Page ref
<b>Rostering</b>	Change rostering processes, restart rostering meetings and accelerate e-rostering roll out (tracking impact by ward)	2.3 – 4.6	7
<b>Discretionary spend</b>	Targeted campaign to deselect catalogue choices, educate and communicate with users, apply central challenge (procurements and finance) and report on compliance through dashboards	1.9 – 3.3	12
<b>M12 spike</b>	Review and remove budget (plus finance challenge of orders for M11 and M12) to reduce all spend (defer or cancel) and maintain or better M11 averages	1.8 – 3.5	12
<b>Agency booking</b>	Changes to booking controls including documenting and confirming revised processes to safely reduce agency spend	1.0 – 2.0	5
<b>Sickness</b>	HR to continue and accelerate actions around sickness reporting and actions to reduce in hot spot areas	1.0 – 2.0	5
<b>Job plans</b>	Electronic job planning and reviewing all job plans – starting with oldest / areas of most likely financial benefit	1.0 – 2.0	10
<b>Rota management</b>	Electronic rota management and reporting of compliance with policies and advanced visibility to flexibly work around issues to reduce reliance on temporary workers	1.0 – 2.0	10
<b>Long term Temps</b>	Target conversion of temporary workers to substantive, including communicating reduced use of temporary staff and developing exit/transition plans (including seeking skills transfer from temporary workers not converting to substantive)	1.0 – 2.0	10
<b>Overtime</b>	Policy changes around granting and what overtime is approved. This control will be supported by roster management and other actions to reduce need for staffing	0.5 – 1.0	8
<b>Thornbury</b>	Centralising and raising sign-off requirements through to consideration of outright ban (except when facing exceptional operational pressures)	0.3 – 0.4	8
<b>Exit controls</b>	Changing process to inform HR/payroll earlier (to reduce time to replace and overpayments) and ensuring decisions are not being taken by line manager which adversely impact health board by requiring further temporary workforce cover by offering shorter notice periods	0.2 – 0.5	6
<b>HCSW</b>	Raising seniority of sign off controls and reporting of use of HCSW agency as target should be for zero use	0.1 – 0.1	8
<b>Acting down / paid breaks</b>	Change in approach to acting down and quarterly/ad-hoc reviews of breaks being paid to agency (plus communications to timesheet approvers)	0.1 – 0.1	10
<b>Total</b>		<b>12.2 – 23.5</b>	

# Grip and control – pay opportunity

Our comments largely relate to pay as the area of highest opportunity, though some non-pay opportunities are identified. We have estimated a grip and control pay opportunity of £8-16m, across all staff groups. This represents 2-4% of total pay spend, with the detailed opportunities being set out in the following pages.

Staff group	Pay spend type (18/19)				Assessed annualised opportunity				
	Substantive	Agency / Locum	Bank	Unknown	Total	Min	Max	Min	Max
Nursing	118	14	3	-	135	3.8	7.4	2.8%	5.5%
M&D	79	19	-	-	98	3.2	6.2	3.2%	6.3%
A&C	52	0	0	2	55				
ACS	35	0	7	13	54				
AHP	-	1	0	24	26				
Other	-	0	2	44	46				
Unallocated						1.2	2.5		
<b>Total</b>	<b>284</b>	<b>35</b>	<b>12</b>	<b>82</b>	<b>414</b>	<b>8.2</b>	<b>16.1</b>	<b>2.0%</b>	<b>3.9%</b>

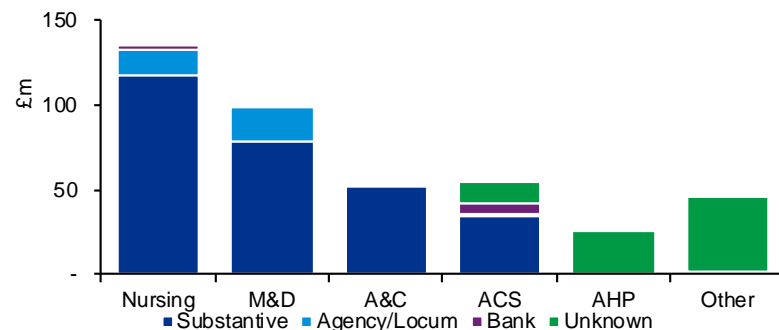
The assessed opportunity is a high level indication of the estimated potential savings based on our analysis of available data and our experience.

The actual potential savings could be higher or lower depending on the Health Board's appetite and further work to validate and quantify the identified opportunities. This would need to take place through a structured process to ensure that risks are identified and assessed.

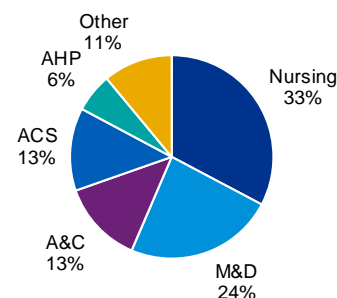
We have focussed on Nursing and Medical as these have high levels of variable spend, though other staff groups should be reviewed too for savings opportunities.

The "unknown" spend categories are unknown as it is unclear from the ledger description if it relates to agency/bank/substantive etc.

18/19 pay spend by type and category (per ledger)



Pay spend by staffing category (per ledger)



# Grip and control key recommendations – Pay: General

## RAG Key

- To be addressed urgently
- To be addressed as a matter of importance
- Room for improvement

Area	RAG	Current situation/issue	Recommendation	Estimated value
<b>Sickness</b>  Compliance with existing control	<span style="color: orange;">●</span>	<p>The sickness absence rate for 18/19 is 4.86%, with an estimated absence cost of £12.6M.</p> <p>Compared to the other health boards, HDUHB has the second lowest sickness rate of 4.95% in 17/18. Powys teaching leads with 4.61% whilst Abertawe Bro Morgannwg is the worst at 5.92%.</p> <p>Within the Health Board, "Pemb's director and commissioner" directorate has the highest absence rate of 6.8% in 18/19, while "Mental health and learning disabilities" represent the highest sickness absence cost.</p> <p>As a staff group, ACS has the highest average rate, of c.7% against a Health Board average of c.5%.</p>	Reducing sickness rates can take time with benefits likely to be primarily in the next financial year. Focus on reducing sickness rates in areas which are significantly above average through identification of long term sick individuals, ensuring the relevant procedures have been followed and ensuring appropriate support to enable accelerated return to work is provided.	£1.0-2.0M
<b>Agency booking process and control</b>  Environment and compliance failures	<span style="color: red;">●</span>	<p>Senior sisters on wards are able to request agency cover from the bank office without further checks. The head nurse of each site is notified of shifts which have not been filled one day out and given the option of offering to Thornbury. A previous control requiring Nursing Director sign-off for Thornbury has been removed.</p> <p>Wards are circumventing the process, with 23% of agency nurse bookings going direct to the nurse, and a further 8% going direct to the agency.</p> <p>As a consequence, retrospective bookings are high (21%), with 45 of the 199 wards who used agency YTD only making bookings retrospectively.</p> <p>We would expect nearly all of substantively unfilled shifts to be advertised through the Nurse bank between 35 and 42 days from the shift if the 6 week time limit is being adhered to, with a much smaller number 0-3 days away due to unforeseen sickness etc. The proportion at HDUHB advertised between 3 and 35 days is 40%.</p>	<p>Communicate to agencies that only bookings made through the bank office will be paid for and put in place procedure to ensure this is adhered to.</p> <p>Holding to Account meetings to be held for those who circumvent the process (e.g. retrospective bookings) or who have unacceptably high agency spend.</p> <p>Introduce a cascade system for bookings based on time to shift, e.g.:</p> <ul style="list-style-type: none"> <li>— anything more than 15 days away is only visible to bank staff</li> <li>— 0-15 days is visible to bank and contract agencies</li> </ul> <p>Ensure that unfilled shifts which need to be filled are sent to the Bank Office &gt;35 days from the date of the shift (i.e. within a week of the roster being completed).</p> <p>Refresh and re-issue to all requesters and bookers the revised agency booking processes (along with seasonal reminders and kit-card/help cards)</p>	£1.0-2.0M

# Grip and control key recommendations – Pay: General (cont.)

Area	RAG	Current situation/issue	Recommendation	Estimated value
<b>Controls over staff leaving the Health Board ('exit controls')</b>  Compliance failure	●	<p>Since 13/14, the number of instances of staff overpayments have increased 9x to 154 in 18/19. The current outstanding overpayment balance is £120k. The current process for leaving HDUHB is a sign off by the employee's line manager which leads to several issues, including:</p> <ol style="list-style-type: none"> <li>Any delay in notifying HR results in a delay in the recruitment process which may need to be filled with agency/overtime.</li> <li>Where payroll is not notified of the employee's final date in a timely manner salary overpayments will arise which then lead to significant time recouping the balance by Finance (not always possible)</li> <li>There is the potential for line managers to agree a shorter notice period than what has been contracted. This also leads to the possibility of backfilling at a higher cost.</li> </ol>	<p>Whilst responsibility for exit date should remain with line managers, there needs to be (i) immediate communication to HR and payroll (to reduce time to start recruiting to required roles and to reduce the risk of any staff overpayments) and (ii) an independent check that a decision is not unduly made to release staff early which places increased burden on remaining staff, as well as the need for agency staff – which will increase the financial cost to the health board.</p> <p>HR should ideally review the exit date of the employee after discussion and update payroll accordingly. Saving will largely relate to agency.</p>	£0.2-0.5M
<b>WTE budgets</b>  Control and compliance failure	●	<p>Ten directorates and 195 cost centres appear to have a contracted workforce which is higher than the establishment, before factoring in overtime/bank/agency. For the directorates, 50% of the over-establishment is in 'Carms – director and commissioner' and 'medical director corporate'.</p> <p>This suggests that either the establishment figures are incorrect or that the recruitment/temporary staff controls require tightening.</p>	<p>Undertake a rapid establishment review (demand/capacity) of those areas which are over-budget. Focus on over-established directorates first, as over-established cost centres may be matched by an off-setting under-established cost centre.</p> <p>Where establishment is inappropriate, rectify in the financial system.</p> <p>Where genuinely over established, ensure the relevant parts of the Health Board which should challenge external recruitment/internal transfers (VCP, HR, Finance) are sufficiently robust to block requests which would result in over establishment. Ensure no variable pay is being incurred and exit or transfer the excess staff.</p> <p>Review how Executives are held to account for their areas of the Health Board to ensure they are adequately challenged.</p>	Driver

# Grip and control key recommendations – Pay: Nursing

Area	RA G	Current situation/issue	Recommendation	Estimated value
Rostering	●	At present there are 167 wards on e-rostering, with approximately 25 awaiting transition to e-rostering.	Re-start the rostering efficiency meetings to review rosters for the next week and cancel excess temporary staffing.	£2.3-4.6M
Compliance		<p>In terms of rostering, HDUHB's 'Roster Matrix' assesses 6 KPIs for ward rosters and would indicate that rosters are generally in good health. It considers 66 of the approximately 200 wards and, in relation to these 66, indicates the following in relation to rostering 6 weeks in advance:</p> <ul style="list-style-type: none"> <li>— 48 are green.</li> <li>— 12 of the wards are orange.</li> <li>— 6 are red.</li> </ul> <p>The other measures are for management of annual leave, hours owed etc. which are broadly assessed as green.</p>	<p>Extend and accelerate e-rostering to all wards (and monitor impact on agency usage after changes made).</p> <p>We understand that there is a feature within the rostering system which requires the roster planner to sign off that their roster meets the policy. This should be switched on.</p> <p>Cease short duration agency bookings where possible by improving roster management. Ensure the balance of shift times is spread evenly across the workforce where possible.</p>	
Compliance	●	<p>A sample of wards (BGH Ceredig; BGH Dyfi; CAR Amman Valley; GGH ITU; PPH Ward 9; WGH A&amp;E; WGH Theatres) were reviewed for over-establishment. The data indicated that there were numerous examples of over-establishment in these areas, in some cases by more than 50%. This is before overtime and additional basic hours are factored in.</p> <p>Analysis of the agency shifts shows that:</p> <ul style="list-style-type: none"> <li>— 50% of shifts were nights, 30% were long day; 10% were early and 10% were late. This indicates that substantive staff are potentially not being rostered onto unpopular (more expensive) shifts.</li> <li>— There were 244 shifts worked of fewer than 6 hours, in some cases as short as one hour.</li> </ul>		

# Grip and control key recommendations – Pay: Nursing (cont.)

Area	RAG	Current situation/issue	Recommendation	Estimated value
<b>Overtime / additional hours</b>  Potential to strengthen control	●	There 22,000 instances of nursing overtime (£3M) in 18/19. There were 30 wards where the overtime bill to P3 was more than 5% of the total staffing charge in the same period (it was 12% at PPH – Theatres).	Change the policy such that overtime will not be granted except in extraordinary circumstances where it will need to be approved by the Director of Nursing or their deputy and it will not be granted for less than 2 hours. Additional hours to be worked through bank.  Will need to be planned and implemented properly with management holding the line. If management yield to staff pressure to reinstate overtime there is a risk that an increase in spend will have been achieved as agency are likely to be used in an initial period until bank uptake reaches a critical threshold.	£0.5-1.0M
<b>Target reduction Thornbury usage</b>  Potential to strengthen control	●	Thornbury usage is high, with 10% of agency shifts YTD fulfilled by Thornbury, which typically charges double other agencies.  A high proportion of Thornbury usage is across 5 wards (GGH: Teifi, A&E, CDU; WGH: A&E Ward 3).  Beyond the financial implication of using an off framework supplier, there are potential legal / contractual implications that the Board need to consider.	Thornbury shifts to be approved by exception by Director of Nursing or Deputy Director of Nursing.  Targeted focus on wards using significant Thornbury to ensure rosters are developed in a timely fashion, unfilled shifts are advertised to the Bank Office in a timely fashion, hours owed have been utilised, vacancy is well managed.  We are aware some Health Boards have completely banned the use of agency, however this may have safety and operational impacts. We believe that the controls above should be implemented as a first step and then seek a full ban if levels are still high (except where safety issue or in exceptionally high activity periods/ exceptionally severe staffing issues).	£0.3-0.4M
<b>HCSW agency</b>	●	There were approximately 100 HSCW shifts worked to M3, including 15 through Thornbury.	HCSW agency requests to be approved by Director of Nursing or Deputy Director of Nursing. Along with dashboard reporting (and change in policy communicated to not use HCSW)	£0.01M
<b>Paid breaks</b>	●	It is unclear whether agency nurses should receive paid breaks, though if not there are a number of shifts which are 8 or 12 hours, suggesting that breaks are being paid in some circumstances.	Ensure that agency breaks are in line with contracts and review compliance.	Not quantified

# Grip and control key recommendations – Pay: Nursing (cont.)

Area	RAG	Current situation/issue	Recommendation	Estimated value
<b>High usage agency</b> Control	●	There are a number of agency staff with high usage over the period from 1 April 2019. The top 10 each work in excess of 50 hours per week on average (top Thornbury worker has averaged 37 hours per week).	Targeted recruitment programme for agency staff, implementing a pause for top ten agency workers where alternative cover is available and seek to recruit substantively, or other innovative strategies as determined by the Health Board. If successful repeat.	
<b>Policy on nursing staff returning as agency</b> Control	●	The current policy permits substantive staff to return to work at HDUHB after 6 months. Anecdotal evidence suggests there have been an increasing number of instances of staff who have left and then returned as agency.	Make bank more attractive to existing staff (see below). Understand drivers for leaving and put in place a retention programme. Ensure 6 month policy is enforced to make it less attractive to leave for agency.	Driver
<b>Promote Bank sign up</b> Opportunity	●	There are currently 1,653 workers signed up to the bank, split roughly 50/50 between those who also have a substantive contract and those who are only on the bank (typically former staff who have retired).  We understand that there are approximately 4,000 nurse WTEs at the Health Board, which indicates that the sign up of substantives is approximately 20% which is low in comparison to other health providers we have reviewed (40%+).  The bank sign up is concentrated at the band 2 level, which accounts for 55% of total people on the bank.  Bank work is paid at current spine point except for in one location where band 5 is paid at band 7.	Concerted recruitment campaign to bank. Implement other recommendations noted herein to make agency less attractive relative to bank.  Consider paying bank staff at a high rate than current band (e.g. at Trusts we have seen payment to band 5 at band 6 rate). Although the financial impact and knock-on impact for substantive shifts needs to be considered and modelled.  In line with other healthcare providers, the Health Board should consider auto-enrollment of all new staff onto the bank (with an opt-out rather than opt-in approach adopted) to maximise availability of the bank.	Driver
<b>Promote Bank usage</b> Opportunity	●	The level of activity of the bank of those with a substantive contract is low, with 80 WTEs worked in aggregate (11% of the substantive WTE).  Amongst those without a substantive contract activity is also low, with 169 WTEs worked out of the 787 population (21%).  Bank shifts are currently notified by text message but given the high number of shifts requested (approximately 9,000/month) it is likely that this system is reasonably ineffective at enabling staff to identify and book on to shifts.	Bank notification systems should be enhanced to ensure that bank users can easily see what shifts are available and book on. (We understand that there is a setting within Roster Pro which can be enabled (R Roster Plus) which would allow staff to view and sign up for available shifts but that it has not yet been approved by IT).  It is possible for shifts booked by agency staff to be bumped by Board bank staff. At present, shifts which have been booked by agency staff are not visible to bank staff.	Driver
<b>Rostering policy</b> Control	●	We understand that the rostering policy was last updated in 2015 and that a revised version has been in draft since mid-2018.	Draft rostering policy to be reviewed and approved as appropriate. To include recommendations from this report and a review of the compliance (including swapping shifts, annual leave booking etc.)	Driver

# Grip and control key recommendations – Pay: Medical

Area	RAG	Current situation/issue	Recommendation	Estimated value
<b>Job plans</b> Compliance	●	<p>The majority of job plans are paper based. &lt;10% is electronic (Allocate). Plans are to run a training in Sep/Oct on electronic job planning but to date there has been reluctance from the medical community. Where electronic job planning has been enabled it has helped identify improvements in productivity.</p> <p>The total number of medical consultants is 250. For 30% of these, their job plan was reviewed more than 2 years ago.</p> <p>There are 8 job plans that were last reviewed more than 5 years ago and it is unclear why they have not been reviewed more recently.</p>	<p>Enable electronic job planning across all areas.</p> <p>Review all job plans (old ones as a priority) to ensure they are appropriate, efficient, in line with best practice and delivering best value for the Health Board.</p> <p>This is expected to reduce demand from agency/locum medical staff and from substantive.</p>	£1.0-2.0M
<b>Rota management</b> Control and Compliance	●	<p>Rotas are managed in a decentralised fashion with limited central oversight/review. They are typically prepared by the rota co-ordinator/service manager/doctor and are manual (e.g. paper/Excel).</p> <p>Typically we have found when performing detailed reviews of paper based rotas that there are numerous discrepancies to the job plans.</p>	<p>Transition to electronic rota preparation which offers improved visibility, control and assurance and would be expected to lead to a reduction in run-rate. They are also simpler to prepare and there is a drive across the NHS towards electronic rotas/rosters.</p> <p>This is expected to reduce demand from agency/locum medical staff and from substantive.</p>	£1.0-2.0M
<b>Long term temporary staff</b>	●	<p>For the first 14 weeks of the year, there were 7 agency medical workers who worked in excess of 30 hours per week.</p> <p>We do not have visibility on the extent to which locums are working regularly at HDUHB but given the size of the locum spend compared to the agency spend we expect it is a significant opportunity.</p>	<p>Approach agency medical and locums who are working extensively at HDUHB to seek to bring them on as substantive staff / communicate that the Health Board is actively reducing reliance on temporary workforce and therefore they may not have an on-going role unless it is substantive.</p> <p>Develop exit and succession plans for all long term agency / fixed term contractors – and require skill transfer and handover for any temporary workers not converting to substantive.</p>	£1.0-2.0M
<b>Acting down and unpaid breaks</b> Control and Compliance	●	<p>Consultants have been required to “act down”, at three times their rate, 100 times over the year from August 2018. A&amp;E WGH, General Medicine BHS and Radiology account for 72% of this usage.</p> <p>We understand that breaks are unpaid. However, 13% of the spend to Medacs relates to shifts which are either 4, 8 or 12 hours, suggesting that breaks may be being paid in some instances</p>	<p>Use middle grade agency or substantive in place of consultants acting down, at approximately 25% of the cost.</p> <p>Review instances where hours were 4, 8 or 12 to ensure that breaks were not claimed. Communicate with relevant agencies and communicate with all timesheet approvers (and specific emails to any who have not spotted unpaid breaks being paid)</p>	£0.1M

# Grip and control key recommendations – Pay: Medical (cont.)

Area	RAG	Current situation/issue	Recommendation	Estimated value
<b>Agency mileage</b>  Control	●	Some of the medical agency are claiming mileage. It is not clear why this is though we would only expect mileage to be claimable if the worker was required to be at one site in the morning and a different site in the afternoon.	Review terms of agreement with agency workers to remove mileage costs if material and being paid for travel from home.  If arising due to work required at two sites in one day, seek to manage rotas so as to remove this requirement.	Unquantified
<b>On call rates</b>	●	On-call rate for agency is supposed to be 60% of the agreed rates but we have not had a response to confirm that this is actually being applied in practice. We have been unable to confirm what on-call rates are applied to locums as this is managed.  It is difficult to identify what the on-call spend was but within the Medacs data there was £600k of spend for shifts of >10 hours, 30% of the total. There was approximately £19m of medical agency spend in 18/19.	On call rates at Trusts in England we have reviewed have been agreed at 50%. Seek to reduce the agreed pay for non-resident on-call to 50% in discussions with Medacs.	Unquantified
<b>Agency authorisation process</b>  Compliance	●	Over the past year there were 735 shifts where there is no record of submission for authorisation to the workforce control panel, in addition to 21 retrospectively approved shifts. The primary areas of shifts without a record of going to panel are: General Medicine WGH and BGH, A&E WGH, Mental Health and LD. These four areas represent 65% of the total unauthorised shifts.	Hold to Account meetings to challenge Directorates as to why there are any shifts without approval. Monthly report of instances to be sent to the Executive.	Driver
<b>Locum authorisation process</b>  Control	●	We understand that there is limited central data on locum shifts or authorisation and that it is largely devolved.	Considering this is the main driver of medical temporary spend, this should be controlled so that there is much greater visibility and control being exercised centrally to enable effective monitoring.	Driver
<b>Agency requests</b>  Control	●	Agency staff are requested where there is a gap in the rota. Requests are passed to the workforce team which seeks to fill the request from the 0 hour doctor pool and if this is unsuccessful, and AG1 form is completed and it is passed to Medacs, the staffing provider. Medacs then present the potential candidates to the workforce panel.  At times the rota co-ordinator would seek to source directly from the 0 hour pool.  Where a shift date is too soon to wait for the next workforce panel, approval should be sought from an Exec and this approval can be sought retrospectively. It is not clear how many such instances there are.	The AG1 form at present does not include a requirement to specify the establishment and contracted position of the cost centre – this should be included.	Driver

# Grip and control key recommendations – Non-pay

Area		Current situation/issue	Recommendation	Estimated value
General	RAG			
<b>Discretionary spend</b>	●	We have identified £33.2M of discretionary spend areas in FY19 which we believe could be reduced through a series of actions (see recommendations) and have successfully delivered between 20-30% sustainable reductions in other healthcare providers. We also note that this is £1.9M ahead of budget.	Targeted campaign to reduce these key spend areas through: deselection of catalogue choices on procurement, targeted email to users of these items, removing relevant budgets (and finance to monitor compliance), dashboard reporting of non-compliance, providing guidance (and escalation channels) to reduce spend areas and procurement/finance to challenge requisitions in these areas.	£1.9M-£3.3M
<b>Month 12 spike</b> Compliance	●	Month 12 non pay spend has been significantly higher in at least the last 4 years, although we note that often some of this is in relation to catch up payments (e.g. integrated care fund payments from local authorities) however it is also common for some spending to budgets.	Close financial performance management in month 11 and month 12 (potentially including centralisation of historical underspends) to seek to defer, reduce or cancel spend which is outside of budgets or above normal run rate of spend.	£1.8M – £3.5M
<b>Reduce clinical preference</b>	●	In addition to discretionary spend (above), HDUHB procure similar supplies from different manufacturers at the moment largely down to historic reasons and clinical preference.	Standardise supplies such that the number of suppliers for the same product are reduced to as few as possible. Setup clinical preference meetings (hosted by MD or similar) to make clinical preference decisions – supported by Procurement.	Included above
<b>Enforce no PO no pay policy</b> Compliance	●	Over the past year the number per month has averaged 147, though this is largely due to a spike in January to March 2019, which peaked at 396. The top 10 suppliers without a PO represent 44% of the total instances, with one alone representing 20% though this was primarily in January to March and has since dropped off to nearly nil, suggesting the policy is effective.	Continue the no-PO no-pay policy and monitor effectiveness on an ongoing basis to ensure suppliers in breach on a regular basis are identified at an early stage. As we are not able to identify the amount of 'inappropriate' POs or lost VFM without reviewing all non-PO items, we recommend the Health Board monitors and seeks to identify improvements in compliance and then determine any financial benefit to be quantified.	Un-quantified
<b>Business cases – post-implementation on review</b>		We understand there is limited post implementation effectiveness review in relation to business cases.	Ensure that benefits in relation to business cases are tracked and where they materially deviate from expectations, reviews are performed to identify if the benefits can be improved.	Un-quantified

# Grip and control key recommendations – Pharmacy

Area		Current situation/issue	Recommendation	Estimated value
Stock management		Stock days are currently at 29-44 days depending on the location, against a UK average of 24 days. This represents an opportunity to obtain a one off benefit by reducing stock levels and potentially to assist in reducing wastage.	<p>Update relevant policy to ensure that stock levels are brought into line with UK average and kept there.</p> <p>This benefit may affect working capital by reducing inventory levels (i.e. less cash tied up) but may also reduce stock wastage. The impact on wastage cannot be easily quantified as it is highly dependent on inventory changes throughout the year. We recommend the health board track these changes through wastage reports and then reduce the costs in the relevant budgets next year.</p>	Un-quantified

# Grip and control – opportunity quantification assumptions

Area	Cost saving analysis	Estimated value
<b>Pay – general</b>		
<b>Sickness</b>	In 18/19, the total estimated absence cost by the Health Board was £12m with an average absence rate of 4.9% across staff groups. The lower bound saving is based on reducing those staffing groups with above average sickness (ACS (6.8%), Estates (5.8%), Nursing (5.0%)) to the average. The upper bound is based on the average excluding ACS and Estates, which are outliers, and then reducing sickness levels to this level (4.2%).	£1.0-2.0M
<b>Controls over staff leaving the Health Board</b>	The saving is calculated based only on the Nursing sub-group and is based on an attrition rate of 9.6%, 4,000 WTEs and an assumed delay of one month in notifying HR. The saving is based on the incremental cost of agency against substantive if the recruitment process had started sooner. A lower bound of 50% of the above calculation has been used to give a range. No other staff groups have been included on the basis that A&C staff are unlikely to receive agency cover for a vacancy, though there are likely to be benefits, particularly in relation to the medical workforce and overtime in Estates. This does not include potential savings from ensuring employees work their notice or from stopping salary overpayments.	£0.2-0.5M
<b>Pay – nursing</b>		
<b>Rostering</b>	Rostering opportunity has been calculated as a percentage of the total nursing substantive spend of £118m (as agency spend reduction is covered elsewhere), with a range of 2-4% of the 18/19 spend used.	£2.3-4.6M
<b>Contract agency booking process and control</b>	In the first 4 months of 19/20, there were 116k hours of contract agency staff shifts (£27.49 per hour). If this is reduced by a total of 30%, with 10% due to demand reduction from better planning and 20% replaced by bank staff (assumed £21.68 per hour) this indicates a potential saving of £2.0M. The lower bound has been estimated as half of the upper bound.	£1.0-2.0M
<b>Overtime /additional hours</b>	In the 18/19, there was overtime spend of c.£3.1m, with overtime paid at rates starting from 1.5x base. The upper bound assumes that all overtime is 1.5x and that it can all be covered by bank (i.e. it disregards 2x overtime and overtime shifts which can simply be stopped). The lower bound assumes that only 50% of the overtime can be stopped.	£0.5-1.0M
<b>Target reduction Thornbury usage</b>	There were 11k hours of Thornbury shifts between M1-M4 of 19/20, making up 9% of total agency shifts. The savings range is based on assuming that Thornbury shifts can be reduced to 2%. The upper bound is based on filling the shifts with bank, the lower bound based on filling the shifts with contract agency.	£0.3-0.4M
<b>HCSW agency</b>	There were 110 agency shifts by HCSW between M1-M4 19/20, of which 15 was Thornbury. Savings have been calculated assuming 8 hours/shift and based on the saving between the bank and 2 rate and the agency rate.	£0.01M

# Grip and control – opportunity quantification assumptions

Area	Cost saving analysis	Estimated value
<b>Pay – Medical</b>		
<b>Job plans</b>	Job plans have been estimated as 1-2% of the total medical spend in 18/19 (agency, locum and substantive).	£1.0-2.0M
<b>Rota management</b>	Rota efficiency opportunity has been estimated as 1-2% of the total medical spend in 18/19 (agency, locum and substantive).	£1.0-2.0M
<b>Long term temporary staff</b>	Medacs data identifies 7 agency workers who have worked in excess of 30 hours per week, on average, in 19/20 at a cost of £287k for the first 14 weeks of the year. Assuming that agency costs c.30% more than a fully loaded substantive, and scaling to the full year, gives a potential opportunity of £250k just in relation to these 7 agency medical. Given locums (not in the Medacs data) represent a more significant additional spend than agency, we have estimated the lower bound as four times the £250k, and the upper bound as eight times the £250k.	£1.0-2.0M
<b>Acting down</b>	This is estimated based upon 100 shifts over the past year, with an assumed duration of 8 hours. The base consultant hourly rate is assumed as £50, with 30% on-costs. This is compared to the fully loaded middle grade hourly rate estimated at £46 or agency at £53, representing the upper and lower savings bounds, respectively.	£0.1M
<b>Unpaid breaks</b>	Calculated based on information from Medacs, which sets out that there were 428 agency medical shifts in Q1 of 19/20 of an 8 hour duration. Taking one sixteenth of the cost of the 8 hour shifts (to account for a 30 minute break) was £1,555 and then the proportion of this compared to the total spend on medical agency in the period (£269k) was applied to the total medical agency and locum spend in 18/19 to determine an upper bound. The lower bound was taken as 50% of this value. We have not factored in potential breaks for 4 hour and 12 hour shifts.	£0.0-0.1M
<b>Non pay</b>		
<b>Discretionary spend</b>	Taken as the overspend last year (low end) and 10% of prior year budget (high end)	£1.9M-£3.3M
<b>Month 12 spend spike</b>	The incremental non-pay spend in M12 is c. £7.0m. Assuming this can be transitioned into the following year's spend, there is a one off opportunity to reduce spend. We have taken the lower bound to be 25% of this figure and the upper bound to be 75%.	£1.8-5.3m



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# Delivery Framework – HDUHB

Welsh Government

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06/12/2019



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The fieldwork commenced on 29 July 2019 and was completed on 31 October 2019. We have not undertaken to update our report for events or circumstances arising after that date.

In preparing this Report, the primary source of information has been obtained from HDUHB. KPMG does not accept responsibility for such information which remains the responsibility of the HDUHB. We have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information which was made available to us in the course of our work in accordance with the terms of the Letter of Appointment. We have not, however, sought to establish the reliability of the sources by reference to other evidence.

This engagement is not an assurance engagement conducted in accordance with any generally accepted assurance standards and consequently no assurance opinion is expressed. Nothing in this Report constitutes a valuation or legal advice.

KPMG emphasises that the realisation of the prospective quality and performance and other information set out within the Report is dependent on the continuing validity of the assumptions on which it is based. The assumptions will need to be reviewed and revised to reflect such changes in service/delivery trends, workforce, cost structures or the strategic intentions of existing services as they emerge. KPMG accepts no responsibility for the realisation of the prospective quality and performance and financial information. Actual results are likely to be different from those shown in the prospective financial information because events and circumstances frequently do not occur as expected, and the differences may be material.

The contents of our Report have yet to be reviewed in detail by the directors of HDUHB for the purposes of factual accuracy. All recommendations made are subject to Health Board governance processes (including QIA) and the responsibility for quality, safety and patient experience rests with the Health Board

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# Executive summary

<b>Purpose of the report</b>	<p>The purpose of this report is to review the delivery framework in place within Hywel Dda UHB and provide recommendations that will enable the Health Board to achieve their control total in 19/20 and achieve a sustainable financial trajectory going forward. The existing arrangements were reviewed at various management levels and across various functions and recommendations have been provided to enhance and strengthen delivery of the financial position at various points during this programme. This was undertaken through a mix of interviews, surveys and observations at meetings and working group meetings with the senior Finance team, Workforce manager, PMO project manager and Turnaround Director and review of key documentation. The key meetings that were observed included the HTA meetings, Finance Committee, Audit Committee, directorate finance meetings.</p> <p>It must be noted that the Health Board has been on an improvement journey and has started putting in place some of the building block of good governance over the past two years, however there are significant improvements that can be made and this report will build on the work to date to enable the organisation to step up their performance</p>
<b>Overall findings</b>	<p>Overall, the delivery arrangements that are in place are good building blocks for the organisation however the accountability arrangements has become a process to follow and has lost some of its effectiveness. This has been compensated by increasing central control from the Exec team which is unsustainable for an organisation of this size and complexity. This is very similar to findings in other financially distressed organisations.</p> <p>The recommendations in this report will help rebalance and rejuvenate the delivery framework and is a mixture of process, capacity/capability and content recommendations</p> <ul style="list-style-type: none"> <li>• More frequent directorate accountability and performance management will be key to improving the performance culture of the organisation. One of the primary enablers is ownership of the weekly forecasts of schemes and turning the dial of performance indicators of various cost drivers by the core directorate team.</li> <li>• Although the planning of schemes to address the financial challenge can be improved; there has been a significant step up in this area from previous years and the main challenge is delivery of the schemes. Related to this point, the capacity and capability to support delivery within the service and by the PMO is constrained and therefore the pace and momentum is limited. The proposed structure and capacity of the PMO has been included in Section 6</li> <li>• On reviewing the information that was presented at the various fora, it was clear that in many instances data was available but it needs to be presented in a way that enables effective decision making i.e. avoiding information overload, using prioritisation criteria, using relevant and prioritised drivers and indicators that reveal the underlying issues.</li> <li>• The level between the Execs and the directorates also needs to be reviewed i.e. assistant director level and aggregation of directorates as the complexity of the operating model with the number of directorates compounded by capacity and some capability challenges at directorate level makes it difficult for the escalation process to be effective.</li> <li>• The organisation would benefit from rolling out a business partnering approach in other corporate functions particularly HR given the scale of the workforce change that needs to happen through the turnaround and transformation programme.</li> </ul>

# Executive summary

## Section 1,2 – Turnaround governance, accountability and planning

Section 1 and 2 details the current turnaround governance structure and provides recommendations to strengthen it. We attended the HTA meetings, exec turnaround meeting some workstream meetings where available, interviews with finance and PMO and reviewed documentation. Some of the key themes include the following

- Accountability and performance management of the financial position is not sufficiently robust at directorate level as its mainly delivered through the monthly HTA meetings (Holding to Account) and month end meetings rather than a weekly cycle. The escalation arrangements (HTA meetings) which have been embedded within the organisation has helped provide a process to detect and mitigate risk to the savings plans however the lack of weekly rigour and accountability at directorate level has resulted in issues being escalated that could have been dealt with at a directorate level and also impacts on the pace of delivery. Therefore its recommended that weekly directorate financial performance are embedded into the governance process
- The Health Board did not have one version of the truth for its pipeline schemes with ideas and opportunities at various stages in various action logs of various fora. Since we flagged this at an early stage of the programme, it has now been pulled together into the main tracker. The next step is ensuring through the weekly sessions and a programme of workshops, a healthy pipeline is maintained with a flow through the maturity stages..
- The HB wide schemes need to be strengthened at a workstream level through capacity and capability support to ensure cross cutting schemes are operationalised at a directorate level. This is a significant gap currently within the delivery framework of the organisation in terms of implementation.

## Section 3,4,5 – Financial planning, budgeting, management

Section 3, 4, 5 details observations and views of the financial planning and management within the organisation. This was based on a survey of budget holders and observation at key finance meetings as well as finance committee, audit committee and review of documentation.

- Although there has been work by the Finance team to improve the budget setting processes, our work has identified a number of significant improvements required. These include:
  - The need to strengthen the process in terms of: commencing planning earlier in the year; (which is taking place for 2020/21); workshops with budget holders (to agree expectations, standardise the process, challenge plans and ensure budgets are owned by budget holders); ensuring budgets are signed off prior to commencement of the year;
  - Critically, there needs to be a much greater focus on triangulating HDUHB demand, what is required to service that demand and planned outcomes (quality, access, workforce, transformational savings and finance). This triangulation also needs to take account of prior year performance (key pressures and drivers of underperformance), new year cost pressures and testing the quantum of planned savings to ensure plans are realistic and appropriately phased. At the moment there is a risk that annual planning is finance led.
  - *We note that HDUHB is currently undertaking a review of budget holders and employees with budget responsibility to ensure appropriate spans and layers of authority/ delegation*

# Executive summary

<b>Section 3,4,5 – Financial planning, budgeting, management</b>	<ul style="list-style-type: none"> <li>• Finance reports and in-year performance management focus on variances to budget for YTD and full year outturn rather than the recommended actual run rate trend and forecast outturn.</li> <li>• Opportunities for improved business partnering has been highlighted in the report (e.g. the ability to be a critical but challenging friend) and the need for forecasting to be underpinned by operational drivers, lead indicators and associated tolerances/ early warning signs for required action as well as continued demand &amp; capacity modelling. This extends to Informatics/ Business Intelligence and Workforce planning,</li> <li>• We note that Finance has recently started to input operational metrics into Directorate Finance dashboards to support services in understanding the impacts of operational performance on their financial performance so that they can then make more informed decisions and/or plan better. This however needs to be supported by input from Informatics/ Business Intelligence and Workforce planning teams.</li> </ul>
<b>Section 6 – Capacity and Capability</b>	<p>Section 6 provides a view of the capacity and capability of the organisation as a whole to deliver the financial challenge and recommendations to flexibly use resource to support priority areas. It is based on interviews with the PMO, observations at various finance and HTA meetings.</p> <ul style="list-style-type: none"> <li>• There is limited delivery support capacity and capability for the cross cutting workstreams and directorates in terms of project management and delivery support as the turnaround PMO serves mainly a governance function. Delivery support is required for an organisation at this stage in its improvement journey so they can embed bottom up change. The organisation has project management support in other areas such as the Service improvement team and transformation team and this resource needs to be used flexibly to support the immediate need of the organisation which is achieving the control total. (To note, the Health Board is in the process of redeploying its resource as a response to this recommendation)</li> <li>• The clinical leadership and ownership of the financial position needs to be strengthened at directorate and workstream levels. This currently is variable as observed at the HTA meetings and at the workstreams.</li> <li>• Workforce does not have the capacity to support the themes and directorates in true 'business partnering' style and therefore the skills and expertise that the HR function bring to support the financial position is not embedded at a local level although they do support specific projects</li> </ul>

# Additional information

## Glossary

1. HTA – Holding to Account
2. ETT – Executive Turnaround Team
3. TD – turnaround Director
4. DoF – Director of Finance
5. CEO – Chief Executive Officer
6. COO – chief Operating officer
7. MD – Medical Director
8. HB – Health Board
9. HDUHB – Hywel dda University health Board
10. ED – Executive Director
11. ARAC – Audit, risk and assurance Committee

## RAG rating for observations – based on urgency which is driven by the significance of weakness in terms of impact



To be addressed urgently



To be addressed as a matter of importance



Room for improvement



# Section 1

**Turnaround Governance and accountability**

# Turnaround programme governance

This chart illustrates the Turnaround programme governance arrangements as at September 2019. The observations and recommendations of the various fora are outlined in Slide 12-15.

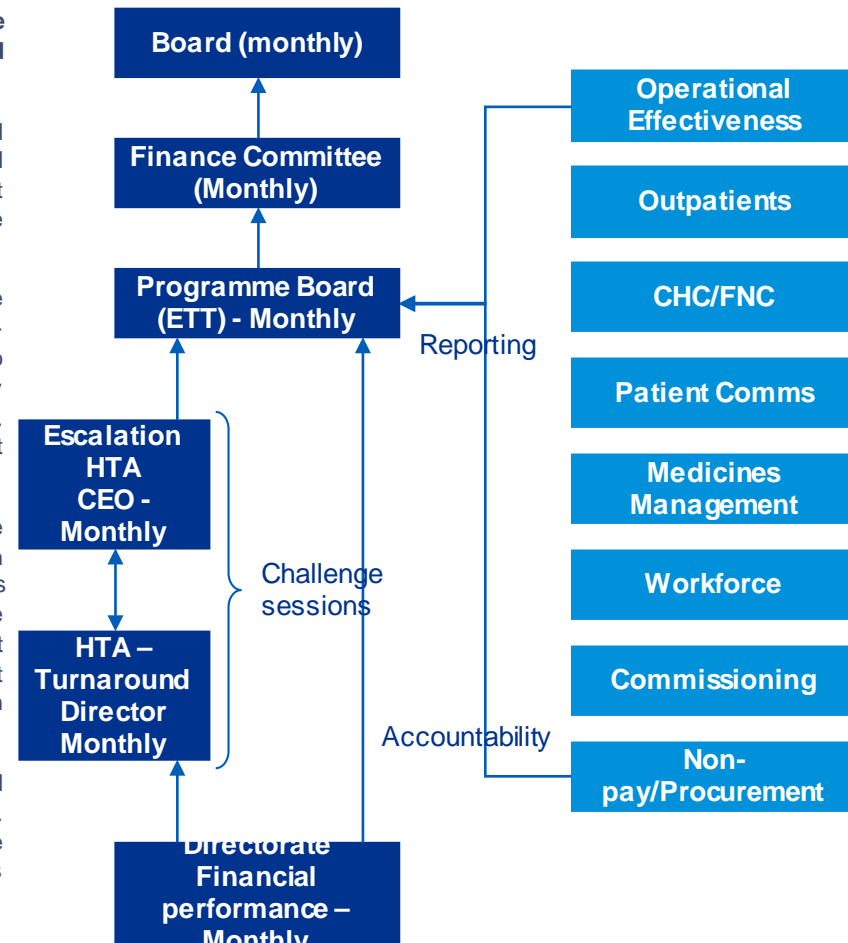
The Health Board have an Executive Turnaround Team Programme Board which is monthly and oversees the Turnaround Programme and is supposed to have updates from the HTA meetings and the workstreams. Although most of the Execs attended the observed meeting, there was no update from the workstreams and the forum would benefit from focussing on key themes.

The Execs commit a significant proportion of their time every month to the Holding To Account meetings (two tiers of HTA with TD/FD and with CEO) - 16 directorates of 39 were at the HTA meetings. A number of these need to be de-escalated by embedding robust challenge at directorate level so only those that require Exec team support to unblock issues are escalated. Control at a central level for an organisation of this size and complexity is not effective and unsustainable.

The frequency of workstreams meetings is variable with some areas like Outpatients meeting on a more regular basis than others. Theatres was taken out of the Turnaround programme and a separate operational meeting was set up at the time of drafting this report. It is also early days for some of the others like non pay and procurement and Workforce which form significant proportions of the savings programme. The workstreams don't report consistently into the Exec Turnaround team partly due to the variability in holding the meetings.

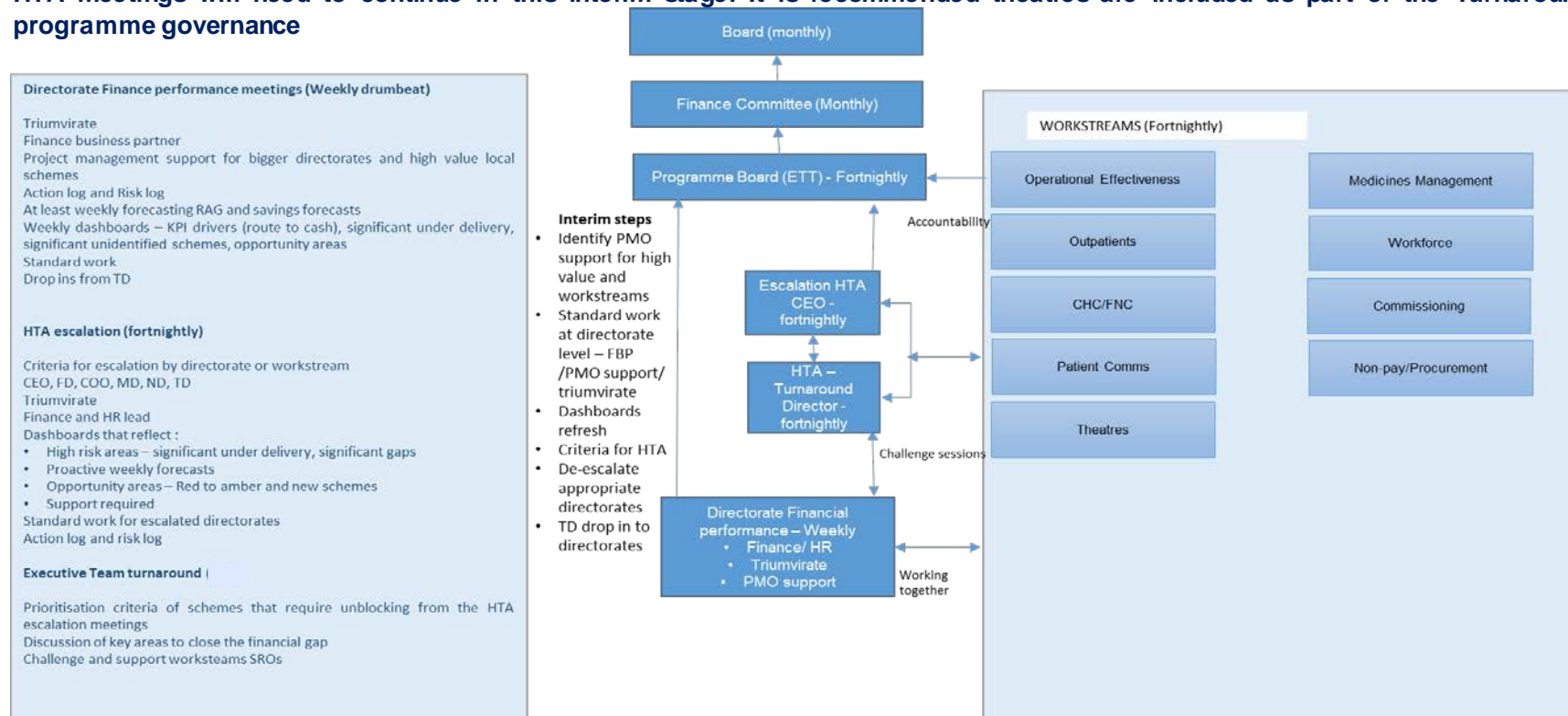
The month end directorate financial performance meetings have a standard agenda and will benefit from greater challenge from the business partners. Directorates, generally do not have weekly standardised meetings to drive delivery of schemes and update forecasts on a live basis (although business partners may have informal sessions with leads as and when)

The level of delivery support for priority areas (directorates and workstreams) is severely limited and this includes insufficient PMO, HR, analytics support



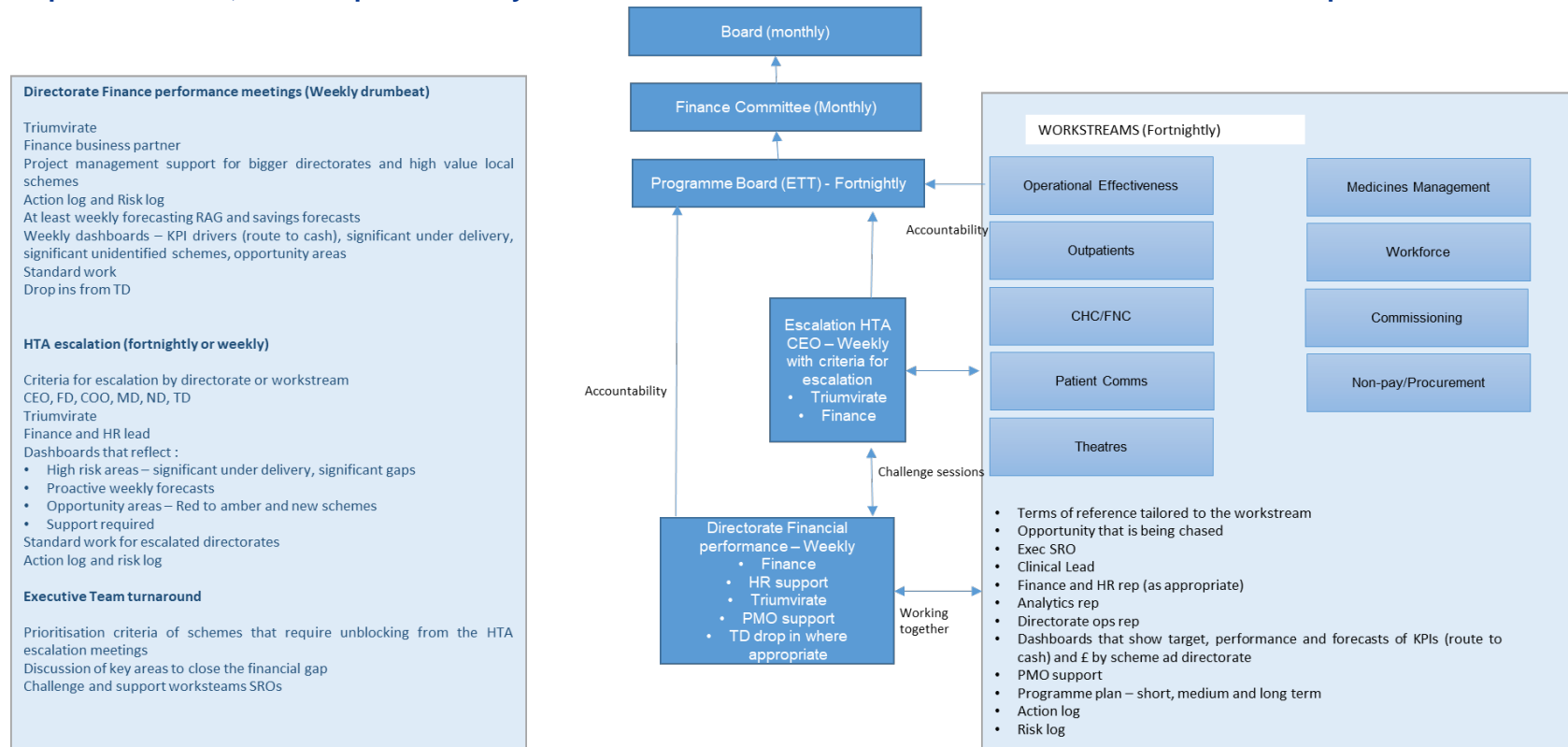
# Turnaround governance – Proposed interim

This chart outlines the proposed interim changes to the turnaround governance structure. It is suggested that the strengthening of the programme governance happens in a phased manner to provide confidence to the Execs that changes are effective at a directorate level. The 3 main changes include 1) Embedding weekly directorate financial performance and challenge meetings to review savings and key indicators 2) Strengthen the workstreams with a regular fortnightly drumbeat and increased capacity and capability support and 3) Fortnightly HTA meetings focused only on priority areas and key indicators so they are truly escalation meetings. As the weekly directorate meetings take time to get embedded, there will be a period of time where the two tier TD and CEO HTA meetings will need to continue in this interim stage. It is recommended theatres are included as part of the Turnaround programme governance








# Turnaround governance – Proposed target

This chart outlines the proposed target turnaround governance structure. The target stage assumes the implementation of the 3 main changes highlighted in the previous slide which would require the embedding of the directorate weekly meetings and strengthening of the workstreams and allowing de-escalation of a number of directorates. At the point of drafting this report, based on discussions with the Turnaround Director, it was thought 4-5 directorates could be de-escalated provided there was confidence from the Execs that there would be robust challenge at directorate level. The weekly challenge and support by the business partners and where required the PMO, ownership and drive by the triumvirate at directorate level as described in Slide 12 will help achieve this







# Turnaround governance

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>1. Turnaround governance and accountability</b>				
<b>Directorate financial performance meetings</b>	1.1 Monthly directorate financial performance meetings are held at Month end. Weekly meetings to discuss operational finance and CIP performance may be held during the month and is variable in content and frequency. [Process issue]	<ul style="list-style-type: none"> <li>Weekly Directorate meetings with the triumvirate, finance business partner, HR and PMO (where appropriate) to be established with agreed agenda so actions to progress savings are turned around quicker and pace increases, use of leading indicators to take timely corrective action.</li> <li>Proactive ideas generation and closing the gap actions at the weekly meetings</li> </ul>		DoF/ COO/MD
	1.2 The attendance includes the Clinical Director, General manager, Nursing lead and Finance. The teams report on the financial performance however the level of proactive planning, challenge and support to close the gap is variable as is the weekly forecasting	<ul style="list-style-type: none"> <li>Information for the meetings to be agreed to ensure constructive challenge and support. Forecasts to be updated on a weekly basis as agreed with the service.</li> </ul>		
	1.3 The schemes and reporting are more transactional rather than transformational. This appears to be due to capacity and capability (project management and understanding of CIP delivery) gaps.	<ul style="list-style-type: none"> <li>FBP and PMO to provide challenge, support and coaching to develop more transformational schemes with the rigour of project management tools.</li> </ul>		
	1.4 The level of constructive challenge provided by the Finance Business partners at these monthly meetings is variable	<ul style="list-style-type: none"> <li>Prioritised areas KPIs and dashboards to track delivery of schemes to be used by FBPs and appropriate training on tools for route to cash and operationalising schemes</li> </ul>		
	1.5 Ownership and engagement from clinical directors is variable at the various observed for a.	<ul style="list-style-type: none"> <li>Clinical engagement and ownership to be consistently strengthened through coaching and carve out of protected time</li> </ul>		





# Turnaround governance (cont.)

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>1. Turnaround governance and accountability</b>				
<b>Holding to Account meetings</b>	1.6 Currently 8 directorates are with the HTA process chaired by the Turnaround Director, DoF and the COO attending whenever possible and 8 that are escalated to the CEO. The CEO HTA are for the directorates that require further escalation (also attended by the COO, DoF, TD, Nurse Director). The number of directorates in escalation suggests a push upwards of responsibility to problem solve. [Process issue]	<ul style="list-style-type: none"> <li>Strengthen directorate performance and accountability sessions so majority of schemes are proactively managed and issues resolved in a timely manner with only those that require Exec support escalated to HTA meetings. The HTA meetings need to be weekly/fortnightly for high risk areas and higher value schemes. The de-escalation will need to be introduced in a phased manner as the Directorate level governance becomes more robust.</li> <li>Consider aggregating directorates to units/divisions for more effective management</li> </ul>		Turnaround Director/ CEO
	1.7 The attendances at the meetings observed seemed to be good with the operational lead and finance lead attending however engagement from clinical leads was variable [Compliance issue]	<ul style="list-style-type: none"> <li>Triumvirate attendance at the HTA meetings needs to be mandatory so it is being driven by the clinical lead.</li> </ul>		
	1.8 There is an escalation process and the HTA meetings have a drumbeat and Execs carve out the time to attend showing it is a priority for the organisation, however it can be strengthened. [Process issue]	<ul style="list-style-type: none"> <li>Increase frequency and focus on fewer high risk areas so majority are being resolved at Directorate and workstream level</li> </ul>		
	1.9 There wasn't a link to the workstreams within the observed HTA meetings although there were themes that came through as issues. [Process issue]	<ul style="list-style-type: none"> <li>Themes need to be supported and resolved at the Workstream meetings that are led by Exec SROs in a proactive and timely manner and only if unable to resolve should be escalated to HTA. Regular feedback loop to workstreams from HTA meetings.</li> </ul>		





# Turnaround governance (cont.)

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>1. Turnaround governance and accountability</b>				
<b>Holding to Account meetings (cont.)</b>	1.10 There are standard dashboards supporting these meetings and prep sessions by the directorates. However, a number of the directorates did not come prepared with worked up ideas to close the gap and the discussion for new ideas happened at the HTA level rather than directorate level. Therefore some of the issues discussed were not material in value. [Compliance issue]	— Strengthening the weekly directorate and workstream meetings will help filter the issues discussed at the HTA meetings. Prioritisation criteria for the HTA meetings to be agreed example schemes in delivery that are slipping by value, amber/red schemes that should have turned green and plans to close the gap.		Turnaround Director/ CEO
<b>Workstreams</b>	1.11 The workstreams have generic terms of reference that need to be customised to the workstream. They are led by an Exec SRO who oversees and drives the programme and effectiveness is variable depending on the workstream. It is attended by operational representatives from the directorates however they do not have a Clinical lead. [Process issue]	— Workstream governance to be strengthened with clear roles and responsibilities and accountability/ reporting arrangements to the Programme Board and fortnightly formal meetings with clinical lead, project management tools and PMO support. Feedback loops required to directorate and HTA meetings.		Workstream Exec SROs
	1.12 Theatres productivity has been stood down as a turnaround workstream. The intention is to run it as an operational workstream and there has been an initial meeting but the risk is that it does not get the required focus of the turnaround programme. [Process issue]	— It is suggested theatres productivity is monitored and reported as part of the turnaround programme as the Values work has identified a significant opportunity.		
	1.13 There was minimal PMO support, HR, Finance and IMT support which is a contributing factor to lack of pace. [Process issue]	— PMO, HR, Finance and IMT lead to be assigned to main workstreams eg theatres, OP, Ops effectiveness		

# Turnaround governance (cont.)

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>1. Turnaround governance and accountability</b>				
<b>Workstreams (cont.) Executive Turnaround Programme Board</b>	1.14 There is no consistency in the use of dashboards and KPIs reflecting performance on a timely basis. At the observed meetings there was a lack of robust project management tools and processes such as programme plans, KPIs, proactive forecasting and risk logs. There was an action log however there was insufficient pace and work in between meetings potentially reflecting the lack of capacity. [Process issue]	— Refresh of dashboards and responsibility to be assigned for circulating the dashboards and KPIs for the meeting. Programme plan, KPIs, forecasts and risk logs to be used as standard tools in addition to action logs with leads and deadlines.		DoF/ Turnaround Director
	1.15 The route to cash was also not clear from the work being discussed	— Route to cash to be agreed for all schemes at PID stage		
<b>Executive Turnaround Programme Board</b>	1.16 There was good attendance from most Execs at the observed Turnaround Programme Board but the effectiveness can be enhanced. This is a monthly forum where Execs provide oversight of the programme and a level of challenge to SROs. [Process issue]	— It is suggested that the challenge and associated actions have greater rigour and pace with deadlines in between the formal meetings and frequency is increased to fortnightly meetings.		CEO
	1.17 With regard to content, the group went through all the ambers schemes and assigned Exec leads to progress them. The agenda can be amended to be more effective as it does not have the prioritisation of schemes that have maximum benefit. [Process issue]	<ul style="list-style-type: none"> <li>— It is suggested that the amber and red schemes are progressed at workstream and directorate level and summary updates are provided at the programme Board with high risk areas and decisions required being raised at the Programme Board based on scheme value.</li> <li>— It is also suggested focus of the group needs to be weighted towards closing the gap from the directorates and workstreams rather than existing schemes as the HTA meetings should deal with these.</li> </ul>		

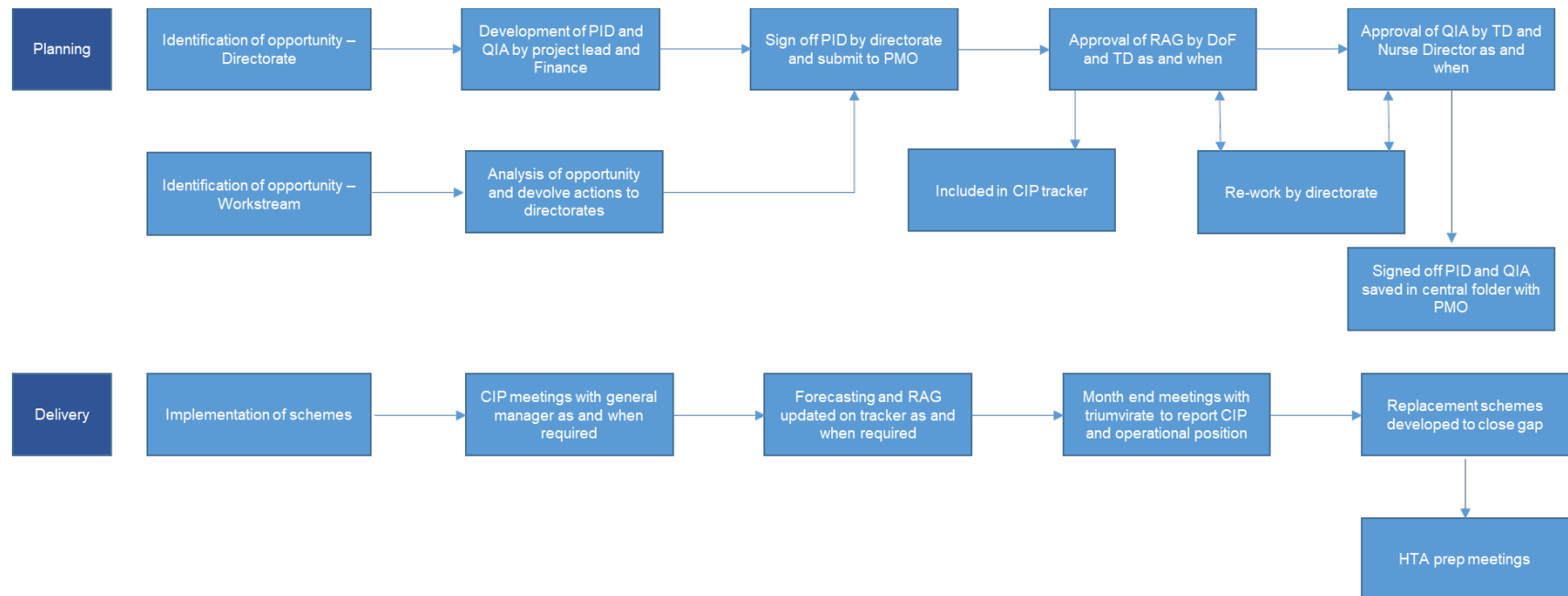


# Section 2

## Savings planning

# Savings plans

This slide outlines the current CIP approval process during the planning stage and the monitoring and reporting process at Delivery stage. The process has been helpful in providing consistency and structure and can be strengthened further as outlined on the points in the next slide





# Savings plans (cont.)

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>2. Savings planning</b>				
<b>Process</b>	2.1 There is a PID and QIA process that has been established as part of the Turnaround programme	— This is the first year that PIDs and QIAs have been developed and approved		Turnaround Director
	2.2 The identification of schemes is undertaken annually at year end for the following year and therefore the new year starts with a gap in addition to slippage of schemes. The continuous planning of savings opportunities is not robust within workstreams and at best is variable eg Outpatients is more advanced than other workstreams.[Process issue]	— The identification of schemes and PIDs development needs to be a continuous cycle through the weekly directorate sessions and regular workshops so there are sufficient schemes coming through the pipeline to cover slippage as well as being proactive for the following year. — Workstream agenda to include a continuous cycle of planning and provide the steer and challenge to deliver savings		
	2.3 The quality of PIDs is variable and the RAG rating is variable with a strong optimism bias and route to cash not clearly articulated. [Compliance issue]	— The directorates need further coaching on PIDs completion so there is consistency of key aspects like KPIs and route to cash identified and RAG rating in the tracker reflective of the planning stage or/and delivery risk.		
	2.4 The PIDs are submitted to the PIA to quality check and hold centrally, There is insufficient capacity within the PMO to perform this function for over 100 PIDs all coming through over a similar time period (1 PMO manager)	— Capacity within the PMO needs to be increased to support the governance and project management support/ challenge of the schemes.		
<b>Content</b>	2.5 There is no differentiation between high and low value PIDs.[Process issue]	— Consider having a threshold for PID requirement c25k.		
	2.6 The quality of PIDs is variable and the RAG rating is variable with a strong optimism bias and route to cash not clearly articulated. In addition there is inconsistency in articulating key milestones and action plans. [Compliance issue]	— The directorates need further coaching on PIDs completion so there is consistency of key aspects like KPIs, milestones and route to cash identified and RAG rating in the tracker reflective of the planning stage or/and delivery risk.		

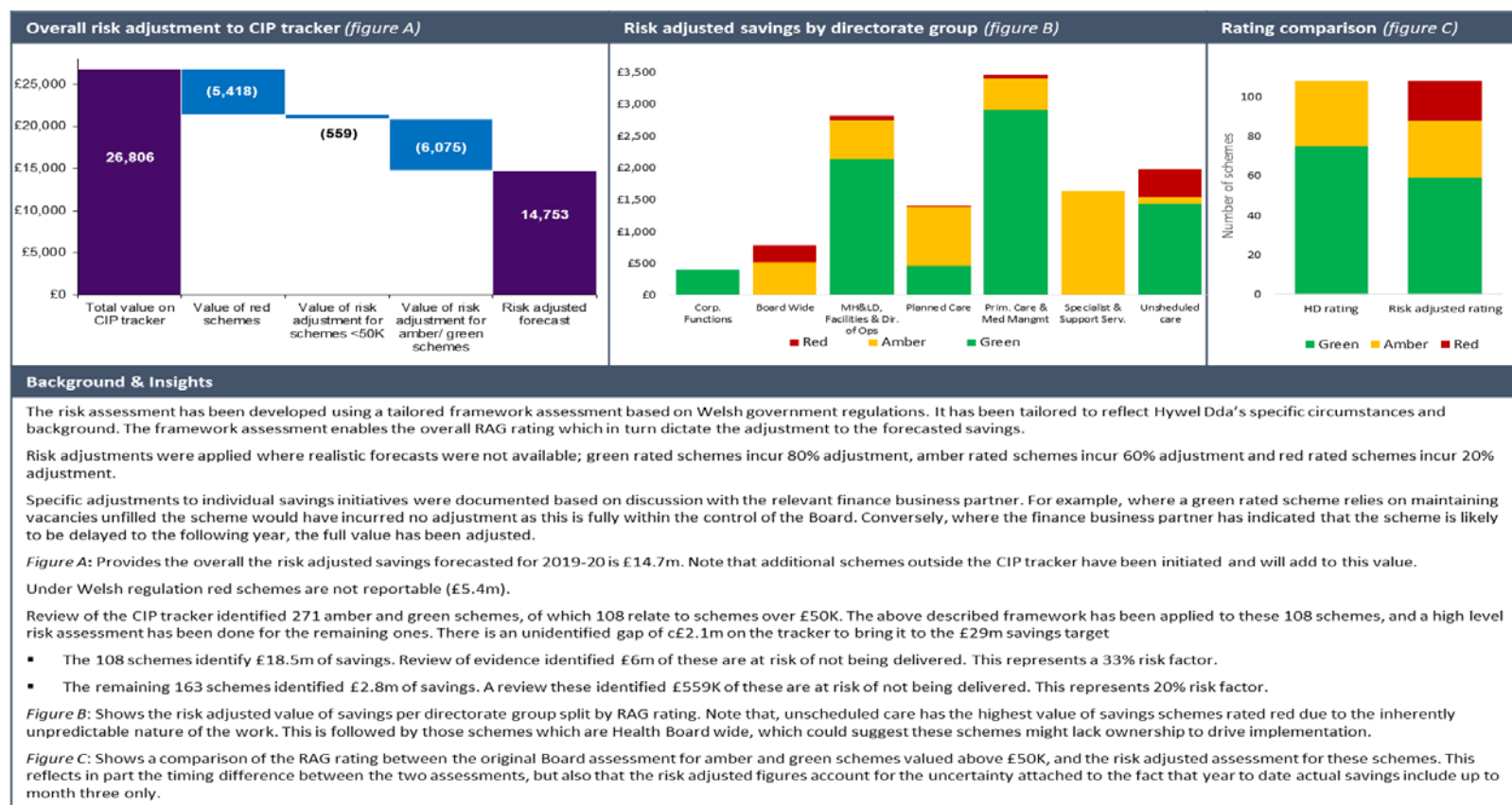
# Savings plans (cont.)

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>2. Savings planning</b>				
<b>Governance</b>	2.6 Of the 107 amber/green schemes over 50k, 43 did not have PIDs, these were mainly corporate and medicines management although there were a few other directorates as well. [Compliance issue]	— There needs to be consistency for PIDs requirement for schemes over an agreed threshold value.		Turnaround Director
	2.7 The PIDs were approved by the DoF and TD and Nurse director. The Medical director was not involved in reviewing the QIA. The schemes did not have formal QIA approval although they were all reviewed and feedback provided. [Compliance issue]	— Consider having an electronic approval process. The QIA needs to be signed off by the Medical director as well. QIAs to be formally approved for schemes.		

# Risk assessment of savings plans

The following slide provides a summary of the risk assessment of the savings plans that was undertaken based on desktop review of schemes >50k and interviews with business partners and service teams (wherever possible). It reflects planning delivery risks of the programme. This is currently being validated by the finance team and the teams will update their forecasts where appropriate.






# Section 3

**Planning and budget setting**

# Planning & budget setting

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


**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix 1 for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>3. 19/20 Planning and Budget setting</b>				
<b>19/20 Annual planning and budget setting</b>	<p>3.1 The 19/20 Annual planning and budget setting commenced in August 2018 with the approach and plan detailed in a Finance Committee paper tabled in Sept 18.</p> <p>3.2 Finance BPs initially worked with budget holders to populate a budget template (using month 5 18/19 outturn, adjusted for non- recurrent items, existing cost pressures, new unavoidable cost pressures, new developments and investments, savings plans, capital investments and workforce). These were then sent to general managers for review, approval and final submission to the finance planning team for aggregation. The Planned Care Directorate template was only partially completed for cost pressures with some marked as TBC.</p> <p>3.3. The Directorate returns were then aggregated by the Finance planning team with overlay of national planning assumptions e.g. increased income allocations and pay awards and HDUHB strategic service developments;</p>	<p><b>The KPMG review and budget survey has identified significant improvements required to strengthen the annual planning and budget setting process. Recommendations include:</b></p> <ul style="list-style-type: none"> <li>— An executive hosting a budget setting workshop to set out the planning process with all Directorate budget holders/ employees with budget holder responsibility and their supporting Finance Business Partners to confirm accountability and need for collaboration.</li> <li>— Finance challenge sessions to be hosted to ensure completion of templates and to test the robustness of assumptions made to support the preparation of robust plans, including:</li> <li>— Alignment with HDUHB strategy;</li> <li>— Focus on addressing the drivers of the deficit;</li> <li>— Testing triangulation of demand/ activity forecasts and workforce (including capacity modelling and setting budgets based on actual establishment i.e. not prior year spend);</li> </ul>		DoF

# Planning & budget setting (cont.)

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



**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix 1 for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>3. 19/20 Planning and Budget setting</b>				
<b>19/20 Annual planning and budget setting</b>	<p>3.4 The aggregated HDUHB 19/20 plan for income and expenditure was then reviewed on a high level basis by Finance focusing on the bottom line deficit position.</p> <p>3.5 A uniform percentage cost reduction target was then applied to all directorates to deliver a planned deficit of £29.8M.</p> <p><b>Survey results</b> - The results highlight low %'s for:</p> <ul style="list-style-type: none"> <li>Confirmed budget holder involvement: Overall = 49%; £3M -</li> <li>£10M = 89% BUT &gt;£10M = 50%</li> <li>Setting of realistic budgets: Overall = 43%; £3M - £10M = 33% and &gt;£10M = 14%</li> <li>Integrated budget informed by operational plans: Overall = 37%; £3M - £10M = 45% and &gt;£10M = 21%</li> </ul>	<ul style="list-style-type: none"> <li>Testing the robustness of assumptions, including completeness of cost pressures, supporting evidence for new cost pressures, approvals for new service developments and completeness of risks and opportunities identified, taking into account key learnings from the current year (e.g. unplanned cost pressures and known demand changes);</li> <li>Honest and transparent conversations regarding savings targets to develop realistic and achievable plans owned by Directorates and budget holders (supported by analysis and benchmarking). Any gaps to planned deficit should be highlighted to enable CIPs to close the gap.</li> </ul>		DoF

# Planning & budget setting

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


**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix 1 for survey results

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>3. 19/20 Planning and Budget setting</b>				
<b>19/20 Annual planning and budget setting (cont.)</b>	3.6 Base budget deficit of £29.8M (including CIPs) was flat phased equally into 12 months in the original plan submitted to WG. <b>Survey results</b> - The results show a high % for appropriately phased budgets across all budget holder groups: Overall = 76%	— Budgets (including supporting savings targets) should be appropriately phased and take into account key learnings from the current year (e.g. seasonality trends, M12 accounting adjustments, number of working days and expected timing of key events to allow meaningful variance analysis as the year progresses.		DoF
	3.7 The budget was then updated for full year forecast outturn at M9. The overall budget deficit of £29.8M was however maintained despite run rate cost pressures of £1.4M through pay assumptions (for example the Agenda for Change pay award) being reduced by a corresponding amount.	— To maintain the integrity of budget assumptions and consequent performance reporting and forecasting for the budget year, new cost pressures based on review of existing run rates should be investigated and accounted for (where not capable of being mitigated prior to the budget year commencing) with savings targets updated accordingly. The planned introduction of Power BI will enable HDUHB to plan on 'run rates' which are activity driven.	 Given materiality	DoF

# Planning & budget setting (cont.)

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


**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix 1 for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>3. 19/20 Planning and Budget setting</b>				
<b>Budget approval and signoff process</b>	<p>3.8 A 'draft interim' plan was presented to the Board on 28th March 2019 and approved for onward submission to the Welsh Government.</p> <p>3.9 The finance team then retrospectively initiated the process of signing off budgets from the Directorates with a letter sent to 52 budget holders on 10 April 2019, to be returned back by 23 April 2019. However, there are approximately 182 budget holders and 200 individuals with budget responsibilities in the Board. As at month 5, signed accountability letters are still outstanding for the CEO and Primary Care (due to some historic discrepancies to be concluded during September). Letters were not sent to all budget holders as there was not capacity in finance to explain budgets at that level to all budget holders.</p> <p>3.10 The plan was then revised to a control total deficit of £25M (approved by the HDUHB Board in May) to reflect control total agreement with Welsh Government with the additional savings requirement of £4.8M back end loaded. (compliance issue)</p>	<p><b>The KPMG review and budget survey has identified significant improvements required to strengthen the budget approval and signoff process. Recommendations include:</b></p> <ul style="list-style-type: none"> <li>— A review of budget holders and employees with budget responsibility to be undertaken to ensure appropriate spans and layers of authority/ delegation</li> <li>— All budget holders and those with budget responsibility to be required to agree to their budgets prior to submission and approval by the Board and prior to submission to Welsh Government before the start of the new year (the annual planning cycle needs to allow sufficient time for this while budget preparation monitoring arrangements need to escalate non compliance to the Executive).</li> </ul>		DoF

# Planning & budget setting (cont.)

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

**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix 1 for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>3. 19/20 Planning and Budget setting</b>				
<b>Budget approval and signoff process</b>	<p>3.11 We note that:</p> <ul style="list-style-type: none"> <li>— There is no cascade process in place that requires lower level budget holders to agree that they will adhere to their budget and the required procedures.</li> <li>— The current system is email based which is less robust and more time consuming and prone to errors than a policy management system.</li> <li>— Budget holders have up to 45 active cost centres to manage.</li> </ul> <p><b>Survey results</b> - The results show a low % for signoff of budgets: Overall = 37%; £3M - £10M = 44% and &gt;£10M = 57%</p>	<ul style="list-style-type: none"> <li>— Consider the possibility of an electronic signoff system. Such systems can be used for multiple issues (e.g. that other policies have been read and will be adhered to).</li> </ul>		DoF

# Planning & budget setting (cont.)

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

**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix 1 for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>3. 19/20 Planning and Budget setting</b>				
<b>Alignment of planning, finance, workforce and Transformation</b>	<p>3.12 In developing the financial plan, there is a lack of robust alignment between operational, workforce, activity and financials. This is reflected in the relative silo working of the various teams.</p> <p>3.13 This lack of alignment is also reflected in having two separate committees for finance and performance and therefore the decision making process is not aligned.</p> <p>3.14 In addition to the above there is no clear roadmap from the current state (operationally, financially and workforce) to the Transforming clinical services strategy that is aligned to the annual plans</p>	<ul style="list-style-type: none"> <li>— There needs to be closer working between HR, finance and Operations in developing the operational and financial plan with clear links in how the plans impact on each other.</li> <li>— Consider having a Performance and Finance committee</li> <li>— Develop a robust roadmap to Transformation with Transformation teams supporting the priorities of the organisation at every stage of its improvement journey including Turnaround.</li> </ul>		



# Section 4

**Financial management/ reporting**

# Financial management/reporting

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


**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/Reporting output</b>				
<b>Monthly reporting on Health Board performance to Board and committees</b>	<p>4.1 Reports showing financial performance against budget are prepared on a monthly basis for the Health Board as a whole.</p> <p>4.2 The Finance &amp; Turnaround Update and Finance Committee papers are in a consistent reporting format for month 1 with the same level of detail provided to each. This raises the risk of duplicate discussion and ability of the Finance Committee to provide assurance / complete it's remit.</p> <p>4.3 Papers presented to the Health Board report historic positions and are focussed on telling the story of the YTD and savings delivery, for example, no cash flow forecasts are provided. There is also limited view of the medium / long term in the papers which could inhibit completeness and accuracy of risks reported in risk registers.</p> <p>4.4 As there are a significant number of Directorates (38), the Finance and Turnaround Update report shows only the largest 14 Directorates, with others grouped together. This reporting shows Directorate YTD financial performance against budget without any further specialty split or full year financial forecast for HDUHB or Directorates.</p>	<ul style="list-style-type: none"> <li>Review the information provided to ensure that it enables the user to identify where areas of challenge are to take appropriate action.</li> <li>Report by speciality in addition to Directorate as this is likely to result in additional challenges/opportunities being identified.</li> <li>Include appropriate financial and non financial KPI and workforce and activity information to triangulate performance. Reports should also include required actions, dates for completion and progress made. A summary page which shows the position by Directorate – YTD Actual, YTD Variance, Forecast, Forecast Variance, Savings YTD (Act vs Target), Savings (Forecast vs Target), Risk would link it all together and could be RAG rated to provide clarity on key items.</li> <li>Reports need to focus on analyses of actual run rate trend and forecast outturn as opposed to variances of actual to budget for YTD and full year.</li> <li>Ensure the reports are aligned to the savings tracker and ledger.</li> </ul>		DoF

# Financial management/reporting

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


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Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/ Reporting output</b>				
<b>Monthly reporting on Health Board performance to Board and committees (cont.)</b>	<p>4.5 The papers present results at a Directorate level and then consider specific HDUHB line items such as pay expenditure, non pay expenditure, income and savings. This creates a fragmented report which can make it difficult for a user of the report to identify consistent messages and trends.</p> <p>4.6 The lack of consistency throughout the papers makes it difficult to identify specific trends or themes, for example, through the reporting is not possible to identify which Directorates have an improving or worsening position over time. This clarity would assist in highlighting areas of concern or potential future risks earlier in the reporting cycle.</p> <p>4.7 In the ledger, HDUHB offsets the planned deficit for the year through a corresponding reserve 'income' adjustment to set a balanced budget. This reserve can then be rephased in the year to 'smooth out' actual performance for aggregated Health Board performance.</p>	<ul style="list-style-type: none"> <li>— A rolling 12 month cash position forecast (i.e. past year end) should be prepared to support the I&amp;E forecast.</li> <li>— The Board should not smooth out any monthly fluctuations in YTD or full year budget phasing through release of central reserves – as this impacts the robustness of the monthly variance analysis. The planned introduction of Power BI and activity profiling will help inform understanding and forecasting of monthly performance.</li> </ul>		DoF

# Financial management/reporting

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



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Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/Reporting output</b>				
<b>Monthly reporting on Health Board performance to Board and committees (cont.)</b>	<p>4.8 HDUHB monitors in-year performance for each directorate, comparing actual performance versus budget. However, the budgets being compared are the updated budgets, with no comparison of actual performance against original plan / budget.</p> <p>4.9 Additionally, HDUHB reports the 'variances' to these revised budgets in their management reports, and comments on month on month changes to variance to plan - real performance against plan is therefore difficult to understand if the budget has been changed or reserves have been re-profiled.</p>	<ul style="list-style-type: none"> <li>— HDUHB should compare actual YTD performance with the original plan. If there are material changes to circumstances which warrant updates to the budget, the management reports should compare actual YTD performance with the revised plan, as well as show the original plan as part of the analysis, supported by commentary.</li> <li>— Reports and in-year performance management need to focus on actual run rate trend and forecast outturn as opposed to variances to budget for YTD and full year outturn. By being forward looking, the capability of Finance and BI functions can support the front line to take corrective, timely action to improve forecast performance (particularly given variance analyses is backward looking with budget assumptions often outdated). The quality of reporting for Board members and the WG to understand likely full year outturn and actions required to improve is also significantly increased.</li> </ul>		DoF

# Financial management/reporting

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



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Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/Reporting output</b>				
<b>Financial reporting to Directorates</b>	4.10 A monthly finance dashboard for each Directorate is produced and provided to budget holders. This details in- month performance against plan, actual and normalised expenditure trend, saving plan performance, pay trend (by type of staff and nature of spend e.g. substantive, bank and agency), non pay trend (drugs, clinical and other) and projected outturn. In addition, the dashboard highlights some operational indicators (e.g. surge pressures), key required actions together with responsibility and due dates.	<ul style="list-style-type: none"> <li>— This is a strong start to increasing grip on Directorate performance and addresses some of the development points raised above. In addition, we would recommend:</li> <li>— Expanding the current forecast model to reflect 12 month actuals and 18 months forward look which is then underpinned by statistical analyses, demand and capacity modelling, operational 'business' drivers (together with agreed in-year tolerances/ early warning indicators to highlight when action is required) and planned outcomes (financial and non financial).</li> </ul>		DoF
<b>Financial reporting to budget holders</b>	4.11 Financial information is not provided to budget holders of individual cost centres. Budget holders are able to review their financial position through QlikView though it is unclear how extensive use of this functionality is.	<ul style="list-style-type: none"> <li>— Training for budget holders to use QlikView and/or monthly emails to budget holders of the financial performance against budget, with appropriate follow up by the relevant BP where adverse.</li> <li>— Update QlikView if required to ensure the reporting is user-friendly and enables effective management.</li> </ul>		DoF

# Financial management/reporting

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



**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/ Reporting output</b>				
<b>Financial reporting to budget holders</b>	<p>4.11 (Cont.) Survey results - The results show :</p> <ul style="list-style-type: none"> <li>— A high % of budget holders have access to monthly management accounts or budget reports: Overall = 96%</li> <li>— Most budget holders report within 2 weeks of month- end (36% of budget holders however responded with 'not applicable' which implies that they are not involved in month-end reporting).</li> <li>— A high % do not undertake validation of the monthly management accounts: Overall = 46%; £3M - £10M = 33% and &gt;£10M = 29%</li> </ul>	<ul style="list-style-type: none"> <li>— Training for budget holders to use QlikView and/or monthly emails to budget holders of the financial performance against budget, with appropriate follow up by the relevant BP where adverse.</li> <li>— Update QlikView if required to ensure the reporting is user-friendly and enables effective management.</li> </ul>		DoF
<b>Financial reporting to HTA (Holding to Account meetings)</b>	<p>4.12 There are a standard set of reports for the monthly HTA meetings which highlight YTD variances to plan and full year forecast outturn on a Directorate level based on forecast run rate, risks identified, mitigations (where developed) and opportunities. However the forecast savings do not match the CIP tracker forecast that is reported in the monitoring returns. (compliance issue)</p>	<ul style="list-style-type: none"> <li>— There needs to be one version of the truth between the CIP tracker and HTA documentation with an owner reconciling the two information sets</li> <li>— Reports need to focus on analyses of actual run rate trend and forecast outturn as opposed to variances of actual to budget for YTD and full year.</li> </ul>		DoF

# Financial management/reporting

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




**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/Reporting output</b>				
<b>Workforce reporting</b>	4.13 Ensure workforce reporting focuses on key elements of variable pay spend (agency, bank, overtime etc.) and supports the financial reporting.	<ul style="list-style-type: none"> <li>Weekly/monthly reporting as appropriate to areas of the Health Board (including directorates) in relation to staffing based on agreed metrics and covering all staffing groups but focused on variable spend.</li> <li>Establish a headcount tracker and reconcile to workforce information systems, underlying data sets and all reports to ensure 'one version of the truth' for reported establishment</li> </ul>		DoF
<b>Savings Tracker</b>	4.14 Forecasts are not consistently updated on the tracker although it is updated in the HTA documentation. Therefore monitoring returns do not have an updated savings forecast. (compliance issue)	<ul style="list-style-type: none"> <li>Savings tracker must be kept updated on a 'live' basis and as a minimum weekly with owners for the schemes and overall tracker. There needs to be one version of the truth between the tracker and HTA documentation</li> </ul>		DoF
	4.15 RAG rating for schemes that are not expected to deliver is also not updated	<ul style="list-style-type: none"> <li>The RAG rating on the tracker need to reflect the status of the PIDs with expected Go green dates that are monitored weekly</li> </ul>		
	4.16 There is inconsistency of recording of pipeline and red schemes in the CIP tracker with a number of ideas that are being worked not being recorded on the tracker. This means there is no visible central repository of a continuous savings pipeline.	<ul style="list-style-type: none"> <li>Pipeline schemes need to be recorded on a tracker and monitored with a go green date on a weekly basis/ live basis.</li> </ul>		

# Financial management/reporting

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

**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>4. Financial management/ Reporting output</b>				
<b>Reporting locations</b>	4.17 While we recognise that Finance do know which sites cost centres relate to (though some are Health Board wide), HDUHB's ledger codes do not have corresponding locations tagged, making it difficult to track budget or spend by location. This is particularly relevant in relation to spend where there are controls at a site level (e.g. nursing agency).	— Include mapping of cost centres to locations to assist in internal cost and efficiency benchmarking, identifying opportunities for efficient utilisation of resources across sites, consistent monitoring of financial performance across locations, and engaging with relevant frontline staff to collaboratively address budget variances.		DoF
<b>Reports preparation</b>	4.18 We note that Finance prepares monthly reports from an extract of the ledger taken out from Oracle, processed in Qlikview, manually processed in MS Excel and subsequently copied into MS Word with commentary added on to it.	— Review reporting processes to identify opportunities for automation and self-serve, to free Finance resource to deliver more value add activity.		DoF
<b>WG Monitoring returns</b>	4.19 Savings forecasts in the monitoring returns did not reflect the risk associated with green/amber schemes. This is due to the risks being considered as operational pressures in the returns and netted off against mitigating actions (compliance issue)	— It is suggested that savings forecasts are updated on a weekly basis with programme risks reflected in the returns and actions separately identified.		DoF




# Section 5

**Financial performance management**

# Financial performance management

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


**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>5. Financial performance management</b>				
<b>Month end HTA performance meetings</b>	<p>5.1 Any Directorate with an adverse variance to assigned budget, or a projected adverse variance to assigned budget of £200k or more, is escalated into the Holding to Account (HTA) process</p> <p>Although the month end HTA meeting which we attended, was well chaired, it highlighted opportunities for improved business partnering (e.g. the ability to be a critical but challenging friend) and the need for forecasting to be underpinned by operational drivers and associated tolerances/ early warning signs for required action as well as continued demand &amp; capacity modelling.</p> <p><b>Survey results - The results show:</b></p> <ul style="list-style-type: none"> <li>— That the % of budget holders having regular monthly meetings with their finance manager to clarify or explain variances is low at HDUHB = 54% BUT high for £3M - £10M = 89% and &gt;£10M = 93%</li> <li>— A high proportion of budget holders do not keep a documented audit trail of actions being taken to address any variances (and their impact). Overall = 47%; £3M - £10M = 33% and &gt;£10M = 36%</li> </ul>	<ul style="list-style-type: none"> <li>— There needs to be an increased focus on development of Finance Function capability, including effective corporate service business partnering through a potential finance function review and through provision of appropriate training. It is important that Finance transforms from a back office scorekeeper to a front line enabler for driving improvement.</li> <li>— This can be achieved through a continued shift to a financial forecast management system.</li> <li>— By being forward looking ('mindset') and developing forecasts that are underpinned by an understanding of demand, what is required to service that demand and key operational 'business' drivers (together with their non financial and financial impacts), corporate business partners (Finance, BI and workforce) can then develop the 'skillset' to support the front line to plan effectively and to take corrective, timely action to improve actual forecast performance (including in-month).</li> </ul>		DoF

# Financial performance management


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

**Basis of preparation:** Findings and recommendations are based on interviews with HDUHB finance staff and review of available documentation. In addition, they have been triangulated with a budget survey completed by 70 budget holders/ employees with budgetary responsibilities (35% completion rate based on population of 200) – refer Appendix for survey results.

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>5. Financial performance management</b>				
<b>Month end HTA performance meetings</b>	<ul style="list-style-type: none"> <li>— A high proportion of budget holders are not asked to report a projected year end budget position. Overall = 52%; £3M - £10M = 33% BUT &gt;£10M = Nil%</li> <li>— A high proportion of budget holders felt they would benefit from receiving regular training on budget setting and monitoring. Overall = 77%; £3M - £10M = 78% and &gt;£10M = 64%</li> </ul>	<ul style="list-style-type: none"> <li>— It will also require a change in toolset i.e. timely, visual system data and dashboards for operational drivers and in- month leading indicators to highlight deviation from budget/ forecast.</li> <li>— All budget holders with significant budgets should receive budget holder setting and monitoring training to improve the capability of HDUHB for improving non financial and consequent financial performance (quality, access, workforce, productivity and value). It is pleasing to see that a high number of respondents are seeking such training.</li> </ul>		DoF


# Financial performance management

The following section outlines the findings and recommendations of a review of the financial performance management arrangements within the Health Board

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Business cases</b>	<p>5.2 HDUHB has revised its approval process (effective autumn 2018) for revenue business cases to improve grip on:</p> <ul style="list-style-type: none"> <li>— Preparation, particularly evidence for alignment to HDUHB's and Directorate strategy, options testing, planned financial and non financial benefits and pay and non pay investment.</li> <li>— Required approvals</li> <li>• Consideration through the relevant management (and accountability) structure and corporate functions including Finance and Workforce. This includes signoff from Director, Directorate manager, Other affected managers, Finance Business Partner;</li> <li>• Executive approval at fortnightly meeting (documented in minutes);</li> <li>• Finance Committee approval for all cases above £100k.</li> </ul>	<ul style="list-style-type: none"> <li>— Whilst the process for preparation and signoff of revenue business cases has been strengthened, its important that the focus now shifts to monthly monitoring of actual post implementation costs and benefits realisation for newly approved cases so that corrective action can be identified where required and key individuals held to account. This should include disinvestment if required.</li> <li>— Given reviews are not currently taking place, we would recommend that the performance for all business cases (approved in the past 12 months and with significant planned benefits and investments costs) is analysed and a decision made on potential disinvestment where these are underperforming.</li> </ul>		DoF


# Financial performance management

The following section outlines the findings and recommendations of a review of the financial performance management arrangements within the Health Board

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Finance Committee observation</b>	<p>5.3 Our observations highlighted the following:</p> <ul style="list-style-type: none"> <li>— There was appropriate challenge from the Chair and Independent Members ('IM') throughout the agenda. Responses from Executive Directors ('EDs') and officers were clear and addressed the questions. For example: <ul style="list-style-type: none"> <li>• IMs pressing for a completion date for outstanding action.</li> <li>• Clarification of whether surge beds were included within the forecast position and how this could be linked to DTOC.</li> <li>• Requesting a report to come back to the committee on grip and control following challenge around the management of bank and agency.</li> </ul> </li> <li>— The Chair focused on the need for assurance to be provided to the committee, in line with the objectives outlined in the Terms of Reference. For example, the need to provide assurance on the balance of transactional vs transformational saving schemes, certainty of the pipeline and assurance over 2021 plan.</li> </ul>	<ul style="list-style-type: none"> <li>— The meeting ran over time with a large volume of papers to review prior to the Committee, despite a number of items being deferred to later committees. Whilst the discussions summarised key papers and the presentation of the finance report highlighted key items, we recommend that the agenda is streamlined to reduce the volume of reports provided to each committee:</li> <li>— RTT, establishment control and capital projects were not discussed due to time pressures – the reports did not appear to be key requirements and therefore may not be required each month. We recommend that such papers should be staggered over a three month period, with RTT being provided in month 1, establishment in month 2 and capital in month 3 to spread the volume of reports across the periods).</li> <li>— The Turnaround report was not discussed in detail as key items were already discussed in the financial report. Given the inherent links between the items, we recommend that the reports are merged so reducing the detail included in papers.</li> </ul>		DoF/ Chair of Finance Committee


# Financial performance management

The following section outlines the findings and recommendations of a review of the financial performance management arrangements within the Health Board

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Finance Committee observation (cont.)</b>	<ul style="list-style-type: none"> <li>Although the majority of the Committee was looking at the current financial position and focussed on the short term, this reflected the timing in the financial year. There was discussion around the medium term, including the expected financial targets for the 2021 financial year.</li> <li>Detailed presentations were provided in relation to the financial position. This included detail of the Directorate positions and YTD and forecast position. The presentation clearly noted the 'risk' of £7.1m to forecast and £5m of savings and there was discussions around plans to mitigate the £12.1m gap.</li> <li>The close period at the meeting was used to reflect on the meeting and agree key items to be reported to the Board.</li> </ul>	<ul style="list-style-type: none"> <li>The Finance Report contained a presentation and detailed report for committee members. The detailed report could be moved to a 'for information' section of the agenda, or provided as an accompanying paper, as the presentation picks out the key items for discussion. This will allow members with limited time to focus on other papers which are not presented in as much detail.</li> </ul>		DoF/ Chair of Finance Committee


# Financial performance management

The following section outlines the findings and recommendations of a review of the arrangements financial reporting and management in the Health Board at Board and sub-committee level and to WG

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Finance Committee observation (cont.)</b>	<ul style="list-style-type: none"> <li>Each member of the committee was given appropriate opportunity to present reports, with time also available for relevant challenge. Our analysis noted a relatively even split of discussion time between IMs and Health Board management.</li> <li>The Deep Dives gave useful information and background to the relevant areas, but the sessions lasted over one hour in total and it was not clear how the content discussed helped the committee to address the objectives. For example, there was limited discussion over the savings plans or future financial challenges in the relevant areas.</li> </ul>	<ul style="list-style-type: none"> <li>Given the heavy agenda for the Committee, it may not be beneficial to allocate such large portions of meetings to the Deep Dives. The Committee may also benefit from providing a template for Deep Dives to ensure the relevant information is provided and key areas addressed.</li> </ul>		DoF/ Chair of Finance Committee


# Financial performance management

The following section outlines the findings and recommendations of a review of the arrangements financial reporting and management in the Health Board at Board and sub-committee level and to WG

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Finance Committee observation (cont.)</b>	<ul style="list-style-type: none"> <li>— There was limited reporting from HTA meetings or the Programme Board directly, with the Committee challenging ED's to provide assurance from these meetings.</li> <li>— All reporting provided in the meeting focussed on financial performance. Whilst this satisfies the remit of the Committee, the challenge from IM's often related to how this linked to performance, such as surge beds, DTOC, use of agency / bank.</li> </ul>	<ul style="list-style-type: none"> <li>— There is a need for a reporting mechanism for HTA or the Programme Board to the Committee so that it can be assured that the meetings achieve their objectives and there is robust challenge and discussion.</li> <li>— The Committee may benefit from increased integration with the relevant Performance Committees so that finance and performance can be reviewed as one integrated report to ensure members see the full picture.</li> <li>— From the observed meeting, there are limited links to other committees. The Finance Committee has an objective to review financial control and therefore needs to ensure appropriate links to the Audit and Risk Assurance Committee (ARAC). For example, where finance related internal audit reports are reported to ARAC, the actions are referred across to be followed up by the relevant committee.</li> <li>— The Committee currently holds the ED's to account for the performance of the Directorates – the Committee should look to hold Directorates to account directly, for example, through the Deep Dives, to ensure accountability takes effect at relevant levels within the UHB.</li> </ul>		DoF/ Chair of Finance Committee


# Financial performance management

The following section outlines the findings and recommendations of a review of the arrangements financial reporting and management in the Health Board at Board and sub-committee level and to WG

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Audit Committee observation</b>	<p>5.4 Our observations highlighted the following:</p> <ul style="list-style-type: none"> <li>— The Chair and Independent Members ('IM') provided appropriate challenge throughout the agenda. Responses from Executive Directors ('EDs') and officers were generally clear and addressed the questions.</li> <li>— The Chairman made it clear that Financial Performance was the remit of the Finance Committee and that the role of the ARAC was to provide assurance on wider financial matters via the Financial Assurance Report.</li> <li>— The Chair focused on the need for assurance to be provided to the committee. For example, the need to provide assurance on the productivity and efficiency of UHB's estate, with a clear plan for how that could be achieved requested for the next meeting. Our analysis of agenda items identified that the majority of the meeting was spent on items providing assurance rather than items for note or discussion.</li> <li>— Each member of the committee was given appropriate opportunity to present reports, with time also available for relevant challenge. Our analysis noted a relatively even split of discussion time between IMs and UHB management.</li> </ul>	— N/A		DoF/ Chair of Audit Committee


# Financial performance management

The following section outlines the findings and recommendations of a review of the arrangements financial reporting and management in the Health Board at Board and sub-committee level and to WG

Area	Current situation/Issue	Recommendation	RAG	Owner
5. Financial performance management				
<b>Audit Committee observation (cont.)</b>	<ul style="list-style-type: none"> <li>From the observed meeting, there were clear links made to other committees. The Chair summarised clearly at the end of each item the actions that were required. For example, if a report needed to be presented at another committee or if an update to a later meeting was required.</li> <li>The meeting kept largely to time and lasted 3.5 hours. The volume of papers was large but members attending had clearly read papers beforehand and provided relevant comment and challenge. For example one member when referring to the Clinical Audit Annual Report questioned how plans would need to change in line with the UHB's transition plans.</li> <li>The Committee's Audit Tracker brings together and tracks recommendations from a wide range of external bodies, such as internal and external audit, but also Health Improvement Wales, Wales Audit Office and the Coroner.</li> <li>A closed period at the end of the agenda was used to reflect on the meeting's effectiveness and agree key items to be reported to the Board..</li> </ul>	<ul style="list-style-type: none"> <li>The Audit Committee should streamline the audit tracker to enable more focus on the most high risk outstanding actions.</li> </ul>		DoF/ Chair of Audit Committee

# Financial performance management

The following section outlines the findings and recommendations of a review of the arrangements financial reporting and management in the Health Board at Board and sub-committee level and to WG

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>5. Financial performance management</b>				
<b>Audit Committee observation (cont.)</b>	<ul style="list-style-type: none"> <li>— The committee reviews audit recommendations via an Audit Tracker. The Tracker is very long (over 20 pages) and contains a lot of historic information. Many deadlines in action plans and audit trackers show evidence of slippage, despite tough challenge from lay members. For example, recommendations related to consultant job planning remain outstanding from a review in 2016.</li> <li>— The quality of papers and their delivery by managers varied. For example the paper on Primary Care Applications Committee was clear and succinct and provided the committee with the assurance they needed on progress. Whereas the Estates progress report, while succinct, did not provide the committee with sufficient information to demonstrate assurance and prompted hard challenge from IMs. Some reports also contained unnecessary levels of detail, such as the management response to the WAO job planning report with an appendix that ran to 21 pages listing the 23 original recommendations, although only two recommendations remained outstanding.</li> </ul>	<ul style="list-style-type: none"> <li>— The quality of papers and level of detail contained in them should be appropriate to provide the committee with sufficient assurance</li> </ul>		DoF/ Chair of Audit Committee

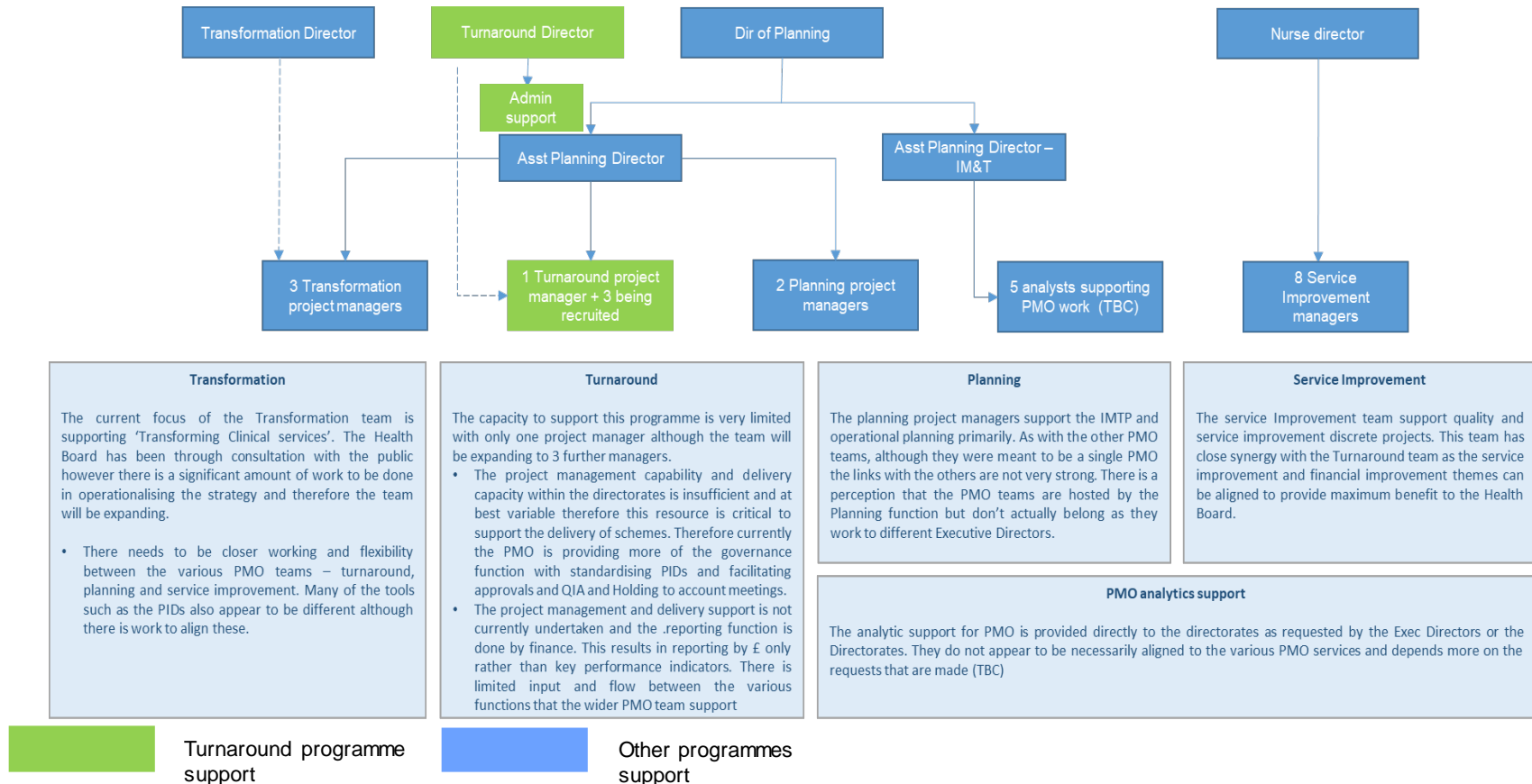


# Section 6

**Capacity and capability**

# Current PMO

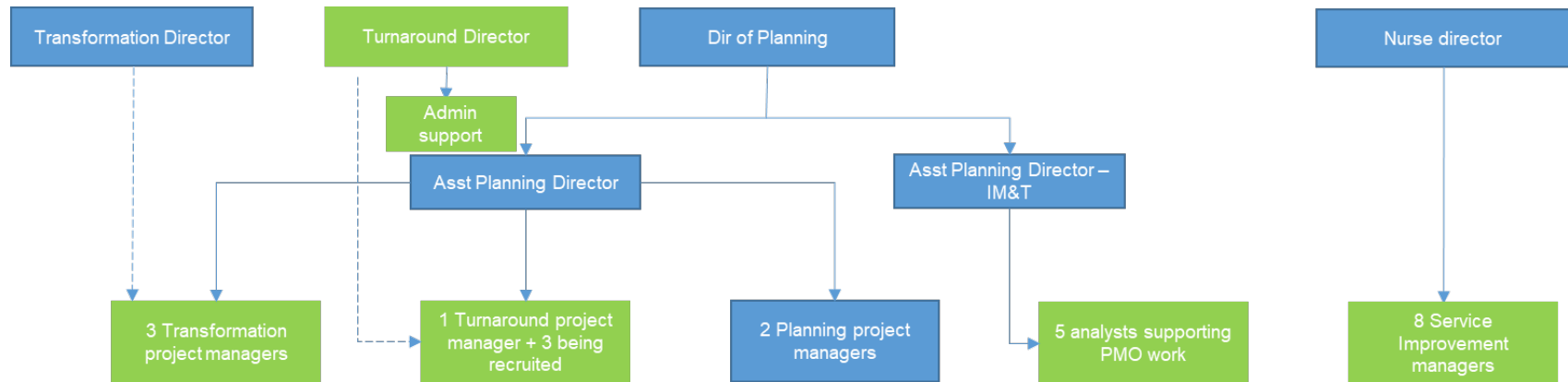
The following slide outlines the current structure of the PMO. There are a number of teams providing project management support for the Transformation programme, Service/Quality improvement, Planning, Analytics and Turnaround. The boxes in green highlight the limited support to the Turnaround programme. The following slides provide an option to strengthen the PMO for discussion




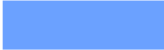
# Proposed PMO

The following slide outlines an option for the use of the PMO to strengthen the component supporting the Turnaround Programme and financial position. This includes using the Transformation and Service improvement teams to work flexibly across the priority programmes of work for the organisation. Ideally the organisation would have one PMO that it can use flexibly across, the planning, turnaround, service improvement and transformation programmes.

Since the drafting of this report the organisation has identified priority areas that will support the organisation achieve its financial control total in its journey from Turnaround to Transformation and is starting to deploy its project management resource across these areas.






 Work flexibly across priority programmes including Turnaround programme

 Other programmes support





# Capacity and capability

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>6. CIP Capacity and capability, Culture and Leadership</b>				
<b>Capacity</b>	6.1 The capacity within the Directorates to progress schemes at pace is limited. Although there are actions that can be taken by having weekly directorate CIP meetings, the scale of change required within tight timescales is significant.	— Project management support for larger schemes/ directorates. Increase PMO/ Finance challenge at directorate meetings		Turnaround Director
	6.2 The capacity within the Turnaround PMO is severely limited (1 project manager) and therefore it cannot support project management, challenge and delivery within the directorates. To be noted that the organisation is recruiting 3 additional project managers to support turnaround..	— The turnaround PMO for an organisation this size and in distress needs to be at least 6-7 people working alongside Finance with a project management, challenge, governance and monitoring function. Ideally there will be a central PMO function which can be used flexibly across Turnaround, Transformation, planning and Service Improvement depending on the stage of the organisation in its journey.		Turnaround Director
	6.3 The capacity within Finance seems to be sufficient as per the new business partnering arrangement that have been put in place recently	— The business partners are aligned to directorates however there also needs to be Finance input into the Workstreams		DoF



# Capacity and capability

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>6. CIP Capacity and capability, Culture and Leadership</b>				
<b>Capacity</b>	6.4 Workforce does not have a business partnering model and therefore does not have the capacity to embed within directorates to support the drive for savings schemes. They provide a level of support for specific projects	— Review the capacity and structure of the Workforce function to ensure there is sufficient capacity to support the significant workforce changes required to be implemented by the organisation		Workforce Director
<b>Capability</b>	6.5 The project management capability within the directorates is variable but may also be impacted by capacity constraints	— Coaching in specific areas on an ongoing basis within the department will help upskill and maintain skills within the team.		Turnaround Director
	6.6 The senior finance business partners have experience and capability to support the directorates. There are some coaching requirements for the business partners in areas such as weekly forecasting, risk assessment and providing challenge to the triumvirate.	— Coaching in specific areas on an ongoing basis within the department will help upskill and maintain skills within the team.		DoF
<b>Clinical Engagement</b>	6.6 The engagement of clinical leads at the HTAs is variable. This could indicate a reliance on Finance and operational leads to solve the financial challenge	— Commitment is required from the clinical leads with time carved out to support the programme and may require backfill support. Coaching for clinical leads by the PMO and finance to drive the programme		Medical Director/ Nurse Director

# Capacity and capability

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

Area	Current situation/Issue	Recommendation	RAG	Owner
<b>6. CIP Capacity and capability, Culture and Leadership</b>				
<b>Operational engagement</b>	6.7 The capacity (in terms of financial savings) of the operational leads appear to be limited although they do attend the HTA regularly (which shows willingness). The capability gaps relate to project management/delivery of savings.	— Coaching for operational leads by the PMO and finance to drive the programme		COO
<b>Executive leadership</b>	6.8 The executives are committed to the Turnaround programme and have made time for the HTA meetings however there has been a softer approach with directorates and workstreams. The slowness of pace of more complex transformational schemes could also be due to the political context in which the Health board operates.	— To step up performance, Execs need to prioritise high value and high risk areas with a greater appetite towards more challenging options to close the gap		CEO

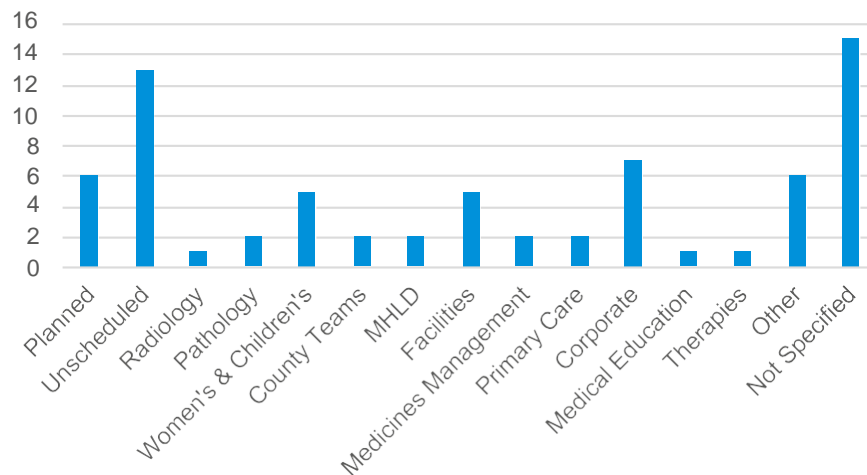
# Appendix – Budget holder survey findings

# Context

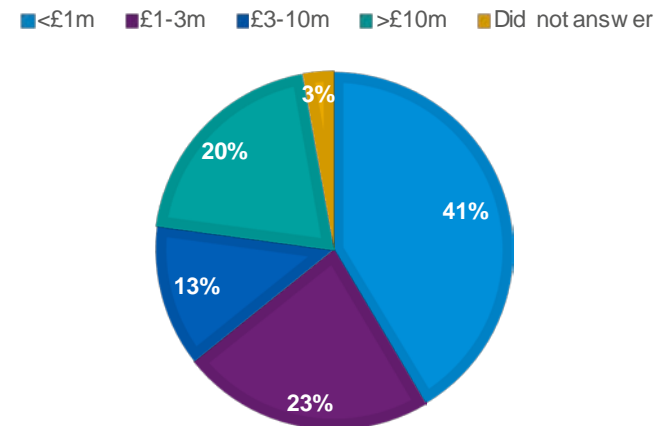
## Budget holder survey

- 70 surveys were completed from a population of 200 (35%) budget holders and/or colleagues with budget responsibility. Due to this low response rate there is a risk of selection bias having a significant skewing influence on the responses, with the most compliant members of staff returning the survey thereby giving a more positive view than maybe the case in the general population of budget holders.
- Some participants noted that they were part of several directorates, while 15 did not specify which Directorate they were in.
- Almost two thirds of respondents (64%) managed budgets of £3m or less, 13% budgets of £3-10m and 20% budgets > £10m.

Responses per Directorate



1.1 SIZE OF BUDGET

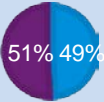
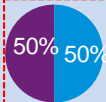
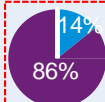
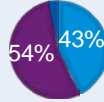
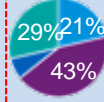
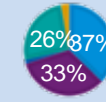
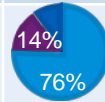
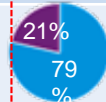
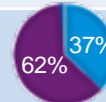
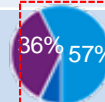
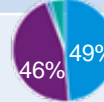
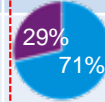


# Budget Holder survey - context

Index

No	Yes
>£10m	

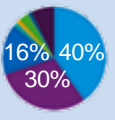
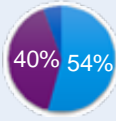
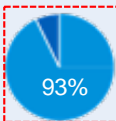
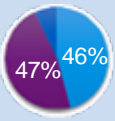
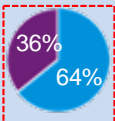
The table below summarises survey results for HDUHB as a whole and for budget holders with budgets greater than £10M. Further detail is provided on supporting pages

Category	Significant opportunity	Opportunity	Relatively strong	Strong	Comments
Involvement in budget setting		 			The results highlight a low % for confirmed budget holder involvement: Overall = 49%; £3M - £10M = 89% BUT >£10M = 50%
Realistic budget					The results highlight a low % for setting of realistic budgets: Overall = 43%; £3M - £10M = 33% incorporated into and >£10M = 14%
Integrated budget - informed by operational plans		 			The results show a low % for integrated budgets informed by operational plans: Overall = 37%; £3M - £10M = 45% and >£10M = 21%
Appropriately phased budget				 	The results show a significant number of budget holders believe their budgets are appropriately phased.
Budget signoff					The results show a low % for signoff of budgets: Overall = 37%; £3M - £10M = 44% and >£10M = 57%
Validation of budget reports					The results show a reasonably high % for validation of budget reports, particularly for those >£10M = 71%

# Budget Holder survey - context

Index

No	Yes
>£10m	

Category	Significant improvement required	Improvement required	Relatively strong	Strong	Comments
In year variations					The results show that the majority of budgets remained unchanged and/or that there were only minor variations to budget in the year
Meetings to discuss performance					The % of budget holders having regular monthly meetings with their finance manager to clarify or explain variances is low = 54% BUT high for £3M - £10M = 89% and >£10M = 93%
Noting of actions from meetings					A high proportion of budget holders do not keep a documented audit trail of actions being taken to address any variances (and their impact). Overall = 47%; £3M - £10M = 33% and >£10M = 36%
Forecasting a year end position					A high proportion of budget holders are not asked to report a projected year end budget position. Overall = 52%; £3M - £10M = 33% BUT >£10M = Nil%

# Budget Holder survey – involvement in budget setting

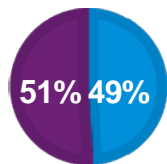
## Budget holder survey

- On an overall Health Board basis, just under half of budget holders were involved in the budget setting process. **This highlights the risk that budgets have been prepared in isolation by finance and that budgets are not owned by budget holders.**

### Overall basis

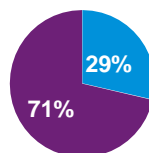
#### INVOLVEMENT IN BUDGET SETTING

■ Yes ■ No



### Budget holders holding <£1M

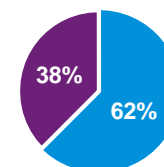
#### Involvement in Budget Setting



■ Yes ■ No

### Budget holders holding £1M - £3M

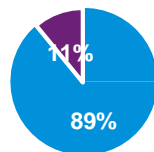
#### Involvement in Budget Setting



■ Yes ■ No

### Budget holders holding £3M - £10M

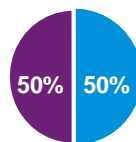
#### Involvement in Budget Setting



■ Yes ■ No

### Budget holders holding >£10M

#### Involvement in Budget Setting



■ Yes ■ No

### Recommendations:

- The list of budget holders is currently being reviewed by HDUHB to refine to a more manageable number
- Budget setting workshops need to be held to support annual planning with further work then conducted by corporate service partners with budget holders to develop robust budgets which take into account prior year performance and operational plans (including savings) for the following year

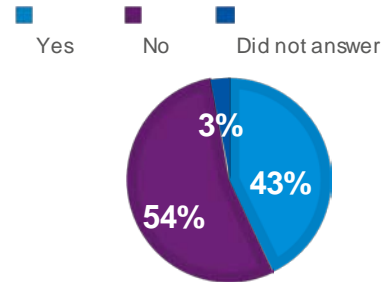
# Budget Holder survey – realistic budget

## Budget holder survey

- 54% of budget holders on the Health Board basis felt their budget was unrealistic. This highlights the risk that budgets have been prepared in isolation by finance and that budgets are not owned by budget holders

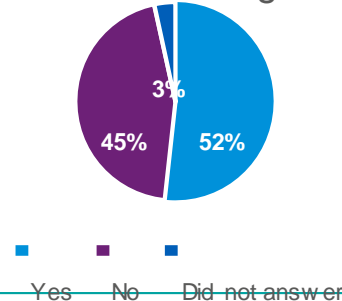
### Overall basis

#### REALISTIC BUDGET



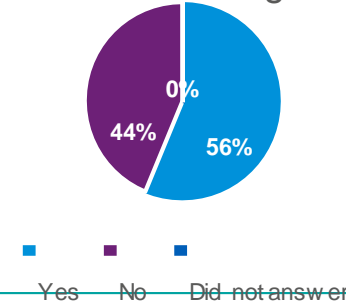
### Budget holders holding <£1M

#### Realistic Budget



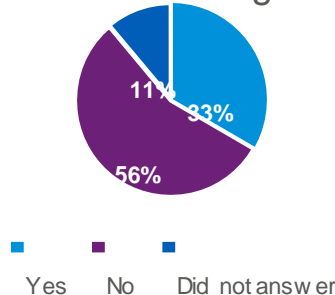
### Budget holders holding £1M - £3M

#### Realistic Budget



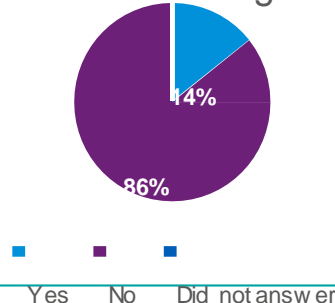
### Budget holders holding £3M - £10M

#### Realistic Budget



### Budget holders holding >£10M

#### Realistic Budget



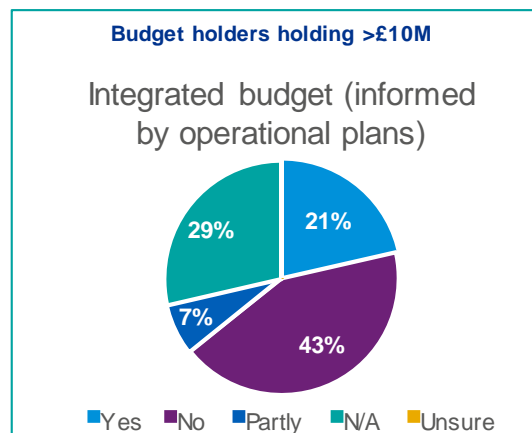
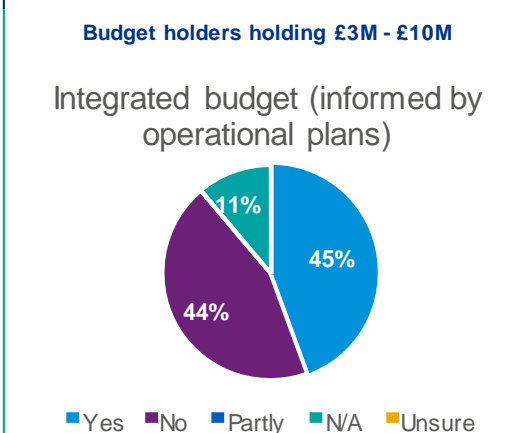
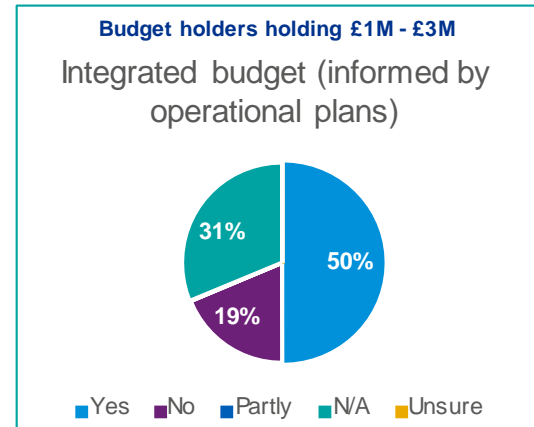
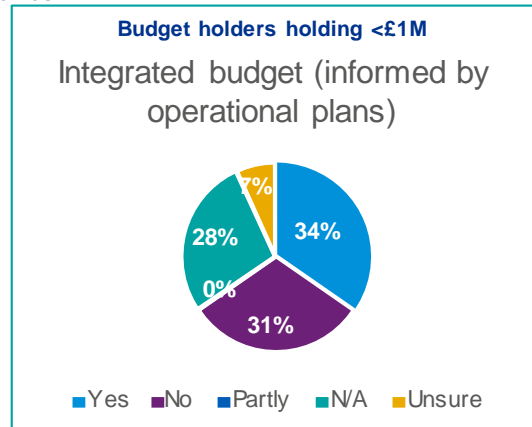
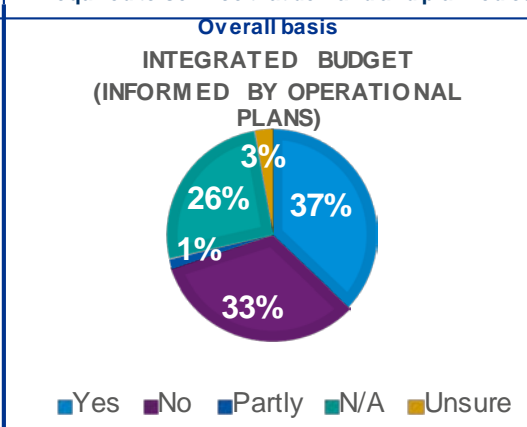
### Recommendations:

- Budget setting workshops need to be held to support annual planning with further work then conducted by corporate service partners with budget holders to develop robust budgets
- Budgets need to take into account prior year performance and operational plans (including savings) for the following year. These need to be predicated on an understanding of demand, what is required to service that demand and planned outcomes for quality, access, productivity, workforce and finance

# Budget Holder survey – integrated budget

## Budget holder survey

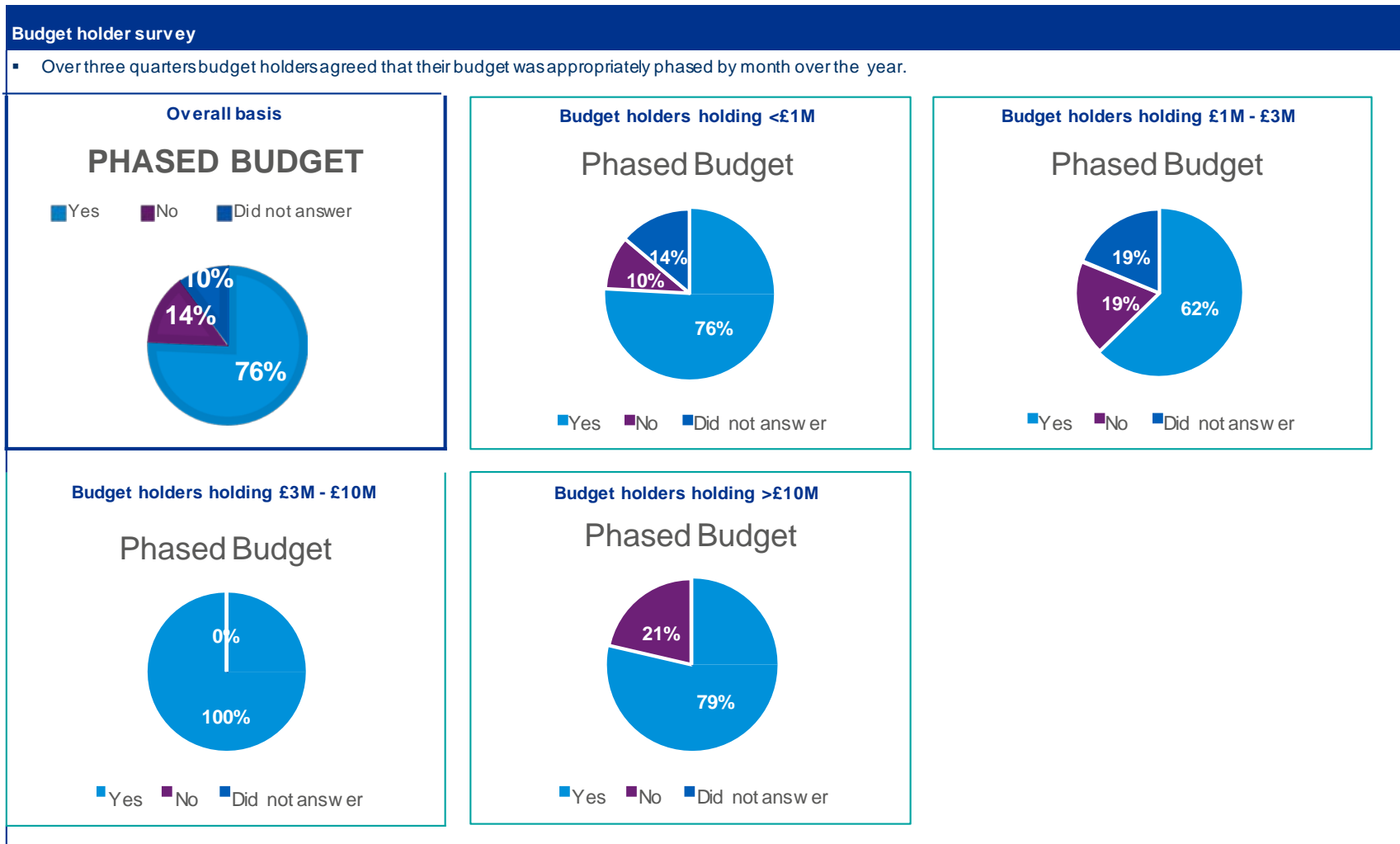
- Although 37% of budget holders felt their budgets were informed by/triangulated with operational plans, a third said they weren't and a 26% felt integration was not applicable. This highlights the risk that budgets are being prepared in isolation by finance and not through working with the front line to understand demand, what is required to service that demand and planned outcomes



### Recommendations:

- Budget setting workshops need to be held to support annual planning with further work then conducted by corporate service partners with budget holders to develop robust budgets
- Budgets need to take into account prior year performance and operational plans (including savings) for the following year. These need to be predicated on an understanding of demand, what is required to service that demand and planned outcomes for quality, access, productivity, workforce and finance

# Budget Holder survey – phased budget



# Budget Holder survey – budget signoff

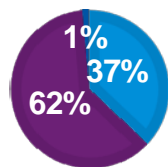
## Budget holder survey

- On an overall basis, and 62% of budget holders did not sign off the final agreed budget. This highlights a significant lack of financial governance with risk that budgets are not owned with subsequent underachievement/ overspends.

### Overall basis

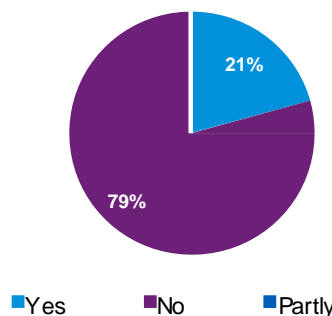
#### SIGN OFF OF FINAL BUDGET

■ Yes ■ No ■ Partly



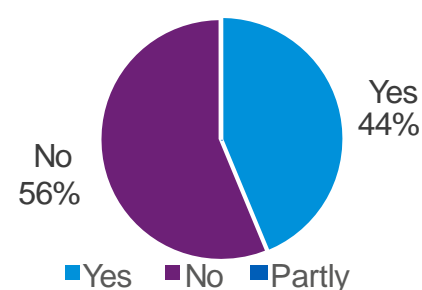
### Budget holders holding <£1M

#### Sign off of final budget



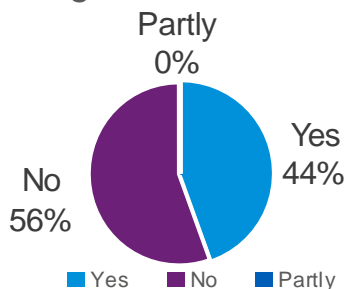
### Budget holders holding £1M - £3M

#### Sign off of final budget



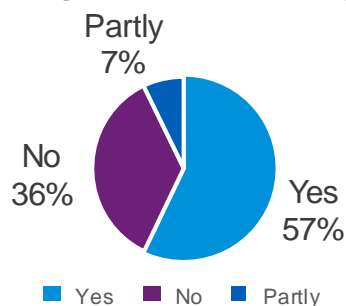
### Budget holders holding £3M - £10M

#### Sign off of final budget



### Budget holders holding >£10M

#### Sign off of final budget



#### Recommendations:

- Financial governance arrangements need to be strengthened to focus on:
  - Early annual planning
  - Mandatory signoff of budgets prior to commencement of the financial year
  - Where budgets are not signed off, this needs to be escalated to the Director of Finance and the Finance Committee for resolution

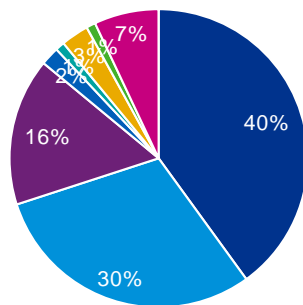
# In year variations

## Budget holder survey

— The majority of budgets remained unchanged or with only minor variation (<5%) during the year.

### Overall basis

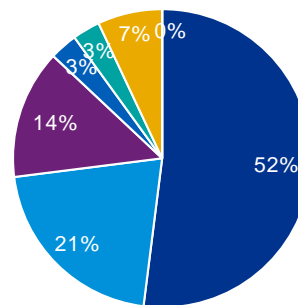
#### In-year variations



- Unchanged
- Changed with minor variations (<5% change)
- Changed with moderate variations (5-20% change)
- Changed with major variations (>20% change)
- Changed with % Variation Unknown
- Unsure
- N/A
- Did Not Answer

### Budget holders holding <£1M

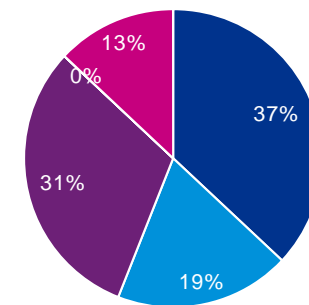
#### In-year variations



- Unchanged
- Changed with minor variations (<5% change)
- Changed with moderate variations (5-20% change)
- Changed with major variations (>20% change)
- Changed with % Variation Unknown
- Unsure
- N/A
- Did Not Answer

### Budget holders holding £1M - £3M

#### In-year variations



- Unchanged
- Changed with minor variations (<5% change)
- Changed with moderate variations (5-20% change)
- Changed with major variations (>20% change)
- Changed with % Variation Unknown
- Unsure
- N/A
- Did Not Answer

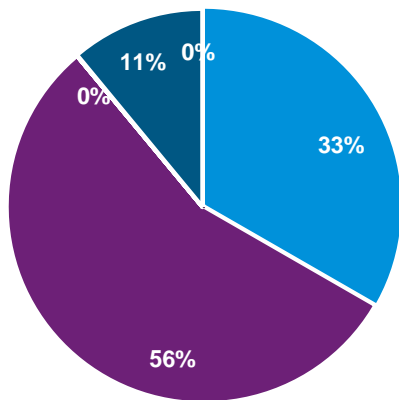
# Budget Holder survey – in year variations (cont.)

## Budget holder survey

### Budget holders holding £3M - £10M

#### In-year variations

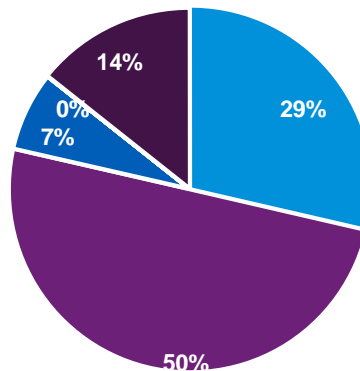
- Unchanged
- Changed with minor variations (<5% change)
- Changed with moderate variations (5-20% change)
- Changed with major variations (>20% change)
- Changed with % Variation
- Unknown
- Unsure
- N/A



### Budget holders holding >£10M

#### In-year variations

- Unchanged
- Changed with minor variations (<5% change)
- Changed with moderate variations (5-20% change)
- Changed with major variations (>20% change)
- Changed with % Variation
- Unknown
- Unsure
- N/A



#### Recommendations:

- Realistic budgets need to be set for the year
- There then needs to be a transition to in-year forecasting (underpinned by leading indicators linked to operational drivers, demand and supply) so that action can be taken to improve planned performance. By reallocating budget in the year (outside of new service developments not planned for), there is a risk that adverse operational and financial performance is masked with the key drivers not addressed.

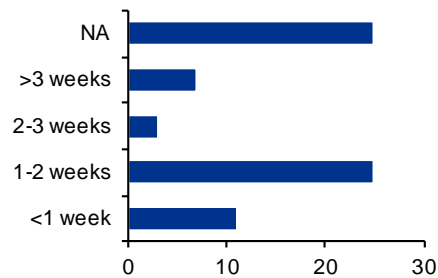
# Timing of reporting

## Budget holder survey

- Most budget holders report within 2 weeks of month-end.
- However, 36% of budget holders responded with 'not applicable' which implies that they are not involved in month-end reporting.

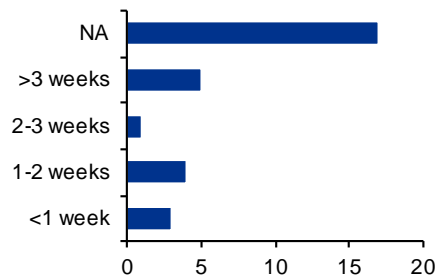
### Overall basis

#### Timing of Reporting



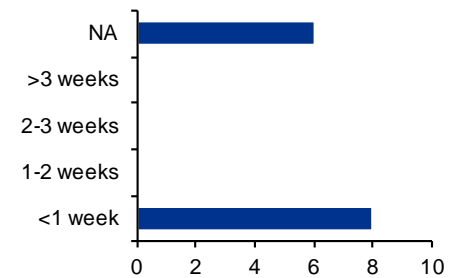
### Budget holders holding <£1M

#### Timing of Reporting



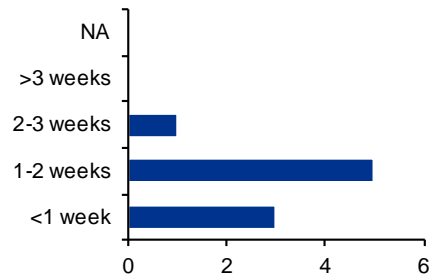
### Budget holders holding £1M - £3M

#### Timing of Reporting



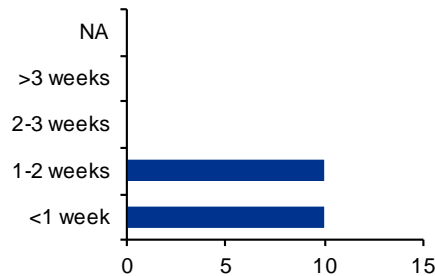
### Budget holders holding £3M - £10M

#### Timing of Reporting



### Budget holders holding >£10M

#### Timing of Reporting



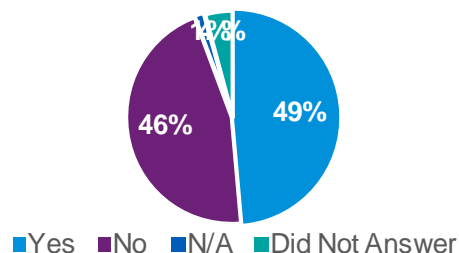
# Budget Holder survey – validation of budget reports

## Budget holder survey

- 46% of respondents do not undertake validation of the monthly management accounts. This highlights a risk that performance is not understood and that corrective actions will not be taken by budget holders where these are required.

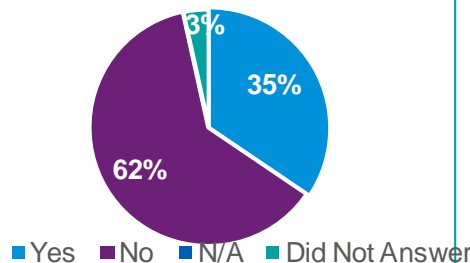
### Overall basis

#### Validation of Budget Reports



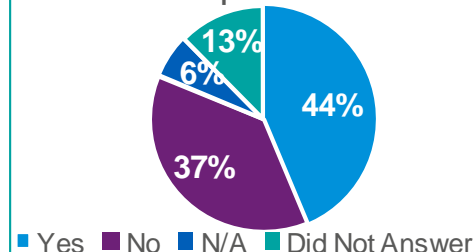
### Budget holders holding <£1M

#### Validation of Budget Reports



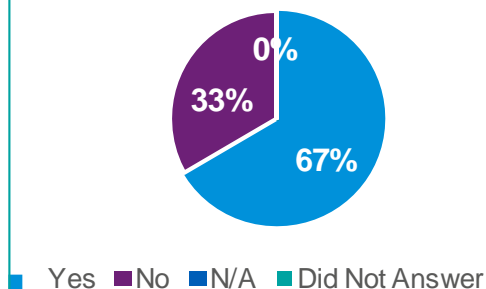
### Budget holders holding £1M - £3M

#### Validation of Budget Reports



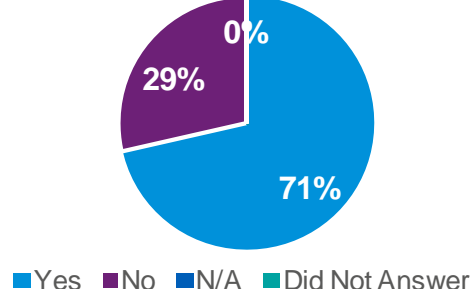
### Budget holders holding £3M - £10M

#### Validation of Budget Reports



### Budget holders holding >£10M

#### Validation of Budget Reports



#### Recommendations:

- Financial governance procedures need to be strengthened so that all budget holders validate their monthly budget reports together with their corporate service business partners post month end.
- At these meetings, there needs to be constructive review from business partners of actual performance with support then provided to agree key actions to improve performance where this is required.

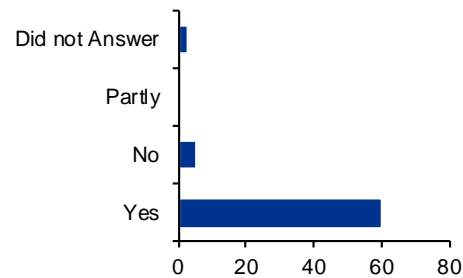
# Identification of variances

## Budget holder survey

— 84% of management account papers highlight both income and expenditure variances.

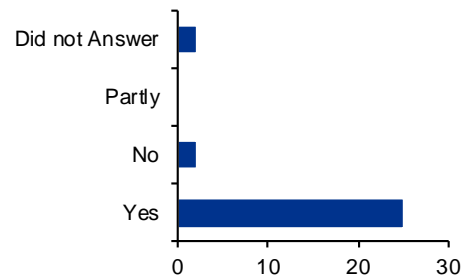
### Overall basis

#### Identification of Variances



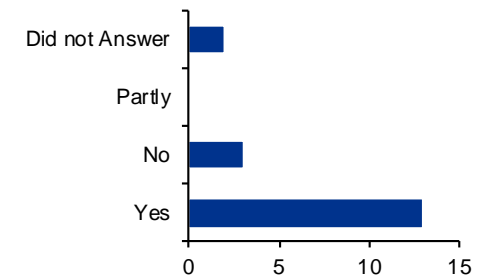
### Budget holders holding <£1M

#### Identification of Variances



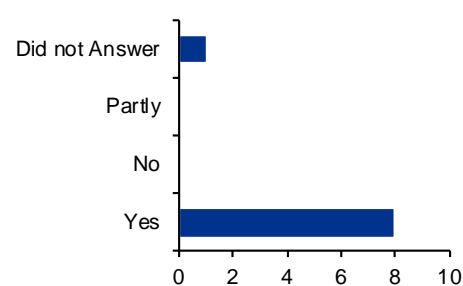
### Budget holders holding £1M - £3M

#### Identification of Variances



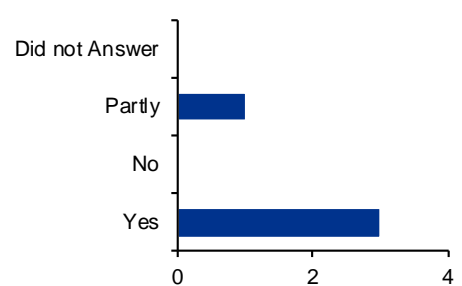
### Budget holders holding £3M - £10M

#### Identification of Variances



### Budget holders holding >£10M

#### Identification of Variances



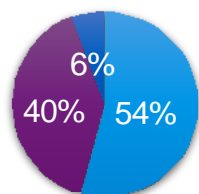
# Budget Holder survey - meetings to discuss performance

## Budget holder survey

- 40% of budget holders do not have regular monthly meetings with their finance manager to clarify or explain variances. And almost half (47%) do not keep a documented audit trail of actions being taken to address any variances (and their impact). **This highlights risk for review of performance and corrective actions required although meetings for budget holders with budgets in excess of £3m is high.**

### Overall basis

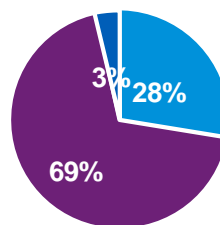
#### Meetings to Discuss Performance



■ Yes ■ No ■ Did Not Answer

### Budget holders holding <£1M

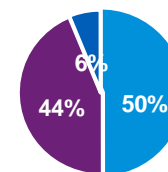
#### Meetings to Discuss Performance



■ Yes ■ No ■ Did Not Answer

### Budget holders holding £1M - £3M

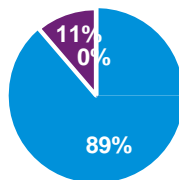
#### Meetings to Discuss Performance



■ Yes ■ No ■ Did Not Answer

### Budget holders holding £3M - £10M

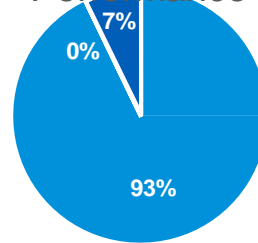
#### Meetings to Discuss Performance



■ Yes ■ No ■ Did Not Answer

### Budget holders holding >£10M

#### Meetings to Discuss Performance



■ Yes ■ No ■ Did Not Answer

#### Recommendations:

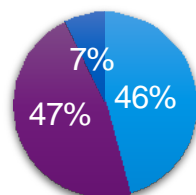
- The list of budget holders is currently being reviewed by HDUHB to refine to a more manageable number
- Financial governance procedures need to be strengthened to make this mandatory.
- That said, monthly performance meetings with budget holders with budgets greater than £3m is high

# Budget Holder survey – notice of actions from meetings

## Budget holder survey

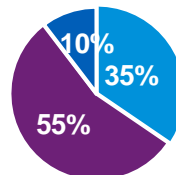
- Almost half of respondents (47%) do not keep a documented audit trail of actions being taken to address any variances (and their impact). **This highlights risk for review of performance and identification, agreement and tracking of required actions to improve performance.**

### Overall basis Noting of actions from meetings



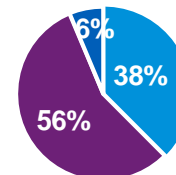
■ Yes ■ No ■ Did Not Answer

### Budget holders holding <£1M Noting of actions from meetings



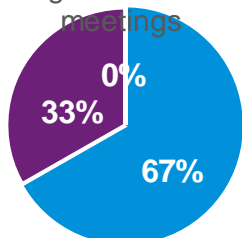
■ Yes ■ No ■ Did Not Answer

### Budget holders holding £1M - £3M Noting of actions from meetings



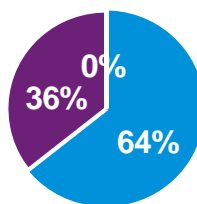
■ Yes ■ No ■ Did Not Answer

### Budget holders holding £3M - £10M Noting of actions from meetings



■ Yes ■ No ■ Did Not Answer

### Budget holders holding >£10M Noting of actions from meetings



■ Yes ■ No ■ Did Not Answer

### Recommendations:

- Financial governance procedures need to be strengthened to make this mandatory.
- A summary of actions need to be integrated into monthly performance review meetings and papers.

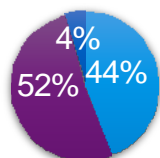
# Budget Holder survey – forecasting a year end position

## Budget holder survey

- Over half of budget holders are not asked to report a projected year end budget position. This highlights a significant risk in being able to deliver the planned full year financial deficit together with limited assurance that the correct actions are being taken to address operational pressures impacting financial performance. We note that even though the response rate for budget holders with budgets over £3m is high, forecasts need to be predicated on operational drivers.

### Overall basis

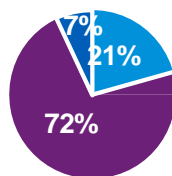
#### Forecasting a Year End Position



■ Yes ■ No ■ Did Not Answer

### Budget holders holding <£1M

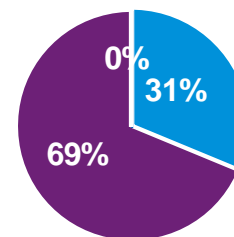
#### Forecasting a Year End Position



■ Yes ■ No ■ Did Not Answer

### Budget holders holding £1M - £3M

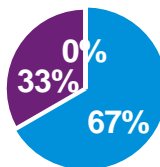
#### Forecasting a Year End Position



■ Yes ■ No ■ Did Not Answer

### Budget holders holding £3M - £10M

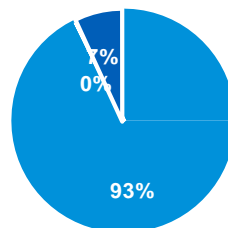
#### Forecasting a Year End Position



■ Yes ■ No ■ Did Not Answer

### Budget holders holding >£10M

#### Forecasting a Year End Position



■ Yes ■ No ■ Did Not Answer

### Recommendation

- Finance function capability and forecasting needs to be strengthened to transform from a back office scorekeeper to a front line enabler for driving improvement.
- This needs to be achieved through the development of the following capability:
  - “Mindset”: understanding demand, resources to service demand, planned outcomes and key operational drivers.
  - “Skillset”: business partnering skills (collaboration, trend analysis & analytics) to support the front line to manage performance
  - “Toolset”: visual system data and dashboards to highlight need for action

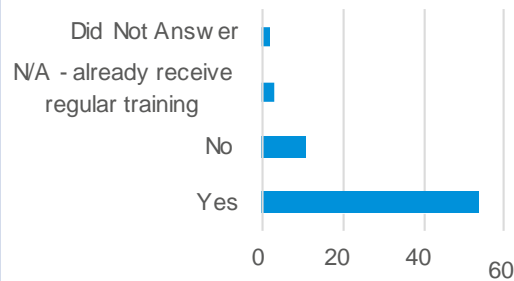
# Budget Holder survey – regular training

## Budget holder survey

- Most respondents (77%) felt they would benefit from receiving regular training on budget setting and monitoring. This raises a risk in that budget holders are saying they are not adequately equipped to manage their budgets. At the same time, it should be seen as a positive in that they are actively seeking to improve their capability.

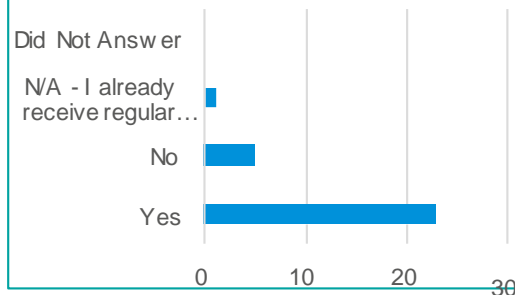
### Overall basis

#### Regular Training



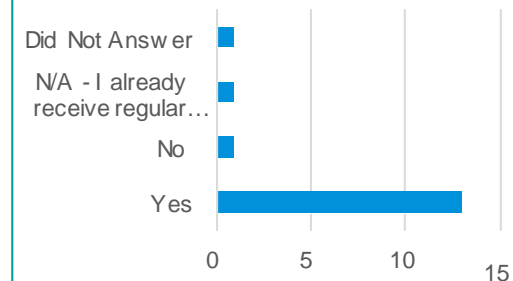
### Budget holders holding <£1M

#### Regular Training



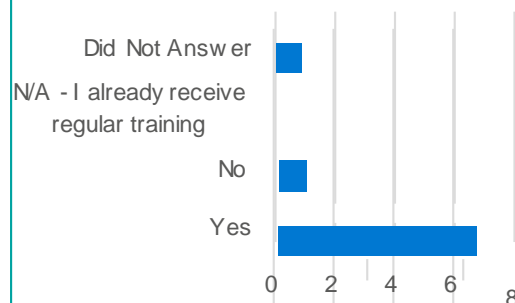
### Budget holders holding £1M - £3M

#### Regular Training



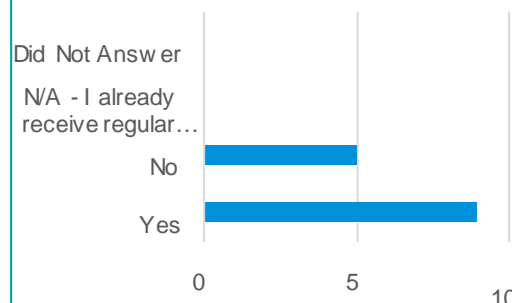
### Budget holders holding £3M - £10M

#### Regular Training



### Budget holders holding >£10M

#### Regular Training



### Recommendation

- This needs to be prioritised immediately by the HDUHB

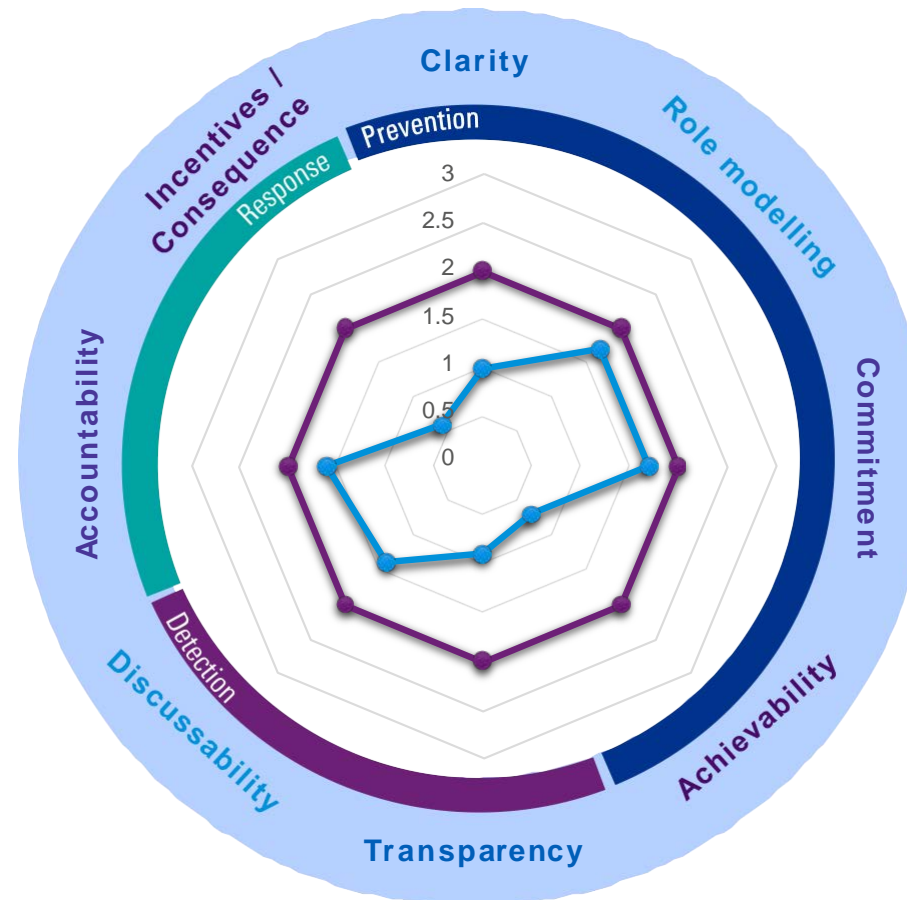
# Budget Holder survey – soft controls

## Strengths

- ✓ **Role-modelling:** Budget holders comment that managers are good role models in promoting compliance with budget setting and monitoring policies.
- ✓ **Commitment:** Respondents are committed to applying UHB's budget setting and monitoring approach
- ✓ **Accountability:** through sufficient senior manager challenge, and confidence in actions to address breaches in policy

## Areas for development:

- **Enforcement/ motivation:** Most respondents felt there was no incentive or reward for following budget setting or monitoring guidance appropriately
- **Achievability/ robustness:** Respondents pointed to insufficient time, training, means or support to ensure effective budget setting and monitoring.
- **Transparency:** Though budget holders felt their actions regarding budgets were transparent to others, they were often not aware of actions taken by colleagues



The ideal level of soft controls represents a balance between too little and too much control, such as excessive challenge compared to inadequate or no challenge

## Key:

Ideal = score of 2 (3 being a top score)

Survey responses



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# Recovery Plan

15 November 2019



# Important notice

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The fieldwork commenced on 29 July 2019 and was completed on 31 October 2019. We have not undertaken to update our report for events or circumstances arising after that date.

In preparing this Report, the primary source of information has been obtained from HDUHB. KPMG does not accept responsibility for such information which remains the responsibility of the HDUHB. We have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information which was made available to us in the course of our work in accordance with the terms of the Letter of Appointment. We have not, however, sought to establish the reliability of the sources by reference to other evidence.

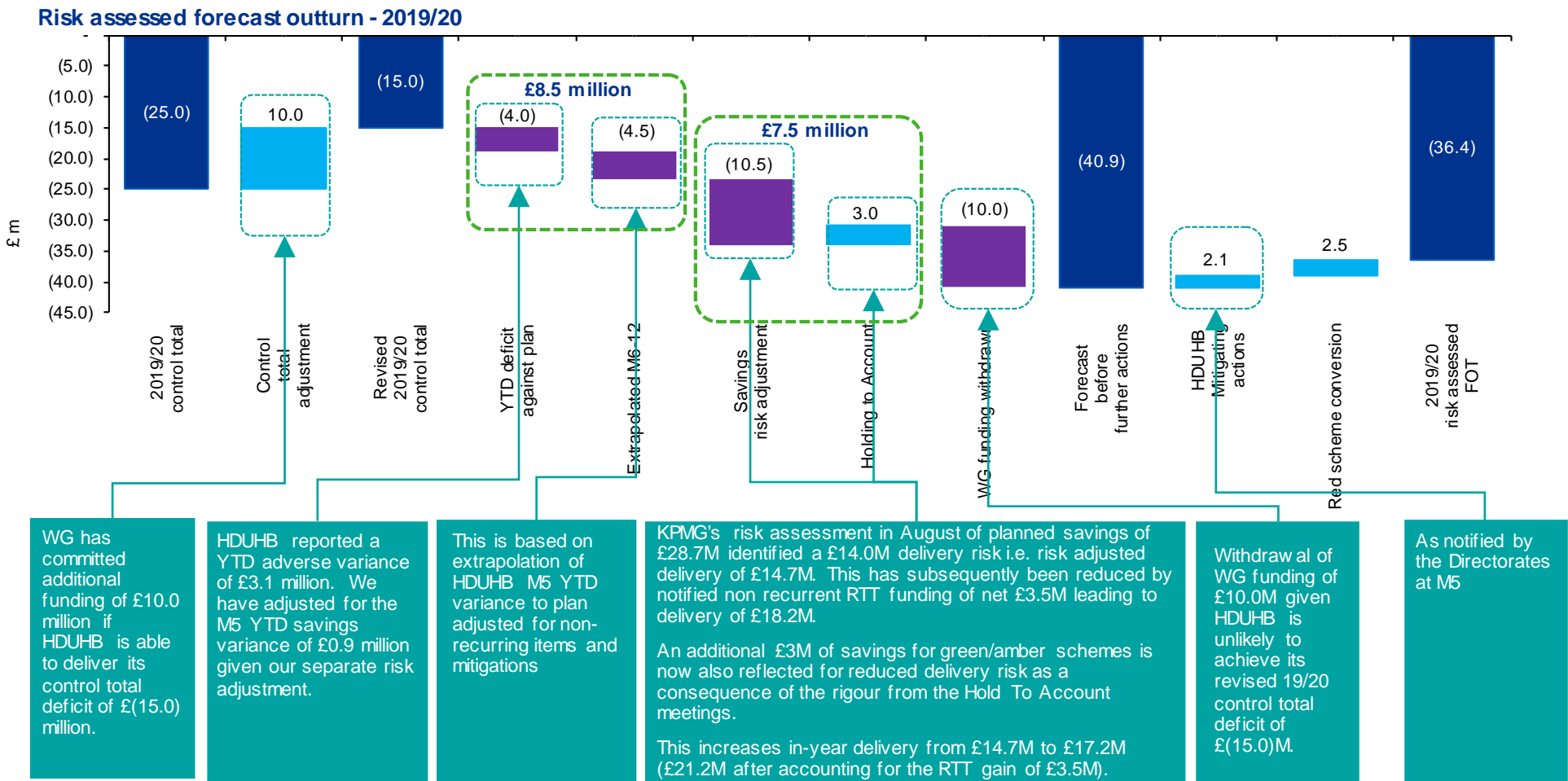
This engagement is not an assurance engagement conducted in accordance with any generally accepted assurance standards and consequently no assurance opinion is expressed. Nothing in this Report constitutes a valuation or legal advice.

KPMG emphasises that the realisation of the prospective quality and performance and other information set out within the Report is dependent on the continuing validity of the assumptions on which it is based. The assumptions will need to be reviewed and revised to reflect such changes in service/delivery trends, workforce, cost structures or the strategic intentions of existing services as they emerge. KPMG accepts no responsibility for the realisation of the prospective quality and performance and financial information. Actual results are likely to be different from those shown in the prospective financial information because events and circumstances frequently do not occur as expected, and the differences may be material.

The contents of our Report have yet to be reviewed in detail by the directors of HDUHB for the purposes of factual accuracy. All recommendations made are subject to Health Board governance processes (including QIA) and the responsibility for quality, safety and patient experience rests with the Health Board

# 19/20 Risk adjusted forecast outturn at September (YTD M5)

Our analysis projects a risk adjusted deficit outturn range of £(40.9) million to £(36.4) million at M5 YTD. Additional opportunities to improve the FY20 risk assessed FOT are shown on the following page.



Source: KPMG Analysis

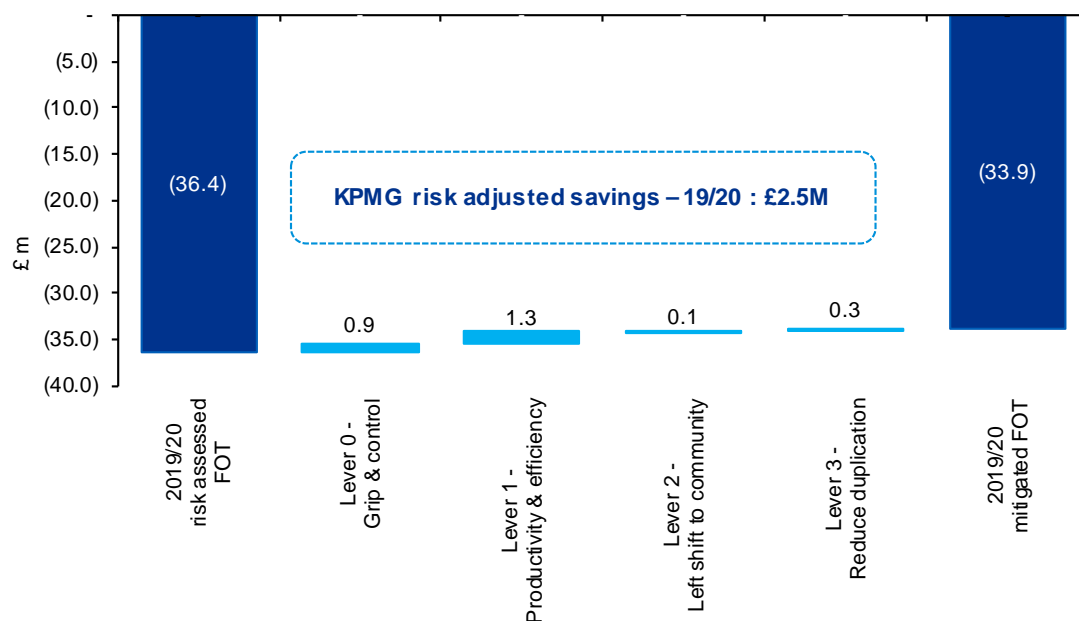


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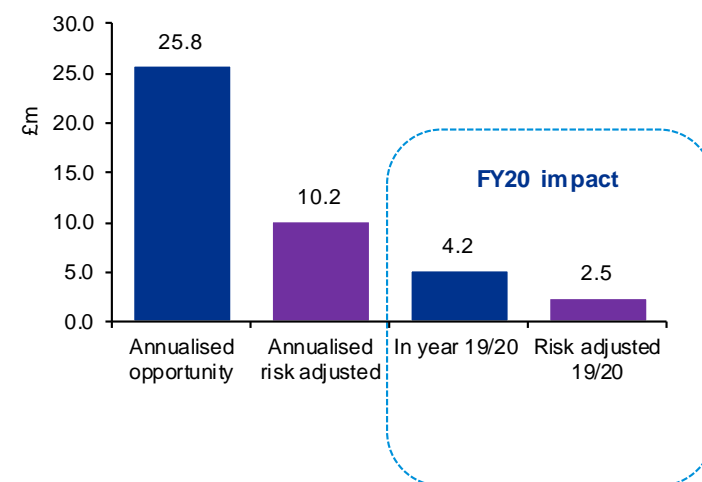
# KPMG identified opportunities

Working collaboratively with the Health Board, we have identified and quantified new ideas and savings schemes which for 19/20 could deliver up to £5.2m. However due to a lack of implementation support and capacity of key operational staff, this has a risk adjusted part year effect of £2.5 million and an annualised value of £10.2 million. This improves the FY20 risk adjusted FOT to a deficit of £(33.9) million. Details of the opportunities are provided on the next slides. Clearly it is incumbent upon the Board to push to deliver as much of the stretch value up to £5.2m as possible.

Risk assessed forecast outturn - 2019/20



Impact of additional KPMG opportunities



# Unplanned cost pressures within/partly within HDUHB's control

The table below summarises the key cost pressures above plan together with their impact prior to mitigation. We have highlighted the required action to be taken by HDUHB.

Cost pressures	Within HDUHB control/ outside of control	M5 YTD spend vs plan	Full year impact if not mitigated	Recommended next steps
LTAs	Yes, for LTAs	Net cost pressure of £0.4M for Swansea Bay and Cardiff	● Net cost pressure of £1.1M (being mainly Swansea Bay: £0.8M and Cardiff: £0.4M) – included in run rate	<ul style="list-style-type: none"> <li>Swansea Bay and Cardiff LTA performance review required over period October/ November with focus on: <ul style="list-style-type: none"> <li>Referral authorisation controls;</li> <li>HDUHB available capacity checks prior to authorisation.</li> </ul> </li> <li>Review to be conducted by end November to analyse LTA activity being performed by other HBs together with the potential for HDUHB to perform such activity if capacity was available.</li> </ul>
Demand on Acute Services	Yes	Significant overspend of £3.6M: £2.2M for unscheduled care across all four sites, Radiology = £0.3M; Woman & Children £0.3M; Planned Care of £0.4M; Pathology of £0.2M and Oncology of £0.2M	● Significant overspend of £7.6M: £3.1M Unscheduled Care (mainly WGH of £2.0M); £0.6M for Radiology and £0.7M Women & Children's.	<ul style="list-style-type: none"> <li>Continued focus on demand reduction to decrease variable pay issues arising on surge – to be incorporated into emerging clinical strategy.</li> <li>Consider pay establishment freeze if individuals not in post and long standing vacancy not being filled by agency.</li> </ul>
NICE and High Cost Drugs	Limited – some patients on pathway which cannot be changed	Secondary drug cost pressures mainly for Oncology of £0.8M	● Full year impact of £1.6M	<ul style="list-style-type: none"> <li>Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification.</li> </ul>
Primary Care Prescribing	Limited	YTD overspend of £0.5M for revised prices for primary care drugs by Pharmaceutical Services Negotiating Committee (PSNC)	● Cost pressure greater than £1.2M	<ul style="list-style-type: none"> <li>Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification.</li> </ul>
Continuing Health Care	Partially	Cost pressure due to increased demand and complexity of cases of £0.2M	● Cost pressure of £0.2M (note: pressure is partly mitigated by increased investment of £3.4M)	<ul style="list-style-type: none"> <li>Continue the development of Core and Community based services for MH &amp; LD Transformation – to be incorporated into emerging clinical strategy.</li> <li>Develop Joint Funding Guidance.</li> </ul>

RAG:



High impact on FOT;







Low impact on FOT;



No impact on FOT

# Unplanned cost pressures not within the control of HDUHB

There are a number of cost pressures impacting the forecast outturn that were unplanned for and are outside the control of HDUHB. The table below summarises them together with their impact prior to mitigation. We have highlighted the required action to be taken by HDUHB.

Cost pressures	Full year impact if not mitigated	Recommended next steps
Prescribing – category M	 Estimated at £3.4M based on notified price increases in August 2019.	<ul style="list-style-type: none"> <li>Explore ability to use alternative drugs based on patient condition/need – to be incorporated into savings programme/ opportunities identification.</li> </ul>
TB costs	 Estimated at £0.8 million. Potential for costs to increase to c.£1m based on extended screening programme. Expectation of funding from WG.	<ul style="list-style-type: none"> <li>Regular meetings being held with Public Health Wales to monitor the number of active cases. Currently being managed by HDUHB internal resources.</li> </ul>
Final pension charges	 Full year impact of £0.4M based on 3 cases	<ul style="list-style-type: none"> <li>Seek advice on managing pensions risk, including discussion with WG.</li> </ul>
Continuing Health Care	 Cost pressure of £0.2M due to increased activity and complexity (note: pressure is partly mitigated by increased investment of £3.4M)	<ul style="list-style-type: none"> <li>Continue the development of Core and Community based services for MH &amp; LD Transformation – to be incorporated into emerging clinical strategy.</li> <li>Develop Joint Funding Guidance.</li> </ul>

RAG:



High impact on FOT;



Low impact on FOT;



No impact on FOT

# 19/20 Opportunities by category

Financial values are subject to Exec approval to proceed, project initiation document (PID) sign off and QIA. Values are in £000s; Annualised value is the assessed opportunity for 12 months, PYE is value in 19/20.

We have worked with the Health Board to identify and quantify new ideas and schemes that have not been included in the financial forecast (at a high level) and savings with an in year impact on both the CIP programme and the projected run rate challenges/risk. We have identified c77 ideas of which 34 have indicative opportunity values (c£26m) and 18 have in year 19/20 potential £2.5m - £4.2m in year with a FYE £10.2m - £17.1m. The range is due to a risk adjustment being applied to take account of the schemes planning maturity, complexity and timescale to deliver. Some of the schemes have had a level of sign off within the organisation while others have had initial discussions with further PID development required (significant schemes listed below). We have also identified in Slide 10 schemes that have potential to deliver in year and require further work up or/and strategic choices to be made (annualised c£2m). Further ideas in the pipeline for 20/21 and beyond are outlined in Slide X and needs to be explored with service leads £6.5m.

Category	Description	Next steps	Annualised opportunity	Annualised risk adjusted	In year 19/20	Risk adjusted 19/20
<b>Lever 0 – Grip and Control</b>						
<b>Agency</b>	Enhancements to agency processes, increasing availability and access to bank, and discouraging/reducing use of high cost agency workers	PIDs developed and submitted to Director of Workforce HB to implement actions that are a response to the Grip and control report	1,250	800	305	200
<b>Rostering</b>	Rostering process enhancements, system changes, re-introduction of challenge meetings and associated policies to reduce use of temporary workforce		1,075	600	270	150
<b>Pay</b>	Changes to overtime controls, reducing overpayments and time to recruit and review of unpaid breaks		695	400	175	100
<b>Electronic rota and long term temp staff</b>	Transition to electronic rota preparation which offers improved visibility, control and assurance and would be expected to lead to a reduction in run-rate. They are also simpler to prepare and there is a drive across the NHS towards electronic rotas/rosters. Challenge and conversion of posts from locum to bank, including working with agencies to minimise reliance on temporary workers		1,000	600	250	150
<b>Non Pay</b>	Enhancing processes and controls to increase approach to challenging spend and ensuring value for money (through training, education, deselecting catalogue items, increased challenge and reporting by Procurement and Finance and creating a culture of cost-consciousness)	PIDs developed and submitted to Head of management accounts HB to implement actions that are a response to the Grip and control report	2,500	1500	450	250
<b>Other</b>	Sickness (£1.0M per report, already being covered), Annual leave (validation required), Month 12 spike (£1.8M per report, need to determine overlap with non pay), job plans (£1.0M per report, already being covered) and other actions have not been quantified					
<b>Sub Total lever 0</b>			<b>6,520</b>	<b>3,900</b>	<b>1,450</b>	<b>850</b>

# 19/20 Opportunities by category

Financial values are subject to Exec approval to proceed, project initiation document (PID) sign off and QIA. Values are in £000s; Annualised value is the assessed opportunity for 12 months, PYE is value in 19/20.

Category	Description	Next steps	Annualised opportunity	Annualised risk adjusted	In year 19/20	Risk adjusted 19/20
<b>Lever 1 – Productivity and Efficiency</b>						
<b>Theatres productivity</b>	<p>Board Wide Theatres Improvement Programme to reduce WLIs by specialty and site and rebase capacity where appropriate, which aims to improve use of funded capacity from 59% to 90% (i.e. utilisation of funded sessions) and in session utilisation from 69% to 85% (i.e. utilisation of actual sessions that ran), example focus areas include:-</p> <ul style="list-style-type: none"> <li>• Booking and scheduling (ie improved management of planned Surgeon absence, grip on capacity use of operating time)</li> <li>• Reduction turnaround time and late starts/early finishes</li> <li>• Improved pre-operative assessment service to reduce cancellations</li> <li>• Efficient end to end process on the day of surgery</li> <li>• Workforce scheduling and kit availability</li> <li>• KPIs and enablers such as management information to enable service leads identify service improvement opportunities, track and monitor initiatives</li> </ul>	<ul style="list-style-type: none"> <li>• PID developed and total potential opportunity agreed with Ops lead – Theatres manager</li> <li>• PID submitted to Scheduled Care GM, Turnaround Director</li> <li>• FBPs to finalise financial assumptions</li> <li>• Establish governance and delivery support</li> <li>• Further detail on action plans so benefits are realised in Q4</li> <li>• Start implementation</li> <li>• Further opportunity to reschedule lists between specialties to be explored</li> </ul>	3,000	2,000	750	500
<b>Patient flow</b>	<p>Patient flow improvement programme opportunities by site to reduce escalation/surge spend and increase income from patients from neighbouring Health Boards. Initial focus on frailty and ambulatory pathways</p> <ul style="list-style-type: none"> <li>• Reducing average length of stay compared to Welsh average by HRG by improved discharge and in hospital processes</li> <li>• Top down opportunity worked up to reflect overall LoS opportunity</li> <li>• Bottom up opportunity identified through discussions with the site GMs to ensure feasibility of recommendations and specific pathways identified by site for short term opportunity/immediate focus</li> </ul>	<ul style="list-style-type: none"> <li>• PID developed for the 4 sites including both top down (long term) and bottom up (immediate focus) opportunities</li> <li>• Bottom up opportunity was calculated to be £8.1m across BGH, GGH and WGH, PPH and submitted to Service Improvement team</li> </ul>	2,800	1,400	700	350

# 19/20 Opportunities by category

Financial values are subject to Exec approval to proceed, project initiation document (PID) sign off and QIA. Values are in £000s; Annualised value is the assessed opportunity for 12 months, PYE is value in 19/20.

Category	Description	Next steps	Annualised opportunity	Annualised risk adjusted	In year 19/20	Risk adjusted 19/20
<b>Lever 1 – Productivity and Efficiency</b>						
<b>Patient flow (contd)</b>	<ul style="list-style-type: none"> <li>Ambulatory Sensitive Conditions identified as opportunity across the 4 sites for admission avoidance</li> <li>Frailty identified as LoS efficiency opportunity across all 4 sites, accompanied by Respiratory Medicine and Cardiology at BGH, Stroke and T&amp;O at GGH, Cardiology, Stroke and T&amp;O at WGH, TBC at PPH</li> <li>DTOC identified as an opportunity but not quantified – it is part of LoS efficiency. Discharge to assess model and use of community pathways recommended across all sites with focus on the specific specialty areas identified as opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>Top down opportunity was calculated to be £15.6m</li> <li>Further detail on action plans to be taken forward by each site and to be built into overall unscheduled care plan for Q4 and phased across years. Also to be linked to Transforming clinical services strategy</li> </ul>				
<b>Outpatients productivity</b>	Board Wide Outpatients improvement programme to release benefits through rebasing capacity (WLLs have reduced significantly in the last 12 months) : <ul style="list-style-type: none"> <li>improve clinic utilisation</li> <li>reduction in N:Fup in line with benchmarks</li> <li>standardise consultant templates (incl. review start &amp; finish times, review activity against job plans)</li> <li>improved booking and scheduling across the Board</li> </ul>	<ul style="list-style-type: none"> <li>PID developed and signed off with OP steering group</li> <li>Detailed actions to be further developed by specialties and implementation to be started to realise benefits in Q4</li> </ul>	1,000	750	250	188
<b>Endoscopy productivity</b>	Increase endoscopy productivity to reduce WLLs and release benefits through rebasing capacity in Q4 <ul style="list-style-type: none"> <li>Improve utilisation from X% to Y%</li> <li>Target 12 points per list</li> <li>Improved booking and scheduling</li> <li>Income from other health Boards?</li> </ul>	<ul style="list-style-type: none"> <li>PID developed and initial discussion with service lead</li> <li>Follow up discussion to agree in year opportunity, data cleanse and actions to be further developed and implementation to be started to realise benefits in Q4</li> </ul>	500	250	125	63
<b>Other</b>	Various – Estates allocation of staff on projects, procurement, medical job plans		770	445	283	201
<b>Sub Total lever 1</b>			<b>8,070</b>	<b>4,845</b>	<b>2,108</b>	<b>1,302</b>

# 19/20 Opportunities by category

Financial values are subject to Exec approval to proceed, project initiation document (PID) sign off and QIA. Values are in £000s; Annualised value is the assessed opportunity for 12 months, PYE is value in 19/20.

Category	Description	Next steps	Annualised opportunity	Annualised risk adjusted	In year 19/20	Risk adjusted 19/20
<b>Lever 2 – Left shift to community and closer to home where appropriate</b>						
<b>Sub acute care</b>	Appropriate targeted care for sub-acute patients – step up/ step down/ reablement with appropriate primary care, social care, therapy input.	<ul style="list-style-type: none"> <li>Undertake rapid bed audit to quantify % of sub-acute patients in acute beds</li> <li>Development of PID for reablement beds in GGH and step up/step down beds in PPH</li> <li>Explore potential in WGH and BGH</li> </ul>	250	200	100	50
Sub Total lever 2			250	200	100	50
<b>Lever 3 – Reduce duplication</b>						
<b>Strategic choices</b>	Reduce duplication of services across specific areas subject to detailed workup and Board level risk discussion. Safety, Quality and sustainability concerns driving this process – with financial position as consequence.	<ul style="list-style-type: none"> <li>Further detailed planning and impact assessment</li> <li>Development of detailed action plan and decision to be taken by Board</li> </ul>	2,250	1,250	563	313
Sub Total Lever 3			2,250	1,250	563	313
<b>Opportunities targeted in 19/20</b>			<b>17,090</b>	<b>10,195</b>	<b>4,221</b>	<b>2,515</b>

# Potential initiatives 19/20

The following pipeline schemes will require further work to quantify and plan the changes. Where possible, we have identified where schemes may be accelerated to start in 19/20

Category	Initiative	Indicative annualised value £'000	Actions to accelerate
Commissioning	Mobile cath lab to repatriate activity from neighbouring Health Boards and reduce spend and potential to sell capacity.	300	Value to be quantified and PID finalised Q4 19/20
Commissioning	Cardiology - Pacing - 3 months of local provision and reduce spend	200	Discussion with service lead and quantification for Q4 19/20
Radiology	MRI capacity issues – review utilisation to reduce outsourcing costs	200	Discussion with service lead and quantification for Q4 19/20
Medicines management	Pharmacy / medicine spend - Low priority funding treatment expenditure reduction	150	Discussion with service lead and quantification for Q4 19/20
Medicines management	One off reduction in stockholdings. Excess medicine stock - Reduce stock days to average to reduce obsolescence and disposal costs. (Non recurrent)	100	Discussion with service lead and quantification
Planned care	Theatres: Out of hours provision BGH	To be quantified as a priority	Further discussion with Planned care service leads and finance required if it can be accelerated in 19/20
Planned care	Theatres: Standardisation / bulk ordering schemes extension		
Planned care	Waiting List: Centralisation of WL across HB, increased flexibility and use across sites		
Planned care	OPD: Apprentices in OPD bringing potential to re-evaluate the current B2 roles and B4/5 roles		
Planned care	OPD: Linking with Phlebotomy re nurses currently undertaking blood tests in OPD		
Planned care	OPD: Collaboration with Primary Care regarding location of clinics in HB		
Planned care	Urology: SKYPE clinics		
Planned care	Urology: Patient knows best		
Planned care	Rheumatology: 1 stop ERA pathway on 1 or 2 sites		
Planned care	Orthopaedics: Reduction WL / Backfill costs by employing movable consultant		
Planned care	Ophthalmology: AMD in non-NHS setting		
Planned care	Ophthalmology: Pre-assessment model review		
Non pay inflation assumptions	Anticipated inflationary impact of 0.54% Mainly for utilities, rates, estate maintenance and medical equipment contracts for service and repair. Reduce prices and defer spend	500	
CHC	Review of CHC packages for community and MH patients	500	
Ward staffing review	Review of ward staffing - Nurse staffing act impact	200	
<b>Potential initiatives that can be accelerated (some schemes not quantified)</b>		<b>2,150</b>	

# Ideas list 20/21 and beyond

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

Category	Initiative	Indicative annualised value £'000	Actions to accelerate
Learning disabilities	Service review to transform learning disabilities	1,500	<ul style="list-style-type: none"><li>Discussions required with service to test idea, route to cash and develop action plans</li><li>Opportunities based on interviews and benchmarking and efficiency documents but require testing and work up with ops leads</li><li>Likely 20/21 and beyond</li></ul>
Community	New models of district nursing care which make use of mobile technology could increase productivity and deploy remote monitoring services whilst increasing the number of patient contacts.	500	
Mental Health	Service modernisation - To review adult mental health packages of care (£275k), to increase supported living provision (£20k) and to review contract arrangements (£38k)	333	
Rationalise - Medical coding	Medical coding - follow above aggregation per medical records.	200	
Commissioning	Review SLA with Swansea for termination of pregnancies	120	
Commissioning	The Board does not currently recover income from Mental Health patients that are not theirs (eg English patients or from the catchment areas of the other Welsh Boards). (e.g. Powys THB and BCU UHB)	100	
Rationalise - Medical records	Medical records - shift first from 5 repositories, to one, then moving to electronic records.	100	
Procurement	Review spend on equipment across 3 areas - hypothesis that there is opportunity to standardise	To be quantified by the HB	
Procurement	Podiatry - patients appliance budget - working with procurement and outside to find cheaper stock.		
Service redesign	Palliative care opportunity - overarching strategy and approach across 3 areas		
Facilities	Maintenance contracts - increase use of in-house provision		
Commissioning	LTAs/SLAs - To review current Long Term Agreements and Service Level Agreements		
Planned care	Ophthalmology: ENP for RACE does this mean reduction of medical posts		
Planned care	Ophthalmology: Extended roles in nursing		
Workforce	Transforming our hospitals: Align with TCS pathway review / workforce redesign for the future - introduction of Physicians Associates on the medical wards and Emergency Department, Advanced Nurse Practitioners, Emergency Nurse Practitioners and Care of the Elderly / Rehab departments and initiate service redesign in line with our strategy		
Sub Total ideas 20/21 (some schemes not quantified)		2,853	

# Ideas list 20/21 and beyond

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

Category	Initiative	Indicative annualised value £'000	Actions to accelerate
Service redesign	Transforming our hospitals: Withybush General Hospital: Improve Cardiology services commissioned to neighbouring Health Boards Develop and enhance the frailty Model within Withybush (subject to Business Case approval) Review and enhance day surgery services	To be quantified by the health Board	<ul style="list-style-type: none"> <li>Discussions required with service to test idea, route to cash and develop action plans</li> <li>Opportunities based on interviews and benchmarking and efficiency documents but require testing and work up with ops leads</li> <li>Likely 20/21 and beyond</li> </ul>
Service redesign	Standardise community care pathways including a revised model for assessment of ADHD patients to support reduction of current waiting times and achievement of the 26 week Neuro-developmental assessment target		
Workforce	Theatres: Flexible job planning for surgeons, run surgeons as a group rather than in portfolios		
Service redesign	Waiting List: Telephone hub for endoscopy		
Service redesign	Orthopaedics: Robotic knee surgery development		
Service redesign	Ophthalmology: Hub and spoke model		
Service redesign	Ophthalmology: Day surgery centre		
Facilities	Benchmarking - specific areas: Areas identified from corporate services / facilities benchmarking eg high energy costs, staffing numbers and mix in support services etc		
Mental Health	Introduce liaison officers at each acute hospital to reduce pressure on mental health care.	2,280	
Back office	Reduce the overhead of support services, "back office"		
Sub Total ideas 20/21 (some ideas not quantified)		2,280	

# Ideas list 20/21 and beyond

The following pipeline schemes will require further work to quantify and plan the changes. These schemes have been identified separately as they are strategic choices and will require additional consideration

Category	Initiative	Indicative annualised value £'000	Actions to accelerate
Rationalise on call Paediatrics	Implement Paediatric Task & Finish Group proposals to rationalise on-call consultant cover in the south of the UHB on to one site (Glangwili)	To be quantified by the health Board	<ul style="list-style-type: none"> <li>Discussions required with service to test idea, route to cash and develop action plans</li> <li>Opportunities based on interviews and benchmarking and efficiency documents but require testing and work up with ops leads</li> <li>Likely 20/21 and beyond</li> </ul>
Rationalise Stroke	Reduce numbers of admitting stroke units from 4 to 2		
Rationalise Breast	Breast: New model to reduce sites		
Service redesign	Decommissioning - To decommission services provided by the LA, including day care services for people with dementia (£30k) and EMI Social Worker (£30k)		
Community	Review community pharmacies service and enhanced service provision	800	
Primary care	Review and aggregate admin and management functions for 4 managed practices	300	
Rationalise - Sterile services	Sterile services - have 4 departments - short term operational improvement opportunities; medium and longer term potential to rationalise services	300	
Sub Total ideas 20/21 (some ideas not quantified)		1,400	

Total Ideas 20/21 and beyond (some ideas not quantified)	6,533			
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Total pipeline (only quantified schemes) 19/20 schemes + 19/20 potential + ideas list 20/21 and beyond	25,773			
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# Assessment of HDUHB financial plan

10 December 2019



# Important notice

This report ('the Report') has been prepared for Welsh Government ('WG') on the basis set out in the call off order signed 31 July 2019 ('Letter of Appointment'). This Report is for the benefit of Welsh Government only, and has been released to them on the basis that it shall not be copied, referred to or disclosed, in whole or in part, without our prior written consent. Any disclosure of this Report beyond what is permitted under the Letter of Appointment will prejudice substantially this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If Welsh Government receive a request for disclosure of the product of our work or this Report under the Freedom of Information Act 2000 or the Freedom of Information (Scotland) Act 2002, having regard to these actionable disclosure restrictions, Welsh Government should let us know and should not make a disclosure in response to any such request without first consulting KPMG LLP and taking into account any representations that KPMG LLP might make.

This Report is not suitable to be relied on by any party wishing to acquire rights against KPMG (other than WG) for any purpose or in any context. Any party, other than the WG, that obtains access to this Report or a copy (under the Freedom of Information Act 2000 or otherwise) and chooses to rely on this Report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG does not assume any responsibility and will not accept any liability in respect of this Report to any party other than WG.

The fieldwork commenced on 29 July 2019 and was completed on 31 October 2019. We have not undertaken to update our report for events or circumstances arising after that date.

In preparing this Report, the primary source of information has been obtained from HDUHB. KPMG does not accept responsibility for such information which remains the responsibility of the HDUHB. We have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information which was made available to us in the course of our work in accordance with the terms of the Letter of Appointment. We have not, however, sought to establish the reliability of the sources by reference to other evidence.

This engagement is not an assurance engagement conducted in accordance with any generally accepted assurance standards and consequently no assurance opinion is expressed. Nothing in this Report constitutes a valuation or legal advice.

KPMG emphasises that the realisation of the prospective quality and performance and other information set out within the Report is dependent on the continuing validity of the assumptions on which it is based. The assumptions will need to be reviewed and revised to reflect such changes in service/delivery trends, workforce, cost structures or the strategic intentions of existing services as they emerge. KPMG accepts no responsibility for the realisation of the prospective quality and performance and financial information. Actual results are likely to be different from those shown in the prospective financial information because events and circumstances frequently do not occur as expected, and the differences may be material.

The contents of our Report have yet to be reviewed in detail by the directors of HDUHB for the purposes of factual accuracy. All recommendations made are subject to Health Board governance processes (including QIA) and the responsibility for quality, safety and patient experience rests with the Health Board

# Summary

Area	Findings
<b>Scope</b>	<p>Welsh Government has tasked Hywel Dda University Health Board (HDUHB) with setting a clear and deliverable 2019/20 financial plan to deliver a £15 million deficit (based on a revised control total deficit of £25 million). The plan and associated savings required, need to be informed by the work already undertaken for the 2018/19 baseline assessment with a specific focus on addressing the key identified drivers of the deficit.</p> <p>This document assesses the 2019/20 planning assumptions and YTD trading to August (month 5) to identify cost pressures and required actions to mitigate them. In addition, we have worked with HDUHB to prepare a risk adjusted full year forecast at August (month 5).</p>
<b>Important notice</b>	<p>At the point of this assessment, the risk adjusted forecast for HDUHB at the end of August (month 5) is a downside deficit of £(30.9) million prior to any further recovery actions. This excludes the withdrawal of WG funding of £10.0 million as a consequence of HDUHB not achieving its £(15.0) million control total deficit. The recovery actions are outlined in the Financial Recovery Plan and aligned to an opportunities log.</p>
<b>2019/20 Planning and YTD M5 performance</b>	<p>HDUHB's full year forecast assumes cost pressures &amp; demand growth of £36.4 million. We have reviewed these assumptions together with HDUHB to identify areas of high risk of potential overspends as well as to identify opportunities to limit spend where this is in the control of HDUHB, not committed and where it will not have a significant adverse impact on patients or BAU.</p> <p>In reviewing the planning assumptions and in-year YTD performance, we note that:</p> <ul style="list-style-type: none"> <li>▪ The original 19/20 plan of £(29.8) million deficit needed to be adjusted in-year to align with the agreed Welsh Government control deficit of £(25.0) million.</li> <li>▪ The original plan was predicated on savings delivery of £23.9 million (increased to £28.7 million on alignment to the control total) although the current value of plans identified was only £21.3 million in April 2019 with savings plans also flat phased.</li> <li>▪ There is risk of understatement for non pay inflation for utilities, rates, estate maintenance and medical equipment contracts given this was only 0.5%: 2018/19 Welsh Costing Framework guidance and 19/20 English Foundation Trust planning assumptions indicate that 2% to 2.5% would have been more realistic (substantiated by the in-year YTD M5 adverse variance for 'other' non pay);</li> <li>▪ Cost uplifts were mainly applied to 18/19 YTD month 6 extrapolated performance. This raises the risk that increased spend in months 7 to 12 (particularly Q4), was not taken into account in setting the 19/20 baseline with cost uplifts then understated. This would then also impact the ability of the HB to understand the drivers of 19/20 monthly variances to plan and to identify corrective actions i.e. understated baseline vs. in-year unplanned cost pressures). Examples include: <ul style="list-style-type: none"> <li>- LTA cost growth (Swansea Bay and Cardiff): actual performance for Q3 to Q4 18/19 was £1.7 million higher than Q1 and Q2;</li> <li>- CHC growth: actual spend for Q3 to Q4 18/19 was £1.4 million higher than Q1 to Q2 (with Q4 increased spend being £1.6 million above Q1 and Q2 average);</li> <li>- Primary care prescribing: Q3 to Q4 18/19 spend was £2.2 million higher than Q1 to Q2 (Q4 increased spend being £2.1 million above Q1 and Q2 average);</li> <li>- NICE and High cost drugs: actual spend for Q3 to Q4 18/19 was £1.7 million higher than Q1 and Q2.</li> </ul> </li> </ul> <p>We note that each of the above items have an in-year adverse spend to plan at 19/20 YTD.</p> <ul style="list-style-type: none"> <li>▪ Pay and non pay spend is predominately flat phased despite monthly volatility and an increasing overall run rate spend in Q3 to Q4 18/19.</li> <li>▪ Review of YTD month 5 performance identifies a key risk of overspend against plan for: LTA over performance (Swansea Bay and Cardiff); demand on acute services (primarily for unscheduled care and Withybush General Hospital A&amp;E); NICE and High Cost drugs (mainly Oncology drugs); primary care prescribing drug costs; and Continuing Health Care costs (due to both increased demand and complexity of cases). Given CHC was the most significant cost driver (£2.7m), followed by Drugs (£2.3m) in 18/19, these pressures should have been foreseeable and appropriately planned for in 19/20.</li> </ul> <p>To ensure more robust financial planning in future years as well as understanding of consequent in-year performance, we would recommend that:</p> <ul style="list-style-type: none"> <li>- The approved HB plan aligns with the agreed WG control total and that assumptions are clearly understood across the HB prior to the new financial year;</li> <li>- Cost uplift assumptions are tested for reasonableness against prior year run rates, identified pressures and available benchmarks;</li> <li>- Assumptions are appropriately phased based on prior year run rates and known seasonality;</li> <li>- Savings plans are identified and developed over a three year time horizon to ensure appropriate focus on transformation and to enable plans for the forthcoming year to be fully identified, developed and phased prior to the commencement of the new year. We note that savings delivery was £26.6 million for 18/19 which highlights the need for ongoing transformational planning to ensure this level of saving requirement can be maintained.</li> </ul>

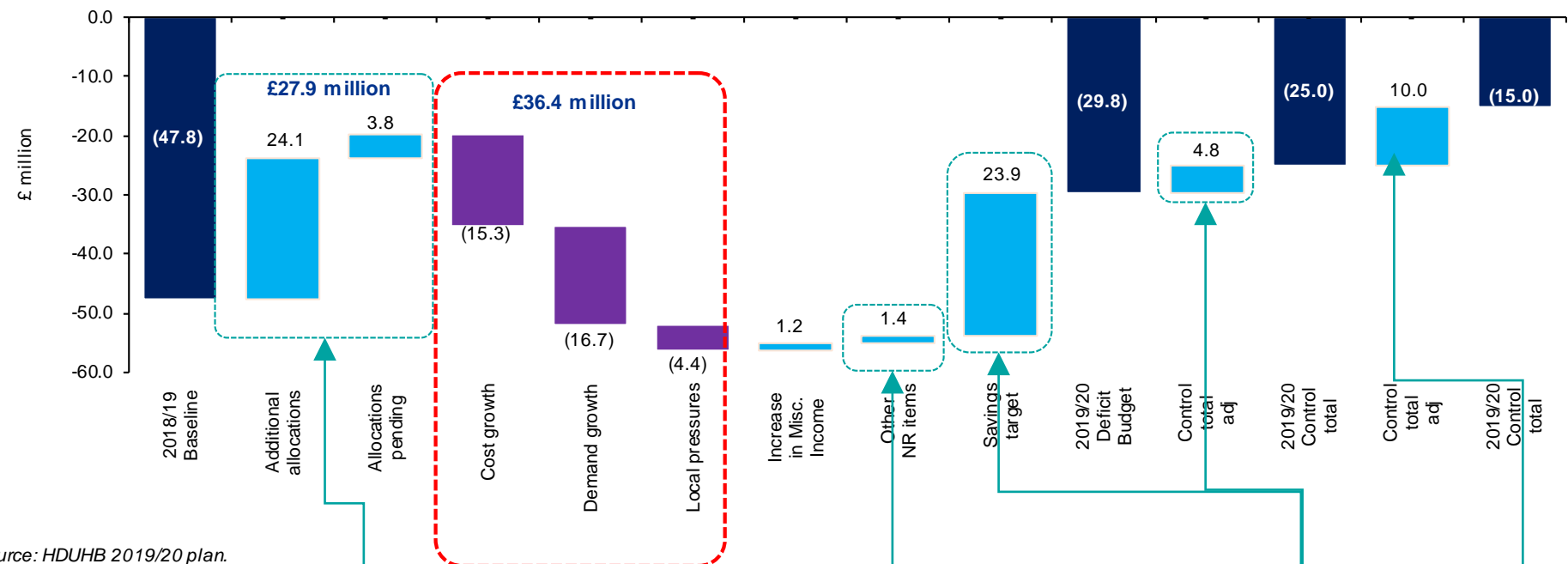
# Summary (continued)

Area	Findings
<b>2019/20 risk assessed forecast outturn at month 5 (August)</b>	<p>We have worked with HDUHB to develop a 19/20 risk adjusted forecast deficit range of £(30.9) million (downside) to £(26.4) million (upside). Significant assumptions include:</p> <ul style="list-style-type: none"> <li>▪ Adjustment for £10 million of in-year Welsh Government funding to reduce the control total deficit of £25 million to a £15 million deficit plan;</li> <li>▪ Extrapolation of the month 5 YTD adverse variance to plan adjusted for savings under-delivery and non-recurrent items;</li> <li>▪ Risk adjusted savings gap of £10.5 million based on our review in August (being a risk adjustment of £14.0 million against required savings of £28.7 million which has subsequently been reduced by notified non recurrent RTT funding of net £3.5 million). An additional £3 million of savings for green/amber schemes is now also reflected in the bridge to reflect reduced delivery risk as a consequence of the rigour from the Hold To Account meetings. This would increase in-year delivery from £14.7 million to £17.2 million (before RTT of £3.5 million).</li> </ul> <p>Significant assumptions in the upside case of £36.4 million are:</p> <ul style="list-style-type: none"> <li>▪ Planned mitigations of £2.1 million based on identified actions developed by Directorates to mitigate in year pressures and saving shortfalls;</li> <li>▪ Conversion of £2.5 million of red saving schemes to delivery (reducing the saving's gap to £8.0 million).</li> </ul> <p>The risk adjusted forecast range excludes withdrawal of WG funding of £10.0 million should HDUHB not achieve its £(15.0) million control total deficit – refer page 10.</p>
<b>Next steps – immediate and high priority actions</b>	<p><b>To achieve the best possible outturn for 19/20, including trying to achieve the control total of £15.0 million deficit, it is imperative that HDUHB:</b></p> <ol style="list-style-type: none"> <li>1. Implements effective grip and control over spend (particularly for opportunities highlighted in our Grip &amp; Control report).</li> <li>2. Planned spend is reduced or deferred where this is within the control of HDUHB and there is no adverse clinical quality or BAU impact (refer pages 5 to 9). This needs to include cessation of approvals for all future business case approvals where there is risk that planned benefits will not be delivered unless such business cases are predicated on urgent required improvements for clinical quality.</li> <li>3. There needs to be robust tracking of in-year cost pressures so that early action can be taken to mitigate in-year overspends, particularly for unscheduled care. This needs to include the development of improved forecasting capability (with demand/ activity linked to required resources to deliver and identification of leading operational indicators).</li> <li>4. Identified savings schemes rated as red or amber/green need to be fully developed into green schemes with schemes successfully implemented through adequate assessment of required resources for delivery, robust benefits tracking and investigation of drivers for unsuccessful delivery. In addition, there needs to be continued focus on identification and implementation of new schemes and continued development of planned mitigating actions.</li> </ol>

# 18/19 to 19/20 original plan bridge (income & expenditure)

The original 19/20 plan of £29.8 million deficit was based on a 18/19 baseline of £47.8 million, additional allocations from Welsh Government of £27.9 million, cost pressures of £36.4 million and savings requirement of £23.9 million. The plan was then adjusted to reflect a control total deficit of £25.0 million with a revised savings requirement of £28.7 million. Welsh Government has subsequently committed to additional funding of £10.0m if HDUHB is able to deliver its control total of £25.0 million resulting in a revised deficit plan of £15.0 million deficit.

## 2019/20 Deficit budget



Source: HDUHB 2019/20 plan.

Increased Welsh Government recurrent allocation of £24.1M.

Additional recurrent allocations still to be approved by the Welsh Government (£1.9 million for substance misuse and £1.9 million for Treatment Fund) to offset corresponding cost pressures.

Total revenue resource allocation of £828.8 million.

Refer following pages for detail

Multiple NR items

Aggregated savings gap of £28.7 million

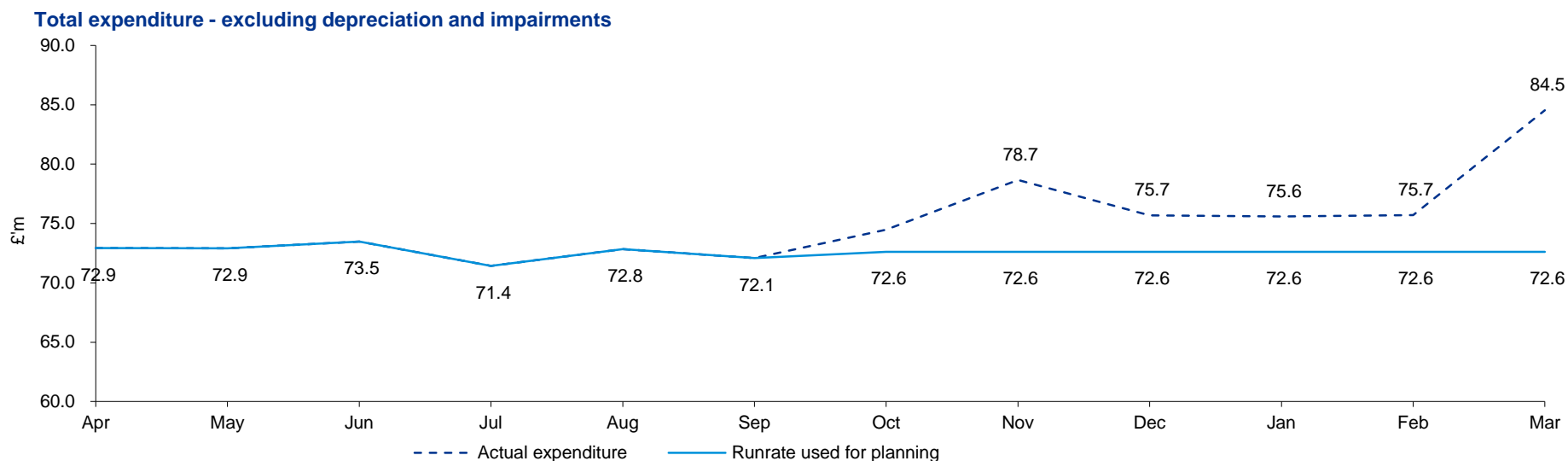
WG has committed additional funding of £10.0 million if HDUHB delivers its control total of £25.0 million.

# Net and gross funding

The health board's financial plan was based on cost pressures applied to the 18/19 outturn, based on simple extrapolation of YTD (month 6) results, without taking into account factors affecting second half of the year. As a result, the extrapolated spend (excluding impairments and depreciation) was £29.0 million lower than actual expenditure for 18/19. Part of this was due to pay award and changes in provision for holiday entitlement announced in month 8 of 18/19.

However, excluding pay costs, the financial plan expenditure baseline was underfunded by £16.7 million. Had the health board used seasonality trend of actual 17/18 spend for the extrapolation, the expenditure baseline (excluding depreciation, impairments and pay costs) would have been underfunded by only £0.4 million, which the health board could have managed in-year with an increased focus on savings delivery.

The planning process primarily underfunded assumptions related to primary care contracting, primary care prescribing, non pay spend excluding drugs, spend on secondary care drugs, spend on LTAs with other bodies and CHC spend.



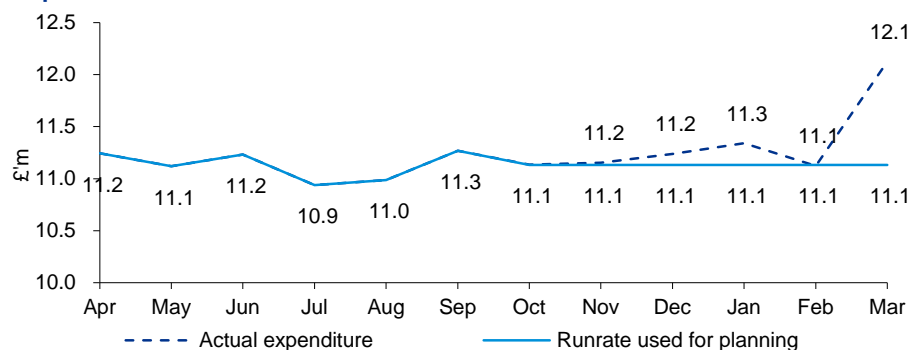
Source: KPMG Analysis on month 12 monitoring returns for 17/18 and 18/19.

# Net and gross funding (cont.)

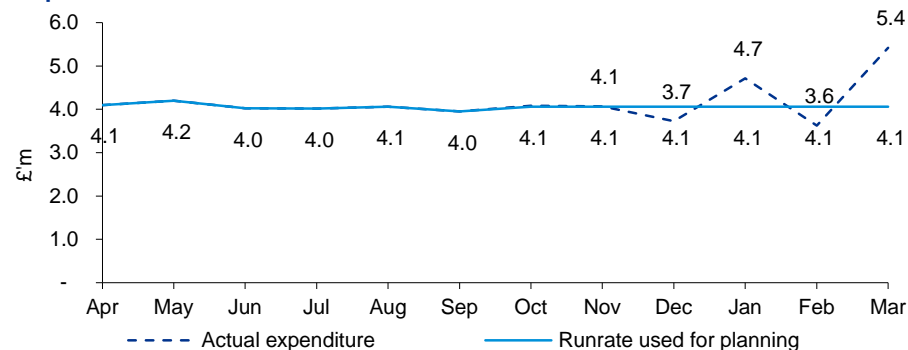
Had the health board used 17/18 seasonality to extrapolate these expenses, in-year pressures on CHC spend would have been fully mitigated, with increased assumption by £1.1 million as compared to a pressure of £0.2 million. NICE and high cost drugs in-year pressure of £1.6 million would have been mitigated by increased funding assumption by £1.2 million. Primary care prescribing in-year pressure of £1.2 million would also have been mitigated by additional funding assumption of £1.0 million.

While extrapolating spend on LTAs based on 17/18 trend would result in further underfunding, this would have been overcompensated by overfunding on general non-pay spend. LTAs represent an in-year pressure of £1.1 million. Finally we note that setting budgets in this way would have set a much larger requirement for savings than was planned in order to hit the £25m control total.

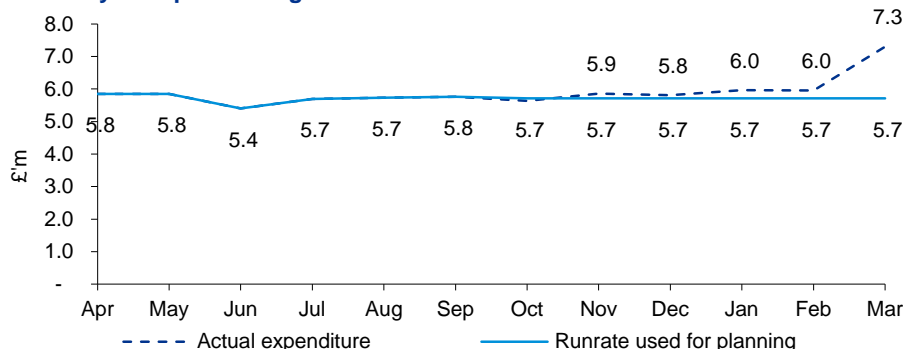
**Spend on LTAs**



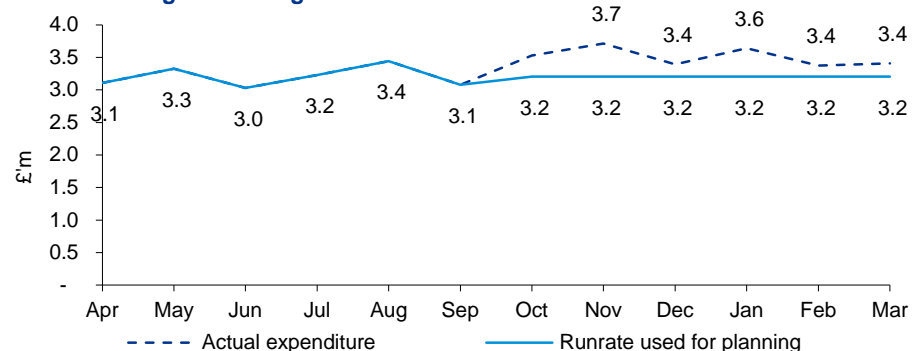
**Spend on CHC**



**Primary care prescribing**



**NICE and high cost drugs**






Source: KPMG Analysis on month 12 monitoring returns for 17/18 and 18/19.



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# Cost pressures, pre-commitments and inflation, growth & service demand

HDUHB's total forecast cost pressures of £36.4 million are described below. We have reviewed these with HDUHB based on YTD M5 performance to identify opportunities to reduce the spend where such spend is within the control of HDUHB, is not committed and will not have a significant adverse consequence on quality of patient care or operations. Where there is opportunity to reduce costs, we have provided recommendations for next steps.

Cost growth	£M	Assumption/ evidence base	Full year impact if not mitigated	Within HB control	Committed	Impact/ risk of reduced spend	Opportunity	Recommended next steps
Pay Inflation	6.5	Impact of A4C and other pay settlements ('Out of Hours' holiday entitlement) as per national framework (average 1.86% uplift and 1% medical pay inflation).	 No significant variation identified	No	N/a	N/a	No	<ul style="list-style-type: none"> <li>None</li> </ul>
Non pay Inflation	3.3	Anticipated inflationary impact of 0.54% and additional cost pressures (provided by Directorates in Sept.18), mainly for utilities, rates, estate maintenance and medical equipment contracts for service and repair. Additional spend for Office 365 rollout.	 Risk of in-year overspend given other non pay YTD M6 adverse variance of £1.1 million. <i>Prior year uplifts, 2018/19 Welsh Costing Framework guidance and 19/20 English Foundation Trust planning assumptions indicate that 2% to 2.5% would have been a more realistic assumption. 2% assumption would have increased assumptions by £8.9M, mitigating in-year pressures.</i>	Yes	No	Limited risk of adverse consequence	Yes (price, deferred spend and alternative consumables/ equipment)	<ul style="list-style-type: none"> <li>HDUHB to conduct a review by the end of November to identify opportunities to negotiate reduced prices (to include benchmarking) - to be incorporated into savings programme/ opportunities identification.</li> <li>To include identification of opportunities to defer spend (post impact assessment) for maintenance and medical equipment and alternative more affordable equipment and consumables.</li> </ul>
Continuing Health Care (community and mental health patients)	3.1	Inflation estimate of £2.0M assumed (subject to negotiation later in the year) and activity growth of £1.0M - based on analyses of activity trends for past 5 years (prepared by CHC team in Sept. 2018).	 No growth variation Potential full year inflation saving of £0.8M based on YTD performance	Partly – activity growth and use of packages	Partly	Low impact - refer recommended next steps	Yes	<ul style="list-style-type: none"> <li>Continued monitoring of potential £0.8M inflation benefit.</li> <li>HDUHB review of potential for transfer of patients to lower cost care packages on transfer from healthcare setting to nursing home/ at home care needs to be expedited (deadline set for end of October with reviews to become BAU) - to be incorporated into savings programme/ opportunities identification.</li> </ul>

# Cost pressures, pre-commitments and inflation, growth & service demand

HDUHB's total forecast cost pressures of £36.4 million are described below. We have reviewed these with HDUHB to identify opportunities to reduce the spend where such spend is within the control of HDUHB, is not committed and will not have a significant adverse consequence on quality of patient care or operations. Where there is opportunity to reduce costs, we have provided recommendations for next steps.

Cost growth	£M	Assumption/ evidence base	Full year impact if not mitigated	Within HDUHB control	Committed	Impact/ risk of reduced spend	Opportunity	Recommended next steps
Statutory Compliance	0.5	Implementation of external review recommendations for Shared Services Fire team (£0.1M) & Health & Safety Executive Compliance team (£0.4M) – provided by Directorates in Sept. 18.	● Recruitment delays in M1-M2 but posts now filled	No - regulated	Yes	Medium to high	No	▪ None
General Medical Services	0.9	Cost increases provided by GMS team based on 18/19 YTD M6 extrapolation for: - HDUHB Managed Practices (£0.3M) and transfer of previous GMS practice (£0.2M impact); - Direct Enhanced Services for Care Homes and NOAC (anti-coagulation) of £0.4M.	● No significant variation identified	Yes	No	Low (unless in rural areas)	Yes (transfer managed practices to GMS contract or potentially reduce number of practices).	▪ Continued development of plan to support savings target of £0.8M based on transfer to GMS contract. ▪ If not successful, to include: - Review of potential to close (to be completed by November) - Targeted campaign to convert locums to substantive.
Quality & Safety	0.3	All pay related to predominantly county schemes to address known quality and safety concerns e.g. vision screening. Provided by Directorate teams in Sept 18.	● No significant variation identified	Yes	Yes	Medium to high	Limited	▪ Review whether quality and safety concerns are still present to identify whether potential to reduce spend. To be concluded in November.
Other	0.7	Wide range of cost pressures provided by Directorates in Sept. 18 with values of less than £0.1 million (e.g. Unfilled GP shifts £0.1M, Equipment stores £0.1M, critical care & outreach £76k, ART – Part fund mainstream workforce £65k, Telemedicine £50k).	● No significant variation – not tracked individually as immaterial	Yes	No	Low given materiality	Yes	▪ Even though these are small values, there needs to be a review conducted in October/November to identify opportunities to cease expenditure where it is not committed - to be incorporated into savings programme/ opportunities identification.
<b>Total cost</b>		<b>15.3</b>						

RAG: ● High impact on FOT; ● Low impact on FOT; ● No impact on FOT




# Cost pressures, pre-commitments and inflation, growth & service demand

HDUHB's total forecast cost pressures of £36.4 million are described below. We have reviewed these with HDUHB to identify opportunities to reduce the spend where such spend is within the control of HDUHB, is not committed and will not have a significant adverse consequence on quality of patient care or operations. Where there is opportunity to reduce costs, we have provided recommendations for next steps.

Demand growth	£M	Assumption/ evidence base	Full year impact if not mitigated	Full year impact if not mitigated	Committed	Impact/ risk of reduced spend	Opportunity	Recommended next steps
Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and LTAs	6.1	Assumes 2% inflation (£1.9M) and growth (£4.2M) based on: <ul style="list-style-type: none"> <li>18/19 YTD M6 extrapolated performance and known 19/20 service dev.'s, supported by notification from WHSSC &amp; WG and EASC;</li> <li>Changes to risk share allocation assumed cost neutral.</li> </ul> £1.7m risk of understatement due to increased 18/19 M6-M12 LTA activity (Swansea Bay and Cardiff and WHSSC).	● YTD LTA cost pressure of £0.4M for M1 to M6 and £1.1M full year (being mainly Swansea Bay: £0.8M and Cardiff: £0.4M)	Yes for LTAs only	Yes, majority are contractual	Consider medium for LTAs	Yes for LTAs	<ul style="list-style-type: none"> <li>Swansea Bay and Cardiff LTA performance review required over period October/ November with focus on: <ul style="list-style-type: none"> <li>Referral authorisation controls;</li> <li>HDUHB available capacity checks prior to authorisation.</li> </ul> </li> <li>Review to be conducted by end November to analyse LTA activity being performed by other HBs together with the potential for HDUHB to perform such activity if capacity was available.</li> </ul>
NICE and High Cost Drugs	3.0	Forecast based on provisional estimates which subsequently aligned to the Horizon Scanning report released in November / December.	● Secondary drug cost pressures mainly for Oncology of £0.8M YTD M5 and £1.6M full year	Limited – some patients on pathway which cannot be changed	No	Low if alternatives can be sourced	Yes	<ul style="list-style-type: none"> <li>Analyse opportunity to reduce costs over period by end of November through review and benchmarking of type and volume of drugs used based on patient conditions i.e. identify opportunity for alternative lower cost drugs and/or reduced usage. To be incorporated into savings programme/ opportunities identification.</li> </ul>
Demand on Acute Services	5.4	Relates mainly to non delivery of 18/19 saving schemes to reduce Unscheduled Care activity of £3M (e.g. planned bed reductions). Additional pay establishment investment of £1.2M for Pathology agency consultant (£0.2M); Dermatology (£0.2M); Urology (£0.3M); Orthopaedics (£0.1M); Unscheduled Care (£0.2M); Radiology (£0.2M).	● Overspend of £3.6M YTD M5 with significant full year overspend of £7.6M: £3.1M Unscheduled Care (mainly WGH of £2.0M); £0.6M for Radiology and £0.7M Women & Children's.	Yes for both pressures and pay establishment	No	Low	Significant for demand reduction	<ul style="list-style-type: none"> <li>Continued focus on demand reduction to decrease variable pay issues arising on surge – to be incorporated into emerging clinical strategy.</li> <li>Consider pay establishment freeze if individuals not in post and long standing vacancy not being filled by agency.</li> </ul>

# Cost pressures, pre-commitments and inflation, growth & service demand




HDUHB's total forecast cost pressures of £36.4 million are described below. We have reviewed these with HDUHB to identify opportunities to reduce the spend where such spend is within the control of HDUHB, is not committed and will not have a significant adverse consequence on quality of patient care or operations. Where there is opportunity to reduce costs, we have provided recommendations for next steps.

Demand growth	£M	Assumption/ evidence base	Full year impact if not mitigated	Within HDUHB control	Committed	Impact/ risk of reduced spend	Opportunity	Recommended next steps
Primary care developments	1.2	Includes £0.3M for pacesetter, £0.2M for GP and paramedic increases and £0.6M for primary care contract increases as notified by Directorates based on 18/19 YTD M6 extrapolation & known full year impact of 18/19 developments.	 No significant variation	Yes	Yes	Low	Yes, but limited in short term (due to GMS contracts)	<ul style="list-style-type: none"> <li>Contracting team to review all 3<sup>rd</sup> party contracts (LTAs, SLAs, GMS and Other) over next 3 months for cost reduction opportunities and to introduce a contracts register and contract framework for improved grip - to be incorporated into savings programme/ opportunities identification.</li> </ul>
Primary Care Prescribing	0.7	Budgeted price increase for NCSO (No Cheaper Source Obtainable) – only one supplier therefore limited bargaining potential Based on average growth in 17/18 and 18/19.	 M5 YTD overspend of £0.5M for revised prices for primary care drugs by Pharmaceutical Services Negotiating Committee (PSNC). Full year impact of £1.2M.	Limited	No	Can be mitigated	Yes	<ul style="list-style-type: none"> <li>Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification.</li> </ul>
Continuing Health Care	0.3	Known demand increase for Mental Health from 2018/19 fully budgeted for based on 18/19 YTD M6 extrapolated.	 M5 YTD and full year cost pressure of £0.2M.	Partially	No	Medium to high given patient impact	Limited in short term	<ul style="list-style-type: none"> <li>Continue the development of Core and Community based services for MH &amp; LD Transformation – to be incorporated into emerging clinical strategy.</li> <li>Develop Joint Funding Guidance.</li> </ul>
<b>Total cost</b>	<b>16.7</b>							

RAG:  High impact on FOT;  Low impact on FOT;  No impact on FOT

# Cost pressures, pre-commitments and inflation, growth & service demand

HDUHB's total forecast cost pressures of £36.4 million are described below. We have reviewed these with HDUHB to identify opportunities to reduce the spend where such spend is within the control of HDUHB, is not committed and will not have a significant adverse consequence on quality of patient care or operations. Where there is opportunity to reduce costs, we have provided recommendations for next steps.

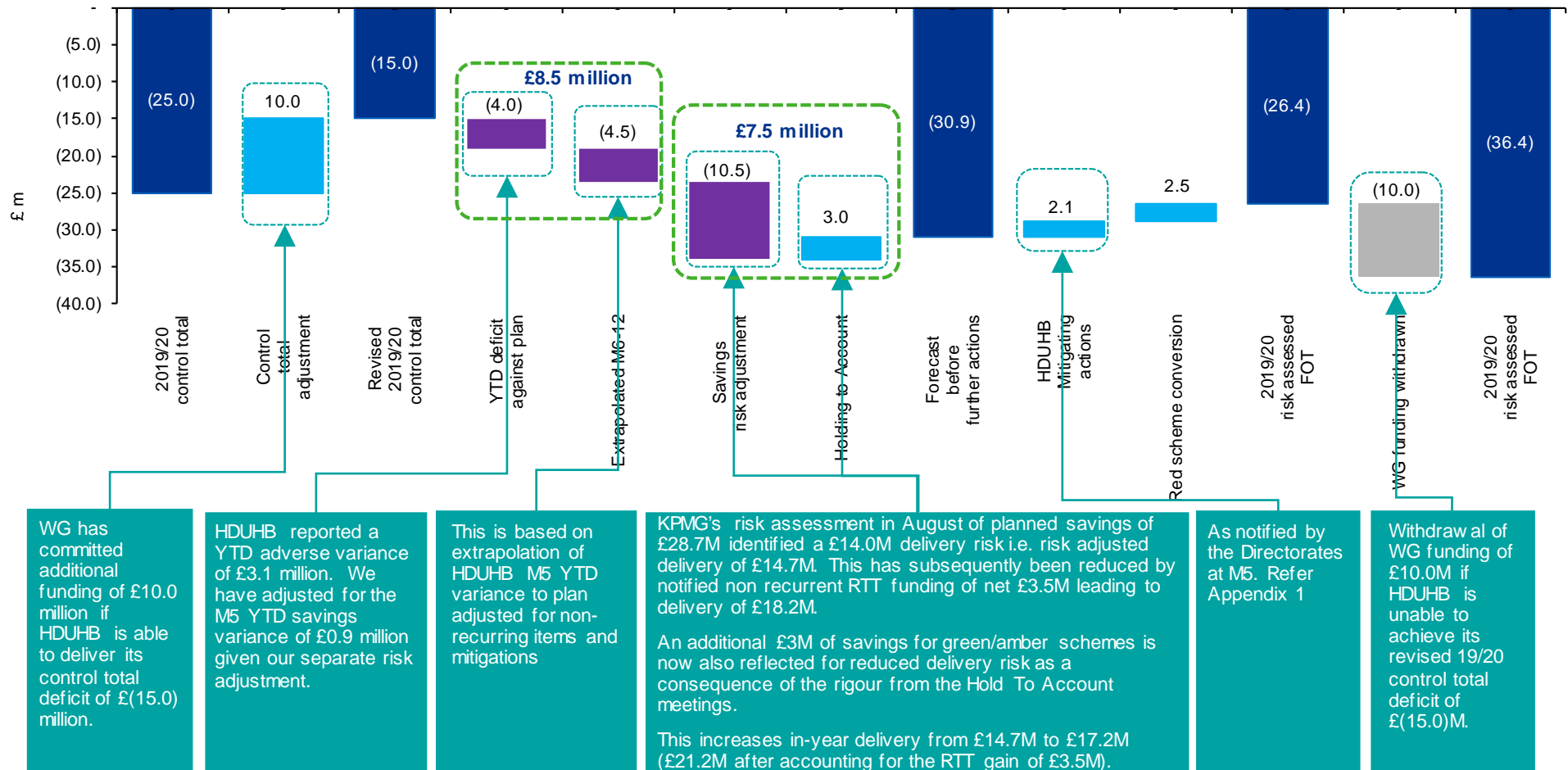
Local pressures	£M	Assumption/ evidence base	Full year impact if not mitigated	Within HDUHB control	Committed	Impact/ risk of reduced spend	Opportunity	Recommended next steps
Nurse Staffing Act	1.0	Phased implementation over 2018/19 to 2020/21 (3 years) at £1m per year. Budget for 2019/20 has been allocated in M5 for implementation from M6.	 No significant variation identified	Yes but regulatory guidelines	Not completely	Potential risk needs to be understood	Potentially if costs can be deferred	▪ Review potential to defer costs in October/ November.2019/20.
Winter Pressures	1.0	HDUHB has assumed costs of £1.0M (based on a potential winter plan forecast range of £1.5M to £2.5M).  We note that HDUHB has not assumed any winter funding given this is still to be announced.	 No significant variation identified	Yes, if proper planning conducted	Only £0.1M committed to date	Patient access	Limited – likely to be a risk given 2018/19 spend was £3M	▪ Continue to develop and test winter plan to reduce costs where possible.
Integrated Care Fund	2.4	Pass through spend to match increase in ICF allocation for dementia and therapies.	 No significant variation identified	Linked with regional partners	Yes	Low	Limited and pass through	▪ N/a
<b>Total cost</b>		<b>4.4</b>						

RAG:  High impact on FOT;  Low impact on FOT;  No impact on FOT

# 19/20 Risk adjusted forecast outturn at August (YTD M5)

Our analysis projects a risk adjusted deficit outturn range of £(30.9) million to £(26.4) million at M5 YTD. The downside increases to £(36.4) million if WG funding of £10.0 million is withdrawn as a consequence of HDUHB not achieving it's £(15.0) million control total deficit.

## Risk assessed forecast outturn - 2019/20



Source: KPMG Analysis



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# Performance by directorate at M5 YTD

Month 5 YTD overspend of £3.1 million is primarily due to overspend in Unscheduled care of £2.2 million (4.4%) as per previous months as a consequence of additional agency spend across all sites. The ability to mitigate this overspend (particularly over winter) is a risk to HDUHB achieving its control total and needs to be addressed through planned grip and control and other initiatives.

Performance by Directorate								
£ '000	Annual budget	M5 YTD Budget	M5 YTD Net spend	M5 YTD Variance	M5 YTD Variance %	M6-12 extrapolation	FY over/ under spend	FY Variance %
Unscheduled care	116.3	49.2	51.3	2.2	4.4%	0.9	3.1	2.6%
Facilities	36.1	14.9	15.2	0.2	1.5%	(0.1)	0.2	0.5%
Primary care and Medicines Management	188.3	79.3	79.4	0.1	0.1%	0.9	0.9	0.5%
Mental health & learning disabilities	73.5	31.0	30.8	(0.2)	-0.6%	(0.6)	(0.8)	-1.1%
LTA's with other NHS providers	135.5	56.5	56.6	0.1	0.2%	1.0	1.1	0.8%
Oncology & cancer services	13.6	5.7	5.8	0.2	3.2%	0.1	0.3	2.1%
Pathology	20.3	8.5	8.7	0.2	2.0%	0.3	0.5	2.4%
Planned care	100.3	43.2	43.5	0.4	0.9%	(0.5)	(0.1)	-0.1%
Radiology	15.1	6.5	6.8	0.3	4.7%	0.3	0.6	3.9%
Corporate	135.4	40.7	40.2	(0.5)	-1.2%	(0.2)	(0.7)	-0.5%
Other	(31.1)	(13.0)	(13.1)	(0.1)	1.1%	(0.1)	(0.3)	0.8%
County teams	53.8	22.7	22.7	(0.0)	-0.1%	0.1	0.1	0.2%
Women & children	36.7	15.5	15.8	0.3	1.9%	0.4	0.7	1.9%
<b>Total</b>	<b>893.8</b>	<b>360.7</b>	<b>363.8</b>	<b>3.1</b>	<b>0.9%</b>	<b>2.4</b>	<b>5.5</b>	<b>0.6%</b>

Source: FY20 Month 5 ledger



# Appendices

## Appendix 1

# HDUHB Mitigating actions at Month 4

The table below provide the basis of mitigating actions identified by HDUHB reflected in our 19/20 risk adjusted bridge on page 10.

Mitigating actions									
	5	6	7	8	9	10	11	12	Total
<b>Planned care</b>									
Expected slowdown in Critical Care pressure in summer	20,000	20,000	20,000						60,000
Appointment into Vacancies Critical Care	10,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	150,000
Exit strategy high cost locum		13,000	13,000	13,000	13,000	13,000	13,000	13,000	91,000
Reduction in locum/ ad hoc fees	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	80,000
Orthopaedic Vacancy Appointment		1,000	1,000	1,000	1,000	1,000	1,000	1,000	7,000
Orthopaedic Vacancy Appointment	13,000	-	-	-	-	-	-	-	13,000
Orthopaedic Vacancy Appointment	-	-	1,720	1,720	-	-	-	-	3,440
Critical Care Outreach Funding	55,556	55,556	55,556	55,556	55,556	55,556	55,556	55,556	444,448
	<b>108,556</b>	<b>119,556</b>	<b>121,276</b>	<b>101,276</b>	<b>99,556</b>	<b>99,556</b>	<b>99,556</b>	<b>99,556</b>	<b>848,888</b>
<b>BGH</b>									
Band 8B replace by Band 7	-	-	-	1,851	1,851	1,851	1,851	1,851	9,255
Job planning opportunities (GB)	-	-	1,500	1,500	1,500	1,500	1,500	1,500	9,000
Band 4 seconded no backfill 0.8wte	1,367	-	-	-	-	-	-	-	1,367
Establishment Control - HCSW reduction to funded establishment	20,010	20,010	20,010	20,010	20,010	20,010	20,010	20,010	160,080
Rota Coordinator (Band 4 to band 3)	-	336	336	336	336	336	336	336	2,352
A&E over establishemnt (night 1.5wte)	6,330	6,330	6,330	6,330	6,330	6,330	6,330	6,330	50,640
Patient Flow removal of weekend work	600	600	600	600	600	600	600	600	4,800
Medical Pay - Reduction due to 4 new starters (from zero contract)	12,565	12,565	12,565	12,565	12,565	12,565	12,565	12,565	100,520
Non Pay - review (red scheme £10k pm)	-	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000
Meurig ward long term sick resolution	-	3,911	3,911	3,911	3,911	3,911	3,911	3,911	27,377
Meurig recruitment 2 x RN (1 new 1 return from sick)	-	3,713	3,713	3,713	3,713	3,713	3,713	3,713	25,991
Dyfi long term sick terminating	-	2,882	2,882	2,882	2,882	2,882	2,882	2,882	20,174
New starters 6.4 wte (y Banwy, Caredig, Ystwyth & Rhiannon), risk adjus	-	5,570	5,570	5,570	5,570	5,570	5,570	5,570	38,987
A&E of site storage of patient records SLA price reduction	243	243	243	243	243	243	243	243	1,944
Agency reduction due to bed reconfiguration (4 wte)	-	-	-	-	-	7,426	7,426	7,426	22,278
	<b>41,115</b>	<b>66,160</b>	<b>67,660</b>	<b>69,511</b>	<b>69,511</b>	<b>76,937</b>	<b>76,937</b>	<b>76,937</b>	<b>544,765</b>
<b>Oncology</b>									
Aseptic Outsourcing ceases December					20,000	40,000	40,000	40,000	140,000
	-	-	-	-	<b>20,000</b>	<b>40,000</b>	<b>40,000</b>	<b>40,000</b>	<b>140,000</b>

## Appendix 1

# HUHB Mitigating actions (cont.)

Mitigating actions (cont.)									
	5	6	7	8	9	10	11	12	Total
<b>Facilities</b>									
Gap analysis minimum savings due to recruitment			25,000	25,000	25,000				75,000
Min Aeron Capital Credit								60,000	60,000
Retirement of senior staff			7,500	7,500	7,500	7,500	7,500	7,500	45,000
	-	-	32,500	32,500	32,500	7,500	7,500	67,500	180,000
<b>Therapies</b>									
Reduction in Agency costs	11,808	11,808	21,408	21,408	21,408	21,408	21,408	21,408	152,064
	11,808	11,808	21,408	21,408	21,408	21,408	21,408	21,408	152,064
<b>WGH</b>									
Nurse Recruitment - 14 Nurses (Green recovery plan)	-	-	27,336	27,336	27,336	27,336	27,336	27,336	164,016
General Medicine Middle Grade locum reduction (NP)	-	5,849	5,849	5,849	5,849	5,849	5,849	5,849	40,943
	-	5,849	33,185	33,185	33,185	33,185	33,185	33,185	204,959
<b>Total mitigating actions</b>	<b>161,479</b>	<b>203,373</b>	<b>276,029</b>	<b>257,880</b>	<b>276,160</b>	<b>278,586</b>	<b>278,586</b>	<b>338,586</b>	<b>2,070,676</b>



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## **KPMG Report – Retrospective**

### **Overview**

KPMG were commissioned by WG to undertake a review of finances in Hywel Dda University Health Board during 2019. Four separate reports were compiled and initially presented to the Finance Committee in December 2019. The Health Board's response to the recommendations were presented to the Finance Committee in March 2020 prior to the COVID 19 pandemic.

The reports covered:





- Grip and Control
- Assessment of 2019/20 Financial Plan
- Delivery Framework including a Budget Holder Survey
- Recovery Plan

The reports reference the processes and governance structures in place at the time of the review e.g. Holding to Account and Finance Committee. Whilst several changes have happened in the intervening period, some of the key themes from the recommendations remain relevant and the Health Board's status, and these are listed below. Some areas have been fully implemented although delivery maybe challenging, others are on-going or no longer relevant.

The report covering the Assessment of the 2019/20 Financial Plan can be discounted as the items have been covered elsewhere or are no longer relevant having closed the 2019/20 financial year.

### **Status Key:**

The following definitions describe the red, amber or green status that has been used to highlight, in summary form, where the Health Board considers itself against the original recommendations:

-  Outstanding with limited or no plan to address
-  In progress with a clear plan, deliverables, and timelines in place
-  Complete
-  Closed without improvement action

## Report – Grip and Control

Ref	Pay	Recommendations and Status	Current position	Owner	Next steps
8.2	Agency	Agency booking process and control	<ul style="list-style-type: none"> <li>Workforce Efficiency Programme developed from KPMG recommendations. Programme is reported to Executive Team (bi-weekly) and monitored via PODCC. (Last update Aug 22)</li> <li>As result of TI, People Effectiveness Team established and Stabilisation Programme phase 1</li> <li>Nurse agency and Medical Agency are key transformation programmes</li> <li>Non-clinical agency guidelines now established, with policy compliance reactively monitored</li> <li>Several services are over established, and mitigating actions have yet to be identified to reduce the overspend</li> <li>Wagestream has been implemented, at a cost to the HB, to support financial wellbeing and also to attract Agency to Bank with the favourable wage draw down solution, focusing on retention of existing staff</li> </ul>	Lisa Gostling for key transformation programmes and People Effectiveness Team including adherence, and all other budget holders for the services they manage	Covered as part of terms of reference of stabilisation programme
8.7		Target reduction Off-contract usage			New escalation process to be agreed for booking of all agency staff
8.8		HCSW agency			Fill rate of funded establishment (including headroom) to be agreed by Corporate Nursing team to avoid overspend.
8.9		Paid breaks			Overseas recruitment programme in place to recruit 130 nurses in 2022/23. 100 appointed, recruitment in progress for remaining 30
8.10		High usage agency			Detailed stabilisation plans by ward in GGH in development
8.11		Policy on nursing staff returning as agency			All Wales agreement. Agency workers are not able to return to HB for minimum 6 months and no return possible for working
8.19		Agency mileage			
8.21		Agency authorisation process			
8.23		Agency requests			
8.22		Locum authorisation process			
8.12	Rostering	Promote Bank sign up			

8.5		Compliance	<ul style="list-style-type: none"><li>Establishment control reports issued by Workforce, and enhanced Allocate controls are in progress across all clinical staff rosters</li></ul>		with non-framework agencies.
8.13		Promote Bank usage			
8.14		Rostering policy – agreed w/c 6/12/22			
8.15		Job plans			
8.16		Rota management			
8.6		Overtime / additional hours			
8.1	Sickness	Implement clear reviews, supported with appropriate workforce data and policies, with escalation measures through appropriate executive lead for their area of responsibility			
8.17	Long term temporary staff				
8.18	Acting down and unpaid breaks				
8.2	On-call rates				
8.3	Controls over staff leaving the Health Board ('exit controls')				
8.4	WTE budgets				
Ref	Non pay	Recommendations and Status	Current position	Owner	
8.24	Discretionary spend – catalogue compliance	Catalogue is continuously updated and reviewed by Procurement team to reduce the variety offered on them and to reduce spend, reviewing suppliers of the catalogue items to add more competitive options. Drive down the use of non-catalogue purchases where suitable alternatives are available on catalogue.	<ul style="list-style-type: none"><li>The catalogue is continuously updated on an ongoing basis and catalogue coverage has continued to grow steadily over the last two years. Current catalogue coverage stands at 86%.</li></ul>	Huw Thomas	As part of Procurement's ongoing Purchase Order governance, one week of active scrutiny will be undertaken every three to six months, with reporting at all other times.

		All discretionary spend is scrutinised prior to placing orders for non-catalogue purchases.			
8.26	Reduce clinical preference	Implement a standardised offering for all appropriate clinical consumables, reducing variation of items available to clinicians, but maintaining multiple suppliers at competitive rates for standard items. Clinical input and engagement is key to agreeing the appropriate offering to standardise.	<ul style="list-style-type: none"> <li>The appointment of the new Clinical Procurement Nurse will help drive standardisation and reduce clinical preference.</li> </ul>	Phil Kloer	On-going review process.
8.27	Enforce no PO no pay policy	Continuously implement policy.	<ul style="list-style-type: none"> <li>Policy in place and routinely monitored via ARAC</li> </ul>	Huw Thomas	Closed, action completed
8.28	Business cases – post implementation review	Benefits realisation tracking.	<ul style="list-style-type: none"> <li>Priority objective to refocus on a hierarchical investment process and accountability in progress</li> <li>The digital team has developed a benefits realisation framework. An intranet page has been created which colleagues can access that contains the framework and a template to follow.</li> </ul>	Huw Thomas	The digital team is going to arrange a session to demonstrate the benefits realisation model to other teams. We will look to see how this can be embedded across the organisation.
8.29	Stock management	Stock maintained at level to minimise waste.	<ul style="list-style-type: none"> <li>Stock Management Policy reviewed in October 2020, and deemed appropriate</li> <li>It is recognised a best in class solution would be a fully integrated stock management system, but without additional investment this would not be achieved within current</li> </ul>	Huw Thomas	Closed, action completed

			resources and tangible payback not clear		
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## Report – Recovery Plan

Ref	Theme	Recommendations and Status	Current position	Owner	Next steps
7.8 7.9	Opportunity Ideas and Themes	Potential Initiatives 2019/20 and 2020/21	<ul style="list-style-type: none"> <li>Opportunities Framework and Roadmap</li> </ul> <p>Key Transformation Programmes 2022/23 –</p> <ul style="list-style-type: none"> <li>Transforming urgent and emergency care</li> <li>Integrated Localities</li> <li>Long Term Care (MHLDD)</li> <li>Nurse agency</li> <li>Medical agency</li> <li>Alternative Care Unit</li> <li>Family Liaison Officers</li> </ul>	Huw Thomas	Implementation of transformation programmes
7.9		Back office – reduce the overhead of support services	<ul style="list-style-type: none"> <li>Reviewed by Execs but deemed not appropriate to take forward at the time</li> <li>Individual reviews of Finance, Workforce and Planning support have already been undertaken to see how they can best support organisational delivery</li> </ul>	Huw Thomas Executive Team	We will undertake a review to determine what is the optimum size and shape of the collective corporate support functions that will help us deliver what is in our strategic plans.
7.1	Long Term Agreements (LTAs)	<ul style="list-style-type: none"> <li>Swansea Bay and Cardiff LTA performance review required over period October/ November with focus on: - Referral authorisation controls; - Hywel Dda University Health Board</li> </ul>	<ul style="list-style-type: none"> <li>Continuous review process established. All contract values will need to reflect budgets in annual planning cycles each financial year, and signed off by</li> </ul>	Huw Thomas	Closed, action completed

		<p>(HDdUHB) available capacity checks prior to authorisation.</p> <ul style="list-style-type: none"> <li>Review to be conducted by end November to analyse LTA activity being performed by other HBs together with the potential for HDdUHB to perform such activity if capacity was available</li> </ul>	budget holder response for contracts and service offering		
7.2	Demand on Acute Services	<ul style="list-style-type: none"> <li>Continued focus on demand reduction to decrease variable pay issues arising on surge – to be incorporated into emerging clinical strategy.</li> <li>Consider pay establishment freeze if individuals not in post and long standing vacancy not being filled by agency.</li> </ul>	<ul style="list-style-type: none"> <li>Analysis of demand has been undertaken as part of our understanding the drivers of our deficit. Initiatives to help address this were part of the Roadmap and feature as key transformation programmes.</li> <li>TUEC and ILP initiatives awaiting trajectories to significant impact the areas of waste highlighted</li> </ul>	Andrew Carruthers	This will be covered by the TUEC work programme
7.3	NICE and High Cost Drugs	Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification.	<ul style="list-style-type: none"> <li>Undertaken on an on-going basis, but has seen a net increase in growth and price</li> </ul>	Jill Paterson	Closed, action completed
7.4	Primary Care Prescribing	Explore ability to use alternative drugs based on patient condition/ need – to be incorporated into savings programme/ opportunities identification	<ul style="list-style-type: none"> <li>Undertaken on an on-going basis, but has seen a net increase in growth and price</li> </ul>	Jill Paterson	Closed, action completed
7.5	Continuing Health Care (CHC)	Develop Joint Funding Guidance.	<ul style="list-style-type: none"> <li>Long Term Care (MHLD) is one of the key transformation programmes</li> </ul>	Jill Paterson	This will be covered by the Long Term Care (MHLD) transformation programme

7.5	Continuing Health Care (CHC)	Continue the development of Core and Community-based services for Mental Health & Learning Disability (MH&LD) Transformation – to be incorporated into emerging clinical strategy.	<ul style="list-style-type: none"> <li>TMH/LD is an on-going strategy, which has demonstrated improvements in the past year.</li> </ul>	Andrew Carruthers	This will be covered by the Long Term Care (MHLD) transformation programme
7.6	TB Costs	Regular meetings being held with Public Health Wales to monitor the number of active cases. Currently being managed by HDdUHB internal resources.	<ul style="list-style-type: none"> <li>Closed – being picked up by Director of Public Health as part of service they manage</li> </ul>	Jo McCarthy	Closed, action completed
7.7	Final Pension Charges	Seek advice on managing pensions risk, including discussion with WG.	<ul style="list-style-type: none"> <li>National policy issue, but variable level of funding received from WG dependent on reason. However, management of decision making currently resides with line managers still.</li> </ul>	Lisa Gostling	We will look to challenge the pensions agency, as soon as we become aware of the issue, if the pension tax charge arises as a result of someone being promoted as part of a recruitment process as opposed to someone who is regraded prior to retirement.

## Report – Delivery Framework

Turnaround Governance and Accountability					
Ref	Theme	Operational Recommendations and Status	Current position	Owner	Next steps
1.1	Directorate Financial Performance meetings	Weekly triumvirate meetings to include Finance, Workforce and PMO (as appropriate) to progress savings	<ul style="list-style-type: none"> <li>The health board is committed to adopting frequent directorate accountability and performance management sessions.</li> <li>The Improving Together framework is going to Executive Team on 14 December.</li> <li>The Framework outlines the performance management arrangements at the different levels within the organisation</li> <li>The arrangements will be used to identify areas for quality, finance and performance improvement.</li> <li>The sessions will be supported by key enablers e.g. planning, risk management, performance, finance, improvement, transformation, workforce, data and digital</li> </ul>	Andrew Carruthers	Closed - Strategic Improving Together framework will cover these issues
		Use of indicators			
		Proactive ideas generation and 'closing the gap' actions at weekly meetings			
1.2		Standard set of data			
		Forecasts to be updated weekly as agreed with service			
1.3		FBPs and PMO to provide challenge and support to develop transformational schemes			
1.4		Training on tools for route to cash and operationalising schemes			
1.5		Clinical engagement and ownership to be strengthened through coaching and allocation of protected time			We will work on a plan to address clinical engagement

1.6 1.10	Holding to Account Meetings	Strengthen directorate accountability so only those requiring Executive support are escalated	<ul style="list-style-type: none"> <li>The Use of Resources Group meetings are now in place</li> </ul>	Huw Thomas	As above
1.6 1.8		Increase frequency for higher risk/higher value schemes and agree de-escalation process			
1.7		Mandatory Triumvirate attendance to ensure it is driven by Clinical Lead			
1.9		Feedback loop to Workstreams			
1.11	PMO and Workstream Structure	Governance to be strengthened with clear roles and responsibilities and accountability/reporting arrangements to Programme Board	<ul style="list-style-type: none"> <li>Key transformation programmes have been established for 2022/23. Each has an Executive Lead, Operational Lead, Finance Lead and Project manager. There is a weekly reporting cycle from programme leads to SRO (DoF) to Executive Team to programme leads.</li> </ul>	Andrew Carruthers	Link to how corporate teams support major programmes of work as 7.9 above
		Fortnightly meetings with Clinical Lead, project management tools and PMO support			
		Feedback loops required to Directorate and HTA meetings			
1.13		PMO, Finance and IMT Lead to be assigned to workstreams			
1.14		Agreed set of reporting tools			
1.15		Route to cash agreed for all at Project Initiation Document (PID) stage			
1.16 1.17	Executive Turnaround Programme Board	Greater challenge and pace of actions	<ul style="list-style-type: none"> <li>Weekly finance updates to highlight overspending areas, and movement in forecast and opportunity status'</li> </ul>	Steve Moore	The situation has moved on since the KPMG review. The support to major programmes has been outlined above
		Summary updates with focus on high-risk areas where decisions required Focus on ways to close gap rather than existing schemes			

					and we will further review the corporate response as per 7.9
Savings Plans/Opportunities Framework					
Ref	Theme	Operational Recommendations and Status	Current position	Owner	
2.1	Process	PIDs and Quality Impact Assessments need to be embedded	<ul style="list-style-type: none"><li>We have changed our approach to financial savings delivery since turnaround. We have identified major programmes of work to improve services which will lead to financial benefits. These programmes are well supported with supporting structures in place to deliver.</li></ul>	Executive Team in Lieu of a PMO lead	This will be picked up as part of the planning cycle as part of savings approach
2.2		Continuous cycle of scheme identification so that there is a pipeline to cover slippage			
2.3		Support to Directorates to complete PIDs to ensure consistency of reporting			
2.4		Capacity within PMO to be strengthened to support schemes			
2.5	Content	Threshold for PID requirement	<ul style="list-style-type: none"><li>Set at £100k from 2020/21</li></ul>	Huw Thomas	Closed, action completed
2.6	Governance	Consistency for PID requirements above threshold	<ul style="list-style-type: none"><li>Consistent PID and QIA templates agreed</li><li>PMO discussions needs attention</li></ul>	Executive Team in Lieu of a PMO lead	
2.7		<ul style="list-style-type: none"><li>Consider having electronic approval process</li><li>QIA needs to be signed off by Medical Director</li></ul>			
Planning and Budget Setting					
Ref	Theme	Operational Recommendations and Status	Current position	Owner	
3.12	Alignment of Planning, Finance, Workforce and	Closer working required between Workforce, Finance and Operations in developing the Operational and Financial plans and clearly showing links and how they impact on each other.	<ul style="list-style-type: none"><li>The Operational Planning and Delivery Programme meeting has been used to raise the alignment of plans, and this will be increased through the re-</li></ul>	Andrew Carruthers	Future actions will be picked up by the TI Planning review

	Transformation		<p>alignment of the programme</p> <ul style="list-style-type: none"> <li>The structure of the Improving Together programme and the proposed performance framework will provide alignment between performance, value, activity, quality, workforce, risk management and finance to identify areas of improvement</li> <li>Evidence from the 2022 Structured Assessment showed that: <i>Additional capacity has enabled the planning team to increasingly become more involved in wider plans through the Operational Planning and Delivery Programme, and the ARCH programme.</i></li> </ul>		
		Develop a robust roadmap to Transformation with Transformation teams supporting the priorities of the organisation	<ul style="list-style-type: none"> <li>Roadmap prepared in 2020</li> <li>Transformation priorities highlighted</li> <li>Limited PMO structure and support in place to add pace to improvements</li> </ul>		Transformation team aligned to major strategic programmes
<b>Ref</b>	<b>Theme</b>	<b>Finance Recommendations and Status</b>	<b>Current position</b>	<b>Owner</b>	
3.8	Annual planning, budget	Require sign-off before Board/WG submission	<ul style="list-style-type: none"> <li>Accountability letters sent out following submission to Board, as they are not</li> </ul>	Huw Thomas	Closed, action completed
3.11		Consider electronic sign-off system			

	setting and Committee governance		approved until that stage is complete		
3.12		Consider having a Performance and Finance Committee	<ul style="list-style-type: none"> <li>Email versions sent out not physical paper letters</li> <li>Sustainable Resources Committee established. Integrated Performance Assurance Report is discussed here.</li> </ul>		
3.1		ED hosted budget setting workshop	<ul style="list-style-type: none"> <li>FY22, FY23 and FY24 planning cycles have set up planning principles and incorporated top down and bottom-up savings requirements, with gaps identified, but in FY23 it resulted in an Accountable Officer letter for undelivered savings</li> <li>Operational drivers are explained for cost pressures, but limited evidence of activity benefit confirmed</li> <li>Drivers of deficit and waste have been shared across the Executive Team and Directorates with programmes of work established to improve the position</li> </ul>		
		Finance challenge sessions to ensure completeness of templates and test robustness of assumptions including alignment with strategy and triangulation with workforce and performance			
		Focus on addressing drivers of the deficit			
3.4		Test evidence for new cost pressures; approvals for service developments and completeness of risks and opportunities			
		Honest and transparent conversations regarding savings targets to develop realistic and achievable plans owned by Directorates			
		Any gaps to planned deficit should be highlighted to enable savings schemes to close the gap			
3.6		Budgets phased appropriately			
3.7		Update as new information becomes available			
Financial Management/ Reporting					
Ref	Theme	Finance Recommendations and Status	Current position	Owner	

4.1	Monthly reporting on HB performance to Board and committees	Ensure reports identify where areas of challenge are to take appropriate action	<ul style="list-style-type: none"> <li>Number of actions have been completed, however, further reporting developments required around activity and specialty information</li> <li>A comprehensive finance dashboard has been implemented in a consistent and drillable format</li> <li>Rolling 23 month forecast implemented, and comparisons to key milestones within the year, including original plan, are reported at least monthly, with some comparisons weekly into Executive Team</li> </ul>	Huw Thomas	Closed, action completed
		Report by specialty in addition to Directorate			Consideration if further reporting developments are required around activity and specialty information to help identify areas for further challenge/opportunity at Board level – the matrix also addresses this issue.
		Include financial and non-financial Key Performance Indicators (KPIs) with workforce and activity information to triangulate – summarise to show YTD, forecast and variance and RAG rate for risk			Closed, action completed
		Focus on analyses of actual run rate trend and forecast outturn as opposed to variance to budget – being forward looking will help take timely corrective action			
		Ensure reports are aligned to the savings tracked and ledger			
		Prepare a rolling 12 month cash forecast to support I&E forecast			
		Monthly fluctuations in YTD or full year budget phasing should not be smoothed through release of central reserves as this impacts on monthly variance analysis			
4.8		Compare actual YTD performance with original plan. If material changes occur and budget is changed compare with both revised and original plans as part of analysis			

4.10	Financial reporting to Directorates	Expand forecast model to reflect 12 month actuals and 18 months forward look underpinned by statistical analysis, demand and capacity modelling, operational 'business' drivers and planned outcomes – financial and non-financial	<ul style="list-style-type: none"> <li>Rolling 23 month forecast in place.</li> <li>Power BI dashboard developed to provide monthly reporting information to budget holders.</li> <li>Training video and guidance included on its use.</li> <li>Summary management information now made available monthly for all directorates with business review presentation packs</li> </ul>	Huw Thomas	Closed, action completed
4.11		Training for budget holders to use QlikView and/or monthly e-mails to budget holders re financial performance with appropriate follow up by Business Partners			
		Update QlikView to ensure reporting is user friendly and enables effective management			
4.12	Financial reporting to HTA meetings	One version of the truth between CIP tracker and HTA documentation	<ul style="list-style-type: none"> <li>Consistent reporting of savings in place</li> </ul>	Huw Thomas	Closed, action completed
4.13	Workforce reporting	Weekly/monthly reporting in relation to staff based on agreed metrics and covering all staff groups but focused on variable spend	<ul style="list-style-type: none"> <li>Finance have developed detailed pay dashboards with further work planned</li> </ul>	Huw Thomas	Closed, action completed
		Establish a headcount tracker and reconcile to workforce information to ensure one version of the truth for reported establishment	<ul style="list-style-type: none"> <li>Workforce grip and control linked to transformation programmes</li> <li>Headcount tracker not introduced due to complexities to manage systems eg vacancy control and use of generic roles. All workforce data reported from ESR as common data source.</li> </ul>	Lisa Gostling	No further action to be taken

4.14	Savings tracker	Tracker must be kept live and updated at least weekly with owners for the schemes and overall tracker	<ul style="list-style-type: none"> <li>Opportunities framework – tracks from idea inception to saving delivery</li> </ul>	Huw Thomas	Closed, action completed
4.15		RAG rating needs reflect status on PID			
4.16		Pipeline schemes need to be recorded on a tracker and monitored on a weekly basis			
4.17	Reporting locations	Include mapping of cost centres to locations to assist in internal cost and efficiency benchmarking	<ul style="list-style-type: none"> <li>Locality reporting using PLICS data has been undertaken</li> </ul>	Huw Thomas	Closed, action completed
4.18	Reports preparation	Review reporting processes to identify opportunities for automation and self-service to free Finance resource to more value added activity	<ul style="list-style-type: none"> <li>Finance part of Robotic Process Automation (RPA) project</li> <li>Work done on developing the Power BI reporting tool has reduced the need for manual compilation</li> </ul>	Huw Thomas	Closed, action completed
4.19	WG monitoring returns	Suggest that saving forecasts are updated weekly and programme risks and actions separately identified in the MMR	<ul style="list-style-type: none"> <li>Reported monthly in line with WG agreement. However, weekly forecasts are prepared and reported to ET as a priority item</li> </ul>	Huw Thomas	Closed, action completed
<b>Financial Performance Management</b>					
Ref	Theme	Operational Recommendations and Status	Current position	Owner	
5.2	Business Cases	The performance for all business cases (approved in the last 12 months) should be analysed and a decision made on potential disinvestment where they are underperforming	<ul style="list-style-type: none"> <li>Whilst efforts have been made to track and review business cases, too many decisions are made outside of a business case process and therefore a priority top down process and response is required</li> </ul>	Huw Thomas	Will be reviewed as part of annual plan process and identifying move from £25m-£62m deficit. This will identify where we have spent money and why and what benefits have been seen and if none

					whether there should be disinvestment.
<b>Ref</b>	<b>Theme</b>	<b>Committee Recommendations and Status</b>	<b>Current position</b>	<b>Owner</b>	
5.3 a-d	Finance Committee observation	<p>Recommend streamlining of agenda to reduce volume of papers presented to each meeting</p> <p>Potentially look at items on a cyclical basis and not each meeting</p> <p>Consider merging reports where the same items are duplicated</p> <p>Consider items that can be included in the 'for information' section so that focus is on key items</p> <p>Consider amount of time spent on 'deep dives' and provide a template to ensure relevant information is provided and key areas addressed</p> <p>Need for a reporting mechanism for HTA to Programme Board to Committee so that assurance can be given that objectives are being met</p> <p>Consider increased integration with relevant Performance Committees so that finance and performance can be viewed as one integrated report so members see full picture</p> <p>Strengthen links with other Committees especially ARAC</p>	<ul style="list-style-type: none"> <li>Periodic agenda setting is in place</li> <li>Rolling workplans agreed throughout the coming 12 month period</li> <li>No clear escalation route through to committee from those areas in financial distress</li> <li>Committee now incorporates performance reporting and is framed under the broader title of Sustainable Resources Committee (SRC)</li> </ul>	Jo Wilson/Huw Thomas (to discuss with Chair and Committee Chair)	Closed, action completed

		Committee to consider holding Directorates to account directly for performance for example through deep dives	<ul style="list-style-type: none"><li>We believe it is more appropriate for the SRC to hold Executives to account</li></ul>		No further action to be taken.
5.4 a-d	Audit Committee observation	ARAC should consider streamlining the audit tracker to focus on the most high-risk outstanding actions	<ul style="list-style-type: none"><li>Periodic agenda setting is in place</li><li>Rolling workplans agreed throughout the coming 12 month period</li><li>The audit tracker has been refined following work undertaken during the pandemic.</li></ul>	Jo Wilson (to discuss with Chair and Committee Chair)	Closed, action completed
		The quality of papers and level of detail included should be appropriate to provide the Committee with sufficient assurance	<ul style="list-style-type: none"><li>Through the committee self- assessment process work has been undertaken to review the papers in terms of quality and levels of information</li></ul>		Closed, action completed
Ref	Theme	Finance Recommendations and Status	Current position	Owner	
5.1	Month end HTA performance meetings	Finance to transform from a back office scorekeeper to a front line enabler for driving improvement	<ul style="list-style-type: none"><li>Hywel Dda significant contribution to a national finance business partner training programme with a market leading provider</li><li>Hywel Dda finance representative leading an All Wales best practice guide to planning, budgeting and forecasting</li><li>Training offered and delivered to all senior budget holders through the</li></ul>	Huw Thomas	Lot of work already done to develop business partnering role. We are now undertaking a refresh post COVID to further develop the enabling role and get Business Partners embedded with the operational service.
		Continued shift to a financial forecast management system			Closed, action completed

		<p>Look at ways of improving corporate business partners (Finance, BI and Workforce) to support the front line to plan effectively</p> <p>Develop systems that support this approach</p> <p>All budget holders with significant budgets should receive budget setting and monitoring training to improve financial and non-financial performance</p>	roll out programme of the financial dashboards		
5.2	Business Cases	<p>Focus on monthly monitoring of actual post-implementation costs and benefits realisation of newly approved cases should be put in place including disinvestment if required</p>	<ul style="list-style-type: none"> <li>Priority objective to refocus on a hierarchical investment process and accountability</li> </ul>	Huw Thomas	Outstanding - needs to be embedded into monthly process.
<b>Capacity and Capability; Culture and Leadership</b>					
<b>Ref</b>	<b>Theme</b>	<b>Operational Recommendations and Status</b>	<b>Current position</b>	<b>Owner</b>	
6.1-6.4	Capacity	<p>Project management support for larger schemes required</p> <p>Project management for the size of the organisation and the challenge faced needs to be strengthened that can be used flexibly</p> <p>There needs to be Finance input into the Workstreams</p> <p>Capacity and structure of the Workforce function to support the significant workforce changes required by the organisation needs to be reviewed</p>	<ul style="list-style-type: none"> <li>Transformation Programme Office (TPO) work programme agreed with Executive Team to align with major workstreams, with good support in most areas.</li> <li>Finance Business Partners are mapped to all transformation programmes</li> <li>Workforce have implemented OD Relationship managers to focus their delivery to improved cultural wellbeing across the whole organisation, a workforce</li> </ul>	Executive Team in lieu of a PMO lead	Further work required on how we handle project management of smaller c100 schemes we have running at any one time. Will link to the review of corporate support in 7.9

			planning team support the service to map future provision and the operational HR team are aligned with services to implement service change.		
6.5 6.6	Capability	Coaching in specific areas within departments will help upskill and maintain skills	<ul style="list-style-type: none"> <li>• Programmes are in progress for those areas that have been identified as needing assistance</li> <li>• Work with relationship managers</li> <li>• Reverse mentoring in place for Board members</li> <li>• Consultant development programme in place</li> <li>• Behavioural insights programme held to lead key developments in HB</li> <li>• SAS doctors steering group in place</li> <li>• Star programme in place for nursing leaders</li> <li>• 17 coaches trained, 53 in training and 381 coaching sessions provided</li> </ul>	Lisa Gostling	Coaching in place in all areas
6.7	Clinical Engagement	Commitment is required from clinical leads to support programmes	<ul style="list-style-type: none"> <li>• Commitment is confirmed, with developments ongoing for transformation programmes</li> <li>• Recognised as leading in Wales on Value Based</li> </ul>	Phil Kloer	Closed, action completed

			Health Care demonstrating clinical engagement		
6.8	Operational Engagement	Coaching for operational leads may be required to drive programmes	<ul style="list-style-type: none"> <li>Programmes are in progress for those areas that have been identified needing assistance</li> <li>Link to 6.5 and 6.6 above</li> </ul>	Andrew Carruthers	See 6.5 and 6.6
6.9	Executive Leadership	Executives need to prioritise high value and high risk areas with a greater appetite towards more challenging areas to close the gap	<ul style="list-style-type: none"> <li>The gap remains significant, and is growing with an additive recent track record, recognising the challenges posed by the pandemic and recovery requirements</li> <li>Matrix and improved risk management process eg Board Assurance Framework (BAF) have led to the development of programmes of change</li> </ul>	Steve Moore	Choices to the Board will be picked up as part of planning cycle

## **Paper: Recovery Plan**

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

### Unplanned cost pressures within/partly within HDdUHB's control

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

RAG rating key:





No impact on EOY outturn





Low impact on EOY outturn



High impact on EOY outturn

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

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

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

### **Ref 7.8 - 2019/20 Potential Initiatives**

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

<b>Category</b>	<b>Initiative</b>	<b>Indicative annualised value £'000</b>	<b>Actions to accelerate</b>
Commissioning	Mobile Catheter lab to repatriate activity from neighbouring Health Boards and reduce spend and potential to sell capacity.	300	Value to be quantified and PID finalised Q4 19/20
Commissioning	Cardiology - Pacing - 3 months of local provision and reduce spend.	200	Discussion with Service Lead and quantification for Q4 19/20
Radiology	MRI capacity issues –review utilisation to reduce outsourcing costs	200	Discussion with Service Lead and quantification for Q4 19/20
Medicines Management	Pharmacy / medicine spend - Low priority funding treatment expenditure reduction.	150	Discussion with Service Lead and quantification for Q4 19/20
Medicines Management	One-off reduction in stock holdings. Excess medicine stock - Reduce stock days to average to reduce obsolescence and disposal costs. (Non recurrent).	100	Discussion with Service Lead and quantification for Q4 19/20
Planned Care	Theatres: Out of hours provision Bronglais General Hospital.	TBC	Further discussion with Planned Care Service Leads and Finance required if it can be accelerated in 19/20.
Planned Care	Theatres: Standardisation / bulk ordering schemes extension.		
Planned Care	Waiting List (WL): Centralisation of WL across HB, increased flexibility and use across sites.		
Planned Care	Outpatients Department (OPD): Apprentices in OPD bringing potential to re-evaluate the current B2 roles and B4/5 roles.		
Planned Care	OPD: Linking with Phlebotomy re. nurses currently undertaking blood tests in OPD.		

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

#### Health Board Response:

The above items are included in the Opportunities Framework.

### **Ref 7.9 - 2020/21 and Beyond - Potential Initiatives**

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

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

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

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

Recommended actions to accelerate:

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

#### Health Board Response:

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

## **Paper: Delivery Framework**

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

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

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

*RAG rating key:*



*Room for improvement*



*To be addressed as a matter of importance*





*To be addressed urgently*

### **1. Turnaround Governance and Accountability**

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

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
1.1	Directorate financial performance meetings	1.1 Monthly Directorate financial performance meetings are held at Month end. Weekly meetings to discuss operational finance and savings scheme performance may be held during the month and are variable in content and frequency. [Process issue]	<ul style="list-style-type: none"><li>Weekly Directorate meetings with the Triumvirate, Finance Business Partner, Human Resources (HR) and Project Management Office (PMO) (where appropriate) to be established with agreed agenda so actions to progress savings are</li></ul>		Executive Director of Finance (DoF)	<ul style="list-style-type: none"><li>All Directorates have at least monthly meetings, with many Directorates now having weekly meetings, however these are yet to have a <b><u>consistent format or lead indicators</u></b>. Those Directorates not yet in a weekly cycle represent an area of focus as part of the new processes and linkages with transformation and other support teams, and will evolve during 2020/21. The Lead Indicators gap will be</li></ul>

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

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
						<ul style="list-style-type: none"> <li>A <b><u>“Building Opportunities for Delivery” workshop</u></b> is scheduled in February 2020 with a wide finance, clinical and operational representation to facilitate Health Board-wide, cross-service and cross-site opportunity identification.</li> <li>The “Hywel Dda Way” will accelerate the Health Board’s strategy, which is focused on transformation.</li> </ul>
1.4	Directorate financial performance meetings	1.4 The level of constructive challenge provided by the Finance Business partners at these monthly meetings is variable	<ul style="list-style-type: none"> <li>Prioritised areas KPIs and dashboards to track delivery of schemes to be used by FBPs and appropriate training on tools for route to cash and operationalising schemes</li> </ul>		DoF	<ul style="list-style-type: none"> <li>Finance Business Partnering is not yet fully embedded in Finance or the culture of the organisation, having been the operating model for less than a year; however this is now fully resourced and gaining traction with the service.</li> <li>The DoF will begin a process of <b><u>sitting in on local meetings to gauge performance</u></b> and improve consistency and quality.</li> <li>The Lead Indicators gap will be addressed through the Power BI reporting tool (more detail in section 4).</li> </ul>
1.5	Directorate financial performance meetings	1.5 Ownership and engagement from clinical directors is variable	<ul style="list-style-type: none"> <li>Clinical engagement and ownership to be consistently strengthened through coaching and allocation of protected time.</li> </ul>		DoF	<ul style="list-style-type: none"> <li>A Medical Leaders Forum has been established to provide a platform for clinical leads to engage and influence one another.</li> <li>A <b><u>Financial Development Plan</u></b> will support a change to the organisation’s culture.</li> <li>Organisation Development are running a senior leaders training programme</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
						with representation from corporate, clinical and operational teams, which supports the coaching objective.
1.6	Holding to Account meetings	1.6 Currently 8 Directorates are engaged with the HTA process chaired by the Executive Director of Finance, the Turnaround Director (now Executive Director of Finance), and the Chief Operating Officer attending whenever possible and 8 that are escalated to the Chief Executive Officer (CEO). The CEO HTA apply to Directorates that require further escalation (also attended by the COO, DoF, Turnaround Director (now Executive Director of Finance) and Nurse Director). The number of Directorates in escalation suggests a push upwards of responsibility to problem solve. [Process issue].	<ul style="list-style-type: none"> <li>Strengthen directorate performance and accountability sessions so the majority of schemes are proactively managed and issues resolved in a timely manner with only those that require Executive support escalated to HTA meetings. The HTA meetings need to be weekly/fortnightly for high-risk areas and higher value schemes. The de-escalation will need to be introduced in a phased manner as the Directorate level governance becomes more robust.</li> <li>Consider aggregating Directorates to units/divisions for more effective management.</li> </ul>	●	Turnaround Director (now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> <li>HTA savings reporting has been refreshed to prioritise high risk schemes and ensure that HTA discussions are appropriately focused.</li> <li>The <b><u>HTA Framework will follow a risk based approach.</u></b></li> <li>The Director of Operations has reviewed his operational structures and our reviews will follow his revised structure.</li> <li><b><u>Assessing the service on a locality basis</u></b> is part of the strategy. The current best proxy is the combined HTA meetings in place for Unscheduled Care and Counties which allows discussion of the interaction between Community and hospital(s) in each county.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
1.7	Holding to Account meetings	1.7 The attendances at the meetings observed seemed to be good with the Operational Lead and Finance Lead attending, however engagement from clinical leads was variable [Compliance issue]	<ul style="list-style-type: none"> <li>Triumvirate attendance at the HTA meetings needs to be mandatory so it is being driven by the Clinical Lead.</li> </ul>	●	Turnaround Director (now Executive Director of Finance)/ CEO	<ul style="list-style-type: none"> <li>A small number of areas have achieved this consistently. See 1.6 above.</li> </ul>
1.8	Holding to Account meetings	1.8 There is an escalation process, the HTA meetings have a drumbeat and Executives assign protected time to attend, showing it is a priority for the organisation; however, it can be strengthened. [Process issue]	<ul style="list-style-type: none"> <li>Increase frequency and focus on fewer high risk areas so majority are being resolved at Directorate and workstream level</li> </ul>	●	Turnaround Director (now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> <li>As the weekly Directorate financial performance meetings grow in maturity (see above) this will be able to be achieved.</li> </ul>
1.9	Holding to Account meetings	1.9 There was no link to the workstreams within the observed HTA meetings although there were themes that came through as issues. [Process issue]	<ul style="list-style-type: none"> <li>Themes need to be supported and resolved at the Workstream meetings that are led by Executive Senior Responsible Officers in a proactive and timely manner and only if unable to resolve should be escalated to HTA. Regular feedback loop to workstreams from HTA meetings.</li> </ul>	●	Turnaround Director (now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> <li>Applying the “Hywel Dda Way” to HTAs will resolve this.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
1.10	Holding to Account meetings	1.10 There are standard dashboards supporting these meetings and preparation sessions by the Directorates. However, a number of the Directorates did not come prepared with worked up ideas to close the gap and the discussion for new ideas happened at the HTA level rather than Directorate level. Therefore, some of the issues discussed were not material in value. [Compliance issue]	<ul style="list-style-type: none"> <li>Strengthening the weekly Directorate and workstream meetings will help filter the issues discussed at the HTA meetings. Prioritisation criteria for the HTA meetings to be agreed, with examples of schemes in delivery that are slipping by value (amber/red schemes that should have turned green), and plans to close the gap.</li> </ul>	●	Turnaround Director (now Executive Director of Finance) / CEO	<ul style="list-style-type: none"> <li>As the weekly Directorate financial performance meetings grow in maturity (see above) this will be able to be achieved.</li> <li>HTA savings reporting has been refreshed to prioritise high risk schemes and ensure that HTA discussions are appropriately focused.</li> </ul>
1.11	Workstreams	1.11 The workstreams have generic terms of reference that need to be customised to the workstream. They are led by an Executive SRO, who oversees and drives the programme; effectiveness is variable depending on the workstream. It is attended by operational representatives from the Directorates,	<ul style="list-style-type: none"> <li>Workstream governance to be strengthened with clear roles and responsibilities and accountability/ reporting arrangements to the Programme Board and fortnightly formal meetings with Clinical Lead, project management tools and PMO support. Feedback loops required to Directorate and HTA meetings.</li> </ul>	●	Workstream Executive SROs	<ul style="list-style-type: none"> <li>The “Hywel Dda way” will redirect resource to co-ordinate all Health Board projects, feeding into governance forums to create a means of working and managing projects.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
		however, they do not have a Clinical lead. [Process issue]				
1.12	Workstreams	1.12 Theatres Productivity has been stood down as a turnaround workstream. The intention is to run it as an operational workstream and there has been an initial meeting but the risk is that it does not get the required focus from the Turnaround Programme. [Process issue]	<ul style="list-style-type: none"> <li>It is suggested Theatres Productivity is monitored and reported as part of the Turnaround Programme, as the Values work has identified a significant opportunity.</li> </ul>	●	Workstream Exec SROs	<ul style="list-style-type: none"> <li>See 1.11 above.</li> </ul>
1.13	Workstreams	1.13 There was minimal PMO support, HR, Finance and Information Management and technology (IMT) support which is a contributing factor to lack of pace. [Process issue]	<ul style="list-style-type: none"> <li>PMO, HR, Finance and IMT Lead to be assigned to main workstreams eg theatres, OP, Ops effectiveness</li> </ul>	●	Workstream Executive SROs	<ul style="list-style-type: none"> <li>See 1.11 above.</li> </ul>
1.14	Workstreams	1.14 There is no consistency in the use of dashboards and KPIs reflecting performance on a timely basis. At the observed meetings,	<ul style="list-style-type: none"> <li>Refresh of dashboards and responsibility to be assigned for circulating the dashboards and KPIs for the meeting. Programme plan, KPIs, forecasts and</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>See 1.11 above</li> <li>The Power BI reporting tool (more detail in section 4) will be extended to ensure consistent and meaningful <b><u>dashboards</u></b> are produced <b><u>for each workstream</u></b>. A draft <b><u>dashboard</u></b> was</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
		there was a lack of robust project management tools and processes such as programme plans, KPIs, proactive forecasting and risk logs. There was an action log however there was insufficient pace and work between meetings, potentially reflecting the lack of capacity. [Process issue]	risk logs to be used as standard tools in addition to action logs with leads and deadlines.			completed for some <b><u>workforce metrics</u></b> in January 2020 – once this is <b><u>finalised</u></b> it can be piloted before the equivalent dashboards are designed.
1.15	Workstreams	1.15 The route to cash was also not clear from the work being discussed.	<ul style="list-style-type: none"> <li>Route to cash to be agreed for all schemes at Project Initiation Document (PID) stage.</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>This will form part of the 20/21 planning and in-year process.</li> </ul>
1.16	Executive Turnaround Programme Board	1.16 There was good attendance from most Executives at the observed Turnaround Programme Board but the effectiveness can be enhanced. This is a monthly forum where Executives provide oversight of the programme and a level of challenge to SROs. [Process issue]	<ul style="list-style-type: none"> <li>It is suggested that the challenge and associated actions have greater rigour and pace with deadlines between the formal meetings and frequency is increased to fortnightly meetings.</li> </ul>	●	CEO	<ul style="list-style-type: none"> <li>See 1.11 above.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response Jan 2020
1.17	Executive Turnaround Programme Board	1.17 With regard to content, the Group went through all the Amber-rated schemes and assigned Executive Leads to progress them. The agenda can be amended to be more effective as it does not reflect prioritisation of schemes that have maximum benefit. [Process issue]	<ul style="list-style-type: none"> <li>It is suggested that the Amber and Red-rated schemes are progressed at workstream and Directorate level, and summary updates are provided at the Programme Board, with high risk areas and decisions required being raised. at the Programme Board, based on scheme value.</li> <li>The focus of the group needs to be weighted towards closing the gap from the Directorates and workstreams rather than existing schemes as the HTA meetings should deal with these.</li> </ul>	●	CEO	<ul style="list-style-type: none"> <li>See 1.11 above.</li> </ul>


## 2. Savings Plans

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

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
2.1	Process	2.1 There is a PID and Quality Impact Assessment (QIA) process that has been	<ul style="list-style-type: none"> <li>This is the first year that PIDs and QIAs have been</li> </ul>	●	Turnaround Director (now Executive	<ul style="list-style-type: none"> <li>This process will continue and be improved by the <b>implementation of CAMMS</b>, an electronic project management system.</li> </ul>


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		established as part of the Turnaround Programme.	developed and approved.		Director of Finance)	
2.2	Process	2.2 The identification of schemes is undertaken annually at year end for the following year and therefore the new year starts with a gap in addition to slippage of schemes. The continuous planning of savings opportunities is not robust within workstreams and at best is variable e.g. Outpatients is more advanced than other workstreams. [Process issue]	<ul style="list-style-type: none"> <li>The identification of schemes and PIDs development needs to be a continuous cycle through the weekly Directorate sessions and regular workshops so there are sufficient schemes coming through the pipeline to cover slippage as well as being proactive for the following year.</li> <li>Workstream agenda to include a continuous cycle of planning and provide the steer and challenge to deliver savings.</li> </ul>	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>An <b>Opportunities Framework</b> is under development (first draft was presented to the Executive Team in January 2020) to capture in one location identified opportunities. This combines internal benchmarking, Finance Development Unit (FDU) and KPMG analysis, existing workstreams and directorate ideas/schemes. The process will be to capture opportunities as widely as possible to identify leads to assess and validate whether the opportunity can be converted into a formal savings scheme, at which point there is an agreed Finance, Service and Executive Lead and the savings governance process is applied. Any “rejected” opportunities will be formally reported to the Finance Committee for appropriate scrutiny and challenge. An audit trail of decisions will therefore be available on the Framework.</li> </ul>
2.3	Process	2.3 The quality of PIDs is variable and the Red Amber Green (RAG) rating is variable with a strong optimism bias and route to cash not clearly articulated. [Compliance issue]	<ul style="list-style-type: none"> <li>The Directorates need further coaching on PIDs completion so there is consistency of key aspects eg. Key Performance Indicators (KPIs)</li> </ul>	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>See 1.11 above</li> </ul>


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
			and route to cash identified and RAG rating in the tracker, reflective of the planning stage and/or delivery risk.			
2.4	Process	2.4 The PIDs are submitted to the PIA to quality check and hold centrally, There is insufficient capacity within the PMO to perform this function for over 100 PIDs all coming through over a similar time period (1 PMO manager)	<ul style="list-style-type: none"> <li>Capacity within the PMO needs to be increased to support the governance and project management support/ challenge of the schemes.</li> </ul>	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>See 1.11 above – the “Hywel Dda Way” will ensure that a consistent management approach is adopted across the Health Board.</li> <li>The CAMMS system will ensure that all required fields are completed.</li> </ul>
2.5	Content	2.5 There is no differentiation between high and low value PIDs.[Process issue]	<ul style="list-style-type: none"> <li>Consider having a threshold for PID requirement c25k</li> </ul>	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>The agreed threshold from 20/21 is £100k.</li> </ul>
2.6	Governance	2.6 Of the 107 amber/green schemes over 50k, 43 did not have PIDs, these were mainly corporate and medicines management although there were a few other Directorates as well. [Compliance issue]	<ul style="list-style-type: none"> <li>There needs to be consistency for PIDs requirement for schemes over an agreed threshold value</li> </ul>	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>For 20/21 all Directorates will be required to prepare PIDs for schemes &gt;£100k.</li> <li>The “Hywel Dda Way” will ensure that a consistent management approach is adopted across the Health Board.</li> </ul>



Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
2.7	Governance	2.7 The PIDs were approved by the DoF and TD (now EDoF) and Nurse Director. The Medical director was not involved in reviewing the QIA. The schemes did not have formal QIA approval although they were all reviewed and feedback provided. [Compliance issue]	<ul style="list-style-type: none"> <li>Consider having an electronic approval process. The QIA needs to be signed off by the Medical director as well. QIAs to be formally approved for schemes.</li> </ul>		Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>The CAMMS system has a hierarchy of mandatory escalating approvers which is tailored to the organisation.</li> </ul>


### 3. Planning and Budget Setting


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


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
3.1	19/20 Annual planning and budget setting	<p>3.1 The 19/20 Annual planning and budget setting commenced in August 2018 with the approach and plan detailed in a Finance Committee paper tabled in Sept 18.</p> <p>3.2 Finance BPs initially worked with budget holders to populate a budget template (using month 5 18/19 outturn, adjusted for non- recurrent items, existing cost pressures, new unavoidable cost pressures, new developments and investments, savings plans, capital investments and workforce). These were then sent to general managers for review, approval and final submission to the Finance Planning Team for aggregation. The Planned Care Directorate template was only partially completed for cost pressures with some marked as TBC.</p> <p>3.3. The Directorate returns were then aggregated by the Finance Planning Team with overlay of national planning assumptions e.g. increased income allocations and pay awards and HDdUHB strategic service developments.</p>	<p>The KPMG review and budget survey has identified significant improvements required to strengthen the annual planning and budget setting process.</p> <p>Recommendations include:</p> <ul style="list-style-type: none"> <li>• An Executive hosting a budget setting workshop to set out the planning process with all Directorate budget holders/ employees with budget holder responsibility and their supporting Finance Business Partners to confirm accountability and need for collaboration.</li> </ul>		DoF	<ul style="list-style-type: none"> <li>• A “Building Opportunities for Delivery” workshop is scheduled in February 2020 with a wide finance, clinical and operational representation to facilitate Health Board wide, cross-service and cross-site opportunity identification.</li> </ul>
			<ul style="list-style-type: none"> <li>• Finance challenge sessions to be hosted to ensure completion of templates and to test the robustness of assumptions made to support the preparation of robust plans, including: <ul style="list-style-type: none"> <li>○ Alignment with HDdUHB strategy;</li> </ul> </li> </ul>		DoF	<ul style="list-style-type: none"> <li>• The Investment Schedule templates have been refreshed to increase the robustness of plans and to clearly identify sources of funding and assessment of financial and clinical benefits.</li> <li>• The “Building Opportunities for Delivery” workshop will focus on the acceleration of the Strategy and this will also</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
			<ul style="list-style-type: none"> <li>○ Testing triangulation of demand/ activity forecasts and workforce (including capacity modelling and setting budgets based on actual establishment i.e. not prior year spend)</li> </ul>			focus on demand and activity.
			<ul style="list-style-type: none"> <li>○ Focus on addressing the drivers of the deficit;</li> </ul>		DoF	<ul style="list-style-type: none"> <li>• The Opportunities Framework will address this (see 2.2 above).</li> </ul>
3.4	19/20 Annual planning and budget setting	<p>3.4 The aggregated HDdUHB 19/20 plan for income and expenditure was reviewed at a high level basis by Finance, focusing on the bottom line deficit position.</p> <p>3.5 A uniform percentage cost reduction target was applied to all Directorates to deliver a planned deficit of £29.8M.</p> <p>Survey results -The results highlight low percentage ratings for: —</p> <p>Confirmed budget holder involvement:</p> <ul style="list-style-type: none"> <li>• Overall = 49%; £3M — £10M = 89%</li> <li>• BUT &gt;£10M = 50%</li> </ul>	<ul style="list-style-type: none"> <li>• Test the robustness of assumptions, including completeness of cost pressures, supporting evidence for new cost pressures, approvals for new service developments and completeness of risks and opportunities identified, taking into account key learning from the current year (e.g. unplanned cost pressures and known demand changes);</li> <li>• Honest and transparent conversations regarding</li> </ul>		DoF	<ul style="list-style-type: none"> <li>• The robustness of financial assumptions has been challenged internally within Finance. Work that needs to be built on for the 2021/22 planning cycle is the identification of non-recurring gains that are reflected in the ongoing Directorate position.</li> <li>• Significant work has been undertaken on the Opportunity Framework during 2019/20 and embedding this as part of the 'Hywel Dda Way'. This process will be a continuous</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		<ul style="list-style-type: none"> <li>Setting of realistic budgets: Overall = 43%; £3M £10M = 33% and &gt;£10M = 14%</li> <li>Integrated budget informed by operational plans: Overall = 37%; £3M - £10M = 45% and &gt;£10M = 21%</li> </ul>	savings targets to develop realistic and achievable plans owned by Directorates and budget holders (supported by analysis and benchmarking). Any gaps to planned deficit should be highlighted to enable savings schemes to close the gap			process and not a process that stops and start with the Planning Cycle.
3.6	19/20 Annual planning and budget setting	3.6 Base budget deficit of £29.8M (including Cost Improvement Programmes – CIPs) was flat-phased equally into 12 months in the original plan submitted to WG (WG). Survey results -The results show a high % for appropriately phased budgets across all budget holder groups: Overall = 76%	<ul style="list-style-type: none"> <li>Budgets (including supporting savings targets) should be appropriately phased and take into account key learning from the current year (e.g. seasonality trends, M12 accounting adjustments, number of working days and expected timing of key events to allow meaningful variance analysis as the year progresses).</li> </ul>		DoF	<ul style="list-style-type: none"> <li>The Financial Plan provides the overall quantum of budgets for the year, the Business Partnering teams have the flexibility to review and revise the phasing of their budgets.</li> </ul>
3.7	19/20 Annual planning and budget setting	3.7 The budget was updated for full year forecast outturn at M9. The overall budget deficit of £29.8M was however maintained despite run rate cost pressures of £1.4M through pay assumptions (for example the Agenda for Change pay award)	<ul style="list-style-type: none"> <li>To maintain the integrity of budget assumptions and consequent performance reporting and forecasting for the budget year, new cost pressures based on review of existing run</li> </ul>		DoF	<ul style="list-style-type: none"> <li>The content of the 2020/21 Financial Plan has been refreshed monthly since September 2019 as updated information has become available on cost pressures and revised forecasts.</li> </ul>


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		being reduced by a corresponding amount.	rates should be investigated and accounted for (where not capable of being mitigated prior to the budget year commencing) with savings targets updated accordingly. The planned introduction of Power BI will enable HDdUHB to plan based on 'run rates' which are activity-driven.			
3.8	Budget approval and signoff process	<p>3.8 A 'draft interim' plan was presented to the Board on 28th March 2019 and approved for onward submission to the WG.</p> <p>3.9 The Finance Team then retrospectively initiated the process of signing off budgets from the Directorates with a letter sent to 52 budget holders on 10 April 2019, to be returned by 23 April 2019. However, there are approximately 182 budget holders and 200 individuals with budget responsibilities in the Board. As at month 5, signed accountability letters are still outstanding for the Chief Executive Officer (CEO) and Primary Care (due to some historic discrepancies to be concluded during September). Letters were not</p>	<p>The KPMG review and budget survey has identified significant improvements required to strengthen the budget approval and signoff process.</p> <p>Recommendations include:</p> <ul style="list-style-type: none"> <li>• A review of budget holders and employees with budget responsibility to be undertaken to ensure appropriate spans and layers of authority/ delegation;</li> <li>• All budget holders and those with budget responsibility to be</li> </ul>		DoF	<ul style="list-style-type: none"> <li>• Review of budget holders undertaken in 2019/20 by Deputy Director of Finance, there are currently 11 Executive Level and 44 Senior Manager budget holders who will be expected to sign off accountability letters for 2020/21 budget.</li> <li>• Accountability letters will be sent out by 6<sup>th</sup> March 2020 for return by 20<sup>th</sup> March 2020.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		sent to all budget holders as there was not capacity in Finance to explain budgets at that level to all budget holders. 3.10 The plan was revised to a Control Total deficit of £25M (approved by the Health Board in May) to reflect Control Total agreement with WG with the additional savings requirement of £4.8M back end-loaded. (compliance issue).	required to agree to their budgets prior to submission and approval by the Board and prior to submission to WG before the start of the new year (the annual planning cycle needs to allow sufficient time for this while budget preparation monitoring arrangements need to escalate non-compliance to the Executive).			
3.11	Budget approval and signoff process	<p>3.11 It is noted that:</p> <ul style="list-style-type: none"> <li>There is no cascade process in place that requires lower level budget holders to agree that they will adhere to their budget and the required procedures.</li> <li>The current system is email-based, which is less robust and more time-consuming and prone to errors than a policy management system.</li> <li>Budget holders have up to 45 active cost centres to manage.</li> </ul> <p>Survey results -The results show a low % for signoff of budgets: Overall = 37%; £3M - £10M = 44% and &gt;£10M = 57%</p>	<ul style="list-style-type: none"> <li>Consider the possibility of an electronic signoff system. Such systems can be used for multiple issues (e.g. that other policies have been read and will be adhered to).</li> </ul>		DoF	<ul style="list-style-type: none"> <li>Work is undertaken between HR and Finance to align the Financial Plan but timelines need to be aligned to ensure that there is sufficient time for triangulation between, HR Finance and Operational teams</li> <li>Consideration will be given/ has been given to establishing a Performance and Finance Committee. The Finance Committee was set up to specifically deal with the Financial Agenda of the organisation in turnaround.</li> <li>The Transformation agenda is currently reviewed, managed and supported through the Strategic Financial Planning</li> </ul>


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
						Group and the Strategic Change Finance Director.
3.12	Alignment of Planning, Finance, Workforce and Transformation	<p>3.12 In developing the financial plan, there is a lack of robust alignment between operational, workforce, activity and financials. This is reflected in the relative silo working of the various teams.</p> <p>3.13 This lack of alignment is also reflected in having two separate committees for Finance and Performance and therefore the decision-making process is not aligned.</p> <p>3.14 In addition to the above there is no clear roadmap from the current state (operationally, financially and in terms workforce) to the Transforming clinical services strategy that is aligned to the annual plans</p>	<ul style="list-style-type: none"> <li>There needs to be closer working between HR, Finance and Operations in developing the Operational and Financial Plan, with clear links to reflect how the plans impact on each other.</li> <li>Consider having a Performance and Finance Committee</li> <li>Develop a robust roadmap to Transformation with Transformation teams supporting the priorities of the organisation at every stage of its improvement journey including Turnaround.</li> </ul>		CEO	<ul style="list-style-type: none"> <li>Work is underway between HR and finance to align the Financial Plan.</li> <li>Consideration has been given to a Performance and Finance Committee. The Finance Committee was set up specifically to deal with the financial agenda of an organisation in turnaround, and this remains necessary. However, better alignment of operational and financial reporting is being undertaken.</li> </ul>

#### 4. Financial Management/ Reporting


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


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
4.1	Monthly reporting on Health Board performance	4.1 Reports showing financial performance against budget are prepared on a monthly	<ul style="list-style-type: none"> <li>Review the information provided to ensure that it enables the user to identify where areas of challenge are to take appropriate action.</li> </ul>		DoF	<ul style="list-style-type: none"> <li>The Finance paper has been shortened to provide greater focus on key information. The same report is provided to Board and Finance Committee for consistency, however</li> </ul>


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
	e to Board and committees	<p>basis for the Health Board as a whole.</p> <p>4.2 The Finance &amp; Turnaround Update and Finance Committee papers are in a consistent reporting format for Month 1 with the same level of detail provided to each. This raises the risk of duplicate discussion and impacts the ability of the Finance Committee to provide assurance / complete its remit.</p> <p>4.3 Papers presented to the Health Board report historic positions and focus on providing background to Year To Date (YTD) positions and savings delivery, for example, no cash flow forecasts are provided. There is also limited view of the medium / long term in the papers which could inhibit completeness and accuracy of risks reported in risk registers.</p>	<ul style="list-style-type: none"> <li>• Report by speciality in addition to Directorate as this is likely to result in additional challenges/ opportunities being identified.</li> <li>• Include appropriate financial and non-financial KPI and workforce and activity information to triangulate performance. Reports should also include required actions, dates for completion and progress made. A summary page which shows the position by Directorate – YTD Actual, YTD Variance, Forecast, Forecast Variance, Savings YTD (Act vs Target), Savings (Forecast vs Target), Risk would link it all together and could be RAG rated to provide clarity on key items.</li> <li>• Reports need to focus on analyses of actual run rate trend and forecast outturn as opposed to variances of actual to budget for YTD and full year.</li> <li>• Ensure the reports are aligned to the savings tracker and ledger.</li> </ul>			<p>Finance Committee is now provided with a supplementary report providing more detailed Directorate level and technical information. This will allow Finance Committee to properly fulfil its remit.</p> <ul style="list-style-type: none"> <li>• Scoping work is underway for <b><u>specialty and locality intelligence reporting</u></b>.</li> <li>• A <b><u>Power BI project</u></b> has been launched, led by Finance, to identify and validate non-financial metrics, such as activity, and assess the linkages to financial performance. This will be an iterative process to initially triangulate core and available drivers, progressing to capture data which may need improvements to quality or availability and to identify areas where new data recording processes need to be implemented in order to continuously improve.</li> <li>• The Finance Paper has a dedicated section to the forecast financial outturn, which factors in savings forecast. There is also a dedicated section for the savings forecast.</li> <li>• Monthly finance dashboards are currently produced for every directorate and circulated to budget holders to inform on-going discussions with FBPs and the HTA process. These include the</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		4.4 As there are a significant number of Directorates (38), the Finance and Turnaround Update report shows only the largest 14 Directorates, with others grouped together. This reporting shows Directorate YTD financial performance against budget without any further specialty split or full year financial forecast for HDdUHB or Directorates				<p>suggested financial information and action log in the Recommendation.</p> <ul style="list-style-type: none"> <li>Both the Finance Papers and the directorate dashboards are produced using the same ledger and savings tracker data.</li> </ul>
	Monthly reporting on Health Board performance to Board and committees	<p>4.5 The papers present results at a Directorate level and then consider specific HDdUHB line items such as pay expenditure, non-pay expenditure, income and savings. This creates a fragmented report, which can make it difficult for a user of the report to identify consistent messages and trends.</p> <p>4.6 The lack of consistency throughout the papers makes it</p>	<ul style="list-style-type: none"> <li>A rolling 12-month cash position forecast (i.e. past year end) should be prepared to support the I&amp;E forecast.</li> <li>The Board should not smooth out any monthly fluctuations in YTD or full year budget phasing through release of central reserves –as this impacts the robustness of the monthly variance analysis. The planned introduction of Power BI and activity profiling will help inform understanding and forecasting of monthly performance.</li> </ul>		DoF	<ul style="list-style-type: none"> <li>See section 4.1-5 above.</li> <li>Cash-flow forecasting is an area of lesser risk compared to the financial outturn. Assessments of end of year strategic cash requirements from WG are regularly assessed and reported to WG from Month 6 to year end. However, for 2020/21, a <b>rolling cash forecast</b> will be implemented and reported to the Finance Committee.</li> <li>The planned deficit is not “offset” as described – it is a centrally held gross line. Variances to budget are described both in terms of variance to breakeven and operational variance (i.e. variance to plan) for</li> </ul>




Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		<p>difficult to identify specific trends or themes, for example, is not possible to identify through the reporting which Directorates have an improving or worsening position over time. This clarity would assist in highlighting areas of concern or potential future risks earlier in the reporting cycle.</p> <p>4.7 In the ledger, HDdUHB offsets the planned deficit for the year through a corresponding reserve 'income' adjustment to set a balanced budget. This reserve can then be re-phased in the year to 'smooth out' actual performance for aggregated Health Board performance.</p>				<p>clarity. The description of Reserves is inaccurate – these are not treated as Income – Reserves is a centrally held budget which is allocated to Directorates once an appropriate phasing profile can be validated.</p>
4.8	Monthly reporting on Health Board performance to Board	4.8 HDdUHB monitors in-year performance for each Directorate, comparing actual performance versus budget. However, the budgets being	<ul style="list-style-type: none"> <li>HDdUHB should compare actual YTD performance with the original plan. If there are material changes to circumstances which warrant updates to the budget, the management reports should</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>The comparison of financial performance against live budgets is appropriate if budgets are permitted to be fluid during the financial year, as this ensures that the ledger is the single source of "truth". Budgets are fluid during the year to allow for</li> </ul>

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

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		normalised expenditure trend, saving plan performance, pay trend (by type of staff and nature of spend e.g. substantive, bank and agency), non-pay trend (drugs, clinical and other) and projected outturn. In addition, the dashboard highlights some operational indicators (e.g. surge pressures), key required actions together with responsibility and due dates.	<ul style="list-style-type: none"> <li>Expanding the current forecast model to reflect 12 month actuals and 18 months forward look which is then underpinned by statistical analyses, demand and capacity modelling, operational 'business' drivers (together with agreed in-year tolerances/ early warning indicators to highlight when action is required) and planned outcomes (financial and non-financial).</li> </ul>			<p>the platform to produce annual and three-year forecasting.</p> <ul style="list-style-type: none"> <li>However, this will not be as sophisticated as incorporating demand and capacity modelling. This type of modelling would not be in the remit of Finance, so would require an alternative "owner". Further, the data required and complexity of the model would be beyond current capabilities – this would be a longer term strategic aim. Non-financial outcome data is also in a state of infancy across the NHS.</li> </ul>
4.1 1	Financial reporting to Directorates	<p>4.11 Financial information is not provided to budget holders of individual cost centres. Budget holders are able to review their financial position through QlikView though it is unclear how extensive use of this functionality is.</p> <p>Survey results:</p> <ul style="list-style-type: none"> <li>A high % of budget holders have access</li> </ul>	<ul style="list-style-type: none"> <li>Training for budget holders to use QlikView and/ or monthly emails to budget holders of the financial performance against budget, with appropriate follow up by the relevant BP where adverse.</li> <li>Update QlikView if required to ensure the reporting is user-friendly and enables effective management.</li> </ul>		DoF	<ul style="list-style-type: none"> <li>The need for budget holders to access Qlikview will be replaced by the Power BI reporting tool (more detail in section 4).</li> <li>Regular training for budget holders is provided by both the Finance Systems Team and Finance Business Partners.</li> <li>An audit report is available to identify which users are accessing Qlikview and to what extent.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		<p>to monthly management accounts or budget reports: Overall = 96%</p> <ul style="list-style-type: none"> <li>• Most budget holders report within 2 weeks of month-end (36% of budget holders however responded with 'not applicable' which implies that they are not involved in month-end reporting).</li> <li>• A high % do not undertake validation of the monthly management accounts: Overall = 46%; £3M - £10M = 33% and &gt;£10M = 29%</li> </ul>				
4.1 2	Financial reporting to HTA (Holding to Account meetings)	4.12 There are a standard set of reports for the monthly HTA meetings which highlight YTD variances to plan and full year forecast outturn on a Directorate level based on forecast run rate, risks identified,	<ul style="list-style-type: none"> <li>• There needs to be one version of the truth between the CIP tracker and HTA documentation with an owner reconciling the two information sets — Reports need to focus on analyses of actual run rate trend and forecast outturn as opposed to variances of actual</li> </ul>		DoF	<ul style="list-style-type: none"> <li>• WG guidelines for the completion of the monitoring returns does not allow any changes to the plan values for savings schemes and, as such, the plan values do not match the live tracker (which generates the HTA reports) which is reconciled to the financial ledger. The financial ledger, tracker and HTA report all match and reconcile to the Finance</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		mitigations (where developed) and opportunities. However the forecast savings do not match the CIP tracker forecast that is reported in the monitoring returns [Compliance issue].	to budget for YTD and full year.			Papers presented to Board and Finance Committee. The reason for this is to maintain a focus on the real situation and risks/ issues rather than on the budgeted plan at the beginning of the financial year.
4.1 3	Workforce Reporting	4.13 Ensure workforce reporting focuses on key elements of variable pay spend (agency, bank, overtime etc.) and supports the financial reporting	<ul style="list-style-type: none"> <li>Weekly/ monthly reporting as appropriate to areas of the Health Board (including Directorates) in relation to staffing based on agreed metrics and covering all staffing groups but focused on variable spend. — Establish a headcount tracker and reconcile to workforce information systems, underling data sets and all reports to ensure 'one version of the truth' for reported establishment</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>As Workforce is a workstream, this will be addressed by the Power BI reporting tool (more detail in section 4).</li> <li>Limitations to reporting headcount and whole time equivalents currently exist in respect of the medical and dental cohort (substantive and temporary) due to data limitations and work needed on e-job planning (see Grip and Control Paper)</li> </ul>
4.1 4	Savings Tracker	4.14 Forecasts are not consistently updated on the tracker although it is updated in the HTA documentation. Therefore monitoring returns do not have an updated savings forecast [Compliance issue]	<ul style="list-style-type: none"> <li>Savings tracker must be kept updated on a 'live' basis and as a minimum weekly with owners for the schemes and overall tracker. There needs to be one version of the truth between the tracker and HTA documentation.</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>The savings tracker is now refreshed weekly.</li> <li>The tracker records both the finance lead and service owner.</li> <li>The HTA report has been generated from the savings tracker for all of 2019/20.</li> </ul>


Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
4.1 5	Savings Tracker	4.15 RAG rating for schemes that are not expected to deliver is also not updated	<ul style="list-style-type: none"> <li>The RAG rating on the tracker need to reflect the status of the PIDs with expected 'Go Green' dates that are monitored weekly.</li> </ul>		DoF	<ul style="list-style-type: none"> <li>The RAG rating is updated and if a scheme moves between either Green/ Amber and Red the ledger is adjusted to ensure that it reconciles to the tracker – this practice has been in place for all of 2019/20.</li> <li>"Date to Green", "Date to Amber" and "Date to Red" fields have been added to the tracker, and the HTA process is used to escalate missed deadlines.</li> </ul>
4.1 6	Savings Tracker	4.16 There is inconsistency of recording of pipeline and Red schemes in the CIP tracker with a number of ideas that are being worked not being recorded on the tracker. This means there is no visible central repository of a continuous savings pipeline	<ul style="list-style-type: none"> <li>Pipeline schemes need to be recorded on a tracker and monitored with a 'Go Green' date on a weekly basis/ live basis</li> </ul>		DoF	<ul style="list-style-type: none"> <li>"Ideas" was not a savings category adopted by the Health Board as this was not a recommendation in the FDU savings guidance issued for 2019/20 (which concluded that having too many RAG categories was overly complex).</li> <li>The Opportunities Framework will supersede this recommendation.</li> </ul>
4.1 7	Reporting locations	4.17 While we recognise that Finance do know which sites cost centres relate to (though some are Health-Board wide), HDdUHB's ledger codes do not have corresponding locations tagged, making it	<ul style="list-style-type: none"> <li>Include mapping of cost centres to locations to assist in internal cost and efficiency benchmarking, identifying opportunities for efficient utilisation of resources across sites, consistent monitoring of financial performance across locations, and engaging with relevant frontline staff to</li> </ul>		DoF	<ul style="list-style-type: none"> <li>Cost centres have been reviewed and amended where appropriate. <b>Locality based reporting</b> will supersede this over 2020/21.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		difficult to track budget or spend by location. This is particularly relevant in relation to spend where there are controls at a site level (e.g. nursing agency).	collaboratively address budget variances.			
4.1 8	Reports preparation	4.18 We note that Finance prepares monthly reports from an extract of the ledger taken out from Oracle, processed in Qlikview, manually processed in MS Excel and subsequently copied into MS Word with commentary added to it.	<ul style="list-style-type: none"> <li>Review reporting processes to identify opportunities for automation and self-serve, to free Finance resource to deliver more value-added activity.</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>Oracle data is not extracted as described – Qlikview is used for data extract as this is an automated direct feed of Oracle data. Excel is currently the only software platform available to finance, so is used to generate automated analysis and graphs/tables using standard templates which are refreshed monthly. The Power BI tool (see section 4) will improve the automation of this process further, however it will still be a requirement to produce a written report in Word in order to provide a supporting narrative.</li> </ul>
4.1 9	WG Monitoring returns	4.19 Savings forecasts in the monitoring returns did not reflect the risk associated with Green/ Amber schemes. This is due to the risks being considered as operational pressures in the returns and netted off against	<ul style="list-style-type: none"> <li>It is suggested that savings forecasts are updated on a weekly basis with programme risks reflected in the returns and actions separately identified.</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>The savings forecast (and associated RAG rating) in the monitoring return is identical to that reported to Board, Finance Committee and Directorates. A high level risk assessment of future non-delivery of those schemes is included in a separate Table of the monitoring return, as required by WG guidance.</li> </ul>

Ref	Area	Current situation/Issue	Recommendation	RAG	Owner	Health Board Response
		mitigating actions [Compliance issue]				<ul style="list-style-type: none"> <li>The Directorate forecasts will include any projected over/non-delivery of savings schemes as this will be a key factor in financial performance. The monitoring return Tables do not treat non-delivery of savings schemes as an operational pressure – these are explicitly presented as gross items.</li> </ul>

## 5. Financial Performance Management

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

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

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		<p>associated tolerances/ early warning signs for required action as well as continued demand &amp; capacity modelling.</p> <p>Survey results:</p> <ul style="list-style-type: none"> <li>• That the % of budget holders having regular monthly meetings with their finance manager to clarify or explain variances is low at HDdUHB = 54% BUT high for £3M - £10M = 89% and &gt;£10M = 93%</li> <li>• A high proportion of budget holders do not keep a documented audit trail of actions being taken to address any variances (and their impact). Overall = 47%; £3M - £10M = 33% and &gt;£10M = 36%</li> <li>• A high proportion of budget holders are not asked to report a projected year end budget position. Overall = 52%; £3M - £10M = 33% BUT &gt;£10M = Nil%</li> </ul>	<p>and workforce) can then develop the 'skillset' to support the front line to plan effectively and to take corrective, timely action to improve actual forecast performance (including in-month).</p> <ul style="list-style-type: none"> <li>• It will also require a change in toolset i.e. timely, visual system data and dashboards for operational drivers and in- month leading indicators to highlight deviation from budget/ forecast.</li> <li>• All budget holders with significant budgets should receive budget holder setting and monitoring training to improve the capability of HDdUHB for improving non-financial and consequent financial performance (quality, access, workforce, productivity and value). It is pleasing to see that a high number of respondents are seeking such training.</li> </ul>			


Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		<ul style="list-style-type: none"> <li>A high proportion of budget holders felt they would benefit from receiving regular training on budget setting and monitoring. Overall = 77%; £3M £10M = 78% and &gt;£10M = 64%</li> </ul>				
5.2	Business cases	<p>5.2 HDdUHB has revised its approval process (effective autumn 2018) for revenue business cases to improve grip on:</p> <ul style="list-style-type: none"> <li>Preparation, particularly evidence for alignment to HDdUHB's and Directorate strategy, options testing, planned financial and non-financial benefits and pay and non-pay investment.</li> <li>Required approvals;</li> <li>Consideration through the relevant management (and accountability) structure and corporate functions including Finance and Workforce. This includes sign-off from</li> </ul>	<ul style="list-style-type: none"> <li>Whilst the process for preparation and sign-off of revenue business cases has been strengthened, it is important that the focus now shifts to monthly monitoring of actual post-implementation costs and benefits realisation for newly approved cases so that corrective action can be identified where required and key individuals held to account. This should include disinvestment if required.</li> <li>Given reviews are not currently taking place, we would recommend that the performance for all business cases (approved in the past 12 months and with significant planned benefits and investments costs) is analysed and a decision made on potential disinvestment where these are underperforming.</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>A new investments template has been developed to require new business cases/ investments to demonstrate an expected 3:1 payback ratio before funding is authorised. The "Hywel Dda Way" will bring consistency to the approach to business cases. This will include a <b><u>post-investment assessment of implementation costs and benefits. A review of investments in the last 12 months</u></b> will be conducted to assess the performance compared to the original business case.</li> </ul>

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		<p>Director, Directorate Manager, Other affected managers, Finance Business Partner;</p> <ul style="list-style-type: none"> <li>Executive approval at fortnightly meeting (documented in minutes);</li> <li>Finance Committee approval for all cases above £100k.</li> </ul>				
5.3a	Finance Committee observation	<p>5.3a Our observations highlighted the following:</p> <ul style="list-style-type: none"> <li>There was appropriate challenge from the Chair and Independent Members ('IMs') throughout the agenda. Responses from Executive Directors ('EDs') and officers were clear and addressed the questions. For example: <ul style="list-style-type: none"> <li>IMs pressing for a completion date for outstanding action. Clarification of whether surge beds were included within the forecast position</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>The meeting ran over time with a large volume of papers to review prior to the Committee, despite a number of items being deferred to later committees. Whilst the discussions summarised key papers and the presentation of the Finance Report highlighted key items, we recommend that the agenda is streamlined to reduce the volume of reports provided to each Committee.</li> <li>RTT, establishment control and capital projects were not discussed due to time pressures – the reports did not appear to be key requirements and therefore may not be required each month. We recommend that such papers should be staggered over a three month period, with RTT being provided in month 1, establishment in month 2 and capital in month 3 to spread the volume of reports across the periods).</li> <li>The Turnaround report was not discussed in detail as key items were already</li> </ul>	●	DoF / Chair of Finance Committee	<ul style="list-style-type: none"> <li>Papers are circulated a minimum of seven days prior to a Committee meeting to allow members sufficient time to read and consider.</li> <li>Whilst the agenda is long, given the significant financial deficit, and the current adverse run rate against plan, the role of the Committee is critical and its remit requires a broad and up-to-date assessment of the key drivers. The Committee's workplan is kept under review as developments arise.</li> </ul>

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		<p>and how this could be linked to DTOC.</p> <ul style="list-style-type: none"> <li>○ Requesting a report to come back to the Committee on grip and control following challenge around the management of bank and agency staff.</li> <li>• The Chair focused on the need for assurance to be provided to the Committee, in line with the objectives outlined in the Terms of Reference. For example, the need to provide assurance on the balance of transactional vs transformational saving schemes, certainty of the pipeline and assurance over 2021 plan.</li> </ul>	discussed in the financial report. Given the inherent links between the items, we recommend that the reports are merged so reducing the detail included in papers			<ul style="list-style-type: none"> <li>• The Committee needs to be able to provide assurance to the Board in a timely manner on key financial areas of risk and pressure.</li> <li>• Capital is typically a brief item during the meeting, unless there are exceptional circumstances.</li> <li>• The Turnaround report provides members with scheme-level detail to enable them to provide detailed scrutiny of progress/ issues by scheme (questions are typically raised by exception). The Finance Report is very high level by comparison in order to present the Health Board-wide position. No change to these reports is considered appropriate at this time.</li> </ul>
5.3b	Finance Committee observation	5.3b Although the majority of the Committee was looking at the current financial position and focused on the short term,	<ul style="list-style-type: none"> <li>• The Finance Report contained a presentation and detailed report for committee members. The detailed report could be moved to a 'for information' section of the agenda, or provided as an</li> </ul>	●	DoF / Chair of Finance Committee	<ul style="list-style-type: none"> <li>• Papers are shared electronically using iBabs, members can choose to only refer to those papers which</li> </ul>

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

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

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

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

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

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		bodies, such as internal and external audit, but also Health Improvement Wales, Wales Audit Office and the Coroner. — A closed period at the end of the agenda was used to reflect on the meeting's effectiveness and agree key items to be reported to the Board.				
		<p>5.4c The Committee reviews audit recommendations via an Audit Tracker. The Tracker is very long (over 20 pages) and contains a lot of historic information. Many deadlines in action plans and audit trackers show evidence of slippage, despite tough challenge from lay members. For example, recommendations related to Consultant job planning remain outstanding from a review in 2016.</p> <p>The quality of papers and their delivery by managers varied. For example, the paper on Primary Care Applications Committee</p>	<ul style="list-style-type: none"> <li>The quality of papers and level of detail contained in them should be appropriate to provide the Committee with sufficient assurance</li> </ul>	●	Board Secretary / Chair of Audit Committee	<ul style="list-style-type: none"> <li>When reviewing progress against previous reports and management responses, the Committee has asked that the report includes the original report and the agreed management response, with clear updates detailing the action taken or to be taken to ensure recommendations are fully responded to. This is to ensure the Committee has access to all relevant information to enable constructive and robust challenge. The Committee will request</li> </ul>

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		was clear and succinct and provided the Committee with the assurance they needed on progress. Whereas the Estates Progress Report, while succinct, did not provide the Committee with sufficient information to demonstrate assurance and prompted hard challenge from IMs. Some reports also contained unnecessary levels of detail, such as the management response to the WAO job planning report with an appendix that ran to 21 pages listing the 23 original recommendations, although only two recommendations remained outstanding.				progress updates where there have been issues with pace of delivery or non-delivery of actions to seek assurance.

## 6 Capacity and Capability; Culture and Leadership

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

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
6.1	Capacity	6.1 The capacity within the Directorates to progress schemes at pace is	<ul style="list-style-type: none"> <li>Project management support for larger schemes/ Directorates. Increase</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>See 1.1 and 1.11 above.</li> </ul>

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		limited. Although there are actions that can be taken by having weekly directorate CIP meetings, the scale of change required within tight timescales is significant.	PMO/ Finance challenge at Directorate meetings			
6.2	Capacity	6.2 The capacity within the Turnaround PMO is severely limited (1 project manager) and therefore it cannot support project management, challenge and delivery within the Directorates. To be noted that the organisation is recruiting 3 additional Project Managers to support turnaround.	<ul style="list-style-type: none"> <li>The turnaround PMO for an organisation this size and in distress needs to be at least 6-7 people working alongside Finance with a project management, challenge, governance and monitoring function. Ideally there will be a central PMO function which can be used flexibly across Turnaround, Transformation, Planning and Service Improvement, depending on the stage of the organisation in its journey.</li> </ul>	●	Turnaround Director (now Executive Director of Finance)	<ul style="list-style-type: none"> <li>See 1.1 and 1.11 above.</li> </ul>
6.3	Capacity	6.3 The capacity within Finance seems to be sufficient as per the new business partnering arrangement that have been put in place recently.	<ul style="list-style-type: none"> <li>The Business Partners are aligned to Directorates; however there also needs to be Finance input into the workstreams</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>See 2.2 above – the Opportunities Framework will address the finance input.</li> </ul>
6.4	Capacity	6.4 Workforce does not have a business partnering model and therefore does not have the capacity to embed	<ul style="list-style-type: none"> <li>Review the capacity and structure of the Workforce function to ensure there is sufficient capacity to support the significant</li> </ul>	●	Workforce Director	<ul style="list-style-type: none"> <li>The HR Business Partnering model business case is included in the Draft</li> </ul>

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		within Directorates to support the drive for savings schemes. They provide a level of support for specific projects.	workforce changes required to be implemented by the organisation			Financial Plan for 2020/21.
6.5	Capability	6.5 The project management capability within the Directorates is variable but may also be impacted by capacity constraints.	<ul style="list-style-type: none"> <li>Coaching in specific areas on an ongoing basis within the department will help upskill and maintain skills within the team</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>A budget holder training framework is being developed as part of the Finance Strategy.</li> </ul>
6.6	Capability	6.6 The Senior Finance Business Partners have experience and capability to support the Directorates. There are some coaching requirements for the Business Partners in areas such as weekly forecasting, risk assessment and providing challenge to the Triumvirate	<ul style="list-style-type: none"> <li>Coaching in specific areas on an ongoing basis within the department will help upskill and maintain skills within the team</li> </ul>	●	DoF	<ul style="list-style-type: none"> <li>All Finance Business Partners and Senior Finance Business Partners have attended interactive coaching training sessions. Further coaching and management training has commenced ("Senior Finance Leadership Programme") in 2020.</li> </ul>
6.7	Clinical Engagement	6.6 The engagement of clinical leads at the HTAs is variable. This could indicate a reliance on Finance and operational leads to solve the financial challenge.	<ul style="list-style-type: none"> <li>Commitment is required from the clinical leads with time allocated to support the programme; this may necessitate backfill support. Coaching for clinical leads by the PMO and Finance to drive the programme.</li> </ul>	●	Medical Director / Nurse Director	<ul style="list-style-type: none"> <li>See 1.5 above.</li> </ul>
6.8	Operational engagement	6.7 The capacity (in terms of financial savings) of the	<ul style="list-style-type: none"> <li>Coaching for operational leads by the PMO and</li> </ul>	●	COO	<ul style="list-style-type: none"> <li>See 1.11 above.</li> </ul>

Ref	Area	Current situation/ Issue	Recommendation	RAG	Owner	Health Board Response
		operational leads appears to be limited although they do attend the HTA regularly (which shows willingness). The capability gaps relate to project management/ delivery of savings.	Finance to drive the programme.			
6.9	Executive leadership	6.8 The Executives are committed to the Turnaround Programme and have made time for the HTA meetings however there has been a softer approach with Directorates and workstreams. The slowness of pace of more complex transformational schemes could also be due to the political context in which the Health Board operates	<ul style="list-style-type: none"> <li>To step up performance, Executives need to prioritise high value and high risk areas with a greater appetite towards more challenging options to close the gap.</li> </ul>	●	CEO	<ul style="list-style-type: none"> <li>See 2.2 above – the Opportunities Framework will increase the focus and governance arrangements around considering all opportunities and moving the focus to pursue transformational schemes.</li> </ul>

## Paper: Assessment of 2019/20 Financial Plan

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

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

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

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

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

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

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

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

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

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

## Paper: Financial Grip and Control

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

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

RAG rating key:



Room for improvement



To be addressed as a matter of importance



To be addressed urgently

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

Ref	Area	RAG	Recommendation	Health Board Response
			Ensure that unfilled shifts which need to be filled are sent to the Bank Office >35 days from the date of the shift (i.e. within a week of the roster being completed). Refresh and re-issue to all requesters and bookers the revised agency booking processes (along with seasonal reminders and kit-card/help cards).	and cover requests. Block booking is maximised where possible dependant on on-contract agency cover. <ul style="list-style-type: none"> <li>• <b><u>Pilot Long Term Rostering</u></b> – this will be completed in line with the <i>Allocate</i> rollout.</li> </ul>
8.3	<b>Controls over staff leaving the Health Board ('exit controls')</b> Compliance failure	●	Whilst responsibility for exit date should remain with line managers, there needs to be (i) immediate communication to HR and Payroll (to reduce time to start recruiting to required roles and to reduce the risk of any staff overpayments) and (ii) an independent check that a decision is not unduly made to release staff early which places increased burden on remaining staff, as well as the need for agency staff – which will increase the financial cost to the Health Board. HR should ideally review the exit date of the employee after discussion and update payroll accordingly. Saving will largely relate to agency.	<ul style="list-style-type: none"> <li>• A Task and Finish Group has been set up, with representation from Finance, Payroll, ESR and Counter-Fraud Departments.</li> <li>• An <b><u>All-Wales Overpayment Policy</u></b> is being developed. Payroll Department will link in to ensure changes required to strengthen the process are included.</li> <li>• A <b><u>resource pack will be developed</u></b> to ensure all forms/ links to forms are easily accessed, and that there is clear signposting and clarity around the Termination process.</li> <li>• Communication will be sent to managers via the Global Email system and a <b><u>'Manager's Communication List'</u></b> will be developed, comprising managers within Manager Self Service (MSS) in ESR to allow reminders to be distributed.</li> <li>• Work is ongoing between HDdUHB and NHS Wales Shared Services Partnership (NWSSP) to develop <b><u>electronic forms</u></b> for roll-out in March 2020. An issue has been identified with regard to HDdUHB's roll-out of Office 365. IT will be tasked to identify whether this will impact the roll-out of the electronic forms.</li> <li>• <b><u>Overpayments</u></b> are in future to be <b><u>reported to the Directorate Performance Reviews</u></b> to ensure increased accountability.</li> </ul>

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

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

Ref	Area	RAG	Recommendation	Health Board Response
8.11	Policy on nursing staff returning as agency Control	●	Make bank more attractive to existing staff (see below). Understand drivers for leaving and put in place a retention programme. Ensure 6 month policy is enforced to make it less attractive to leave the organisation for agency working.	<ul style="list-style-type: none"> <li>Bans live around leavers from HB Bank to agency within 6 months.</li> </ul>
8.12	Promote Bank sign up Opportunity	●	<p>Concerted recruitment campaign to Bank. Implement other recommendations noted herein to make agency less attractive relative to Bank.</p> <p>Consider paying Bank staff at a high rate than current band (e.g. at Trusts we have seen payment to band 5 at band 6 rate). Although the financial impact and knock-on impact for substantive shifts needs to be considered and modelled.</p> <p>In line with other healthcare providers, the Health Board should consider auto-enrolment of all new staff onto the Bank (with an opt-out rather than opt-in approach adopted) to maximise availability of the Bank.</p>	<ul style="list-style-type: none"> <li>Process changed for substantive nursing – staff now able to get secondary assignment within 72hrs working with Recruitment and Payroll.</li> <li><b><u>Allocate</u></b> system has been procured and contract signed – <b><u>to be implemented</u></b>.</li> <li><b><u>Opt-out not viable at this time</u></b>.</li> <li>A letter has been drafted to all Band 2 HCSW explaining Bank opportunities.</li> <li>Facebook page plan drafted – awaiting <b><u>feedback from Governance</u></b> before goes live.</li> <li><b><u>Work on-going</u></b> with new nurses in the area and existing staff to sign them up onto <b><u>Nurse Bank</u></b>; also <b><u>work on-going with community</u></b> to provide a <b><u>larger Nurse Bank</u></b>.</li> </ul>
8.13	Promote Bank usage Opportunity	●	Bank notification systems should be enhanced to ensure that Bank users can easily see what shifts are available and book on. (We understand that there is a setting within Roster Pro which can be enabled (R Roster Plus) which would allow staff to view and sign up for available shifts but that it has not yet been approved by IT). It is possible for shifts booked by agency staff to be replaced by Board Bank staff. At present, shifts which have been booked by agency staff are not visible to Bank staff.	
8.14	Rostering policy Control	●	Draft roosting policy to be reviewed and approved as appropriate. To include recommendations from this report and a review of the compliance (including swapping shifts, annual leave bookings etc.)	<ul style="list-style-type: none"> <li>Overarching <b><u>policy</u></b> reviewed, and specific Nursing appendix added to provide guidance on efficient staffing of wards in line with nursing staffing levels in Wales in draft form. To be <b><u>signed off</u></b> by March 2020.</li> </ul>
8.15	Job plans Compliance	●	<p>Enable electronic job planning across all areas.</p> <p>Review all job plans (old ones as a priority) to ensure they are appropriate, efficient, in line with best practice and delivering best value for the Health Board.</p>	<ul style="list-style-type: none"> <li>The Audit and Risk Assurance Committee (ARAC) has confirmed that e-job planning is now mandated from 01.01.2020. The trajectory for full compliance (100%) of completed e-job plans is 31.12.2020. However, 100%</li> </ul>

Ref	Area	RAG	Recommendation	Health Board Response
			This is expected to reduce demand from agency/locum medical staff and from substantive.	<b><u>compliance for all job plans</u></b> (paper and e-job plans) is expected and on trajectory for 31.03.2020.
8.16	<b>Rota management</b> Control and Compliance	●	Transition to electronic rota preparation which offers improved visibility, control and assurance and would be expected to lead to a reduction in run-rate. They are also simpler to prepare and there is a drive across the NHS towards electronic rotas/rosters. This is expected to reduce demand from agency/locum medical staff and from substantive staff.	<ul style="list-style-type: none"> <li>• <i>Single Rota for A&amp;E</i>: Conversations have been held with General Managers and Health Directors at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) regarding the potential benefits for improved rota management and associated efficiencies within Emergency Departments (ED). This initiative has been highlighted further by the additional fragility in both the Consultant and Middle grade rotas at these two sites, resulting from recent reductions in substantive staff members. An Urgent Response Group (URG) has been created to respond to this additional fragility, with a single rota proposal being one option considered. This <b><u>piece of work will be progressed by the A&amp;E URG group</u></b>. Estimated completion by December 2020.</li> <li>• <i>Centralised Rota Management/Electronic Rostering System for Medical and Dental (M&amp;D) Staff Group</i>: It is recommended that this be treated as a medium-term objective. The current Nurse rostering system is being upgraded, and e-job planning for the M&amp;D staff group is being progressed. <b><u>These two programmes of work need to be prioritised</u></b>. Timescales will be influenced by capacity, linked to roll-out of new rostering system for Nursing and successful implementation of e-job planning. At this stage, a date cannot be provided to progress e-rostering for medical staff.</li> </ul>

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

Ref	Area	RAG	Recommendation	Health Board Response
			(and specific emails to any who have not identified unpaid breaks being paid).	<ul style="list-style-type: none"> <li>• <b><u>A paper will now be finalised</u></b> and presented to the Executive Director of Operations, Medical Executive Director and Executive Director of Workforce &amp; Organisational Development (W&amp;OD) in the first instance to explore options for resolution and recommendations by the end of February 2020.</li> <li>• No action required with regard to Medical Agency cases, as rest breaks are deducted automatically using an electronic system for timesheet approval. <b><u>Internal ad hoc Locum cases link to a much larger piece of work to introduce a Medical Bank Model</u></b>, involving significant capacity requirements in order to complete at pace in this financial year. Further discussion needed, linked to the vision for a Medical Bank Model and to the pace of developments at NHS Wales level relating to this matter.</li> </ul>
8.19	Agency mileage Control	●	Review terms of agreement with agency workers to remove mileage costs if material and being paid for travel from home. If arising due to work required at two sites in one day, seek to manage rotas so as to remove this requirement.	<ul style="list-style-type: none"> <li>• Data audited. One example of 'home to assignment' mileage claimed in error by Agency Worker and approved in error by the Authoriser of the timesheet. Error addressed and refund being processed. Guidelines for authorisers of timesheets re-issued to stress that only internal mileage from base site of assignment to another Health Board site can be claimed.</li> </ul>
8.20	On-call rates	●	On-call rates at Trusts in England we have reviewed have been agreed at 50%. Seek to reduce the agreed pay for non-resident on-call to 50% in discussions with the supplier.	<ul style="list-style-type: none"> <li>• The Health Board works to an agreed reduction rate of 40% of the day time rate. It is often challenging to achieve this, given current labour market conditions.</li> </ul>
8.21	Agency authorisation process	●	Hold to Account meetings to challenge Directorates as to why there are any shifts without approval. Monthly report of instances to be sent to the Executive.	<ul style="list-style-type: none"> <li>• All medical agency worker shifts are approved via the weekly workforce expenditure control panel which is Executive Director led.</li> </ul>

Ref	Area	RAG	Recommendation	Health Board Response
	Compliance			
8.22	<b>Locum authorisation process</b> Control	●	Considering this is the main driver of medical temporary spend, this should be controlled so that there is much greater visibility and control being exercised centrally to enable effective monitoring	<ul style="list-style-type: none"> <li>For external Locums, a review of the authorisers have been completed and <b>re-communication of guidelines</b> will be issued.</li> <li>For internal Locums, a <b>review</b> of the control process and recording of shifts is <b>underway</b>.</li> </ul>
8.23	<b>Agency requests</b> Control	●	The AG1 form at present does not include a requirement to specify the establishment and contracted position of the cost centre –this should be included.	<ul style="list-style-type: none"> <li>See Agency booking process and control section above.</li> </ul>
8.24	<b>Discretionary spend</b>	●	Targeted campaign to reduce these key spend areas through: deselection of catalogue choices on procurement, targeted emails to users of these items, removing relevant budgets (and finance to monitor compliance), dashboard reporting of non-compliance, providing guidance (and escalation channels) to reduce spend areas and procurement/finance to challenge requisitions in these areas.	<ul style="list-style-type: none"> <li>Catalogue is continuously updated and reviewed monthly by the procurement team. This looks at reducing non-catalogue spend and replacing with catalogue /contract alternatives. From December 2019 to current month, 2,800 lines have been added. As well as more closely controlling discretionary spend and obtaining improved value for money, this also provides significant efficiency improvements across the P2P process.</li> <li>Additionally, discretionary spend is closely scrutinised as all non-cat / non-clinical requisitions are now personally reviewed and challenged by the Head of Procurement. These are then either approved or returned for further justification of the requirement or switched in to a contract alternative.</li> </ul>
8.25	<b>Month 12 spike</b> Compliance	●	Close financial performance management in Month 11 and Month 12 (potentially including centralisation of historical underspends) to seek to defer, reduce or cancel spend which is outside of budgets or above normal run rate of spend	<ul style="list-style-type: none"> <li>The Control Total requirements issued to Directorates in Quarter 3 for delivery in Quarter 4 included the need to defer, reduce or cancel expenditure outside of the delivery of core services.</li> </ul>
8.26	<b>Reduce clinical preference</b>	●	Standardise supplies such that the number of suppliers for the same product are reduced to as few as possible. Setup clinical preference meetings (hosted by MD or similar) to	<ul style="list-style-type: none"> <li>The Head of Procurement has met with Transformational Director and PMO to start the establishment of a clinical governance and</li> </ul>

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