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Annual Audit Report 2017 – **Powys Teaching Health Board**

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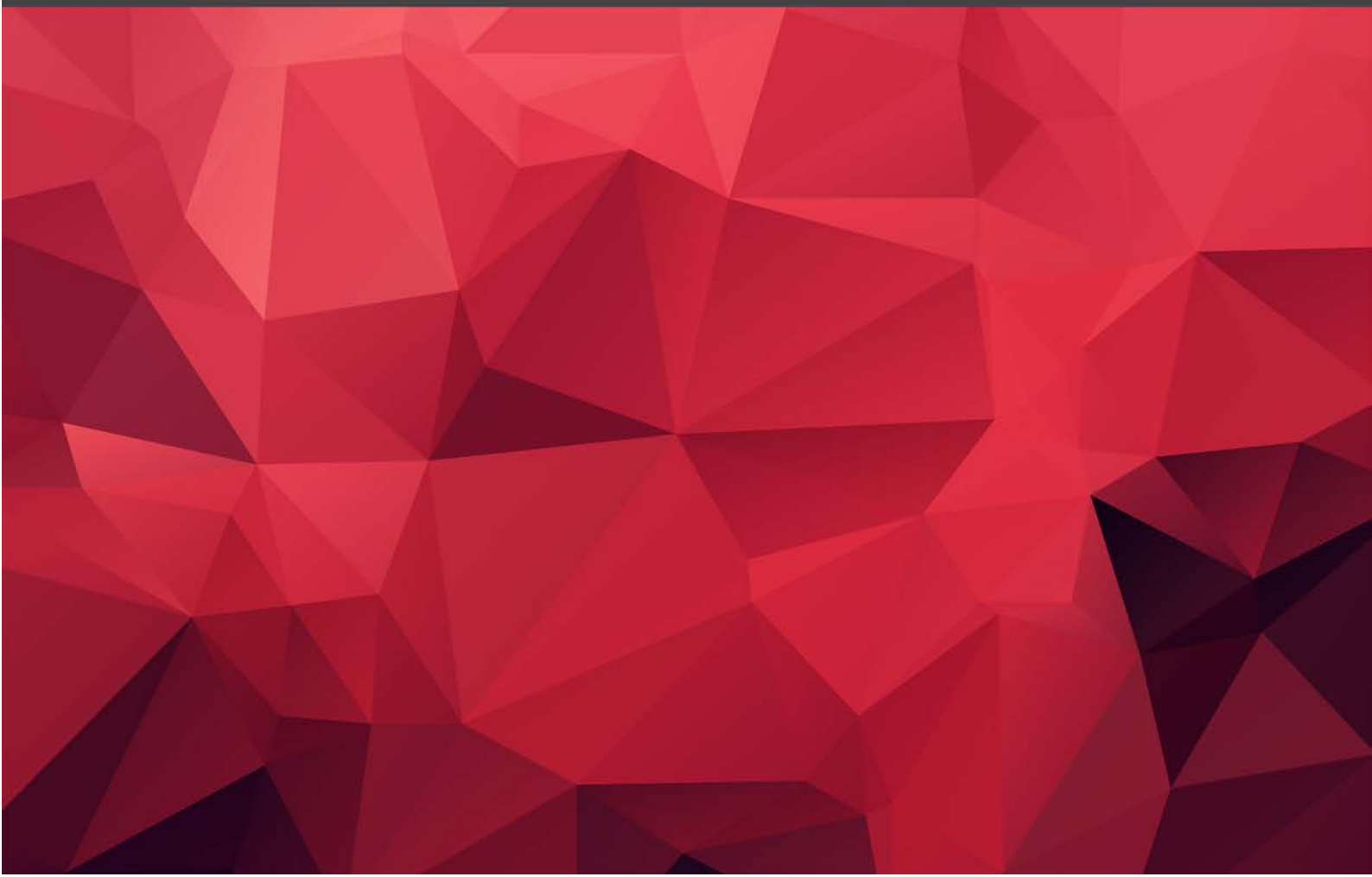

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

The team who prepared this report on my behalf comprised Elaine Matthews, Barrie Morris, Grace Hawkins and Dave Thomas.

Contents

Summary report

Summary

1 This report summarises my findings from the audit work I have undertaken at Powys Teaching 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 and Assurance 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 and Assurance Committee on 18 January 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 an unqualified opinion on the 2016-17 financial statements of the Health Board, although in doing so I have brought several issues to the attention of officers and the Audit and Assurance Committee. The key issue being in relation to the write back of historic liabilities.

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

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

8 The Health Board achieved financial balance for the three-year period ending 2016-17, therefore, it met its first financial duty. 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

9 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 has a reasonable track record of achieving recurrent savings, strengthened monitoring arrangements and met its statutory break-even requirement for the three-year period ending 2016-17

10 In recent years, the Health Board has set balanced financial plans, delivered most of its identified savings schemes and is broadly on track to deliver its 2017-18 planned savings.

11 The Health Board has improved its approach to the planning and delivery of savings schemes and recognises that savings will need to be based on more strategic transformational service changes to address future financial challenges.

12 The Health Board has strengthened its system for effective monitoring of financial savings which will be tested as future savings planning becomes more ambitious.

13 The Health Board has made good progress in addressing previous recommendations on financial planning and reporting.

Arrangements for planning and governance are broadly sound with further work ongoing to support organisational resilience and to strengthen information governance

14 The Health Board has an approved integrated medium-term plan, in line with the statutory requirements of the 2014 NHS (Wales) Finance Act. It also has a longer-term Health and Care Strategy agreed jointly with Powys County Council, although more work is needed to develop underpinning plans. In addition, my work at the Health Board over the last 12 months has found that:

- the Board and committees have clear terms of reference with the active involvement of members;
- work continues to strengthen organisational resilience and capacity;
- the Board has an approved assurance and risk management framework, which is now embedding across the organisation;
- information governance is an area of risk given limited staff capacity and the need to implement the EU General Data Protection Regulations;
- the Health Board is working to improve performance management arrangements for both provided and commissioned services;
- work is underway to identify the workforce elements of the IMTP delivery plans, while systematic scrutiny of workforce management arrangements have resulted in improvements in some workforce metrics;
- the Health Board has not made effective use of the National Fraud Initiative (NFI) to detect fraud and overpayments; and

- the Health Board has made good progress addressing the issues identified in last year's structured assessment.

My performance audit work has identified opportunities to secure better use of resources in a number of key services which are either provided by the Health Board or commissioned from other providers

15 The Health Board has begun to address the risks that accompany its complex arrangements for securing consultant-led services, although there is further work to do to ensure contracting and job planning arrangements are robust for all consultants working with its patients.

16 Radiography services provided by the Health Board are generally satisfactory, although there are challenges due to the long-term absence of a head of service and a fragile IT infrastructure, as well as opportunities to strengthen performance management.

17 The governance arrangements for GP out-of-hours services are generally sound and the available data suggest patients receive timely appointments. However, there are limitations in performance data and there is scope to improve strategic and workforce planning to address risks that threaten the service's sustainability.

18 The Health Board can demonstrate its intention to improve discharge planning in collaboration with key stakeholders, but staff training is poor, performance monitoring is limited and the absence of formal discharge pathways presents a barrier to improvement.

19 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.

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

21 We would like to thank the Health Board's staff and members for their assistance and co-operation during the audit.

Detailed report

About this report

22 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 December 2016 and November 2017.

23 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.

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 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; and
- the results of the work of other external review bodies, where they are relevant to my responsibilities.

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:

- Section 1: audit of accounts
- Section 2: arrangements for securing efficiency, effectiveness and economy 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 2017 Audit Plan.

28 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

29 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.

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 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 (usually the annual report) is consistent with them; and
- the regularity of the expenditure and income in the financial statements.

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

I have issued an unqualified opinion on the 2016-17 financial statements of the Health Board, although in doing so, I have brought several issues to the attention of officers and the Audit and Assurance Committee

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

32 We received the draft financial statements for the year ended 31 March 2017 on 28 April 2017, in line with the agreed deadline. The working papers were prepared to a high standard.

33 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 Assurance Committee on 30 May 2017. Exhibit 1 summarises the key issue set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements report

The following table summarises and provides comments on the key issue identified.

Issue	Auditors' comments
Write back of liabilities	Our audit identified that the write back of prior-year accruals, totalling £3 million, had been incorrectly classified as other income within the financial statements, rather than reversing this from original categories of expenditure. We discussed this with the Director of Finance and agreed that these amounts should be written back to where the original liability was recorded in the financial statements. An adjustment was processed to correct this error.

34 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.

35 My separate audit of the charitable funds financial statements is due to be concluded in December 2017.

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

36 I reviewed the Health Board's internal controls that I considered to be relevant to the audit to help me identify, assess and respond to the risks of material misstatement in the accounts. I did not, however, consider them for the purposes of expressing an opinion on the operating effectiveness of internal control. 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

37 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 NFI;
- specific use of resources work on radiology services, GP out-of-hours services, discharge planning and a local audit review on arrangements for securing NHS consultant services; and
- reviewing the Health Board's arrangements for tracking progress against external audit recommendations.

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

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

The Health Board has a reasonable track record of achieving recurrent savings, strengthened monitoring arrangements and met its statutory break-even requirement for the three-year period ending 2016-17

40 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.

In recent years, the Health Board has set balanced financial plans, delivered most of its identified savings schemes and is broadly on track to deliver its 2017-18 planned savings

41 Each year, the Health Board is allocated revenue by the Welsh Government to provide the resources for the Health Board to pay for locally provided and contracted healthcare services for its resident population. The Board and Welsh Government approved a balanced financial plan for the year 2016-17 as part of the IMTP for 2016-19. Over a three-year rolling period, the Health Board has a statutory responsibility to spend within the limits of its financial allocations. The first statutory test of this requirement was the three-year period to 2016-17.

42 The Health Board set an approved, balanced budget for 2017-18 as part of the three-year IMTP for 2017-21. The Health Board's longer-term health and care strategy to 2027 sets the scene for transformational service developments to be implemented with the Council. The Health Board is developing a detailed model of care which will shape the allocation of resources going forward.

43 Over the last five years, the Health Board has set relatively ambitious but generally achievable savings targets. While they have not achieved all the savings in any year, the Health Board has broadly delivered against those expectations in all bar one year (2013-14).

44 The Health Board achieved financial balance in 2016-17, delivering £3.5 million of savings from identified savings schemes against a target of £4.6 million in the IMTP. It also met its statutory financial duty to break even over the three years 2014-15 to 2016-17.

45 For 2017-18, the Health Board is forecasting to achieve the full planned savings of £3.3 million, with an actual achievement at month 7 of £1.6 million against a plan to date of £1.8 million (91%). It expects to break even for the year ending 31 March 2018 through the achievement of its savings schemes; reducing expenditure on agency staffing, continuing healthcare and primary care; and a further review of balance sheet opportunities.

The Health Board has improved its approach to the planning and delivery of savings schemes and recognises that savings will need to be based on more strategic transformational service changes to address future financial challenges

46 In November 2016, the incoming Director of Finance and IT set the savings targets for the financial plan for 2017-18. The figure on which the targets were based was derived from the midway point between the 1% historical achievement of the NHS and the 1.5% identified as required by the recent Health Foundation report[2]. All directorates were targeted with achieving savings in the order of 1.5%, with the exception of provider services pay budgets, which were required to achieve 0.75%. Further details on all the savings schemes were shared with the Finance Planning and Performance Committee in September 2017.

47 The savings planning process is fully integrated with the IMTP process and therefore savings plans are aligned with the risks and objectives identified within the IMTP. The IMTP for 2017-20 outlines an increasing underlying funding gap which requires additional savings to be achieved. Furthermore, the IMTP identifies that savings plans at similar levels will be required for each year through to 2019-20 to ensure continued financial balance. The savings schemes planning cycle for 2018-19 was brought forward to October 2017.

[2] Watt T and Roberts A, **The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31**, The Health Foundation, October 2016

48 A greater focus on recurring schemes should make the budgetary pressure lower in following years. The proportion of recurring savings in 2017-18 is 82%, up from 70% the previous year. This increase shows that the Health Board is seeking to implement more transformational changes which will support its long-term strategy. The Health Board adopts the all-Wales risk assessment approach which incorporates a red, amber or green (RAG) rating. The ratings are applied consistently across all projects. We noted that the majority of schemes are rated as green and there are no red ratings. Based on our knowledge of schemes and reported performance, it is reasonable to conclude that the ratings are being applied appropriately.

The Health Board has strengthened its system for effective monitoring of financial savings which will be tested as future savings planning becomes more ambitious

49 The Health Board has operational monitoring processes in place at all levels of the organisation on a day-to-day, monthly and quarterly basis. The main operational forum at which risks to savings plans is addressed is the monthly Financial Plan Delivery Review team meeting. At this meeting each business partner is required to give the Director of Finance and IT an update on the progress of each scheme including the risk rating. We observed this at the October 2017 meeting. There was sufficient time to discuss schemes that had an amber rating (there were no red-rated schemes), highlight the issues and consider the corrective actions needed. The Delivery and Performance Group is where Executive Director level scrutiny of savings takes place.

50 The Finance Planning and Performance Committee is the sub-committee of the Board that scrutinises finances and savings plans. In order to provide a further layer of scrutiny, the Health Board presented a paper at the September 2017 committee outlining changes to the reporting process. The paper included a detailed listing of progress against all savings schemes to be provided at each future meeting. At each meeting one of the locality general managers (or equivalent) gives a presentation of their savings schemes and answers questions raised by the members. The first presentation was by managers from the north locality and women's and children's services. The committee received the presentation positively, both as a means of scrutinising the savings schemes in those areas of the business and as a model for scrutinising other areas of the business.

The Health Board has made good progress in addressing previous recommendations on financial planning and reporting

51 We made eight recommendations on financial management in 2016. Four recommendations are now complete. They relate to the budget approval procedure; development of savings plans; arrangements for financial control and stewardship; and arrangements for monitoring and reporting achievement of

savings. One recommendation, on updating standing orders and standing financial instructions is partially complete; standing orders have been updated but the update of the standing financial instructions is still in progress.

52 Three recommendations are on track but not yet complete. They relate to: implementing succession planning arrangements in the finance directorate; re-prioritising the budget to align it more closely with the Health Board's long-term strategy; and strengthening the evidence so that the workforce, financial, estates and ICT implications are robustly considered when developing the delivery plans as part of the IMTP.

Arrangements for planning and governance are broadly sound with further work ongoing to support organisational resilience and to strengthen information governance

53 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 and improvement issues. My findings are set out below.

The Health Board has an approved integrated medium-term plan and, jointly with Powys County Council, an agreed longer-term Health and Care Strategy, although more work is needed to develop underpinning plans

54 The Welsh Government stipulated that for the IMTP 2017-20 that there is no longer a requirement to submit individual local delivery plans. However, organisations still need to plan for these important services and reflect the key areas of intended improvement in their three-year plans. Following an audit of the IMTP development process, the Audit and Assurance Committee noted the need for further refinement and improvement of underpinning plans. Strengthening the development of the plans will be considered within the development process of the directorate plans for 2018-19.

55 The Health Board is involved in the numerous strategic change programmes that are underway in the organisations that Powys patients access. This involvement uses considerable Health Board resources at a senior level. Communication of the Health Board's plans has improved.

56 The Health Board has an agreed capital programme for 2017-18 which lists intended project and equipment bids linked to the IMTP. The Health Board has developed and supported plans for a major reconfiguration of Llandrindod Wells Hospital and Machynlleth Hospital Primary and Community Care Project.

57 The Board is rewriting its objectives as part of the development of its 2018-21 IMTP to fit with the Health and Care Strategy and Well-being of Future Generations (Wales) Act 2015, with the intention of having the IMTP as the vehicle for taking

forward the Health and Care Strategy. The Health Board has undertaken significant engagement work to inform the IMTP although the first meeting of its formal Stakeholder Engagement Group is not scheduled until January 2018.

The Board and committees have clear terms of reference with the active involvement of members

58 The Board approved revised Standing Orders and a separate Scheme of Reservation and Delegation of Powers in January 2017. The scheme provides greater detail to ensure that there is no ambiguity in relation to roles and responsibilities.

59 The Board Secretary has ensured that all the committee terms of reference have been reviewed and self-assessments carried out. Action logs are maintained and reviewed for the Board and each committee at every meeting. Items that need to be escalated to the Board are agreed at the end of every meeting. Annual reports were prepared and approved by the Board in July for each committee. The only omission was the work programmes for the Board and each committee which for 2017-18 were only finalised from August 2017 onwards. While we were assured that all the committees were working to draft work programmes, it is important that work programmes are finalised and issued earlier in the year.

60 All Board papers are now public and available on the internet unless they need to be confidential. In-committee sessions are reported to the Board, aiding transparency. It is important that internet links are reviewed regularly and kept live. The Board Secretary reviews all papers before they are made public on the internet to ensure that they do not contain information that should not be made public and that they comply with the General Data Protection Regulation (GDPR).

61 From our attendance at committees and reviews of committee agendas and papers, we have seen that the committees are functioning well.

62 Two experienced independent members have moved on due to reaching the end of their terms of office. New independent members have been strong appointments and have settled in quickly, resulting in a smooth transition period. All Board members participate in regular Board development sessions following a programme that is scheduled but also responsive to events.

63 The internal control environment has further improved during the year. Internal audit has a broad ranging programme focusing on areas of risk and where there was concern that improvement was needed. Despite significant activity to improve assurance over recent years, the Head of Internal Audit Opinion for 2016-17 was again rated as ‘limited assurance’. The Board met its annual reporting requirements. Good progress has also been made to strengthen clinical audit and counter fraud services, as recommended in last year’s structured assessment.

Work continues to strengthen organisational resilience and capacity

64 The Health Board has been working on a refresh of the operating model that was implemented during 2016. The focus for this work will be on the operational delivery arm of the Health Board, within the Primary, Community Care and Mental Health Directorate.

65 A recent challenge for the Health Board will be replacing the Director of Primary and Community Care and Mental Health who will be joining Cwm Taf UHB from the end of 2017. Arrangements have been put in place with the current Director of Nursing taking on responsibilities for community services, women's and children's services, mental health and learning disabilities. The Chief Executive will lead on primary care with support from the Programme Director for Primary Care while the Medical Director will provide clinical leadership. An interim Director of Nursing has recently been appointed.

The Board has an approved assurance and risk management framework, which is now embedding across the organisation

66 In January 2017, the Board approved a suite of documents to underpin its governance arrangements: the risk management framework; the assurance framework; and the corporate risk register. Directorate level assurance frameworks have been in place since the end of June 2017 with a programme of spot checks and self-assessment developed and rolled-out. Work is also continuing on the committee risk registers to draw together relevant risks for each committee from the corporate risk register, assurance framework and relevant directorate risk registers.

67 The arrangements on de-escalating corporate risks, as suggested by the Executive Committee, have strengthened. They now include a review by the relevant committee before approval by the Board.

68 While these arrangements could appear bureaucratic and have taken some time to develop, they are intended to provide a 'golden thread' so that high-level risks that emerge within the services are visible and can be escalated as necessary to the Board. One example of a high-level risk that was escalated to the corporate risk register in July 2017 is risk CR10, service failure of in and out of hours GMS care. The Shropshire Doctors' Co-operative (Shropdoc)[3] was facing financial challenges and the NHS commissioners in Powys, Shropshire, Telford and Wrekin agreed some interim support. The Board has been fully engaged in considerations and decisions to ensure the continuity of care to local patients. Internal audit will be undertaking a review of the risk assurance measures early in 2018 to test how well the arrangements are working in practice.

[3] Shropdoc is a not-for-profit company providing services to 600,000 patients in Shropshire, Telford and Wrekin and Powys.

Information governance is an area of risk given limited staff capacity and the need to implement the EU General Data Protection Regulations

69 My structured assessment reports in the last three years have focused on the Health Board's continuing efforts to strengthen information governance delivery and oversight arrangements.

70 The Head of Internal Audit opinion for 2016-17 raised concerns within the domain of information governance and IT security which was rated overall as limited assurance. This was due to the limited assurance rating on the review of Information Governance and Resilience on arrangements to enable the integration of the ICT functions between the Council and Health Board. A follow up review on the 2015-16 Data Quality limited assurance report reported significant progress implementing the recommendations, resulting in a reasonable assurance rating.

71 The Information Management, Technology and Governance Committee (IMTGC) oversees information governance assurance on behalf of the Board. The Board Secretary is Executive Lead for Information Governance and is the senior information risk owner (SIRO). She manages the small information governance team supported by directorate information governance champions.

72 The information governance team is preparing for the introduction of the GDPR. Key information governance policies and procedures are in place, and some of the document review dates have been extended until May 2018, due to work preparing for the introduction of the GDPR.

73 The corporate risk register for September 2017 highlights the following risk as high: CR8 Lack of a robust and stable ICT system. The Director of Finance is the Executive Lead for IT and has been in post throughout 2017 bringing some stability to the information management and technology (IM&T) portfolio which changed three times during 2016.

74 It is unclear whether the joint IM&T service, provided by the Council, is effectively resourced to meet the delivery requirements from a Health Board perspective. No recent user satisfaction surveys have been carried out, and the service desk is not fully meeting its target regarding the time taken to answer calls, which is currently running at 80%.

75 The current (2016-18) Joint ICT Strategy has gone through a major refresh and has been aligned to the Digital Health and Social Care Strategy for Wales. It is anticipated that the revised strategy will be finalised early in 2018. Cyber security is covered under the information security policy and ICT Incident Response Procedures.

The Health Board is working to improve performance management arrangements for both provided and commissioned services

76 The Board approved a new framework for improving performance in September 2017. This framework supports overall Board assurance on the management of the

major risks to the delivery of strategic objectives and the delivery of quality patient care.

77 The Health Board has been strengthening commissioning arrangements since 2015 and approved a new strategic commissioning framework in November 2016. The framework sets out the arrangements needed to support effective commissioning. The aim is to ensure the organisation has the right strategy, people, processes and structures in place; and a model which reflects the values and arrangements of NHS Wales. It sits alongside the commissioning assurance framework which provides a mechanism to review concerns about finances and performance of commissioned services. An internal audit report in May 2017 gave a reasonable assurance rating as to the effectiveness of the system of internal control in place to manage the risks associated with commissioning.

78 The commissioning assurance framework is used in 14 NHS organisations spanning five health economies across England and Wales. As reported to the Finance Planning and Performance Committee and Patient Experience, Quality and Safety Committee in October 2017, three providers in England were in special measures and two providers were at level 4 escalation according to the framework. Recent presentations on Wye Valley NHS Trust highlighted that while it came out of special measures in November 2016, the services it provides are still of concern. It is important that both committees are clear about the different aspects they are focusing on so that there is no duplication of effort but key elements of assurance are covered.

79 The Finance Planning and Performance Committee reviews an integrated performance report at each meeting, as does the Board. The integrated report covers the performance of services which are both delivered by the Health Board, and those commissioned from other organisations. Delivery against plan and performance against measures were good at the end of quarter two of 2017-18, as reported to the Board in November 2017. All six of the aims have a consolidated positive position against measures and against delivery of the plan. Nine of the ten strategic objectives with associated performance measures reported a positive consolidated performance against measures in quarter two. Eight of 12 strategic objectives have a consolidated positive position of delivery against plan. Areas that are not meeting targets are discussed in detail by the Board and committees.

80 The north and south localities provided detailed presentations on performance of services in their areas to the Patient Experience, Quality and Safety Committee at the February 2017 and March 2017 meetings. Committee members were interested in the presentations, asked lots of questions and were provided with satisfactory answers about performance of services provided by the community hospitals.

Work is underway to identify the workforce elements of the IMTP delivery plans, while systematic scrutiny of workforce management arrangements have resulted in improvements in some workforce metrics

81 Workforce planning is a key focus for the Health Board and is reflected in one of the six strategic aims and one of the 12 strategic objectives. Workforce plans as set out in the IMTP are in development. The plans show that recruitment is required in a number of areas, subject to business case approval, and some delivery plans require support in development of training. Reviews are also underway for existing workforce capacity and staff skill mix in some areas.

82 Internal audit carry out reviews across the domain of workforce management each year. The report on workforce planning in September 2017 says the Health Board can take reasonable assurance from its arrangements. The major risk for the Health Board continued to be the ability to recruit to key clinical posts. Work was continuing to improve the recruitment and retention of workforce at all levels within the Health Board. The risk to recruitment is on the corporate risk register and is kept under review by the Workforce and Organisational Development Committee.

83 It is important that the Health Board has efficient recruitment processes. The Health Board has improved the average time taken to go through all the steps in a recruitment process from almost 90 days in 2013-14 to 65 days in 2016-17 which is similar to the all-Wales average. The Director of Workforce and OD is currently reviewing ways to further speed up recruitment processes.

84 During the year there has been an increase in the turnover rate of staff. In the 12 months to October 2017 the rolling turnover increased to 11.55%, up from 9.21% in the previous October. While the Health Board has an exit questionnaire in place, we heard that some leavers were reluctant to complete it. Further work is needed to improve collection of information from staff leaving the organisation and making use of this intelligence.

85 In common with other NHS organisations, the Health Board has a reliance on temporary staff to cover vacancies and other gaps in staffing. Spend on agency is monitored as part of the monthly finance report. A new Temporary Staffing Unit covering both nursing and medical staff was set up during the year, which is expected to improve arrangements, for example, through stronger links with rostering. Internal audit is undertaking a review of Agency and Consultancy Spend which will report in 2018.

86 A number of areas of workforce management have shown some improvements during the year, and are better than other health boards, the Welsh Government targets were not met. These areas are: sickness absence; statutory and mandatory training compliance; and the performance appraisal and development review (PADR).

The Health Board has not made effective use of the NFI to detect fraud and overpayments

87 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.

88 Participating bodies submitted data to the current NFI data matching exercise in October 2016. The outcomes were released to participating bodies in January 2017.

89 It is of significant concern that the Health Board has failed to make effective use of the NFI as part of its arrangements to prevent and detect fraud. The Health Board has recently undertaken a review of its NFI data matches and has prioritised this work to be taken forward during January 2018 and beyond, focusing on the small number of high priority matches first. It is important that the Health Board ensures that the matches it receives in future are reviewed and where necessary investigated in a timely manner.

The Health Board has made good progress addressing the issues identified in last year's structured assessment

90 Last year's structured assessment made three recommendations relating to board and committee effectiveness and internal controls, and one on risk management. Three recommendations have been completed: develop and implement a strategy for clinical audit; establish a robust and sustainable counter fraud service; and implement board assurance arrangements. Further work is required on the fourth recommendation which was for the Audit and Assurance Committee to review the full recommendations tracker at least annually.

91 In addition to reviewing the actions taken to address our 2016 structured assessment recommendations, we also considered the effectiveness of the Health Board's wider arrangements to manage and respond to our audit recommendations. The Board Secretary provided the Audit and Assurance Committee in May 2017 with a presentation on the progress being made addressing audit recommendations from both internal and external audit, and exception reports on recommendations where there has been little or slow progress. The Board Secretary is liaising with NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance service to make use of their recommendation tracker database. This would simplify access to live tracking on progress against all recommendations, although the date for its roll out is not yet available.

My performance audit work has identified opportunities to secure better use of resources in a number of key services provided by the Health Board and commissioned from other providers

92 My auditors have undertaken a number of reviews across different service areas:

- Arrangements for Securing NHS Consultant Services
- Radiology Services
- GP Out-of-Hours Services
- Discharge Planning
- Emergency Ambulance Services Commissioning
- Collaborative Arrangements for Managing Local Public Health Resources

The Health Board has begun to address the risks that accompany its complex arrangements for securing consultant-led services, although there is further work to do to ensure contracting and job planning arrangements are robust for all consultants working with its patients

93 In February 2017 I reported the findings from my review of consultant job planning and contracting arrangements. The main findings from this work are summarised below.

94 Job planning and appraisal arrangements for directly employed consultants are generally working well, although the Health Board could clarify and standardise its approach across the organisation to ensure that all consultants have:

- clearly set out and agreed activities and outcomes expected from all their sessions;
- their job plan reviewed annually and that all job plans are signed off by all relevant parties; and
- are up to date with their appraisals in order to properly support revalidation processes as required by the General Medical Council.

95 The complexity of current commissioning arrangements for services provided by consultants employed primarily by other health bodies highlights the need for more robust governance arrangements.

- the Health Board has clarified the contracting arrangements with the main employers for the consultants who provided a total of 123 different services to patients in the Health Board; and
- the interim Medical Director has obtained assurance that all visiting consultants had been through the revalidation process.

96 The Health Board is becoming less dependent on high risk, ad hoc arrangements with consultants, but services provided in this way do not always conform to good governance principles:

- the Health Board has reviewed the arrangements by which it employs consultants through payroll, their own company or directly by invoice, and reduced the numbers of consultants employed in this way.
- these arrangements were set up on an ad hoc basis when historically a service could not be provided any other way. Whilst some of the arrangements have run for many years with no reported quality concerns, they do present the Health Board with a number of risks which need to be addressed.

Radiography services provided by the Health Board are generally satisfactory, although there are challenges due to the long-term absence of a head of service and a fragile IT infrastructure, as well as opportunities to strengthen performance management

97 Radiology is a key diagnostic and interventional service for the NHS and supports the full range of specialties in acute hospitals, primary care and community services. The Health Board provides radiology services of plain x-ray and ultrasound (US). Images are reported by radiologists based in other health boards in Wales and NHS trusts in England. Other imaging and interventional procedures, including computed tomography (CT) and magnetic resonance imaging (MRI), are commissioned by the Health Board from a range of providers. This review focused on radiography imaging services provided by the Health Board.

98 The review, which reported in April 2017, examined the actions health boards are taking to address the growing demand for radiology services, and the extent to which these actions are providing sustainable and cost-effective solutions to the various challenges that exist.

99 My review found that patient satisfaction levels are high and access to x-ray and ultrasound is good although there are delays reporting images.

100 Referrals are well-managed and there have not been problems recruiting operational staff, although a significant proportion of staff are potentially within five years of retirement.

101 Equipment will soon be updated, but leadership, performance monitoring and information infrastructure need addressing as part of the Health Board's plans to transform diagnostic services.

The governance arrangements for GP out-of-hours services are generally sound and the available data suggest patients receive timely appointments. However, there are limitations in performance data and there is scope to improve strategic and workforce planning to address risks that threaten the service's sustainability

102 The model of GP out-of-hours services varies within Powys. The Health Board uses Shropdoc to deliver the GP out-of-hours service, providing the call-taking function, all aspects of the triage process and face-to-face provision. Patients in the Ystradgynlais area or Ystradgynlais Community Hospital have their GP out-of-hours services provided by Abertawe Bro Morgannwg University Health Board with Shropdoc providing call-handling in the Ystradgynlais area. This review aimed to establish whether the Health Board is ensuring that patients have access to effective and resilient GP out-of-hours services.

103 In April 2017 I reported the findings from my review of GP out-of-hours services in Powys. I found that governance of GP out-of-hours services was generally sound, and that strategic planning was becoming more focussed. There were clear leadership arrangements for GP out-of-hours at all levels and the Health Board assesses itself as achieving most of the national standards. There was scope to improve performance monitoring of GP out-of-hours services at the Board and committee level.

104 My review noted that the Health Board spends more on GP out-of-hours than most other NHS bodies in Wales and that work was underway to develop more resilience within the service's workforce plans.

105 Powys patients have comparatively good access to in-hours primary care and the out-of-hours service provides timely appointments, but my review identified issues with the quality of the data along with scope to improve the signposting to out-of-hours services.

106 Since I completed my review of GP out-of-hours services, a number of concerns have arisen around the financial sustainability of the Shropdoc out-of-hours service. The Health Board has been working closely with the Welsh Government and the relevant Clinical Commissioning Groups in England to manage these risks and ensure continuity of service delivery. The Health Board has helpfully kept my staff informed of relevant developments and future plans for the service.

The Health Board can demonstrate its intention to improve discharge planning in collaboration with key stakeholders, but staff training is poor, performance monitoring is limited and the absence of formal discharge pathways presents a barrier to improvement

107 My review of discharge planning, completed in November 2017, examined whether the Health Board has sound governance and accountability arrangements in relation to discharge planning from its community hospitals.

108 I found that the Health Board is taking steps to work with key stakeholders in planning improvements to discharge planning and patient flow, but that there was scope to strengthen its discharge policy and that progress was being hindered by a lack of formal discharge pathways.

109 Dedicated resources to support discharge planning within the Health Board are relatively small with availability limited to weekdays. In addition, whilst the Health Board is taking steps to improve access to information about community services, my work highlighted a lack of training on discharge planning and the need to do more to raise awareness of discharge policies amongst staff.

110 Lines of accountability for discharge planning are clear and there is regular operational scrutiny of discharge planning performance, which includes partners. However, performance monitoring for discharge planning is limited and work to improve discharge planning is not yet reflected in improvements to key performance measures.

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

111 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®[4] 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. And 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 impacting on attendance by health board staff and the ability of the subgroups to make a meaningful contribution.

112 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

[4] 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.

set out by EASC, however, health boards' compliance with and level of understanding of the requirements set out in CAREMORE® vary.

113 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 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). But, 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 do

114 My review of Public Health Wales' collaborative arrangements for managing local public health resources with the Directors of Public Health 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.

115 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 Public Health Wales NHS Trust (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.

116 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.

117 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.

118 Mechanisms for communicating and sharing information between the Trust and local public health teams are underdeveloped. There is no standardised approach for sharing information 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 co-ordinating work developed or delivered locally or nationally, and communicating information to the same shared partners.

119 I have noted the collective and collaborative management response that has been prepared by the Trust, Health Boards and the Welsh Government to my findings. I intend to undertake further work in 2018 to assess the progress that has been made to address the concerns identified above.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2017.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	May 2017
Opinion on the Financial Statements	June 2017
Independent Examination Report on Charitable Fund	December 2017
Performance audit reports	
Arrangements for Securing NHS Consultant Services	March 2017
Radiology Services	April 2017
Emergency Ambulance Services Commissioning	April 2017
GP Out-of-Hours Services	April 2017
Collaborative Arrangements for Managing Local Public Health Resources	October 2017
Review of Discharge Planning	November 2017
Structured Assessment 2017	December 2017
Other reports	
2017 Audit Plan	March 2017

Exhibit 3: performance audit work still underway

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

Report	Estimated completion date
Outpatient follow-up	February 2018

Appendix 2

Audit fee

The 2017 Audit Plan set out the proposed audit fee of £265,955. 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 plan.

Appendix 3

Significant audit risks

Exhibit 4: significant audit risks

My 2017 Audit Plan set out the significant financial audit risks for 2017. The table below lists these risks and sets out how they were addressed as part of the audit.

Significant audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is 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.	Work completed: • Review of entity controls; review of accounting estimates, judgments and decisions made by management; testing of journal entries; and review of unusual significant transactions. Key Findings: • My audit work has not identified any evidence of management override of controls. In particular, the findings of our review of journal controls and testing of journal entries has not identified any significant issues.
In all entities, significant judgements and accounting estimates will be made at the year-end. An example of these specific to the Health Board include continuing health care claims and primary and specialist health care expenditure.	My audit team will focus its testing on areas of the financial statements which could contain reporting bias.	Work completed: • Documentation of our understanding of processes and key controls over the transaction cycle; and Estimates reviewed where applicable, eg Depreciation, Indexation. Key findings: • My audit work has not identified any additional significant issues in relation to the risk identified.

Significant audit risk	Proposed audit response	Work done and outcome
Employee Remuneration and benefit obligations and expenses understated.	My audit team will: • document our understanding of the processes and key controls over the transaction cycle; • walk through the key controls to assess whether those controls are designed effectively; • reconcile the payroll figure in the Statement of Comprehensive Net Expenditure (and supporting notes) to the general ledger and payroll subsidiary system; • undertake a trend analysis of monthly payroll data, to identify any unusual variances for which additional audit procedures may be required; • review pensions disclosures and agree to underlying evidence for completeness and accuracy; and • review senior managers' remuneration, salary banding and exit packages disclosures, for completeness and accuracy.	Work completed: • Completion of walkthrough and trend analysis around the completeness assertion for Employee Remuneration. Key Findings: • My audit work did not identify any significant issues in relation to the risk identified.

Significant audit risk	Proposed audit response	Work done and outcome
Revaluation measurements not correct.	My audit team will: • review the internal financial controls relating to PPE valuations; and • review the accounting entries in respect of any revaluations to ensure these are fully and accurately reflected in the financial statements.	Work completed: • We have reviewed Revaluations, Indexation and Impairments within the financial statements. We have also performed a walkthrough around the risk area. Key findings: • My audit work did not identify any significant issues in relation to the risk identified.
Healthcare commissioning – Activity variation adjustments to expenditure not correct.	My audit team will: • walk through the controls; • substantively test contract expenditure; • agree NHS creditors, debtors, income and expenditure to balance agreements; • test around the year-end transactions to ensure that accruals are complete; and • substantively test accruals.	Work completed: • We have completed a walkthrough for secondary healthcare information, and tested contract activity for Welsh and English authorities. Key findings: • My audit work did not identify any significant issues in relation to the risk identified.

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