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Annual Audit Report 2012

Betsi Cadwaladr University Local Health Board

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Status of report

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This report has been compiled by Mike Usher, Dave Thomas, Mandy Townsend and Matthew Edwards on behalf of the Auditor General for Wales.

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Summary report

Introduction

1. This report summarises my findings from the audit work I have undertaken at Betsi Cadwaladr University Local Health Board (the Health Board) during 2012.

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

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

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

- Audit of 2011-12 accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

Audit of 2011-12 accounts

5. I have issued an unqualified opinion on the 2011-12 financial statements of the Health Board. I concluded that the 2011-12 financial statements were prepared to a high standard. This is a significant achievement, given the additional work required in preparing the consolidated financial statements.

6. Arising from my financial audit work, I have brought several issues to the attention of officers and the Audit Committee. These include improving processes to support the basis for capitalising staff costs, and developing internal controls and systems to identify and account for the value of replaced elements of property, plant and equipment.

7. With total expenditure of some £1.22 billion, the Health Board achieved financial balance at the end of 2011-12, as a result of additional funding from the Welsh Government of £17 million received in October 2011, and the implementation of a number of non-recurrent savings schemes and one-off technical accounting adjustments.

8. I also concluded that:

- 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, although there were some areas for improvement; and

- the Health Board's significant financial and accounting systems were appropriately controlled and operating as intended, although there were some system weaknesses which required management action.

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

9. As required by statute, I have reviewed the Health Board's arrangements for securing efficiency, effectiveness and economy in the use of its resources. My Structured Assessment work has examined the robustness of the Health Board's financial management arrangements and the adequacy of its Board assurance framework and internal control environment. Performance audit reviews have also been undertaken on specific areas of service delivery. This work has led me to draw the following conclusions: I have concluded that arrangements for securing economy, efficiency and, effectiveness in the use of resources are not fully effective and further action is urgently needed in some key areas.

The Health Board is forecasting that it will fail to achieve a breakeven position at the end of 2012-13 and the medium-term financial position is very difficult. Whilst there are schemes underway to change services, a comprehensive plan to revise service delivery to fully meet the financial gap is yet to be developed

10. Key findings from my review of the Health Board's financial management arrangements are as follows:

- the budget setting process for 2012-13 highlighted significant financial challenges but the process was delayed, and did not identify sufficient cost reductions to deliver a balanced budget;
- required cost reductions are not being achieved and the Health Board is forecasting a deficit of £19 million at the end of 2012-13, although there is a significant element of risk around this forecast; and
- the medium-term financial position is very difficult and better links are needed between service, financial, workforce and capacity planning.

Weaknesses in governance and the lack of a comprehensive plan to revise service delivery risk jeopardising the Health Board's sustainability in the medium-term

11. Despite some strengths, internal control arrangements still exhibit some fundamental weaknesses, particularly around embedding practice at the front-line. Good arrangements are in place to comply with data confidentiality, but arrangements to support data quality, and ICT business continuity and disaster recovery need to be strengthened to ensure they are fully effective. Board operations require strengthening to improve transparency and record keeping and the Health Board cannot fully demonstrate its effectiveness. Strategy and planning need to address the concern that some services are not sustainable going forward, and despite substantial effort to engage external stakeholders, this has not always facilitated progress. Accountability arrangements relating to Clinical Programme Groups (CPGs) have been strengthened recently but the significant differences in CPGs' span of responsibilities needs to be reviewed whilst concerted effort is going to be needed to establish effective models of clinical leadership and engagement. Management information needs to be strengthened to ensure it covers the breadth of the Health Boards responsibilities, routinely including quality indicators to support effective governance and assurance by providing the necessary triangulation, and depth. My data matching as part of the National Fraud Initiative (NFI) has not identified any cases of fraud and error.

My other performance work highlights limited progress on substantial issues, which will be difficult to progress without better clarity on medium-term transformation of services, and faster delivery of change by Clinical Programme Groups

12. My other performance work highlights limited progress on resolving issues inherited from predecessor organisations, in particular around service delivery and delivering improvement at the front-line. I also found some concerning indications that the current pattern of service provision is not clinically sustainable in light of increasing medical specialisation. I concluded that this is contributing to some of the difficulties the Health Board faces in transforming its unscheduled care services and in seeking to replace locum doctors with more permanent employees. More specifically I found that:

- unscheduled care services remain under pressure and chronic condition services are still fragmented and underdeveloped;
- progress in implementing a whole-system approach is hampered by the complexity of internal structures and partnerships, insufficient clinical engagement and underdeveloped plans to implement a comprehensive model;
- while the Health Board is using locum doctors to maintain service delivery, the current approach represents poor value for money, presents some risk to the quality of services and does not address the situation in a strategic way; and
- my follow-up performance work found slow progress has been made on the areas of hospital catering and consultant contract benefits realisation.

The factual accuracy of this report has been agreed with the Executive Team

13. This report has been agreed for factual accuracy with the Chief Executive and the Executive team. The draft report was presented to joint Quality and Safety and Audit Committee on 20 December 2012 and the subsequent Board meeting and a copy provided to every member of the Health Board. We strongly encourage wider publication of this report by the Health Board. Following Board consideration, the report will also be made available to the public (in both English and Welsh) on the Wales Audit Office's own website (www.wao.gov.uk).

14. The Health Board will be developing a formal response to the issues raised in this report. Many of the changes to governance arrangements and operational practices that the Health Board is currently considering will help to address the issues I have raised. I will continue to monitor progress during 2013 as part of my on-going audit work.

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

Detailed report

About this report

16. This Annual Audit Report to the Health Board members of the Health Board sets out the key findings from the audit work that I have undertaken between December 2011 and December 2012.

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

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

b) satisfy myself that the expenditure 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.

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

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

19. I have issued a number of reports to the Health Board this year. The messages contained in this Annual Audit Report for 2012 represent a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.

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

- Audit of 2011-12 accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

21. Finally, Appendix 2 presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my 2012 audit work at the Health Board, and shows that it is in accordance with the original fee that was set out in the Audit Outline.

Section 1: Audit of 2011-12 accounts

22. This section of the report summarises the findings from my audit of the Health Board's financial statements for 2011-12. 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. Timely and accurate preparation of an organisation's financial statements is an essential element in demonstrating appropriate stewardship of public money.

My responsibilities

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

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

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

25. In undertaking this work, my 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 2011-12 financial statements of the Health Board, although in doing so, I have brought several issues to the attention of the Audit Committee

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

26. The draft sets of healthcare and Welsh Risk Pool financial statements were submitted on a timely basis to meet the Welsh Government's 4 May 2012 deadline. Notably, and for the first time since the Health Board was established, the draft Consolidated financial statements (incorporating both the healthcare and the Welsh Risk Pool financial statements) were also made available to us by the submission date. This was a significant achievement by the Health Board, given the additional work required in preparing the Consolidated financial statements.

27. All were prepared to a high standard and were supported by comprehensive working papers. There was also clear evidence that the financial statements had been subject to internal quality assurance checks.

28. My team has continued to work closely with Health Board finance staff throughout the year to ensure potential issues are identified and resolved in a timely manner. Following completion of the audit, we also held a joint post-project learning session. This will help inform our joint planning for 2012-13.

29. 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 financial statements. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 7 June 2012.

30. My report highlighted that a number of presentational misstatements in the draft financial statements had since been corrected by management. During the audit process my staff identified a number of matters, and discussed these with Health Board management. These included amendments to miscellaneous income to ensure appropriate classification. The reported ratio of the highest paid director against the median remuneration of the workforce decreased from 9.59 to 7.81 times, as the median remuneration of the workforce had not been calculated in accordance with revised guidance issued by the Welsh Government. The 'Continuing Health Care costs' contingent liability was also overstated by £2.9 million, as the amount disclosed also included the provision element in error. Exhibit 1 summarises other key issues set out in my 7 June report.

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

Issue	Auditors' comments
Annual Governance Statement	The Health Board experienced delays in preparing the Annual Governance Statement (replacing the Statement on Internal Control from 2011-12). The initial draft was not available until 10 May 2012 and a more comprehensive draft was provided on 29 May 2012. Whilst the draft was updated to ensure compliance with HM Treasury and Welsh Government guidance, the final statement was too long and lacked clarity. The Health Board should develop arrangements for preparing the Annual Governance Statement for 2012-13 and beyond, ensuring improved timeliness and full compliance with the requirements of the Welsh Government.

Issue	Auditors' comments
Capitalised salaries	International Accounting Standard (IAS) 16 provides scope for employee costs arising directly from the construction or acquisition of an item of property, plant and equipment to be capitalised, rather than reported as revenue items, because they are directly attributable capital costs. The Health Board has not been able to demonstrate that employee costs of £180,000 within the £1.57 million total are directly attributable to specific assets and we therefore cannot fully conclude on the appropriateness of capitalising these costs. This matter was raised in 2009-10 and 2010-11, and the Health Board has confirmed to us that it is continuing to develop its processes in order to fully demonstrate that costs are appropriately capitalised.
Asset de-recognition	The IAS 16 has applied to all NHS bodies since 2009-10. It sets out the specific accounting requirements for the recognition and measurement of fixed assets (known as 'property, plant and equipment') in the Statement of Financial Position. The IAS 16 requires that, when parts of assets are replaced, any outstanding value of the replaced asset needs to be taken out of the property values (de-recognised) and any gain or loss is recognised in the revenue account. The Health Board has developed arrangements during the year but, in common with other health boards, it relies upon information from the District Valuer to fully comply with this standard. The Health Board confirmed that it will continue to address this in 2012-13.
'Hutton' disclosures for median pay	The new 'Hutton' disclosure for median pay did not comply with HM Treasury and Welsh Government guidance. It is clear from the audit process that health bodies across Wales have sought to apply this guidance appropriately to their own individual circumstances. However, there are variations in the calculations of these disclosures between health bodies, making it more difficult in making meaningful comparison. The Health Board sought additional guidance from the Welsh Government on specific aspects in applying this guidance. This resulted in a change to the ratio of the highest paid director against the median remuneration of the workforce. Further work is required in 2012-13 to ensure HM Treasury and Welsh Government guidance is complied with.
Pooled budget disclosure	Delay also arose with the preparation of Note 31 'Pooled Budgets' that was submitted for audit 25 May 2012, as the Health Board was awaiting information from partner organisations. We are satisfied that the Health Board took all reasonable steps to obtain the information for the Conwy Community Equipment Loans Store and Denbighshire Community Equipment Services early in financial statements planning process.

Issue	Auditors' comments
Segmental reporting	There is a requirement under International Financial Reporting Standard (IFRS) 8 to provide 'segmental' financial information in published accounts, based on how information is routinely reported to top management to support their decisions. In line with enhanced guidance from the Welsh Government, the Health Board developed a written rationale to support its decision to disclose two business segments: Healthcare; and the Welsh Risk Pool. Whilst we are broadly content with this rationale we note that, unlike other health boards in Wales, the Health Board provides information to its top management that is analysed by CPGs. The Health Board therefore has the scope, should it wish to do so, to provide users of its published accounts with additional information on the activities of each CPG.

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

- **Whole of Government Accounts return** for 2011-12 – I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2012 and that the return had been prepared to a good standard, in line with the required timescales and in accordance with the Treasury's instructions.
- **Summary Financial Statements and Annual Report** for 2011-12 – I concluded that the summary statements were consistent with the full statements and that the full Annual Report was largely compliant with Welsh Government guidance.
- **Audit of the transfer of assets and liabilities to the NHS Wales Shared Services Partnership** - The NHS Wales Shared Services Partnership (NWSSP) was established on 1 April 2011 to manage and provide shared services to the NHS in Wales, operating as a virtual organisation. On 1 June 2012 the NWSSP functions transferred to Velindre NHS Trust as host body and the assets and liabilities relating to these shared service functions (which were previously undertaken on behalf of the NWSSP virtual organisation by individual NHS bodies throughout Wales) were transferred from these bodies to the NWSSP. The Health Board submitted S1 and S2 returns setting out the value of assets and liabilities transferred. On 26 October 2012, I concluded that that nothing had arisen to indicate that the entries in the returns did not agree with the accounting records of the Health Board.

32. The Health Board's draft 2011-12 Charitable financial statements were prepared in May 2012, considerably earlier than in previous years. Whilst we did encounter some difficulties and delays in agreeing some aspects of the Charitable financial statements, their earlier preparation was a significant achievement for the Health Board. This was especially so, given the considerable additional work undertaken during the year to effectively merge the former charitable funds, investment portfolios and financial systems. I issued an unqualified opinion on the Charitable financial statements on 25 July 2012.

The Health Board had an effective internal control environment to reduce the risks of material misstatements to the financial statements, although there are some areas for improvement

33. My financial audit work focuses primarily on the accuracy of the financial statements, reviewing the internal control environment to assess whether it provides assurance that the financial statements are free from material misstatement. I did not identify any material weaknesses in your internal control environment.

34. Internal Audit reported that: 'Adequate Assurance can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of particular objective at risk'.

35. Whilst Internal Audit issued a number of 'limited assurance' and 'no assurance' reports during 2011-12, they reported that their review of key financial systems confirmed that a sound system of internal financial control was in place.

36. My review of Internal Audit confirmed an effective service is provided that is fully compliant with nine of the 10 NHS Internal Audit Standards. I did identify opportunities to further improve its management and service delivery in 2012-13 and beyond as the new all-Wales Shared Service develops. In particular:

- whilst Internal Audit met all of the prescribed organisational standards and is adequately staffed and resourced, as yet there is no formal continuous professional development process in place; and
- Internal Audit fully met four out of the five prescribed operational standards, but the change in service provision meant that no documented Internal Audit Manual was in place.

The Health Board's significant financial and accounting systems were appropriately controlled and operating as intended, although there are some system weaknesses which require management action

37. I did not identify any material weaknesses in the Health Board's significant financial and accounting systems which would impact on my opinion. There were a number of detailed issues arising from my financial audit work and these were reported to the Audit Committee in September 2012.

38. In particular, the Health Board continues to have a significant number of payroll overpayments made to employees during the year (both former and current employees). The payroll department confirmed that this was largely due to departments failing to inform the payroll team of staffing changes on a timely basis. In some cases the payroll team was not informed until after the employee had left.

39. The level of payroll overpayments is regularly monitored by Health Board management and is reported to the Audit Committee. The Health Board has reported to the Audit Committee that it is proactively working with the NWSSP to resolve the issues that give rise to the payroll overpayments and to reducing any repayment periods.

40. Internal Audit also reported a number of system weaknesses which require on-going management action. Action plans have been developed to strengthen the control weaknesses identified in these reports and progress is regularly scrutinised by the Audit Committee.

The Health Board achieved financial balance at the end of 2011-12 with additional funding from the Welsh Government and other mechanisms

41. The Health Board met its statutory break even duty for 2011-12 despite facing significant financial pressures. For the 2011-12 financial year, the Health Board incurred net expenditure of £1.219,424 billion against its resource limit. Its final resource limit was £1.219,499 billion.

42. The Welsh Government allocated additional funding to all NHS bodies across Wales, with the Health Board receiving an additional £17 million structural support in October 2011, despite the fact that it had consistently projected financial breakeven throughout the year. The Health Board also implemented a number of non-recurring savings schemes and one-off technical accounting adjustments to achieve financial balance. However, and in contrast to a number of other health boards across Wales, the Health Board did not require additional late 'brokerage' as a 'draw forward' of funding from 2012-13 to help it meet its 2011-12 financial targets.

Section 2: Arrangements for securing economy, efficiency and effectiveness in the use of resources continue to evolve, but further action is urgently needed in some key areas

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

- reviewing the Health Board's financial management arrangements, including the progress being made in delivering cost reduction plans and their contribution to achieving financial balance;
- assessing the effectiveness of the Health Board's governance arrangements through my Structured Assessment work with a particular emphasis on the robustness of the overall Board assurance framework and internal control environment;
- specific use of resources work on workforce planning, management information and stakeholder engagement; and
- assessing the progress the Health Board has made in addressing the issues identified by previous audit work on maternity services.

44. I have concluded that arrangements for securing economy, efficiency and, effectiveness in the use of resources are not fully effective and further action is urgently needed in some key areas. The main findings from this work are summarised under the following headings.

The Health Board is forecasting that it will fail to achieve a breakeven position at the end of 2012-13 and the medium-term financial position is very difficult. Whilst there are schemes underway to change services, a comprehensive plan to revise service delivery to fully meet the financial gap is yet to be developed

The budget setting process for 2012-13 highlighted significant financial challenges, but the process was delayed and did not identify sufficient cost reductions to deliver a balanced budget

45. The Health Board reported in its Annual Income and Expenditure Budget for 2012-13 that meeting the significant financial pressures requires a clear Operational Plan with strategic change to support the financial and service control measures. As such, future plans will need to focus increasingly on the more difficult areas for recurring savings: reducing costs by reforming and reshaping services.

46. Due to on-going developments with the Health Board's Operational Plan for 2012-13 including the need to identify sufficient costs reductions to deliver a balanced budget, an interim budget for April 2012 was adopted. The subsequent 2012-13 draft financial plan was approved by the Health Board in May 2012, almost two full months into the financial year to which it relates. Despite this, there have been significant delays with budget holders signing up to their budgets, and unusually in many cases, were only done so with caveats. This is extremely rare and undermines the planning and budgeting process.

47. The 2012-13 financial plans highlighted that urgent actions were required to deliver a balanced financial plan for the year. An initial financial gap of £90.3 million was identified (including £17 million additional funding from the Welsh Government), which was subsequently revised to £64.6 million. Whilst savings plans were identified for managing this, at that time it did not include clear plans to demonstrate how the shortfall would be met.

Required cost reductions are not being achieved and at 31 October 2012 the Health Board was forecasting a deficit of £19 million for the 2012-13 financial year, although there is a significant element of risk around this forecast

48. The monthly Health Board's finance reports during 2012-13 have consistently reported that urgent action was required to provide assurances that it would achieve a breakeven position and stay within its resource limit. The reports also identified that delivery of the financial plan was not without significant risk.

49. From October 2012 onwards, the finance reports confirmed a projected year-end deficit of £19 million, with best and worst case scenarios ranging from £10 million to £27 million. At the end of October 2012 just £15.6 million (56.9 per cent) of the £27.4 million savings which were profiled to be achieved by that point in the year had been delivered against the original year-to-date budget. The Health Board has reported that urgent action is required to ensure savings plans are developed and accelerated to deliver the required savings.

50. To arrive at the forecast deficit for the year of £19 million, the Health Board has made a number of high risk assumptions including achieving £28.2 million of savings, the delivery of £7.8 million of escalation and turnaround measures and the use of £15 million of centrally retained contingencies and innovations funds. It will also need to effectively manage other cost pressures including locum and agency staffing, and drugs. Given this, and the significant slippage in the delivery of savings plans, the reported current deficit is not unexpected and there is a significant element of risk around the forecast deficit of £19 million.

51. Significant effort is being put into identifying further cost reductions. The Delivery Programme Board (DPB), which was designed to support managers in the delivery of savings schemes, regularly holds performance review meetings with CPGs and Corporate Departments. The Health Board also introduced a Turnaround role for one its Executive Directors from 8 October 2012 to focus the Health Board's efforts to identify opportunities to identify additional recovery actions and to take these forward. Turnaround is recognised as the whole executive teams business, and the role is intended to 'shine a light' or challenge internally; i.e. to change culture throughout the organisation, rather than be a specific programme. As such, turnaround is embedded in performance management arrangements through the DPB, and is not a separate team. With the financial challenges that the Health Board faces, there is clearly need for such a turnaround function. However, the sustainability of the current arrangements that the Health Board has put in place for turnaround is questionable and there is clear need for a more substantive turnaround capacity to be established. Where Turnaround has been successful elsewhere in the UK, dedicated additional teams have delivered smaller levels of savings to achieve service and financial balance. But, the true impact may not be measurable until 2013, and the scale of the financial problem is large, at around 10 per cent of provider spend. Turnaround alone is not the whole answer, as service sustainability issues also need to be addressed.

52. The Health Board prepared a Financial Recovery Plan in October 2012, setting out its commitment and approach to recovering the difficult financial position. This included performance managing the CPG and Corporate Departments with a heightened focus on financial delivery. Some of the organisation-wide opportunities may help improve the Health Board's financial position in 2012-13, but others will take more time to implement.

The medium-term financial position is very difficult indeed and better links are needed between service, financial, workforce and capacity planning

53. As reported to the Finance and Performance Committee in October 2012, the Health Board's financial outlook into 2013-14 and beyond highlights unprecedented challenges that will require significant service change in order to deliver a balanced budget in the future. The Medium-Term Financial Plan to 2015-16 sets out a projected financial gap of £102.9 million (8.9 per cent of operational expenditure) for 2013-14, growing to £176.4 million (15.4 per cent of operational expenditure) by 2015-16. These figures quite starkly illustrate that the Health Board's current service model is not financially sustainable, and that urgent action is needed to move the organisation to a more financially stable position.

54. As an immediate challenge, further work is required by the Health Board to fully integrate and deliver service, workforce and financial plans. Whilst the Operational Plan refers to an integrated approach, in reality individual plans are not always fully integrated or affordable. Furthermore, the financial implications of service changes and priorities need to be considered and built into the Operational Plan at an early stage, with a clear assessment that the proposed plans are affordable.

55. The Health Board has recognised the need for change, and reported in its Financial Recovery Plan issued in October 2012 that it is developing additional actions to deliver transformation of services that will reduce expenditure from 2013-14 and beyond. The timetable for delivering transformational change actions is ambitious, given the current financial pressures facing the Health Board. If the Health Board is to be successful, and to avoid a repeat of the significant financial pressures faced in 2012-13, the Health Board will need to provide a clear steer on service priorities, recognising that there will need to be disinvestment in some areas and improved efficiency in others. Rebasing the budget in this way will provide CPGs and departments with a clear steer, thus enabling them to focus their efforts on delivering more realistic cost reduction targets.

56. The Health Board will also need to prepare and approve sustainable service and financial plans before the start of the 2013-14 financial year. The plans will also need to clearly demonstrate how financial pressures will be managed and addressed.

Weaknesses in governance and the lack of a comprehensive plan to revise service delivery risk jeopardising the Health Board's sustainability in the medium-term

Despite some strengths, internal control arrangements still exhibit some fundamental weaknesses

57. 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. As part of my work on structured assessment, my audit team reviewed the internal control environment, to ensure good governance can be demonstrated across a wide range of key areas.

58. From the beginning, the Health Board put sound arrangements in place to promote probity and propriety, including the introduction of counter fraud and whistle blowing policies. Internal Audit is now provided by the NWSSP, and is compliant in all significant respects with the NHS Internal Audit Standards in Wales, although more testing of CPG level arrangements would be desirable. Compliance with NHS primary care contracts is tested with post-payment verification of General Practice, which expanded to General Optical Services in 2012. The Health Board is at an early stage of a planned expansion of post payment verification into Community Pharmacy and Dental contracts.

59. Whilst the Health Board had taken actions to strengthen governance across a number of areas, others require on-going review to ensure they are operating as intended and are sustainable. In my previous years' structured assessment work, I identified a number of areas where the Health Board needed to strengthen its arrangements. The progress that is being made against these areas is summarised in Exhibit 2.

Exhibit 2: Progress against improvement areas from previous Structured Assessments

Area to strengthen identified under previous Structured Assessments	Progress made by the Health Board
Risk Management arrangements are maturing, but linkages are not yet fully embedded (2011)	The Health Board had developed policies and procedures for risk management which are based on best practice, but in 2011 we found these had not been fully embedded in front-line services, and key posts to support risk management were not yet fully appointed. In 2012, further progress has been made, with posts filled, and links established within CPG structures. However, the legacy paper-based risk assessment and incident reporting systems are still operating in a two of CPGs, and are not due to be "'switched off' until the end of 2012. This means that risks in two critical CPGs are not managed consistently across the Health Board.
Although operational clinical audit is planned and delivered, it is yet to become an effective part of the Health Board's assurance framework (2011)	There has been limited progress in linking clinical audit with risk and health board strategy. The 'must do' National Clinical Audits are generally in place, and there is evidence of audits stimulated by known areas of risk or concern in 2012, and a clinical audit list was considered by the Audit Committee in 2012. However, a formal structured clinical audit strategy linked to the Health Board's strategy, clinical effectiveness and formally identified needs, rather than individual clinicians' interests, remains a gap.

Area to strengthen identified under previous Structured Assessments	Progress made by the Health Board
There are opportunities to further develop and improve the Assurance Framework (2011)	The Health Board's assurance framework is not yet mature, as underpinning systems not truly embedded within front-line services. There is an assurance framework document, which links key controls, strategy and risks, but there is insufficient evidence of testing effectiveness of controls, for example: • a backlog for reviewing incidents and poor engagement of some CPGs with the new DATIX system means there is a risk that learning from clinical incidents may be missed; and • limited assurance from Internal Audit testing of CPG governance arrangements and only two CPGs tested per year. However, the Health Board has adopted a good for testing compliance with healthcare standards, which makes use of a 'Star chambers[1]' for Healthcare standards, and includes input from Internal Audit for additional assurance.
Gaps remain in the Health Boards information governance and management, particularly at a strategic level (2011)	Information management and governance are now developing rapidly following a slow-start. ICT arrangements are starting to mature through new structures and arrangements, although some posts are yet to be appointed at lower tiers, and old fashioned legacy systems are hampering integration in some front-line services.
Standing Financial Instructions (SFIs), and Standing Orders (SOs) were modelled on best practice, but my team did not test their operation (2010)	The corporate-level SFIs and SOs are re-examined annually and updated, and continue to be modelled on best practice using all Wales guidance. However, my work in a number of performance areas shows that this good practice has not been embedded throughout all CPGs. For example, one CPG did not have an agreed scheme of delegation until October 2012. The SFIs are regularly breached by CPGs, demonstrated by many CPGs overspending against budgets. There is no corporate mechanism to officially 'sanction' waivers of SFIs for patient safety or other reasons, although ad hoc approval is sought from the Executive for some items.

[1] 'Star Chambers'- the executive team and independent members, challenge and test the evidence provided in the organisational self-assessment of Healthcare standards. Internal Audit provided significant assurance on this process.

60. Due to late guidance, and in common with other health boards, the approach taken by the Health Board to producing the Annual Governance Statement was not strong in 2012, but is developing for 2013. The 2012 Annual Governance Statement was prepared late, and although it covered most of the necessary items, it required additional depth and triangulation. The Health Board recognised this and is now developing a new process for 2013, which it intends will also produce the forthcoming Annual Quality Statement. My audit will monitor these developments in 2013.

61. The Health Board started to consider the impact of the new Audit Committee Handbook on Board committees and sub-committees in December. A number of changes will be necessary to ensure the Health Board complies with the expected practices set out in the new Audit Committee Handbook. In particular, the requirement that the Audit Committee should bring key assurances together throughout the year. The current committee interoperability and cross-referencing mechanisms which rely on joint meetings or cross-membership will not be sufficient. A formal assurance mechanism will be required, and this may take the form of another Board committee. My audit team will continue to review these developments in 2013.

Good arrangements are in place to comply with data confidentiality, but arrangements to support data quality, and ICT business continuity and disaster recovery need to be strengthened to ensure they are fully effective

62. My audit team has undertaken a high-level examination of the Health Board's arrangements for ensuring the data that it produces is reliable and accurate. Whilst this work has not sought to validate the quality of specific NHS data sets or performance indicators, it has reviewed basic patient demographic data to determine the extent of duplicate and missing information on Patient Administrative and Radiology systems. The Health Board has improving arrangements for ensuring data is valid and accurate, but they need to become more formalised, remove variation in practice across sites and include approaches to provide improved assurance. Data matching on system demographic data indicated reasonably effective controls are in place but records with no NHS number present a risk.

63. In addition to work on data quality, my auditors have also examined the Health Board's arrangements for implementing Caldicott guidance on confidentiality of patient data, and also the robustness of the Health Board's disaster recovery and business continuity processes in the event of an IT system failure. My work found:

- clear well embedded Caldicott arrangements, which were understood by front-line staff on all three sites when my auditor visited; and
- my work on disaster recovery and business continuity processes associated with IT clinical systems indicated that the Health Board did not have sufficiently robust ICT disaster recovery and business continuity arrangements, but it was aware of these risks and was taking improvement action.

Board operation requires strengthening to improve transparency and record keeping and the Health Board cannot fully demonstrate effectiveness

64. My audit team facilitated a governance workshop early in 2012 as part of the Health Board's development agenda. My Structured Assessment included a range of observations of both the Health Board and its committees at various points throughout 2012. These structured observations were supplemented by a detailed review of agendas and papers submitted to the Health Board and Committees. I concluded that the Health Board is unable to consistently demonstrate that it is effective in holding to account and on occasion poor documentation exposes decision makers to risk.

65. In particular, there are some fundamental issues to consider in relation to how the Health Board conducts its business. The recent use of 'in-committee' Board meetings is a positive step forward, and reflects the need to hold private discussions outside the public domain on potential developments and to explore options. However, over the past year there may have been important 'business discussions' held in un-minuted private Board development sessions. Other important discussions were held in Finance and Performance Committee. Whilst Board members are generally of the opinion that no Board decisions were made in these sessions, it does potentially expose the Board to governance risks. This is because there may be no record of challenging discussions, it is of questionable transparency, and could lead to a poor document trail on key strategic discussions. Moreover, using Board development sessions to discuss business issues is likely to squeeze the time that is available for genuine board member development activities.

66. The Board must also guard against giving the impression that its public meetings are managed or anodyne. This is how my auditors characterised some of the public board meetings they observed and probably reflects the fact that substantial elements of the discussions have already taken place in Committee meetings.

67. In addition, although the conduct of Board business continues to mature, Health Board agendas could be better managed to reflect a range of other important points:

- Patient stories are a very recent development at the Health Board, and whilst patient safety items have prominence and discussion, these are not direct experiences through the patient's own 'voice'.
- Some papers discussed in Committees should be discussed by whole Board, e.g. 'scenario' planning.
- The size of the Health Board agenda relative to the time available for the meetings creates the risk there is insufficient consideration and challenge on important items, when compared to the Health Board's Committees. One example of this is the time allowed at Board for scrutiny of sub-committees, and this is despite the use of' issues of significance' on cover-sheets. Other Boards manage their agendas more tightly, by requiring reports from their Chair, Chief Executive, Committee Chairs and 'Board Champions' written in advance as part of the agenda papers.

- The Health Board is only partially able to demonstrate organisational learning of lessons at Board-level. Ombudsman reports have been discussed at Board, but summary lessons from "Level-Four[2]" incidents have not.

68. On the whole, I found that the Board committee structures that are in place are, in the main, working effectively. The Finance and Performance Committee is strong, provides robust challenge to executives and has established linkages with the Quality and Safety committee for reviewing savings scheme proposals. The Audit Committee continues to evolve and there is positive direction of travel – again there are joint committee meetings with Quality and Safety, and in general the level of scrutiny is good, with a clear process for tracking actions and a developing process for tracking implementation of audit recommendations. The Health Board chose to establish a Workforce and Organisation Development Committee, rather than the standard remuneration committee, and this demonstrates Board flexibility to its own recognised requirements.

69. However, I found that Quality and Safety committee arrangements are not sufficiently mature to provide full assurance that all risks are appropriately managed. In particular, despite the positive changes showing since the appointment of a new chair earlier in 2012, the large agenda requires more signposting. The complex sub-structure which helps Quality and Safety manage this large agenda was, in itself, difficult to manage, so the Health Board introduced the Quality and Safety Lead Officers Group (Q&SLOG) to support the Committee. But this Q&SLOG itself introduces the risk of filtering, i.e. issues may not get to Quality and Safety Committee (or not quickly). It is noted that Healthcare Inspectorate Wales (HIW) will be undertaking more detailed review work on quality and safety arrangements early in 2013. My auditors will liaise appropriately with HIW colleagues as they deliver this work.

Strategy and planning need to address the concern that service structures are not sustainable going forward, and despite substantial effort to engage stakeholders, this remains a significant challenge

70. The Health Board has a clear strategic vision based on the *Triple Aim*, and *Our Strategic Direction*, and its intention to put clinicians at the heart of decision-making and service change is laudable. The Health Board also has detailed operational plans, which are updated annually. The Five-Year Plan is operationally focussed, with year-on-year steps set out. However, whilst these annual plans drive incremental service changes, they are not stimulating the step change required to achieve service transformation. Hence, I concluded that the route to achieving the Health Board's vision is not sufficiently clear. Of particular concern is the lack of a clear route to sustainable service models for acute services, given that this was not covered in the recent consultation on *Healthcare in North Wales is Changing.* The need to set out clear proposals for the acute sector model in North Wales is pressing given the concerns over the sustainability of current service models.

[2] Level Four incidents, are the most serious clinical incidents, which either result in lasting harm or a patient death. Best practice would be for a summary of the causes and lessons learned be considered by the Board as part of a 'quality' report.

71. I found that the Health Board has made some progress on modernising service delivery, with work on whole-system patient pathways underway, intensive interventions, for example in Orthopaedic services, and the evidence-based 'service reviews' proposing in some cases quite radical changes, but more pace is needed. The maturity and success of pulling annual service, financial and workforce plans together at a CPG level varies, and this was clearly demonstrated by the failure to agree balanced budgets in 2012. In the absence of medium-term solutions, the service and financial pressures continue to build. My other performance work on unscheduled care and locum doctors examines this pressure in more detail later in this report.

72. In addition, external stakeholders such as the public and partners in other public services are not clear on how it will 'all fit together', and in the absence of information, are suspicious of potential changes. The Health Board made substantial efforts to engage and consult with the public in line with guidance issued by the Welsh Government., and also commissioned an independent review of their processes by the Consultation Institute. However, the public response to the consultation demonstrates that the Health Board has a lot to do in order to win the trust of the public and to get buy in to the service changes which are needed. In looking at the approach the Health Board has taken to date, I have identified are a number of specific issues that the Health Board will need to consider as it looks to progress its future public engagement:

- alongside the demonstration of clear clinical leadership for the service changes, there should be a greater visibility of independent members and the Chief Executive at public meetings;
- the public and their representatives in the form of CHCs need to be sighted of the complete range of service transformation plans, including options on for acute sector service remodelling – gaining the support and endorsement of strategic plans by the CHC will be an important step forward; and
- the use of specialists with specific communication and media handling skills should be considered as a mechanism to help convey difficult messages to the public.

Accountability arrangements relating to Clinical Programme Groups (CPGs) have been strengthened recently but the significant differences in CPGs' span of responsibilities needs to be reviewed whilst concerted effort is going to be needed to establish effective models of clinical leadership and engagement

73. The audit work that I have undertaken during 2012 has pointed to some key challenges around accountability arrangements for the Health Board's CPGs, and issues around the differences in size and maturity, between CPGs.

74. In 2012, executives' responsibility for CPGs was reviewed and divided across four members of the executive team. This was a pragmatic move to release capacity for Medical Director, allowing a change in emphasis for that role, but it also helped clarify accountability for the individual CPGs at Board-level.

75. Another key change in 2012 is a tightening of performance management arrangements through the introduction of the DPB. In the past CPGs have not been held effectively to account, despite performance reviews and SFIs, but the Health Board acted to introduce the DPB to tighten performance management. The DPB scrutinises performance against a range of financial and performance measures at least monthly, depending on CPG performance.

76. The CPGs in the Health Board vary significantly in size and complexity The Primary, Community and Specialist Medicine is very large, accounting for £189 million of the Health Board's spending and is responsible for both the traditional acute focussed care, including unscheduled care and community services, as well as the developing community services agenda. In comparison, Pathology and Radiology CPGs have much smaller spans of control with annual budgets of around £20 million each. It is noted that the Health Board has commissioned a timely internal stocktake of its CPGs, and I would expect that some changes will occur in 2013 as a result of this work to strengthen the current CPG model. My auditors also noted that embedding clinical leadership was a key intention behind the CPG structure.

77. Auditors have noted some differences in extent to which CPGs have matured to deliver the functions expected of them. This is partly a reflection of their size, and the complexity of the agenda they are expected to manage, but is also connected to lack of critical mass in the smaller CPGs to develop expertise, and the time it has taken to work through the organisational change process and appoint staff into the new structures in the larger CPGs. In some CPGs, management and support posts are not fully appointed three years after the creation of the Health Board. Another key factor which requires further review is the management capacity to support clinical leaders within CPGs and the Health Board generally. Clinical leaders should not be undertaking day to day operational management roles, but free to take a more strategic role and engage with their clinical peers to drive service change.

78. Co-ordination at a hospital site level between CPGs has also not been as effective as intended, and as a direct result of this the Health Board refreshed it's Hospital Management Teams in 2012; strengthening and clarifying the roles of site-based Assistant Directors of Nursing and Medicine, but it has not appointed operational managers or operating officers outside the CPG structure. In response to concerns about unscheduled care performance in Ysbyty Glan Clwyd, the Health Board also launched an 'intervention' using the same intense improvement methodology it used early in 2012 to achieve improvement in orthopaedic services. This reflects positive, but belated action to address the risks that were apparent.

79. Engagement with staff, especially clinicians, is a key enabler of strategic service change. I reviewed the Health Board's approach to clinical engagement in 2012. This work entailed interaction with, a wide range of professionals across a number of different staff groups. I found that new clinical leadership models are starting to challenge some longstanding cultural issues, but that wider clinical engagement is still variable and requires concerted action by the Health Board to ensure that is embedded throughout the organisation. In general my work found that clinical staff reported a willingness to engage with modernisation initiatives but that clinical staff typically fell into three clear groups:

- those who are engaged – these were typically staff who had leadership roles within the new CPG structures;
- a reasonably sized minority who were disenfranchised and vocal in opposition, but who reported a willingness to become engaged; and
- the majority who were ambivalent.

80. My work also identified a number of suggestions to help the Health Board move forward. These included ensuring clinical leaders have sufficient time for face-to-face contact with their clinical peers to provide visible leadership on all sites; extending and continuing the wider conversations with staff groups through such events as the *Big Conversation* and *World Café;* and producing a clear route map of how services are going to be transformed.

Management information needs to be strengthened to support effective governance and assurance

81. My Structured Assessment work this year has focused on whether the Health Board and its sub-committees have access to relevant management information to plan, make decisions and underpin effective scrutiny and board assurance. I found that management information is evolving, but that more emphasis needs to be given to information that describes outcomes and the patient experience; and that different sources of information need to be brought together more effectively to provide a complete picture of services.

82. I have already highlighted the substantial improvement in the clarity and quality of financial reporting, and the Health Board has very recently further improved performance monitoring to consider primary care measures, and tracking of operational and implementation plans on a six-monthly basis. However, the management information taken to Board misses substantial areas of the Health Board's responsibilities, e.g. quality of care, outcomes, and services purchased from England. The absence of patient experience information on most Board agendas (with the notable exceptions of the annual Picker survey, and Fundamentals of Care), and the absence of a dashboard or data-book approach available to all Board members are all areas that require attention.

83. Information on Quality and Safety issues is improving but could be better. Complaints and incident reports do not get to Board as separate documents neither do level-four serious incident reviews, even as summary lessons learnt. In particular, the lack of an overall quality report is notable at Board-level, and quality reports to Board Committees are not sufficiently explicit about where the problems are within the Health Board. By aggregating data there is a risk that poor quality care is masked. For example, for some incidents and concerns relating to unscheduled care, the information provided does not indicate whether the problem occurred at one individual Emergency Department, or whether it was spread across all three. The timeliness and completeness of quality data also compromises the integrity of management information. The DATIX backlog in some CPGs means that Board members cannot be assured that they are receiving up -to-date information. For example an increase in incidents within a department was related to staff sickness or reduced staffing levels caused by vacancies.

84. Overall, despite some progress and a general picture of improving management information, some significant gaps remain in the management information available to the Board which need to be addressed.

Data matching as part of the National Fraud Initiative has not identified any cases of fraud and error

85. The NFI matches data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. I concluded that the Health Board's approach was well managed overall, but at the time of my review, more progress could have been made on the investigation of duplicate creditors and records matches.

My other performance work highlights limited progress on substantial issues, which will be difficult to progress without better clarity on medium-term transformation of services, and faster delivery of change by Clinical Programme Groups

Unscheduled care services remain under pressure while chronic condition services are still fragmented and underdeveloped: progress in implementing a whole-system approach is hampered by the complexity of internal structures and partnerships, insufficient clinical engagement and underdeveloped plans to implement a comprehensive model

86. Previous Wales Audit Office reports in 2008 and 2009 have highlighted the need to improve key aspects of unscheduled care and chronic conditions management services. During 2011 and 2012 I undertook a detailed programme of follow-up audit work on chronic conditions and unscheduled care across Wales. This work considered progress against previous audit recommendations, but also aimed to provide new insight into the barriers and enablers affecting progress locally. As there are a number of key interrelationships between chronic conditions and unscheduled care, the work was delivered as a single integrated review.

87. My follow up work has shown that the Health Board is struggling to improve unscheduled care performance because acute capacity is stretched and the shift of services into the community has been slow, resulting in only limited reduction in demand on acute services. A large contributor to this is the slow improvement to patent flow over the last few years, which means that not only do patients stay in beds longer than they need to, but the bed is then not available for the next patient who needs it.

88. Patient flow issues have been compounded by the small reduction in bed capacity since 2008. Slower patient throughput through the hospital system, alongside increased demand for unscheduled care have contributed to significant pressure being placed on the Health Board's Emergency Departments. Slower patient transit through Emergency Departments is also contributing to delayed handover of ambulance patients and ambulances queuing outside the Departments. Collectively this is contributing to poor performance against national targets, negative patient experience and increasing risks to patient care when departments are particularly busy.

89. The pressure on unscheduled care services is partly due to the fact that the Health Board has only been able make limited progress in developing effective chronic conditions management programmes that cover the whole North Wales population. The Health Board inherited demonstrator sites from its predecessor organisations, but my work found limited progress building on this legacy due, in a large part, to delays in fully establishing locality teams. Problems in accessing primary care with poor opening hours, and slow progress on rationalising local enhanced services for patients with chronic conditions contribute to the pressure on acute services. This pressure is compounded by the way the public uses services, with limited progress on influencing the way the public chooses to use services, and to improve self-care.

90. Looking forward, my work indicates some positive developments. Specifically, the Health Board has a vision for both Unscheduled Care and chronic conditions management services, with a clear strategic commitment to treating people safely, appropriately and as close to home as possible. However, I found that plans to implement this vision are vague, high-level and undermined by a number of challenges made harder by complexity of management arrangements. In particular, the Health Board's vision for unscheduled care and chronic conditions management services is not supported by appropriate and detailed transformation plans, and whilst there are numerous action plans for specific areas, these do not add up to a clear plan for moving from the current services to the desired whole system approach.

91. A number of challenges are impacting on the pace of change including complex management arrangements, which are poorly understood by partners and some other stakeholders; performance management arrangements for unscheduled care and chronic conditions management which are not supported by comprehensive performance information; and the Health Board's clinical leadership model is not yet delivering sufficient clinical engagement to drive successful change in these important services.

While the Health Board is using locum doctors to maintain service delivery, the current approach represents poor value for money, presents some risk to the quality of services and does not address the situation in a strategic way

92. In common with other NHS bodies, the Health Board will to make use of locum doctors in order to be able to respond to unplanned urgent gaps in rotas, and to sustain effective service delivery when there are problems recruiting permanent staff. The use of locum doctors in the Health Board has been increasing year-on-year. However, the overuse of agency locums in particular is resulting in costs which are now unaffordable.

93. The Health Board has a good understanding of its medical workforce needs, but has had limited success in recruiting and retaining permanent staff. There has only been limited progress in dealing with recruitment issues while accountability for addressing the issue of medical staffing rests with each CPG. My auditors found some CPGs have been more proactive than others.

94. The Health Board's expenditure on locum doctors increased to £18.3 million in 2011-12, and basic relevant administrative arrangements are in place and are improving, but the Health Board cannot be assured of appropriate quality of care from the temporary staff it relies upon to deliver services. Another concern is the reliance the Health Board places on agency checks for short-term locums at short notice, which comply with minimum standards, but are not as extensive as the Health Boards own checks on medical staff before appointment.

95. The Health Board does not have a clear and coherent plan for safely moving to the right level of locum doctors. The Health Board clearly wants to move to a more affordable option, but there is no corporate-wide plan to address the long-standing drivers of demand for locums. It is recognised that there are some actions currently being taken, but these are not yet co-ordinated to a level that will reduce pressures both now and in the future.

My follow-up performance work found slow progress on implementing recommendations

96. During the last 12 months my audit team have kept a watching brief on progress that has been made in addressing concerns and recommendation arising from previous audit work in specific areas of service delivery. This has been achieved through the review of formal progress reports to Board and other committees and through contact with the Health Board operational managers. The findings from the follow-up work are summarised in Exhibit 3.

Exhibit 3: Progress in implementing audit recommendations

Area of follow-up work	Conclusions and key audit findings
Hospital Food and Catering	This work was delayed at the request of Health Board managers, due to on-going disciplinary investigations within key parts of the catering team. The Health Board has been proactive in requesting and distributing my leaflets on what patients should expect, and monitors nutrition through its ward level fundamentals of care audits. A recent HIW report also highlighted good progress on embedding key improvements around nutrition, with the implementation of the Nutritional Care Pathway, and the all-Wales Food Record Chart. A site visit by my staff in the summer of 2012 did provide some assurance that improvements identified in 2010 had been made to the kitchen facilities. However, my key recommendation to replace out-dated food delivery trollies on the Wrexham Maelor site had not been implemented in December 2012. Detailed follow-up is scheduled for January 2013, when the trollies are due to be commissioned.
Consultant Contract benefits realisation	The Health Boards Workforce reports now include monthly monitoring of the percentage of consultants who have an up-to-date appraisal and job plan, and the team established within the Office of the Medical Director to standardise policies and procedures across the Health Board is on track with its revised implementation plan. However, my fieldwork in specific CPGs on unscheduled care, chronic conditions management and locum doctors shows there is still variability in the quality of job-plans between CPGs, and their effectiveness in engaging this important staff group in modernising service delivery.

Appendix 1

Reports issued since my last Annual Audit Report

Report	Date
Financial audit reports	
Financial Accounts Audit Deliverables	March 2012
Assessment of Internal Audit 2011-12	May 2012
Audit of Financial Statements Report	June 2012
Opinion on the Financial Statements	June 2012
Opinion on the Whole of Government Accounts return	July 2012
Audit of Charitable Financial Statements Report	July 2012
Opinion on the Charitable Financial Statements	July 2012
Final Accounts Memorandum 2011-12	September 2012
Performance audit reports	
ICT Business Continuity/Disaster Recovery	February 2012
ICT Data Quality	March 2012
Structured Assessment	November 2012
Combined Review of Unscheduled Care and Chronic Conditions Management	December 2012
Locum Doctors	December 2012
Follow Up monitoring of previous audit recommendations, included in this report	December 2012
Other reports	
Outline of Audit Work 2012	March 2012
Annual audit Report	December 2012

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

Report	Estimated completion date
Hospital catering	February 2013
GP Prescribing-	February 2013
Orthopaedics-	June 2013

Appendix 2

Audit fee

The Outline of Audit Work for 2012 set out the proposed audit fee of £610,856 (inclusive of VAT). My latest estimate of the actual fee is in accordance with the fee set out in the outline.

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