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Annual Audit Report 2017 – **Abertawe Bro Morgannwg University Health Board**

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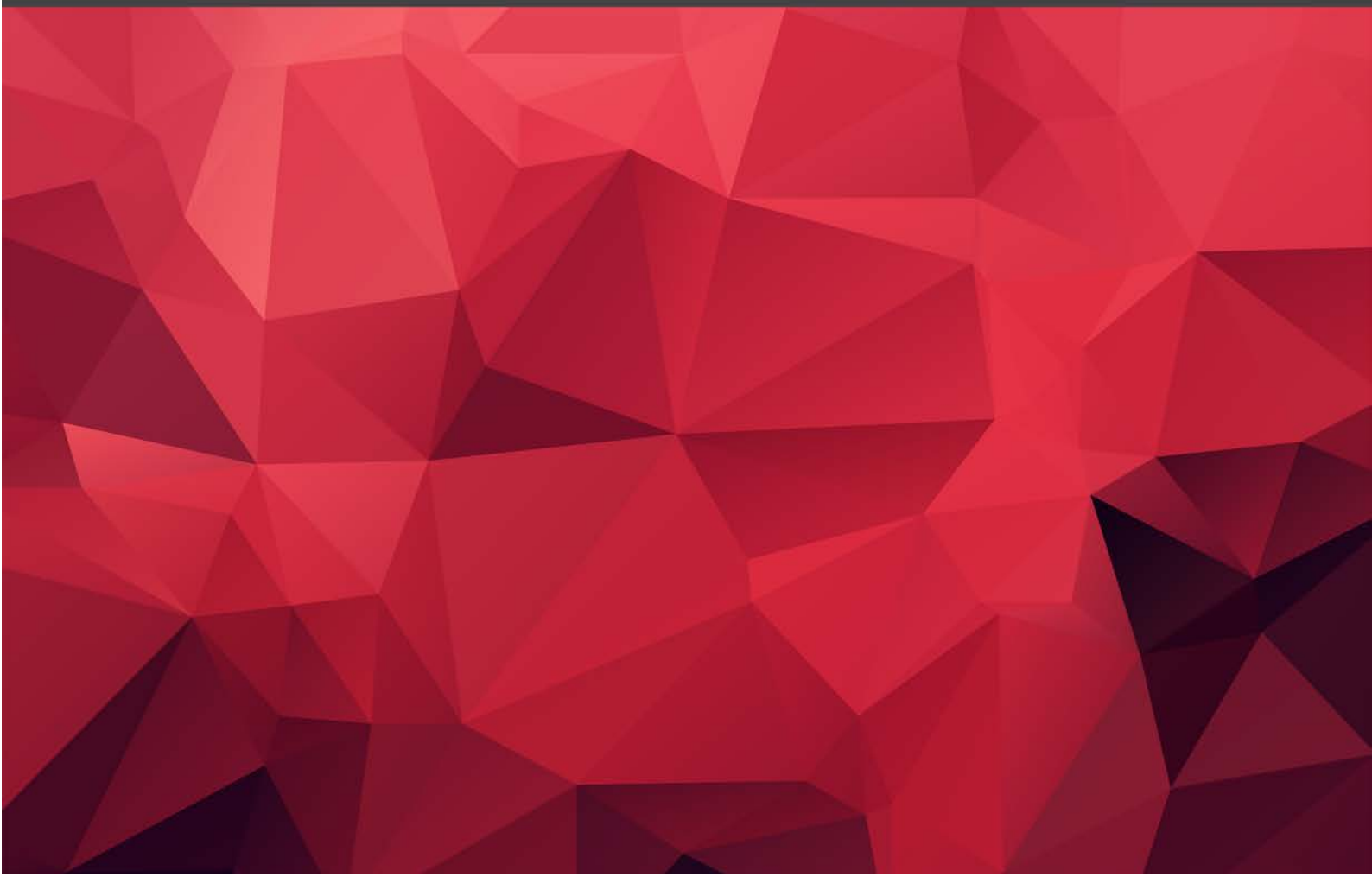

The team who helped me prepare this report comprised Carol Moseley, Geraint Norman, Dave Thomas and Ann-Marie Harkin.

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Summary report

Summary

1 This report summarises my findings from the audit work I have undertaken at Abertawe Bro Morgannwg University Health Board (the Health Board) during 2017. I did that work 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.

2 My audit work focused on strategic priorities and the significant financial and operational risks facing the Health Board, and which are relevant to my audit responsibilities. The separate reports I have produced during the year have more detail on the specific aspects of my audit. We discuss these reports and agree their factual accuracy with officers before presenting it to the Audit Committee. My reports are shown in Appendix 1.

3 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report, which we presented to the Audit Committee on 15 March 2018. The Board will receive the report at a subsequent Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange wider publication of this report. Following Board consideration, we will make the report available to the public on the Wales Audit Office website.

4 My audit work can be summarised under the following headings.

Section 1: audit of accounts

5 I have issued a qualified opinion on the 2016-17 financial statements of the Health Board, and in doing so I have brought several issues to the attention of officers and the Audit Committee. The qualification relates solely to the regularity opinion and is because the Health Board failed to achieve its first financial duty under the NHS Finance (Wales) Act 2014, to achieve financial balance for the three-year period ending 2016-17.

6 Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements to highlight its failure to meet its financial duties.

7 I have also concluded that the Health Board's accounts were properly prepared and materially accurate.

8 My work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts.

9 Section 2 of this report has more detail about the financial position and financial management arrangements.

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

10 I have examined the Health Board's financial planning and management arrangements, its governance and assurance arrangements, and its progress on the improvement issues identified in last year's Structured Assessment. I did this to satisfy myself that the Health Board has made proper arrangements for securing efficiency, effectiveness and economy in the use of its resources. I have also undertaken Performance Audit reviews on specific areas of service delivery. My conclusions based on this work are set out below.

The Health Board continues to find itself in a very challenging financial situation although the actions needed to address the problems are recognised and there is evidence that improvements are being made

11 Key findings from my review of the Health Board's arrangements for planning and delivery of financial savings are as follows:

- the Health Board continues to experience significant financial challenges and whilst savings are helping to close the resource gap, they are insufficient to achieve financial balance;
- arrangements for planning and delivering savings have not been effective or sustainable but the Health Board is strengthening its approach and recognises the need to increase focus on service transformation and efficiency; and
- the Health Board has improved its arrangements for monitoring, reporting and scrutiny of savings.

There have been significant challenges because of transitional leadership arrangements and board member turnover over the last year. However, the Board now finds itself in a more stable position to take forward key actions such as developing a longer-term strategy, embedding new governance arrangements and strengthening aspects of performance management

12 Key findings from my review of the Health Board's governance and assurance arrangements are as follows:

- following a period of unstable Board membership, the Board is aware that it needs to develop its new Board, revise its committee structures and strengthen overall governance arrangements with pace;
- whilst working to an Annual Operating Plan, the Health Board is redeveloping its clinical strategy to inform its longer-term, more transformational planning although planning capacity is limited;
- the Health Board has managed the impact of major executive changes in 2017 and recognises that developing the new executive team, building

leadership and capacity, and embedding new programme board arrangements are priorities for 2018;

- risk management is maturing but performance management would benefit from more integrated reporting and a stronger focus on accountability and outcomes;
- information governance arrangements support compliance with current legislation but meeting the new General Data Protection regulations will be challenging within current resources;
- the Health Board has made good progress in its use of National Fraud Initiative (NFI) to detect fraud and overpayments; and
- although there is more to do to fully complete some actions, the Health Board has made progress in addressing the issues identified in last year's structured assessment and has the necessary arrangements in place to track audit recommendations.

My performance audit work has identified opportunities to secure better use of resources in a number of key areas

13 I have undertaken a number of performance audit reviews at the Health Board over the last 12 months. The key findings from those reviews are as follows:

- the Health Board has maintained positive stakeholder engagement but faces a number of challenges in respect of workforce, asset management and ICT and programme management;
- day to day radiological operations are well managed, but increasing demand, significant workforce challenges, aging equipment and weak strategic planning are leading to reporting backlogs and other risks to future delivery;
- the GP out-of-hours service has effective governance arrangements and fewer staffing problems than in most parts of Wales. However, the Health Board needs to improve its understanding of demand, address issues with performance data and strengthen its strategic and workforce planning;
- the Health Board is working collaboratively with stakeholders to improve patient flow and discharge planning, and while there are improvements in performance there is still more to do;
- the Health Board has made some progress in addressing recommendations from my previous work, but more focus is required to reduce follow-up appointment delays, both through improving operational processes and modernising services.

14 In addition to the above, I have also undertaken all Wales work in areas that are of relevance to the Health Board. This work has shown that:

- collaborative commissioning arrangements have helped drive some important changes for emergency ambulance services in Wales; however, the maturing arrangements require greater commitment from some partners; and
- collaborative arrangements for managing local public health resources do not work as effectively as they should do.

15 We would like to thank the Health Board's staff and members for their assistance and cooperation during the audit.

Detailed report

About this report

16 This Annual Audit Report 2017 to the Board members of the Health Board sets out the findings from the audit work that I have undertaken between January and December 2017.

17 I undertake my work at the Health Board in response to the requirements set out in the 2004 Act[1]. 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.

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

- the results of audit work on the Health Board's financial statements;
- work undertaken as part of my latest structured assessment of the Health Board, which examined the arrangements for financial management, governance and assurance;
- 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 as part of the National Fraud Initiative (NFI).

19 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.

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

- section 1: audit of accounts
- section 2: arrangements for securing economy, efficiency and effectiveness in the use of resources

21 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 2017 Audit Plan.

22 Finally, Appendix 3 sets out the significant financial audit risks highlighted in my 2017 Audit Plan and how they were addressed through the audit.

[1] Public Audit (Wales) Act 2004

Section 1: audit of accounts

23 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2016-17. 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.

24 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 prepared in accordance with statutory and other requirements, and comply with relevant requirements for accounting presentation and disclosure;
- whether that part of the remuneration report to be audited is properly prepared;
- whether the other information provided with the financial statements (the Annual Report) is consistent with them; and
- the regularity of the expenditure and income in the financial statements.

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

I have issued a qualified regularity opinion on the Health Board's 2016-17 financial statements, and in doing so, I have also brought several issues to the attention of officers and the Audit Committee and placed a substantive report alongside my audit opinion

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

26 I received draft accounts by the deadline and the supporting working papers were of good quality.

27 I am required 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 and Risk Assurance Committee on 31 May 2017. 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
Uncorrected misstatements	There were no uncorrected misstatements.
Corrected misstatements	There were several adjustments made to the draft accounts which in the main related to additional narrative to provide more clarity.
Other significant issues	I qualified my regularity opinion and issued a substantive report because the Health Board did not achieve its financial duty to achieve financial balance for the three years ending 2016-17. I reported that the Health Board needed to improve its governance arrangements for managing the departures of senior staff.

28 As part of my financial audit, I also undertook a review of the 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 2017 and the return was prepared in accordance with the Treasury's instructions.

29 My separate audit of the Charitable Funds financial statements is complete and I issued an unqualified opinion on the accounts in November 2017.

My work did not identify any material weaknesses in the Health Board's internal controls

30 I reviewed the Health Board's internal controls that I considered relevant to the audit to help me identify, assess and respond to the risks of material misstatement in the accounts. I did not consider them however for the purposes of expressing an opinion on the operating effectiveness of internal control. With the exception of the issues set out in Exhibit 1, my review did not identify any significant deficiencies in the Health Board's internal controls.

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

31 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 planning and delivery of financial savings and their contribution to achieving financial balance;

- assessing the effectiveness of the Health Board's governance and assurance arrangements through my structured assessment work, including a review of the progress made in addressing structured assessment recommendations made last year;
- assessing the application of data-matching as part of the National Fraud Initiative (NFI);
- specific use of resources work on radiology services, GP out-of-hours services and discharge planning; and
- assessing the progress the Health Board has made in addressing the recommendations raised by previous audit work on the management of follow-up outpatients, and reviewing the Health Board's arrangements for tracking progress against external audit recommendations.

32 I have also undertaken performance audit work that has examined the governance arrangements within the Emergency Ambulance Services Committee, and the collaborative working arrangements between local public health teams and Public Health Wales NHS Trust.

33 The main findings from the work referenced above are summarised under the following headings.

The Health Board continues to find itself in a very challenging financial situation although the actions needed to address the problems are recognised and there is evidence that improvements are being made

34 In addition to commenting on the Health Board's overall financial position, my structured assessment work in 2017 has considered the actions that the Health Board is taking to achieve financial balance and create longer-term financial sustainability. I have assessed the corporate arrangements for planning and delivering financial savings in the context of the overall financial position of the organisation. I have also reviewed progress made in addressing previous structured assessment recommendations relating to financial management. I summarise my findings below.

The Health Board continues to experience significant financial challenges and whilst savings are helping to close the resource gap, they are insufficient to achieve financial balance

35 The Health Board has arrangements in place for the setting of its revenue and capital budgets. These have remained largely as in prior years but continuing financial pressures have meant that despite these arrangements, the Health Board has been unable to agree a balanced financial plan for the last three years and the cumulative deficit has continued to grow.

36 In 2016-17, the Health Board ended the year with a £39.3 million deficit. The position looks similar for 2017-18 with the Health Board forecasting a deficit of £36 million. This is not a sustainable position going forward and recovering the deficit position to achieve financial balance in the near future will prove to be very challenging.

37 The Health Board does not have a track record of delivering planned financial savings targets and the success of individual savings schemes is variable. Over the last five years, the Health Board has set ambitious savings targets but has not fully met any of its annual savings targets and has in most years, set targets greater than that it achieved in the previous year. In addition, the Health Board has incurred additional unplanned growth in service costs, which have added to the underlying financial deficit and in turn, influences the level of savings requirement.

38 As part of NHS Finance Act (Wales) 2014 (the Act) requirements, the Health Board must spend within its financial allocations over a rolling three-year financial period. The Health Board's three-year deficit position for the period 2015-18 is expected to be some £75.2 million.

Arrangements for planning and delivering savings have not been effective or sustainable but the Health Board is strengthening its approach and recognises the need to increase focus on service transformation and efficiency

39 The Health Board's approach to savings and wider financial planning has remained broadly the same for a number of years despite the declining trend in financial performance. There has been a lack of buy in and ownership from budget holders as the Health Board has historically rolled forward previous annual budgets year on year.

40 As we have commented in previous years, financial, service and organisation objectives need to be better linked. Similarly the Health Board's budget is not zero based, either in totality or for discrete parts and that the links between the budget, objectives and other plans is unclear. Without this, the ability to identify efficient and inefficient areas and to benchmark against good practice is difficult.

41 Establishing the Recovery and Sustainability Programme in January 2017 is a positive step although the scale of the challenge is significant. It is also positive that for 2018-19, the Health Board is planning to include savings plans in the 'bottom line' position of budgets rather than managing savings plans in isolation.

The Health Board has improved its arrangements for monitoring, reporting and scrutiny of financial savings

42 In previous years, the Board has not received sufficiently detailed information to support effective scrutiny and challenge of financial savings, although there have been improvements in the information provided and improve scrutiny.

43 Operational scrutiny and monitoring of savings plans and delivery has been weak in previous years, but steps are being taken to strengthen the arrangements. The key issue for the health Board is to establish the integrated reporting of the finances alongside service performance.

There have been significant challenges because of transitional leadership arrangements and board member turnover over the last year. However, the Board now finds itself in a more stable position to take forward key actions such as developing a longer-term strategy, embedding new governance arrangements and strengthening aspects of performance management

44 My structured assessment work has assessed the Health Board's governance and assurance arrangements. This included the effectiveness of the board and its governance structures, and the progress made in addressing previous structured assessment recommendations. My findings are set out below.

Following a period of unstable Board membership, the Board is aware that it needs to develop its new Board, revise its committee structures and strengthen overall governance arrangements with pace

45 Independent member and executive turnover have created instability during 2017 but the risks and opportunities for developing the new Board and strengthening governance are recognised. The Board is aware that the number of new Independent Members and Executive Directors in interim positions continues to present a risk and this has been added to the corporate risk register.

46 The Health Board has commissioned a Board development programme for the new Board, to focus on Board behaviours, corporate leadership, a cohesive team and ensuring effective challenge. The Health Board also needs to consolidate actions on governance improvement issues identified in previous reviews.

47 Quorate committee meetings have been sustained despite Board membership fragility and the introduction of a Performance and Finance Committee has been a positive step. However, some committees have not been wholly effective, in particular the Workforce and OD Committee, and the Health Board is currently considering proposals for revisions to its existing committee structure and memberships.

48 An executive led Quality and Safety Forum reporting to the Quality and Safety Committee has been established and work undertaken to map and streamline the management groups providing assurances on Quality and Safety. This has simplified reporting lines although further work is needed.

49 Development of a Board Assurance Framework (BAF) has been slow but with new Board membership and proposed governance structures changes, it is now being progressed as a priority. The Health Board recognises the benefits of risk and assurance mapping and is keen to progress the work alongside the wider development of its new Board. In the meantime, the existing system of assurance continues to operate.

Whilst working to an Annual Operating Plan (AOP), the Health Board is redeveloping its clinical strategy to inform its longer-term, more transformational planning although planning capacity is limited

50 The Health Board does not have an approved Integrated Medium Term Plan (IMTP) and is working to an Annual Operating Plan. Development of the 2018-19 plan has been informed by key planning principles, with an earlier focus on activity, finance and performance requirements for 2018, and a more thorough engagement of the Board. The Health Board will need to consider how committee level reporting and scrutiny aligns across the new Performance and Finance Committee and the proposed reinstatement of the Strategy Committee.

51 There has been a necessary focus on responding to targeted intervention, although this has led to a short-term approach to strategy and planning. The clinical strategy, developed in 2013 is out of date and there is current uncertainty about the funding of the ARCH[2] programme. The Health Board is aware that it needs to set the direction and longer-term vision for the organisation and is currently developing a new clinical strategy.

52 The Health Board is operating in a complex strategic environment with a number of major strategic programmes and service change consultations to both manage and account for. The Health Board's planning capacity is limited and it is looking to commission help to support demand and capacity planning and build operational planning skills and expertise.

The Health Board has managed the impact of major executive changes in 2017 and recognises that developing the new executive team, building leadership and capacity, and embedding new programme board arrangements are priorities for 2018

53 Executive officers have shown commitment to maintaining leadership during a period of major executive changes, and the Health Board recognises establishing its new leadership team as a priority for 2018. The revised executive membership provides an opportunity to develop closer collaborative working as a single leadership team, and for ensuring balance across executive portfolios.

54 The Delivery Unit Structure is now fully established and there are some examples of good collaborative working between units. However, there is also evidence that

[2] A Regional Collaboration for Health (ARCH) is a regional model for health in south west Wales, built on collaboration with Swansea University and Hywel Dda Health Board

indicates cross-system working between unit management teams is not wholly embedded or consistent. The Health Board has been taking steps to build a senior leadership team approach between unit management teams and the Executive, to develop a collective and corporate view of Health Board wide service delivery and unit management responsibilities.

55 The Health Board has recently stood down its Commissioning and Delivery Boards and three new Programme Boards that incorporate both planning and improvement are being established. Commissioning and value based principles are to be intrinsic to the planning work of the new Programme Boards. It is too early to assess the effectiveness of the new Boards and mapping of the strategic change programmes previously managed by the Commissioning Boards has yet to be completed.

Risk management is maturing but performance management would benefit from more integrated reporting and a stronger focus on accountability and outcomes

56 The Health Board is updating its risk management strategy and taking steps to further mature its approach. A workshop for Board members has recently been held to consider its current risk management approach. The Health Board intends to introduce Executive portfolio risk registers and improve the corporate risk register template, with clearer assignment and scrutiny of specified risks by individual committees. The work will be proceeding alongside development of the Health Board's Board Assurance Framework.

57 The Health Board has focused on performance issues that contributed to targeted intervention and while a Recovery and Sustainability Programme has led important work, greater Delivery Unit ownership is needed. Performance management arrangements are in place but the documented framework is out of date, the number of performance related meetings may not be sustainable and there needs to be a stronger outcomes focus. The introduction of a new Performance and Finance Committee is strengthening scrutiny but aspects of reporting could be improved and more integrated reporting could better meet Health Board needs.

Information governance arrangements support compliance with current legislation but meeting the new General Data Protection regulations will be challenging within current resources

58 An Information Governance Board is responsible for all Health Board information and provides assurance to the Audit Committee on the effectiveness of information governance arrangements. An audit by the Information Commissioners Office (ICO) in 2016 identified a number of improvement areas, many of which having relevance to the Health Board's ability to comply with the new General Data Protection Regulation (GDPR) coming into effect in May 2018.

59 The Health Board has been making good progress in addressing the issues identified by the ICO. However, there is a significant amount of work remaining to

be compliant with GDPR requirements, including completion of the Health Board's Information Asset Register and making significant further progress in ensuring all staff have received information governance training. The risk that the Health Board will not be compliant by May 2018 has recently been added to the Corporate Risk Register, not least due to the significant financial penalties should a breach occur. It is unlikely that the Health Board will be able to achieve and subsequently maintain compliance within current resources, and additional capacity is being sought.

The Health Board has made good progress in its use of National Fraud Initiative (NFI) to detect fraud and overpayments

60 The NFI is a biennial data-matching exercise that helps detect fraud and overpayments by matching data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. It is a highly effective tool in detecting and preventing fraud and overpayments, and helping organisations to strengthen their anti-fraud and corruption arrangements.

61 The Health Board is a mandatory participant in NFI. In January 2017, the Health Board received NFI data-matches through the NFI web application. Data-matches highlight anomalies which when reviewed can help to identify fraud and error. The Health Board has made good progress in reviewing the data-matches. No frauds have been identified because of the review undertaken, providing assurance that the Health Board's counter-fraud arrangements are working effectively. However, I note that the Health Board has not reviewed the data-matches in two NFI match reports – these reports match payroll, creditor payment and Companies House data, and can help to identify undisclosed staff interests and procurement fraud. I therefore recommend that the Health Board review these data-matches as a matter of urgency.

Although there is more to do to fully complete some actions, the Health Board has made progress in addressing the issues identified in last year's structured assessment and has the necessary arrangements in place to track audit recommendations

50 The Health Board has made reasonable progress in addressing the recommendations in last years structured assessment work. Of the 12 recommendations, six are complete, and six are in progress but not yet complete. This progress is broadly consistent with the progress update presented by the accountable officer to the Audit Committee.

51 In addition to reviewing the actions taken to address my 2016 structured assessment recommendations, I also considered the effectiveness of the Health Board's wider arrangements to respond to my audit recommendations. I found that the Health Board has arrangements to monitor management responses to my audit recommendations and those of internal audit, with the Committee receiving an Audit Register and Action Plan Report highlighting the number of

recommendations complete, in progress or overdue. Arrangements to track recommendations of other audit and inspection bodies, including HIW and the Delivery Unit are not in place.

52 The tracking report to Audit Committee has been improved with the longest number of overdue days for outstanding recommendations from each audit now included. Whether these overdue actions relate to high-risk issues is being added to future reports to better inform and help the Committee target its scrutiny and holding to account where progress, particularly in areas of limited assurance and high-risk, is slow.

My performance audit work has identified opportunities to secure better use of resources in a number of key areas

The Health Board has maintained positive stakeholder engagement but faces a number of challenges in respect of workforce, asset management and ICT and programme management

53 My structured assessment work has reviewed how a number of key enablers of efficient, effective and economical use of resources are managed. My key findings are summarised in Exhibit 2.

Exhibit 2: key findings on use of resource enables from structured assessment

Issue	Summary of findings
Change management capacity	A Programme Management Office to support the Recovery and Sustainability Programme has been set up and significant organisational development work is progressing, but programme management capacity to support wider strategic change is limited and strategic change programmes need review and remapping to new delivery structures.
Workforce planning	The Health Board continues to face a number of workforce challenges including recruitment, sickness and completion of appraisals and statutory and mandated training. It also needs to strengthen its workforce planning and scrutiny arrangements.

Issue	Summary of findings
Asset management	The Health Board has yet to define its asset management strategies and faces difficult resource prioritisation decisions with a £60 million estates backlog and £75 million of plant and equipment having reached the end of its economic life. ICT strategy is well developed but projects are needing to be prioritised and ICT capacity presents longer term challenges for supporting modernisation.
Partnership and stakeholder engagement	The Health Board continues to positively engage with stakeholders, although the complexity of partnership working and service change puts significant demand on the organisational capacity available to support this work.

Day to day radiological operations are well managed, but increasing demand, significant workforce challenges, aging equipment and weak strategic planning are leading to reporting backlogs and other risks to future delivery

54 My work on radiology services found that open access to services differs across the Health Board. Despite significant increases in demand, patients receive their radiological examination within eight weeks across all modalities, but reporting backlogs and reporting times vary across sites, and there are barriers to improvement. Both units have their own programme of clinical audit and some joint audits take place each year, although the level of peer review of reporting quality is low. Staff are encouraged to report complaints and incidents, and patient feedback mechanisms have improved, while some environment issues may affect patient experience.

55 The major factors driving up demand for radiological services are largely beyond the Health Board's control. The Health Board relies on national referral guidelines, although the absence of an electronic request system creates a risk, and while the quality of radiologist advice is good, it is not always easily accessible. A lack of coordinated appointment booking arrangements limits the ability to further improve waiting list management, although some session capacity is protected to accommodate urgent activity. Across the Health Board, the number of radiologists and radiographers approaching retirement is higher than the Wales average, and recruitment to fill radiology vacancies is very challenging. Staff carry out more examinations than the Wales average and the radiology workforce profile is just above the Wales average. My team identified that radiologists and sonographers are less likely to be compliant with statutory and mandatory training than other staff, and staffing constraints hinder training opportunities. The number of scanners is broadly in line with the Wales average, although some have shorter operating

hours, and whilst there is potential to further optimise weekend usage, this may cost the service more.

56 The Health Board's radiology services lack a joint strategic plan, and there are no detailed annual operational plans or financial plans, although there is a workforce plan. Management and accountability arrangements are clear at delivery unit and executive level, although there is a need to focus on delivery of a radiology service for the Health Board as a whole, and some key joint radiology meetings no longer take place. The service is also not well represented on Board committees and sub-committees. In recent years, service expenditure has been close to budget, although savings targets have not been achieved and appear to be unrealistic. While there is no capital allocation budget, each radiology service produces an equipment replacement programme, and some older equipment poses significant risks to patient care and service continuity. The lack of a clear timeframe for a single core radiology system limits the development of more joined up radiology services. Radiology performance is regularly reviewed at service level and through corporate performance team meetings, although there is more limited reporting of radiology performance at unit level.

The GP out-of-hours service has effective governance arrangements and fewer staffing problems than in most parts of Wales. However, the Health Board needs to improve its understanding of demand, address issues with performance data and strengthen its strategic and workforce planning

57 My review of GP out-of-hours services found that the Health Board needs to improve its understanding of capacity and demand, and ensure that the service has sufficient profile within the broader planning of 111. The staff survey shows positive views about clinical and operational leadership of GP out-of-hours and changes to the management structure aim to provide further clarity. Performance management and scrutiny arrangements are in place and work continues to address problems in providing performance data to the Welsh Government.

58 Although there is no GP out-of-hours workforce plan, the service has few unfilled shifts, staff are positive about the support they get and some non-traditional roles are being tested. Despite increasing its spending on GP out-of-hours services, the Health Board's cost per contact is comparatively low and the service is taking a rigid approach to sessional pay for GPs.

59 Signposting to GP out-of-hours services is good and access to in-hours primary care is around the average for Wales, however the Health Board was unable to provide monthly performance data about call taking, hear-and-treat, and see-and-treat services. My work found that co-locating out-of-hours and emergency departments has led to stronger working relationships and the new directory of services is a key enabler of appropriate referrals to other services.

The Health Board is working collaboratively with stakeholders to improve patient flow and discharge planning, and while there are improvements in performance, there is still more to do

60 My work identified that there are clear plans in place to improve discharge planning, which have been developed with local authorities and focus on collaborative working and responding to winter pressures. There is scope to strengthen the discharge policy, although overall it compares well against good practice. There are a number of discharge pathways in place, however, links between generic and specific pathways are unclear and they are not clearly set out in the discharge policy.

61 Dedicated multidisciplinary resources are in place in hospitals to support discharge planning, but operate on weekdays only. Staff training has been rolled out to increase awareness of new policies and pathways and the Health Board recognises it needs to address staff confidence to ensure safe and timely discharge.

62 There are clear lines of accountability for discharge planning, with regular scrutiny of performance both strategically and operationally. A range of information is used to support timely scrutiny of patient flow, but could incorporate data that is more specific to discharge planning when reporting to Board committees. Performance relating to lengths of stay and waits in Emergency Departments are showing signs of improvements, but there is more to do to reduce delayed transfers of care.

The Health Board has made some progress in addressing recommendations from my previous work, but more focus is required to reduce follow-up appointment delays, both through improving operational processes and modernising services

63 In addition to reviewing the effectiveness of the Health Board's arrangements to manage and respond to recommendations made as part of my audit work as discussed in paragraphs 50-52, my work has found that the Health Board is making progress in addressing recommendations from my previous audit work, although at times progress can be slow. Of the outstanding recommendations as at end December 2017 and reported to Audit Committee in January 2018, 133 actions were complete, 118 were in progress and within timescales, and 32 (11%) were overdue.

64 During the last 12 months, I have also undertaken detailed follow-up audit work to assess the progress that the Health Board has made in addressing concerns and recommendations arising from previous audit work on follow-up outpatient appointments. The findings from this follow-up work are summarised in Exhibit 3.

Exhibit 3: progress in implementing audit recommendations in specific service areas

Area of follow-up work	Conclusions and key audit findings
Follow-up outpatient appointments	The Health Board has made some progress in addressing recommendations, but more focus is required to reduce follow-up outpatient delays, both through improving operational processes and modernising services.

Collaborative commissioning arrangements have helped drive some important changes for emergency ambulance services in Wales; however, the maturing arrangements require greater commitment from some partners

65 My review of the all-Wales arrangements for commissioning emergency ambulance services found that the Emergency Ambulance Services Committee (EASC) has helped drive some important changes, such as the development of the CAREMORE®[3] model. However, structures and roles to secure accountability for emergency ambulance services are unclear. I found that there is scope to clarify the roles of EASC, the Welsh Government and the Chief Ambulance Services Commissioner in relation to emergency ambulance service performance, finance and service modernisation. Moreover, although the formation of EASC has supported all-Wales ownership of emergency ambulance services, my team identified that EASC needs to do more to drive through service transformation. In addition, the sub-group structure, which underpins EASC, lacks clarity and purpose, which is affecting attendance by health board staff and the ability of the subgroups to make a meaningful contribution.

66 Partners support the commissioning model but the pace with which health boards are driving the necessary changes to enable it to work as intended varies, and the model does not consider regional or cross-border activity. My work identified that there is a general willingness of WAST and health boards to work together to improve ambulance services, but the level of ownership of emergency ambulance performance and pathway modernisation by health boards is variable, with the predominant focus on the latter stages of the ambulance pathway, such as, ambulance handovers. I reported that WAST is properly responding to agreements set out by EASC, however, health boards' compliance with and level of understanding of the requirements set out in CAREMORE® vary.

67 My work found that commissioning arrangements are underpinning some improvements to emergency ambulance services. The introduction of the new clinical response model is supporting partners to achieve Welsh Government performance targets, with the potential for further performance improvements from

[3] The CAREMORE® model is a 'made in Wales' commissioning method. Its registered trademark belongs to Cwm Taf University Health Board on behalf of NHS Wales.

other recently agreed initiatives. Planned service changes and performance monitoring of partners are now increasingly aligned with the Ambulance Patient Care Pathway (referred to as the five-step model). However, more consistency is needed across health boards and it is too soon to say if this is having an impact. There is a significantly improved and broader set of measures, which focus on activity and performance through the Ambulance Quality Indicators. However, partners are not yet doing enough to fully understand patients' outcomes and experience when receiving emergency ambulance care.

Collaborative arrangements for managing local public health resources do not work as effectively as they should

68 My review of collaborative arrangements between Public Health Wales NHS Trust (the Trust) and health boards for managing local public health resources found that effective collaboration in relation to health improvement work is dependent upon consensual leadership, which is not always evident. In the overall public health system, a broad range of people and organisations contribute to protecting and improving health and wellbeing, and reducing health inequalities in Wales. No one organisation is wholly responsible for achieving improvements in population health and wellbeing but achievement is predicated on effective collaboration.

69 While it may not be desirable to identify a single system leader, there does need to be greater clarity over respective roles of the different stakeholders within the system. My work found that there is a lack of meaningful dialogue between the Trust, local public health teams and Directors of Public Health about respective roles, responsibilities and an agreed framework about what work is best done collectively.

70 Currently, there is an absence of effective arrangements to ensure that value for money is being secured from the resources allocated to local public health teams. Meetings do not take place between the Trust and Directors of Public Health to discuss how resources to improve health and wellbeing are used and whether they deliver the intended benefit. My work also found a lack of robust methods for allocating or changing resources of local public health teams. Instead, ad hoc discussions take place as vacancies arise.

71 My work found that arrangements are in place to support professional registration of staff deployed across local teams, but more clarity is needed on how this is used to demonstrate professional competence and career progression. New arrangements are also helping to strengthen appraisal processes and personal development planning, but more needs to be done to assess the collective development needs of local public health teams.

72 Mechanisms for communicating and sharing information between the Trust and local public health teams are underdeveloped. There is no standardised approach for sharing intelligence about what works well, and what different players were doing at both a national and local level. My work also found a lack of arrangements

for coordinating work developed or delivered locally or nationally, and communicating information to the same-shared partners.

73 I have noted the collective and collaborative management response that has been prepared by the Trust, health boards and Welsh Government to my findings. I intend to undertake further work in 2018 to assess the progress that has been made to address my recommendations.

Appendix 1

Reports issued since my last annual audit report

Exhibit 4: reports issued since my last annual audit report

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2017
Opinion on the Financial Statements	June 2017
Performance audit reports	
Radiology Services	February 2017
Emergency Ambulance Services Commissioning	April 2017
GP Out-of-Hours Services	August 2017
Collaborative Arrangements for Managing Local Public Health Resources	October 2017
Review of Discharge Planning	January 2018
Progress update of Follow-up Outpatients	January 2018
Other reports	
2017 Audit Plan	March 2017

Exhibit 5: performance audit work still underway and estimated completion dates

Report	Estimated completion date
Structured Assessment 2017	Draft report: February 2017 Finalisation: March 2018
Review of Primary Care Services	Draft report planned for summer 2018
Cross-cutting review of the Integrated Care Fund	Fieldwork due to commence in March 2018. A single national report is planned for November 2018.

74 In addition, as part of my 2017 plan my auditors agreed to support the development of the new Board, through wider presentation of my structured assessment findings and contribution to the induction of new Independent Members in relation to the role of scrutiny and assurance. My team are in discussion with the Health Board's Board Secretary to confirm timing.

Appendix 2

Audit fee

The 2017 Audit Plan set out the proposed audit fee of £421,807 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is that the total final fee will be some £416,000.

Appendix 3

Significant audit risks

Exhibit 6: significant audit risks

Significant audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	My audit team: • tested journal entries; • reviewed accounting estimates, particular primary care payments; and • did not identify any transactions outside of the normal course of business. No matters arose from the work carried out.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.26-27].	My audit team will: • review and test the individual funding and income streams received by the Health Board; and • consider whether all funding and income streams have been identified.	My audit team reviewed income streams for completeness and tested for accuracy. No matters arose from the work carried out.
There is a significant risk that the Health Board will fail to meet its revenue resource allocation. The month 9 position showed a year-to-date deficit of £26.6 million and forecast a year-end deficit of £39.2 million. I may choose to place a substantive report on the financial statements explaining the failure and the circumstances under which it arose. The current financial pressures on the Health Board increase the risk that	My audit team will focus its testing on areas of the financial statements, which could contain reporting bias.	My audit team reviewed year-end transactions, in particular accruals and cut-off. No matters arose from the work carried out. I chose to place a substantive report on the financial statements explaining the failure and the circumstances under which it arose.

Significant audit risk	Proposed audit response	Work done and outcome
management judgements and estimates could be biased in an effort to achieve the resource limit.		
In 2015-16 we reported an issue in respect of a contract over £1 million with a private healthcare provider which did not have the required Welsh Government approval. For 2016-17 there is a risk that there are contracts above £1 million which have not received the required Welsh Government approval. This could have an impact on my regulatory opinion.	My audit team will test a sample of contracts over £1 million including private healthcare providers to ensure that Welsh Government approval has been obtained.	My audit team sample tested contracts over £1 million. No matters arose from the work carried out.
Liabilities for continuing healthcare costs continue to be a significant financial issue for the Health Board. The 31 July 2014 deadline for the submission of any claims for continuing healthcare costs dating back to 1 April 2003 resulted in a large increase in the number of claims registered last financial year and the Health Board includes within its accounts amounts relating to those uncertain continuing healthcare costs. However, in addition the Health Board has a further 207 claims, which were received by the 31 July 2014 deadline and a further 83 received after this date. There is a risk that these amounts are not correctly reflected in the financial statements and the financial statements could be materially misstated.	My audit team will audit Continuing Healthcare and ensure the correct accounting treatment.	My audit team sample tested Continuing Healthcare expenditure, creditors, provisions and contingent liabilities. No matters arose from the work carried out.

Significant audit risk	Proposed audit response	Work done and outcome
The Health Board is agreeing a number of severance packages with staff during 2016-17. These items are materially sensitive by nature and if the correct procedures are not followed there could be an impact on my regularity opinion.	My audit team will work with the Health Board during the year. My team will then review a sample of severance packages at the year end.	My audit team worked with the Health Board during the year. I have reported in Exhibit 1 that the Health Board needed to improve its governance arrangements for managing the departures of senior staff.

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