WALES AUDIT OFFICE
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Annual Audit Report 2013

Abertawe Bro Morgannwg University Health Board

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Status of report

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The team who prepared this report comprised Richard Harries, Dave Thomas, Matthew Coe and Carol Moseley.

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Summary report

Summary

1. This report summarises my findings from the audit work I have undertaken at Abertawe Bro Morgannwg University Health Board (the Health Board) during 2013.

2. The work I have done at the Health Board allows me to discharge my responsibilities under the Public Audit (Wales) Act 2004 (the 2004 Act) in respect of the audit of accounts and the Health Board's arrangements to secure efficiency, effectiveness and economy in its use of resources.

3. My audit work has focused on strategic priorities as well as the significant financial and operational risks facing the Health Board, and which are relevant to my audit responsibilities. More detail on the specific aspects of my audit can be found in the separate reports I have issued during the year. These reports are discussed and their factual accuracy agreed with officers and presented to the Audit Committee. The reports I have issued are shown in Appendix 1.

4. This report has been agreed for factual accuracy with the Chief Executive and the Director of Finance. It was presented to the Audit Committee on 16 January 2014. It will then be presented to a subsequent Board meeting and a copy provided to every member of the Health Board. We strongly encourage wider publication of this report by the Health Board. Following Board consideration, the report will also be made available to the public on the Wales Audit Office's own website (www.wao.gov.uk).

5. The key messages from my audit work are summarised under the following headings.

Section 1: Audit of accounts

6. The Health Board achieved financial balance in 2012-13 and I have issued an unqualified opinion on the 2012-13 financial statements, although in doing so I have brought several issues to the attention of officers and the Audit Committee. I have also concluded that:

- the Health Board's accounts were properly prepared and materially accurate;
- the Health Board had an effective control environment to reduce the risks of material misstatements to the financial statements; and
- the Health Board's significant financial and accounting systems were appropriately controlled and operating as intended.

7. The Health Board reported savings of £21.4 million, and achieved financial balance in 2012-13 after receiving £10 million of additional non-recurring funding in November 2012 from the Welsh Government to manage service pressures. The Health Board underspent by £141,000 against its 2012-13 resource limit. In addition, it provided resource brokerage of £2.5 million to the Welsh Government in 2012-13, which it will receive back in 2013-14. As the Health Board met its resource limit, its regularity opinion was unqualified.

Section 2: Arrangements for securing efficiency, effectiveness and economy in the use of resources

8. I have reviewed the Health Board's arrangements for securing efficiency, effectiveness and economy in the use of its resources. My Structured Assessment work has examined the robustness of the Health Board's financial management arrangements and the adequacy of its governance arrangements, including quality governance and arrangements for measuring and improving patient/user experience. From this work I have concluded that arrangements which support good governance, quality assurance and the efficient, effective and economical use of resources have continued to evolve, but further improvement is needed in some important aspects and achieving financial balance for 2013-14 remains a major challenge. This work, and performance audit reviews undertaken on specific areas of service delivery, has led me to draw the following conclusions:

Despite the urgent measures being taken to close the remaining funding gap and its past record of sound in-year financial management, current projections indicate that the Health Board is unlikely to achieve financial balance in 2013-14

9. Despite a funding gap at the start of 2012-13 of £38.6 million, good budgetary control and in-year financial management ensured financial targets were met. £21.4 million of savings were achieved and with £10 million additional, non-recurrent funding from the Welsh Government, the Health Board met its financial targets for 2012-13. However the position is not sustainable and significant risks remain around the estate, equipment and setting balanced budgets.

10. Despite receiving additional funding in 2013-14 and identifying further cost reductions and savings in-year, as it currently stands the Health Board is unlikely to achieve financial balance in 2013/14.

Arrangements to support effective governance have continued to mature and the Board is promoting an open quality focused culture. However some arrangements need further improvement and progress in some areas has been slow. There is also more to do to strengthen organisational capacity and fully embed organisational learning.

11. My review of the Health Board's governance arrangements found that:

- the Health Board has set out its strategic objectives, is integrating strategic change programmes and building an improvement culture;
- the executive team have responded to and managed significant pressures and challenges in-year, but organisational capacity appears stretched and possible structural changes may create some short-term uncertainty and instability;
- Board dynamics continue to evolve, and changes to Board administration and good scrutiny and challenge have strengthened Board effectiveness;
- there are improvements in performance and risk management, but clinical audit is not yet contributing fully to the system of assurance;

- management information has been substantially refined but, at present, key gaps remain around primary care, community and patient experience;
- although most data back-up controls are in place, changes to backup procedures are not always formally agreed and communicated, and the record of routine Disaster Recovery tests is incomplete;
- the Health Board is committed to developing a positive listening and learning culture, but a systematic, co-ordinated approach is needed to embed organisational learning;
- the Health Board is committed to strengthening quality and safety assurance arrangements, and recognises that some aspects of arrangements need further improvement; and
- the Health Board has made effective use of the National Fraud Initiative to detect fraud.

My performance work has identified that while the Health Board has made some progress in improving its use of resources, the pace needs to be quicker in some areas and improvements in unscheduled care performance and timely access to services are needed

12. Key findings from my review of the Health Board's use of resources are as follows:

- Partnership working and engagement continues to develop positively, but progress in addressing some aspects of workforce planning and management has been slow.
- Based on a review of performance against a number of key indicators, performance for efficiency and quality are comparable with the rest of Wales, although improvement is needed in the timely access to some services.
- The Health Board has strengthened its strategic approach to attendance management but sickness levels are high and further improvements are needed to reduce absence rates, ensure a greater focus on attendance and wellness, and increase operational confidence in data.
- The Health Board is reshaping community services but resource and capacity planning and stakeholder engagement are not yet effective enough to support reduced demand on acute services and sustainable improvements in unscheduled care performance.
- The Health Board has set a clear short-term agenda for primary care prescribing and has well-managed arrangements for prescribing support. However, the lack of a longer-term strategic plan for these services limits the potential to focus the use of resources so that clear opportunities to improve the safety, quality and economy of prescribing can be achieved.

13. The assistance and co-operation of the Health Board's staff and members during the audit is gratefully acknowledged.

Detailed report

About this report

14. This Annual Audit Report to the Board members of the Health Board sets out the key findings from the audit work that I have undertaken between December 2012 and November 2013.

15. My work at the Health Board is undertaken in response to the requirements set out in the 2004 Act. That act requires me to:

a) examine and certify the accounts submitted to me by the Health Board, and to lay them before the National Assembly;

b) satisfy myself that the expenditure and income to which the accounts relate have been applied to the purposes intended and in accordance with the authorities which govern it; and

c) satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

16. In relation to (c), I have drawn assurances or otherwise from the following sources of evidence:

- the results of audit work on the Health Board's financial statements;
- work undertaken as part of my latest Structured Assessment of the Health Board, which examined the arrangements for financial management, governance and accountability, and use of resources;
- the Health Board's self-assessment against the Governance and Accountability module of the Standards for Health Services in Wales;
- performance audit examinations undertaken at the Health Board;
- the results of the work of other external review bodies, where they are relevant to my responsibilities; and
- other work, such as data matching exercises and certification of claims and returns.

17. I have issued a number of reports to the Health Board this year. The messages contained in this Annual Audit Report represent a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.

18. The findings from my work are considered under the following headings:

- audit of accounts; and
- arrangements for securing economy, efficiency and effectiveness in the use of resources.

19. Appendix 2 presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my work at the Health Board, alongside the original fee that was set out in the Annual Audit Outline.

20. Finally, Appendix 3 sets out the priorities for the financial accounts work highlighted in my Annual Audit Outline for 2013 and how they were addressed through the audit.

Section 1: Audit of accounts

21. This section of the report summarises the findings from my audit of the Health Board's financial statements for 2012-13. These statements are the means by which the organisation demonstrates its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Preparation of an organisation's financial statements is an essential element in demonstrating appropriate stewardship of public money.

22. In examining the Health Board's financial statements, I am required to give an opinion on:

- whether they give a true and fair view of the financial position of the Health Board and of its income and expenditure for the period in question;
- whether they are free from material misstatement – whether caused by fraud or by error;
- whether they are prepared in accordance with statutory and other applicable requirements, and comply with all relevant requirements for accounting presentation and disclosure;
- whether that part of the Remuneration Report to be audited is properly prepared; and
- the regularity of the expenditure and income.

23. In giving this opinion, I have complied with my Code of Audit Practice and the International Standards on Auditing (ISAs).

24. In undertaking this work, auditors have also examined the adequacy of the:

- Health Board's internal control environment; and
- financial systems for producing the financial statements.

The Health Board achieved financial balance in 2012-13 and I have issued an unqualified opinion on the 2012-13 financial statements, although in doing so, I have brought several issues to the attention of officers and the Audit Committee

The Health Board's accounts were properly prepared and materially accurate

25. The draft financial statements were produced for audit by the agreed deadline of 3 May 2013 and were of a high standard. We received information in a timely and helpful manner, and we found the information provided to be relevant, reliable, comparable, material and easy to understand. The significant estimates included within the financial statements relate primarily to accruals (primary care expenditure and holiday pay), and provisions (Continuing Health Care, clinical negligence, personal injury and other). We concluded that accounting policies and estimates are appropriate and financial statement disclosures unbiased, fair and clear. We encountered no significant difficulties during the audit and were not restricted in our work.

26. I am required by ISA 260 to report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 3 June 2013. Exhibit 1 summarises the key issues set out in that report.

Exhibit 1: Issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Continuing Healthcare provisions	Errors were identified in the claims database, managed by Powys LHB, resulting in an extrapolated overstatement of the continuing healthcare provision of £203,000 and the related contingent liability of £201,000. Given the claims exposure and the methodology utilised to establish the provision, management considered that the amounts already included in the draft financial statements were still reasonable and no amendment was made. There was no impact on the audit opinion.
Welsh Health Specialised Services Committee balances	As the Health Board shares financial risks for the Welsh Health Specialised Services Committee (WHSSC) with all local health boards in Wales, any amendments from the audit of WHSSC need to be reflected in each local health board's own financial statements. We confirmed with the WHSSC audit team that there were no issues arising from the audit of WHSSC affecting the Health Board's financial statements.
Holiday pay accrual	We concluded that the methodology used to calculate this accrual was reasonable. However, we identified instances where the employee had stated their untaken leave in hours, but this was recorded as days in the accrual calculation. If the error detected in the sample was replicated across the whole workforce, the effect was to overstate the accrual by £301,000. The accrual was amended in the final audited financial statements.

27. As part of my financial audit, I also undertook the following reviews:

- Whole of Government Accounts return – I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2013 and the return was prepared in accordance with the Treasury's instructions; and
- Summary Financial Statements and Annual Report – I concluded that the summary statements were consistent with the full statements and that the Annual Report was compliant with Welsh Government guidance.

28. My separate audit of the Charitable Funds financial Statements is also complete. There were no issues to report to Trustees at their meeting on 12 September 2013 and I issued an unqualified opinion on those financial statements on 7 October 2013.

The Health Board had an effective control environment to reduce the risks of material misstatements to the financial statements

29. In considering the internal control environment, I assess arrangements that include high-level controls over the main accounting and budgetary control systems, the work and role of internal audit, and the work of the Audit Committee which plays an active role in reviewing and strengthening the internal control environment.

30. I found that controls were operating as effectively as intended and therefore formed a reliable basis for preparing the financial statements.

31. Following my review of the Audit and Assurance Service provided by the NHS Wales Shared Services Partnership, I concluded that the Audit and Assurance Service met the *2009 Internal Audit Standards for the NHS in Wales* and that there are some key areas where improvements are required to achieve further consistency. The new Internal Audit Charter was adopted by the Health Board in January 2013 and other planned developments are already underway which will further improve the service provided to health bodies in Wales. This includes the preparation of an Internal Audit Quality Manual, on an all-Wales basis.

32. The work that I have undertaken supports the external auditor's opinion on the financial statements. This does not constitute an assessment of internal audit under the new Public Sector Internal Audit Standards (PSIAS). Under PSIAS (which came into effect on 1 April 2013) organisations are required, every five years, to conduct an external assessment of internal audit. This goes beyond the work that external audit undertake to place reliance upon, or take assurance from, the work of internal audit.

The Health Board's significant financial and accounting systems were appropriately controlled and operating as intended

33. I did not identify any significant weaknesses within the Health Board's financial systems. However, there were some less significant areas for improvement identified during the audit and recommendations have been made to management to address these.

34. Internal Audit reported on a number of system weaknesses which require ongoing management action. Management action plans have been developed to strengthen the control weaknesses identified in these reports, and progress is scrutinised by the Audit Committee.

The Health Board reported savings of £21.4 million and achieved financial balance in 2012-13 after receiving additional non-recurring funding from the Welsh Government to manage service pressures

35. In November 2012, the Minister for Health and Social Services announced additional, non-recurrent resource funding of £82 million to 'allow the NHS to manage current pressures and maintain quality of care'. The Health Board's share of this was £10 million, which contributed to a revised forecast year-end position at month eight of a break-even position.

36. On 5 March 2013 the Chief Executive NHS Wales wrote to the NHS body Chief Executives to clarify that there would be no further funding available from the Welsh Government and that LHBs failing their targets would receive an accounts qualification and be subject to escalation procedures.

37. The Health Board underspent by £141,000 against its 2012-13 resource limit. In addition, it provided resource brokerage of £2.5 million to the Welsh Government in 2012-13, which it will receive back in 2013-14. As the Health Board met its resource limit, its regularity opinion was unqualified.

Section 2: Arrangements for securing efficiency, effectiveness and economy in the use of resources

38. I have a statutory requirement to satisfy myself that NHS bodies have proper arrangements in place to secure efficiency, effectiveness and economy in the use of their resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing the Health Board's financial management arrangements, including the progress being made in delivering cost saving plans and their contribution to achieving financial balance;
- assessing the effectiveness of the Health Board's governance arrangements through my Structured Assessment work, with a particular emphasis on quality governance and the robustness of arrangements for assessing patient/user experience; and
- specific use of resources work on attendance management, unscheduled care and chronic conditions management, primary care prescribing, and performance against key service targets for service efficiency, quality and access.

39. The main findings from this work are summarised under the following headings.

Despite the urgent measures being taken to close the present funding gap and its past record of sound in-year financial management, current projections indicate that the Health Board is unlikely to achieve financial balance in 2013-14

Despite a funding gap at the start of 2012-13, good budgetary control and in-year financial management ensured financial targets were met for that year. However the position is not sustainable and significant risks remain around the estate, equipment and setting balanced budgets.

40. Against the background of flat cash financial settlements and non-recurrent additional funding in 2011-12, the Health Board had effective in-year controls for the budget setting process. The Board did receive various iterations of the draft 2012-13 Resource Plan in early 2013, but the final 2012-13 Resource Plan was not balanced and was approved by the Board after the start of the financial year.

41. The total funding gap for 2012-13 was £38.6 million against which £24.4 million of savings were identified, and this gap was consistently reported. A high percentage – 88 per cent or £21.4 million – of the savings target was achieved. The remainder of the funding gap was closed through other one off measures, accountancy gains and additional, non-recurrent funding from the Welsh Government. So whilst the Health Board met its financial targets for 2012-13, this is not a sustainable financial position going forward.

42. Total capital funding has decreased by 42 per cent over the last three years from £64 million to £37 million. Within this, discretionary capital funding that the Health Board can use for non-specific projects has fallen by £2.2 million (20 per cent) to £8.4 million in 2012-13. Whilst Capital Resource limit targets have been consistently met year on year, significant risks remain around the resources to address the high level of backlog maintenance and the replacement of out of life assets (mainly medical equipment).

After receiving additional funding and identifying further cost reductions and savings, as it currently stands the Health Board will not achieve financial balance in 2013/14 without some adverse impact on service delivery and performance

43. In 2013-14 Welsh NHS bodies again received flat cash settlements which excluded the additional, non-recurrent funding received in 2012-13. The Health Board's discretionary capital funding has fallen by a further £0.7 million to £7.7 million. However, the financial plan for 2013-14 is not a balanced plan, and the starting deficit, after identified savings, is getting worse year on year: £28 million for 2013/14 compared to £15 million in 2012/13 and £20 million in 2011-12. This funding gap subsequently grew from £28 million to £32.5 million during the year as a result of Welsh Government requirements for NHS bodies to build capacity for winter pressures in 2013-14.

44. The Minister for Health and Social Services announced additional, non-recurrent funding in October 2013 of £150 million for the NHS in Wales. The Health Board was allocated £25.45 million of this additional funding, of which £20.5 million was uncommitted funding that reduced the funding gap from £32.5 million to £12 million.

45. Additional savings/cost reductions of £6 million have been identified to date which includes approximately £2 million of measures that are high risk. Further work is being done to identify how the remaining funding gap of £6 million can be closed, and the Health Board is carefully assessing service impact before committing to further savings.

The Health Board continues to have robust in-year financial management processes and is developing better links between financial planning and wider service modernisation goals, supported by a robust medium-term plan

46. The Health Board continues to have sound controls in place for in-year budget monitoring, and is implementing improvements to these budgetary control procedures and monitoring processes using good practice from NHS Trusts in England. Senior finance staff continue to hold monthly meetings with key directorates and localities to monitor delivery against individual savings targets. Monthly reporting to the Executive Board and Welsh Government, and bi-monthly reporting to the Board continues to be consistent and prepared in a transparent manner.

47. The Health Board continues to develop its three year medium-term financial plan, which the Welsh Government will need to approve before granting financial flexibility to the Health Board for the three year period 2014/15 to 2016/17. The Health Board is using external support to strengthen its strategic planning arrangements so that the medium-term financial plan is robust, balanced, and not overly reliant on additional funding or short-term, non-recurrent measures.

48. Further work is needed to link financial, service and workforce planning so that the full impact of the different service delivery options in the South Wales Programme – when known – can be understood and managed. The wider service changes from the South Wales Programme and 'Changing for the Better' do, however, provide an opportunity to zero base the budgets required for the remodelled services.

Arrangements to support effective governance have continued to mature and the Board is promoting an open quality focused culture. However some arrangements need further improvement and progress in some areas has been slow. There is also more to do to strengthen organisational capacity and fully embed organisational learning.

49. Last year I found that the Health Board had maintained a positive direction of travel, with broadly sound governance arrangements and recognition of the need to continue to strengthen some aspects of internal control. There is evidence of committed and proactive work to further develop arrangements this year. The Board is promoting an open, quality focused culture and demonstrates a candid and self-critical approach to reviewing its arrangements and performance. I have also found there to be a progressive approach to designing for the future and an increasing focus on accountability.

50. However, the Health Board faces some challenges including ensuring sufficient organisational capacity to deliver improvement at a reasonable and sustained pace and in ensuring that arrangements are applied consistently, and work as intended throughout the organisation. In some areas, such as managing concerns, the pace of improvement has not been fast enough.

51. The Health Board understands this position and is committed to addressing these challenges. They also recognise that there may be some short term risks and instability as they implement sustainable, long-term solutions. My findings are summarised in more detail below.

The Health Board has set out its strategic objectives, is integrating strategic change programmes and is building an improvement culture

52. The Health Board has developed and continues to refine its three-year business plan for 2013/14 – 2015/16, and recognises this as an opportunity to secure better links between financial, workforce, capacity and service planning. Organisational aims and objectives are set out in the plan, with transformational change the key vehicle for delivering strategic vision and sustainable service improvement.

53. The Health Board's 'Changing for the Better' programme has continued in the year, and has been broadened to encompass all strategic change programmes within the Health Board. There continues to be close working with partners, positive engagement with stakeholders and active change management. This, and the clear commitment from the Board to drive positive change, has helped to accelerate the pace of strategic service changes in a constructive way.

54. A framework to better integrate the ambitious set of strategic change programmes has been developed. A 'Changing for the Better' Delivery Board has also been recently established to provide clearer management oversight and coordination of all change programmes and projects. The 'Managing Successful Programmes' (MSP) methodology introduced last year provides a structured approach to programme management with a formal project initiation process in place. However, there are some risks around protracted project initiation timescales and the reporting arrangements to Board need further clarification. There is also the need to ensure interdependent work streams are fully aligned and coordinated.

55. A commissioning programme is being established to provide population needs analysis and a robust evidence base to inform future service design and clinical models. Further, the Health Board is committed to developing a culture of improvement through its strategic change and service improvement processes. An 'Innovation, Support and Improvement Science' programme[1] (ISIS) is being developed to help underpin strategic change with a quality improvement focus. Other improvement streams include patient pathway work and developing 'lean' approaches.

The executive team have responded to and managed significant pressures and challenges in-year, but organisational capacity appears stretched and possible structural changes may create some short-term uncertainty and instability

56. The Health Board has faced a number of challenges in 2013, with continuing financial and service pressures, and a number of emergent quality and safety matters needing attention. This put the executive team and board secretary under considerable pressure, at a time when the Chief Executive was required to provide support to another Health Board (June to October 2013).

57. These pressures have generally been coped with well, and have eased somewhat with the Chief Executive's full-time return to the Health Board. External input has been sought to support key strands of vital improvement work during the period. This provided access to expertise, adding to organisational capacity and ensuring momentum in critical areas such as unscheduled care improvement. However, the capacity to progress some important work, such as the revised accountability framework was hampered, making progress slower than intended.

[1] ISIS stands for Innovation, Support and Improvement Science. This is a planned and systematic quality improvement programme following an evidence based approach to enable sustained organisational performance. The role of ISIS will be to help build people in understanding improvement science to deliver the Health Board's purpose: 'To improve the health of our community and to deliver effective and efficient healthcare in which our patients and users feel cared for, safe and confident.'

58. The Nursing Director post became vacant during the year and additional capacity to support the Director of Primary Care, Community and Mental Health (who also holds the role of Chief Operating Officer) was needed to support primary care development work. Acting arrangements and internal secondments have been used to provide the executive cover and support, but this has stretched capacity in the central nursing team and in some locality structures. In addition, the variable maturity and operational capacity of directorate/locality management teams, reduces the extent to which the executive team can substantially delegate issues, adding pressure to the senior leadership team.

59. The Health Board has advertised the executive posts of Nursing Director and Medical Director (filled on an interim basis for the past year). The appointments to these crucial roles need to proceed without unnecessary delay. It is positive to note that the Health Board is taking the opportunity to re-examine clinical governance responsibilities to bring greater focus and clarity around these arrangements, for example, the Nursing Director post will now have specific responsibility for patient experience. A review of wider executive remits is already planned and this should consider the breadth and sustainability of current executive roles and responsibilities and how they fit together.

60. The Health Board is also looking at reviewing structures to strengthen hospital site management arrangements, drive strategic change, and develop community networks. It is important that as this work proceeds, the Health Board is prepared to manage any short-term uncertainty and instability that may be created as a result.

61. The Health Board is making investment in the central communications and patient experience teams, but there are tensions between delivering central cost reductions across corporate functions and ensuring sufficient resources in teams that are essential for delivering organisational priorities and objectives. The Health Board will need to continue to assess and prioritise so that there is enough capacity to do all that is necessary in the future.

Board dynamics continue to evolve, and changes to Board administration and committee structures, coupled with good scrutiny and challenge have strengthened Board effectiveness and assurance arrangements

62. Since my work last year, the Board Assurance Framework, entitled ‘System of Assurance’, has been updated. Board meetings are well managed and the new agenda structure for Board meetings provides clarity between items for noting and discussion. ‘Rules’ are applied for the timeliness, completeness and standards for papers; although many papers are still for information and managing the agenda length remains a challenge. There is some further scope to more explicitly signpost critical information in Board papers and the assurance being provided to Board.

63. Board dynamics are still evolving, with more strategic discussion taking place compared to last year and a marked increase in good challenge and scrutiny by independent members observed. A programme of Board development is in place to support effective Board working, demonstrating a positive commitment to learn and reflect. There is also a greater resolution among Board members to tackle the historic and future challenges facing the Health Board. However, as some relationships are relatively new, and with new executive appointment to be made, the Board will need to ensure its role is clear and constructive relationships between members are maintained.

64. The Chair has placed a greater focus on the skills and experience of the independent members, with changes in chairmanship of some committees. A review of committees as part of a wider governance review is planned to further strengthen the relationships between committees. Work programmes and action logs are in place and self-assessment is used by both the Audit Committee and Quality & Safety Committee to self-assess and improve their effectiveness.

There are improvements in performance and risk management, but clinical audit is not yet contributing fully to the system of assurance

65. A Performance and Accountability Framework has been developed to better clarify and define accountabilities and responsibilities throughout the organisation, and ensure that performance is driven by those involved in providing services. Monthly executive led directorate and locality performance reviews are established, and my work in 2013 has seen a shift from performance monitoring to performance management. There is now a clear escalation process set out in the recently updated 'System of Assurance', identifying the actions to be taken when performance is below what is expected.

66. Risk management arrangements are continuing to be strengthened by the work of the Risk Management Group. Although directorates and localities are still of varying maturity, local risk registers now provide a stronger underpinning of the corporate risk register and work to integrate and triangulate performance and risk information has begun.

67. Last year I reported that there had been a renewed commitment to the national clinical audit programme and greater scrutiny of the clinical audit plan. However, I found little evidence that clinical audit activity was linked to strategic risks and objectives, or that it was balanced across the breadth of Health Board activities. This continues to be the case although a clear policy framework has been developed and there is an engaged central audit team. As such there remains scope for clinical audit to play a stronger role in supporting board assurance. The Health Board also needs to build greater clinical ownership of local clinical audit plans and further improve audit completion rates to contribute to clinical improvements.

Management information has been substantially refined but, at present, key gaps remain around primary care, community and patient experience

68. Management information and the way it is reported has benefitted from continued development this year. Board performance reports have been substantially refined and our survey found that Board Members feel that 'information in the changed format has given more clarity'. Using a mix of context, qualitative information and data, the new report format sets out:

- How are we doing?
- How do we compare with our peers?
- What are the main areas of risk?
- What actions are we taking to improve and when will they start to take effect?

69. Trend data is used and the performance report clearly identifies performance against targets for national measures. The use of local targets is less clear but the identification of lead managers responsible for actions is a comparative strength of the Health Board's report. Inclusion of wider comparative benchmarking, monitoring of programme performance, delivery by partner agencies, and the use of forecasting to predict future position (for demand, performance and financial risk) would however further strengthen Board reporting.

70. The balance of information remains more biased towards secondary care and information gaps remain on patient experience, primary care, community, and commissioned services. Work on developing primary and community scorecards is progressing, although there is still more to do to fully develop the information reported in these areas.

Although most data back-up controls are in place, changes to backup procedures are not always formally agreed and communicated, and the record of routine Disaster Recovery tests is incomplete. Additional controls in these areas need to be developed and implemented.

71. There is clarity about the range of IT systems in use with responsibility for data backups clearly set out. However, in common with other LHBs, the Health Board recognises that there are some electronic medical devices which are not currently captured as part of the IT systems list and backup arrangements.

72. Policies and procedures for data backup are in place at the Health Board and are built into the backup software and the standard operating procedures (SOP's) for each system. An appropriate backup regime is largely in place, however changes to the SOPs for each system are not currently formally signed off by the system owners, data owners or IT team.

73. The backup routines and processes are monitored reasonably well although currently, there is no complete list of Disaster Recovery tests run as part of routine system maintenance (ie, creation of test systems). Therefore it is not possible to confirm that Disaster Recovery tests are run regularly on all systems.

The Health Board is committed to developing a positive listening and learning culture but responding to complaints in a timely manner is problematic, and a systematic, co-ordinated approach is needed to embed organisational learning

The Health Board is committed to listening to patients and recognises the value of the patient voice in service planning, delivery and service improvement but has more to do to fully develop and embed its approach for systematic patient experience capture across the Health Board

74. My structured assessment work has found that the Health Board is committed to listening to patients and recognises the value of the patient voice in service planning, delivery and service improvement. Patient experience is one of the Health Board's strategic change programmes and comprises of a number projects to advance capture and understanding of patient experience.

75. There is a small but very committed patient experience unit (PEU) which provides an expert resource and driver for patient experience work in the Health Board. The unit provides wards and departments with a framework for undertaking patient experience surveys and supports the analysis and reporting of results for directorate action planning and monthly performance reviews.

76. In addition to bespoke surveys developed by PEU, the friends and family 'test' was introduced in the Princess of Wales Hospital in July 2013 ahead of wider roll-out, and the all-Wales framework is currently being implemented. Wi-Fi access is now available across all hospitals in the Health Board and provides the opportunity to develop internet and web-based surveys. The use of 'Patient Reported Outcome Measures' is being piloted in conjunction with Swansea University and the Health Board also intends to develop its brand 'You Tell Us' for engagement and feedback with patients and service users.

77. There are approximately 8,000 patient contacts per year, with a range of methods to seek patient views but this survey activity only spans a small percentage of patient episodes and is acute hospital focussed. Ownership of survey activity, action planning, implementing change and feeding back to staff and service users is still variable at ward and department level although there are pockets of good practice. The Health Board recognises that, despite the recent positive work, more needs to be done to fully develop and embed its approach for systematic patient experience capture across the Health Board.

78. A patient experience forum has been set up to provide scrutiny of the patient experience strategic change programme and development of a Patient Experience and Improvement Team. Progress has been slower than envisaged however, causing some frustration. Greater clarity is also needed on the relationship between the patient experience programme and the patient experience forum, the strategic approach to patient centric service design, sustainability and co-production, and the future role and responsibilities of the PEU team as a processing centre or lead for patient experience work. The appointment of a new Nursing Director with specific responsibility for patient

experience will provide leadership to address these issues and progress will need to be monitored.

There is an organisational framework in place for managing patient concerns, but significant issues remain, including the timeliness of responses to complaints. The Health Board is addressing the current backlog of complaints and improving the structures and arrangements which underpin concerns management, and recognises that this work needs to progress quickly.

79. The Department of Investigations & Redress (DIR) oversees the management of concerns, incidents and claims and leads on concerns and complaints classed as 'amber' or 'red'. Each directorate and locality has local governance structures which include a lead for managing concerns, and complaints categorised as 'yellow' or 'green' are managed at a local level. An Investigation & Redress sub-group receive reports from directorates and localities and in turn reports to the Quality and Safety Committee via a Quality and Safety Forum.

80. While these arrangements provide an organisational framework to support the investigation of concerns and progress implementation of the Putting Things Right (PTR) guidance, there are some significant issues to be addressed. Internal Audit has previously issued critical reports in respect of complaints and incidents management, and there is a recurrent backlog of complaints and issues with the timeliness of responses. The Health Board is taking actions to address the complaints backlog, with changes to DIR staff responsibilities and additional temporary resources in place to focus on complaints. Whilst expedient in dealing with the current backlog, this position is not sustainable. Expert review and advice has been sought on concerns management structures and arrangements.

81. DIR effectiveness is affected by increasing numbers and complexity of 'cases', the number of available case handlers and variability in directorate/locality 'ownership' of concerns management. Although some 250 managers have been trained in Root Cause Analysis, the availability of trained managers to undertake investigations is resulting in delays and variable quality of investigations. This increases the level of DIR 're-work' and adds to response delays.

82. Plans to reorganise the DIR under proposals to develop a Patient Experience and Improvement Team (PEIT) have been delayed to take account of the current DIR review. Detailed plans need to be urgently developed on completion of the DIR review and will need to clarify DIR and directorate/locality relationship, responsibility and capacity. Proposals to introduce clinical triage to support more responsive informal resolution are positive. But this model needs to be more fully considered against other support roles, such as patient advice and liaison, and the role of the patient experience team. The new Nursing Director will be critical in driving these improvements forward.

83. Formal PTR policies are in place, although staff awareness of the policies is variable. Staff did not identify that they had received training to deal with complaints and concerns and many rely on 'word of mouth' instruction from colleagues. The Health Board uses e-Datix for incident reporting which has been supported by a programme of training during roll-out. Staff are encouraged to report errors, near misses and incidents but find Datix entry to be time-consuming, the system not to be user-friendly, and are discouraged by a lack feedback on the actions taken on the incidents they have reported. My work on primary care prescribing (discussed later in this report) found little evidence of consistent and robust adverse drug reaction and medication incident reporting.

The Board is promoting an open culture to address staff concerns but better training is needed to raise awareness and improve staff confidence in the system

84. The Board is committed to building a culture of openness and willingness to listen, with visible executive leadership and patient safety walkabouts. My combined work on unscheduled care and chronic conditions management (discussed later in this report) found that senior managers were supportive and understood concerns and issues raised by staff. The NHS Survey however identified that 42 per cent of staff disagree that senior management will act on the results of the survey, demonstrating a lack of confidence in management. An action plan is in place to respond to the staff survey, but a shift in culture and increased confidence will take time.

85. My work found differences across hospital sites and management teams in staff confidence about raising concerns and that their concerns would be addressed. Weekly accountability sessions for ward based nursing staff at Princess of Wales Hospital have recently been used to build awareness and confidence, with a reported increase in informal concerns being raised.

86. However, the Health Board has not supported implementation of the all-Wales Raising Concerns (whistleblowing) policy with training, awareness raising or guidance for managers on what constitutes 'blowing the whistle'. Most issues are managed informally or addressed under other policies such as 'Dignity and Respect'. This makes it difficult for the Health Board to collate concerns, analyse trends or protect individuals under the law from discrimination.

The Health Board recognises it needs a more systematic approach to learning lessons, taking action and triangulating patient experience information

87. The Board demonstrates openness to learning lessons to improve quality, safety and patient experience, with patient stories regularly reported and active work to understand and improve the quality and safety of its services. However, board members responding to our survey do not feel fully informed of what patients think and not all Board Members are fully confident about the current learning culture in the organisation.

88. A key improvement area from my work last year was to improve the learning from complaints and incidents, and make better linkages with work to measure patient experience. At present however, there is little central thematic analysis of patient feedback, complaints and incidents or triangulation of these patient experience measures. This is a barrier to the Health Board in gaining a wider organisational perspective on patient experience and thematic learning, which is recognised and is being addressed by the Health Board.

89. There are examples of local learning but these are not systematic, and lessons are not routinely shared between wards and departments, despite numerous local action plans. This has contributed to some adverse behaviours being repeated and there is a need for current learning processes to be simplified and streamlined, with greater clarity on how actions are evaluated and lead to improvement.

90. Proposals to develop a Patient Experience and Improvement Team reflect the Health Board's intention to develop organisational learning, bringing together the Department of Investigation and Redress (DIR) and Patient Experience Team (PET), although these plans are not yet fully developed. Further, current DIR and PET capacity is hindering their ability to undertake thematic analysis, support organisational learning and develop ward to board reporting. The focus of learning also needs to extend beyond the acute hospital.

The Health Board is committed to strengthening quality and safety assurance arrangements, and recognises that some aspects of arrangements need further improvement

The Board is promoting an open, quality focused culture but it is not yet fully embedded throughout the organisation

91. Quality and safety is integral to board assurance and the Quality Assurance Framework affirms the primary importance of quality. The Health Board articulates and promotes an open culture, and has improved public accessibility of information. There is a clear balance of positive and negative issues discussed openly at Board, including investigations at the Princess of Wales Hospital and the review of cardiac surgery at Morriston Hospital.

92. The Board applies self-critical scrutiny of its performance against the Standards for Health Services in Wales and has assessed itself against NHS quality reviews. These include the Francis report on Mid-Staffordshire NHS Trust, and the joint report by Healthcare Inspectorate Wales and the Wales Audit Office '*An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board*'.

93. The Health Board has taken quality and safety concerns about care at the Princess of Wales hospital very seriously, setting up a focused Quality and Safety Programme and commissioning Advancing Quality Alliance (AQuA) to undertake an external quality and safety review at the hospital. The Health Board intends to roll out the AQuA 'deep dive' methodology across the Health Board once the review at the Princess of Wales hospital is completed. The additional independent review recently commissioned by the Minister for Health and Social Services has also been welcomed by the Health Board, to further help identify key areas of strength which can be built upon, and potential areas of risk where further action may be needed.

94. Development and use of quality triggers has continued since my work last year, with some progress in establishing a better early warning system of when quality of care may be at risk. This work is supported by investigative analysis of apparent anomalies, development of a barometer of care and significantly improving compliance with the systematic mortality review process.

95. Operational governance structures and arrangements are in place although there remains some variability in terms of the maturity of local arrangements and the strength of focus on quality governance locally. While the Health Board is actively promoting a quality focused culture, it is not yet consistently embedded across all directorates/localities. The Health Board has increased focus on quality as part of local monthly performance reviews this year, maintained regular directorate/locality presentations to the Quality & Safety Committee, and is investing in leadership development and quality improvement training. These actions should help support the embedding of quality assurance and a quality focused culture.

Quality oversight arrangements continue to be refined and are generally adequate to underpin quality governance

96. The Quality & Safety (Q&S) Committee is proactive, with good attendance and robust challenge and scrutiny by independent board members. The restructured meeting format should help improve agenda management although this remains a challenge at present. Greater discipline has been introduced to improve the quality of papers received. I also found evidence of performance information being used alongside other sources of assurance, such as patient safety walkabouts and observational visits, to confirm (or challenge) interpretation and understanding of information and performance.

97. The structure of groups reporting to the Q&S Committee has been refined and mapped, with most providing assurance to the Q&S Committee via an executive led Q&S Forum. There is evidence of positive on-going action by the Q&S Forum to ensure appropriate assurance is gained from the sub-committees, groups, and directorates/localities, but Q&S Committee members are not yet fully confident that reporting to the Q&S Committee reflects all relevant issues. As part of an overall review of governance arrangements being led by the Board Chairman, the Chair of the Q&S Committee is reviewing how this committee functions and the robustness of data and reporting mechanisms.

98. The Q&S Committee reports on its activities and brings significant matters to the Board's attention, but more systematic use of Assurance Statements would strengthen the chain of assurance to the Board. The Audit and Q&S Committee's roles for scrutiny of arrangements and scrutiny of quality and safety respectively, are also being reviewed to ensure clarity.

The Health Board has strengthened quality performance reporting and recognises further improvements are needed

99. The quality performance report has been re-designed, with a reasonable mix of qualitative and quantitative information, and insights into what has influenced quality performance. Reporting on quality triggers is generally good, data is timely and board members are generally confident in the quality of the data. There is reasonable use of trend analysis, but there is limited benchmarking and little disaggregation of data.

100. Scrutiny can be diluted by both volume and aggregation of data. In recognising this risk, consideration is being given to how the Committee can provide more in-depth scrutiny of key indicator performance within the large number of indicators monitored. In developing its approach, the Committee has opportunity to build on its recent experience of in-depth examination of performance on providing timely discharge information.

101. The Health Board is developing metrics for primary and community services as current reporting is largely focused on the acute services provided. The quality report template encourages identification of actions to improve performance, which is strength of the Health Board's approach. However there needs to be a greater focus on time-bound actions, the outcomes intended and whether improvement has been delivered as a result.

The Annual Quality Statement approved in September 2013 provided an open and candid report to the public. It provides depth and readability but there are some opportunities for improvement.

102. Overall I found the Annual Quality Statement (AQS) to be a well-articulated document that summarises the organisations quality arrangements and objectives. The Health Board is open and honest about its strengths and weaknesses, and clearly identifies where it has not performed well. Although long, it provides depth and readability with a good balance between context, text, and graphics. Easy to navigate, its style makes it more publicly accessible.

103. The Health Board has not explicitly identified its key risks to quality, although does identify that it has a process to do so. The AQS is written from a service provider perspective and there are some areas where the AQS could be improved. These include:

- clearer statement of the Board's quality assurance framework and its effectiveness;
- identifying dependencies and links with partners and the impact on quality; and
- better balance between reporting on the quality of services provided compared to primary care or other commissioned services.

The Health Board has made effective use of the National Fraud Initiative to detect fraud

104. The National Fraud Initiative (NFI) is a biennial data-matching exercise that helps detect fraud and overpayments. It matches data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. The Auditor General for Wales conducts data matching exercises in Wales under statutory powers contained in Part 3A of the Public Audit (Wales) Act 2004. The NFI is a highly effective tool in detecting and preventing fraud and overpayments, and helping organisations to strengthen their anti-fraud and corruption arrangements.

105. Participating bodies submitted data to the current NFI exercise in October 2012. The data was matched and the outcomes were released to participating bodies in January 2013.

106. The Health Board is engaged with NFI and making good progress. All reports classed as 'key' have been inspected and all 'recommended matches' have been checked, along with a number of other matches. No frauds have been identified but two errors have been found relating to clerical input errors, which have since been corrected.

My performance work has identified that while the Health Board has made some progress in improving its use of resources, the pace needs to be quicker in some areas and improvements in unscheduled care performance and timely access to services are needed

Partnership working and engagement continues to develop positively and good strategic estates planning maintained, but progress in improving some aspects of workforce planning and management has been slow

107. My Structured Assessment work has indicated that the Health Board has made progress in developing its approach to partnership working and estates management but despite some positive actions and developments, workforce challenges remain. This progress is summarised in Exhibit 2.

Exhibit 2

Issue	Progress made by the Health Board
Workforce	Despite some positive actions and developments, similar workforce challenges remain in 2013, including the need to address sickness, improve workforce and training plans and ensure managers are well-prepared to lead: • workforce planning is now being developed to underpin the Health Board's three-year plan; • whilst affected by delayed decisions on the South Wales Programme, workforce plans still need to be better integrated with financial and strategic change plans; • positively, a primary care workforce plan, including the GP Out-of-Hours service, is being developed; • core staffing principles set by the Chief Nursing Officer in 2012 have been recognised and investment made in nurse staffing ; • despite active recruitment there are continuing workforce gaps in some professions/ specialities (eg, emergency departments); • staff appraisal rates are much improved and the health board is now considering review of appraisal quality as the next step; • there is investment in leadership and improvement training but not all staff have completed statutory/ mandated training, and staff in some areas find it difficult to access non-statutory training; • the need to develop people management skills and better prepare operational managers for leading complex change remains, at a time when a reduction of central HR support is planned; and • the Health Board is responding proactively to the NHS Staff Survey results.
Partnership and engagement	The Health Board has built on the good partnership working and engagement we found in 2012, with developments on the Western Bay Programme showing significant commitment to and progress towards delivering joined up health and social care: • the Western Bay Programme is an example of the Health Board's commitment to working with partners to deliver joined up health and social care; • programme board and governance arrangements have been established; • the Health Board has built up a positive track record of good public engagement and is developing the 'You Tell Us' 'brand'; • there is a constructive working relationship with the Community Health Council; • discussion on how co-production can support future service design is beginning; and • the relationship between patient experience approaches and wider public engagement and service design has not yet been developed.

Issue	Progress made by the Health Board
Estates and assets	Estates strategy and planning is good and there is significant investment in capital development work, but risks remain around estates and equipment: • a good strategic knowledge of configuration and use of estates remains evident; • there is significant investment in a major capital development programme, particularly for the Morriston hospital site; and • strategic capital plans for the next five years have been developed and submitted to Welsh Government but there are risks around backlog maintenance and equipment replacement.

Based on a review of performance against a number of key indicators, performance for efficiency and quality are comparable with the rest of Wales, but staff sickness rates are high and improvement is needed in the timely access to some services

108. This year's Structured Assessment has included an analysis of centrally available performance data on key service targets. This data has been used to assess the extent to which the Health Board is delivering good-quality, economical and accessible services for patients.

109. My review of the data showed that the Health Board's performance across a number of efficiency measures is comparable to all-Wales averages and trends, but scope to improve exists, particularly in reducing staff sickness rates. Key findings include:

- Average lengths of stay, day surgery and out-patient DNA rates compare typically with all-Wales performance and trends, but opportunity exists to improve on this performance.
- Progress has been made in increasing the percentage of operations carried out on the same day of surgery. At 72.4 per cent, this rate is now better than average.
- ABMU's sickness rate has continued to increase and is the highest of all health boards in Wales.

110. Performance against a number of quality measures is also comparable to the Welsh average and in some instances better:

- Rates for MRSA & Clostridium Difficile have reduced and are below the Welsh average per 100,000 population.
- The risk adjusted mortality index, at 103, is just above the expected level of 100 and the second lowest in Wales.
- Performance on stroke bundles 1 and 2, whilst close to the all-Wales average, is variable and the 95 per cent target is not consistently met. Performance on bundles 3 and 4 however, is more consistent and amongst the best performance.

111. The Health Board's performance for timely and accessible services needs to improve, particularly in relation to cancer access and unscheduled care, where Welsh Government escalation levels 2 and 3 apply respectively. In summary:

- elective waiting times performance (RTT) is better than for other health boards in Wales, but performance has deteriorated and the number of patients waiting more than 26 weeks is increasing (Welsh Government escalation level 1);
- cancer access targets are not being met and are currently performance is below the Welsh average (Welsh Government escalation level 2); and
- unscheduled care performance has not improved and is generally the poorest in Wales (Welsh Government escalation level 3).

The Health Board has strengthened its strategic approach to attendance management but sickness absence is high and further improvements are needed to reduce absence rates, ensure a greater focus on attendance and wellness, and increase operational confidence in data

112. Sickness levels remain high and are the highest of all health boards. The Health Board's sickness rate has increased at a higher rate than the Welsh average over the past two years and the 'gap' appears to be increasing.

113. The Health Board takes absence and wellbeing seriously and has strengthened its strategic approach in line with good practice principles; but a more consistent approach to sickness absence policy implementation is needed to address current levels of sickness.

114. Service managers feel supported to manage absence by HR and there have been some very positive developments in Health and Well-being services, but there are issues with the timeliness of occupational health intervention. In addition, there is inconsistent application of wider attendance related policies by management (eg, redeployment), which is resulting in a focus on sickness rather than wellness.

115. There are good structures for monitoring absence although there needs to be improved operational confidence in the sickness data and consideration of wider health, wellbeing and attendance reporting.

The Health Board is reshaping community services but resource and capacity planning and stakeholder engagement are not yet effective enough to support reduced demand on acute services and sustainable improvements in unscheduled care performance

116. During the year, my team concluded my combined work on unscheduled care and chronic conditions management which was undertaken in 2012 as part of my mandatory reviews. My work found that at the time the Health Board had taken positive steps to increase provision in the community but not enough demand had been taken away from pressurised acute services. Specifically I found that:

- emergency departments remained under significant pressure and there were issues with performance and patient flow;
- the rate of emergency admissions for a range of chronic conditions had reduced but progress on reducing multiple admission rates, lengths of stay and delayed transfers of care had been mixed;
- there had been positive progress in extending the range of community services and developing out-of-hours primary care but more needed to be done to reduce reliance on acute services; and
- public awareness initiatives had had no apparent impact on demand for unscheduled services, progress on developing a single point of access had been slow and more people could benefit from patient education programmes.

117. The Health Board was developing its strategic approach for transforming unscheduled care and chronic conditions services, underpinned by 'Setting the Direction'. Significant effort had been invested in setting up a good infrastructure for overseeing the implementation of 'Setting the Direction', but local implementation plans needed to be more detailed and joined-up. There were also opportunities to strengthen the arrangements for driving unscheduled care improvements and bringing about better alignment with related actions targeted at chronic conditions management. I also found scope to improve performance management by developing a greater focus on measures of quality and whole system performance.

118. Clinical leaders were in place and engagement with staff and GPs was very positive. Maintaining engagement, improving staff morale and ensuring that quality and safety are not compromised were priority considerations for the Health Board, given the continued high levels of emergency demand and resultant service pressures. There were particular challenges for emergency department staff given the high levels of demand coupled with staffing and capacity pressures. Staff support measures were in place and staff reported that executive officers were supportive and understood concerns and issues raised by staff. However, better capacity and resource planning was needed to address a number of key risks around the unscheduled care and chronic conditions workforce, particularly in respect of emergency department staffing.

119. In general staff were motivated and determined to work with colleagues to drive through the transformational changes required. The Health Board's strategy has been to engage clinicians in decisions about the difficult funding and service redesign issues that it is facing. However, until the outcome of the South Wales Plan is known and the future regional network of hospital services decided, the Health Board cannot be fully clear about its vision and workforce plans.

120. Much of the organisation's focus thus far had been on improving its own emergency departments, rather than broader, partnership work. This approach was understandable due to the poor historic performance of these departments in relation to waiting times. However, the Health Board's commitment to partnership working was evident, with for example, local authority funding of community resource teams in Swansea, and joint equipment stores funded through pooled budgets. There had also been some positive working with the Welsh Ambulance Service Trust (WAST) in relation to developing pathways and joint working with the emergency departments during periods of high demand. However, greater strategic engagement with WAST on issues such as escalation and ambulance diverts was needed.

121. Since my fieldwork, the Health Board has continued to take action to build community service capacity and improve unscheduled care systems and performance. The Health Board reports progress having been made in a number of areas in 2012-13, but recognises that this has not led to sustainable improvement and achievement of the unscheduled care standards. A detailed unscheduled care improvement programme is in place for 2013-14, recognising Ministerial and Welsh Government expectations for a whole system response, and cross-referencing actions to the national Unscheduled Care Programme work streams established in 2013.

The Health Board has set a clear short-term agenda for primary care prescribing and has well-managed arrangements for prescribing support. However, a longer-term strategic plan for these services is needed in order to secure the opportunities that exist to improve the safety, quality and economy of prescribing.

122. My work on primary care prescribing has identified that the Integrated Prescribing and Medicines Management (IPMM) Directorate has a well-developed and integrated annual plan which informs and focuses action on delivering a savings plan for the year. The plan aligns to strategic priorities, such as supporting the frail elderly, and is linked to the health needs of the patient population, for example the management of COPD and cardiovascular disease. Implementing national prescribing guidance and targeting the use of a range of drugs is also a key part of planning. While wider service reconfiguration has previously constrained the potential to develop a longer-term strategic plan, the Directorate recognises that this will be necessary going forward, to help sustain rational prescribing improvements.

123. The Health Board has comprehensive, robust and timely data on the use of drugs which is used effectively to target interventions, improve rational prescribing and support the prioritisation and delivery of operational plans. While the draft Integrated Medicines Management Plan (IMMP) for 2013-14 has seven work streams, each with identifiable actions, many do not have not measurable targets with key milestones, preventing success measures from being effectively monitored.

124. Primary care medicines management roles and accountabilities are clear and primary care prescribing support is well-managed. The overall level of primary care prescribing support within the Health Board is just above the Welsh average, although there is some variation across the three localities. There are a number of routine meetings and on-going training opportunities for GPs and their staff, but unlike some other organisations, the Health Board does not yet have a medicines management website, accessible to the wider community of prescribers and to the public.

125. The Health Board has a single local formulary which has recently been updated in conjunction with the introduction of a new software interface for the intranet formulary. Formulary compliance monitoring is recognised as challenging, and while there are pockets of effective practice, this is an area that needs to be further strengthened. Clinical effectiveness pharmacists have worked with clinicians from secondary and primary care to develop a suite of shared care protocols which are accessible on the Health Board's GP portal. The Health Board has reported that the quality of discharge summaries has been improving although GPs told us that the quality of medical discharge information is sometimes poor.

126. Health Board expenditure is above average in some of the areas defined by the British National Formulary, but appears to be maintaining reasonable costs, relative to other health boards. However, the prescribing level on drugs related to nutrition and blood is the highest in Wales. While this level of prescribing may be justifiable, the reasons behind this expenditure need to be understood.

127. We have estimated that with further improvement to prescribing performance there is potential to secure up to £1.6 million of savings without affecting patient care. The Directorate will need to assess the extent to which this can be achieved, drawing on local experience and circumstances, and prioritising its work accordingly.

128. Importantly, there is little evidence of consistent and robust adverse drug reaction (ADR) and medication incident reporting. The Health Board's ADR reporting declined between 2010-11 and 2011-12, reflecting the on-going downward trend across Wales. This local situation is despite periodic staff training, the recent appointment of Yellow Card Champions[2], and the activity of a medication safety group. As part of its strategic approach to improving primary care prescribing the Health Board will need to improve ADR reporting, and should consider what resources need to be devoted to improving the current situation.

[2] The Yellow Card Scheme is run by the Medicines and Healthcare products Regulatory Agency (MHRA) and the Commission on Human Medicines (CHM), and is used to collect information from both healthcare professionals and the general public on suspected side effects or adverse drug reactions (ADRs) to a medicine.

Appendix 1

Reports issued since my last Annual Audit Report

Report	Date
Outline of Audit Work 2013	March 2013
Financial audit reports	
Audit of Financial Statements Report	June 2013
Opinion on the Financial Statements	June 2013
Opinion on the Whole of Government Accounts return	July 2013
Opinion on the Summary Financial Statements	September 2013
Audit of the Charitable Funds Financial Statements Report	September 2013
Opinion on the Charitable Funds Financial Statements	October 2013
Financial Statements Memorandum	December 2013 to management
Performance audit reports	
Financial Management – Structured assessment	September 2013
Sickness management	September 2013
Chronic conditions/unscheduled care follow-up	October 2013
Data backup recovery	October 2013
Primary care prescribing (2012)	December 2013
2013 Structured Assessment	January 2014

There are also a number of performance audits that are still underway at the Health Board. These are shown below, with estimated dates for completion of the work.

Report	Estimated completion date
2013 Structured Assessment: Board Development session	February 2014
Specialty review focus: orthopaedics (2012)	March 2014
Clinical coding (2013)	April 2014
Community nursing (2013)	July 2014
Catering follow-up (2013)	March 2014
Ward staffing: follow-up benchmarking (2013)	Substituted in November 2013 for technologies for survey work (Sense maker pilot)

Appendix 2

Audit fee

The Outline of Audit Work for 2013 set out the proposed audit fee of £434,863 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in accordance with the fee set out in the outline.

Included within the fee set out above is the audit work undertaken in respect of the shared services provided to the Health Board by the Shared Services Partnership.

Appendix 3

Financial accounts work: audit priorities

My Outline of Audit Work 2013 set out the key issues and priorities for the audit of the 2012-13 financial statements. The table below lists these priorities and sets out how they were addressed.

Financial audit priorities	Work done and outcome
The **timetable** for producing and certifying the **annual accounts** remains demanding. The Health Board will need to put in place appropriate arrangements to prepare the accounts and ensure adequate working papers are provided for audit on a timely basis.	We reviewed, discussed and agreed the detailed closedown timetable for the financial statements and the audit process with management. The final audited financial statements were completed within the required deadlines.
The **annual accounts** are compiled under **International Financial Reporting Standards (IFRS) and NHS Manual for Accounts**. The Health Board must have a full understanding of these **requirements**, keeping up to date with changes and ensuring that risks and issues are identified and dealt with appropriately.	We reviewed the draft financial statements to ensure they complied with IFRS and the NHS Manual for Accounts. We also reviewed the Annual Governance Statement to consider its consistency with Manual for Accounts requirements and with other information known to us from our audit work. We reported our audit findings to the Audit Committee on 3 June 2013, and confirmed compliance in the unqualified audit opinion.
Last year we reported to management some minor areas where systems could be improved, including Hutton pay disclosures and asset lives on the fixed asset register. Alongside this, the **District Valuer** has revalued the Health Board's estate at 31 March 2013.	We discussed these areas early on with management and specifically reviewed these areas as part of our audit approach to ensure they were accounted for and disclosed in the financial statements.
On 1 June 2012, some support services **transferred** from the Health Board to the NHS Wales **Shared Services Partnership** (NWSSP). The Health Board must properly account for the transfer in its annual accounts.	We reviewed the transfer forms summarising the resources transferred to the NWSSP and confirmed the transfer had been accounted for appropriately.
The Health Board has a duty to ensure that robust **accounting records** and **internal controls** are in place to ensure the regularity and lawfulness of transactions.	We reviewed the internal controls and an unqualified regularity opinion was provided on the financial statements.

Financial audit priorities	Work done and outcome
The **financial duty** of the Health Board is to contain annual expenditure within a predetermined resource limit. The statutory target will be in place for both revenue and capital. The Health Board must ensure good financial management in the period to meet its own financial targets for 2012-13. Currently the Health Board is forecasting that it will meet its statutory targets at 31 March 2013.	The Health Board met all of its financial targets for 2012-13 and the Auditor General for Wales provided an unqualified audit opinion on the financial statements.
Strong financial governance arrangements are required for the Health Board to ensure procedures and arrangements are in place to manage its finances in accordance with the guidance in the Welsh Government's e-governance manual.	We did not identify any instances on non-compliance from our audit work.

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