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Annual Audit Report 2009-10

Powys Teaching Health Board

Contents

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Summary

1. This report summarises the findings from audit work I have undertaken at Powys Teaching Health Board (the Health Board) during the latter part of 2009 and throughout 2010.
2. The work I have done allows me to discharge my responsibilities under the Public Audit (Wales) Act 2004 in respect of the audit of accounts and the Health Board's arrangements to secure efficiency, effectiveness and economy in its use of resources.
3. I have adopted a risk-based approach to planning the audit, and my audit work has focused on the significant financial and operational risks facing the Health Board, and which are relevant to my audit responsibilities. Separate reports I have issued and discussed and agreed with officers, contain more detail on the specific aspects of my audit. These reports have also been presented to the Audit Committee and are shown in Appendix 1.
4. The key messages from my audit work are summarised under the following headings.

Audit of accounts

I have issued an unqualified opinion on the financial statements of the Health Board

5. My work on the audit of accounts has led me to give an unqualified opinion on the financial statements of the Health Board. I have also concluded that:
   - the Health Board's financial statements were properly prepared and materially accurate;
   - the Health Board achieved financial balance at the end of 2009-10, but only as a result of additional non-recurring funding from the Assembly Government;
   - the Health Board had an effective internal control environment to reduce the risks of material misstatements to the financial statements; and
   - the Health Board's significant financial and accounting systems were appropriately controlled and operating as intended.
6. My audit team have met finance staff in order to discuss how improvements can be made to next year's accounts production processes.

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

7. 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. To assist in this, I have:
   - reviewed the financial position of the Health Board;
   - delivered a 'structured assessment' which focused on arrangements to manage finances, govern the business and manage resources;
   - considered the challenges facing the Health Board in the context of its ambitious vision; and
   - considered the findings from my performance audits that have been reported since my last audit letter.

The Heath Board faces a number of significant financial challenges in achieving its financial targets for 2010-11

8. In the current economic climate, high standards of financial management are more important than ever. A combination of the low funding increase for 2010-11, and the economic situation generally, made it difficult for the Health Board to set a balanced financial plan at the start of the year.
9. In August 2010, the Health Board approved an annual budget (currently of £243 million), in line with a revenue resource limit of some £234 million. This was based on the assumption that the Assembly Government would provide further strategic assistance of £8.75 million, subject to a due diligence review. This additional funding has recently been confirmed. The Health Board is also progressing with financial recovery plans and savings schemes but these are not yet guaranteed to be delivered in full.

My structured assessment indicates that the Health Board has arrangements in place to manage its business, but its current service delivery model does not allow the Health Board to use its resources economically or efficiently

10. Although the Health Board accounts for its finances well on a day-to-day basis and is starting to deliver short-term cost savings, progress is slow and the Health Board has not yet been able to develop a clear strategic plan to deal with its current structural financial issues.
11. The Health Board's governance arrangements are appropriate to meet day-to-day healthcare delivery requirements, but will need to be re-assessed if plans to deliver the complex inter-organisational whole-systems change are to be successful.
12. The Health Board has assessed that the current healthcare delivery model is costly and therefore resources are not yet utilised efficiently; the draft service workforce and financial framework recognises the current service model is neither fit for purpose nor affordable.

The Health Board has developed a good vision but does not yet have sufficient finance, change management capacity or stakeholder support to implement it

13. The Health Board has responded appropriately to its inherited position and issues and has developed a good vision for improving the quality and safety of health services while also seeking to provide a more affordable service for the taxpayer. If this vision is implemented successfully, it will deliver improved healthcare for the community and help make the Health Board financially viable.

14. The Health Board does not yet have a clear financial strategy to implement its vision. Upfront investment will be needed to fund the required changes, but at present the extent of the financial requirements has not been determined and therefore it is difficult to develop an innovative financial strategy.

15. There is a good board team and there is a mutual recognition at board level of the strength of the current team (both executive and independent members). While the Health Board has just started to create the new programme and project structures, it has only just begun to identify the change capacity required to achieve the vision and plans are not yet in place to re-engineer the capability of the organisation to meet its long-term (inter-organisational) working model.

16. The Health Board also needs to develop and focus its relationships with GPs, staff, the public and politicians. The Service, Workforce and Financial Framework is in its early days and the Health Board has not yet developed a systematic approach to communicate and engage the public in future patient healthcare improvements and outcomes. Although starting to develop good relationships with GPs and other NHS service providers, more needs to be done to align these relationships with the vision and the required change programme. The Health Board also needs to secure local and national political buy-in.

Performance audit reviews have highlighted specific challenges for the Health Board, particularly in implementing change and improvement

17. My performance audit work at the Health Board has included reviews of a number of specific service areas. Collectively these have demonstrated that the Health Board continues to face specific challenges in the delivery of its services, particularly in implementing change and improvement. I have drawn this conclusion following detailed audit work on:

- new models of health and social care;
- waiting list data accuracy;
- Information Management and Technology (IM&T) governance arrangements;
- adult mental health services;
- unscheduled care; and
- hospital catering.

Agreeing my findings with the Executive Team

18. I have agreed this report with the Chief Executive and the Director of Finance, and the key messages were discussed with board members at the board development day on 18 January 2011. The detailed report was discussed with the Audit Committee on 9 February, and will be presented to a subsequent board meeting, with a copy provided to every member of the board.

19. My audit team and I gratefully acknowledge the assistance and co-operation of the Health Board's staff and members during the audit.

About this report

20. This Annual Audit Report to the board members of the Health Board, sets out the key findings from audit work undertaken between October 2009 and November 2010.

21. I undertake my work at the Health Board in response to the requirements set out in the Public Audit (Wales) Act 2004. The Act requires me to:
    - examine and certify the accounts submitted to me by the Health Board;
    - satisfy myself that the expenditure to which the accounts relate has been incurred lawfully and is in accordance with the authorities which govern it; and
    - satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

22. In relation to the last requirement above, 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 structured assessment of the Health Board examining the arrangements for financial management, governance and accountability and management of resources;
    - performance audit examinations undertaken at the Health Board;
    - the results of the work of other external review bodies where they are relevant to my responsibilities; and
    - other work such as data matching exercises and certification of claims and returns.

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

24. I plan to discuss the findings from my structured assessment work in more detail with board members, but the messages from that work, which I have reported here, have been agreed with Executive Directors.

25. The findings from my work are considered under the following headings:
    - audit of accounts; and
    - arrangements for securing economy, efficiency and effectiveness in the use of resources.

26. Finally, Appendix 2 presents the latest estimate on the audit fee that I will need to charge to undertake my work at the Health Board, alongside the fee that was set out in the Audit Strategy.

Section 1: Audit of accounts

27. This section of the report summarises the findings from my audit of the Health Board's financial statements for 2009-10. 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.

28. Examination of an organisation's financial statements is an essential element in demonstrating appropriate stewardship of public money.

My responsibilities

29. In examining the Health Board's financial statements, auditors are required to give an opinion on:

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

30. In giving this opinion, auditors are required to comply with International Standards of Auditing (ISAs). In undertaking this work, auditors have also examined the adequacy of the Health Board's:

- internal control environment; and
- financial systems used for producing the financial statements.

I have issued an unqualified opinion on the financial statements of the Health Board

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

31. The timetable set by the Assembly Government for the preparation and audit of the annual financial statements places considerable expectations on audited bodies, their Audit Committees and external auditors. Whilst these deadlines were achieved this year, there is scope to improve the overall quality of the draft financial statements submitted for audit. My audit team have met finance staff in order to discuss how improvements can be made to next year's accounts production processes.

32. The ISA 260 requires me 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 Partner reported these issues to the Health Board's Audit Committee on 23 June 2010.

33. Exhibit 1 summarises the key issues set out in that report.

Exhibit 1: Issues identified in the ISA 260 report

Issue	Auditors' comments
Provisions and accruals	In overall terms, the financial statements accurately reflect the value of provision and accruals, and work recently completed to review the actual costs has confirmed that the Health Board's processes for producing primary care estimates are robust.
Compliance with Internal Financial Reporting Standards (IFRSs)	Elements of two particular standards have caused some problems at most health boards during 2009-10. These are the recognition and 'de-recognition' of assets that are replaced and the disclosure of future commitments of operating leases. Whilst not material to the financial statements, more work is required during 2010-11 to ensure full compliance with these elements of the IFRSs.

The Health Board achieved financial balance at the end of 2009-10, but only as a result of additional non-recurring funding from the Assembly Government

34. The audited financial statements confirm that the Health Board reported a £13,000 underspend against its revenue resource limit (of £221.3 million). It therefore met the financial duty to break even for 2009-10, but this was only made possible due to the Assembly Government approving non-repayable strategic assistance of £11 million towards the end of the year.

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

35. In considering the internal control environment, I assess arrangements that include high-level controls over the main accounting and budgetary control systems, the work and role of internal audit and the work of the Audit Committee.

36. The main accounting system controls are satisfactory, and a fuller complement of finance staff in 2010-11 will address potential weaknesses arising from the absence of a second signatory on some financial journals. Budgetary control is also effective, although there is scope to improve the way in which finance staff and departmental budget holders document their formal meetings.

37. Internal audit work undertaken during the year complied with the NHS Wales Internal Audit Standards and supported the Head of Internal Audit's annual opinion, as reported to the Audit Committee in June 2010.

38. The Health Board's Audit Committee plays an active role in reviewing and strengthening the internal control environment. Its recent 'self-assessment' has highlighted how the Committee can extend its role further.

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

39. I did not identify any significant weaknesses within the Health Board's financial systems although improvements can be made to ensure that officers sign and date all reconciliations as evidence that they have been completed correctly and on time. In addition, given changes to financial systems introduced during 2010-11, the Health Board needs to review and update a number of specific policies and procedure notes.

40. Controls within the Business Services Centre (BSC) continue to operate effectively, although the Health Board will need to monitor changes in arrangements for managing the release of payments to other health boards.

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

41. 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. To assist in this I have developed a 'structured assessment', which is being undertaken throughout all NHS bodies in Wales, following a consistent approach.

42. This section of the report summarises my findings from the structured assessment work undertaken during October and November 2010, including an assessment of the financial position of the Health Board during 2010-11.

The Health Board faces a number of significant financial challenges in achieving its financial target for 2010-11

43. In the current economic climate, high standards of financial management are more important than ever. This section of the report summarises the financial position of the Health Board for the current financial year, 2010-11.

44. The underlying deficit, coupled with the low funding increase for 2010-11, made it difficult for the Health Board to set a balanced financial plan at the start of the year. For the first four months the Health Board approved an organisational budget on a month-by-month basis, with permission to spend approved by the Assembly Government.

45. In August 2010, the Health Board approved an annual budget in line with a revenue resource limit of some £243 million. This was on the assumption that the Assembly Government would provide further strategic assistance of £8.75 million, subject to a due diligence review. The Assembly Government has recently confirmed that the additional funding will be provided.

46. Now that uncertainty about the funding level has been resolved, attention will need to be focussed on achieving the Cost Improvement Programmes (CIPs) and financial savings plans. Exhibit 2 summarises the position, based on the month 7 (October 2010) financial report.

Exhibit 2: Financial plan 2010-11

Net operating costs and revenue resource limit	Month 7 position
Net operating cost £243 million, including:	
• £4 million held in reserves (as an unallocated in-year resource).	£3.6 million to be used during the last five months of the year.
• £3 million CIPs.	£1.4 million achieved, annual target expected to be met.
• £9.4 million financial savings plans.	£2.2 million achieved, risk identified that annual target may not be achieved (by £3.5 million).
Revenue resource limit £243 million:	
• Initial Assembly Government strategic assistance of £11 million.	Agreed.
• Additional Assembly Government funding of £5.5 million for additional 'payment by results' costs of patients in English Trusts.	Agreed.
• £8.75 million strategic assistance (subject to a due diligence review).	£8.8 million additional funding confirmed by the Assembly Government in January 2011.

47. Whilst the month 7 financial report forecasts a break-even position at the year-end, there is clearly a risk that the Health Board may not achieve the assumptions in relation to the financial savings plans.

The Health Board has arrangements in place to manage its business, but its current service delivery model does not allow the Health Board to use its resources economically or efficiently

48. The exhibits below summarise my assessment of the Health Board's current arrangements for securing economy, efficiency and effectiveness in its use of resources, focusing on the three areas of the structured assessment:

- financial management;
- governance and accountability; and
- managing resources.

The Health Board accounts for its finances well on a day-to-day basis and is starting to deliver short-term cost savings, but progress is slow and the Health Board is not yet able to demonstrate a clear strategic plan to deal with its structural financial issues

Exhibit 3: Financial management

Financial planning	The Health Board understands its financial position and has short-term financial plans to address some of the finance issues. These plans should result in some recurring savings. However, the Health Board remains reliant on significant strategic financial assistance from the Assembly Government and longer-term planning and financial strategy is not yet sufficiently robust (see additional comments in paragraphs 54 to 59).
Monitoring finances	There are adequate arrangements in place to monitor financial performance at a strategic level: • there is appropriate monitoring of the monthly position within Board meetings; and • the Audit Committee has, throughout the year, invited other members of the board to attend an additional forum to comment on and challenge the Cost Improvement and Financial Recovery Plans. The Health Board has developed five workstreams under the banner of financial recovery (the three localities, continuing healthcare and support services) whereby executive team members support and hold each team to account on the delivery of their savings plans.
Delivering savings	The Health Board's expenditure is exceeding its available resources. The Cost Improvement and Financial Recovery Plans savings are weighted to the end of the financial year and are currently slipping (month 7 finance report shows that only 28.5 per cent of the planned savings have been delivered).

The Health Board's governance arrangements are appropriate to meet day-to-day healthcare delivery requirements, but are not yet robust enough to deliver the required complex inter-organisational whole-systems change. The current healthcare delivery model is costly

Exhibit 4: Governance and accountability

Development of vision, strategy and outcomes	The Health Board has developed a clear long-term strategic vision. However, at present strategic business and clinical outcomes are unclear. If this vision is to be successful and secure public and stakeholder support, the Health Board needs to be clear about what improvement outcomes the patient will see and be able to measure success. The current corporate plan stands alone and is set out well but is heavily output based, and while progress against actions can be tracked, it lacks clear measurable outcomes. The Health Board should now be developing a revised corporate plan aimed at delivering its revised strategy, over a medium-term period.
Organisation structure	The Health Board structure does support the delivery of corporate objectives and also day-to-day running of 'the business' and the structure is starting to link accountability between the Executives and designated Locality General Managers. While emerging integration programme and project board models are in the process of being developed, the structure does not yet have the required capability or capacity to deliver complex inter-organisational change. The Health Board faces a significant challenge to deliver a vision that both improves care and also recovers the financial position. While the Health Board is not unique in having a financial deficit, it has less freedom for manoeuvre because a significant proportion of its expenditure is tied to less flexible contracting and commissioning frameworks. The Health Board's current delivery model is utilising more costly Payment By Results services commissioned from England. The Health Board uses estates which are no longer economic and also makes development of centres of excellence difficult.
An effective board	There is an effective board to lead and govern normal day-to-day operational healthcare delivery, with an adequate scheme of delegation to meet present needs.
Risk management	There are risk management arrangements in place but these focus mainly on clinical risk (in common with many health boards in Wales). However, partnership, project and strategic risk are not effectively built into governance arrangements and this shortcoming presents an issue for future delivery of the Health Board's ambitious vision.

Internal control environment	The internal control environment is adequate and meets basic operational requirements. Audit committee functions have developed considerably during the year and the committee recognises that it needs to hold internal and external audit to account more effectively. Internal audit, Capital Audit and Counter Fraud are proportionate to the internal controls risks and size of the organisation and generally in line with the quality of service experienced in other health boards.
Information Governance and IM&T	Information governance arrangements are in the process of being developed. Information Management and Technology has a new promising management structure, but it is starting from a weak baseline, and tangible improvements may take some time.
Performance management	There are developing arrangements for performance management, but the Health Board needs to do more to monitor and manage activity and costs. Performance management currently is qualitative in nature and there are some shortcomings in the availability of good quantitative information to support performance management, both at the corporate level and within the localities.
Probity and propriety	The Health Board has probity and propriety arrangements in place.

The Health Board's resources are not yet utilised efficiently; the draft service workforce and financial framework recognises the current service model is not fit for purpose or affordable

Exhibit 5: Managing resources

Workforce planning	The Health Board does not yet have a sound approach to the strategic workforce planning required to deliver its future vision. This is because the future state of an integrated model of health and social care service has not yet been designed, and it is therefore difficult to determine new skills, roles and structures.
Asset management	We have not identified weakness in day-to-day asset management arrangements. The Health Board is aware that it has an estate which is underutilised, has some health and safety issues and in some areas is not fit for purpose.
Procurement	The procurement arrangements are adequate to meet requirements.
Partnership working	There are a large number of partnerships and a strong high-level commitment to integrated working with the Council.
User engagement	Ongoing patient and public engagement includes the use of third party feedback from the Powys Association of Voluntary Organisations and the Community Health Councils. There are developing arrangements to enable the Health Board to engage with the community, but these are not yet focused on delivering the longer-term vision and strategy. There is a good level of focus on complaints monitoring and management.

The Health Board has developed a good vision but does not yet have sufficient finance, change management capacity or stakeholder support to implement it

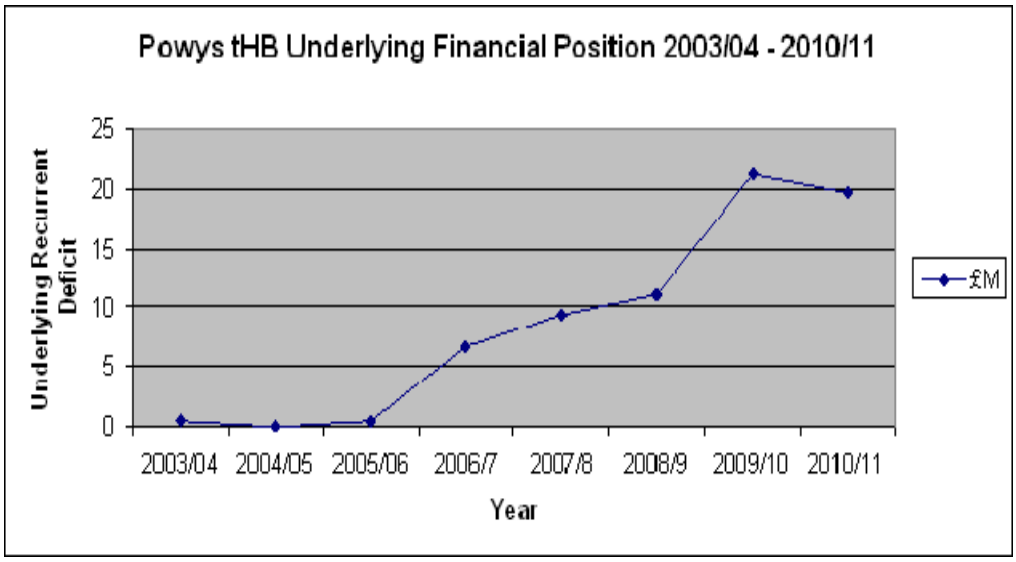
49. In undertaking the structured assessment work, it is clear that the Health Board faces a particularly challenging future. I have therefore highlighted areas I consider to be some of the key priorities for the Health Board:

- the Health Board's vision;
- strategic finance;
- the capacity and capability to deliver complex change; and
- fostering relationships with the public, staff, GPs and politicians.

The Health Board has a good vision which, if implemented successfully, would deliver improved healthcare for the community and help make the Health Board financially viable

50. The Board has faced a number of challenges over recent years. The current Health Board was formed in October 2009, but it inherited a legacy model of healthcare that was recovering from quality and safety issues identified in the 2008 Clinical Governance review. The Health Board also faces a growing underlying financial deficit, which it has identified in Exhibit 6.

Exhibit 6: The Health Board's underlying financial deficit



51. The Health Board has had to respond to this underlying financial deficit. It has done so in the short term by attempting to stem the growth in annual deficit but, more importantly, by developing a high level vision for the future of public healthcare in Powys.

52. The Health Board's vision, as outlined in its Service, Workforce and Financial Framework, is to provide high quality community-based services in the most accessible place to the people of Powys. This vision is ambitious and is one that has the potential, if well designed, to provide:

- care services which are closer to the community, by providing care in a range of settings, including patients' own homes;
- care services which are more integrated with social care and primary care;
- access to specialist secondary care services which are not possible to provide in-county; and
- a more efficient and affordable health service for the taxpayer.

53. Independent members, executive officers and senior staff share, in principle, this view of service provision, as being the most effective way of both providing and improving health services within Powys. It will provide a logical framework to facilitate the joint provision of both health and social care with both Powys County Council (the Council) and other community and voluntary providers.

The Health Board does not yet have a clear financial strategy to implement its vision

54. As highlighted above, there has been a growing structural financial deficit and although the Health Board has taken some steps to prevent it worsening, recovery is slow. The Health Board and its senior executives are heavily engaged in managing a Financial Recovery Programme (FRP) and an internal Cost Improvement Programme (CIP).

55. These programmes outline a variety of activities that the Health Board expects will help it break even, and the savings arising have been profiled over the 2010-11 financial year. However, the savings are slipping and savings for the first seven months of the year are less than forecast, providing an extra challenge to a savings schedule already heavily weighted to the fourth quarter.

56. Senior managers and independent members focus much of their time on the current year's financial position, including a heavy scrutiny of the savings plans. There are a large number of savings plans, which on an individual basis may be relatively small sums, but collectively combine to make the overall savings plan. Whilst there must be a focus on delivery to achieve these savings (in order to meet the requirement to break even financially each year), there is a risk that this might distract from progressing the bigger structural changes.

57. Attention to service re-design, commissioning modelling and workforce strategy will require significant management input. The Health Board must not allow the necessary focus on breaking even each year to distract from the strategic finances that are required to make it financially sustainable in the longer term.

58. The Health Board will need upfront investment to fund the required changes, but at present the extent of the financial requirements has not been determined and therefore it is difficult to develop an innovative financial strategy. There is no plan at present for estimating the quantum of pump priming to facilitate the implementation of the alternative services. This is dependent on more detailed service and workforce modelling to determine the costs.

59. A financial strategy is required that:

- includes clear business and health outcomes, with future service modelling;
- places long-term structural recovery in front of short-term savings;
- identifies innovative mechanisms to pump prime the required changes; and
- has clear support from the Assembly Government for the short and medium-term funding requirements.

60. In addition, there needs to be a clearer focus on cost consciousness, making the impact on the financial strategy a key consideration for all executive and board decisions.

There is a good board team but it does not yet have the required organisational capability and capacity to develop a clear approach to change management

61. There is a mutual recognition at board level of the strength of the current team (both executive and independent members) and this is a good basis for strengthening board level working.

62. However the Health Board does not appear to have the time to develop its 'strategy into action' further as a team. Executive directors' capacity is stretched, but their attention needs to focus on the strategic aims of the Health Board, including the structural changes, consultation and public engagement and managing the change process.

63. Many members of the current management team are interim appointments. While this creates some flexibility, it may impede the pace of change and hamper the ability of the Health Board to make the necessary tough decisions. Whilst there is no doubting the enthusiasm of the board and the experience and passion that executives and Locality General Managers demonstrate, the need for a degree of permanency remains. It is, therefore, disappointing to note that a permanent Chief Executive was not appointed following the recent recruitment exercise. The board needs to have a clear strategy for managing the current position regarding interim appointments.

64. The implementation of the Health Board's vision requires development of a change enabling structure and capacity that is currently not available.
The Health Board faces significant and complex changes, which will take a number of years to implement. The pace of change needs to increase but an approach to managing the changes is in its infancy.

65. Plans are not yet in place to re-engineer the capability of the Health Board to meet its long-term (inter-organisational) working model. In particular, workforce planning will need considerable development. The Health Board recognises that service modeling may need to come first, but, should the new working model proceed, there will be a need for a more sophisticated approach to workforce planning with an emphasis on:

- how the Health Board will interact with and develop the GP workforce needed to develop an integrated area approach to Locally Enhanced Services; and
- joint workforce planning, design and development required to work across organisational boundaries, particularly with the Council.

The Health Board also needs to develop and focus its relationships, but has not yet sufficiently sold the vision to the public, staff and politicians

66. Achievement of the vision is not the sole preserve of the Health Board. It requires buy-in and potentially contribution from a number of stakeholders, for example, political, patient/public, GP and staff.

67. Patients are often concerned about how changes will affect them and the services that are familiar to them. The challenges facing the Health Board are significant and securing the confidence of patients, carers and the public will be fundamental. It is therefore important that the Health Board demonstrates added value and assures patients and the public that the quality of service will improve.

68. The Service, Workforce and Financial Framework is in its early days and the Health Board has not yet developed a systematic approach to identify its different audiences and to communicate and engage the public in future patient healthcare improvements and outcomes. Currently there are limited capacity, processes or systems that will enable the Health Board to assimilate in a meaningful way the large number of views, concerns and questions arising from any consultation.

69. There are about 1,500 staff employed by the Health Board who also need to be clear about what the future looks like, how it affects them and what changes will be required from them. More needs to be done in order to communicate directly with staff and to share the future vision.

70. Staff are also members of the close knit community within which the Health Board works and should be ambassadors for the exciting changes that the Health Board hopes to make.

71. The Health Board is starting to develop good relationships with GPs and other NHS service providers, but needs to do more to align itself with the vision and the required change programme. Engagement with GPs is a key area for focus.

72. General Practitioners direct much of the Health Board's spend in the way they refer patients to other organisations, provide services themselves and prescribe medication. The Health Board is currently only using a small number of opportunities to engage with GPs and secure their buy-in and confidence in the necessary changes.

73. Some GPs remain concerned about changes in Powys, and as they often represent the voice of the community, they need to be fully engaged and used as advocates for delivering the vision.

74. The Health Board must secure local and national political buy-in, but the existing arrangements remain fragile. In order to achieve the implementation of the vision there is a need to engage clearly with politicians at both local and national level.

75. Securing recognition of the scale of change, and the potential rewards for achieving sustainable, community-orientated and integrated health and social care services is key. The Health Board cannot underestimate the link between political support and success.

Performance audit reviews have highlighted specific challenges for the Health Board, particularly in implementing change and improvement

76. This section of the report brings together the findings and an overall conclusion from performance audit work that has looked at specific areas of service delivery within the Health Board.

77. My performance audit reviews during the year have included:

- a review of new models of health and social care (January 2010);
- the accuracy of waiting list data (March 2010);
- IM&T governance arrangements (July 2010);
- adult mental health services (September 2010);
- unscheduled care (September 2010); and
- hospital catering (November 2010).

78. These reports reflect the completion of work done during 2009 and 2010. The findings show the position at the time the work was undertaken and the Health Board is taking, or has taken, appropriate action to address the weaknesses identified for many of the reviews.

79. My audit team will review the progress of these actions and consider whether these have led to tangible improvements as part of future years' audit programmes.

Exhibit 7: New models of health and social care

The Health Board and the Council are demonstrating commitment to working in partnership to modernise health and social care services and recognise that further progress is needed for the agencies to be well placed for implementing a new model to deliver better provision for Powys

Scope of the review

The Health Board and the Council share a commitment to improving the quality of services for adults, through re-organisation and modernisation.

This is an exceedingly challenging agenda and I examined whether the Health Board and the Council are well placed to deliver a new model of health and social care to achieve better services for Powys residents.

Findings

The Council and the Health Board have set out strategic plans for a new model of health and social care services but have not clarified the relationship between the development of county-wide plans and local delivery:

- the Council and the Health Board have agreed the principal elements of a new model at a high level with significant recent progress in the planning arrangements at the County and local levels; and
- work to align the planning and delivery of local services within a Powys-wide approach is in progress but still at early stages.

The progress on the development of detailed analysis and delivery arrangements has been relatively slow and is impeded by the need for more complete needs analysis and further strengthening of partnership arrangements:

- the rate of progress since the Clinical Governance Phase 1 report and initial consultation on proposals for provision at Builth Wells in 2007 has been slower than intended;
- the analysis of need and service options is incomplete although work in these areas is now progressing; and
- the Council and the Health Board have developed a partnership structure including third sector and other stakeholders but this does not yet provide an appropriate hierarchy of clear responsibilities and decision making.

Uncertain affordability and lack of developmental capacity are likely to constrain implementation of the new model:

- the resource requirements for delivering a new model of services are not clear and therefore the affordability of the new model is not clear; and
- staff capacity to develop the necessary planning and project management arrangements has not been assessed and present capacity may be insufficient.

Exhibit 8: Accuracy of waiting list data

The Health Board has acceptable systems and arrangements for data accuracy and robust arrangements for recording and reporting waiting list information

Scope of the review

In March 2005, the then First Minister and the Minister for Health and Social Services announced that, by December 2009, no patient in Wales will wait more than 26 weeks from GP referral through to treatment (RTT) .

In 2007, the Wales Audit Office undertook a review to provide independent assurance that the waiting list figures reported by the NHS trusts in Wales were accurate. Powys Local Health Board was not included in the 2007 review.

However, given concerns raised in 2007, and the new challenges faced by all local health boards in meeting the RTT target, I examined whether the necessary management arrangements were in place to produce robust waiting list data.

Findings

The accuracy of the Health Board's waiting list data is acceptable:

- there were no differences found between the GP referral information and the Health Board's records; and
- the processes for managing patient-initiated delays could mean some patients are seen out of order.

The arrangements for recording and reporting waiting list information are robust:

- robust management arrangements are in place;
- the Health Board was prepared for RTT implementation; and
- current IT systems and processes are effective (for the purpose of waiting list management).

Exhibit 9: Information management and technology governance arrangements

Weaknesses in IM&T strategic planning, decision making and operational arrangements are leading to a lack of resilience and a failure to realise the full potential of IM&T to achieve efficiency savings and service improvement

Scope of the review

This work focused on the strategy, decision making and operational effectiveness of the Health Board's IM&T services.

Findings

The Health Board does not have effective IM&T strategic planning and decision making arrangements:

- the IM&T strategy is out of date and is not aligned with national and local plans;
- effective decision making arrangements are not clearly defined; and
- the Health Board is not maximising the investment or potential in technology to deliver sustainable efficiency savings and service improvements.

The IM&T operational arrangements are insufficient to provide a robust and resilient service:

- IM&T resources are not organised and managed efficiently and effectively; and
- the development and maintenance of the IM&T infrastructure are not linked to sustainable levels of service.

Exhibit 10: Adult mental health services

Powys health community has not made adult mental health services a high priority, and consequently, very little progress has been made since 2005 in meeting national standards and service user needs

Scope of the review

In 2005, the Wales Audit Office issued a report on adult mental health services in the Powys area. This follow-up review again covered both the local authority and health board services. The focus of this follow-up audit was on planning and funding, mental health services in primary care, community-based services, talking therapies, accommodation and housing, and involving service users in their care.

Findings

- The health community has not been effective at strategic planning of adult mental health services and the reduced expenditure suggests that adult mental health services are not a priority. There is still no agreed mental health service model, and while plans have been in place, these have not been effective in improving services.
- The community has taken some steps to improve primary care provision of mental health services although there are still issues around GP training and Section 12 doctors. Many service users continue to be very positive about the care that they receive from primary care. There has been an improvement in training for practice nurses, however, no progress has been made in supporting GPs in diagnosing and managing adults with a mental health problem.
  While there has been limited take-up of the enhanced services, the physical health checks are reported to be having a positive impact on care.
- There remains an overreliance on inpatient facilities, there are fewer community based staff and there are still key gaps in community services. Service users are generally satisfied with the care they receive but one in five rate their care as poor or very poor. There remains an overreliance on inpatient beds and there has been a worrying reduction in community-based resources. Psychiatry staffing levels have increased but waits for a routine appointment are still comparably long. There remains an overreliance on inpatient beds and there has been a reduction in community-based resources. There is no Crisis Resolution Home Treatment service, Assertive Outreach service or Early Intervention in Psychosis service in Powys. Co-ordination and joint working between specialist mental health services and with other parts of the NHS are not fully in place.
- Whilst elements of psychology therapies have improved, long waiting times remain an issue and there has been no progress in developing and implementing a stepped model of care. Service users want more counselling services and better relationships with psychologists and counsellors, and positive steps have been taken to provide structured counselling across the whole of primary care. There has been an expansion in the number of community team staff trained in and delivering psychological therapies, but there has been no increase in psychologist or psychotherapist staffing levels.
- There is no clear vision or shared strategy to meet the accommodation needs of people with mental health problems and access to appropriate housing remains a problem. One in 10 service users think their housing is inappropriate and one in four want more support with their accommodation needs. People with a mental health problem are still being placed out-of-area, although agencies were unaware of the exact size of the problem.
- Despite some positive features of user engagement, service providers are not adequately involving service users in their own care and non-statutory advocacy services are not available.

Exhibit 11: Unscheduled care

The Health Board recognises the need to develop unscheduled care services but progress has been limited and a whole system approach consistent with the wider modernisation agenda for Powys is required

Scope of the review

Unscheduled care is a term used to describe any unplanned health or social care and can be in the form of help, treatment or advice provided urgently or in an emergency at any time of the day or night.

The review determined whether the Health Board was well-placed to deliver effective services to respond to the need for unscheduled care.

Findings

The demand on unscheduled care services is high and continues to grow:

- Demand placed on the primary care out-of-hours service is relatively high and not easily explained. There was considerable variation across the former LHBs in relation to the number of calls to primary care out-of-hours providers per 1,000 registered patients. The number of calls per 1,000 registered patients in Powys was considerably higher (228.9 calls per 1,000 registered patients) than the average for Wales (170.2 calls per 1,000 registered patients).
- Emergency ambulance calls are rising and too many people in Powys experience delays. The number of emergency ambulance calls across the Council area totalled 10,596 in 2008-09, a small rise of 3.5 per cent on the previous year. The number of emergency calls has continued to increase with 11,388 emergency calls made in 2009-10.
- Attendances at MIUs are increasing.

The rate of progress on improvements to the unscheduled care system has been relatively slow and hindered by a lack of sustained focus and weaknesses in the analysis of demand:

- the Health Board has made improvements to strengthen clinical governance in its community hospitals;
- despite the establishment of the Unscheduled Care Partnership Board, a lack of continuity in leadership and strategic capacity has disrupted focus and hindered the rate of progress;
- the analysis of need and demand to underpin the planning and development of unscheduled care services is not comprehensive or fully utilised;
- reliance on hospital admissions will continue until suitable and co-ordinated alternative community services are in place; and
- work is underway to develop new models of unscheduled care but much still needs to be done.

Plans for developing unscheduled care are not strategically set within the wider context of modernising health and social care:

- in planning and implementing changes to the unscheduled care system, the Health Board has yet to achieve strategic alignment with the wider modernisation of health and social care in Powys;
- financial constraints add impetus to collaborative working across the whole health and social care system and for reviewing opportunities for providing services differently; and
- public expectations and demands are confused about the new models of health and social care currently being planned.

Exhibit 12: Hospital catering and nutritional support

The Health Board demonstrates several aspects of recognised good practice although there are some areas including ward-based patient support, seeking patient feedback and the catering service's cost management that could be improved

Scope of the review

The review of the catering services included assessing the catering strategy, financial management, catering service, quality of food and nutritional support in hospital wards.

Findings

- From its position in 2007, the Health Board developed a strategic catering approach which over the last three years has been effective in ensuring a consistent quality service. There are, nevertheless, complex future challenges such as the integration of health and council services as well as significant cost pressures. Because of this, a new broader nutrition and catering framework is now required.
- Procurement and production arrangements are effectively designed to meet the needs of both the patient and the Health Board. Procurement approaches follow the all-Wales framework and utilise Welsh Health Supplies, although the Health Board has effectively collaborated with the Council for local fresh supplies. The kitchen production aspects of catering are fit for purpose and utilise a hybrid model, which is a mix of fresh cook and freeze cook. The freeze-cook products are supplied by an industry-recognised manufacturer that supplies a range of meals to cost and nutritional standards. The kitchen facilities and equipment are fit for purpose and the kitchen equipment is well maintained. Cost control approaches are in place at a high level and enable a reasonable financial overview, but the associated cost control arrangements within individual sites could be improved, for example by implementation of the planned Menumark system and computerised stock control.
- The Health Board provides food that normally arrives in the ward in a good state. At all sites the food is checked to ensure that it has been cooked to standards and is at the correct temperature, and at most sites the time between production and serving to the patient is minimal. We undertook food taste testing which indicated that good quality meals are served to patients at most of the sites that we tested. One site in particular operates a kitchen-plated service, and this increased the time from production to consumption and ultimately affected the quality of the food. Some sites were very good at presenting the food, making it more appealing to patients, while others were less careful.
- The quality of nutritional assessment process is generally consistent and identifies patients at risk. We did find wider variation, however, between different sites regarding the quality of patient mealtime support and assistance. Where the patient mealtime support was good, we noticed that not only was the service efficient, but also that all staff actively encourage patients to eat, particularly those who cannot feed themselves.
- While there are good mechanisms to obtain feedback from stakeholder groups and staff, the approach to collecting patient feedback on the meal service could be improved. This would ensure that variation in patient satisfaction can be explored with the aim of providing consistently good quality service.

Appendix 1

Reports issued since my last Annual Audit Letter

Report	Date
Financial audit reports	
Business Services Centre – Financial and Contractor Services	March 2010
Annual accounts audit processes (presentation)	June Audit Committee
Audit of Financial Statements – report to the Audit Committee	June 2010
Audit of the Financial Statements – update for Audit Committee	September 2010
Audit of the (Charitable Funds) Financial Statements – report to Charitable Funds and Audit Committees	November 2010
Performance audit reports	
Review of new models of health and social care	January 2010
Waiting list data quality	March 2010
IM&T governance arrangements	July 2010
Unscheduled care	September 2010
Adult Mental Health Services	September 2010
Hospital catering and nutrition	November 2010
Structured assessment	Reported in this Annual Audit Report, January 2011
Other reports	
Audit Strategy	January 2010
Annual Audit Report	January 2011

The following performance work was included in the 2009-10 audit strategy, and will be completed as follows:

- follow-up review of Child and Adolescent Mental Health Services (CAMHS), planned for completion in spring 2011;
- follow-up of 'New Models of Health and Social Care' – ongoing review of previous recommendations;
- review of theatre utilisation and short stay/day surgery – fieldwork and report in February 2011; and
- Continuing Health Care – an all-Wales high level review of progress being made by health boards in dealing with backdated claims for CHC, planned for spring 2011.

Audit fee

The Audit Strategy for 2009-10 set out the proposed audit fee of £263,067 (excluding VAT). The table below sets out my latest estimate of the actual fee, on the basis that some work remains in progress.

Analysis of proposed and actual audit fee 2009-10

Code area	Planned fee (£)	Estimated actual fee (£)
Audit of accounts	144,207	144,207
Performance audit	118,860	118,860
Total	**263,067**	**263,067**

The 2009-10 Audit Strategy stated that this fee did not include the charge for audit work undertaken in respect of the shared services provided to the Board by the BSC. This fee was recharged by the BSC and amounted to £10,992.

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