

Archwilydd Cyffredinol Cymru  
Auditor General for Wales



WALES **AUDIT** OFFICE  
SWYDDFA **ARCHWILIO** CYMRU

## Annual Audit Report 2014

# Abertawe Bro Morgannwg University Local Health Board

**Issued:** February 2015

**Document reference:** 125A2015

# Status of report

---

This document has been prepared for the internal use of Abertawe Bro Morgannwg University Local Health Board as part of work performed in accordance with statutory functions.

No responsibility is taken by the Auditor General or the staff of the Wales Audit Office in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at [infoofficer@wao.gov.uk](mailto:infoofficer@wao.gov.uk).

The team who assisted me in the preparation of this report comprised Dave Thomas, Richard Harries, Ann-Marie Harkin, Matthew Coe and Carol Moseley.

# Contents

---

Summary report	4
Detailed report	
About this report	7
Section 1: Audit of accounts	8
I have issued an unqualified opinion on the 2013-14 financial statements of the Health Board, although in doing so, I have brought several issues to the attention of officers and the Audit Committee	8
Section 2: Arrangements for securing efficiency, effectiveness and economy in the use of resources	12
The Health Board continues to control budgets and monitor savings plans effectively, but the scale of the savings required in the next three years raises significant risks to the financial position, and services	12
The Board has set a clear vision and is promoting a quality focused culture. There have been improvements to governance arrangements and in the management of concerns but further improvements are needed to strengthen important aspects of quality governance, build organisational capacity, and fully embed organisational learning	15
While my performance audit work has identified examples of good practice, there are opportunities to secure better use of resources in a number of key areas	29
Appendices	
Reports issued since my last Annual Audit Report	37
Audit fee	38
Significant audit risks	39

# Summary report

---

1. This report summarises my findings from the audit work I have undertaken at Abertawe Bro Morgannwg University Local Health Board (the Health Board) during 2014.
2. The work I have done at the Health Board allows me to discharge my responsibilities under the Public Audit (Wales) Act 2004 (the 2004 Act) in respect of the audit of accounts and the Health Board's arrangements to secure efficiency, effectiveness and economy in its use of resources.
3. My audit work has focused on strategic priorities as well as the significant financial and operational risks facing the Health Board, and which are relevant to my audit responsibilities. More detail on the specific aspects of my audit can be found in the separate reports I have issued during the year. These reports are discussed and their factual accuracy agreed with officers and presented to the Audit Committee. The reports I have issued are shown in [Appendix 1](#).
4. This report has been agreed for factual accuracy with the Chief Executive and the Director of Finance. It will be presented to the Audit Committee on 19 February 2015 and subsequently at the Board Board meeting 26 March 2015, with a copy provided to every member of the Health Board. We strongly encourage wider publication of this report by the Health Board. Following Board consideration, the report will also be made available to the public on the Wales Audit Office's own website ([www.wao.gov.uk](http://www.wao.gov.uk)).
5. The key messages from my audit work are summarised under the following headings.

## Section1: Audit of accounts

6. I have issued an unqualified opinion on the 2013-14 financial statements of the Health Board, although in doing so I have brought several issues to the attention of officers and the Audit Committee. These issues were two non-material uncorrected misstatements; and two areas for financial reporting improvements relating to indexation and the reversal of prior year impairments, and the measurement of compliance with the Public Sector Payment Policy.
7. I have also concluded that:
  - the Health Board's accounts were properly prepared and materially accurate;
  - the Health Board had an effective control environment to reduce the risk of material misstatements to the financial statements; and
  - the Health Board's significant financial and accounting systems were appropriately controlled and operating as intended.
8. The Health Board achieved financial balance at the end of 2013-14. I set out more detail about the financial position and financial management arrangements in section 2 of this report.

---

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

9. 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, the adequacy of its governance arrangements, and the progress made since last year on quality governance and arrangements for measuring and improving patient/user experience. Performance audit reviews have also been undertaken on specific areas of service delivery. This work has led me to draw the following conclusions:

The Health Board continues to control budgets and monitor savings plans effectively, but the scale of the savings required in the next three years raises significant risks to the financial position and services

10. As in previous years, good in-year budgetary control, financial management and additional funding ensured the Health Board achieved financial balance in 2013-14. However there was an impact of reduced elective activity and significant risks remain around setting balanced budgets in the future.
11. The Health Board needs to make a similar level of savings in 2014-15 as previously, and is relying on national achievement of further savings to break even. Risks remain that the financial position is not sustainable or achievable in the medium term.

The Board has set a clear vision and is promoting a quality focused culture. There have been improvements to governance arrangements and in the management of concerns but further improvements are needed to strengthen important aspects of quality governance, build organisational capacity, and fully embed organisational learning

12. Key findings from my review of the Health Board's governance arrangements are as follows:
- The Health Board's Integrated Medium Term Plan (IMTP) sets a clear vision and provides a reasonably sound basis for taking the organisation forward and guiding its improvement activity.
  - Executive portfolios have been refined and the organisational structure is being revised to better support delivery of the organisation's strategic objectives but changing management culture and building operational capacity remain challenges.
  - The Board provides good strategic leadership and the revised committee structures support good governance. There have been improvements to some governance arrangements but there are important aspects of quality governance which need to be improved.
  - Internal controls are generally effective and arrangements for managing information, risk and performance continue to be strengthened.

- 
- The Health Board demonstrates commitment to improving quality and patient experience with significant progress made in capturing patient feedback and improving the management of concerns. However, some important aspects of quality scrutiny arrangements need to be progressed and there is more to do to embed organisational learning.

While my performance audit work has identified some examples of good practice, there are opportunities to secure better use of resources in a number of key areas

**13.** Key findings from my performance audit reviews are as follows:

- The Health Board has set an ambitious change agenda, demonstrates strong community engagement and is investing in supporting technologies. But there are risks around estates and equipment and challenges for improving workforce planning and ensuring managers are equipped to lead.
- The role of the district nursing service is not clearly defined, there is unexplained variation in district nurse deployment, resources and service demand are not sufficiently aligned, and there is a lack of systematic monitoring of quality and performance at an organisational level.
- The Health Board recognises the importance of clinical coding and some of the associated processes are robust, but more needs to be done to address the wider factors affecting accuracy and timeliness of coding.
- A rising level of orthopaedic demand is placing pressure on outpatient services and there are inefficiencies in the inpatient pathway that are impacting on the use of resources and patient experience, with some outcomes following surgery less positive than elsewhere.
- Sickness absence data used for corporate performance management is reliable and executive input has improved sickness absence management and scrutiny, although it needs to be more devolved in the longer term.
- The Health Board has made progress in addressing recommendations from previous audits but pace of response could be faster and actions remain outstanding in a few key areas.

**14.** We gratefully acknowledge the assistance and co-operation of the Health Board's staff and members during the audit.

# Detailed report

---

## About this report

15. This Annual Audit Report to the Board members of the Health Board sets out the key findings from the audit work that I have undertaken between December 2013 and November 2014.
16. My work at the Health Board is undertaken in response to the requirements set out in the 2004 Act. That act requires me to:
  - a) examine and certify the accounts submitted to me by the Health Board, and to lay them before the National Assembly;
  - b) satisfy myself that the expenditure and income to which the accounts relate have been applied to the purposes intended and in accordance with the authorities which govern it; and
  - c) satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.
17. 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;
  - 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.
18. I have issued a number of reports to the Health Board this year. The messages contained in this Annual Audit Report represent a summary of the issues presented in these more detailed reports, a list of which is included in [Appendix 1](#).
19. The findings from my work are considered under the following headings:
  - Section 1: Audit of accounts; and
  - Section 2: Arrangements for securing economy, efficiency and effectiveness in the use of resources.
20. [Appendix 2](#) presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my work at the Health Board, alongside the original fee that was set out in the Annual Audit Outline.
21. Finally, [Appendix 3](#) sets out the significant financial audit risks highlighted in my Annual Audit Outline for 2014 and how they were addressed through the audit.

---

## Section 1: Audit of accounts

- 22.** This section of the report summarises the findings from my audit of the Health Board's financial statements for 2013-14. These statements are the means by which the organisation demonstrates its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Preparation of an organisation's financial statements is an essential element in demonstrating appropriate stewardship of public money.
- 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 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, 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 2013-14 financial statements of the Health Board, although in doing so, I have brought several issues to the attention of officers and the Audit Committee**

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

- 26.** The draft financial statements were produced for audit by the agreed deadline of 2 May 2014 and were of a high standard. We received information in a timely and helpful manner, and we found the information provided to be relevant, reliable, comparable, material and easy to understand. The significant estimates included within the financial statements relate primarily to accruals (primary care expenditure and holiday pay), and provisions (Continuing Health Care, clinical negligence, personal injury and other). We concluded that accounting policies and estimates are appropriate and financial statement disclosures unbiased, fair and clear. We encountered no significant difficulties during the audit and were not restricted in our work.



27. I am required by ISA 260 to report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 3 June 2014. [Exhibit 1](#) summarises the key issues set out in that report.

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

Issue	Auditors' comments
Continuing Healthcare and Prescribing expenditure accruals	<p>We reviewed the methodology for calculating the accrual for Continuing Health Care expenditure and tested the data underpinning this calculation. We concluded that the methodology to calculate the provision is reasonable. However, our testing of the underlying data identified that an incorrect weekly rate had been used in one locality resulting in the accrual being understated by £187k.</p> <p>The Prescribing accrual totalling £14.381 million relates to the estimated prescribing expenditure for the months of February and March 2014. We are satisfied with the process of estimation for this accrual. During May 2014, the Health Board has been advised of the actual expenditure values from the prescribing audit reports for February and March 2014. The actual expenditure for this period amounted to £14.214 million and as such the accrual was overstated by £167k.</p> <p>The net position of £20k of these two uncorrected misstatements above did not impact on the Health Board's financial targets or the audit opinion.</p>
Welsh Health Specialised Services Committee balances	<p>As the Health Board shares financial risks for the Welsh Health Specialised Services Committee (WHSSC) with all local Health Boards in Wales, any amendments from the audit of WHSSC need to be reflected in each local Health Board's own financial statements. We confirmed with the WHSSC audit team that there were no issues arising from the audit of WHSSC affecting the Health Board's financial statements.</p>
Indexation and reversals of prior year impairments	<p>One issue arose in respect of the accounting treatment of indexation across Welsh NHS bodies. The Welsh Government's Manual for Accounts states that the indexation on assets should initially be used to reverse prior year impairment depreciation in the first instance and credited to revaluation reserve thereafter. The Health Board has confirmed with its software provider that indexation is not currently being treated in accordance with the Welsh Government Manual for Accounts. The Health Board was unable to quantify the exact impact of any potential misstatement as it would involve an extensive manual exercise. The Health Board has since requested its software provider to develop a programme update to resolve the issue in 2014-15. On the basis of the information available to us we concluded that the financial statements were not materially misstated.</p>

Issue	Auditors' comments
Public Sector Payment Policy (PSPP) – Measure of Compliance	The financial statements set out the Health Board's performance against the PSPP 'prompt payment code' – the Welsh Government has set a target of 95% for the number of non-NHS payments within 30 days of delivery. The Health Board has reported performance of 94.7% against this target for 2013-14. The Manual for Accounts explicitly requires Health Boards to include payments made to primary care contractors in their PSPP performance data. The Exeter system used by the Health Board to process primary care payments does not provide any statistical information on the number of days it has taken to make payments. In common with some other Welsh health bodies, the Health Board has therefore assumed that all payments are made within 30 days. We are therefore of the view that the PSPP performance data for both NHS and non-NHS may be overstated but we are unable to quantify the level of overstatement. The Health Board has improved its arrangements for 2014-15.
Annual Governance Statement (AGS)	The Health Board is required to prepare and include in its financial statements an AGS. This sets out the Health Board's governance structures, systems of internal control and risk management and the effectiveness of these systems in operation during the year. The Health Board has included in its AGS, a number of performance and operational issues that have arisen during the past year, most notably centred on the Princess of Wales Hospital. Alongside Health Inspectorate Wales and the Welsh Government, we have been following these issues closely through ongoing discussions with senior staff. At this stage we continue to keep a watching brief on the actions the Health Board is taking to address concerns and recommendations from recent public reports.

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

- Whole of Government Accounts return – I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2014 and the return was prepared in accordance with the Treasury's instructions; and
- Summary Financial Statements and Annual Report – I concluded that the summary statements were consistent with the full statements and that the Annual Report was compliant with Welsh Government guidance.

**29.** My separate audit of the Charitable Funds financial Statements is also complete. There were no issues to report to Trustees at their meeting on 13 November 2014 and I issued an unqualified opinion on those financial statements on 2 December 2014.

---

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

- 30.** In considering the internal control environment, I assess arrangements that include high-level controls over the main accounting and budgetary control systems, the work and role of internal audit, and the work of the Audit Committee which plays an active role in reviewing and strengthening the internal control environment.
- 31.** I found that controls were operating as effectively as intended and therefore formed a reliable basis for preparing the financial statements.
- 32.** Following my review of the Audit and Assurance Service provided by the NHS Wales Shared Services Partnership, I concluded that the Audit and Assurance Service met the *2009 Internal Audit Standards for the NHS in Wales* and that there are some areas where improvements are required to achieve further consistency.
- 33.** The work that I have undertaken supports the external auditor's opinion on the financial statements. This does not constitute an assessment of internal audit under the new Public Sector Internal Audit Standards (PSIAS). Under PSIAS (which came into effect on 1 April 2013) organisations are required, every five years, to conduct an external assessment of internal audit. This goes beyond the work that external audit undertake to place reliance upon, or take assurance from, the work of internal audit.

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

- 34.** I did not identify any significant weaknesses within the Health Board's financial systems. However, there were some less significant areas for improvement identified during the audit and recommendations have been made to management to address these.
- 35.** Internal Audit reported on a number of system weaknesses which require ongoing management action. Management action plans have been developed to strengthen the control weaknesses identified in these reports, and progress is scrutinised by the Audit Committee.

---

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

- 36.** I have a statutory requirement to satisfy myself that NHS bodies have proper arrangements in place to secure efficiency, effectiveness and economy in the use of their resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:
- reviewing the Health Board's financial management arrangements, including the progress being made in delivering cost saving plans and their contribution to achieving financial balance;
  - assessing the effectiveness of the Health Board's governance arrangements through my Structured Assessment work, including review of the progress made since last year on quality governance and arrangements for measuring and improving patient/user experience;
  - specific use of resources work on clinical coding, and a performance indicator audit of sickness absence data; and
  - assessing the progress the Health Board has made in addressing the issues identified by previous audit work on hospital catering and reviewing the Health Board's arrangements for tracking external audit recommendations.
- 37.** The main findings from this work are summarised under the following headings.

### The Health Board continues to control budgets and monitor savings plans effectively, but the scale of the savings required in the next three years raises significant risks to the financial position, and services

As in previous years, good in-year budgetary control, financial management and additional funding ensured the Health Board achieved financial balance in 2013-14. However there was an impact of reduced elective activity and significant risks remain around setting balanced budgets in the future

- 38.** We have reported in previous years that the Health Board has good in-year budgetary control and financial management procedures in place. Our review this year found much of the 2013 position has continued with some further improvements in 2014. There were flat cash settlements for revenue funding of NHS bodies in Wales again for 2014. Total capital funding did rise slightly from £36.7 million in 2012-13 to £40.7 million in 2013-14 (discretionary funding £8.7 million against £7.7 million in 2012-13). There have also been improvements in budget monitoring at the Health Board via Budget Holder Dashboard and e-learning packages.

- 
39. The 2013-14 Resource Plan was approved by Board in March 2013 but was not financially balanced. The total revenue funding gap for 2013-14 was £57.0 million against which £29.0 million of savings and cost avoidance were identified, leaving a remaining funding gap of £28 million. This remaining funding gap was consistently reported to Executive Board, Board and Welsh Government in 2014. There were some differences in figures reported as the real time financial position changed and explanations could be clearer for these changes.
  40. A high percentage – 93 per cent or £26.8 million - of the £29 million savings target was achieved, which compares well to other Health Boards in Wales, although there were significantly more non-recurrent savings in 2013-14 than in previous years. The urgent savings plans from month seven in 2013/14 also impacted on some elective activity. These plans were risk assessed, and clearly reported to and approved by the Board.
  41. The remaining funding gap of £28 million was again closed after £20.5 million of additional non-recurrent funding from Welsh Government, and one off savings and measures by the Health Board. However, not all of the financial targets in 2013-14 were achieved: the revenue and capital resource limits were met but the Public Sector Payment performance was 94.5 per cent against the 95 per cent target.

The Health Board needs to make a similar level of savings in 2014-15 as previously, and is relying on national achievement of further savings to break even. Risks remain that the financial position is not sustainable or achievable in the medium term

42. The NHS Finance (Wales) Act 2014 has introduced a more flexible finance regime. It provides a new legal financial duty for Local Health Boards to break even over a rolling three financial years rather than each and every year. The Act allows Local Health Boards to focus their service planning, workforce and financial decisions and implementation over a longer, more manageable, period and moves away from a regime which encourages short-term decision making around the financial year. The financial flexibilities are, however, contingent upon the ability of NHS bodies to prepare suitably robust integrated medium-term plans, and the formal approval of those plans by Welsh Ministers.
43. Business and Service Planning is linked to the Financial Planning through the Annual Resource Plan process and through the production of the IMTP although there is scope to improve this. The Health Board's three year IMTP covering 2014-15 to 2016-17 and integrating workforce, finance and services plans has been approved by the Board and by the Minister.
44. In 2014-15 Welsh NHS bodies again received flat cash settlements, excluding the additional funding received in 2013-14. Capital funding has increased to £44 million but discretionary capital funding is largely unchanged.

45. The Health Board produced its IMTP for the three years 2014-15 to 2016-17 which was approved in June 2014 by the Minister. However, the IMTP was not financially balanced, with a total £90.6 million total shortfall for the three year period (Exhibit 2), for which savings/funding had not yet been identified.

Exhibit 2: IMTP funding gap 2014-15 to 2016-17

(in £m)	2014-15	2015-16	2016-17
<b>Projected costs</b>	59.5	39.5	37.5
<b>Identified savings</b>	(33.4)	(36.3)	(31.6)
<b>In-year annual funding gap</b>	<b>26.1</b>	<b>3.2</b>	<b>5.9</b>
Underlying deficit	-	26.1	29.3
<b>Cumulative annual funding gap</b>	<b>26.1</b>	<b>29.3</b>	<b>35.2</b>

46. In December 2014 the Minister announced additional funding to NHS bodies and the Health Board received additional funding of £26.1 million. This meets the 2014/15 IMTP requirement and will also be provided on a recurring basis, reducing the underlying deficit position to £nil in 2015/16 and £3.2 million in 2016/17.
47. £10 million of the £33.4 million of savings identified in 2014/15 is being managed on an NHS Wales national basis. The £23.4 million of locally managed savings in the IMTP is a similar level as in previous years and approximately £22 million are recurring savings.
48. The overspend for the year to date at November 2014 is £26.058 million but the additional funding of £26.1 million returns the Health Board to a break even position. Savings delivered are behind the year to date target, and additional service costs are being incurred in agency costs, higher CHC costs and prescribing costs. The Health Board forecasts that further overspends of £5.9 million between December 2014 and February 2015 will be offset in full by savings in March 2015, and a break even position maintained at the year end.
49. Whilst details of savings slippage by directorate/locality are regularly provided to the Executive Board and the Changing for the Better Board, the reasons for the slippage and corrective actions being taken are not reported in detail. Non executive directors receive this information only at a Health Board level. However regular meetings are being held between the Director of Finance and directorates and localities to ensure that this position is recovered.

---

The Board has set a clear vision and is promoting a quality focused culture. There have been improvements to governance arrangements and in the management of concerns but further improvements are needed to strengthen important aspects of quality governance, build organisational capacity, and fully embed organisational learning

- 50.** This section of the report considers my findings on governance and board assurance, presented under the following themes:
- strategic planning;
  - organisational structure;
  - Board effectiveness and governance structures;
  - internal controls, including management information, risk and performance management; and
  - progress in responding to governance issues identified in last years Structured Assessment.
- 51.** The Health Board has generally sound governance arrangements and recognises the need to further strengthen some aspects of quality assurance and internal control. The Board continues to promote an open, quality focused culture and demonstrates a candid and self-critical approach to reviewing its arrangements and performance. There is evidence of work to further develop governance arrangements and an increasing focus on accountability.
- 52.** The Health Board demonstrates strong commitment to addressing quality concerns. The 'Action after Andrews' programme constitutes a challenging organisational change plan to address the recommendations in the *Trusted to Care*<sup>1</sup> report. The associated improvement work has received significant focus, with dedicated resources to lead the respective project streams and significant staff, patient and public engagement to take key actions forward. Work to develop organisational values and behaviours and build a culture of learning has been a significant aspect to the organisational development work this year.
- 53.** There is a progressive approach to designing for the future, in terms of strategy and service change. The Health Board responds well to new challenges and there is clear commitment to delivering complex strategic change and improvement. However, the number and complexity of service change and improvement initiatives raise challenges for co-ordination and prioritisation of programmes and initiatives, and risks around capacity, pace and securing staff ownership of change. The Health Board understands this position and is committed to addressing these challenges, demonstrating both awareness and proactivity.

---

<sup>1</sup> Report of the independent review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board, led by Professor June Andrews. May 2014

---

54. My findings are summarised in more detail below.

The Health Board's Integrated Medium Term Plan (IMTP) sets a clear vision and provides a reasonably sound basis for taking the organisation forward and guiding its improvement activity

55. The Health Board is one of only four NHS bodies to have its IMTP receive Ministerial approval in 2014. In developing the plan, a planning task and finish group provided strategic focus and a steering group met weekly to support the development of the IMTP. Internal planning capacity and capability was supplemented by advice and support from Finnemore consultancy and the Board and its members were engaged during IMTP development. The draft plan was subject to a process of scrutiny and Board approval before its submission to Welsh Government.
56. The IMTP sets out a clear strategic vision and programme of change underpinned by six organisational aims and seven strategic change programmes. The commissioning development programme is particularly important in that it aims to further improve Health Board planning and delivery of services on the basis of population health need, evidence of clinical effectiveness, value for money and improvements in population health. The programme includes the development of a planning and commissioning framework and the establishment of six commissioning boards. Pilot work is currently underway to test proof of concept. The IMTP and strategic change plans are also clear about the future role of hospitals. The strategic land acquisition at Morriston unlocks this site for the development of a major acute centre, which fits the direction of the South Wales plan.
57. The funding needed to deliver the IMTP is understood but financial challenges for implementing the planned changes over the three years remain. Additional Welsh Government funding of £26.1 million in December 2014 meets the IMTP requirement for 2014-15, but the Health Board still faces a substantial savings target in each year of the updated IMTP and some capital requirements are dependent on approval of strategic outline plans by Welsh Government.
58. The Changing for the Better Delivery Board oversees the seven strategic change programmes and has had responsibility for monitoring and reporting on the IMTP. There have however been recent changes following the introduction of revised Board committees. The new Strategy, Planning and Commissioning Committee (SPCC) and the Performance Committee will now oversee the development, performance and delivery of the IMTP. The Board still retains ultimate responsibility for the oversight and monitoring of the IMTP. The revised management and reporting framework will need to be documented in the IMTP update, to reflect the new Committee structure and the inter-relationships between the committees and the Changing for the Better Delivery Board.



- 
59. The Board received a six-month report on progress in November 2014. This report focussed on the underpinning strategic change programmes, whilst assurances on other strategic commitments within the IMTP have been reported separately to Board during the year. Consolidated Board reporting on IMTP and strategic change delivery would support more integrated Board assurance and should also be considered within the revised management and reporting framework.
  60. The Health Board has a well-planned approach for completing a refreshed draft of its IMTP by 31 January 2015. The updated IMTP will incorporate 'Action after Andrews' quality improvement work (as publication of the Andrew's report – '*Trusted to Care*' came after the development of the IMTP in 2013-14). There is also a clear intent to develop a 10 year strategy to inform longer term strategic vision and provide a more focused platform for the IMTP in future years.
  61. Ensuring there is sufficient internal planning capacity at both corporate planning and operational unit level remains a challenge. The Health Board is putting in place revised management arrangements to better support the central planning function and the introduction of commissioning boards will be positive in driving the IMTP as the core planning vehicle. Steps to ensure earlier engagement of operational units in the planning process have been taken although there is more to do to strengthen operational delivery plans and their integration with the IMTP. Better workforce planning and stronger linkages between objectives and outcomes are also needed.

Executive portfolios have been refined and the organisational structure is being revised to better support delivery of the organisation's strategic objectives but changing management culture and building operational capacity remain challenges

**The Health Board is reviewing its organisational structure to better support its role as both commissioner and provider and to bring greater focus on accountabilities, responsibilities and clinical leadership**

62. The current organisational structure of 13 directorates and localities has provided a stable base and supported service change to date. However, changes are being proposed to better enable the organisation to fulfil its role as both commissioner and provider, enable the Board to operate more strategically, and to bring greater focus on accountabilities, responsibilities and clinical leadership. The underpinning principles link to the Health Board's work on organisational values in terms of empowering operational management teams and improving communication, team working, leadership and performance.
63. The proposed structure includes six operational delivery units comprised of: primary and community services, mental health and learning disabilities services, and four hospital units. Each delivery unit will be led by a leadership team consisting of a Service Director, Unit Medical Director and Unit Nurse Director. The new operational management model, piloted at Princess of Wales Hospital last year, should provide stronger clinical engagement and leadership and clearer lines of accountability for patient care and experience within each hospital. A single division responsible for primary and community care is intended to support better alignment to community networks and reduce operational variability across existing localities.

- 
64. There has been engagement with staff about the outline proposals, the rationale and the principles behind the proposed structure. Once proposals have been approved, it will be important for clear transition plans to be put in place to ensure reasonable implementation timescales and manage any risks around short term uncertainty.

**The executive team has been strengthened by appointments to vacancies and a review of portfolios although capacity pressures have been evident during the year and there is more to do to empower front line staff and build operational capacity**

65. There has been significant change within the executive team during the last 12 months, with new appointments to four director posts. Vacancies have been covered on an interim basis, although this had an unavoidable impact on corporate infrastructure and capacity at senior management levels and presented challenges for maintaining continuity. The executive team coped well with these pressures with the commitment and resilience of senior staff evident. Focused attention on 'Action after Andrews' work and momentum across strategic change programmes was maintained, with expert external input sought to support key strands of vital work during the period.
66. The new executive appointments bring the executive team up to full compliment. A review of executive portfolios has also been completed to further strengthen the team by clarifying roles, remits and responsibilities. This work has resulted in more tightly focussed remits and revised management arrangements to better support key portfolios. Examples include the remit and supporting infrastructure for the Chief Operating Officer and Director of Strategy and Planning portfolios.
67. The Health Board is progressing an ambitious and complex range of improvement and service change work, which requires senior management capacity to both ensure efficient and safe service delivery, and to lead on improvement and modernisation. At present, executive directors are leading on strategic change and improvement, driving performance within the organisation and leading from the front on a number of operational matters. In the short term, such executive intervention appears to be delivering improvements, but is not a sustainable position.
68. The Health Board recognises the need to build operational capacity and capability and to up skill operational managers in areas such as effective people management. Workshops with the Board, the Executive Team and the Changing for the Better Delivery Board have been held to agree a way forward in terms of improving management and clinical accountabilities. The Health Board has also been investing in leadership development for operational managers and clinical directors and intends to use the organisational values and behaviours work to help change management culture and empower staff.

---

The Board provides good strategic leadership and the revised committee structures support good governance. There have been improvements to some governance arrangements but there are important aspects of quality governance which need to be improved

**The Board demonstrates good strategic leadership, generally effective administration and conduct and a clear commitment to openness and quality improvement**

69. The Board has an annual business cycle, receives regular assurance reports from its committees, has assessed its performance against governance and accountability standards<sup>2</sup> and demonstrates leadership and good conduct. Agendas are well structured although ensuring that Board papers are issued 10 days in advance of meetings is sometimes challenging due to the timeliness of management papers. There is a scheme of delegation which aligns strategic aims to structural delivery responsibilities, although these will need to be reviewed in light of any changes to organisational structure and executive portfolios.
70. There has been a stable cadre of independent Board members who provide good scrutiny and challenge. Board development sessions are used to support member development, consider critical governance issues and to develop the values, culture and behaviours of the organisation. Independent Members value these development opportunities but welcome further training opportunities, both role specific and on particular issues, such as clinical coding.
71. The Board demonstrates openness and candour in the conduct of its business and a clear commitment to quality improvement. Board papers are publicly accessible and the range of information in the public domain continues to grow. The Health Board supported by consultants April Strategy, has carried out a significant listening exercise to develop organisational values and behaviours. Due to be launched in February 2015, the organisational values are: caring for each other, working together and always improving.

**The structure, function and membership of Board committees has been revised to better support the Board in delivering its strategic objectives**

72. A new Board Committee structure became operational from October 2014. The revised structure introduces committees for performance, and for strategy, planning and commissioning. The Chairs' Advisory Committee provides a forum for committee chairs to meet regularly and link governance issues across committees. The forum reduces the need for cross committee membership so that Independent Members can maximise their time and focus on single committees. This principle has been applied to membership of the Quality and Safety and Audit Committees where cross-membership by the respective committee chairs previously existed.

---

<sup>2</sup> Doing Well Doing Better - Standards for Health Services in Wales: sets out what is expected of all health services and includes a module on governance and accountability

- 
73. The Health Board intends to carry out a six month review to assess the effectiveness of the new committees, the interoperability of the revised structure and whether committee membership arrangements are working to best effect. In principle however, the revised structure, function and membership of committees should support the Board in delivering its strategic objectives.

**The Audit Committee is effective in supporting the organisations governance and internal control arrangements**

74. Audit Committee agendas and meetings are well managed and an action log is used to track issues. Where appropriate, issues are referred to the Quality and Safety Committee for on-going monitoring and scrutiny. An annual self-assessment of effectiveness is used to improve the Committee's operation and inform its forward work plan. The recently updated work plan incorporates an annual review of the assurance system, risk management system, standing orders and Standing Financial Instructions (SFIs). It also includes a review of its terms of reference, and a review of the interrelationships and work programmes of other committees.

**The Quality and Safety Committee continues to mature and improve in its operation but agenda management and continuity of the work programme remain challenging**

75. The Quality and Safety Committee is continuing to strengthen and improve its arrangements to provide good scrutiny of quality and safety. The Committee has carried out a self-assessment this year. Analysis has taken longer than expected but the results are to be included in the annual quality and safety report to Board. The Committee is rotating its meetings to different sites and applying the 15 step challenge<sup>3</sup> to clinical area walkabouts, thereby increasing the Committee's visibility and strengthening scrutiny and triangulation through observation. Reporting on the findings and actions following these site visits is currently being developed.
76. Quality and Safety Committee agenda management has been more disciplined and structured to maximise the time for scrutiny. Meetings continue to be very lengthy given the complexity and size of the agenda and the on-going challenge for ensuring the right balance between detail and oversight. An action log is used to track issues and a work programme is in place, which includes rotational presentation from operational areas on their local governance arrangements.
77. The work programme notes items received and issues added for follow-up although arrangements could be further strengthened with for example, the scheduling of presentations so that all operational units present within an agreed period. The interim nature of nursing and medical director posts earlier in the year made continuity of work and executive attendance at the Quality and Safety Committee more difficult and late papers and/or requests to defer reports have disrupted the committee's work programme on occasion. The positive impact of permanent director appointments is now becoming evident.

---

<sup>3</sup> 15 Steps Challenge is a method for creating positive improvements and dialogue about the quality of care: <http://www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html#sthash.Ixd0Oyal.dpuf>

---

**Independent Members provide good scrutiny and challenge but assurance reporting, particularly to the Quality and Safety Committee, needs improvement**

78. Independent Members provide good scrutiny and challenge and are focused in following up issues with management and seeking assurance that relevant actions are being taken with sufficient pace. There is also evidence that Independent Members interpret and use management information to support scrutiny, triangulating information from different sources and their own observations gained from walkabouts.
79. Committee papers are issued in advance of meetings and are generally clear and concise, although editorial input is still required prior to the issue of some quality and safety papers. There is on-going work to reinforce the importance of the quality and timeliness of papers and to ensure compliance with reporting format. More explicit statement of any risks or concerns and a stronger focus on outcomes would give Independent Members increased confidence in the assurances provided and help maintain a healthy balance of trust and challenge between Independent Members and executives.

**Quality governance arrangements are in place at sub-committee and operational levels but there are important aspects which need to be improved**

80. The Health Board demonstrates a strong focus on ensuring that quality governance arrangements are effective. A quality governance review is currently in progress to assess what is working well and what can be improved at quality and safety sub-committee and operational levels. This work needs to be concluded swiftly and acted upon.
81. There are more than 43 executive based groups underpinning quality governance, the majority of which provided assurance to the Quality and Safety Committee via a Quality and Safety Forum. This forum, disbanded in January 2014, has not yet been replaced pending completion of the quality governance review. A new oversight group chaired by the Medical and Nursing Directors is to be established, with representation from clinical directors, directorate managers and heads of nursing.
82. In the meantime, the Assistant Director (patient safety) reviews performance and sub-group information to prepare an assurance report for the Committee Chair, although the new oversight committee needs to be established quickly to ensure effective coordination of and assurance flows from the large number of sub-groups. The Quality and Safety Committee also receives some sub-group reports directly. While generally timely, some gaps in reporting, requests to defer reports, and the regularity and attendance of some sub-group meetings create challenges for ensuring continuity of assurance reporting.
83. Local governance arrangements are in place in all directorates and localities, although there is some variation in governance structures and their levels of maturity across operational areas. A bottom-up review of quality and safety governance arrangements at operational units has commenced. The approach, piloted in the musculoskeletal directorate and the Neath Port Talbot locality, is to roll-out across all operational areas and the learning from the review applied to the design of governance arrangements within the new organisational structures.

- 
84. It is positive that the Health Board is keeping the effectiveness of its arrangements under review and seeking continual improvement. The review of sub-committees, assurance reporting and local governance arrangements needs to be completed urgently however. This is necessary to give assurance to the Quality and Safety Committee, and ultimately the Board that the quality governance, oversight arrangements and assurance flows are operating effectively throughout the organisation.

Internal controls are generally effective and arrangements for managing information, risk and performance continue to be strengthened

**The Health Board is actively developing how management information is presented and used in support of effective scrutiny and decision making**

85. The Health Board has redesigned its performance reporting framework during 2014, for better alignment with strategic objectives and the IMTP and support stronger scrutiny and clearer accountability. Performance domains have been assigned to specific committees and responsibilities aligned to lead executive portfolios. The new report format includes summary performance, indicator report cards and an aggregate of Health Board performance for Board and committees.
86. Overall, the reporting of management information has been improved and is supporting scrutiny and decision making. Data is generally timely with a reasonable mix of qualitative and quantitative data, improved quality target setting, increased use of trend analysis and benchmarking and an improved RAG<sup>4</sup> rating system. There is a better range and application of information, with stronger patient experience reporting and triangulation of quality indicators and observational audit. The new reporting format continues to be refined and the completeness of quality and safety indicators within the new reports is being addressed. However, there are still areas that could be improved. These include:
- exception reporting to highlight key performance issues;
  - a broader range of workforce measures;
  - stronger focus on outcomes and time bound actions; and
  - greater attention to primary, community and commissioned care.
87. It will also be important for the Health Board to ensure that the current level of data aggregation does not impact on effective scrutiny at committee level. The Quality and Safety Committee is addressing this risk with detailed indicator reviews and directorate / locality presentations carried out on a rotational basis. Disaggregated operational unit data should be available to support this work.

---

<sup>4</sup> A performance rating system using traffic light coding: Green: on or above target, Amber: within 5%, and Red: 5% or more from target

- 
88. The Health Board is committed to the continuing development of management information and is working to develop an extended range of outcome measures, a primary care contracting services dashboard, and more formalised use of NHS benchmarking to better inform understanding of performance. Draft quality metrics have also been developed by the Health Board on behalf of NHS Wales and submitted for Welsh Government approval. Development of a data quality assurance process to test data confidence levels is also underway.

**New arrangements are bringing more joined up accountability for both information and its governance**

89. Previous work has found the Health Board to have generally good control of information security, compliance with IT laws and standards and on-going monitoring of licensing for systems and applications. My work to date has not identified any information security or Caldicott issues. However, work planned as part of my continuous structured assessment approach will consider these areas of information governance further in 2015.
90. The Medical Director has recently become the single accountable officer for information and its governance. This supports more joined up accountability and the previously separate information governance and informatics teams are being brought together under single reporting lines. The composition and operation of the Information Governance Committee will need to be reviewed to account for these changes, ensure an appropriate balance between strategic and operational focus and improve the current irregularity of reporting to the Quality and Safety Committee.

**Internal controls are generally effective in meeting current assurance requirements but some aspects, including the use of clinical audit, need further improvement**

*There is a documented 'System of Assurance' but clinical governance and quality assurance frameworks need to be updated to reflect structural changes*

91. The Health Board has a formally agreed and documented 'System of Assurance', which was updated in November 2014 to reflect the revised Board Committee arrangements. A further review in 2015 is planned, to account for evaluation of the new committee arrangements, introduction of the organisational values and behaviour framework, changes to operational management arrangements and any impact on organisational objectives and risks arising from the IMTP update.
92. It is positive that the Health Board is taking a strategic approach to the on-going development of its system of assurance, although it now needs to bring its clinical governance and quality assurance frameworks up-to-date to account for the quality strategy and reflect changes to roles, responsibilities and management groups. To progress this, the review of governance arrangements needs to be brought to a swift conclusion.

---

*Internal controls are generally effective but there is further opportunity to use the AGS, AQS and healthcare standards to support continuous improvement and learning*

- 93.** Internal controls are generally robust and include a well-planned and delivered programme of internal and capital audit work, and an effective counter fraud service. Arrangements are in place to monitor compliance with standing orders and SFIs, and to promote probity and propriety in the conduct of business.
- 94.** The Health Board's AGS and Annual Quality Statement (AQS) were underpinned by directorate/locality assurance statements and reported in line with Welsh Government requirements. Scrutiny arrangements are in place and Internal Audit work is used to confirm factual accuracy. There is however further opportunity to use the AGS and AQS to better support continuous improvement and learning by strengthening operational assurance statements and moving to a less annualised approach.
- 95.** The 2014 AQS was presented in an honest and publicly accessible way, using shorter text and info graphics to improve readability. An editorial panel has already been established to further improve public facing reporting next year, although final drafting in 2014 was subject to a pressurised timescale. An earlier start for preparing the 2015 AQS, clearer responsibilities and better coordination with the drafting of the Annual Report would improve the 2015 process.
- 96.** The Health Board also draws on other sources of assurance as part of internal control measures. These include Fundamentals of Care Audit<sup>5</sup> and the Standards for Health Services in Wales<sup>6</sup>. The Health Board has used a scrutiny panel to review and challenge self-assessment against the healthcare standards for a number of years. This arrangement has previously worked well but in 2014 the effectiveness of the panel was affected by cancelled meetings, late papers and the quality of submissions. Pending executive appointments and changes to portfolios may have had an impact but the process will need reinvigoration to ensure effective scrutiny and to support the standards being used as a tool to drive the quality of the organisation in 2015.

*Changes to strengthen Clinical audit's contribution to Board assurance are being made although it is not yet playing a full role*

- 97.** Clinical audit is important in supporting clinical improvement and Board assurance but as I reported last year, it is not yet playing a strong role. The Health Board recognises this and is putting in place revised arrangements to strengthen clinical audit's contribution. Recently approved proposals include tighter prioritisation of clinical audit activity and stronger scrutiny of the plan. The NHS Wales National Clinical Audit and Outcome Review (NCAOR) plan will form the backbone of the Health Board's clinical audit plan from April 2015, while audits identified from patient feedback, risk management, external review and service change will provide linkages to strategic priorities.

---

<sup>5</sup> Fundamentals of Care is a Welsh Government initiative which aims to improve the quality of care for adults, measured against twelve Fundamental Aspects of Health and Social Care indicators

<sup>6</sup> Doing Well Doing Better - Standards for Health Services in Wales: sets out the requirements of what is expected of all health services in all settings



- 
98. Tighter authorisations for ad hoc local audit work will be required, as these projects are still being initiated in place of planned directorate/locality activities. This is currently resulting in uncoordinated demands for central audit resource and poor audit plan completion. Attendance at the Effective Practice and Monitoring Group has been poor and building clinical engagement and ownership at an operational level remains a key challenge. Reporting on the participation and outcomes of projects is planned to be via the Clinical Outcomes Steering group, with assurances provided to the Quality and Safety Committee and in turn, the Board.

*Arrangements for addressing audit recommendations and monitoring implementation are established but some aspects, including action planning, can be improved*

99. As part of my commitment to help secure and demonstrate improvement through audit work, I have reviewed the effectiveness of the Health Board's arrangements for responding to recommendations made as part of my nationally mandated and local programme of audit work during 2012 - 2014. I found that the Health Board has well-established arrangements for considering my reports and monitoring the implementation of my recommendations.
100. All Wales Audit Office reports and management responses are received by the Audit Committee, with the executive lead for each audit responsible for developing and presenting the management response to the Committee. There is however opportunity to improve the timeliness of action planning and the consistency of action plans in terms of the level of detail and clarity about responsibilities, timescales and intended outcomes.
101. The approach for tracking (internal and external) audit recommendations is well established. A tracking log, compiled from management returns, is reported at every Audit Committee meeting and identifies the number of recommendations that are complete, ongoing or overdue. Supplementary notes are used to highlight exceptions and the Committee uses the tracking intelligence to challenge the pace and effectiveness of management response. The log supports monitoring and scrutiny of progress against the total number of recommendations although a periodic detailed management summary of progress and outcomes from each action would further strengthen the current arrangements for scrutiny and assurance.
102. The oversight process for findings and recommendations from other regulatory and inspection bodies has been less clear, but a log of regulatory and inspection visits has been developed during 2014 by the Learning and Assurance group. This is a positive but relatively new development and reporting on external regulatory inspection activity to the Quality and Safety Committee is still being established at present.

**Risk management arrangements have continued to be strengthened and provide a reasonable basis to understand and respond to key organisational risks**

103. A risk management strategy sets out the corporate risk appetite and provides guidance on risk assessment. The revised format of the corporate risk register aligns risks to strategic objectives and identifies the context, controls and actions being taken, together with the assigned action lead and the committee responsible for monitoring the risk.

- 
104. The learning and assurance group oversees risk management processes, and provides a forum for reviewing operational risks and promoting consistency in risk scoring and management. All risks rated 20 or above are included in the corporate risk register and are discussed at monthly performance review meetings. Corporate and local risk registers have been updated in readiness for transfer to the new Datix web<sup>7</sup> system in December 2014 and a three year risk management training programme is in place.
105. Risk management arrangements have continued to be strengthened although the Health Board recognises that there is more to do. Future actions should include assessing risk appetite and the effectiveness of actions to reduce risk, as many risks on the register show little movement in risk scoring following actions.

**Monthly directorate/locality performance reviews are established with an escalation process set out in the 'System of Assurance' but waiting time performance is a key challenge**

106. The Health Board's performance management framework is set out within the 'System of Assurance'. Directorates and localities agree their annual delivery targets with the Chief Operating Officer as part of the planning process, based around the strategic aims for the organisation and IMTP delivery profiles.
107. Monthly performance reviews take place with each directorate/locality. An overall RAG rating is applied based on performance against Tier 1 targets, six quality and safety triggers, and agreed process measures such as milestone delivery of agreed service change. The rating reflects current performance, provides an indication of direction of travel, and informs escalation decisions. A process for assessing progress against annual objectives and delivery plans is also established through mid-year and year-end review meetings.
108. The Health Board is seeking to develop a greater focus on accountability through revised management structures. Models of earned autonomy for service teams are being considered and a service line management<sup>8</sup> pilot in regional and cardiothoracic services is planned. Currently however, waiting times performance remains a key performance challenge for the Health Board in terms of the four hour Emergency Department target, general referral to treatment waiting time performance and cancer waiting times. In addition to the impact on patient experience, this is a risk to IMTP delivery. A recovery programme has been put in place.

---

<sup>7</sup> Datix web is a software system supporting integrated patient safety, risk management, incident and adverse event reporting and analysis.

<sup>8</sup> Service-line management combines management and business planning techniques to improve healthcare delivery. <https://www.gov.uk/government/collections/service-line-management-an-approach-to-hospital-management>

---

The Health Board demonstrates commitment to improving quality and patient experience with significant progress made in capturing patient feedback and improving the management of concerns. However, some important aspects of quality scrutiny arrangements need to be progressed and there is more to do to embed organisational learning

- 109.** In 2013, I found the Health Board to be committed to developing a positive listening and learning culture but responding to complaints in a timely manner was problematic and a systematic, coordinated approach was needed to embed organisational learning. During 2014, significant progress has been made in relation to the capture of patient experience and the management of concerns. A patient experience improvement programme has been established, and is reported to be on target to achieve its main deliverables by March 2015. Key achievements to date include:
- redesign of the patient experience team (PET) and long term funding to build the team's capacity;
  - significant expansion of and investment in patient experience survey work;
  - introduction of Datix web<sup>9</sup> for better reporting, analysis and triangulation of information; and
  - development of arrangements to encourage and make it easier for staff and patients to raise concerns.
- 110.** A rolling programme of monthly directorate/locality reviews is improving the timeliness, quality and consistency of complaint responses and progress has been made in reducing the previous backlog of complaints. Clinical staff have been appointed to the PET to support early resolution and management of concerns. Training to improve the quality and speed of investigations has been run in conjunction with the National Patient Safety Agency and a serious investigations team established. The Health Board's management and response to Ombudsman's cases has also improved with the appointment of a lead nurse.
- 111.** The PET has been fundamental in driving changes in complaints management process and performance to date, but these improvements need to be embedded operationally for the Health Board to sustain the improvement. Responsibility for patient experience has in the past rested with local governance teams and stronger engagement from clinical directors, general managers and head nurses is needed. Changing for the Better events have been used to reinforce accountabilities for patient experience and concerns management.

---

<sup>9</sup> Datix web modules for patient experience, complaints, risk, and claims went live December 2014. Incident reporting will go live in 2015 after Datix and electronic staff record system integration.

- 
- 112.** The Health Board has been proactive in expanding the methods for and numbers of patient feedback captured. In the 12 months ending 31 October 2014, more than 14,000 responses were gathered from patient experience questionnaires and the friends and family test<sup>10</sup>, with increased use of online and mobile technology alongside traditional surveys. SNAP 11<sup>11</sup> survey software has been procured to assist in the management and analysis of surveys as the Health Board continues to expand the capture of patient feedback across its services. This includes use of patient reported outcome measures, with a pilot in the Trauma and Orthopaedic service planned.
- 113.** The Health Board is also participating in the Welsh Government pilot of iWantGreatCare<sup>12</sup> and received 991 responses from the two pilot wards within the first two months. The Health Board may need to reflect on the range and alignment of methods used to capture patient experience following evaluation of the pilot, particularly if iWantGreatCare is adopted by NHS Wales.
- 114.** There has also been improvement in central analysis and reporting of patient experience measures (feedback, complaints and incidents) but better triangulation of these measures is needed to gain a wider organisational perspective on patient experience. The Health Board recognises this and is investing in information systems to further improve thematic analysis and underpin a more systematic framework for learning lessons. The introduction of Datix web will provide a single system for recording, analysing and triangulating patient experience, complaints, risk, incident and claims information, and support better feedback to staff on the concerns and incidents they have reported. The Health Board is also working with Swansea University to bring together Datix and SNAP reporting into a single patient experience dashboard, although this work is not yet complete.
- 115.** While the Board's commitment to organisational learning and improvement is very evident, arrangements are not yet sufficiently systematic or fully embedded. The recently formed Learning and Assurance group now provides a forum for sharing learning across the organisation and there are examples of local learning. However, processes for learning, and evaluating the effectiveness of actions taken are not sufficiently clear and still lack consistency. More systematic approaches need to be developed and embedded.
- 116.** The Board remains committed to building a culture of openness and willingness to listen to staff and patient concerns, with visible executive leadership and patient safety walkabouts. The Health Board has initiated the 'If You See It - Say It' campaign to encourage and make it easier for patients and staff to report a concern about standards of care or practice, promoting a culture which supports earlier detection and resolution of concerns.

---

<sup>10</sup> The 'test' asks patients whether they would recommend the hospital/ward/service to friends/ family.

<sup>11</sup> SNAP 11 is a software tool for creating, managing and analysing, online, paper and mobile surveys.

<sup>12</sup> iWantGreatCare, an independent company, collects patient/carer/family feedback on NHS services.

- 
- 117.** The campaign, widely publicised across the organisation and on the Health Board's website, reinforces that excellent care is everyone's business. Patients are encouraged to tell a member of staff straight away if concerned so that immediate action can be taken, but confidential reporting processes are also in place via email, text and telephone. Reporting on concerns raised through these mechanisms is now in place, enabling collation of issues raised and actions taken to inform wider learning.
- 118.** The number of staff raising concerns via the formal all-Wales Raising Concerns (whistleblowing) policy remains low, but staff are increasingly using the 'If You See It - Say It' channels to raise issues. The increased informal reporting is positive, but it will be important for the Health Board to ensure that staff are confident in raising and addressing issues through operational line management and not relying on anonymous reporting channels.
- 119.** The Board has continued to demonstrate a focus on quality governance, promote a quality and safety culture and seek improvement to quality scrutiny and assurance. A Quality Strategy was approved by Board in January 2015 and a supporting delivery plan and priorities for 2015-16 are being drawn up. Revised quality assurance arrangements and an annual assurance plan for 2015/16 are also due to be published in January 2015. The quality governance review described in paragraph 79, signals the Health Board's awareness and commitment to ensuring quality governance and scrutiny arrangements are effective, but faster action to address some important issues is needed. These have been referred to earlier in this report but include:
- addressing the complexity of the quality and safety sub-committee structure;
  - improving the regularity of sub-committee meetings and attendance;
  - strengthening the quality and completeness of assurance reporting; and
  - reducing the variability of local quality governance processes, structures and maturity.

**While my performance audit work has identified examples of good practice, there are opportunities to secure better use of resources in a number of key areas**

The Health Board has set an ambitious change agenda, demonstrates strong community engagement and is investing in supporting technologies. But there are risks around estates and equipment and challenges for improving workforce planning and ensuring managers are equipped to lead

- 120.** My Structured Assessment work has reviewed how a number of key enablers of efficient, effective and economical use of resources are managed. This work has indicated that the Health Board is promoting an improvement culture, committed to community engagement and investing in the use of information systems and technology. But there are workforce and change capacity challenges and risks associated with estates and equipment. Key findings are summarised in Exhibit 3.

Exhibit 3: Structured Assessment: key enablers of effective use of resources

Issue	Summary of findings
Change management	<p><b>Strategic change programmes underpin the IMTP and the Health Board is promoting a positive improvement culture, but ensuring coordination and clarity of programme interconnections and operational engagement are challenges</b></p> <ul style="list-style-type: none"> <li>• The Health Board has an ambitious and progressive approach to delivering its vision and strategic objectives. The seven strategic change programmes underpinning the IMTP, each comprise of a number of sub-programmes and projects and represent complex and significant change.</li> <li>• There is a focus on promoting cultural change through organisational values and behaviours work to influence the improvement culture and promotion of Finance as an enabler of change. Investments have also been made to support change delivery, with for example, the establishment of a change programme office, adoption of MSP methodology, and a new improvement faculty.</li> <li>• However, the number and complexity of change programmes, work streams and arrangements creates challenges and potential risks for:             <ul style="list-style-type: none"> <li>– coordination and prioritisation;</li> <li>– managing the interface between the programme office and service improvement team (which are under the separate remits of Finance and the Chief Operating Officer);</li> <li>– securing and sustaining operational ownership of and engagement with change;</li> <li>– integrated assurance reporting across strategic change programmes and against delivery of the IMTP; and</li> <li>– capacity risks, for change management and during strategic change transition.</li> </ul> </li> <li>• There are strong interrelationships between the IMTP, the seven underpinning strategic change programmes, and ‘Action after Andrews’ but ensuring the interconnections, accountabilities and delivery of the respective ‘streams’ are understood across the organisation is also challenging. It was important to have a discrete focus on ‘Action after Andrews’ work during 2014 although the principles are now being incorporated into the updated IMTP and on-going actions mainstreamed into operational business.</li> </ul>

Issue	Summary of findings
Workforce	<p><b>Actions to address workforce risks are being taken but improving workforce planning and ensuring managers are equipped to lead are key challenges</b></p> <ul style="list-style-type: none"> <li>• Annual workforce plans have been developed and HR managers are currently reviewing in the context of the IMTP update. But workforce planning needs to improve to effectively underpin the IMTP, and there is a need for better workforce development and skill profiling, and transitional plans to support a shift from acute to community.</li> <li>• The Health Board is facing a number of workforce challenges including recruitment to areas where national staff shortages exist and reliance on bank and agency staff. Actions to address workforce risks are being taken and include recruitment task and finish work, nursing workforce profiling and sickness monitoring.</li> <li>• There has been investment in a range of training for change/ improvement e.g. coaching and as part of action after Andrews work, although the capacity and resourcing to meet future training needs appears limited.</li> <li>• Workforce information to inform both management and scrutiny is not sufficient. There is only a limited range of workforce measures reported; and a lack of accurate information on performance appraisal and training completion until Electronic Staff Record (ESR) data entry is complete. ESR benefits realisation work is however underway.</li> <li>• Developing people management skills and better preparing operational managers to lead complex change remain key challenges.</li> </ul>
Estates and assets	<p><b>The Health Board is prioritising available capital funding and is managing a number of significant estate and equipment risks</b></p> <ul style="list-style-type: none"> <li>• Major capital developments including the Morriston hospital re-development and modernising mental health services in Swansea are progressing and strategic land acquisition 'unlocks' the Morriston site for future development.</li> <li>• 2014/15 discretionary allocation has been used to purchase IT and medical equipment. A database is being developed to support an on-going equipment replacement programme register.</li> <li>• Environmental improvements are being made as part of 'Action after Andrews' work. £200,000 of capital funding has been made available to improve the overall environment e.g. signage and the King's fund 'toolkit' is being used to evaluate care environments. A programme for Ward refurbishment is being developed.</li> <li>• There are significant risks and challenges for estates and equipment: <ul style="list-style-type: none"> <li>– £60 million estates backlog: mainly in areas subject to current capital development work (Cefn Coed and Morriston estates);</li> <li>– ability to replace key pieces of equipment and upgrade infrastructure, including IT network and systems, is limited by funding;</li> <li>– needing to seek innovative funding solutions for primary care estate;</li> <li>– the ward refurbishment programme is dependent on the availability of decanting wards; and</li> <li>– there are limited isolation facilities.</li> </ul> </li> </ul>

Issue	Summary of findings
Engagement and partnerships	<p><b>Building on the good practices I found in previous years, the Health Board has shown significant commitment to proactively engaging with patients, staff and stakeholders and continuing to build partnership working</b></p> <ul style="list-style-type: none"> <li>• There has been significant staff, stakeholder and public engagement to develop organisational values and care standards for elderly patients. Over 6000 staff, patients, carers, families, and third sector groups were involved in listening events and views on the draft quality strategy sought.</li> <li>• Communication on 'Action after Andrews' progress has been proactive using a variety of media including the 'Action after Andrews' website, a newsletter to the health community and stakeholders and update meetings with local Assembly Members.</li> <li>• Responsibility for partnership working has been assigned to a single executive director, supported by lead officers for each partnership.</li> <li>• A continuing commitment to partnership working is demonstrated through: <ul style="list-style-type: none"> <li>– the Western Bay programme;</li> <li>– working with local authority partners to secure a £7 m intermediate care fund;</li> <li>– new collaboration with public and third sector organisations to establish 'Help Point Plus': an inner-city alcohol treatment centre; and</li> <li>– increasing work in partnership with universities.</li> </ul> </li> </ul>
Use of technology	<p><b>The Health Board is committed to making effective use of information systems and technology and is making some progress</b></p> <ul style="list-style-type: none"> <li>• Use of information systems and technology is one of the seven strategic change programmes and the strategic programme for IT is set out in the IMTP. The strategic programme supports investment in infrastructure and capacity although full implementation is dependent on the success of a £21 million strategic outline plan.</li> <li>• The Health Board has been proactive in learning how other NHS bodies are using technology to understand and improve patient experience and clinical care. The appointment of the Medical Director as the lead executive for information has been instrumental in this.</li> <li>• The Health Board demonstrates commitment to establishing effective information systems. Progress to date includes: <ul style="list-style-type: none"> <li>– Wi-Fi in all hospital sites;</li> <li>– SNAP 11 software and Datix web procured and being implemented;</li> <li>– new systems 'online': single theatre system, clinical portal, e-referrals;</li> <li>– other business cases progressing, for example, electronic prescribing; and</li> <li>– a review of electronic rostering systems in progress.</li> </ul> </li> <li>• Development of a digital health care strategy has been endorsed by the SPCC to support longer term Health Board strategy.</li> </ul>



---

The role of the district nursing service is not clearly defined, there is unexplained variation in district nurse deployment, resources and service demand are not sufficiently aligned, and there is a lack of systematic monitoring of quality and performance at an organisational level

- 121.** My review found that the Health Board has clarity in its vision for delivering more care in the community. It is moving towards integrated health and social care services and work to align community and district nursing services, into ten integrated community health and social care networks is in progress. However, the remit of district nursing needs to be defined and operational plans developed. There are clear managerial and professional lines of accountability, but the localities operate in silos leading to variation in the way district nursing services are delivered.
- 122.** The Health Board understands the demand on the district nursing service, measured by caseload numbers and high level need, but there is inconsistency in how dependency is measured and the management of demand needs to improve. It is not clear whether the Health Board has the right number and mix of staff to meet demand, with low numbers of staff per registered population, a high proportion of healthcare support workers, and variation between teams. Workforce requirements are considered by localities, but numbers and skill mix have not been reviewed at Health Board level. There is investment in formal training for district nursing staff, but inconsistent compliance with the appraisal and performance review process undermines the Health Board's ability to identify gaps in skills. Meanwhile, low compliance with some statutory and mandatory training present corporate and operational risks.
- 123.** Unexplained variation in the deployment and distribution of district nurses means that the Health Board cannot take assurance that their district nursing resource is effectively deployed. There is variation in the way district nursing teams spend their time and staff are unevenly distributed across the caseloads. District nursing teams are acting in the role of case manager, coordinating the varied healthcare services that patients receive. However, there are no formal systems to share information between different service provider teams and more could be done to support local district nursing caseload management.
- 124.** Systems to monitor and report on the performance of the district nursing service are in place at locality level but these are inconsistent between the localities and there is scope for improvement. A community nursing dashboard is being developed and annual practice audits are undertaken, but it is unclear how the outcomes from the audit are used. Lead nurses hold monthly safety, quality and risk information meetings, but there is no consistent approach for capturing patient feedback. The Fundamentals of Care audit is soon to be rolled out to district nursing services and the Health Board plays an active role in the development of district nursing services across Wales. Learning and good practice is generally shared, although there are mixed views of how well the information is cascaded and sharing across localities can be strengthened.

---

The Health Board recognises the importance of clinical coding and some of the associated processes are robust, but more needs to be done to address the wider factors affecting accuracy and timeliness of coding

- 125.** Clinical coding of patient data underpins the generation of management information used by NHS bodies to govern the business and ensure that resources are used efficiently and effectively and that services are safe and of high quality. During 2014, my team carried out a review of the Health Board's arrangements to generate timely and accurate clinical coding. The work was undertaken collaboratively with the NHS Wales Informatics service.
- 126.** While the importance of clinical coding is recognised to some extent, more needs to be done to raise its profile and to focus on wider factors affecting its accuracy. There is clear governance and executive accountability for coding, with strong links to data quality and health records. There is also a positive focus on training and development for coders. However, there may not be sufficient clinical coding resources and confidence in clinical coding arrangements and their governance is lacking. The Health Board's focus is primarily on reporting accurate mortality data, and on the timeliness and completeness of coding. There is routine audit and validation of the accuracy of clinical coding, but with the exception of the high-level data quality indicators provided by the benchmarking organisation CHKS, the accuracy of clinical coding is not reported to the Board and its subcommittees. Therefore, the Board is currently unable to take full assurance on the robustness of its clinical coding.
- 127.** Some aspects of the clinical coding process are robust but clinical engagement is lacking, and the quality of medical records varies considerably. Clinical coding practices across the Health Board are generally consistent and local policies and procedures in place, although these need to be updated. Access to information is good but the quality of health records is variable with risks arising from the use of temporary notes. The approach to coding is generally sound and processes for validation and audit are positive with opportunities to embed these further. There has been a stable workforce with clear career progression, but more needs to be done to ensure that there is time for appropriate mentoring for trainees and there needs to be better engagement between clinicians and the coding process.
- 128.** Clinical coded data meets the targets for validity and consistency, is used appropriately and is generally of a good standard. However, timeliness is deteriorating and despite the accuracy of coding being generally good, there are some problems with the accuracy of the data and Board members would like to know more about the accuracy of coding and its implication.

A rising level of orthopaedic demand is placing pressure on outpatient services and there are inefficiencies in the inpatient pathway that are impacting on the use of resources and patient experience, with some outcomes following surgery less positive than elsewhere

- 129.** My conclusion on the efficiency, effectiveness and economy of orthopaedic services at the Health Board is based upon the data gathered as part of my national review of orthopaedic services in Wales, due to be published early in 2015. My analysis of all-Wales data has shown that within the Health Board:

- 
- investment in primary care services is low and decreasing, while GP referral rates are increasing and are now one of the highest in Wales, and the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is struggling to meet demand;
  - increasing demand on outpatients is placing pressure on waiting times, along with high rates of patients who do not attend and patient cancellations, although physiotherapy and radiology services are generally meeting demand;
  - the use of inpatient resources varies across the Health Board's hospital sites with scope to improve day case rates, timely pre-operative assessment, theatre utilisation, bed occupancy and minimise the number of procedures with limited effectiveness undertaken; and
  - patients are followed-up although some outcomes are less positive than elsewhere in Wales with higher rates of elective orthopaedic mortality and surgical site infections.

Sickness absence data used for corporate performance management is reliable and executive input has improved sickness absence management and scrutiny, although it needs to be more devolved in the longer term

**130.** My review of sickness absence in 2013 identified high sickness levels and a lack of operational confidence in the data used for corporate performance management. In 2014, I carried out a performance indicator audit to assess data reliability and concluded that assurance can be taken on the accuracy of reported sickness absence figures. I found:

- no significant deficiencies in the process used to capture sickness absence data;
- no issues with the calculation used to derive the sickness absence performance indicator that would significantly affect the ability to monitor and manage sickness absence at an organisation level; and
- strong analysis and validation arrangements led by the finance directorate.

**131.** In undertaking this work, I also identified that considerable effort and investment has been made by senior management to improve sickness absence management and scrutiny. Going forward, the Health Board will need to ensure these management controls are embedded and delegated across the organisation, to ensure that the time invested by senior management returns to a more sustainable level.

The Health Board has made progress in addressing recommendations from previous audits but pace of response could be faster and actions remain outstanding in a few key areas

**132.** In addition to reviewing the effectiveness of the Health Board's arrangements to manage and respond to recommendations made as part of my nationally mandated and local programme of audit work as discussed in paragraph 99, I have considered the completeness and timeliness of the actions taken. My work has found that while the Health Board can demonstrate progress in addressing my recommendations the timeliness of initiating and completing actions can be improved. Specifically I found:

- 
- The Health Board takes a considered approach to developing action plans but the pace of action planning has meant a lengthy lapsed period before initiating actions to respond to the recommendations I have made in 2014.
  - Actions have been taken to address 24 of the 34 recommendations I made during 2013. Seven of the 10 on-going recommendations relate to primary care prescribing and one action relating to sickness absence is overdue compared to planned timescales.
  - Actions to address my 2012 recommendations are reported as fully complete and are no longer included in the Audit Committee's recommendations tracking log. My current follow-up review of operating theatres will assess the progress made and the effectiveness of the actions taken to meet the recommendations.
  - Five out of the 10 recommendations for maternity services made in 2011 remain outstanding and overdue. These areas relate to community access to IT systems, medical staffing and comprehensive provision of perinatal mental health services. Whilst challenging issues to address, progress on these issues would have been expected within the timescale.
- 133.** During the last 12 months, I have also undertaken detailed follow-up audit work to assess the progress made since my review of hospital catering in 2010. I found that the Health Board has made progress towards implementing my recommendations in relation to catering and patient nutrition services but a number of significant issues still need addressing. I reached this conclusion because:
- while there have been developments in the monitoring and benchmarking of local and national indicators and measures, there are concerns that the Board is not in a position to give sufficient scrutiny to performance on catering and nutrition;
  - progress towards a single approach to food production is being made and the ward catering model has improved in some areas, but these arrangements are not yet standardised and nutritional assessment of all locally developed recipes and menus has not been completed;
  - there is a clearer understanding of the cost of food production and delivery, including the need to effectively manage the cost implications of All Wales Contracts for food and the financial impact of competition from non-NHS food outlets;
  - compliance with the Welsh Government's nutritional assessment e-learning tool for nurses and the take-up of food safety training by nursing staff is poor;
  - there has been progress with some aspects of nutritional screening and planning but the Health Board needs to sustain its focus on improving rates of compliance particularly for follow-up screening; and
  - most staff work to maintain protected mealtimes, although variable practice was observed and there is a need to improve patient information about food and nutrition.

# Appendix 1

---

## Reports issued since my last Annual Audit Report

Report	Date
Outline of Audit Work for 2014	March 2014 (updated May 2014 for final fee information)
<b>Financial audit reports</b>	
Audit of Financial Statements Report	June 2014
Opinion on the Financial Statements	June 2014
Opinion on the Whole of Government Accounts return	July 2014
Opinion on the Summary Financial Statements	September 2014
Audit of the Charitable Funds Financial Statements Report	November 2014
Opinion on the Charitable Funds Financial Statements	December 2014
<b>Performance audit reports</b>	
Catering follow up review	July 2014
PI Audit: sickness absence data	July 2014
Clinical Coding	November 2014
Structured Assessment 2014 (Financial management module reported October 2014)	January 2015
Review of Orthopaedic Services	January 2015
Review of Community Nursing	January 2015

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
Follow up review of operating theatres	March 2015
ICT Diagnostic Review	April 2015
Review of Medicines Management	May 2015
Review of Out-patient follow up appointments	May 2015

# Appendix 2

---

## Audit fee

The update Outline of Audit Work for 2014 set out the proposed audit fee of £423,238 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in accordance with the fee set out in the outline.

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

# Appendix 3

## Significant audit risks

My Outline of Audit Work for 2014 set out the significant financial audit risks for 2014. The table below lists these risks and sets out how they were addressed as part of the audit.

Significant audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is an inherent risk present in all entities in the public and private sector. Due to the unpredictable way in which such override could occur, it is always viewed as a significant risk under the auditing standards [ISA 240.31-33].	My audit team will: <ul style="list-style-type: none"> <li>test the appropriateness of journal entries and other adjustments made in preparing the financial statements;</li> <li>review accounting estimates for biases; and</li> <li>evaluate the rationale for any significant transactions outside the normal course of business.</li> </ul>	No issues were noted from our review and testing of journal entries. We reported one issue relating to the calculation of the estimate of the prescribing accrual. There were no issues noted in relation to other significant estimates in the accounts.
The risk of material misstatement due to fraud in revenue recognition is an inherent risk present in all entities in the public and private sector. As such, this is also viewed as a significant risk by auditing standards [ISA 240.26-27].	My audit team will: <ul style="list-style-type: none"> <li>review and test the individual funding and income streams received by the Health Board; and</li> <li>consider whether all funding and income streams have been identified.</li> </ul>	No revenue recognition issues were noted from our review and testing of income and expenditure.
There is a significant risk that the Health Board will fail to meet its revenue resource limit. The current financial pressures on the Health Board increase the risk that management judgements and estimates could be biased in an effort to achieve both the revenue resource limit and the capital resource limit.	My audit team will: <ul style="list-style-type: none"> <li>focus its testing on areas of the financial statements which could contain reporting bias;</li> <li>review accounting estimates included in the financial statements as noted above; and</li> <li>conduct testing to ensure income and expenditure are recognised in the correct accounting period.</li> </ul>	The Health Board put in place a number of actions that meant it met all of its financial targets for 2013-14. Our testing of areas of reporting bias, significant estimates, and income and expenditure did not identify any material misstatements. The Auditor General for Wales provided an unqualified audit opinion on the financial statements.

---

Significant audit risk	Proposed audit response	Work done and outcome
<p>On 1 April 2013, some hosted services transferred from the Health Board to the NHS Wales Shared Services Partnership. The IVF clinic service was also transferred to the Health Board. These transfers must be properly accounted in the annual accounts.</p>	<p>My audit team will discuss with officers and verify the transfer has been properly accounted for in the financial statements.</p>	<p>We reviewed the transfer forms summarising the resources transferred to the NWSSP and confirmed the transfer had been accounted for appropriately.</p>





Wales Audit Office  
24 Cathedral Road  
Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: [info@wao.gov.uk](mailto:info@wao.gov.uk)

Website: [www.wao.gov.uk](http://www.wao.gov.uk)

Swyddfa Archwilio Cymru  
24 Heol y Gadeirlan  
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500

Ffacs: 029 2032 0600

Ffôn Testun: 029 2032 0660

E-bost: [info@wao.gov.uk](mailto:info@wao.gov.uk)

Gwefan: [www.wao.gov.uk](http://www.wao.gov.uk)