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Annual Audit Report

Hywel Dda Local health Board

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Summary

1. An interim Annual Letter was issued to the Hywel Dda Local Health Board (Health Board) in May 2010. That report related to my audit work in the final six month period to 30 September 2009 of the Health Board's predecessor bodies.
2. This report summarises the findings from audit work I have undertaken at the Health Board during the latter part of 2009 and throughout 2010. This allows me to discharge my responsibilities under the Public Audit (Wales) Act 2004 in respect of the audit of 2009-10 accounts and the Board's arrangements to secure efficiency, effectiveness and economy in its use of resources.
3. I have adopted a risk-based approach to planning the audit. My audit work has focused on the significant financial and operational risks facing the Health Board 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.
4. The Health Board has had a challenging first year. Bringing together a complex NHS Trust (which had only recently merged) with three former Local Health Boards is a significant task. The new Health Board employs some 9,000 staff and services are spread across a range of sites across a wide geographical area. The Health Board has responded well to these challenges. It is well managed and has established an interim corporate strategy and developed new structures. There is a commitment to ensuring safe and cost effective services but the Health Board recognises further work is required. The key messages from my audit work are summarised under the following headings.

Audit of accounts

I have issued an unqualified opinion on the financial statements of Hywel Dda Local Health Board, although in doing so I have brought several issues to the attention of officers and the Audit Committee Financial Management

- The Health Board's financial statements were properly prepared and materially accurate.
- The Health Board had an effective internal control environment to reduce the risks of material misstatements to the Financial Statements. However, the Health Board needs to further improve its arrangements for budgetary control and fixed assets.
- The Health Board achieved financial balance at the end of 2009-10 but only as a result of additional non-recurring funding from the Assembly Government.

Financial Management

The Health Board is developing robust budgetary control and financial planning arrangements although the organisation faces significant financial challenges.

- Financial Planning arrangements are in place although going forward they need to be more inclusive and longer term.
- Monitoring of performance against budgets is improving but arrangements need to ensure sufficient delegation.
- The Health Board achieved its statutory financial targets in 2009-10 but only after significant year-end assistance from the Welsh Assembly Government. There is an underlying shortfall and a £32 million deficit is predicted for 2010-11 if planned savings of £27 million, currently significantly behind target, are achieved.

Governance and accountability

Whilst governance arrangements are broadly sound, further work is needed to strengthen arrangements in some important areas such as risk management and information governance.

- The Health Board has a clear strategic direction and is progressing along an agreed process which will develop a new clinical and service model. Success will be dependent upon a range of factors such as effective engagement and accountability, staff redeployment and sufficient resources to create new estate solutions.
- The Health Board has developed a matrix organisational structure but that has yet to become fully established and operational.
- The Board of the Health Board is effective and has established a robust governance framework for the organisation.
- The Health Board has recently developed a framework for managing risk but these arrangements are not yet embedded and there is still some way to go before they provide the necessary assurance.
- Internal control mechanisms are broadly sound although clinical audit services have recognised resource constraints.
- The Health Board has generally sound arrangements for IM&T but restricted resources could slow progress. The Health Board has weak information governance arrangements which pose a significant risk.
- The performance management framework is robust and holistic and whilst the performance information is improving, the absence of comprehensive data assurance mechanisms pose a risk.
- The Health Board has established appropriate arrangements to promote and ensure probity and propriety in the conduct of its business.

Management of resources

Although there has been significant progress, further work is required to strengthen important ‘enablers’ that can assist in more effective, efficient and economical use of resources

- The Health Board’s approach to workforce planning is still evolving and needs to be further developed to ensure that it supports delivery of the Health Board’s strategic objectives.
- The Health Board has a developed a sound approach to managing its asset base.
- Procurement arrangements are developing well although the Health Board recognises further improvements are required.
- The establishment of partnership working arrangements is progressing, but the Health Board still faces significant challenges to achieve the intended service transformations across health and social care.
- The Health Board is developing a more strategic approach to engagement with service users to improve on its previous ad hoc activities.

Specific performance audit reviews

- The performance audit work has highlighted positive examples of service delivery but also opportunities to reduce variation in a number of service areas, and improve the safety and efficiency of medicines management.

Agreeing my findings with the Executive Team

5. This report has been agreed with the Chief Executive and the Director of Finance. It was presented to the Audit Committee on 21 December 2010. It will then be presented to a subsequent Board meeting and a copy provided to every member of the Health Board.
6. The assistance and co-operation of the Health Board’s staff and independent members during the audit is gratefully acknowledged and we look forward to working with the Health Board in the future.

About this report

7. This report sets out the key findings from audit work undertaken between October 2009 and November 2010. My work at the Health Board is undertaken in response to the requirements set out in the Public Audit (Wales) Act 2004. The Act requires me to:
   a) examine and certify the accounts submitted to me by the Health Board;
   b) satisfy myself that the expenditure to which the accounts relate has been incurred lawfully and is 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.
8. 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 structured assessment of the Health Board examining the arrangements for financial management, governance and accountability, and management of resources;
   - 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.
9. I have issued a number of audit reports to the Health Board this year. The messages contained in this report represent a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.
10. The detailed report arising from my structured assessment work is still being finalised, although the messages from that work which are reported here have been agreed with Executive Directors.
11. The findings from my work are considered under the following headings:
   - Audit of accounts;
   - Financial Management;
   - Governance and accountability;
   - Managing resources; and
   - Specific performance audit reviews.
12. The Audit Strategy for 2009-10 set out the proposed audit fee of £463,512 (plus VAT). My latest estimate of the actual fee for 2009-10, on the basis that some work remains in progress, is that it is in line with the proposed fee.

Section 1: Audit of accounts

13. This section of the report summarises the findings from my audit of the Health Board's financial statements for 2009-10. These statements are the means by which the Health Board demonstrates its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Examination of an organisation's financial statements is an essential element in demonstrating appropriate stewardship of public money.
14. In examining the Health Board's financial statements, auditors are 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 – caused by fraud or other irregularity or 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.
15. In giving this opinion, auditors are required to comply with International Standards of Auditing (ISAs). 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.

I have issued an unqualified opinion on the financial statements of Hywel Dda Local Health Board, although in doing so I have brought several issues to the attention of officers and the Audit Committee

The Health Board's financial statements were properly prepared and materially accurate

16. We received the draft financial statements for the year-ended 31 March 2010 by the deadline of 14 May 2010 which was a considerable achievement. The Finance department have faced a significant challenge in the first year of the Health Board bringing together financial systems and establishing financial planning, budgetary control and reporting arrangements.

17. I am required by International Auditing Standard 260 (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 Partner reported these issues to the Audit Committee in June 2010. Exhibit 1 summarises the key issues set out in that report.

Exhibit 1: Issues identified in the ISA 260 Report

Issue	Auditor's comments
There were £333,000 of uncorrected misstatements.	The Audit Committee agreed with officers that the draft statements should not be amended for these items.
A number of corrections were made to the financial statements	The draft Accounts were amended. The net impact of these amendments was to increase expenditure by £1.4 million. The Health Board was able to agree a £1.34 million increase to its Revenue Resource Limit (RRL) with the Assembly Government. The Health Board was therefore able to stay within the adjusted RRL.
Arrangements to estimate year-end accruals need to be improved	The Health Board is required to make a number of year-end expenditure accrual estimates. These arrangements need to be improved for 2010-11, particularly for Quality Outcome Framework (QOF) expenditure and Dental expenditure. For both of these items, it is likely that expenditure and the year-end accruals are overstated but due to a lack of information we cannot quantify the overstatement. We are, however, satisfied that the amounts involved are not material

18. In December 2010 we issued an unqualified opinion on the Health Board's Charitable Funds' financial statements. We did however identify the Health Board could improve its accounts closure and audit processes and improve governance arrangements particularly around donations and investments.

The Health Board had an effective internal control environment to reduce the risks of material misstatements to the Financial Statements. However the Health Board needs to further improve its arrangements for budgetary control and fixed assets

19. Budgetary Control arrangements inherited from the former organisations have been redesigned and improved upon but need further strengthening during 2010-11:

- budget setting needs to be more long term and better linked to business activity and strategic objectives;
- the Health Board has moved from a directorate structure to a County structure in 2010-11. Further work is required to agree budgetary control delegation arrangements;
- virement controls were weak and need strengthening; and

- the Health Board needs to do more to ensure cost improvement programmes are achievable and that they deliver the required savings.

20. The Health Board owns fixed assets with a Gross Book Value of £288 million. Whilst we have not identified any material errors in our audit of fixed assets, we have identified the following areas where internal controls need to be strengthened:
    - Asset Verification – Internal Audit work in 2009-10 identified some assets included in the Health Board's Fixed Asset Register which could not be located. We recommended that a full asset verification exercise is undertaken.
    - Fixed Asset Register – in 2009-10, the Fixed Asset Register was only updated at the end of September for the six-month accounts and again at the year-end. The Fixed Asset Register should be updated on a monthly basis.
    - Capitalised Salaries/Recharges – in 2009-10, £983,000 of salaries and other recharges for estates and maintenance were capitalised as part of assets under construction additions. The Health Board needs to have a more robust process to demonstrate whether these costs meet the definition of capital expenditure.
21. We have also reviewed the work undertaken by Internal Audit, the Capital Audit Consortium and Counter Fraud. We have no significant concerns - our detailed findings are set out later in this report.

The Health Board achieved financial balance at the end of 2009-10 but only as a result of additional non-recurring funding from the Assembly Government

22. The Health Board achieved financial balance at the end of 2009-10 following additional non-recurrent funding from the Assembly Government. However, the underlying financial position remains a concern with large overspends continuing on some budgets.
23. For 2010-11, the Health Board is predicting a £32 million funding shortfall which has reduced from £72 million at the beginning of the year. Achieving the £32 million deficit is dependent on a £27 million cost savings scheme.

Section 2: Financial Management

24. In the current economic climate, high standards of financial management are more important than ever. This section of the report summarises auditors' findings on the Health Board's financial management arrangements, and considers:
    - financial planning arrangements;
    - cost control and budget monitoring arrangements; and
    - the progress being made with cost savings programmes, and the ability of the Health Board to keep spending within its resource limit.

The Health Board is developing robust budgetary control and financial planning arrangements although the organisation faces significant financial challenges

Financial Planning arrangements are in place although going forward they need to be more inclusive and longer term

25. The Finance Department has achieved a lot in the first year of the Health Board. Bringing together four financial plans and four financial ledgers from predecessor bodies has been a challenge. This is against the background of new corporate and county structures.
26. Given the Health Board is a new organisation, budget setting to date has been centralised and incremental. Going forward, resources will need to be closer aligned to strategic priorities rather than historical financial patterns. There is a need to make better links between budgets and business activity. Whilst zero based budgeting may be too time consuming each year, the Health Board should consider undertaking a rolling programme of zero based budgeting.
27. To date budgets have been set by Corporate Directors. We recognise the Health Board is a new organisation and a number of key staff have only recently been appointed but going forward it will be necessary to engage more fully with relevant staff to ensure appropriate 'buy-in' to the budgets and to ensure that budgets are set at realistic levels.
28. We have seen a range of recent initiatives to improve financial planning. The Finance team are supporting the counties and other departments with responsibility for budget monitoring, financial planning, benchmarking and the costing of patient activity.
29. A key issue for the Health Board is longer term financial planning. There has traditionally been uncertainty about NHS Wales finances and this has not helped longer term planning. As set out later in this report, the Health Board is establishing a new service model and financial planning will be a key part of the redesign strategy.

Monitoring of performance against budgets is improving but arrangements need to ensure sufficient delegation

30. As set out in the previous section, budget setting and monitoring has been centralised given the maturity and financial risks of the new organisation. The Health Board is looking to decentralise budget monitoring and delegation arrangements within the counties and departments.
31. The quality of budget monitoring reports to budget holders is good with a range of information being provided and further support offered through monthly reviews and further ad hoc support. A finance team supports each directorate to provide financial support to budget holders. These arrangements are new and are starting to become embedded.
32. Finance reports are provided to the Board on a bi-monthly basis with reports to the Integrated Governance Committee on a monthly basis and to the Audit Committee on a quarterly basis.

The Health Board achieved its statutory financial targets in 2009-10 but only after significant year-end assistance from the Assembly Government. There is an underlying shortfall and a £32 million deficit is predicted for 2010-11 if planned savings of £27 million, currently significantly behind target, are achieved

33. As set out previously, the Health Board met its statutory financial targets in 2009-10 but only after the receipt of some £25 million of additional funding from the Assembly Government.
34. There remains an underlying deficit that need to be addressed. The Health Board is well aware of this financial position and for 2010-11 has predicted a year-end deficit of £32 million. This forecast is, however, based on delivering£27 million of planned savings during the year. Currently only just over half of the required savings have been delivered. There is evidence that some efficiency savings have been set without full involvement of budget holders which presents a risk to the Health Board.
35. The Health Board recognises these weaknesses and has developed a number of initiatives for greater staff involvement in the development and knowledge of the savings plan, including holding a number of workshops.

36. In terms of monitoring the savings plans, appropriate arrangements are in place including:
    - savings delivered by work streams each with an identified Delivery Lead and Executive Lead;
    - a Corporate Directors Group with overall responsibility for the savings plan and a Sustainability Team which both meet weekly to provide detailed monitoring of the savings plan;
    - weekly reporting into the Corporate Directors Group of performance against key financial measures;
    - monthly reports to the Integrated Governance Committee and the Board;
    - establishment of a Sustainability & Performance sub committee to review progress; and
    - designated 'Programme Governance Arrangements' document clarifying roles and responsibilities.

Section 3: Governance and accountability

37. High standards of governance and accountability are fundamental requirements in demonstrating effective stewardship of public money and the efficient, effective and economical use of resources. Boards of NHS bodies need to ensure that they have an effective ‘assurance framework’ in place to support decision making and to scrutinise performance. This section of the report summarises my views of the Health Board’s arrangements in the following areas:
    - setting a clear strategic vision;
    - having an organisational structure that effectively supports the delivery of strategic objectives;
    - the effectiveness of the board and associated schemes of delegation;
    - the identification and management of risk;
    - the overall internal control environment;
    - information governance arrangements; and
    - monitoring and reviewing performance.

Whilst governance arrangements are broadly sound, further work is needed to strengthen arrangements in some important areas such as risk management and information governance

The Health Board has a clear strategic direction and is progressing along an agreed process which will develop a new clinical and service model. Success will be dependent upon a range of factors such as effective engagement and accountability, staff redeployment and sufficient resources to create new estate solutions

38. In August 2010, the Health Board published its five year plan structured around principles, vision, aims and objectives and includes a series of pledges to the population of Hywel Dda. It sets out the challenges and health needs faced by the community, the case for change and a vision for how health care should be provided in the future based around promoting health, independence, interdependence and self care and with services being personalised, equitable, realistic, sustainable, affordable and free at the point of need. The draft Plan was issued to a wide range of stakeholders and received a high degree of support.
39. The plan emphasises a shift from acute to community care and towards prevention and self-care as well as the need to do more with less resources and simplifying access to services. The plan also features stakeholder communications and engagement as a prominent theme. It explains the process of engaging and involving clinicians through workshops to develop the strategy and in developing stronger partnerships.

40. The Health Board's current objectives and priorities are set out in the Annual Operating Framework (AOF) and supporting Financial Plans. The Health Board's original intention was to translate the 5 year Plan into a more detailed operational and financial strategy but after further consideration decided to apply a forward-looking 'route map'. This comprises four stages aimed at developing a clinical services strategy and model by mid- 2011. The stages of this route map will be informed both by external service and financial imperatives and internally through a range of other strategies including clinical and stakeholder consultation.

41. The process of developing the route map commenced with a series of workshops involving a range of stakeholders to help inform the direction of travel. Seven clinical 'Think Tanks' have been established to engage with clinicians. For the clinical areas chosen, clinicians will be presented with all the key demand factors and constraints such as finances and skills shortages facing their service. Clinicians will be asked to examine their current service and to consider what a future service could look like. In doing so, it is hoped to identify a service that delivers quality, safety, and value for money and thereby establish a blueprint for change that has the support of all. The Health Board will need to consider what course of action to take if this approach does not achieve workable outcomes.

42. The county and locality based structures of the Health Board are intended to comprise the building blocks for the planning and delivery of a new model of community services. The structure has been designed to ensure continuity of working with partners to deliver and develop the Health Social Care and Well Being Strategies particularly by strengthening partnership working. There is emerging evidence of good joint working and the beginnings of a strategic approach to integrate health services better with social care. The HB Health Board has appointed a Director of Strategic Partnerships to support an ambitious agenda of better integrated working to achieve a set of intended outcomes.

43. To run in parallel with the development of a clinical and service model, the Health Board is exploring estate design solutions to produce an outline plan for 3 to 5 years that will set out the criteria and priorities for capital bids. As part of this process, the Health Board will need to consider the most appropriate methods of consulting upon and communicating its detailed plans and be prepared to implement alternative options if not all the necessary support is obtained.

The Health Board has developed a matrix organisational structure but it has yet to become fully established and operational

44. The Health Board has some 9,000 staff and it operates over a large number of locations, spread across a wide geographical area. Developing a new organisational structure will therefore always be inherently difficult.
45. The Health Board has adopted a matrix structure comprising a three county model underpinned by localities and overlaid by nine clinical programmes supported by a corporate structure. As mentioned previously, the county and locality based structure are intended to comprise the building blocks for the planning and delivery of a new service model. The Health Board has made good progress implementing the structure although it has taken some time and significant resources to populate the structure. There is emerging evidence that the matrix structure is working well in some areas and there is good integration across acute, mental health and community and primary care services.
46. Going forward there is a need to guard against the counties and supporting programmes reverting to a 'silo mentality' rather than working corporately to achieve Health Board wide objectives.
47. At lower levels there is a lack of clarity about roles and responsibilities. Some frontline staff are still unclear as to how the structure operates but it is still early days and the Health Board is doing all it can formalise roles and communicate these to staff.
48. At this point it is unclear whether the county structure has sufficient capacity and capability to deliver their objectives. The Health Board needs to keep this issue under review and consider whether it has the right balance between the corporate centre and the counties.

The Board of the Health Board is effective and has established a robust governance framework for the organisation

49. The Health Board has an effective Board in terms of team working, capacity and competency. The Board works well at a strategic level drawing on the range of skills of executives and independent members.
50. The Board has set out the governance framework and a scheme of delegation for the organisation which provides a suitable balance between finance, safety and governance. The Board is supported by a number of committees and sub-committees with clearly defined roles and responsibilities. The key committees supporting the Board are:
    - the Audit Committee - responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management;
    - the Integrated Governance Committee - to provide assurance to the Board on the Health Board's healthcare services and financial management; and
    - the Quality & Safety Committee – meets the Health Board's responsibilities with regard to the quality and safety of healthcare.

51. These supporting Committees are increasingly focusing on the right issues and provide the right fora for mature, open and robust dialogue and decision making.

The Health Board has recently developed a framework for managing risk but these arrangements are not yet embedded and there is still some way to go before they provide the necessary assurance

52. The Health Board has recognised weaknesses in its risk management arrangements and over recent months has revised its risk management framework.

53. The Board approved a risk management strategy and policy. As a statement of intent, the policy appears sound and identifies objectives, principles and responsibilities. More recently, the Health Board developed a risk management procedure which is based on best practice principles and is easy to read and practical. The Health Board sees the procedure as the starting point for improving risk management.

54. The Health Board has developed an executive and operating management structure which reflects the different areas of accountability where risk resides. The responsibility for overseeing risk management in these areas rests with a number of Health Board committees.

55. The Health Board has established a Risk / Assurance Team within the corporate directorate, with responsibility for co-ordinating the Health Board's corporate risk and assurance framework including management of the corporate risk register. The risk team will work closely with the separate Quality and Safety Team, who have Q&S risk managers embedded in the counties to ensure that clinical risk is identified and managed appropriately.

56. There is a three-tiered bottom up approach to identification of risks and the risk register, from team level, up to department level, then to county level.

57. However, although the foundations for developing the risk management arrangements have now been put in place the processes are relatively new and there is still some way to go to embed these arrangements to ensure that the risks are identified, acted upon and managed appropriately.

58. Although the profile has been raised with risk management now featuring on the agenda of key meetings, the process for identifying and categorising risks in risk registers is not yet sufficiently refined. The Health Board recognises that identification of risk within the risk registers at corporate, department and county level have not yet matured and the required programme of education to change culture and practice, which has recently commenced, will be challenging to achieve. The paragraphs below provide a number of examples.

59. The corporate risk register is received by every Integrated Governance Committee and biannually to the Audit Committee. Currently this long list of risks does not adequately reflect the top corporate risks for the Health Board.

60. The counties have been tasked with producing a county risk register but have made limited progress. Where they have been developed, for example in Ceredigion, the top four risks identified do not actually appear to reflect the biggest risks facing that county.

61. In addition, from a review of the corporate, divisional and county risk registers we are concerned that the approach may result in confusion about who has responsibility for identifying and managing risks.

62. Whilst we have a number of concerns about the risk management arrangements, we believe there are examples of systems being put in place to learn lessons from events that have arisen. These include organisational learning events that are being set up in all counties aimed at learning lessons. In each county they will involve lead doctor, claims manager, risk, clinical audit, quality improvement manager, complaints manager, head of nursing, lead pharmacist and therapist.

63. Further, the approach to monitoring and auditing mortality is seen to be a significant improvement not only within the Health Board but also by the Assembly Government. The Health Board has stated that there have been a number of benefits from the approach notably reducing their RAMI (Risk Adjusted Mortality Index) but also improved clinical engagement, coding and case note documentation.

Internal control mechanisms are broadly sound although clinical audit services have recognised resource constraints

64. Standing Orders and Financial Instructions have been adopted by the Health Board and these have been made available to staff.

65. The Health Board has effective Internal Audit and Capital and PFI Audit Services. These services meet their professional standards but going forward they should focus more on the more significant corporate risks and priorities to support improvement.

66. For internal control, the two key committees are the Integrated Governance Committee and the Audit Committee. These committees are developing and providing an effective fora for open and transparent decision making.

67. The Health Board has reviewed its clinical audit service due to capacity constraints and increasing demand. Although the capacity constraints are largely driven by maternity leave, there is an unsustainable growth in demand for clinical audits. As a result, the Health Board, in partnership with the clinical audit service, has prioritised the audit programme to meet higher priority areas.

68. The Statement of Internal Control (SIC) is prepared annually in line with Assembly Government's requirements and it fairly reflected the internal control framework and the operation of the control environment throughout the year. The Health Board could use the SIC more as an assurance tool.

The Health Board has generally sound arrangements for IM&T but restricted resources could slow progress. The Health Board has weak information governance arrangements which pose a significant risk

69. The Informatics Strategy reflects the Health Board 's five year plan and the NHS Wales Informatics Service programme for Information Management and Technology (IM&T). Going forward, the Strategy is well founded and has the support of the Health Board's IT and medical staff.
70. The leadership and accountability arrangements for the technical elements of IM&T are well defined and operational. The IM&T Management team supports the Informatics Steering Group which is attended by knowledgeable and experienced staff from across the Health Board. Risks are managed by the IM&T officers but there is only limited engagement in terms of formal regular monitoring at Executive Director level.
71. Delivery plans to support the NHS Wales Informatics Service programme are less well developed. Whilst plans contain an accurate overall delivery picture, there is less detail in terms of resources and capacity. However it is clear that there is insufficient capacity to deliver all elements of the plan and this could affect progress. This shortcoming is acknowledged by the IM&T Management team.
72. Overall, capacity to deliver the IM&T plan has been reduced as the Health Board has been slow to fill posts; a full complement of staff is not yet in place. The Health Board's main IM&T infrastructure is fit for purpose with local disaster recovery plans in place. Currently IM&T funding is available from NHS Wales Informatics Service although there are now concerns that this funding stream will be subject to cuts. With the entire IM&T delivery programme being inherited from the national programme, any reduction in funding would represent a significant risk to delivery as local financial support for IM&T projects is currently limited.
73. Information governance arrangements are not well developed. Information issues are verbalised at a senior level although there is little evidence to demonstrate a commitment to improve information issues and they appear a low priority.
74. The Health Board is not yet mature in its understanding or management of information. Information governance is the responsibility of a different Executive Director to the one with covering IM&T. Whilst it is good practice to separate policy and operations, it has also resulted in electronic and paper information being managed operationally under separate directorates. Such arrangements cloud responsibilities, resulting in a lack of clarity and ownership.
75. Similar to the approach in technology staff structures, the Health Board has been slow to fill information posts. Overall capacity to deliver has been reduced over the last few years and a full complement of staff is not yet in place.

76. The IT Security policy is not yet in line with good practice and is not approved or applied across the whole organisation. At present there is no IT Security Officer and the job description does not cover the broader information agenda.

77. Whilst the Health Board's risk register does contain risks linked to information management there needs to be a more active approach to risk mitigation.

The performance management framework is robust and holistic and whilst the performance information is improving, the absence of comprehensive data assurance mechanisms pose a risk

78. The Health Board has developed an integrated performance management framework. The framework appears sound and inclusive, covering all business areas, including operational delivery, finance and risk; safety and quality; workforce; primary and community care.

79. The Health Board has devolved responsibility from executives down to county directors with counties having responsibility for delivery of key objectives. Performance management of the counties is implemented through a series of planned performance reviews held monthly and quarterly 'stock take' meetings.

80. This practice provides a regular and formalised structure for using performance information to monitor delivery against objectives and identify areas for further action. The process is based on the principle of earned autonomy so that high performing areas earn the right not to be scrutinised so intensely in future. The outcome of each 'stock take' results in a feedback letter to each county director identifying actions required to improve performance. Action plans resulting from these reviews and letters are discussed at the next review meetings.

81. Audit observation of this process and a review of key documents demonstrates that the process is robust but also supportive. Although there have been a number of areas identified for improvement, the challenging performance agenda means that the Health Board will need to ensure that the momentum is sustained and that the process continues to support and sustain improvement.

82. Monitoring the performance of the counties will soon be overlaid by an assurance framework called 'Foundations 4 Change'. This framework will be an annual process of assessing the county teams against the three themes of outcomes, competencies and governance. These themes are seen as fundamental to the delivery of the aims and objectives set out in the 5-year Plan. The process appears to provide a robust and appropriate means of ensuring that the Health Board's strategy is translated into action by holding the county teams to account. Care must however be taken to ensure that the counties can depend on the correct level of corporate support to help them achieve success.

83. There needs to be more transparency about the processes for holding the Executive Directors to account for their contribution to the achievement of the aims and objectives. This is important as the service and financial challenges facing the Health Board are considerable and shared ownership will be critical to success.

84. Information to support the performance management framework is developing and is continuously being refined. But the Health Board has acknowledged that they need to become more sophisticated, in particular more timely, more linked to opportunity costs and financial benefits and that the right information is collected. The performance reports could be improved by including more narrative to explain performance, provide comparative information and details of the actions being taken.

85. Performance information is routinely presented to the Integrated Governance Committee and to each Board meeting. The Board reports could be improved by bringing together a high level summary which reflects integrated performance covering quality & safety, operational efficiency, use of resources and patient experience.

86. Although there are some examples where the Health Board has undertaken work to demonstrate the accuracy of data, for example, clinical coding indicators and referral to treatment time, we believe that data assurance mechanisms could be more comprehensive. Although system functionality creates challenges, the Health Board must ensure that the information used to inform performance management is sound.

The Health Board has established appropriate arrangements to promote and ensure probity and propriety in the conduct of its business

87. Arrangements, policies and procedures are in place to monitor compliance with standards of conduct which include arrangements for whistle blowing, making declarations of interests and declaring gifts & hospitality

88. Counter Fraud arrangements have developed in the year with a designated Counter Fraud officer in place. Appropriate policies are in place, there has been good progress on awareness which is developing further with alerts and newsletters.

Section 4: Managing resources

89. Sound management of key resources such as people and assets is an essential feature in achieving good value for money. Plans for service development and cost savings need to be underpinned by effective workforce planning, partnership working and engagement with the community. This section of the report summarises my findings in the following areas:
    - workforce planning arrangements;
    - procurement;
    - asset management;
    - working with partner organisations; and
    - engaging with service users.

Although there has been significant progress, further work is required to strengthen important 'enablers' that can assist in more effective, efficient and economical use of resources

The Health Board's approach to workforce planning is still evolving and needs to be further developed to ensure that it supports delivery of the Health Board's strategic objectives

90. The Health Board has a detailed workforce plan dated March 2010, which contains data on workforce demographics and known areas of concern. To aid development of a detailed service strategy, the Health Board has set up think tanks with a strong clinician voice to look at care pathways across a range of specialities and localities which will impact on workforce requirements.
91. HR staff are aiming to develop a revised workforce plan by 17 December 2010. They are developing plans with support from NLIAH based on three scenarios. There is evidence of some joint workforce planning with local authorities and the third sector but this could be further enhanced.
92. The Health Board recently established a Workforce and Organisational Development (OD) Sub-Committee of the Integrated Governance Committee. This group has developed a strategic action plan and monitors delivery of actions relating to workforce and OD. It is also responsible for updating the risk register for workforce and OD. The Health Board's HR data team provides reports on workforce metrics which are monitored at the meetings.
93. Appropriate steps are being taken to improve workforce productivity and efficiency and reduce fixed and variable costs. In particular, the HR department has rolled out training in the NHS sickness absence toolkit. County workforce teams can provide additional training and support for managers. HR staff are carrying out a programme of audits on areas with high levels of sickness absence. Actions taken to address sickness absence has been successful in some areas.

94. The Health Board has established variable pay groups to closely monitor overtime, bank, locum and agency staff usage to try and meet the savings target of £5 million. The new e-rostering system which the Health Board is rolling out will give ward managers closer scrutiny of staffing and help them to know if they need to fill last minute vacancies. Longer term problems are being addressed through the recruitment of new A&E doctors in Withybush and service redesign e.g. out of hours adult mental health services. Data on overtime, bank, agency and locum usage is reported monthly to the Workforce and OD Sub-Committee although not in graphical format or with any comparisons to previous years to help monitor trends.

95. The Health Board is developing a simplified process of delivering appraisals and personal development plans. The Health Board has a well established training function and provides its own mandatory training to staff. In common with many other NHS bodies, they have problems getting staff to attend all mandated training; the Mandatory and Patient Training Group are trying to address this problem by developing a risk based approach to training. They have also developed a framework for training with the aim of ensuring safe and effective delivery of care by support workers. The development of training for healthcare assistants will help the Health Board to meet the AOF target of reducing staff in band 5 and above by three per cent and increasing staff in bands 1-4.

The Health Board has a developed a sound approach to managing its asset base

96. The Health Board has a clear estates strategy which is aligned to other strategic documents and risk management arrangements. Supporting the strategy are robust estates systems which provide the Health Board with a clear position on what assets it has along with their condition. There is evidence that the Estates team is supporting the County Teams and other departments across the Health Board.

97. The Health Board owns land and buildings with a net book value of some £200 million. Strategic planning and the capital programme is well managed involving relevant officers from across the organisation. There is a high level of backlog maintenance with £30 million classified as representing significant or high risk. The Health Board has around £7 million of resources to address significant risk over the next 2 years as well as addressing some of the higher risk areas.

98. The Health Board also recognises that more can be done to assess the performance of its assets and benchmark its performance further with other organisations. Although the Health Board is making progress improving the quality and accuracy of its information, it is constrained by the limited national data, some of which appears inaccurate. The Health Board also recognises that business cases need to be more robust particularly in terms of sustainability.

99. Looking to the future, once the Health Board's longer term service delivery model is established, the estates strategy will need to be updated. A key concern is that service modernisation will require a significant capital investment and this will be dependent on funding from the Assembly Government.

Procurement arrangements are developing well although the Health Board recognises further improvements are required

100. Procurement arrangements are generally operating effectively. An up to date Procurement Strategy covering 2009-2013 has been approved and clear reporting lines for procurement have been established. However, there is currently no detailed guidance/procurement manual for procurement staff to support the day-to-day delivery of procurement operations and there is no action plan to support delivery of the strategy.

101. National, framework and call off contracts are well established within the Health Board, particularly within secondary care. Furthermore, the Value Wales' 'Buy 4 Wales' website is widely used and the Health Board has recently moved towards an electronic tendering system.

102. No workforce planning for the Procurement Department has been undertaken to ensure that the number and skill mix of the staff in post is fit for purpose. During 2011, the procurement function is to be centralised under the Shared Services organisation and workforce planning together with the other improvements identified below, will need to be taken forward.

103. There is currently no formal training plan for procurement staff and the training budget is limited. Despite these limitations, the procurement department have made some efforts to secure ad hoc training for staff.

104. The Procurement Department have delivered some significant financial savings for the Health Board. Going forward, the Health Board recognises it needs to do more to review procurement in primary care and non-acute services areas such as continuing health care.

105. The Health Board has recently appointed a Procurement Clinical Nurse to provide links between the clinicians and the Procurement Department and ensure the need for effective procurement is raised with clinicians. The Health Board recognises that that there is still too much choice available to clinicians within the current contracts which needs to be reduced to standardise clinical items and make further savings.

106. Finally, procurement decisions do not routinely consider sustainability issues. The Health Board is aware of this shortcoming and is in the process of strengthening arrangements.

The establishment of partnership working arrangements is progressing, but the Health Board still faces significant challenges to achieve the intended service transformations across health and social care

107. The Health Board is demonstrating its commitment to partnership working through the development of a new approach to improve its quality and effectiveness. In particular, by enhancing communications between partners and reviewing current joint working practices, in order to develop more realistic, formal and accountable working relations. Partnership working is seen by the Health Board as a major driver of change and to potentially make a major impact on services by providing alternative methods or sources of service delivery – especially in times of financial constraints.
108. Despite there being no overarching strategic document for partnership work, the Health Board intends to embed the ethos of joint working throughout the organisation, in an effort to share resources, streamline processes and improve the quality of services. Therefore, a specialist Director of Strategic Partnerships post has been created, which is believed to be unique in Wales, to specifically identify and develop through negotiation, joint working opportunities in order to support or provide an alternative to health services whenever possible.
109. Although a number of the projects are still at early stages, there are already examples where open and direct negotiations are taking place to establish stronger working links with the Third Sector Co-design Steering Group. The Health Board views the voluntary sector as a reliable source of providing low level care.
110. Established partnership networks such as the Local Service Board and supporting Strategic Partnership groups, still play a major role in these new developments. The Health Board has maintained close working relations with these networks to help integrate Health and Social Care services within communities.
111. In addition, the Health Board, together with the three local authorities, have allocated resources to jointly fund senior posts to help progress integrated working practices both at strategic level – with the joint appointment of the Pembrokeshire Council Social Care Director - and, at a more operational level, the Head of Service in Carmarthenshire Council Adult Services. In addition, the line management of existing Section 33 agreement community services are being formalised in order to make the services more efficient, robust and accountable in order to improve Primary Care provision. Appointments of key jointly funded managers are in train, which is a critical stage in the process of establishing effective integrated working.
112. The majority of external partners appear willing to work more closely with the Health Board. However, significant challenges remain to overcome the variety of their cultures, governance arrangements, accountability, resources and capacity of partners to ultimately being able to provide viable work alternatives and solutions.

113. The Health Board is undoubtedly laying the groundwork towards improving the quality of its joint working with partners. However, performance management arrangements must be sufficiently robust if it is to effectively evidence the improvement of services through the contribution of a variety of partner providers.

The Health Board is developing a more strategic approach to engagement with service users to improve on its previous ad hoc activities

114. There have been processes in place to collect patients' views and experiences from previous Trusts and the former Local Health Boards. However, the current focus is to establish a more strategic and co-ordinated approach in order to develop a more wide ranging and standardised framework and supporting procedures.

115. To achieve this aim, the Health Board is finalising the reconfiguration of its Communications and Patient and Public Engagement approach – including a new staff structure, working groups and supporting strategy. The strategy, entitled the Communications & Engagement Strategy 2010–2015 is currently in draft form and not yet fully approved by the Board. It contains previous practices and procedures undertaken by the predecessor body as well as new proposals to involve and engage both public and patients. However, the actions are not yet prioritised and do not include timescales for completion. The Health Board intends to consult its stakeholders on the final version and status of the strategy and to develop a supporting implementation plan.

116. The new staff structure, led by an Assistant Director, has brought together an appropriate mix of teams including experienced public engagement and consultation staff, Legal and Patient Support , Equalities and Diversity and Volunteer Project Co-ordinators. The Communications and Marketing teams are also to co-locate with the Public and Patient Engagement staff, to improve joint working. The Health Board has therefore ensured that there are adequate resources in place for the delivery of the Communications & Engagement Strategy.

117. Furthermore, both internal and external working groups are being established with specific roles and responsibilities for designing and implementing public and patient engagement projects and improving communications structures. These groups bring together both internal service colleagues and external partners.

118. However, current evidence available does not clearly demonstrate the ultimate use and impact of patient consultation and engagement activity, and the list of performance measures do not contain target outcomes, to reflect the impact of engagement processes on service delivery.

Section 5: Specific performance audit reviews

119. This section of the report brings together the findings from performance audit work which has looked at specific areas of service delivery within the Health Board. It summarises the findings from work carried out on:

- Ward staffing review;
- Medicines Management review: Interface Prescribing;
- Accuracy of waiting list information;
- Adult mental health services; and
- Hospital catering.

The performance audit work has highlighted positive examples of service delivery but also opportunities to reduce variation in a number of service areas and improve the safety and efficiency of medicines management

120. This section of the report summarises the key findings from other local performance audit work. The findings from these reviews are summarised in Exhibit 2 below.

Exhibit 2: Programme of local performance work

Ward Staffing Review
Ward staffing arrangements within the Health Board were imbalanced and further work was required to understand these differences. We reached this conclusion because: • there is no clear explanation for the differences in ward staffing levels across the organisation, with a comparatively higher level at Bronglais General Hospital; • nurse-staffing costs are high at Bronglais General Hospital, particularly within the medical wards; and • there are inconsistencies across the organisation in the way staff are deployed and managed.
Medicines Management review: Interface Prescribing
Improving medicines management was a corporate priority and the Health Board was developing a much–needed whole systems strategy. But practices at the prescribing interface were resulting in significant safety risks and inefficiencies and there was inadequate monitoring of safety, quality and costs. We reached this conclusion because: • collaborative planning had improved but the strategic direction for staff and services at the prescribing interface was not clearly set out; • significant safety risks and inefficiencies occur at various points along the patient pathway and can have broader impacts on patients and service delivery; and • a general lack of data meant that the Health Board did not know the true extent of patient safety issues and whether it was delivering high quality and cost effective services.

Accuracy of waiting list information
The adequacy of arrangements for recording and reporting waiting list data was acceptable. However, we had some concerns regarding the accuracy of the waiting list data that was understating the Health Board's performance. We reached this conclusion because: • we had some concerns regarding the accuracy of waiting list data which was understating the HB's performance; and • we found the adequacy of the HBs arrangements for recording and reporting waiting-list data to be acceptable, although we have some concerns around the sustainability of the resources and ICT systems to support the delivery of the Referral to Treatment Time (RTT) target.
Adult mental health services
There has been good progress in improving adult mental health services since our baseline review in 2005 but the improvement agenda has been driven mainly by the former NHS Trust and has not reflected a wider whole system approach. We reached this conclusion because: • although there is an overarching multiagency implementation plan for the National Service Framework, the planning of adult mental health services has predominantly been focused around the health modernisation agenda; • Primary Care service provision has improved across the health community although there are some variations in the extent of services and training of, and engaging practice staff remains an issue; • there has been a clear expansion in the range of community services and a reduced reliance on inpatient beds, however some services do not meet policy guidelines and others need further development; • there has been a significant expansion in psychological therapies and a stepped care model is being implemented although not all GP practices can access counselling services; • some progress has been made with meeting the housing and accommodation needs of people with a mental health problem but further improvement is needed; and • there is evidence of a clear commitment to supporting and involving service users in their care, although further progress is needed.

Hospital catering
While there is already a strong professional focus on nutrition that demonstrates many aspects of recognised good practice, there is a need to establish consistent catering planning and business arrangements, and to address variations in standards at ward level. We reached this conclusion because: • an agenda for nutrition is clearly set across the Health Board, although there is a need to establish a consistent planning and business framework for catering. There are effective and safe food procurement arrangements in place although food production and cost control systems vary suggesting potential to develop greater consistency and to improve efficiency; • most wards receive food in good condition although there is still scope to improve the patient experience; • ward managers are clearly focussed on the need to ensure appropriate catering and nutrition support, although performance varies and some aspects of patients' nutritional status were not recorded; and • patient views on hospital food and the catering services are collected through a range of mechanisms, which the Health Board intends to make more consistent by sharing the results more widely.

Appendix 1

Reports issued since my last annual audit letter

Report	Date
Financial Audit reports	
Financial Accounts - Report to those Charged with Governance	June 2010
Capital Audit Review	June 2010
Internal Audit Review	June 2010
Charitable Funds - Report to those Charged with Governance	December 2010
Performance Audit reports	
Ward staffing review	April 2010
Accuracy of waiting list information;	April 2010
Medicines Management review: Interface Prescribing	June 2010
Adult Mental Health Services	December 2010
Hospital Catering	December 2010
Other reports	
Audit Strategy	March 2010
Interim annual audit letter	June 2010
Annual Audit Report	December 2010

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