WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Annual Audit Report 2013

Cwm Taf University Health Board

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Status of report

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The team who delivered the work comprised Mike Jones, Derwyn Owen, Dave Thomas and Mandy Townsend.

Contents

Summary report

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

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

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

4. This report has been agreed for factual accuracy with the Chief Executive and the Director of Finance. It was presented to the Audit Committee on 20 January 2014. It will then be presented to a subsequent Board meeting and a copy provided to every member of the Health Board. We strongly encourage wider publication of this report by the Health Board. Following Board consideration, the report will also be made available to the public on the Wales Audit Office's own website (www.wao.gov.uk).

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

Section 1: Audit of accounts

6. I have issued an unqualified opinion on the 2012-13 financial statements of the Health Board, although there were some issues brought to the attention of officers and the Audit Committee. These related to:

- uncertainties over the accuracy of the figures reported on performance against the Public Sector Payment Policy; and
- the Health Board staying within its Revenue Resource Limit for the year but only with the aid of an additional £10 million allocation from the Welsh Government.

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 risks of material misstatements to the financial statements; and
- the Health Board's significant financial and accounting systems were appropriately controlled and operating as intended.

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

8. I have reviewed the Health Board's arrangements for securing efficiency, effectiveness and economy in the use of its resources. My Structured Assessment work has examined the robustness of the Health Board's financial management arrangements and the adequacy of its governance arrangements, including quality governance and arrangements for measuring and improving patient/user experience. 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 is reporting that it will fail to achieve financial balance for 2013-14 and faces significant financial challenges in the short and medium term

9. The Health Board is taking positive steps to put in place a sound and sustainable approach to financial management, and projected cost savings are largely being achieved, but At Month 8 the Health Board is forecasting an overspend of £6 million for the year ended 31 March 2014, and is endeavouring to identify further savings to reduce this overspend. The Health Board has considered and consulted upon where the most significant savings could be made, and has identified saving themes to be considered individually by each directorate.

10. Despite the positive direction of travel, the Health Board still faces significant financial challenges in the short and medium term as:

- the process put in place to identify and deliver savings is relatively new and is not yet fully embedded;
- the size of the financial challenge identified by the Health Board (£72 million over the next three years) will mean even with robust financial management and saving programmes, it will be very challenging to stay within its allocated resource limits; and
- some of the significant expenditure within the system is not directly controlled by the Health Board (for example, staff terms and conditions).

A good organisational culture focused on listening and learning underpins the Health Board's governance arrangements and there are plans in place to develop these arrangements further

11. The Board has continued to develop its arrangements for board assurance and internal controls which are broadly effective and supported by clear and positive challenge and scrutiny.

12. The positive listening culture and appetite to learn from patients need to be converted into a systematic, co-ordinated approach to embed organisational rather than individual or team learning, and expanded to include staff feedback.

13. The Health Board has a good range of mechanisms to capture service-user feedback, and there is a clear appetite to listen to patients. There appears to be a positive culture around complaints, concerns and claims, and good arrangements are in place resulting in timely responses. Staff are encouraged to report incidents; there is a standard investigation process and central analysis of themes.

14. In relation to whistleblowing, staff are able to raise concerns through informal routes and this appears to work in practice, but this presents risks that individuals and management are not protected through the legislation, and importantly that lessons are not systematically learnt.

15. There is a clear appetite to learn from all sources of feedback, and the Health Board recognises the need for a central, systematic approach to learning lessons, taking action and triangulating information.

16. An open culture and a focus on getting basic quality and safety arrangements in place will be strengthened by plans to increase effectiveness and improve quality information.

The Health Board still has some way to go to achieve efficient and effective use of its resources, but is making steady progress across a growing number of areas

17. The Health Board made steady progress in addressing previous use of resources issues, but recognises further work is needed. For example, the new Director of Workforce is revitalising workforce planning arrangements, and improvement of outdated facilities continues with the opening of the Merthyr Tydfil Health Park, and the ongoing refurbishment of Prince Charles Hospital.

18. The Health Board's management of primary care prescribing is supported by a clear strategic vision and good leadership. Good progress has been made in securing financial savings from more rational prescribing, although high volumes of prescribing persist and there is scope to improve both the quality of prescribing, and the cost of prescribing in key areas.

19. The Health Board has struggled to meet a number of the key performance targets in the Welsh Government's delivery framework, although there are signs of recent improvements. In particular, the Health Board's performance against a basket of efficiency measures and quality indicators is mixed. For example, it has one of the lowest Clostridium difficile rates in Wales, and MRSA rates are below the Welsh average. Whilst timely access to services is relatively poor, there were some signs of improvement in 2013.

20. My follow-up work on specific areas, also shows that the Health Board is making progress on issues identified in previous years, with further progress underway. For example, there was good progress on hospital food and catering, and management of the consultant contract.

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

Detailed report

About this report

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

23. 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.

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

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

25. 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.

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

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

27. 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.

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

Section 1: Audit of accounts

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

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

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

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

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

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

I have issued an unqualified opinion on the 2012-13 financial statements of the Health Board, although there were some issues brought to the attention of officers and the Audit Committee

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

33. The unaudited financial statements were provided in line with the required timetable, prepared to a good standard and were supported by a generally good quality of working papers.

34. 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 5 June 2013. Exhibit 1 summarises the key issues set out in that report.

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

Issue	Auditors' comments
Public Sector Payment Policy reported performance	• The Welsh Government has set a financial target of paying at least 95 per cent of invoices received from non-NHS creditors within 30 days of receipt. The Health Board has reported at Note 7.1 to the financial statements that it met this target, paying 97.6 per cent of non-NHS invoices within the specified time. • Welsh Government guidance states that the 'clock should start' when the invoice is initially received by the Health Board. Cwm Taf Health Board currently takes the start date as the date the invoice is received by the Procure to Pay department. Previous audit testing by both Internal Audit and the Wales Audit Office has identified examples where the invoice is received by other departments, but is not stamped as received at that date. It is consequently not always possible to identify the true date of receipt. There is the possibility, therefore, that the Health Board has **overstated** its performance in this regard. • For disputed invoices, the Welsh Government has clarified that the clock should stop when the invoice is identified as being disputed and then re-started when the dispute is resolved. The Health Board has put in place procedures this year to put 'flags' onto the payments system identifying the beginning and end of the disputed period. However, there is some doubt as to whether the figures reported on Note 7.1 have correctly taken this into account. There is the possibility, therefore, that the Health Board has **understated** its performance in this regard.
Financial pressures and funding	I have been monitoring the Health Board's financial position as reported to the Board and Welsh Government throughout the year. As the year progressed, it was clear to the Welsh Government that health boards required additional resource funding. In November 2012, the Minister for Health, Social Services and Children announced additional resource funding of £82 million to 'allow the NHS to manage current pressures and maintain quality of care'. The Health Board's share of this was £10 million, which means that its year-end forecast was to break even rather than the previously forecast £10 million overspend. On 5 March 2013, the Chief Executive of NHS Wales wrote to the NHS body chief executives to clarify that there would be no further funding available from the Welsh Government and that local health boards failing their targets would receive an accounts qualification and be subject to escalation procedures. The Health Board underspent by £17,000 against its 2012-13 resource limit. In addition, it provided resource brokerage of £355,000 to the Welsh Government in 2012-13, which it will receive back in 2013-14. As the Health Board met its resource limit, the Auditor General's regularity opinion was unqualified.

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

35. Whole of Government Accounts return – I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2013 and the return was prepared in accordance with the Treasury's instructions.

36. 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.

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

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

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

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

- reviewing the Health Board's financial management arrangements, including the progress being made in delivering cost-saving plans and their contribution to achieving financial balance;
- assessing the effectiveness of the Health Board's governance arrangements through my Structured Assessment work, with a particular emphasis on quality governance and the robustness of arrangements for assessing patient/user experience;
- specific use of resources work on primary care prescribing, performance against key service targets for service efficiency, quality and access; and
- assessing the progress the Health Board has made in addressing the issues identified by previous audit work on the consultant contract, and hospital food and catering.

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

The Health Board is reporting that it will fail to achieve financial balance for 2013-14 and faces significant financial challenges in the short and medium term

Projected cost savings are largely being achieved, but at Month 8 the Health Board is forecasting an overspend of £6 million for the year ending 31 March 2014

41. The Health Board stayed within its Revenue Resource Limit for 2012-13 through delivery of savings and additional funding of £10 million from the Welsh Government. The Health Board had planned to break even without this funding but savings plans did not meet the ambitious targets and may have been unrealistic.

42. The Health Board initially identified savings plans of approximately £15 million for 2013-14. At that stage, however, the Health Board forecast a shortfall of £20.8 million for the year assuming these savings were realised. In October 2013, the Welsh Government announced £16.9 million of additional funding. This left a potential shortfall of £8.1 million because the Health Board had anticipated £4.1 million in additional funding and built this into its financial plans. The Health Board revisited its forecast after the additional funding was announced. It reduced its predicted shortfall to £6.5 million, which is the current forecast year-end overspend.

43. In addition, the Health Board is anticipating a potential cash flow problem in the first few months of 2014 and may need to consider delaying the payment of creditors before the year-end.

The Health Board is taking positive steps to improve financial management arrangements and move towards a sustainable financial position, but the new arrangements are not yet fully embedded and significant external risks to sustainability have yet to be mitigated

44. The Health Board is taking positive steps towards more sustainable financial management arrangements. The Health Board has considered and consulted upon where the most significant savings could be made. It has identified savings themes to be considered individually by each Directorate. The Executive and Project Management Office holds monthly Clinical Business Meetings with directorates to discuss finance and non-finance issues. This helps to integrate quality, performance and finance issues.

45. The Medium-Term Financial Plan was updated in September 2013. This shows that the Health Board needs £72 million over three years to break even. However, there are significant risks to achieving this plan:

- £72 million is significantly higher than the savings achieved previously by the Health Board;
- £25 million has been identified by the Health Board as relating to 'all-Wales issues' and therefore beyond the Health Board's control (eg, terms and conditions of employment, contracts with GPs and dentists);
- the remaining £47 million would require a potential reduction in the workforce of 639 (nine per cent) over three years; and
- whilst awaiting the outcome of the South Wales Programme, due to uncertainties, the plan makes no allowance for the South Wales Plan and assumes flat cash allocations over the three years.

A good organisational culture focused on listening and learning underpins the Health Board's governance arrangements and there are plans in place to develop these arrangements further

The Board has continued to develop its arrangements for board assurance and internal controls which are broadly effective and supported by clear and positive challenge and scrutiny

46. The Board and its subcommittees have continued to develop within an overall Board Assurance Framework that is operating effectively. There has been some natural turnover in the executive team, and positively, the Board has used this to provide fresh perspectives on its working practices and to refresh them where necessary.
In particular, I have noted progress on the following issues:

- The Board has set out what appears to be a coherent framework for Board assurance, a key recommendation from my 2012 work.
- The Health Board has fully implemented the recommendations made by Health Inspectorate Wales (HIW) in early 2012, and importantly, self-assessed the effectiveness of these changes in the context of Francis, my joint report with HIW on the Governance arrangements of Betsi Cadwaladr University Health Board, the Keogh, Powell and Improving Quality Together reports. The Board is now in the process of implementing further refinements to internal controls, board assurance mechanisms and Board committee structures.
- My team observed that both the Integrated Governance and Finance and Performance committees are functioning as intended; and noted a good level of supportive scrutiny and challenge at both Board and key committees during 2013.

47. Internal controls have been strengthened with a renewed focus on clinically-led site management. The roles of assistant directors and the turnaround team have been refocused to provide support for the key performance areas of unscheduled care and elective or planned care.

48. Management information continues to develop. The improved reporting format provides more clarity on actions needed to improve performance. The Health Board has plans to address the remaining information gaps around community and commissioned services in 2014.

The positive listening culture and appetite to learn from patients need to be converted into a systematic, co-ordinated approach to embed organisational rather than individual or team learning, and expanded to include staff feedback

49. The Health Board uses a good range of mechanisms to capture service user feedback, including paper-based and face-to-face surveys, suggestion boxes, Fundamentals of Care audits, social media and through the community health council and hospital-based patient fora. Executives and Independent Members do regular planned and unplanned walkarounds using a standard template, capturing 1,000 Lives, and dignity and respect issues. The Health Board has plans to expand this further by developing the use of its community engagement forum in each valley community to gather wider user experience feedback. The intention to link citizen engagement with patient experience is positive, but with no dedicated central patient experience resource, co-ordination will remain a challenge. The Health Board has adopted the All Wales Patient Experience Strategy and has an action plan to ensure its full implementation in 2013-14. Positive developments are planned in relation to including patient experience measures in the Board dashboard, and expanding the use of 'digital stories'. However, there is scope to:

- expand scale and coverage of patient surveys, as many of the paper surveys are small scale or restricted to particular departments or services; and
- use a wider range of methods to increase opportunities for people to feed back their views on services (for example, tablet computers, texts, electronic or phone surveys, patient diaries, mystery shopping, and patient journey mapping).

50. The Board and its Committees clearly demonstrate an appetite to learn about patient experience. For example the, Clinical Governance Committee and some Board meetings start with a patient story, and recent Board meetings have received a patient experience report.

51. Good arrangements are in place to deal with complaints resulting in timely responses, challenges remain with the volume of complaints and around maintaining timely responses generally (particularly with the more complex complaints). Concerns and complaints are scrutinised through the Concerns Panel which reports to the Clinical Governance Committee, and hence through to the Board. Complaints appear to be viewed as learning opportunities and my team has been informed that the Chief Executive and Director of Nursing personally review each complaint that is received. The community health council is satisfied with the way the Health Board handles

patient complaints, and reflected positively on the culture that is evolving in the Health Board.

52. The Health Board's operational arrangements for concerns and complaints compare well to the rest of Wales. My team noted that staff have been trained, and report that complaints are handled transparently, and directorates supported in handling complaints by the central team of investigations managers. There appears to be an appropriate balance between centralisation of complaints management and learning with local ownership facilitated by the investigations managers. However, co-ordination of action on common themes needs strengthening.

53. The Health Board has actively encouraged incident reporting, and focus groups reflect staff confidence. A corporate policy, procedure and guidance are in place that clearly define 'incidents' and emphasise the importance of incident reporting. There is a standard investigation process and central analysis of themes. The investigations managers help standardise incidents management, with an approach that focuses not only on reporting but also on action. However, central co-ordination of learning from incidents requires strengthening. Staff have been trained to use Datix, but, there were some issues around the Datix system 'timing out' and the time it takes to complete an incident. There appears to be good compliance with the requirement to report serious incidents to the Welsh Government, but, in common with many health boards, Cwm Taf can be slow at closing incidents reported to the Welsh Government. However, timely updates are provided to either Scrutiny Panel or Board as appropriate.

54. There were no recorded cases of staff whistleblowing in the last 12 months. The Board did not receive any reports on whistleblowing and Independent Members had no involvement in monitoring the staff concerns arrangements. The new all-Wales policy on whistleblowing came into force in July 2013 and, as a result, the Health Board could review its practice. My team found that Health Board staff are able to raise concerns through informal routes: for example, the CEO encourages staff to contact her directly. Whilst these informal arrangements for staff to raise concerns have benefits, the Health Board must ensure that this does not limit its ability to collate concerns and analyse trends and common themes. In addition, without formal recording of the concerns raised, the Health Board cannot guarantee that individuals are protected under law against recrimination or subsequent discrimination. It will also be unable to demonstrate that it has acted appropriately to protect individual whistleblowers.

55. My staff noted that compromise agreements (or 'gagging clauses') have been used in the past when staff have left the organisation but not since 2012. There is no evidence that earlier compromise agreements were related to patient safety.

56. The Health Board recognises the need to develop a central, systematic approach to learning lessons that triangulates information from different sources and supports effective action. Currently, patient experience results from different work-streams are not collated centrally to gain a wider organisational perspective and do not systematically cover narrative, numerical and real-time data. Whilst incident data and actions taken in response to incidents are publicised to staff through a monthly newsletter, the Health Board's approach results in numerous action plans (one for

each episode), which in many cases duplicates actions in different teams.
Local learning happens, and there are many examples of practice change and some of service change, but there is less evidence of organisational learning and there are examples of repeated themes in different clinical areas.

An open culture and a focus on getting basic quality and safety arrangements in place will be strengthened by plans to increase effectiveness and improve quality information

57. The Health Board has an open culture and a clear focus on getting the basics right. Many of the important building blocks for creating a transparent culture – for example, dignity and respect work-streams – are well embedded. Risk management is integral to the Board's assurance framework and quality risks are identified and acted on.
In addition, my team noted that the approaches to managing quality risks are more integrated across the Health Board compared to the separate approaches in the north and south that existed in previous years.

58. Whilst the Board espouses and promotes an open culture, it could better demonstrate this by improving the availability of transparent and publically accessible information, for example, publishing its committee agendas and papers on the internet.

59. Work on developing and using key quality triggers has started, with a systematic mortality review process underway to determine causes of high Risk Adjusted Mortality Index (RAMI) and understand the underlying issues.

60. The Board's quality oversight structures are generally adequate to underpin quality governance:

- All committees and sub-committees have clearly defined roles and terms of reference, and there are no obvious gaps. Although some sub-committees have not been reviewed annually as planned, the Board Secretary is currently reviewing them.
- Separation of Corporate and Clinical Governance allows clear consideration of clinical risks, as opposed to health and safety issues and business risks. However, this approach makes a fully integrated approach to quality, safety and risk more challenging.
- Reliance on escalation from sub-committees could result in important issues being overlooked if the data is not included in the dashboard or other quality reports. But my team saw no evidence of issues missed, and some examples of issues escalated. More systematic use of assurance statements from sub-committees would, however, strengthen the chain of assurance to the Board.

61. The Board recognised that board assurance structures could be strengthened and has recently approved proposals to change Clinical Governance to a Quality and Safety Committee, and develop a formal quality strategy. The new Quality and Safety Committee has a clear and structured work plan. Planned changes to the structures have the potential to make them more efficient and increase effectiveness of scrutiny of quality and safety issues.

62. The Clinical Governance Committee has evolved since the 2012 HIW review, by taking a wider range of reports and ensuring it covered the main risk areas in detail. Membership and attendance of the Clinical Governance Committee is good. We observed good, robust challenge and scrutiny from Independent Members, particularly regarding data robustness, seeking clarity and challenging the evidence base. Reports on incidents are regularly received by the Clinical Governance Committee, its sub-committees and the Board itself. The Clinical Governance Committee effectively provides the Board with assurance, and identifies and escalates risks. It reports regularly to the Board on its activities, and brings significant matters to the Board's attention. However, the workload of the Clinical Governance Committee is considerable, with meetings being long and intense. We observed some important agenda items receiving very minimal time for consideration, although scrutiny and understanding were good. The Clinical Governance Committee proactively assessed its own arrangements against Francis, Keogh, the Betsi Cadwaladr University Health Board joint Governance, and Powell reports, and produced a consolidated plan to revise and strengthen its working arrangements and forward agendas. This consolidated action plan is now in place and will inform the work programme of the new Quality and Safety Committee.

63. The Health Board recognises the need to improve the information that underpins its work on quality and safety by strengthening data quality arrangements and refining its integrated performance dashboard. The Board uses an integrated performance dashboard, which contains some quality indicators and is being refined month on month. The Board is using a pragmatic approach to strengthening its quality reports, however, much of the focus is currently on acute care and national measures, and not enough on primary, community or commissioned services. My team also noted that trend analysis could be better linked to improvement work.

64. The Board understands that data quality can and should be improved. It has a plan to remove the clinical coding backlog and to develop the information function. However, there is still much to do to achieve this aim.

65. The Health Board's Annual Quality Statement (AQS) was published on time and is a candid and public-oriented document but there is a lack of depth in some areas. The AQS style is very public oriented and in most instances the document is easy to read. Whilst this is positive, there is scope to complement this document with a more detailed report that sets out performance in more detail. Of the Welsh Government mandated elements only 16 of the 28 are included, with unnecessary gaps around articulation of the quality framework; coverage of how the Health Board works with partners to ensure quality; statements on how risks are managed; and key issues arising from the Clinical Governance Committee and external reports. The Health Board has recognised it could do more to explain the work it is doing in these areas, and has sought early feedback from my team and through peer reviews, and included a revised drafting process into its plans for the work of the Quality and Safety Committee.

The Health Board still has some way to go to achieve efficient and effective use of its resources, but is making steady progress across a growing number of areas

The Health Board made steady progress in addressing previous use of resources issues, but recognises further work is needed

66. Progress on key issues I identified in previous years' structured assessment work is highlighted in Exhibit 2 below.

Exhibit 2: Update on progress against key issues I highlighted in previous years' structured assessments

Issue	Progress made by the Health Board
Workforce planning	The new Director of Workforce is in the process of revitalising longstanding issues around strategic workforce planning. There are strengths associated with aspects of operational workforce planning with some examples of innovation, but issues remain around sickness levels and medical staff recruitment.
Planning	The development of more realistic medium-term plans is underway, with clear integrated guidance to directorates and templates to support a bottom-up approach, but the current three-year plan remains aspirational in the absence of an agreed South Wales Plan.
Facilities	Facilities continue to improve with the new Merthyr Tydfil health park, and the ongoing refurbishment of Prince Charles Hospital. Backlog maintenance remains high, and this is impacting on energy costs with one combined heat and power plant out of action in Royal Glamorgan Hospital for a number of months, which is now back in action.
Information management	My diagnostic work on data back-up arrangements found they are still under development and I propose to undertake a full review in 2014. My work on waiting lists is underway and I will report on this in 2014.

The Health Board has struggled to meet a number of the key performance targets in the Welsh Government's delivery framework, although there are signs of recent improvements

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

68. The Health Board's performance against a basket of efficiency measures is very mixed. In particular, the Health Board is in the Welsh Government escalation process for a number of targets. Efficiency and cost measures compared to the rest of Wales are generally below average, although there are early signs of improvement. I reached this conclusion because:

- Spend per head of population is higher than most of the rest of Wales, but also has a recognised above average level of need per head of population (Townsend formula).
- Length of stay for emergency admissions is long compared to the rest of Wales;
- Many elective efficiency measures are improving in 2013, although they are poor compared to the rest of Wales. Particularly, elective length of stay, day of admission surgery, day surgery rates and outpatient did not attends all compare badly with the Welsh average and do not meet targets set by the Welsh Government.
- There are high levels of estate backlog maintenance and out-of-date equipment, although performance on these measures is not out of line with other health boards.
- Sickness absence remains higher than targets.

69. The Health Board's performance on a basket of quality indicators is mixed. It has one of the lowest clostridium difficile rates in Wales, and MRSA rates are below the Welsh average. Performance on 'bundles' of care for stroke patients varies from comparatively good to poor, although the Health Board is in the process of developing plans to centralise its stroke expertise to address this. The RAMI is high although the Medical Director has established a comprehensive investigation to understand what is causing this, rather than looking to rely on coding or demographics for an explanation. These mortality reviews cover all deaths in hospital, and focus on learning lessons to improve outcomes in addition to understanding the causes of the high RAMI.

70. Timely access to services is relatively poor, with some signs of improvement:

- relatively good performance on the 31-day Urgent Suspected Cancer target, and typical performance for the 62-day target, yet the Health Board still does not meet the Welsh targets;
- emergency departments are now performing above the Welsh average on access, despite an aging demographic (but again performance does not meet the Welsh targets); and
- poor performance on referral to treatment targets, with a high percentage of patients waiting over 26 and 36 weeks – but this has improved over the last six months.

71. The Health Board recognises it has many opportunities to improve the quality and efficiency of services and has put in place a number of mechanisms to help.
The clinical business meetings for integrated performance review (quality, efficiency, operational plans and finance) with directorates happen monthly. The turnaround team function has evolved into the Programme Office to drive a series of improvement programmes focused on the key efficiency and access areas in elective and

unscheduled care. Whilst the Board, through its Finance and Performance Committee, holds executives and directorates to account on a planned basis.

72. The key challenge ahead is to systematically drive improvement, and there are some early signs to suggest that performance on a number of key measures is gradually improving. A good example is unscheduled care, where progress towards the target 95 per cent admissions within four hours is improving month on month.

The Health Board demonstrates strategic vision and leadership in its management of primary care prescribing although there is scope to improve the quality of prescribing in some important areas

73. The Health Board has a well-understood vision for medicines management that promotes integration across primary and secondary care. It closely monitors the primary care prescribing savings target and action plans, although its focus on financial savings should not be allowed to overshadow the equally important quality agenda:

- The Health Board has set a clear strategic vision for medicines management as part of its Strategic Workforce and Financial Framework for 2010 to 2015. The strategy promotes integration of medicines management across primary and secondary care which will support the Health Board's overall vision of shifting provision from secondary care to community and primary care in line with 'Setting the Direction'.
- The Medicines Management strategy is informed by a clear analysis of factors influencing prescribing behaviour which recognises that the Health Board's high volumes of prescribing are attributed mainly to demographics and levels of deprivation. It also aligns with, and supports the delivery of, national and local policies regarding medicines management, although there is no evidence of involvement of key stakeholders such as GPs and patient representatives in the development of the strategy.
- The Medicines Management strategy includes a financial analysis based on historic growth of the local drugs bill, avoiding cost shifting between primary and secondary care and has an established model for planning, monitoring and forecasting medicines expenditure related to NICE requirements.
- Monitoring outcomes delivery and performance: the Medicines Management Directorate's annual action plan for 2012-13 contains four key deliverables which meet SMART[1] criteria, although the focus on financial savings should not be allowed to overshadow the equally important quality agenda.

[1] Specific, Measurable, Attainable, Relevant, Time-bound.

74. Managerial accountability for medicines management is clear. The Medicines Management Directorate's approach of targeting of the highest spending practices should produce increased return on investment. The Health Board has a well-established formulary and the integration of primary and secondary pharmacy is leading to improvements across the interface:

- The arrangements for executive, professional and managerial accountability for medicines management and primary care prescribing are clear. The integration of medicines management staff across primary and secondary care is already delivering benefits across the Health Board's service areas.
- The Health Board's two prescribing advice teams spend over half of their time with GP practices providing prescribing support to primary care, and benefit from data that is analysed centrally. There is evidence of efficient and effective use of limited resources in the form of the pharmacy advisor support being targeted on the highest spending practices.
- The formulary was developed jointly with Cardiff and Vale University Health Board and is widely accepted and used by GPs.
- The Cwm Taf Medicines Management and Expenditure Committee works closely with the Bro Taf Drugs and Therapeutics Committee to provide assurance that the management of medicines optimises patient care, is safe, legal and provided within the financial resources available for the Health Board.
- The Health Board has a thorough and well-established process for developing protocols and ensuring they are used properly across primary and secondary care. There are over 30 good quality shared care protocols in place to support interface working.

75. The Health Board has a good record of making financial savings from more rational prescribing in primary care. However, scope exists to make additional savings in some areas, such as generic prescribing, with potential to save around £1.2 million without affecting patient care by increasing levels of generic prescribing, and reducing drug wastage (up to £2.6 million). In addition, scope remains to critically review the prescribing of some specific drugs as part of a greater focus on quality and safety issues:

- The Health Board's primary care prescribing savings target of over £1 million for 2012-13 was conservative and derived by using appropriate data on historic costs and future cost pressures. Prescribing costs reduced by £2.3 million compared to 2011-12 which shows the focus on reducing the cost and volume of prescribing is working in practice.
- The Medicines Management Practice Unit (MMPU) produces a monthly 'flash report' covering progress against expenditure, quality and savings targets; these arrangements are working well as the MMPU has the central expertise to carry out extensive data analysis and the medicines management metrics are reported to the Director of Primary, Community and Mental Health, and the Health Board's clinical business meetings.

Good progress was made across a number of areas to improve use of resources, in particular management of the consultant contract, hospital food and catering, and unscheduled care and chronic conditions management

76. During the last 12 months, my team has undertaken follow-up audit work to assess the progress that the Health Board has made in addressing concerns and recommendations arising from previous audit work in specific areas of service delivery. The findings from the follow-up work are summarised in Exhibit 3.

77. I reported my findings on Unscheduled Care and Chronic Conditions Management in full in my 2012 Annual Audit Report, but it is useful to note here that my team are maintaining a watching brief on these important areas. I note that good progress is being made towards achieving targets for unscheduled care access, and the programme management approach intended to support sustained improvement is showing early signs of success.

Exhibit 3: Progress in implementing audit recommendations

Area of follow-up work	Conclusions and key audit findings
Consultant contract	The Health Board is prioritising implementing my recommendations and has made steady progress towards embedding these through job plan reviews for consultants, although not all directorates are progressing at the same pace. In particular, I found that the Health Board established solid foundations by reviewing its guidance and agreeing processes with medical staff before implementation. This took some time, but, once agreed, steady progress towards embedding the new consistent approach was evident, although directorates were progressing at different rates. The Board continues to monitor this area.
Hospital food and catering	The Health Board made good progress in implementing my recommendations in relation to catering and patient nutrition services. A small number of actions need further work: • The historically high cost of catering services is reducing but there continues to be a marked difference in catering cost at the two main hospitals, due in part to the ongoing roll-out of the 'cook-freeze' model at Prince Charles. • The Health Board is recovering a greater proportion of the costs of non-patient catering services but it may be some time before these services breakeven. • The Health Board has reduced food waste and is now comfortably complying with the wastage target set by the Welsh Government. • Ward staff continue to comply with basic food hygiene practice but poor compliance with the national screening tool e-learning package means that nursing staff are not making use of general guidance on food hygiene.

Area of follow-up work	Conclusions and key audit findings
Hospital food and catering	• The Health Board has taken positive steps to improve patients' mealtime experiences; compliance with protected mealtimes has improved, and nursing staff are generally available to help patients at the right time. • There are improvements in nutritional care with patients being screened on admission but nutritional care plans are not always in place and compliance with the national screening tool e-learning package is poor.

Appendix 1

Reports issued since my last Annual Audit Report

Report	Date
Financial audit reports	
Audit of Financial Statements Report	May 2013
Opinion on the Financial Statements	June 2013
Financial Statements Memorandum	October 2013
Performance audit reports	
Follow-up Review of Hospital Catering Services	May 2013
Review of Progress Implementing Recommendations from the Local Report Pay Modernisation: NHS Consultant Contract	June 2013
Primary Care Prescribing	September 2013
Data Back-up Diagnostic	November 2013
Ward Staffing Benchmarking Information	December 2013
Other reports	
Outline of Audit Work for 2013	April 2013

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
Operating Theatres and Day Surgery Follow-up	January 2014
Clinical Coding	January 2014
Ward Staffing Follow-up (summary)	February 2014
Waiting Lists (local project)	March 2014
Orthopaedics	March 2014
Community Nursing	May 2014

Appendix 2

Audit fee

The *Outline of Audit Work for 2013* set out the proposed audit fee of £457,139 (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.

Appendix 3

Financial audit risks

My *Outline of Audit Work for 2013* set out the key financial audit risks for 2013. The table below lists these risks and sets out how they were addressed as part of the audit.

Financial audit risk	Work done and outcome
Due to the tight timetable, the financial statements necessarily contain a number of estimated figures, as actual figures were not available at the time of their production, particularly around Primary Care and Continuing Healthcare.	As part of our planning work we obtained an understanding of how estimates were going to be derived. During the final audit, we confirmed that the Health Board had provided estimated figures in line with our understanding and that the figures produced could be supported and were reasonable.
The Health Board's estate was revalued by the District Valuer (DV). We identified a risk that the DV valuation was not correctly reflected in the account and that the estate may not be valued in line with Welsh Government guidance.	We reviewed the arrangements and the DV's report in line with the requirements of ISA 500 (Management Expert) and confirmed that they were appropriate. The accounting treatment was also agreed.
Potential or actual liabilities arising from the legal dispute between the Health Board and the main contractor for Ysbyty Cwm Rhondda may not be correctly accounted.	We reviewed the advice received from the Health Board's legal advisor and correspondence between the complainant and the Health Board, and concluded that the current position was correctly reflected in the account in line with accounting standards.
Due to a number of changes in the senior management of the Health Board during the year, we identified that the Remuneration Report may not correctly include all the required disclosures.	We reviewed the changes to the Board and considered that the Remuneration Report correctly included all those with appropriate management responsibility and that their remuneration details were correct.
In 2012-13, we reported that the Governance Statement needed to be more embedded within the Governance of the Health Board and the statement should be of a better quality.	Although the first draft contained some minor mandatory omissions as required in Welsh Government guidance, the overall quality and the process for its production was considered and improvement and the final statement fairly reflected our view of the Board's internal control and governance arrangements.

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