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Annual Audit Report 2010

Betsi Cadwaladr University Health Board

Contents

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Summary

1. An interim annual letter was presented to Betsi Cadwaladr University Local Health Board (the Health Board) in June 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 the audit work that I have undertaken at the Health Board between October 2009 and February 2011.
3. 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.
4. I have adopted a risk-based approach to planning the audit, and my audit work has focused on 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 agreed with officers and presented to the Audit Committee. The reports that I have issued are shown in Appendix 1.
5. The findings I have set out in this report need to be taken in the context of the major structural re-organisation which has occurred in the NHS in Wales over the last 18 months, and the programme of nationally driven work that is underway to address health inequalities, mixed performance and financial sustainability. Collectively this represents a significant and extremely challenging change agenda for the Health Board and its staff.
6. The Health Board was created in October 2009 following the merger of eight former NHS organisations: North Wales NHS Trust[1], North West Wales NHS Trust, Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham Local Health Boards.
7. The Health Board serves a population of around 676,000 people, employs approximately 16,500 staff and has an annual operating budget of some £1.2 billion. It is responsible for the operation of three district general hospitals: Ysbyty Gwynedd in Bangor; Ysbyty Glan Clwyd in Bodelwyddan; and Wrexham Maelor Hospital. It also has 22 other acute and community hospitals and a network of over 90 health centres, clinics, community health team bases and mental health units across North Wales and parts of Powys. The Health Board also co-ordinates the work of 121 GP practices and NHS services provided by North Wales dentists, opticians and pharmacies.

[1] North Wales NHS Trust was itself only formed in July 2008 following the merger of Conwy and Denbighshire NHS Trust and North East Wales NHS Trust.

8. This report identifies a number of areas where arrangements and services need to be further developed. Given the scale of the change agenda within the NHS, it is inevitable that many corporate arrangements and service delivery areas within the Health Board are going to be either under review, or in the process of change.

9. It is important that the key messages from my audit work, which are summarised in this report, are used as a stimulus and focus for management attention to ensure that, where improvements are necessary, these are implemented as quickly as possible.

Audit of accounts

I have issued an unqualified opinion on the financial statements of the Health Board. In doing so I have brought several issues to the attention of officers and the Audit Committee

10. My work on the audit of accounts has led me to give an unqualified opinion on the 2009-10 financial statements of the Health Board.

11. I have also concluded that:

- the Health Board's accounts 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, but I noted scope for further improvement as systems and controls are rationalised over the coming year; and
- the Health Board's significant financial and accounting systems were appropriately controlled and operating as intended.

12. In giving an unqualified opinion, I have drawn the Health Board's attention to a number of issues including some qualitative matters relating to the preparation and submission of the draft accounts. I also reported a number of other matters to the Audit Committee which need addressing as the Health Board develops its arrangements for preparing the draft accounts in 2010-11.

13. The Health Board met its statutory financial targets in 2009-10 following the implementation of a number of pay and non-pay initiatives to address the cumulative deficit. The Financial Framework also sets out the significant financial challenges faced by the Health Board and includes a £31 million structural deficit from 2009-10 against planned annual net expenditure of £1.2 billion. The Health Board subsequently told us that the Structural Deficit reduced further to £20 million at the end of 2010-11.

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

The Health Board has made good progress on budgetary control and financial planning arrangements. It faces significant financial challenges in common with other public sector bodies

14. The Health Board, along with the rest of the NHS in Wales, faces significant and increasing financial challenges. It is unlikely that there will be any funding growth in the coming years and cost pressures will continue to increase. Detailed cost savings programmes will be needed to identify efficiency savings that can be achieved without compromising the quality of patient care.

15. In such a challenging climate, high standards of financial management are more important than ever. My overall findings on the Health Board's financial management arrangements were:

- Adequate financial planning arrangements are in place. The Health Board needs to further develop its medium-term financial strategy to provide clear links with the achievement of its overall strategic objectives.
- Financial performance against budgets is closely monitored, although Board reporting should be streamlined.
- The Health Board is predicting to break-even for 2010-11, following the planned delivery of additional savings schemes, and the receipt of £16.7 million of additional funding from the Assembly Government for in-year financial pressures. The Health Board told us that the additional funding also enabled them to proceed with the implementation of a Voluntary Early Release scheme and other 'invest to save' schemes.

The Health Board is clearly focussed on establishing an effective clinically led organisation and the governance framework is developing to address some elements not yet fully in place

16. 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 assure themselves that the organisation is well managed and is providing safe, appropriate and good quality healthcare. The nature and scale of the NHS re-organisation in Wales has resulted in much ongoing work to develop the necessary governance frameworks within new NHS bodies in Wales. This takes time and consequently I expected to see governance arrangements which were still evolving.

17. My overall findings on the Health Board's governance arrangements were:

- The Health Board has established and enacted clear clinically led strategic vision.
- Although still bedding in, the organisational structure reflects the Health Board's focus on clinical leadership.

- The Health Board is taking action to improve business planning processes to support delivery of its strategic vision.
- New arrangements for internal control and probity and propriety are evolving from an adequate baseline, specifically:
  - the internal control environment is adequate and continues to evolve; and
  - the Health Board has put sound arrangements in place to promote probity and propriety, including the introduction of robust counter fraud and whistle blowing policies.
- New Health Board-wide risk management arrangements have been developed. These have been led and promoted by top management. It is too early to judge their effectiveness in penetrating through Clinical Programme Groups to front-line staff.
- Information governance arrangements are not yet sufficiently developed to support strategic planning.
- A comprehensive performance management framework is still bedding in.

The Health Board is consolidating and improving other arrangements that support the efficient, effective and economical use of other resources; significant challenges remain

18. 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 will not be delivered unless underpinned by effective enabler functions. My work identified how well the arrangements are supporting the Health Board's strategic objectives and operational targets. In several of these areas, I recognise that work is inevitably still ongoing to achieve the desired outcomes.

19. My overall findings were that:
    - the Health Board is developing workforce planning, but faces significant challenges in reducing costs and implementing new ways of working;
    - arrangements for managing the asset base are effective but need consolidating to support the achievement of strategic objectives;
    - an effective approach to procurement is in place;
    - the Health Board has a clear focus on partnership working, and local authorities have jointly funded a local authority management representative to support effective relationship management; and
    - the Health Board has made good progress in terms of capturing the views of service users and wider community engagement is still developing.

Individual performance audit reviews have highlighted specific challenges for the Health Board

20. My performance audit work at the Health Board has included reviews of a number of specific service areas. Collectively (Exhibit 1), these have demonstrated that the Health Board faces specific challenges in a number of areas of service delivery. The Health Board has responded positively to the issues identified and has action plans in place to address the areas of concern and to build on the good practice identified.

Exhibit 1: My conclusions are drawn from detailed audit work on[2]

Topic	Overall conclusion
Patient Administration System (PAS) Post Implementation Review – East area	The implementation of the Myrddin PAS within the East area of the Health Board went well overall but aspects of disaster recovery, system functionality and Myrddin support arrangements need to be addressed before implementing Myrddin in the Central area.
Ward staffing	When compared to the benchmark average, the Health Board has slightly fewer ward staff in number but a greater proportion of qualified staff, although there are some unexplained variations between areas.
Medicines management (follow-up of work in Conwy and Denbighshire and North East Wales NHS Trusts)	Central and East areas have made good progress in improving clinical effectiveness and value for money in medicines management, but some infrastructure problems hinder full achievement of all the recommendations, and cost pressures provide a difficult environment.
Hospital catering	Whilst the catering service demonstrates many aspects of recognised good practice, there is a need to strengthen the Health Board's approach to planning and scrutiny and to address the variation in standards at ward level and between hospitals.
Adult mental health services	NHS bodies and local authorities have made some important improvements, but the health community is still some way off providing a comprehensive and equitable mental health service that meets national standards and service user needs.
Accuracy of waiting list data	In the centre and east there were robust management arrangements in place to support the implementation of referral to treatment time targets, but overall PASs were not fully fit for purpose and we had some concerns about the quality of data, particularly in the centre and west.

[2] This table summarises my detailed findings expanded in later sections of my report.

Agreeing my findings with the Executive Team

21. Our normal practice is to agree this report with the Director of Finance, the Chief Executive, and the Director of Governance and Communications, before it is formally issued and presented to the Audit Committee and a subsequent Board meeting, and a copy provided to every member of the Board.

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

About this report

23. This Annual Audit Report to the Board of the Health Board sets out the key findings from audit work undertaken between October 2009 and February 2011.

24. My work at the Health Board is undertaken in response to the requirements set out in the 2004 Act. The 2004 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.

25. 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 and certification of claims and returns.

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

27. 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.

28. Finally, Appendix 2 presents the latest estimate on the audit fee that I will need to charge to undertake my work at the Health Board, alongside the fee that was set out in the Audit Strategy.

Section 1: Audit of accounts

29. 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 organisation 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.

My responsibilities

30. 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.
31. In giving this opinion, auditors are required to comply with International Standards on Auditing (ISAs).
32. 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 the Health Board. 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

33. 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 Partner reported these issues to the Health Board's Audit Committee on 7 July 2010. Exhibit 2 summarises the key issues set out in that report.

Exhibit 2: Issues identified in the ISA 260 Report

Issue	Auditor's comments
Views about the qualitative aspects of the entity's accounting practices and financial reporting.	I reported some qualitative issues relating to the preparation and submission of the draft financial statements. In particular, whilst it was noted that the preparation of the consolidated healthcare accounts was complex in the light of the mid-year merger of the predecessor health bodies, and whilst the draft accounts were submitted by the due date, they contained a number of omissions which were not provided until late in the audit process. I also noted that the quality of the initial draft financial statements needed to be improved, as there were a large number of minor errors and inconsistencies within the accounts and the notes. This was partly due to the complexity of preparing the financial statements from nine ledgers and the tight timescales involved. A number of these issues also arose due to errors in the template accounts provided by the Assembly Government, which were outside the Health Board's control. A more thorough quality control review of the draft statements prior to submission for audit would have identified and corrected many of the errors. All working papers supporting the financial statements were not made available at the start of the audit in accordance with the agreed 'Audit Deliverables' document.
Unadjusted misstatements.	There were no uncorrected misstatements. All non-trivial adjustments and amendments to disclosures identified during the course of the audit were amended by management. Some other non-material adjustments were made as a result of my audit.
Expected modifications to the auditor's report.	I issued an unmodified auditor's report.
Material weaknesses in the accounting and internal control systems identified during the audit.	No matters arose.
Matters specifically required by other auditing standards to be communicated to those charged with governance.	No matters arose.
Any other relevant matters relating to the audit.	I also reported a number of other relevant matters to the Audit Committee including the need to: • develop arrangements to fully account for the value of replaced elements of property, plant and equipment in accordance with International Accounting Standard 16; • develop more robust processes in 2010-11 to demonstrate whether capitalised staff costs meet the definition of capital expenditure in accordance with International Accounting Standard 16; and • review segmental reporting disclosures in light of any future developments to ensure compliance with International Financial Reporting Standard 8.

34. At 31 March 2010, the Health Board reported that it met its Revenue Resource Limit (£1.2 billion) despite having reported a cumulative deficit of £9.7 million at month 11. The Health Board implemented a number of pay and non-pay initiatives to address the cumulative deficit through cost improvement plans.

35. Whist this ensured that financial balance was achieved at the year-end, further work is required to address the underlying issues in 2010-11.

The Health Board had an effective internal control environment to reduce the risks of material misstatements to the Financial Statements, but I noted scope for further improvement as systems and controls are rationalised over the coming year

36. My review of the Health Board's financial systems involved documenting its significant financial systems and, where necessary, testing the operation of internal controls.

37. My review identified that appropriate controls had been established in most areas. Opportunities for further improvement were identified as the Health Board looks to consolidate and rationalise the different systems and arrangements used by predecessor bodies. In particular, whilst asset registers were updated at year-end they were not amended for additions and disposals between 30 September 2009 and 31 March 2010.

38. There also remained scope to strengthen payroll reconciliations. Whilst income tax and social security costs disclosed in the main accounting system were agreed to payroll details produced by the Electronic Staff Record system, gross pay was not reconciled.

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

39. Controls within the main accounting systems operated as intended and this formed a reliable basis for preparing the financial statements, but work is required to resolve a small number of long outstanding imbalances in the main accounting system for the East and West areas.

40. Effective budgetary control arrangements are critical in enabling us to obtain assurance that the outputs generated by the Health Board's accounting system, and in particular the financial statements, are not materially misstated.

41. We are satisfied that the Health Board's arrangements were sufficiently robust to provide us with material assurance upon the financial statements.

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

42. 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. To assist in meeting this requirement, auditors have, for the first time, undertaken a 'Structured Assessment' of the relevant corporate arrangements in the Health Board. The findings from this work have considered the arrangements for:
    - financial management;
    - governance and accountability; and
    - using key 'enablers' to support the efficient, effective and economical use of resources.
43. This section of the report also summarises the findings from a number of specific performance audit reviews I have reported to the Health Board between October 2009 and March 2011.

The Health Board has made good progress on budgetary control and financial planning arrangements. It faces significant financial challenges in common with other public sector bodies

44. The Health Board, along with the rest of the NHS in Wales faces significant and increasing financial challenges. It is unlikely that there will be any funding growth in the coming years and cost pressures will continue to increase. Detailed cost savings programmes will be needed to identify efficiency savings that can be achieved without compromising the quality of patient care.
45. In such a 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;
    - cost control and budget monitoring; and
    - progress against financial targets.

Adequate financial planning arrangements are in place. The Health Board needs to further develop its medium-term financial strategy to provide clear links with the achievement of its overall strategic objectives

46. The Finance Department has achieved a lot in the first year of the Health Board. Bringing together eight financial plans and nine financial ledgers at a time of new corporate structures and appointments has been a challenge. The Health Board's Medium Term Financial Strategy for 2010-2015 was approved in March 2010. The strategy is underpinned by a detailed Financial Framework document and together they set out the overall financial planning principles, and provide the tools to enable the Health Board to effectively manage its finances.

This Medium Term Financial Strategy represents good progress, but it could be further strengthened by providing clearer links with other plans for example workforce, capital, service redesign and the Health Board's overall strategic objectives.

47. The Financial Framework also sets out the significant financial challenges faced by the Health Board in 2010-11, and includes a £31 million structural deficit from 2009-10 against planned annual net expenditure of £1.2 billion. The Health Board subsequently told us that the Structural Deficit reduced further to £20 million at the end of 2010-11.

Financial performance against budgets is closely monitored but Board reporting should be streamlined

48. The Health Board has done considerable work to compile reports to support the monthly monitoring returns required by the Assembly Government and has continued to develop these during the year. Financial monitoring reports provided to the Board and the Finance and Performance sub-committee set out the latest financial position together with the year-end forecast; risks associated with achieving break-even and progress with delivering savings plans. The reports are also reviewed by the Chairman of the Board, the Chair of the Audit Committee, the Chair of the Finance and Performance Committee and the Chief Executive. Whilst the financial reports are comprehensive, the version presented to the Board should be streamlined to focus attention on the overall financial position, the key risks and the actions being taken to achieve financial balance.

49. The Health Board has reported that the delivery of budgets and cost improvement plans, whilst maintaining safe services, is a priority. Delivery of budgets and cost improvement plans is also closely monitored, and is supported by decentralised budget monitoring and delegation arrangements within the Clinical Programme Groups and Directorate Functions. Appropriate arrangements are also in place for monitoring cost improvement plans.

50. The integration of financial performance with wider strategic and operational objectives, including safety of services is explored in paragraphs 77 to 80.

The Health Board is now on track to meet its key financial targets and is predicting to break even for 2010-11 due to the planned delivery of additional savings schemes

51. The Health Board's Medium Term Financial Strategy 2010-2015 identifies a planning deficit of £83.7 million for 2010-11 with future years requiring further recurrent savings of around £60 million per year over the next three years.

52. The Health Board developed and approved cost improvement plans to help it deliver the efficiencies required to achieve financial balance in 2010-11.The cost improvement plans contained a combination of recurring and non-recurring schemes due to the urgency of addressing the planning deficit and also the need to maintain safe services. But, it has not been possible to implement these plans within the anticipated timeframe because a number of schemes rely on workforce redesign, which involves necessarily time-consuming engagement and consultation. The Health Board recognised this early in the year and, as such, took further action designed to achieve a break-even position. This action included holding back reserves from budget lines and the identification of additional savings schemes. The Health Board considers that most of the savings opportunities it has identified will be recurrent, although a number of the additional planned savings schemes will be non-recurrent. Further savings have been identified through the establishment of an in-house team who have developed expertise in negotiation and contracting skills. The team has secured additional savings on the value of English healthcare contracts. For example, negotiation by the in-house team resulted in savings of £0.75 million on the same volume of activity on one English contract.

53. At the end of November 2010, the Health Board reported a cumulative in-year deficit of £16.9 million (compared to a budgeted break-even position at the end of the financial year). The cumulative in-year deficit reduced significantly to £4.9 million at 31 December 2010 following additional revenue allocation of £16.7 million from the Assembly Government. The Health Board has consistently reported that it forecasts achieving a break even position at the year-end as the delivery of savings identified in its schemes are realised. The additional funding from the Assembly Government meant that the Health Board did not have to implement further additional savings plans, some of which would have resulted in changes to services. The Health Board told us that the additional funding also enabled them to proceed with the implementation of a Voluntary Early Release scheme and other 'invest to save' schemes.

54. Although financial plans are not yet delivering the full anticipated savings, the Health Board has reported that slippage is mainly due to the Board's overriding concern to ensure patient safety. Its focus on managing these risks has hampered its ability to reduce costs until service and role re-design achieve their anticipated benefits.

The Health Board is clearly focussed on establishing an effective clinically led organisation and the governance framework is developing to address some elements not yet fully in place

55. 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.

56. The nature and scale of the NHS re-organisation in Wales have resulted in much ongoing work to develop the necessary governance frameworks within each of the new NHS bodies in Wales. The newly convened boards have needed to bed themselves in and new committees have needed to be set up in line with national models for Standing Orders, Standing Financial Instructions and Schemes of Delegation. Supporting structures from predecessor bodies have also needed to be reviewed to ensure that best practice from these bodies is continued and any gaps or new requirements are addressed. Collectively, this takes time and consequently I expected to see governance arrangements which were still evolving. I found that the Health Board is clearly focused on establishing an effective clinically led organisation and the governance framework is developing to address some elements not yet fully in place.

57. I have drawn the conclusion set out above as a result of the following findings.

The Health Board has established a clear, clinically led strategic vision

58. The Health Board's strategic direction provides a clear blueprint for the future delivery of services in the context of five clinically focused strategic themes: making it safe; making it better; making it sound; making it work; and making it happen. This vision was developed across North Wales over the transition period and clinical involvement and leadership were key considerations. These strategic priorities reflect both national and local issues.

59. The strategic themes also provide the framework for the *Five Year Plan*, which contains a summary of the Health Board's high level aspirations and its three key challenges – service, workforce and financial – for the period 2010-15. The *Five Year Plan* identifies 12 strategic priorities to address these three key challenges.

Although still bedding in, the organisational structure reflects the Health Board's focus on clinical leadership

60. The Health Board has approximately 16,500 directly employed staff and works with independent contractors in primary care. It operates over a very large number of locations across a wide geographical area and has faced the challenge of bringing together the different working practices and cultures of nine predecessor organisations. Developing a new organisational structure was always going to be challenging.

61. The Health Board's organisational structure forms part of a clinically led governance framework which is intended to be 'light touch'. The organisational structure is based on an inverted triangle with a 'small' corporate function supporting the strategic and operational delivery of clinical care through 11 Clinical Programme Groups.

62. The Health Board does not at present have a full complement of Independent Members, despite significant efforts made by the Health Board to recruit members. There are a number of reasons for these vacancies, which include an in-year retirement, delay in other public bodies putting forward nominations and failure to recruit candidates with the necessary specialist knowledge. The University Registrar attended Board meetings on a temporary basis to cover the retirement.

63. The Health Board has successfully established its joint committees as set out within the standing orders. These include the Health Professionals Forum, the Stakeholder Reference Group and the Local Partnership Forum.

64. The Health Board has established a Board of Directors. This large, clinically dominated group supports the Board in providing strategic and clinical leadership in the discharge of the organisation's role and function. Services are managed through 11 Clinical Programme Groups (see Exhibit 3). Each Group is led by a clinically qualified, practising professional responsible for managing the delivery of safe and high quality services, and these act as advocates for their respective portfolios of clinical specialties.

Exhibit 3: The Health Board's 11 Clinical Programme Groups

Clinical Programme Groups
• Primary, Community and Specialist Medicine
• Mental Health and Learning Disabilities
• Women and Maternal Care
• Pathology
• Therapies and Clinical Support
• Cancer and Specialist Palliative Medicine
• Pharmacy and Medicines Management
• Children and Young People
• Surgical and Dental
• Radiology
• Anaesthetics, Critical Care and Pain Management

Source: Betsi Cadwaladr University Local Health Board Organisational Structure Chart

65. The organisational structure achieves the Health Board's aim of placing clinicians at the heart of the governance framework. There is clear consensus that this clinician-centred governance framework provides the optimal structure for the delivery of high quality services in the future. Senior staff appreciate that it is still too early to fully assess the effectiveness of the structure in delivering strategic objectives. The Health Board recognises that further work is required in some areas of organisational development, particularly in terms of the effective operation of the Clinical Programme Groups. The Health Board has introduced an organisational development plan which includes Clinical Programme Group development.

The Health Board is taking action to improve business planning processes to support delivery of its strategic vision

66. The task of producing strategic and operational plans for a new organisation, particularly one of the size and complexity of the Health Board, is extremely challenging. The *Five Year Plan* and the Clinical Programme Group plans were produced at a time when the Health Board's organisational structure and business processes – including those associated with the Clinical Programme Groups – were at an early stage of development. The initial stages of the 2010-11 planning process were also undertaken before the Assembly Government issued its own strategic planning guidance. Given this background, it is understandable that not all the plans are of a uniformly high standard. These issues have been recognised by the Health Board, and a summary plan intended to provide improved focus and clarity around organisational and Clinical Programme Group priorities was produced in September 2010. Planning for 2011 commenced in September 2010 , with improved guidance and more formal corporate arrangements to support Clinical Programme Groups.

New arrangements for internal control and probity and propriety are evolving from an adequate baseline

New arrangements for internal control are evolving from an adequate baseline

67. The Health Board has established arrangements to monitor compliance with Standing Orders and Standing Financial Instructions, and implemented robust internal financial controls, underpinned by an effective Audit Committee. There is clear evidence that the Health Board has been working with Executive and Independent Members individually and collectively to develop a relevant and dynamic assurance framework. Although not yet finalised and published, this framework is underpinned by a live tool. Once fully populated, the tool should provide a robust way forward.

68. The Audit Committee supports the organisation's governance and internal control arrangements by drawing on appropriate sources, such as Internal and External Audit. The Internal Audit function is compliant with all the NHS Internal Audit Standards in Wales. New clinical audit arrangements are still developing from a range of generally adequate clinical audit arrangements inherited from predecessor bodies. The level of assurance should be further strengthened as these frameworks become embedded within the business processes of the organisation.

The Health Board has put sound arrangements in place to promote probity and propriety

69. The Health Board has adopted codes of conduct for Independent Board members and employees. Arrangements are in place to monitor compliance with these codes, which include the maintenance of registers for declarations of interests and also for gifts and hospitality. An interim system for managing the registers was put in place following the establishment of the Health Board. In December 2010, a new and more robust system was introduced.

70. The Health Board has an effective approach to counter fraud, underpinned by a comprehensive and widely communicated counter fraud and corruption policy. The Health Board has established an effective and pro-active Local Counter Fraud Service Function, reporting directly to the Director of Finance. Counter fraud work is regularly reviewed by the Audit Committee and arrangements are in place to ensure areas identified as susceptible to fraud or control weaknesses are followed up.

New Health Board-wide risk management arrangements have been developed, although it is too early to judge their effectiveness in penetrating through Clinical Programme Groups to frontline staff

71. The Health Board inherited nine different approaches to risk management and deliberately continued to rely on these approaches during transition into the new organisation. However, the Health Board recognised weaknesses in these arrangements, most importantly the variation in quantifying the level of risk. In addition, the multiplicity of risk registers across even a single Clinical Programme Group made analysing the true level of risk more difficult. For example, Pathology inherited three risk registers, from east, central and west areas, all with slightly different recording and scoring measures.

72. Since transition, the Health Board has developed an executive and operational management structure which identifies clear lines of accountability for specific risks. The responsibility for overseeing risk management rests with a number of committees. These include:

- the **Audit Committee** which is responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management;
- the **Quality and Safety Committee,** to provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- these are supported by **sub-committees**, including the Risk Management and Clinical Effectiveness sub-committees.

73. The Health Board has established a Risk/Assurance Team which reports to the Director of Communications and Governance. That team is responsible for co-ordinating the Health Board's corporate risk and assurance framework including management of the corporate risk register. A new risk management strategy and policy was approved in October 2010, replacing the interim strategy. As a statement of intent, the policy appears sound and identifies objectives, principles and responsibilities and the Health Board has also now developed a set of risk management guidelines based on best practice principles. The Health Board recognises that identification of risk within the new risk registers at corporate, department and Clinical Programme Group level has not yet matured.

74. Systems are being put in place to learn lessons from events that have arisen. These include organisational learning events that are set up across the Health Board aimed at learning lessons, and serious incident reviews. The integrated governance report presented to the Quality and Safety Committee summarises this information so that the Board can have an overview of the trends, issues and remedial action being taken.

Information governance arrangements are not sufficiently developed to support strategic planning

75. Information Governance is led by the Executive Medical Director, supported by an Assistant Director of Information and Technology, and an Information Governance Committee chaired by the Board chairman. The inherited legacy arrangements for the management of IM&T remain largely unchanged across the three former sites and have been adequate in supporting day-to-day operational support and delivery to date. There is an urgent need to develop a detailed IM&T strategy to support the Health Board in delivering these priorities.

76. The Health Board will need to quickly ensure that information management, particularly collection and analysis of clinical and management information is fit for purpose. Specifically that: systems and processes are able to support the national move to outcome focussed targets, replacing process measures; and that data collection systems produce reliable information to support decision-making. Our performance audit work has consistently raised such issues in predecessor bodies, and the need for reliable information is magnified by the Health Board's size and complexity.

A comprehensive performance management framework is still bedding in, and is not yet supporting significant improvement

77. A sound and inclusive performance management framework should cover all business areas, including operational delivery, finance and risk; safety and quality; workforce; mental health, primary and community care; and services provided by the NHS in England. Performance management is not simply about scrutiny and challenge, but effective arrangements to support and drive improvement. In particular, the Board must receive all the necessary information in a form, and of a frequency, which enables it to effectively discharge its responsibility for delivering the organisation's strategic aims, objectives and targets.

Complex performance management arrangements rely on the Board's scheme of delegation

78. The Health Board's performance management framework is, in effect, its scheme of delegation of Board responsibilities. The scheme of delegation is designed to assist the Board to focus on the delivery of strategic objectives and priorities, including the achievement of national targets. It is also intended to support an integrated approach to quality, performance and governance. The Board is responsible for performance management in the round, and committees report through various routes to the full Board.

79. The main corporate vehicle for scrutinising and challenging performance is the Finance and Performance Committee. The Finance and Performance Committee receives a monthly Performance Summary Report which reports the Health Board's performance against Annual Operating Framework and Efficiency and Productivity measures and targets. Financial performance is also closely monitored against a detailed range of measures. And my auditors saw evidence of robust challenge from independent members. The Committee also receives a 'Focus On' report[3] each month which includes performance information for different specialties on a rolling basis. A number of sub-committees report to the Finance and Performance Committee, including the Performance Improvement Sub-Committee.

80. There are also a range of other groups charged with reviewing and reporting performance in other areas of the Health Board's activities such as the Quality and Safety Committee, the Integrated Performance Review Panel, the Board of Directors and the Strategic Planning Co-ordinating Group.

[3] Focus On reports are prepared on specialities such as orthopaedics, rheumatology and ear nose and throat. They provide an overview of the service, their performance and challenges.

Performance management arrangements are still developing and were not evidencing substantial improvement across the whole range of the Health Board's objectives and targets

81. The performance management arrangements that the Health Board has developed are complex, with multiple strands reporting to the full Board through the committee structure.

82. The Health Board is clearly committed to the ongoing development of its performance management arrangements and there are already positive features on which to build. For example, the 'Focus On' reports have been commended by the Assembly Government and the best examples of the 'Focus On' reports provide a balanced, integrated summary of performance across the range of activity in particular specialties. The monthly Performance Summary Report is clearly written and evolving, but the monthly Finance Report is overly detailed.

83. I recognise that the operation and work of the various committees, sub-committees, groups and panels is evolving and that these arrangements are still bedding in. They do not yet provide a fully integrated and easily understood, performance management framework covering all of the Health Board's areas of business, strategic and operational performance. Consequently, I have identified a number of ways in which the performance management arrangements could improve, some of which the Health Board is already addressing, alongside the developments required to support the new Annual Quality Framework from the Assembly Government.

84. The success of a performance management framework is demonstrated by improved organisational performance. The Health Board inherited a challenging position from its predecessors across a range of measures. Substantial improvement was not evident at the time of my fieldwork in many areas, particularly on national targets.

The Health Board is consolidating and improving other arrangements that support the efficient, effective and economical use of other resources, but significant challenges remain

85. 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.

The Health Board is developing workforce planning, but faces significant challenges in reducing costs and implementing new ways of working

86. The Health Board's existing workforce plan was developed in line with timescales and processes operating across Wales, supported by the National Leadership and Innovation Agency for Healthcare (NLIAH). The plan was reviewed by NLIAH which commented that it was a comprehensive plan, containing examples of good practice on the analysis of the current workforce profile and identifying challenges and opportunities in relation to the ageing workforce. The plan also identifies other key issues, such as bank and agency use and the need to reduce the size of the workforce to achieve financial savings.

87. The Health Board recognises that workforce planning is an iterative process that will evolve as it determines how it will deliver services in future. Only when future models of care have been agreed will the Health Board be in a position to map out definitive timelines and more specific aspirations for changes to the shape of the workforce. But work is ongoing to enable the Health Board to address the points raised by the NLIAH in its next iteration of the workforce plan. For example, in terms of identifying the scale of savings and cost reduction required, and to increase the spread and speed of role redesign, and implementation of new ways of working. These challenges cannot be underestimated, and the Health Board will struggle to meet its financial targets if is unable to reduce the reliance on bank and agency staff and realise other workforce savings.

Arrangements for managing the asset base are effective but need consolidating to support the achievement of strategic objectives

88. The Health Board inherited eight[4] estate strategies, with various priorities and plans for investment, and an estate which varies significantly in age and condition. A consolidated estates strategy document has not yet been finalised because:

- inherited backlog maintenance, and asbestos on the Ysbyty Glan Clwyd site meant that, correctly, the Health Board's first priority was developing a 10-year investment plan to ensure that going forward the estate is 'fit for purpose' in terms of both Health and Safety, and facilities capable of supporting 21st century healthcare; and
- until the service delivery model is finalised and agreed – setting out which services will be provided where in North Wales; a final estate plan for modernisation and regionalisation would be subject to change.

89. A draft estates strategy is in place and evolving, built up from the inherited strategies and focused around the central, east and west areas. Preparing an estates strategy, in an environment of continued uncertainties over service redesign and uncertain capital finance from the Assembly Government, remains a challenge for the Health Board.

[4] The former Conwy and Denbighshire LHBs had a joint estate strategy.

90. Responsibilities for asset management are clearly defined, the Capital programme is developing, and the consolidation of all the asset registers of predecessor bodies is underway. Separate Capital Strategy Groups for each element were approved by the Finance and Performance Committee.

91. Capital expenditure is reported monthly to the Board as part of the finance report. Current arrangements are delivering against budgets and plans, and are flexible enough to allow for the in-year purchase of new food delivery trolleys for the Wrexham Maelor site following our review of Hospital Catering (see later paragraphs 114 to 116).

92. I found clear examples of partnership working to improve the use of assets, including community equipment stores in the East, sheltered housing projects in the West and joint working with Local Service Boards. Sustainability, and transport policies are well developed, and progress is being made on backlog maintenance of the estate.

An effective approach to procurement is in place

93. There are good management arrangements governing the Health Board's procurement function which is currently by the Health Board's Business Support Partnership. A five-year plan and procurement strategy supports the NHS in Wales approach and the redesigned function is based on a whole systems approach (taking into account the impact of procurement practices from initial request to payment). There is a formal framework in place to manage the procurement function and reporting arrangements are to the Health Board Finance and Performance Sub-Committee. Efficiencies and savings have been made and the procurement savings target for 2010-11 was reviewed and increased, from £1.8 million to £3.8 million. The Health Board expects to achieve this target.

The Health Board has a clear focus on partnership working, and local authorities have jointly funded a local authority management representative to support effective relationship management

94. The Health Board has a significant range of partners, including all six Local Authorities in North Wales, the Welsh Ambulance Service, North Wales Police, North Fire and Rescue Service and the voluntary sector across North Wales. It also continues to purchase services from England on behalf of NHS Wales.[5] Many of these partnerships have a statutory basis, or provide joint services under section 33 agreements, including mental health services in central and east areas.

[5] Services are purchased for Welsh patients (both from North and Mid Wales and visitors from other health board areas) attending Robert Jones and Agnes Hunt (Gobowen), Alder Hey, Broadgreen, Whiston and Walton in Liverpool, and Manchester hospitals.

95. The Health Board is committed to working in partnership and the *Five Year Plan* outlines its approach and the importance of partnership working to achieving its aims. The *Five Year Plan* was discussed with stakeholders and areas of the plan reflect input from partners. The Health Board is clearly aware that partnership working is essential in achieving the most from increasingly scarce resources. Inevitably, changes in structures, roles and personnel at the Health Board during transition caused some disruption, but all partners are committed to moving forward.

96. To help promote an effective relationship with the Health Board, the six North Wales local authorities have funded the appointment of a Regional Local Authority Management Representative. The Local authority Management Representative ' sits on the Health Board's Board of Directors, and works part-time (two days per week) to improve communications and relationships, distribute briefings and attend strategic meetings. All partners consider this useful to align partnership working and improve outcomes. In addition, the North Wales collaborative approach established several years ago through the Regional Partnership Board continues. This is intended to support the continued development of local plans. For example Health, Social Care and Well Being (HSCWB) strategies. The Health Board continues to work with the six County Voluntary Councils to ensure ongoing engagement and communication with the third sector.

97. The Health Board and its partners acknowledge the need to reform partnership groups and improve consultation and communication. All partners recognise that such a high number of partnership groups is neither sustainable in the current climate, nor an efficient use of resources.

Although the Health Board has made good progress in terms of capturing the views of service users, wider community engagement is still developing

98. Significant progress in the development and implementation of a comprehensive service user engagement strategy is evident, led by the Executive Director of Nursing and Midwifery. This includes robust mechanisms for gathering and responding to service user views, systematic approaches to patient surveys, service user involvement on some Clinical Programme Group Boards, and the development and collation of patient stories.

99. Clear and robust arrangements are also developing in terms of engagement with service users, and other stakeholders, these are illustrated by the strategic service reviews. The Health Board recognises that service reviews can be contentious, and is working to try to ensure all parties have the opportunity for ongoing engagement in the full process. The service review process builds on the tried and tested 3-cycle model (Exhibit 4) used to develop the Health Board's vision and strategy. The outcome of the 3-cycle model is a summary of the solution identified by the process: the 'preferred way forward'. If the 'preferred way forward' relates to service configuration then there may be a recommendation to the Board for 'no change', or for a 'change'. After consideration, the Board would discuss with the Community Health Council

whether any 'change' in the 'preferred way forward' was substantial, and if so, the Community Health Council would start a formal public consultation process.

100. The Health Board believes that the 3-cycle model ensures wide and ongoing stakeholder engagement, together with the development of clinical consensus. In our recent audit work on the consultant contract, theatres, and outpatients, we found that staff are committed to this approach, and there is good clinical engagement with this iterative model. The model was also reviewed by NLIAH and has been published in peer-reviewed literature.

101. The Health Board acknowledges that partners' and public understanding of the 3-cycle model is at an early stage, and that understanding of the model needs further development. Our work across North Wales shows stakeholder understanding of the difference between engagement in the development process and consultation for change is at an early stage. Hence the Health Board's ongoing work to explain the model to local authority scrutiny committees, and its own Stakeholder Reference Group, Health Professions Forum and Local Partnerships Forum.

Exhibit 4: The Health Board's 3-cycle model

The 3-cycle model forms the basis of engagement in service reviews. It is possible that the 3-cycle model may identify the need for a further cycle (or cycles) of work to complete the process – so the process may repeat.

Stage	Stakeholder tasks. There may be several meetings at each stage
Scan	Scanning the current landscape to understand all the dimensions of the issue which the process seeks to resolve which includes identification of population needs; current service configuration, outputs and outcomes, and demand; evidence and best practice.
Focus	Testing the issues and theories raised in the first cycle and refining ideas about what may actually work.
Summarise	Concluding the testing and summarising what has been learnt from the first two cycles, leading to recommendations for the preferred approach and identification of any further stages of work which may need to be undertaken.

Source: Betsi Cadwaladr University Local Health Board

102. The Health Board's overall approach to ongoing public engagement is currently under discussion as part of the development of a comprehensive engagement strategy. Once finalised, this strategy will be signed off by the Board.
Some areas under discussion, in addition to the more usual face to face meetings with key groups across North Wales, include building on the use of digital technologies (internet and other social media), and the development of new opportunities for 'public members' to get involved in the work of the Board.

Individual performance audit reviews have highlighted specific challenges for the Health Board

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

- PAS Post Implementation Review – East Area
- Ward staffing
- Medicines management (follow-up of work in Conwy and Denbighshire and North East Wales NHS Trusts)
- Hospital catering
- Adult mental health services
- Accuracy of waiting list data

The implementation of the Myrddin PAS within the East area of the Health Board went well overall, but some aspects needed to be addressed before implementing Myrddin in the Central area

104. At the end of 2009, my ICT audit team undertook a review of the implementation of the PAS in the East area of the former North Wales NHS Trust. My team found that the implementation of the Myrddin PAS within the East area of the Health Board went well overall, but some aspects needed to be addressed before implementing Myrddin in the Central area.

105. I reached the above conclusion because:

- Good project and information management arrangements supported the transition to the new Myrddin system. Specifically data quality was good, and all operational staff were trained to use the new system.
- The new system is not yet fulfilling all of the requirements identified in the original business case and the limited resources available to the national Myrddin team to support the development of both the outstanding functions, as well as future developments, are a concern.

When compared to the average, the Health Board has slightly fewer ward staff in number but a greater proportion of qualified staff, although there are some unexplained variations between divisions

106. Ward nurses are pivotal to the delivery of high-quality patient care. Insufficient ward staff and the wrong skill mix can adversely affect the quality of patient care. Nevertheless, with ward-staffing costs consuming up to a third of the annual pay budget, it is vital that health bodies achieve value for money from their ward staff. There is no single, nationally accepted system of determining the ideal numbers and grade mix of nurses required on wards. Therefore, health bodies need to use a variety of tools to help them determine their ward staffing requirements. In particular, benchmark comparisons can prove a valuable aid in setting staff numbers.

107. In 2009, my staff undertook a ward staffing benchmarking exercise, utilising a database prepared by the Audit Commission, which included most[6] Welsh health boards and English trusts. This exercise considered both ward staffing numbers and expenditure.

108. I found that:

- overall, staffing levels within the acute wards are on average slightly lower than the benchmark average, although there are some variations between localities which are not clearly explained;
- the Health Board has a higher proportion of qualified staff than many other health bodies with scope to use more Band 2 staff to act as Healthcare Support Workers;
- whilst the cost per whole-time equivalent for the Health Board is higher than average because of its skill mix and stable workforce, the cost per available bed is around average; and
- although there is a low level of temporary staff usage, there are some inconsistencies in the way staff are deployed and managed.

109. Led by the Executive Nurse, the Health Board has used my benchmark information and analysis, alongside other available tools that assess patient acuity, workload, and quality of care to inform their ward-staffing workforce planning. The Health Board has since told us that it subsequently implemented an e-rostering system for over half its wards to help address the issues identified, with a focus on maintaining patient safety.

Central and East areas have made good progress in improving clinical effectiveness and value for money in medicines management, but some infrastructure problems hinder full achievement of all the recommendations and cost pressures provide a difficult environment

110. Medicines form an important component of the care provided to patients in hospitals. NHS organisations need well-developed medicines management processes to help them to deliver high quality, value-for-money and patient-focused care. Effective management of patients' medicines can reduce length of stay and the level of readmissions. Expenditure on medicines represents around five per cent of total hospital costs and around 20 per cent of non-pay expenditure. Effective control of medicines expenditure is therefore important.

6 Participating Welsh health boards include Abertawe Bro Morgannwg, Betsi Cadwaladr, Cwm Taf and Hywel Dda. Aneurin Bevin is currently participating in the benchmark exercise.

111. In 2007, I reported the findings of the Acute Hospital Portfolio Phase 6 benchmark review of medicines management to the former Conwy and Denbighshire NHS Trust (Central) and the former North East Wales NHS Trust (East). As part of my audit strategy for the former North Wales NHS Trust, my staff undertook a follow-up review to ascertain whether progress had been made in implementing the 2007 recommendations included in the medicines management reports within the two localities, and what challenges remain for the new Health Board.

112. From the follow-up audit work that my staff undertook in late 2009, I concluded that Central and East areas have made good progress in improving clinical effectiveness and value for money in medicines management. However, some infrastructure problems hinder full achievement of all the recommendations and cost pressures make it more difficult to make the necessary improvements. I reached that conclusion because:

- both areas had made good progress on ensuring value for money by addressing clinical pharmacy issues, including effective medicines use and patient focus, and specifically:
  - chief pharmacists have harmonised clinical working practices, and spread best practice between East and Central areas;
  - improvements in clinical effectiveness and patient focus are in place, although more needs to be done to minimise patient safety issues; and
  - a good pace of change in the Central area has brought them up to a similar level of clinical pharmacy service to the East area;
- further improvements in value for money are proving more difficult to realise, but are essential in a difficult financial environment, and in particular:
  - problems with infrastructure hinder further efficiencies specifically, with the aseptic units and information technology to support electronic prescribing and transfer of information; and
  - despite good progress on understanding costs, and improving the cost-effective use of antibiotics, further improvements in value for money are possible if investment in clinical pharmacy is maintained across the Health Board.

113. My staff completed a similar follow-up review in the West area, which was reported to the former North West Wales NHS Trust in September 2009. Health Board management requested this report and developed a consolidated way forward as part of the Medicines Clinical Programme Group's operational plans.

Whilst the catering service demonstrates many aspects of recognised good practice, there is a need to strengthen the Health Board's approach to planning and scrutiny and to address the variation in standards at ward level and between hospitals

114. Hospital catering services are an essential part of patient care given that good quality, nutritious meals play a vital part in patients' rehabilitation and recovery. My review sought to determine whether hospitals in Wales were providing efficient catering services that met recognised good practice. I looked at the hospital catering 'food chain' from planning and procurement through to the delivery of food to the ward and the management of meal times. Fieldwork included visits to Ysbyty Gwynedd, Llandudno District General Hospital, Ysbyty Glan Clwyd, and Wrexham Maelor Hospital.

115. Although I found examples of good practice, I concluded that the Health Board needed to strengthen its approach to planning and scrutiny of catering services and that it needed to address the variation in standards across wards and between hospitals. I came to this conclusion because:

- A strategic planning framework is lacking and Board scrutiny of associated risks and challenges is not as strong as it could be.
- 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 a reasonable condition although arrangements for the delivery of food vary across the Health Board and there is scope to improve the patient experience. For example in Wrexham Maelor food was not always delivered at the correct temperature, and practice around protected meal times varies across wards.
- Generally ward managers are focused on the need to ensure appropriate catering and nutrition support, although ward practice varies and some aspects of patients' nutritional status were not recorded at all.
- Patient views on hospital food and the catering services are collected through a number of mechanisms and there is scope to make these activities more consistent and to share the results more widely.

116. I also found strong professional and managerial leadership from the Director of Nursing, Midwifery and Patient Services with regard to nutrition and catering issues. And a clear commitment across all professional groups, at all levels to the nutrition and catering agenda. The Health Board has already started to address many of the areas I identified for improvement, including the replacement of old and inadequate food delivery trolleys, and work is underway to improve the catering environment at Wrexham Maelor Hospital.

NHS bodies and local authorities have made some important improvements but the health community is still some way off providing a comprehensive and equitable mental health service that meets national standards and service user needs

117. Mental illness is common and disabling. The Assembly Government has set out a policy for mental health with a focus on raising the standard of mental health services consistently across Wales. In September 2001, the National Assembly published *Equity, Empowerment, Effectiveness, Efficiency, a Strategy for Adult Mental Health Services in Wales*. This document set out the aspirations for a modern, community focused mental health service for the people of Wales. In April 2002, these aspirations were translated into eight standards (44 key actions and targets) within *Adult Mental Health Services – a National Framework for Wales*.

118. In October 2005, the Wales Audit Office published its all-Wales report on mental health services for adults. This review provided a baseline of service provision, and identified gaps and variations in service which presented a significant challenge for NHS Wales and its partners. I have undertaken a follow-up to the baseline review across both NHS and local government to assess the extent and consistency of improvement in mental health services for adults.

119. My follow-up review, which started in 2009, focused on the six key issues identified in the earlier baseline review as being common problems across Wales. I did not examine service areas in which other major review work was underway or planned, such as the review of the care planning process. The six areas I focused upon are:

- planning and funding;
- mental health services in primary care;
- community based services;
- talking therapies;
- accommodation and housing; and
- involving service users in their care.

120. I concluded that NHS bodies and local authorities have made some important improvements but the health community is still some way off providing a comprehensive and equitable mental health service that meets national standards and service user needs. I reached this conclusion for a number of reasons:

- there are significant variations in levels of expenditure; the effectiveness of planning; and the extent of multi-agency working across North Wales, and these variations have hindered the development of equitable and comprehensive mental health services;
- primary care is now better placed to support and manage service users but issues remain with the adequacy of training and specialist support;
- there is a shift towards community-based provision in some areas, but there are significant differences in the services available for adults with mental illness and some key services are not in place or do not meet national guidelines;

- comprehensive psychological therapies are still not in place, with long waiting times and very variable progress in moving to a stepped model of care;
- housing policies and practices are still not supporting people with mental health problems effectively; and
- many of the service users who responded to our survey in North Wales are being appropriately involved in their care, although there are unacceptable variations in the approach taken and the support that is available.

121. These issues and my subsequent recommendations for action by health boards and councils will require a co-ordinated multi-agency response. Once all of the reports are finalised, I will be writing to both the Health Board and councils for a co-ordinated response from all North Wales bodies.

The Centre and East had put appropriate management arrangements in place to help implement referral to treatment time targets, but overall patient administration systems were not fully fit for purpose, and I had some concerns about the quality of data, particularly in the Centre and West

122. During the later part of 2009, my staff undertook a review of the accuracy of waiting list information at the Health Board. This work followed on from previous audit work undertaken in 2007 at the Health Board's predecessor NHS Trusts. I examined whether the Health Board had the necessary management arrangements in place to support the move from component waits to referral to treatment time targets.

123. I concluded that the Centre and East had put appropriate management arrangements in place to help implement referral to treatment time targets, but patient administration systems were not fully fit for purpose, and I had some concerns about the quality of data, particularly in the Centre and West. Underlying this conclusion I found that:

- There were robust arrangements the Centre and East and acceptable arrangements in the West to ensure implementation of referral to treatment time. Appropriate guidance, procedures and training were available across the Health Board. However, all parts of the Health Board did not have formal waiting list policies; had no dedicated trainer in the West; and clinical awareness was variable.
- The current patient administration systems were not fully fit for purpose for managing referral to treatment time. For example, system shortcomings meant that departments needed to produce additional management information and reports. In addition, none of the systems within the Health Board were able to record adjustments to pathways, which meant that manual adjustments were necessary to record these changes.

- I had some concerns regarding the recording of GP referral dates, and the accuracy of waiting list data, which together mean the Health Board reports longer waits than actual for some patients. For example, the date of GP referral was not always accurate, and patients treated in England sometimes remained as open pathways when they had already been treated.

124. Separately, the Health Board undertook further work on waiting list management across North Wales which found a number of inconsistencies in the way patient access was managed by one predecessor organisation. The Health Board has started to address the issues raised by both the internal and Wales Audit Office reviews, and the Risk Management sub-committee is monitoring progress. The Health Board has:

- introduced a new patient access policy, in October 2010;
- rolled-out standardised training to all staff involved in managing waiting lists;
- implemented an increased level of data quality checking;
- reviewed and updated administration processes and responsibilities; and
- started a process to improve case-note management and tracking of patient pathways.

Appendix 1

Reports issued since my last Annual Audit Letter

Report	Date
Financial audit reports	
Assessment of Internal Audit 2009-10	June 2010
Financial Accounts Audit and Report to those Charged with Governance	June 2010
Opinion of the Financial Statements	June 2010
Audit of Financial Statements – Financial Accounts Memorandum	September 2010
Performance audit reports	
Patient Administration System (PAS) Post Implementation Review – East Locality (Letter of findings)	December 2009
Ward Staffing	February 2010
Medicines Management (follow-up)	February 2010
Hospital Catering	December 2010
Adult Mental Health Services Follow-up	January 2011
Accuracy of Waiting List (follow-up) Memorandum	March 2011
Structured Assessment	March 2011
Other reports	
Audit Strategy 2010	June 2010
Interim annual audit letter for the first six months of the Health Board	June 2010
Annual Audit Report for 2010	March 2011

There are also a number of performance audits that are either planned or underway within the Health Board. These are listed on the next page and estimated dates for completion of the work shown.

Report	Expected date of delivery
Consultant Contract	April 2011
Efficiency focus: Operating theatres and day-case surgery	April 2011
Follow-up reviews of Outpatients; EWTD; maternity services; CAMHS; and preliminary work on unscheduled care.	April – June 2011 The planned follow-up work of unscheduled care has been scaled back to a high-level preliminary review, in view of plans to undertake detailed mandated work on this topic in 2011. Additional fieldwork on outpatients has replaced the remaining time on this project.
ICT Disaster Recovery and business continuity	September 2011
Local project on Continuing Healthcare	It has been agreed not to proceed with local work on Continuing Healthcare at this time because of the current national work on this topic. Discussions with Executive Directors will be taking place regarding substituting or refunding the fee for this project.
Local ICT project: Patient Administration System implementation in central division of former North Wales NHS Trust (brought forward from my North Wales NHS Trust 2009 performance audit strategy).	Implementation of the Myrddin PAS system in central is on hold until 2013. Local work on this project has therefore been cancelled and discussions will be taking place with Executive Directors regarding substituting or refunding the fee for this project.

Audit fee

The Audit Strategy for 2010 set out the proposed audit fee of £684,292 (excluding VAT). The table below sets out my latest estimate of the actual fee, on the basis that some work remains in progress, and that I am likely to refund some fee for cancelled projects.

Analysis of proposed and actual audit fee for

Audit area	Planned fee (£)	Actual fee (£)
Audit of accounts	452,431	452,431
Performance audit	209,412	209,412
Business Services Centre	22,449	22,449
Total	**684,292**	**684,292**

The fee included the charge for the audit work undertaken in respect of the shared services provided to the Health Board by the Business Services Centre (BSC). This was previously excluded from the fee and was recharged to the health bodies by the BSC.

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