AUDIT COMMITTEE
Tuesday, 5 December 2017 at 9.00am

CORPORATE MEETING ROOM, HQ, UHW
AGENDA

PART 1 - SECTION 1: PRELIMINARIES *(Chair)*		
1.	Welcome and Introductions	*Oral*
2.	Apologies for Absence	*Oral*
3.	Declarations of Interest	*Oral*
4.	Minutes of the Committee meetings on 26 September 2017	*Chair*
5.	Action Log following 26 September 2017 Meetings	*Chair*
6.	Any Other Urgent Business: To agree any additional items of urgent business that may need to be considered during the meeting.	*Oral*
SECTION 2: PATIENT SAFETY		
7.	Patient Safety	*Oral* *C Evans*
SECTION 3: AUDIT AND COUNTER FRAUD		
8.	Internal Audit Position Report and updates **Assignment** — **Assurance Rating** 1. Cleaning Standards — Limited 2. Medicine Clinical Board PADRs and Mandatory Training — Limited 3. Claims Reimbursement — Substantial 4. IT System – Welsh Patient Referral System — Substantial 5. IT Strategy – MTeD Deployment — Substantial 6. Children and Women Clinical Board Medical Staff Study Leave — Reasonable 7. Serious Incidents Management — Reasonable 8. Nurse Revalidation — Reasonable 9. Research and Development — Reasonable 10. Carbon Reduction Commitment — Reasonable 11. CD&T Additional Payments Follow-up — n/a	*J Johns*

	*Please see part 2 agenda item 22 for full copies of audit reports	
9.	To receive Wales Audit Office Review of Discharge Planning	*WAO*
10.	To receive the Wales Audit Office Review of GP Out of Hours Services	*WAO*
11.	To receive the Wales Audit Office Progress Update – Management of Follow-up Outpatients	*WAO*
12.	To receive Wales Audit Office Collaborative Arrangements for Managing Public Health Resources	*WAO*
13.	To receive Wales Audit Office Committee Update	*WAO*
14.	Update on Wales Audit Office – Action Plan of Contractual Relationship with RKC Associates Limited and Its Owner	*P Welsh*
15.	To Receive Tracking Report on Audit Recommendations	*P Welsh*
SECTION 4: POLICIES AND COMPLIANCE REPORTS		
16.	Capital Ordering Authorisation Protocol	*R Chadwick*
SECTION 5: CORPORATE GOVERNANCE		
17.	Director of Corporate Governance Report	*P Welsh*
18.	To receive an Update on the Corporate Risk Assurance Framework	*P Welsh*
SECTION 6: ANNUAL FINANCIAL AND GOVERNANCE STATEMENTS		
19.	Topical Legal and Regulatory Items	*Oral* *P Welsh*
20.	To receive Losses and Payments Report	*R Chadwick*
SECTION 7: ITEMS FOR DECISION		
21.	No items to report	
PART 2 - ITEMS FOR INFORMATION		
22.	Internal Audit reports for information: **Assignment** — **Assurance Rating** 1. Claims Reimbursement — Substantial 2. IT System – Welsh Patient Referral System — Substantial 3. IT Strategy – MTeD Deployment — Substantial 4. Children and Women Clinical Board Medical Staff Study Leave — Reasonable 5. Serious Incidents Management — Reasonable 6. Nurse Revalidation — Reasonable	*J Johns*

	7. Research and Development — Reasonable 8. Carbon Reduction Commitment — Reasonable 9. CD&T Additional Payments Follow-up — n/a	
REVIEW AND FINAL CLOSURE		
23.	Items to be referred to Board / Committee	*Oral* *Chair*
24.	To note the date, time and venue of the next meeting of the Committee: • **Tuesday, 27 February 2018, 9.00am** Corporate Meeting Room, Headquarters, University Hospital of Wales	

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 26 SEPTEMBER 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

John Antoniazzi	Independent Member – Capital, Chair
Ivar Grey	Independent Member – Finance
Stuart Egan	Independent Member – Trades Union

In Attendance:

Robert Chadwick	Director of Finance
James Johns	Head of Internal Audit
Charles Dalton	Head of Health and Safety
John Herniman	Wales Audit Office
Anne Beegan	Wales Audit Office
Craig Greenstock	Counter Fraud Manager
Simon Cookson	Director of Audit and Assurance, NWSSP
Ian Virgil	Deputy Head of Internal Audit
Scott Lavendar	Post Payment Verification

Apologies:

Peter Welsh	Director of Corporate Governance
Mark Jones	Wales Audit Office
Carol Evans	Assistant Director of Patient Safety and Quality

Secretariat: Glynis Mulford

AC: 17/035 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Members were informed that the order of the agenda would be rearranged to accommodate Mr Scott Lavendar who had to leave early due to other commitments.

AC: 17/036 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/037 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

AC: 17/038 UNCONFIRMED MINUTES OF MEETINGS HELD ON 24 APRIL 2017, 23 MAY 2017 AND 1 JUNE 2017

The Committee **RECEIVED** and **APPROVED** the minutes of meetings held on 24 April 2017, 23 May 2017 and 1 June 2017.

AC: 17/039 ACTION LOG FROM MEETINGS OF 24 APRIL 2017, 23 MAY 2017 AND 1 JUNE 2017

The Committee **RECEIVED** the Action Log from the meeting of 24 April 2017 and 23 May 2017 and **NOTED** the following:

AC 17/025 – Internal Audit Report – Continuing Healthcare: In regard to Recommendation 8 of the report, for the Management Response to be reworded.

AC 17/007 – Mental Health Clinical Board – Out of Area: Members were informed that there were previous capacity issues within the team which were being resolved with significant investment to ensure that all reviews take place within the appropriate timescales.

AC 16/093 – Internal Audit Position Report and Tracking Report: Action COMPLETE

AC 15/008- Business Continuity Planning: Members were informed that Internal Audit had been requested to push back the work to be reviewed in 2018. The Chair stated that the Committee needed to be assured that improvements were being made and asked for justification to be sought for pushing this back. Internal Audit was asked to present a paper to the next meeting to include what measures were being put in place between now and the next review and for the audit to take place in the first quarter of 2018/19.

ACTION: J Johns and P Welsh to discuss with Lead Director and present a paper to next audit meeting

AC: 17/040 POST PAYMENT VERIFICATION

Mr Scott Lavendar, Post Payment Verification Manager presented the report, which gave an outline on post payments since April 2017. This incorporated new information on the end of the Key Performance Indicators (KPI) report in relation to what the department were looking to achieve and if not, why this had not been attained. This provided some assurance that action was being taken on any issues/errors. In was explained that the FAQs were continually being updated to offer support and guidance and to bring the percentages down as errors rates sat high. It was emphasized that percentage errors had come down considerably compared to a few years ago. Training was also

being offered to new staff on the Service Specification due to misunderstanding and unfamiliarity of processes. The PPV and PCIC teams were working with the EU scheme in regard to retaining letters with GP referrals and were tackling the matter to get these down.

Concerns were raised around administration errors being very high with one of the private pharmacies. In response it was stated a meeting had been held with the Assistant Director of Patient Safety as there was a need to tighten processes across Wales. Due to the size of the organisation, difficulties had been encountered in completing this work. Members were informed that Counter Fraud had quarterly meetings with PCIC and PPV teams and if they were not satisfied with the documentation submitted would inspect the pharmacies concerned. The Committee was assured that Primary Care Services will review this area in 12 months' time and look at a larger sample in regard to any administration errors.

The Committee:
RECEIVED and **NOTED** the Post Payment Verification Report

AC: 17/041 INTERNAL AUDIT POSITION REPORT AND TRACKING REPORT

Mr James John, Head of Internal Audit, highlighted the individual position and progress on each report, stating there had been a review in regard to the content of the progress report and there was now an enhanced level of detail in the progress summary. The section around follow-up had been enhanced which featured additional information. There had also been an amended approach within the department. The key points of the progress report were highlighted looking at the audit assignments that had been completed for 2016/17 and 2017/18. It was stated although a number of reports had been finalized this year, there had been delays in progressing reports and some of these had not advanced at the speed anticipated.

The Chair raised concern about the number of reports not completed and asked what assurance could be given around the number of reports that should come through over the course of the next six months. In response it was explained that the attached Appendix showed the Internal Audits which would be brought to Committee but the bulk of these had been delayed through the briefs not being signed off. It was highlighted that a lot of effort has been put into the process of emphasizing to the Organisation the importance of sign off and review.

ACTION: Chair to speak to P Welsh

Members were informed that a paper had gone to Management Executive emphasizing the need for Lead Executives to attend meetings on request in relation to any queries raised on the Internal Audit Reports.

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There was opportunity to raise concerns at the forthcoming Board meeting to influence the Board and Executive to receive reports in a timely manner as planned. The Wales Audit Office also said they had similar issues in awaiting management responses.

Members were informed of the Internal Reports submitted. Two were of Substantial Assurance, four of Reasonable Assurance and two were Not Applicable. There were comments and discussion made on the following:

4.4 – Specialist Services Clinical Board - Private Patient Payments – (Assurance rating not applicable): The review looked at payments made to Cardiothoracic Registrars for private work in the context of duplicated payments. Internal Audit revisited this area to do further work as additional information came to light. Governance around payments needed to be strengthened and recommendations were made to secure improvements. A follow-up will take place in due course.

In response to the question whether the Health Board was being reimbursed, it was stated that they could conclude from the evidence, correct payments were coming through the Health Board.

4.9 – Mental Health Clinical Board Sickness Management and Rostering – Reasonable Assurance: Some high quality ratings were identified around sickness management where documentation had not being fully completed. Recommendations were highlighted around rostering and temporary staffing.

Concerns were raised around nurses working whole shifts without taking a break and recognized it was not acceptable to let this practice continue.

Issues around staff shortages and safety issues were widely discussed and realized this had increased the stress and demand placed on staff. Members were informed that concerns around staff breaks were being reviewed.

Mr C Dalton was asked to report back to the Director of Corporate Governance in relation to the number of follow ups where there were no actions and around the recommendations that were high. It was stated that the Director of Corporate Governance and his team were creating their own system for tracking and monitoring those high risks to be followed up by Internal Audit and that they would be kept on the agenda for the related Committee. This would be in addition to Internal Audit work.

ACTION: C Dalton to highlight to P Welsh

The Committee:
CONSIDERED and **NOTED** the Internal Audit Progress Report

AC: 17/042 WALES AUDIT OFFICE COMMITTEE UPDATE

Mrs Anne Beegan, Wales Audit Office, presented the update highlighting the following:

- The GP out of hours review had been finalized but was still awaiting management response.
- Draft reports had been issued on discharge planning and a local piece of work on managing follow-up outpatients.
- The progress update on follow-up outpatients has been with the Chief Operating Officer for some time and the Wales Audit Office is still awaiting management response. This was due to come to the September meeting, but will now be presented in December. The date under the heading 'For Audit Committee' was to be returned to the original September date for monitoring purposes.
- Thematic Reviews: The primary care review will initially be on an all Wales basis before focusing at a health board level which was described. The second review will examine the Integrated Care Fund and will include all relevant public bodies.
- In regard to the Structured Assessment work, officers from the Wales Audit Office will make observations at Board meetings and will delve into some of the Clinical Boards to review governance arrangements. A committee survey will be run on Audit and Quality, Safety and Experience. In addition, there will be a watch and brief on the two new committees.
- In view of Local Work, officers will confirm with the Director of Finance the exact focus on the work.
- In regard to the national review of the implementation of the Financial Flexibilities Act, all Health Boards will be presenting evidence to the Welsh Government Health and Social Care Sports Committee in regard to their financial acuity. The Good Practice programme was also highlighted, informing there were webinars and seminars available. Individual links to upcoming events will be circulated and members will have the opportunity to attend training.

The Committee:

- **NOTED** the Wales Audit Office Committee Update

AC: 17/043 WALES AUDIT OFFICE – ACTION PLAN OF CONTRACTUAL RELATIONSHIP WITH RKC ASSOCIATES LIMITED AND ITS OWNER

Mr Charles Dalton, Head of Health and Safety, presented the report on behalf of the Director of Corporate Governance. It was stated that the UHB Chair and Chief Executive attended the Welsh Government Public Accounts Committee recently to discuss the Wales Audit Report and action plan. The

Welsh Government will be presented with a report within 4-6 weeks' time. This will stay as a standard agenda item until all actions are completed in report.

Mr Simon Cookson explained that the procurement function sat within the remit of Shared Services who had responded to the report across Wales. Internal Audit had been asked to do an audit which was complete and a report had been drafted. When the report is finalized it will be distributed to all Health Boards and Trusts in order to have additional assurance of procurement processes.

The Committee:

- **NOTED** the contents of this report;
- **MONITORED** the progress of the action plan and
- **PROVIDED** the Board with the assurances required.

AC: 17/044 DELOITTES FINANCIAL GOVERNANCE REVIEW OF CARDIFF AND VALE UHB

Mr Robert Chadwick, Director of Finance presented the action plan stating they were linked to recommendations in the report. The action plan would be presented to the next Board meeting where it would be monitored and progressed against the timescales by the Finance Committee.

It was suggested for Internal Audit to link in to look at specific points on the Action Plan.

The Committee:

- **NOTED** the Governance Review of Cardiff and Vale UHB Recommendations

AC: 17/045 TRACKING REPORT ON AUDIT RECOMMENDATIONS

The Committee **NOTED** the report and the arrangements for ensuring that all WAO actions had been tracked. Mr Charles Dalton stated that the attachment had been updated with key processes made. This will be presented to the forthcoming Board meeting. Mr Robert Chadwick stated that IT did not sit within his job description and for the Director of Corporate Governance to reallocate this item to the relevant Executive Director.

ACTION: For secretariat to highlight to P Welsh

AC: 17/046 DIRECTOR OF CORPORATE GOVERNANCE REPORT

Mr Charles Dalton, Head of Health and Safety presented the report on behalf of the Director of Corporate Governance stating meetings had taken place with the Director of Finance, the Chair of Audit Committee and Internal Audit. This would be a regular agenda item for a helicopter approach on a regular basis to strengthen links between various committees and to have oversight that they were working together in unison. The objective would be to move forward with some greater intervention. This format has been raised at the Board Secretaries meeting to make this an All Wales wide approach.

It was stated that some of the information should be incorporated with Wales Audit Office.

The Committee:
NOTED the Director of Corporate Governance Report

AC: 17/047 REPORT ON HOSPITALITY REGISTER & REGISTER OF DECLARATIONS OF INTEREST

Mr Charles Dalton, Head of Health and Safety, stated that the report will be brought to Committee on a six monthly basis although this was mandated to be yearly. The registers were being reviewed with the aim of strengthening the Health Boards actions as there may be more to be declared than what had been submitted as low numbers of declarations had been received.

Concerns were reiterated around the number of declarations received, suggesting it should be part of the Consultants PADR. There was a need to be more disciplined and to have a more robust process in place. This would be highlight to the Medical Director to take forward.

ACTION: to Highlight lack of Declarations of Interest forms from clinicians to the Medical Director
ACTION: C Greenstock to speak to P Welsh around best practice from other Health Boards
ACTION: C Dalton to report discussion back to P Welsh and S Rowlands

The Committee:

- **NOTED** the Hospitality Register and Register of Declarations

AC: 17/048 REGULATORY REVIEWED BODIES TRACKING REPORT

The Committee **RECEIVED** and **NOTED** the Regulatory Bodies and Review Tracking Report which showed the level of scrutiny. Mr Charles Dalton stated

that the report was considered at Clinical Boards and the Health and Safety Committee noting external involvement. It was highlighted that the tracking report was not being used to its full potential and there was a need for it to be updated.

AC: 17/049 CORPORATE RISK AND ASSURANCE FRAMEWORK

Members were informed that a workshop had taken place in April and work was still being done on the contents and pilot work. The current format was not conducive with showing progress or the ability to give good assurance. The Director of Corporate Governance and Governance Manager were working on a new register and framework to be completed by April next year, recognising there could be benefits from making some changes.

One of the key issues identified was to present a document that could show progress of where we are at a single glance rather than what we had previously which was viewed static. In addition, to ensure people were educated and understood what the risks were and that they were being managed appropriately.

It was reported, the Health Board had high risk areas for a substantial period of time and should show that the red areas are being moved forward and progressing and show evidence what was being done to mitigate the risk.

Trials had been tested in the Estates and Dental Department to see how this captures realistic evidence on how the picture is being progressed. It was stated that this had to be a cascaded issue to be embedded down at the local level. The Four Cs approach was explained which gave a basis of an appropriate risk register to strengthen the system and provide assurance. It was stated the Organisation was astute at keeping incident recording but there was a need to be as detailed with the risks. A module was being progressed in Datix and explained this was a database system in regards to risks, where they can be compiled and show that progress was being made. The Governance Manager and the Health and Safety team were developing and bringing this area together.

The Committee:

- **NOTED** the Audit Committee Corporate Risk and Assurance (CRAF) Update Report

AC: 17/050 TOPICAL REVIEW

It was stated that a White Paper on governance and quality in the NHS was being produced which included the role of the Board Secretary, stating we had been involved drafting the paper and had responded to questions. The outcomes will be presented at a future meeting.

AC: 17/051 CONSULTATION ON FEES 2018/19

- The Committee **RECEIVED** and **NOTED** the report.

AC: 17/052 REVIEW OF MEETING

It was agreed that the following matters should be raised by the Chair:

- Completion of management responses for internal and external audit reports to be raised at Board meeting.

AC: 17/052 URGENT BUSINESS

There was no urgent business

AC: 17/053 DATE OF NEXT MEETING

The next Committee meeting is scheduled to take place at 9.00am on **Tuesday, 5 December 2017** in the Corporate Meeting Room, Headquarters, UHW

AUDIT COMMITTEE – ACTION LOG FOLLOWING SEPTEMBER 2017 MEETING

MINUTE	DATE OF MEETING	SUBJECT	AGREED ACTION	ACTION TO	STATUS	
					OUTSTANDING	DATE FOR COMPLETION
AC 17/041	26.09.17	Internal Audit Position Report and Tracking Report	To speak to P Welsh in regard to the number of reports being delayed through briefs not being signed off	Chair		**COMPLETE**
AC 17/045	26.09.17	Tracking Report on Audit Recommendations	To highlight to P Welsh for IT to be allocated to the relevant Director who remit was IT	Secretariat	Raised with F Jenkins	**COMPLETE**
AC 17/047	26.09.17	Report on Hospitality Register and Register of Declarations of Interest	To highlight the lack of forms from clinicians			**COMPLETE**
			To speak to P Welsh around best practice of other Health Boards in relation to submission of forms	C Greenstock	Spoken to P Welsh who will be liaising with his peers at both Velindre NHS Trust and NWSSP. A revised policy is being drafted	**COMPLETE**
			To report discussion back to P Welsh and S Rowlands	C Dalton		**COMPLETE**
AC 17/025	23.05.17	Internal Report – Continuing Healthcare	Management Response on Recommendation 8 to be reworded	S Curry	PCIC will monitor compliance of its 3 month reviews through its Clinical Board Performance Meeting	**COMPLETE**

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AC 17/007	24.04.17	Medical Locum Follow-up	To bring back to Committee showing detailed follow-up date in Management Response	J John	The updating of the SLA is still to be completed and similarly the policy is again still to be completed. Firm timelines were unavailable.	**COMPLETE** To be subject to further follow up through IA's follow-up process.
AC 17/007	24.04.17	Mental Health Clinical Board Out of Area	To make enquiries with Director of Nursing for PCIC in regards to Care Plans and patient reviews whether this had an impact on patient safety.	C Evans	The Director of Nursing in Mental Health has confirmed that capacity issues which exist in the team have been resolved with significant investment to ensure all reviews can now take place within the appropriate timescales.	**ONGOING**
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS						
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	Medicines Cost Reduction – to continue conversation with pharmacy in relation to high value drugs	C Evans	Have discussed with Director of Medicines Management. Wastage of high value drugs is	Update to be provided at December meeting.

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					monitored, but it would be too onerous to put in place a system to monitor trends and themes	
AC 16/102	28.02.17	Clinical Audit Programme	Report requested to be submitted to Committee	Secretariat	To be reported at **December 2017** meeting. - **COMPLETE** A detailed report was presented to QSE Committee in February 2017 giving an update of the 2016/17 clinical audit plans and detailing the additional clinical audit activity. The chair of the Audit Committee was satisfied with this and requested that a report be submitted with the proposed clinical audit work for the next year. Subsequently the Clinical Boards have submitted Clinical Audit Plans for 2017/18 and this was presented to QSE committee in September 2017 and an update will be presented to QSE in February 2018.	
AC 16/076	15.11.16	WAO Progress Against Plan	Resources in Corporate Governance Team to be raised at Board	Chair	Resource allocation being reviewed by Management Executive. No action until outcome is known. To be raised at Governance	**COMPLETE** CEO is undertaking a review of Executives portfolios.

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					Coordinating Group	
AC 15/008	24.02.15 8.12.15 26.09.17	Business Continuity Planning	Provider a follow up report in September 2015 To discuss with Lead Director the justification of pushing back the review. For the review to take place in the first quarter of 2018/19 and for assurances that improvements were being made.	J Johns J Johns and P Welsh	The follow up has been put back to the 17/18 plan at the request of the Executive Director The rational for the deferral of the BCP was to do with the progress made since previous audits were undertaken. The Executive Director has taken a paper to the Management Executives in October updating them on BCP actions. IA have subsequently raised where it would be possible to undertake work in Q4 as originally planned.	
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)						
AC 17/025	23.05.17	Internal Report – Medicine Clinical Board Specialling	To review report and policy and raise the weaknesses in record keeping with Executive Nurse Director. Findings to be triangulated with DOLs Limited Assurance report received at earlier meeting. To go forward to QSE and MHCL Committees	C Evans C Evans	Raised with Executive Nurse Director Raised with Medical Director QSE Committee considered action operational and removed from agenda	**COMPLETE** **COMPLETE** **COMPLETE**
AC 17/025	23.05.17	Internal Report – IT System – Trauma and	Report to go forward to IM&TSC	Chair	On agenda for September meeting	**COMPLETE**

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		Orthopaedics Bluespier				
AC 17/007	24.04.17	Llanishen Stores Follow-up	To enquire whether the Local Authority will be putting an IT system in West Point	J John	Confirmation received that system will be rolled out across both areas.	**COMPLETE**

INTERNAL AUDIT	
Audit Committee	**December 2017**

Executive Lead : Director of Corporate Governance
Author : Head of Internal Audit, NWSSP Audit & Assurance Service, UHW 42724
Caring for People, Keeping People Well :
Financial impact : n/a
Quality, Safety, Patient Experience impact : n/a
Health and Care Standard Number - ALL **CRAF Reference Number ALL**
Equality Impact Assessment Completed: n/a

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RECOMMENDATION

The Audit Committee is asked to:

CONSIDER the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports and **APPROVE** updates to the audit plan.

SITUATION

The Internal Audit progress report provides specific information for the Audit Committee covering the following key areas:

- Detail relating to outcomes, key findings and conclusions from the finalised internal Audit assignments
- Specific detail relating to progress against the audit plan and any updates that have occurred within the plan.

BACKGROUND

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Cardiff and Vale University Health Board.

The work undertaken by Internal Audit is in accordance with its plan of work, which is prepared following a detailed planning process and subject to Audit Committee approval. The plan sets out the programme of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the process established with the UHB and is prepared following consultation the Executive Directors.

The progress report provides the Audit Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee, amendments to the plan and also assignment follow ups.

The report highlights some delays with the delivery of the audit plan during the current year and the reasons behind the delays.

The progress report highlights the conclusion and assurance ratings for audits finalised in that period. Reports that are given substantial or reasonable assurance are summarised in the progress report with the reports given Limited Assurance included in full.

Appendix A sets out the Internal Audit plan as agreed by the committee, including details of postponed audits, commentary as to progress with the delivery of assignments and outcomes from completed audits.

A revised follow up report has been prepared for the Committee is included at Appendix B.

ASSESSMENT AND ASSURANCE

The progress report provides the Committee with the level of assurance given to the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan, along with information regarding the necessary actions required to address control weakness identified. The report also sets progress with the delivery of the Internal Audit plan.

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee December 2017

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff and Vale University Local Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. INTRODUCTION

1.1. This progress report provides the Audit Committee with the current position regarding the work being undertaken by the Audit & Assurance Service as part of the delivery of the approved Internal Audit plan.

1.2. The report includes details of the progress made to date against individual assignments, outcomes and findings from the reviews, along with details regarding the delivery of the plan and any required updates.

1.3 The plan for 2017/18 was agreed by the Audit Committee in April 2017 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. ASSIGNMENTS WITH DELAYED DELIVERY

2.1 The full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A. The assignments noted in the table below are those which had been planned to be reported to the December Audit Committee but have not met that deadline.

All other audits are currently planned to be reported to the February and April Committees as set out in Appendix A.

Audits planned for December Audit Committee but not finalised			
Surgery Clinical Board – Anaesthetics Rotas	Work in progress	-----	Continual delay in the provision of key information from the Directorate.
Neurosciences IT System Follow up	Final/Draft	Limited	Executive sign off pending. Delays in agreeing draft report due to mgt. changes.
Stock Control Localities Follow up –	Final/Draft	Reasonable	Initial delay with IA. Now awaiting management feedback.
Capital Scheme – Neo Natal	Work in progress	------	Position of capital scheme and reallocation of audit staff.

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

3.1 A number of assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

3.2 A summary of the key points from the assignments with Reasonable and Substantial assurance are reported in Section four, the two reports with Limited Assurance ratings are included as full versions of the reports at Appendix C.

FINALISED AUDIT REPORT	ASSURANCE RATING	
Claims Reimbursement	Substantial	
IT System – Welsh Patient Referral System		
IT Strategy- MTeD Deployment		
Children & Women Clinical Board Medical Staff Study Leave	Reasonable	
Serious Incidents Management		
Nurse Revalidation		
Research and Development		
Carbon Reduction Commitment		
CD&T Additional Payments - Follow up	n/a *	
Cleaning Standards	Limited	
Medicine clinical Board – PADR's and Mandatory Training		

* The original review was not assigned a rating due to its nature, however the follow up audit has highlighted good progress has been made in addressing the weaknesses previously identified.

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4. DELIVERY OF INTERNAL AUDIT PLAN

4.1 From the table in section three above it can be seen that a number of audits have been finalised since the Committee met last. In addition to that numerous audits are at the work in progress or draft report stage.

4.2 There have however been a number of audits where progress has been slower than planned or delayed for several reasons. The reasons include; time taken to obtain sign-off for the audit brief, queries regarding the appropriateness of assigned executive leads, time to get meetings with key staff through the UHB and subsequently obtaining information. One review has been delayed through the absence of Internal Audit staff. Further detail is given in the audit assignment status schedule at Appendix A.

4.3 The UHB have requested the deferral of several audits during the current year. These audits are Cyber Security, Board Working, Cost Improvement Plans (CIP), Well Bering Objectives and Business Continuity Planning. Two of the reviews; Cyber Security and Board Working are deferred, as other work is ongoing within the organisation or at an all Wales level. As a result the UHB will not be able to take any assurance from Internal Audit on either of these two areas during this year.

Following discussions with the lead Executive Director to clarify the intended scope of work it is now planned that the wellbeing objectives work will go ahead. It is hoped that some work on the CIP audit will go ahead after the WAO structured assessment work, but will be assessed at that point.

4.4 The timing of the follow up of the Business Continuity Audit has been subject to much debate and the Management Executive had requested deferral until Q1 of the 18/19 plan. However the Audit Committee Chairman has requested this is undertaken in Q4 of this audit year.

4.5 Time has been set aside within the plan to be utilised for work at the discretion of the Chief Executive. This work has now been agreed and will include a review of progress and testing of a sample of actions on the WAO, Deloitte and HTA action plans, as well as looking at Data Quality covering EU 12 hour target, RTT and Cancers Targets.

4.6 It is asked that the Audit Committee approve the amendments to the plan noted above.

4.7 As part of ongoing planning and engagement with the Health Board, Internal Audit has had a series of meetings including with the Executive Director of Finance, Director of Corporate Governance, Audit Committee Chairman, Chief Executive and Vice Chairman. Other Executive Directors have been met with in relation to specific audit assignments.

4.8 FOLLOW UP PROCESS

The Internal Audit follow up process has been revised and a change to committee reporting had been made. The follow up report has been included at Appendix B giving details of assignments recently followed up and also a schedule of the status of current assignment follow ups.

5. FINAL REPORT SUMMARIES

5.1 Claims Reimbursement

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated **Claims Reimbursement** is substantial assurance.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

In accordance with WRP Claims Management Standard Assessment Area 23 requirements, the Auditor sampled 25% of the total number of claims submitted (12 claims sampled) for reimbursement.

Review of the sampled claim files confirmed that each reimbursement had been appropriately undertaken and was supported by a properly completed and authorised Appendix U cost reimbursement schedule and a fully completed and authorised Appendix S. All The claims were also uploaded onto the Datix system.

5.2 IT System Welsh Patient Referral System (WPRS)

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the WPRS is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

The WPRS is an established system part developed by C&V IM&T. The roll out process is governed by a formal process and progress is regularly monitored along with identified risks. Changes to the process are formally

approved and subject to testing and data is subject to logging and most data transfer is encrypted. There were minor weaknesses identified relating to the attendance of some services at ISEC (Informatics Services E-Communications Project Board) and one transfer process is not encrypted.

5.3 IT Strategy – MteD Deployment

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the MTeD Deployment is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

MTeD is an established system part developed by C&V IM&T. The roll out process is governed by a formal process and progress is regularly monitored along with identified risks. There were minor weaknesses identified relating to the attendance of some services at ISEC (Informatics Services E-Communications Project Board) and the lack of a formal benefits realisation / assessment process.

5.4 Children & Women Clinical Board – Medical Staff Study and Rotas

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of Medical Staff Rotas and Study within the Children & Women Clinical Board is **Reasonable assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The review noted good practice within the Clinical Board via the timely issue of the staff rota's sampled, standardised templates in operation and good communication between the Clinical Board and medical workforce. These practices ensure that medical staff rotas are being appropriately managed and staff members are working their required sessions.

The review did however identify a number of issues in relation to both Medical staff rotas and study leave. These relate to the availability and appropriateness of procedural guidance within all the areas sampled, the level of compliance with procedures for locums and study leave and the generally low take up levels of study leave by the medical staff.

It should be noted that there were delays in receiving information within one of the directorates and testing was curtailed in this area.

There was one high priority finding noted within this report; From the audit sample, the combined percentage of study days taken, compared to their allowances, was less than 50%.

5.5. Serious Incidents Management

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Serious Incidents Management is **Reasonable Assurance.**

Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Serious Incidents are being appropriately identified within the Health Board and processes are in place to ensure required actions are identified and implemented. The Health Board also has robust reporting processes in place to ensure that lessons are learnt.

Datix is utilised effectively and the 'Putting Things Right' guidance is followed when dealing with serious incidents. CAV web has a dedicated page available for incident reporting, which includes links to Datix for the reporting and management of all incidents. A document outlining Severity Descriptors is also available for staff completing Datix, as well as RIDDOR guidance which will assist if relevant. The pages on CAV web are user friendly and well laid out.

The Health Board's Incident Reporting policy is currently out of date but is in the process of being reviewed and updated.

Testing identified that the Health Board is not always completing the review and closure of SIs within the timescales stipulated by WG. However we did note that there are often extenuating circumstances that prevent the required investigations from being completed within the timescales.

All four sampled Clinical Boards have a Quality, Safety and Experience committee in place which monitors the progress against their SI's. Each Clinical Board also has their own dedicated Patient Safety Team Facilitator allocated to them. Improvements could be made with regards to the completion of action plans and ensuring they are more readily available via the Datix system.

5.6 Nurse Revalidation

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Nurse Revalidation is **Reasonable Assurance.**

Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The Health Board has made considerable progress embedding procedures in relation to the NMC revalidation process even though they have made the decision not to adopt the NHS Wales Nursing and Midwifery Council

Revalidation and Registration Policy.

Whilst many areas of good practice have been demonstrated, that have sufficiently mitigated the risk of lapse from the register due to failure to revalidate, there are opportunities to build on the processes to align with other Health Boards where we have undertaken similar reviews. Examples of these improvements include adopting the All Wales policy, or inclusion of revalidation in the existing Professional Registration Policy, and embedding the nurse revalidation process into the annual Personal Appraisal Development Reviews.

5.7 Research & Development

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Research & Development is **reasonable assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The review noted good practice within Research and Development via the linkage to the IMTP and wellbeing objectivise which demonstrates that the Health Board is attempting to embed research into the culture of the organisation. Also the research departments have strong procedural guidance in place and standard file management arrangements.

However, the review did identify issues within the governance arrangements and also the individual research files.

There was one high priority finding noted within this report relating to the fact that the required Clinical and Directorate lead reviews are not being completed for all projects.

5.8 Carbon Reduction Energy Efficiency Scheme

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the CRC Energy Efficiency Scheme is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Good progress had been made in addressing the recommendations from the previous report with each of the four recommendations implemented.

Satisfactory systems were in place for the Annual Reporting of data, Purchases of Allowances and the retention of the required evidence as part of the require evidence pack.

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5.9 CD&T Clinical Board Neuroradiology Additional Payments

In summary, progress against the seven actions that required implementation was as follows:

No of Management Actions to be implemented	Fully Actioned	Partially Actioned	Not Actioned/ Alternative Action
7	5	1	1

The follow up review concluded that based upon discussions with relevant management and review of the evidence provided good progress has been made and controls have significantly improved.

The management actions completed to date can be summarised as follows:

- Issues previously identified have been raised with the Counter Fraud Department and there is an on-going investigation (Fully Actioned);
- Consultants have been reminded verbally of their contractual responsibilities and what work is claimable as an additional payment. A draft policy on Waiting Lists Initiatives (WLI) has been written encompassing this but it has not been formally circulated yet (Partially Actioned);
- All claims submitted by the Neuroradiology Consultants are now checked by the Clinical Director (CD) prior to authorisation and

recorded on an approved spreadsheet. Testing confirmed the reports tested were accurate as per RADIS (the radiology patient record system) and signed & dated by the CD (Fully Actioned);

- The Director of Operations for CD&T keeps a summary of all claims that are submitted for approval, new claims are manually cross-referenced to this when they are submitted to avoid duplication of payments (Fully Actioned);
- Claims are being reviewed to ensure there is no overlap with job plans, testing confirmed the sampled additional payments made related to un-contracted time (Fully Actioned); and
- After approval from the Clinical Director, claims are submitted to the Clinical Board for authorisation prior to payment. These are reviewed by the Director of Operations (DofO) as opposed to the Clinical Board Director due to the volume of claims. Testing confirmed that all the sampled claims were signed and dated by the DofO (Fully Actioned).

Due to the on-going investigation by Counter Fraud, no separate review has been undertaken by the Clinical Board to quantify the loss to the Health board as a result of the erroneous claims.

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Assignment Status Schedule Appendix A

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Corporate governance, risk and regulatory compliance							
Health and Care Standards	Director Nursing	Q2-Q4	Q2-Q4	Updated approach from 17/18 to monitor on a more ongoing basis through the year.	Planning meeting 9/11. CS		April
Claims Reimbursement	Director Nursing	Q3/4	Q3	Review re WRP claims standard.	FINAL	Substantial.	Dec
Annual Governance Statement	Corporate Governance	Q4	Q4	To review the content of the Statement.	Reported in annual report	n/a	Annual report
Governance, Leadership & Accountability Assessment	Corporate Governance	Q4	Q4	To review the process that has been adopted and evidence supporting the self-assessment.	Reported in annual report	n/a	Annual report
Board Working	Corporate Governance	Q2-3	n/a	n/a	Review deferred following discussions with DoF and CEO.	n/a	N/A
WAO Action plan				To be added As per CEO request			Apr
Deloitte action plan							Apr
Regulatory compliance-HTA action plan							Apr

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Strategic planning performance management and reporting							
Business Continuity Planning Follow up	Director of Planning	Q4	Q2/3	Re Audit including follow up of agreed actions form previous Limited assurance report.	To be brought forward as per directive from Audit Committee Chairman. Mgt Exec Team requested for audit to be deferred to 1819. Pre Audit Committee – AC Chair requested doing in Q4	N/A	N/A – may be Apr?
Research & Development	Medical Director	Q1-2	Q2	Review controls in place to manage key risk areas within the process.	Fieldwork ongoing. Progress affected by delays on other reviews. Now draft report stage. Mgt responses JJ 12/10. Issued as Final.	reasonable 	Dec
Wellbeing Objectives	Director of Public Health	Q3/4	Q3	Review process for setting, delivering and monitoring objectives.	Planned to commence Q3. Met DPH. Way forward agreed.		Feb/Apr
Continuing Health Care	COO	Q3	Q3	Follow up from previous report.	To commence Q3.	WIP	Feb

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Strategic Planning/IMTP	Director of Planning	Q4	Q4	Review on going delivery and monitoring of the plans.	Planned to commence Q4		April
Financial Governance and management							
UHB Core Financial Systems	Director of Finance	Q3/4		Review a selection controls in place to manage key risk areas across the range of the main financial systems.	Work underway as planned.	WIP	Feb
Charitable Funds	Director of Finance	Q1-2	Q1-2	Review governance arrangements, including the management of expenditure and donations.	Final Report. – 29/8. Substantial Assurance.		Sept
Cost Improvement Programme	Director of Finance	Q3	Q3	Review the development and delivery of the improvement plans.	Draft brief prepared. Scope to be agreed. MGT now want work deferred. IA recommended that some work take place follow WAO structured assessment		Feb/ Apr??
Costing	Director of Finance	Q3	Q3	Scope as per work agreed at all wales costing group.	Assignment Brief agreed. Finance requested fieldwork commenced End Oct/ Nov.	WIP	Feb

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Clinical governance quality & safety							
Annual Quality Statement	Director Nursing	Q1	Q1	Review content of AQS.	FINAL Aug.		Sept
DOLS	Medical director	Q3-4	Q3/4	Follow up of agreed actions form previous Limited assurance report	To commence as per plan. -		April
Serious Incidents Management	*Nursing*	*Q2/3*	*Q2*	*Review Incident Closures*	*FINAL*	Reasonable 	*Dec*
Mortality Reviews	Medical	Q1-2	Q3	Review Process and actions taken.	Planning – brief prepared. Start delayed. Medical Director requested end of October for fieldwork commencement.	WIP	Feb
Q&S Governance follow up	Nursing	Q1-2	Q1-2	Follow up of each of the eight report from 16/17.	Final Report. Individual ratings updated for each Clinical Board. Reasonable or above.	As per report.	Sept.

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Information Governance and Security							
IT Strategy	*Director of Therapies*	*Q2*	*Q2/3*	*Strategic MTeD deployment*	*FINAL.*	*Substantial*	*Dec/Feb*
IT System	*Director of Therapies*	*Q3/4*	*Q3*	*Welsh Patient Referral System*	*Final*	*Substantial*	*Dec/Feb*
Neuroscience IT system follow up	*COO*	*Q2-3*		*Follow up on 16/17 report.*	*Response now received 13/11.* *Awaiting Exec sign off*	*Limited?*	*Dec*
Virtulisation	Director of Therapies	Q3	Q3	Review the security and resilience of the updated virtualised environment.	Planning stage		April
Cyber Security	Director of Therapies	Q2/3	n/a		Review deferred at request of UHB.	n/a	n/a.
DATA quality – EU 12 hour				To be added As per CEO request.			Feb
Data Quality - RTT							Apr
Data Quality Cancers targets							Apr

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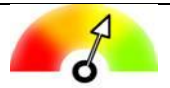
Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Operational service and functional management							
Clinical Board - Medicine	*COO*	*Q1-2*	*Q2/3*	*PADRS and Mandatory training*	*Delay in brief sign off. COO wanted further discussion regarding sign off of brief and appropriateness of exec lead. Work commenced late august. Draft report 25/10 – Limited. Final 21/11,*	*Limited*	**Dec**
Clinical Board - Surgery	*COO*	*Q1-2*		*Anaesthetists Rotas (initially to include staff management as well)*	*Delays in progress. Change of scope, work will now only cover anaesthetists' rotas as per discussions with COO. Final elements of info only obtained wc 24/10. Now need JB top complete ASAP.*	*WIP*	Dec? won't make this now.
Clinical Board – Mental Health	COO	Q1-2		PADRS and Rotas.	Draft report reasonable assurance. Report still Awaiting mgt. responses and sign off. FINAL		Sept
Clinical Board - C&W	COO	Q2		Medical Staff Study Leave.	*Delays with field work and scope reduced as unable to obtain information. Query over*		Dec

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
					Exec lead. Work has now been completed. Draft report prepared for discussion. Now Finalised		
Accommodation/ Residences		Q1-2	Q3	Review arrangements in place for the management of residences.	Request to defer work to Q3 as new systems in place. Brief prepared. Fieldwork commenced. w/c 9/10. Field work nearing completion.	WIP	Feb
WLI follow up	COO	Q2-3	Q3	Follow up on 16/17 report.	First part of Fieldwork in progress.	WIP	Feb
Stock control in localities follow up	COO	Q1	Q2/3	Follow up on 16/17 report.	Fieldwork in progress. Delay with IA. FW complete draft to be prepared. Draft report reasonable 8/11.	Reasonable.	Dec / Now Feb
CD&T Additional Payments follow up	COO	Q2	Q2/3	Follow up on 16/17 work and briefing	WIP w/c 9/10. Draft report and ok from MT on 13/11. Now FINAL	n/a	Dec
PCIC incident management (rolled forward at request by PCIC)	COO	Q3/4	Q3/4	Review process for managing incident that cut across other areas.	To commence as per plan.		April

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Specialist Services Private Patients	COO	Q2/3	Tba? 18/19	Follow up on 16/17 work and briefing	Additional work required, prior to finalising old 16/17 report. 18/19 for follow up.		n/a
Workforce management							
Consultant Job Planning	Medical Director.	Q2-3	Q2-3	Review controls in place to manage key risk areas within the process**.**	Brief agreed. Planned for commencement. October / Nov. Field work progressing.	WIP	Feb
Nurse Revalidation	***Nursing***	***Q2-3***	***Q2-3***	***Review controls in place to manage key risk areas within the process.***	***Draft report – responses received 8/11*** ***Now Final***	***Reasonable***	***Decem ber***
Organisational Values	Director of Workforce & OD.	Q3/4	Q3/4	Review controls in place to manage key risk areas within the process.	To commence Q3. Brief agreed for commencement.	WIP	April
Capital and Estates							
Sustainability Reporting	Director of Planning	Q1-2	Q1-2	To provide an opinion that robust systems are in place to record and report minimum sustainability requirements as required by WG.	Final report Reasonable assurance. .		Septem ber

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Model Ward	Director of Planning	Q1-2	Q3	Review arrangements following trial three month period	Brief agreed. Field work October/ November. Awaiting completion of last phase of fieldwork, one financial info ready.	WIP	Februar y
Cleaning Standards	*Director of Planning*	*Q1-2*	*Q2*	*Review current Service Provision.*	*Now Final. Field work completed. Draft report being prepared. Sept. Awaiting management comments. Comments from GW 13/11 and Exec sign off.*	*Limited*	*Decem ber*
Commercial Outlets	*Director of Planning*	*Q1-2*	*Q4*	Review arrangements for commercial outlets (inc. Aroma and spar UHL)	*Requested that work delayed until Q4 as internal work ongoing. Brief prepared.*		*April*
Carbon Reduction Commitment	Director of Planning	Q2/3		To ensure the Health Board complies with the requirements of the Order and that the information held is accurate, complete and the purchase of the credits is based upon actual usage or informed estimates.	Draft report issued 7/9/17. Final 12/10		Decem ber
Neo Natal	Director of Planning	Q2/3		To review key aspects of the schemes	Planning. Field work September/October. Won't make December audit committee.		Decem ber /feb.

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Rookwood Relocation	Director of Planning	Q2/3		To review key aspects of the schemes	planning		February
Shaping Future Wellbeing Schemes	Director of Planning	Q2/3		To review key aspects of the early part of a scheme.	planning		April

APPENDIX B

Follow-up Summary Report

1. Introduction

This report provides the Audit Committee with a summary of the current progress against the implementation of the agreed management actions from previously finalised Internal Audit reports.

The approach taken to verifying the level of progress made with the implementation of the agreed management actions varies depending on the overall assurance rating of the original report.

For 'Reasonable' or 'Substantial' assurance reports the level of progress is initially established via an Email request to the relevant managers. They are requested to provide information on the current position for each of the agreed management actions from the original report along with any relevant evidence to support the level of progress. Following review of the initial response / evidence Internal Audit will obtain any required additional evidence or carry out follow-up testing as deemed appropriate to verify the stated level of progress.

For 'Limited' or 'No' assurance reports a detailed follow-up review will be undertaken in order to establish the level of progress made and determine the up-dated level of assurance that can be provided. The outcome of these detailed follow-up reviews will be reported to the Audit Committee via the production of separate, individual follow-up reports.

2. Summary of Findings

The current follow-up position for each of the individual reports that have been finalised since April 2016 is summarised within Appendix A below.

The outcomes for those follow-ups that have been completed since the last meeting of the Audit Committee are as follows:

CUHB1718.28 – SPS CB Medical Staff Study Leave

The report was finalised May 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by November 2017.

As at 03/10/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	0	-	-	-
MEDIUM	5	4	1	-
LOW	2	2	-	-
TOTAL	**7**	**6**	**1**	**-**

CUHB17.34 – Dental CB – Medicines Management

The report was finalised in April 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by August 2017.

As at 09/09/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	1	-	-	1
MEDIUM	0	-	-	-
LOW	2	-	-	2
TOTAL	**3**	**-**	**-**	**3**

The Clinical Board were unable to progress the actions within the original agreed timescale as the UHBs Medicines Policy had not been updated. A revised timescale of December 2017 has been agreed.

8

CUHB1718.35 – Cardiff Community Resource Team

The report was finalised May 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by May 2017.

As at 19/09/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	0	-	-	-
MEDIUM	1	1	-	-
LOW	4	4	-	-
TOTAL	**5**	**5**	**-**	**-**

CUHB1718.43 – Dental CB – Medical Devices

The report was finalised January 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by May 2017.

As at 09/09/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	2	2	-	-
MEDIUM	2	2	-	-
LOW	1	1	-	-
TOTAL	**5**	**5**	**-**	**-**

CUHB1718.45 – Operational Services Rotas

The report was finalised September 20176 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by January 2017.

As at 15/09/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	2	2	-	-
MEDIUM	2	2	-	-
LOW	0	0	-	-
TOTAL	**4**	**4**	**-**	**-**

CUHB1718.48 – Medicine Specialling

The report was finalised May 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by August 2017.

As at 06/09/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	1	-	1	-
MEDIUM	6	4	2	-
LOW	1	-	1	-
TOTAL	**8**	**4**	**4**	**-**

For the partially complete actions, extensive work has been undertaken to review and update guidance but this is still to be formally approved and embedded. A revised timescale of November 2017 has been agreed.

Follow ups in progress

In addition to the completed follow-ups detailed above, a further 6 follow-up schedules have been issued to date. Responses are currently being pursued from management for these.

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Follow-up Summary Report

Table 1 – Follow-up position

Assignment Reference	Title	Assurance Rating	Final Report Issue Date	Proposed Follow Up Date	Follow Up Commenced	Follow Up Completed	Total No. of Recs	No. of Recs Actioned	No. of Recs Partially actioned	No. of Recs Not Actioned
CUHB1617.01	Risk Assurance	Reasonable	Sep-16	Dec-16	Aug-17	Sep-17	2	2	0	1
CUHB1617.03	Policy Management	Reasonable	Sep-16	Feb-17	Aug-17	Sep-17	6	6	0	0
CUHB1617.04	Health & Care Standards	Reasonable	Sep-16	n/a			0			
CUHB1617.05	WRP Claims Reimbursement	Substantial	Feb-17	n/a			0			
CUHB1617.06	Public Health Targets - Obesity	Reasonable	Feb-17	Jun-17	Aug-17	Sep-17	3	1	0	2
CUHB1617.08	Patient Access	Substantial	May-17	Aug-17	Sep-17		3			
CUHB1617.09	Core Financials	Substantial	Apr-17	Nov-17			6			
CUHB1617.11	Waiting List Initiatives	Limited	May-17	Nov-17			11			
CUHB1617.12	Annual Quality Statement	Substantial	Oct-17	May-17	June-17	Aug-17	3	3	0	0
CUHB1617.13	Clinical Audit Follow up	Reasonable	Mar-17	n/a						
CUHB1617.15	Quality Governance - surgery	Reasonable	Sep-16	Jan-17	May-17	Aug-17	6	2	3	1
CUHB1617.16	Quality Governance - medicine	Reasonable	Sep-16	Jan-17	May-17	Aug-17	5	1	4	0
CUHB1617.17	Quality Goverance – c&w	Substantial	Sep-16	Jan-17	May-17	Aug-17	6	3	2	1
CUHB1617.18	Quality Governance - pcic	Substantial	Jul-16	Jan-17	May-17	Aug-17	4	0	3	1
CUHB1617.19	Quality Governance - mental health	Reasonable	Aug-16	Jan-17	May-17	Aug-17	6	2	2	1
CUHB1617.20	Quality Goverance - cdt	Substantial	Jul-16	Jan-17	May-17	Aug-17	5	4	1	0
CUHB1617.21	Quality Governance - sps	Reasonable	Sep-16	Jan-17	May-17	Aug-17	5	3	2	0
CUHB1617.22	Quality Goverance - dental	Reasonable	Jun-16	Jan-17	May-17	Aug-17	5	0	4	1
CUHB1617.24	Records Management Follow up	Reasonable	Jul-17	n/a			5			
CUHB1617.25	Blue Spier IT System	Reasonable	Apr-17	Jul-17	Aug-17		6			
CUHB1617.27	Surgery CB Med Staff Study Leave	Reasonable	Feb-17	Jun-17	Aug-17		7			
CUHB1617.28	SPS CB Medical Staff Study Leave	Reasonable	May-17	Sep-17	Sep-17	Oct-17	7	6	1	0

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Follow-up Summary Report

Table 1 – Follow-up position

Assignment Reference	Title	Assurance Rating	Final Report Issue Date	Proposed Follow Up Date	Follow Up Commenced	Follow Up Completed	Total No. of Recs	No. of Recs Actioned	No. of Recs Partially actioned	No. of Recs Not Actioned
CUHB1617.29	Children & Women CB - Staffing	Reasonable	Feb-17	Jun-17	Aug-17	Sep-17	3	3	0	0
CUHB1617.32	CD&T CB - Radiology Treat-In-Turn	Substantial	Apr-17	Aug-17	Aug-17		1			
CUHB1617.33	SPS CB - Patientcare IT System	Limited	Apr-17	Sep-17	Sep-17		8			
CUHB1617.34	Dental CB - Medicines Management	Reasonable	Apr-17	Jul-17	Aug-17	Oct-17	3	0	0	3
CUHB1617.35	Cardiff Community Resource Team	Substantial	May-17	Sep-17	Sep-17	Sep-17	5	5	0	0
CUHB1617.36	Med Locums / MEDACS Follow up	Reasonable	Apr-17	n/a						
CUHB1617.37	Leavers Management Follow up	Reasonable	Apr-17	n/a						
CUHB1617.38	Sustainability Report	Reasonable	Sep-17	May-17			7	5	2	0
CUHB1617.40	PCIC CB - Locality Stock	Limited	Feb-17	Jul-17			8			
CUHB1617.41	Mental Health CB - Information Gov	Reasonable	May-17	Jul-17	Aug-17		3			
CUHB1617.42	CD&T CB - Information Governance	Substantial	May-17	Jan-18			3			
CUHB1617.43	Dental CB - Medical Devices	Reasonable	Jan-17	Aug-17	Sep-17	Sep-17	5	5	0	0
CUHB1617.44	Estates Timesheets Follow up	Reasonable	Dec-16	n/a						
CUHB1617.45	Operational Services Rotas	Reasonable	Jan-17	Jul-17	Aug-17	Sep-17	4	4	0	0
CUHB1617.46	Continuing Health Care (CHC)	Limited	May-17	Nov-17			8			
CUHB1617.47	IMTP	Reasonable	May-17	Jan-18			8			
CUHB1617.48	Medicine CB Specialling	Reasonable	May-17	Aug-17	Sep-17	Sep-17	8	4	4	0
CUHB1617.49	Medicine CB - Med Rotas & Sickness	Reasonable	Sep-17	Dec-18			3			
CUHB1617.51	Theatres Stock Follow up	Reasonable	May-17	n/a						
CUHB1617.52	MH CB - CHC / Out of Area Patients	Reasonable	Apr-17	Aug-17	Aug-17		4			
CUHB1617.54	Llanishen Stores Follow up	Reasonable		n/a						
CUHB1617.56	Health & Care Standards	Reasonable	May-17	n/a						

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Follow-up Summary Report

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GIG CYMRU NHS WALES
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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Cardiff and Vale University Health Board

National Standards for Cleaning in NHS Wales

Final Internal Audit Report

2017/18

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NHS Wales Shared Services Partnership

Audit and Assurance Services

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Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of the National Standards for Cleaning in NHS Wales (the 'Cleaning Standards') was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board.

The Health Board has a responsibility to ensure that healthcare premises are clean and that risks from inadequate or inappropriate cleaning have been reduced to the lowest possible level. All cleaning related risks should be identified and managed on a consistent long-term basis, irrespective of where the responsibility for providing cleaning services lies.

The National Standards for Cleaning in NHS Wales were originally published in July 2003. These have now been revised and new standards were published in December 2009. This revision occurred following the publication of Free to Lead, Free to Care (2008) and the introduction of Health Care Standards (2005). They also reflect the advice and guidance within Healthcare Associated Infections – A Strategy for Hospitals in Wales (2004).

The Standards provide a framework which outlines how the Health Board can demonstrate the achievement of minimum levels of cleanliness and the method of assessment, rather than how services should be provided.

The Health Board has adopted the credits for cleaning system (C4C) which is mandated within the National Standards of Cleanliness. C4C facilitates cooperation between facilities, nursing, housekeeping and estates staff. Initially rolled out to all major hospitals, the system is now required to be used to monitor standards of cleanliness across all NHS healthcare sites. It requires the ward sister/charge nurse to 'sign off' audit results, enabling greater levels of consistency of monitoring.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of the Cleaning Standards, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if the Health Board has appropriate processes in place to enable it to comply with the National Standards for Cleaning in NHS Wales.

The areas that the review will seek to provide assurance on are:

- The Health Board has clear management, supervisory and staffing arrangements in place for environmental cleanliness including Executive responsibility and a multi-disciplinary group;
- The Health Board has an appropriate and up to date environmental cleanliness strategy, cleaning plans and operational policies / procedures in place;

- Effective processes are in place for obtaining the views of patients and their representatives and utilising them to evaluate the cleanliness strategy and cleaning plans;
- Processes are in place to ensure that all cleaning and domestic staff receive appropriate levels of training;
- Cleaning service provision within the Health Board is effectively prioritised via a risk based assessment, in accordance with the criteria stated within the Cleaning Standards and includes a stand-alone 'rapid response' service;
- Regular audits of cleanliness outcomes are appropriately undertaken across the Health Board and are scored in accordance with the monitoring schedule provided by the All-Wales monitoring tool. Instances of poor performance identified are appropriately reported and addressed;
- Performance against the standards is regularly reported to appropriate management and groups / committees throughout the Health Board including departments, Directorates, Clinical Boards and Executives; and
- How the Health Board's performance against the standards compares to that of other Health Board's within Wales.

3. Associated Risks

The potential risks considered in this review are as follows:

- Risk of infection for patients / health and safety risk for the public and staff;
- Areas of poor performance are not identified or addressed; and

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of Cleaning Standards is **Limited Assurance.**

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The Health Board has clear management, supervisory and staffing arrangements in place for environmental cleanliness with overall operational responsibility split across two teams, North and South. A stand-alone 'Rapid Response' team is also in place under the responsibility of the Portering service.

Functional areas across the Health Board have been identified and risk assessed in line with the requirements and guidance set out in the Standards. The Health Board has taken the decision to focus its cleaning resources on those areas identified as high or very high risk in order to minimise the risk of infection.

Regular technical cleaning audits are carried out by supervisors as part of the C4C process. The reported audit results demonstrate that the Health Board is meeting the required scores in the majority of 'Very High' and 'High' risk areas. However, we identified a number of significant weaknesses with the current process for carrying out and scoring the technical audits. These weaknesses mean that the Health Board can't be assured that the reported scores are accurate and therefore that it is meeting the requirements of the Cleaning Standards. This is the main reason for the current limited assurance rating.

Whilst the Health Board has robust operational cleaning procedures in place and effective training for cleaning staff, we identified a number of further issues including the lack of an appropriate multi-disciplinary group to oversee cleanliness, the need to develop a separate Cleaning Operational Plan and The need to carry out managerial audits.

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5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Risk of infection for patients / health and safety risk for the public and staff			✓	
2	Areas of poor performance are not identified or addressed		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

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Design of Systems/Controls

The findings from the review have highlighted 4 issues that are classified as weakness in the system control/design for Cleaning Standards.

Operation of System/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the operation of the designed system/control for Cleaning Standards.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk 1: Risk of infection for patients / health and safety risk for the public and staff

The following areas of good practice were noted:

- Review of Organisational Charts shows that the Health Board has clear management, supervisory and staffing arrangements in place for environmental cleanliness which has been split across the two sites - University Hospital Wales (UHW) and University Hospital Llandough (UHL).
- Overall accountability for all aspects of cleanliness and cleaning staff rests with the Chief Executive and the Board. The Executive Director of Planning has responsibility for the operational management of environmental cleanliness.

- The Health Board has Standard Operating Instructions in place for cleaning services and these are used across both UHW and UHL which ensures that the expected standard of cleaning is consistent across both sites. Additionally there is a cleaning training manual in place and this also details how areas are to be cleaned.
- Patient views are obtained via '2 Minutes of you Time' patient feedback and feedback obtained from National Surveys which includes the question "Thinking of the place you received your care, how clean was it?" We note from our review of feedback received that the majority of respondents noted that they found the premises to be very clean - which was the highest rating available.
- The service has a training manual in place and all staff complete mandatory training that ensures they are trained to the level required by the Standards.
- Housekeeping supervisors have received the relevant training on using the Credits for Cleaning (C4C) system in order to carry out the cleaning technical audits.
- Areas to be cleaned have been broken down into risk based functional areas (Very High Risk; High Risk; Significant Risk and Low Risk) in line with the requirements of the standards. Our sample testing of 10 functional areas confirmed that the assessed level of risk was in line with the standards.
- The Health Board uses the C4C system and as such the items to be cleaned have been accounted for in terms of the 49 generic elements set out in the standards. This has been confirmed from our review of the C4C Cleaning Audit Score Sheet report.
- Both sites have a stand-alone 'Rapid Response' team which sits within the Portering Services.

The following findings were noted:

- The Health Board does not currently have a multi-disciplinary standard of cleaning Group in place with responsibility for implementing the National Standards for Cleaning. Whilst it is acknowledged that regular reports on the cleaning standards are provided to other groups including the Quality, Safety and Experience (QS&E) Committee and Infection Prevention and Control (IP&C), having a specific Group is a requirement of the Cleaning Standards.
- At the time of our review the Health Board did not have a separate Operational Plan in place as required by the Standards. However, we acknowledge that the Cleaning Strategy in place includes a baseline assessment that had been carried out against the standards which could form the basis for an Operational Plan.

Risk 2: Areas of poor performance are not identified or addressed

The following areas of good practice were noted:

- Performance against the standards is appropriately reported at all levels within the Health Board including Functional areas audited; Infection Control and the Quality, Safety and Experience Committee who report to the Board.
- The Health Board uses targets as set out in the Standards as the indicative aims for each of the four risk categories for assessing performance. These are; Very High (98%); High (95%); Significant (85%) and Low (75%).
- The reported C4C audit scores for the 4 week period from 24/07/17 to 20/08/17 indicate that the Health Board met the targets within all but a small minority of the very high and high risk areas. However the findings detailed below illustrate that the reported scores may not be fully reliable.

The following findings were noted:

- The results of cleaning technical audits are not being signed off by the ward sister/charge nurse, as required by the Standards.
- The Health Board is not currently carrying out managerial audits at either site.
- We identified inconsistencies between the two sites in the reporting of the results of the cleaning technical audits.
- We identified inconsistencies in the completion and frequency of technical audits. Some high / very high risk areas are not always being audited as required whilst low risk areas are being completed.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**4**	**0**	**6**

Finding 1 - Multi-Disciplinary Standard of Cleaning Group (Control design)	Risk
Standard 1.5 requires that each Health Board **must** ensure a multi-disciplinary standard of cleaning group is in place with responsibility for implementing the Standards and reporting to the Executive Board Member on progress made against the objectives at least twice a year, and that an annual report is submitted to the Executive Board. The Standards detail that anticipated membership of the group be drawn from the following areas: • Patient representative group (e.g. CHC). • Domestic Management. • Hotel Services. • Estates Department. • Infection Control Nursing. • Patient Representative. • Staff Representative and/or Union Representative. • Ward/Departmental Representative. We acknowledge that Appendix 1 of the Cleaning Strategy details the Terms of Reference for the Healthcare Environment Steering Group which includes representation from the groups listed above. However, at the time of our review this Group was no longer in existence. As mentioned in the good practice above, performance against the Standards is reported to a number of Health Board committees and Groups including the QSE and IP&C Committees. The attendance at these committees covers the majority of the anticipated membership for the multi-disciplinary group which therefore partly mitigates the risk of not having a specific group in place.	Risk of infection for patients/ health and safety risk for the public and staff.

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Recommendation	Priority level
The Health Board should ensure that there is a Multi-Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened.	Medium
Management Response	**Responsible Officer/ Deadline**
Formerly add the Cleaning Standards requirement into one of the existing forums described above into the same agenda. This will save additional meetings and labour resources.	Lee A Wyatt, Jan 2018

Finding 2 – Completion of Technical Audits (Operating effectiveness)	Risk
The reported technical audit scoring process is inconsistent across both sites. At UHW the technical audit is undertaken and this is the score that is reported on the C4C Cleaning Audits reports. At UHL the technical audit is undertaken and remedial action is taken to rectify any fails. Management override the initial technical audit carried out and re-take the technical audit; this is the score that is reported for UHL on the C4C Cleaning Audit Reports. Whilst it is acknowledged that the scoring method utilised within UHL is deemed acceptable as part of the C4C process, the current inconsistency across the 2 sites means that the reported levels of performance are not directly	Areas of poor performance are not identified or addressed.

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comparable. The 'C4C 13 Week Review - Cleaning Audits' report was obtained for both UHW and UHL covering the period 2 January 2017 to week commencing 27 March 2017. We selected a sample of 10 technical audit scores from the reports including 'Very High Risk' and 'High Risk' areas across all weeks (five relating to UHW and five relating to UHL). We obtained the 'C4C Audit Score Sheets' for the sample selected to confirm that the audit undertaken agreed to the report. Two of the Sheets did not agree to the reported technical audit score on the 'C4C 13 Week Review - Cleaning Audits' Report. Both score sheets related to UHL. No explanation was provided for the anomaly, however it could be due to the overriding of the scores as described above.	
Recommendation	**Priority level**
The Health Board should ensure that a consistent approach is used for reporting the technical audit scores across the 2 sites and that accurate scores are reported for all completed audits.	Medium
Management Response	**Responsible Officer/ Deadline**
On checking with C4C both approaches were in accordance with the system and standards, however Facilities will review their approach and standardise when and if appropriate.	John Smith, Jan 2018

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Finding 3 - Ward Staff Sign-off (Control design)	Risk
The Standards require that technical audits are undertaken by the domestic supervisor and are signed off by the ward sister/charge nurse, where appropriate. We sample tested 10 technical audits carried out (five from UHW and five from UHL). No evidence of ward sister/charge nurse sign off was available for any of the 10 technical audits sample tested.	Areas of poor performance are not identified or addressed.
Recommendation	**Priority level**
An appropriate member of the Ward staff should sign off the technical audits undertaken by the domestic supervisor.	High
Management Response	**Responsible Officer/ Deadline**
Facilities to coordinate and request clinical support on audit. Ward Sisters and Charge Nurses will be reminded of their responsibility to, when requested check the validity of the audit and sign off.	Sarah Maggs, Nov 2017 Acting Deputy Nurse Director, Nov 2017

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Finding 4 - Managerial Audits not carried out (Control design)	Risk
The standards detail the following in respect of Managerial Audits: ***Managerial.*** *These are planned audits that should verify cleaning outcomes of technical audits and identify any areas for improvement. The audit team should consist of senior domestic management, ward sisters/charge nurses with responsibility for cleaning, infection control and estates. These audits are undertaken at least quarterly to ensure a representative sample is achieved during a twelve month period. The team validates a sample of technical audit information by sampling some elements across all functional areas, some room types or one or more functional areas. The decision concerning the scale of the review is based upon cleanliness levels already achieved; where the team feel emphasis should be placed; or randomly chosen elements, rooms or functional areas generated by the All-Wales Monitoring Tool.* At the time of our review managerial audits were not being undertaken within the Health Board.	Areas of poor performance are not identified or addressed.
Recommendation	**Priority level**
The Health Board should carry out managerial audits on a quarterly basis in line with the requirements of the Standards.	High
Management Response	**Responsible Officer/ Deadline**
Facilities Staff to arrange audit schedule and invite ward staff to participate with good prior arrangements in place.	Lee A Wyatt, Jan 2018

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Finding 5 - Cleaning Strategy & Operational Plan (Control design)	Risk
The Health board has a Cleaning Strategy in place which was approved by the Quality Safety and Experience Committee in September 2015. Review of the strategy showed that it is potentially over detailed in comparison to the exemplar plan within the Standards. The standards require that the Health Board should also have an Operational Cleaning Plan in place which should include the following as a minimum: • The requirements of the standard; • An audit of compliance with the standard covering: A) all existing work schedules; B) all existing service level agreements; and C) all existing service specifications. • A detailed plan for any changes required in (a) to (c) above; and • A briefing paper for feedback into the strategy document. At the time of our review the Health Board did not have an Operational Cleaning Plan in place. However, we acknowledge that the Cleaning Strategy in place includes a baseline assessment that had been carried out against the standards which could form the basis for an Operational Plan. We also noted that the Health Board's Cleaning Strategy makes reference to the Healthcare Environment Steering Group (HESG). However, this group is no longer in existence.	Risk of infection to patients / health and safety risk for the public and staff.

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Recommendation	Priority level
Management should update the Cleaning Strategy and develop an Operational Cleaning Plan in line with the requirements of the Standards.	Medium
Management Response	**Responsible Officer/ Deadline**
Facilities Senior Management to develop and disseminate to the Cleaning Group for sign off and approval.	Lee A Wyatt, March 2018

Finding 6 – Completion of technical audits (Operating Effectiveness)	Risk
Review of the '13 Week Review - C4C Cleaning Audits' Reports showed that there were gaps in the reports indicating that the cleaning technical audit had not been carried out on some functional areas that had been assessed as 'Very High Risk' areas. However, review of the report for the same week showed that audits had been carried out on lower risk areas. Additionally, there are inconsistencies in the frequency that the technical audits are carried out across the two sites. Review of the 13 week report of UHL shows that almost all risk areas Very High Risk to Low Risk are audited on a weekly basis which is more than the required frequency as recommended in the Standards	Areas of poor performance are not identified or addressed.

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Recommendation	Priority level
Management should ensure that technical audits are completed on all high / very high risk areas as per required timescales.	Medium
Management Response	**Responsible Officer/ Deadline**
Facilities to review audit schedule and make clear programme to Senior Management, stating UHB priorities.	Sarah Maggs, Jan 2018

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Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Cardiff and Vale University Health Board

Internal Medicine Directorate Mandatory Training and PADRs

Final Internal Audit Report

2017/18

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NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Steve Curry – Chief Operating Officer
Distribution:	Geraldine Johnston - Director Of Operations And Delivery Cari Randall – Internal Medicine Directorate Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of Mandatory Training and Personal Appraisal and Development Reviews (PADRs) within the Medicine Clinical Board was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board.

All staff members within the Health Board are required to complete the 13 Core Skills Training Framework (CSTF) modules in order to comply with Statutory & Mandatory Training as required by legislation, policy or best practice.

As part of the Agenda for change agreement, annual reviews are a mandatory requirement for all staff. A Personal Appraisal and Development Review (PADR) should be completed each year for all staff in order to identify objectives and measure achievement against them and also assess required / current skill levels and identify training required to close any gaps or shortfalls.

The relevant lead Executive Director for this review is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Medicine Clinical Board for the management of mandatory training and PADRs, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if appropriate processes are in place within the Clinical Board to ensure that all staff members comply with statutory and mandatory training requirements and annual PADRs are effectively planned and completed.

Detailed testing as part of the review was undertaken within the following 4 areas of the Internal Medicine Directorate:

- Directorate Office;
- Ward C7 Medical at UHW,
- Ward East 4 at UHL; and
- Ward B7 Respiratory at UHW.

The areas that the review sought to provide assurance on were:

- Appropriate and up to date policies and procedures are in place for the completion of Statutory & Mandatory training and PADRs;
- All staff members have completed all required levels of Statutory & Mandatory training within the stipulated timescales;
- Managers comply with policy and ensure PADRs are appropriately completed each year for all relevant staff within the Clinical Board;

- Evidence of completed PADRs is retained for future reference and / or review; and
- Appropriate processes are in place within the Clinical Board to monitor the levels of completion of Statutory & Mandatory training and PADRs. Regular reports on compliance levels are produced and distributed to appropriate staff / groups / committees and actions are taken to address identified issues.

3. Associated Risks

The potential risks considered in this review were as follows:

- Staff members are not appropriately trained;
- Staff performance isn't effectively assessed and addressed; and
- Non-compliance with PADR or training requirements isn't identified or addressed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of mandatory training and PADRs within the Internal Medicine Directorate is **Limited assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The level of compliance for completion of PADRs over the past year is deemed low within the Internal Medicine Directorate, with just over half of PADRs completed in the areas tested. This issue can effect staff due to the introduction of the NHS Wales Pay Progression Policy within the Health Board.

There were other issues identified with PADRs, including staff not being set individual objectives or given Personal Development Plans and there is a lack of tracking being undertaken as part of the PADR to compare progress against the prior year.

There were a number of more significant issues identified in relation to Statutory & Mandatory Training. Low compliance levels were identified across the areas audited, with a compliance rate of 60.15% over the sample selected. Issues also arose with ESR, audit found not all staff are placed under a hierarchy and therefore no one in the directorate has access to their information.

Statutory & Mandatory Training compliance levels are not currently being recorded within ESR and reports are therefore not being received from the Learning and Education Department (LED). The Head of Workforce and OD does receive a list of PADR compliance by Directorate and shares this with each Directorate. There are also processes in place within the Directorate to monitor the level of compliance for both PADRs and Statutory & Mandatory Training, however there are a number of issues identified that are currently affecting the accuracy of the figures and it was found that in the case of Statutory & Mandatory training there was no evidence that the compliance rate is being reported at the Clinical Board level.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Staff members are not appropriately trained		✓		
2	Staff performance isn't effectively assessed and addressed		✓		
3	Non-compliance with PADR or training requirements isn't identified or addressed		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for mandatory training and PADRs within Internal Medicine.

Operation of System/Controls

The findings from the review have highlighted six issues that are classified as weakness in the operation of the designed system/control for mandatory training and PADRs within Internal Medicine.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK 1: Staff Members are not appropriately trained

No areas of good practice were noted by Audit.

The following significant findings were identified:

- There was no hierarchy set up within ESR for one of the wards selected with the employees not assigned to anyone within the Directorate;
- Out of a combined total of 325 mandatory training modules expected to be completed by the employees selected, 176 had been completed, 24 modules had been completed but had expired and 125 had not been completed; and
- The overall Mandatory training compliance rate for the staff sampled was only 60.15%.

The following issue was noted as part of the review:

- The Health Board has policies in place for both PADRs and Statutory & Mandatory training; these are available to all staff via the intranet. However it was noted that the Mandatory Training policy is out of date and does not reflect the current mandatory training modules. It is acknowledged that this is a corporate issue beyond the control of the Internal Medicine Directorate and as such has been communicated separately to Workforce management. The policy is currently under review by the owner and is due to be issued out for consultation in October 2017. The issue is included within this report for completeness but has not contributed to the overall assurance rating for the review.

Risk 2: Staff performance isn't effectively assessed and addressed.

The following areas of good practice were noted:

- There is a corporate policy in place (conducting Personal Appraisal Development Reviews (PADRs) Policy) which is available via the UHB's Clinical Portal, Intranet and Internet sites;
- 5 employees were sampled in the Directorate office, all five had a PADR completed within the last 12 months, with each PADR completed fully and correctly with both organisational and individual objectives set and all being assigned a personal development plan;
- The Directorate office store all previous PADRs electronically for

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directorate staff, with all five sampled having the previous year PADR saved on file; and

- Current year and previous years PADRs within the Directorate office were reviewed which showed evidence of tracking and monitoring of PADRs requirements during the year and on a year on year basis.

The following significant findings were identified:

- 15 of the 35 sampled staff did not have a PADR on file completed within the last 12 months;
- Audit therefore reviewed the 20 available PADRs and the following findings were identified:
  - 6 were completed using the old format;
  - 5 set organisational objectives but did not include individual objectives or a personal development plan;
  - 5 were not signed by the employee and 3 were not signed by the reviewer/manager;
- Ward C7 staff completed their PADRs via a training day as a group. Staff were reviewed and assigned objectives as a group not on an individual basis;
- Out of an expected 30 PADRs (5 new starters not expected to have a PADR) for the previous period, 14 could not be located by audit to compare objectives to the current PADR to see if monitoring and tracking occurs on a year on year basis; and
- No area sampled were uploading the PADR review dates onto ESR.

Risk 3: Non-compliance with PADR or training requirements isn't identified or addressed.

There was no area of good practice identified.

The following significant findings were identified:

- PADR compliance reports are being run based on the figures from an out-dated database held within the Directorate Office, the database also contains out-dated Statutory & Mandatory dates as well as an out-dated staff list;
- PADR compliance rates are not always reported within the Directorate Performance Reviews; and
- Statutory & Mandatory Training compliance rates have not been reported in the previous three Directorate Performance Review meetings.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**2**	**1**	**6**

Finding 1 - Completion of PADRs (Operating effectiveness)	Risk
Audit selected ten staff from each of three sampled Internal Medicine wards (C7 at UHW, East 4 at UHL and B7 at UHW) to establish if a PADR has been carried out within the last twelve months. Audit then checked if the PADRs had been fully and correctly completed with the PADR signed off as approved by both reviewee and reviewer with personal objectives set alongside a personal development plan. The findings for each ward were as follows: **Ward C7 Medical UHW** • 9 of the 10 employees sampled had not had a PADR completed within the last 12 months. • The one PADR completed within twelve months was completed using the old format. • Staff are completing PADRs on a training day, individual objectives and personal development plans were completed in groups and were not specific to each individual. **Ward East 4 UHL** • 1 out of 10 employees sampled had not had a PADR completed within the last 12 months. • 5 of 9 PADRs were completed using the old format. • 4 of 4 PADRs completed using the current format were not completed correctly, only organisational objectives were given no personal objectives or a personal development plan.	Staff performance isn't effectively assessed and addressed.

8.2

Ward B7 Respiratory UHW • 5 out of 10 employees sampled had not had a PADR conducted in the last 12 months. • 1 of the 5 PADRs completed was not dated with a review date. • 1 of the 5 PADRs completed did not set any personal objectives or create a personal development plan. • 5 of the 5 PADRs completed within the last 12 months were not signed by the employee. • 3 of the 5 PADRs completed within the last 12 months were not signed by the reviewer/manager.	
Recommendation	**Priority level**
Management should ensure that all staff within Internal Medicine undertake a PADR, which is completed in full with both organisational and personal objectives agreed by the reviewing manager and employee. Management should create a personal development plan for each employee to help achieve each objective set. Management must ensure that when completing the annual review with staff they are completing the latest and most up to date version of the PADR format.	**High**

8.2

Management Response	Responsible Officer/ Deadline
The Directorate has developed a Project Outline Document to support ward areas to complete PADR. This POD included timelines.	December 2017 Jane Murphy / Dave Pitchforth
The directorate has provided a trajectory of expected completion of PADRs.	March 2018 Jane Murphy / Dave Pitchforth
The directorate will share best practice to ensure learning.	November 2017 Jane Murphy / Dave Pitchforth
Bi-weekly operational meetings will now include PARD compliance as a standing agenda item.	December 2017
Implementation of Tier 1 target meetings chaired by Lead Nurse, this will include a robust discussion of actions required. Senior Nurses will support this robustly.	December 2017 and ongoing
*__Note –__the Directorate Team feels that the actual current position with regard to PADR compliance, since completion of the audit, is now more positive than the results of the sample testing within the report indicate.	

8.2

Finding 2 - Mandatory Training Level of Compliance (Operating effectiveness)	Risk
There are currently 13 core training modules expected to be completed by C&V staff members. Audit tested 5 Directorate support staff and 10 staff from each of the three sampled wards to establish their level of compliance with the required mandatory training. The findings for each area were as follows: **Directorate Support** • No member of staff sampled was 100% compliant on their statutory / mandatory training; • Out of a total of 65 core modules that should have been completed, two modules completed had surpassed the expiry date and 23 had not been completed; • Individual Compliance rates ranged from 30.77% to 84.62%; and • Overall compliance for the area based on the employees sampled was 61.54%. **Ward East 4 UHL** • No member of staff sampled was 100% compliant on their Statutory / Mandatory Training; • Out of a total of 130 core modules that should have been completed, ten modules completed had surpassed the expiry date and 60 modules had not been completed; • Individual Compliance rates ranged from 7.69% to 92.31%; and • Overall compliance for the ward based on employees sampled was	Staff members are not appropriately trained.

8.2

46.15%. **Ward B7 Respiratory Unit UHW** • 9 out of 10 members of staff were not 100% compliant on their Statutory/Mandatory Training; • Out of a total of 130 core modules that should have been completed, 11 modules completed had surpassed the expiry date and 43 modules had not been completed; • Individual compliance rates ranged from 15.38% to 100%; and • Overall compliance for the ward based on employees sampled was 66.15%. **C7 Medical UHW** Audit were unable to check the compliance matrix for the staff located in the ward as they were not included in the hierarchy on ESR. Personal files were checked for certificates but only one employee had any certificates to prove completion of training modules. The audit notes that LED and Workforce's compliance rates only reflect 10 modules with a plan to report on all 13 from April 2018.	
Recommendation	**Priority level**
Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	**High**

8.2

Management Response	Responsible Officer/ Deadline
The Directorate has assigned a member of the team to improve the mandatory training position. All colleagues have been reminded of their requirements. Signposting to where to access the training was provided. If required 'timeout' for colleagues will be provided. POD referenced above includes mandatory training fields – see above	March 2018 (Sarah Edwards Deputy DM, Jane Murphy / Dave Pitchforth) December 2017 (development of POD)

Finding 3 - Monitoring and Reporting (Operating effectiveness)	Risk
Audit were supplied with the previous three Performance Review meeting minutes for the Internal Medicine Directorate. From review of the minutes it was clear that PADR compliance is not always reported, the minutes also showed that Statutory & Mandatory training compliance rates have not been reported in the previous three meetings. From the Performance Review meeting dated 21/09/2017, it is minuted that PADRs were discussed within the meeting with the current compliance percentage supplied, the minutes show that the percentage figure was obtained from the database held within the directorate office, this database is currently out-dated as outlined in the issue 'Directorate Database' below. Statutory & Mandatory training was not discussed during the meeting due to the directorate 'waiting on data in relation to training'. For the Directorate Performance Review dated 01/05/2017 PADR compliance	Non-compliance with PADR or training requirements isn't identified or addressed.

8.2

rate was discussed within the meeting, however there was no reference to Statutory & Mandatory training or the compliance rate at the time. For the Directorate Performance Review dated 29/11/2016 both PADR and Statutory & Mandatory training were not discussed during the review based on the minutes. Based on the latest report from the Directorate Performance review for Internal Medicine the current PADR compliance rate is at 41.47%.	
Recommendation	**Priority level**
Management should ensure that workforce runs monthly reports that highlight the current PADR compliance rate and also separate reports highlighting the current compliance rate for Statutory & Mandatory Training. These reports should be fed back and reported on during the Directorate Performance Review as and when they are held.	**High**
Management Response	**Responsible Officer/ Deadline**
Key links with ESR team will be established and core reports determined, including circulation and frequency, this will ensure that any data discrepancies are highlighted to ensure accurate reporting. Accurate reporting of figures can be provided by Directorate team in due course. Issues to remain on Performance review agenda Operational meeting and Tier 1 meeting referenced above will review nursing position at ward level readily.	Cari Randall, January 2018 MCB November 2017 Jane Murphy December 2017 and ongoing

8.2

Ongoing training by Lead and Senior Nurse to support ward sisters to be able to undertake the process and ensure all reporting hierarchies are correct for reporting.	Jane Murphy December 2017 and ongoing

Finding 4 - Retention & review of PADRs (Operating effectiveness)	**Risk**
The personal files for the sampled staff were reviewed to establish if copies of PADRs from the previous year were retained in order to evidence effective monitoring of progress against previously agreed actions. The findings for each area were as follows: **Ward C7 Medical UHW** • Only two of the ten employees sampled had previous years PADRs stored within their personal files which were both signed and completed. • No individuals sampled have completed a PADR in the current period. • PADR dates are not currently being uploaded onto ESR. **Ward East 4 UHL** • Signed and completed paper copies of previous years PADR forms are stored within the individual's personal files within the ward office and viewed by audit, with the exception of one employee where no PADR completed during the period and another who was new to the organisation. • Audit found that five of the PADRs for the current year did not have personal objectives or personal development plans in place so were unable to determine if any tracking and monitoring had taken place on a	Staff performance isn't effectively assessed and addressed.

8.2

year on year basis. • PADR dates are not currently being uploaded onto ESR. **Ward B7 Respiratory UHW** • Four of the ten employees sampled were new to the Health Board and were not expected to have a PADR held in the personal file. Five out of the six remaining employees did not have the previous year's PADR held within the personal file.	
Recommendation	**Priority level**
Management should ensure that any completed PADRs are retained in employees personal files and recorded onto ESR as evidence the PADR has been completed. PADRs should be retained to support the reviewer when establishing progress against agreed objectives during the year and on a year on year basis.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Directorate has developed an POD to support ward areas to complete PADR. See above	December 2017 Jane Murphy / Dave Pitchforth
The directorate has provided a trajectory of expected completion of PADRs.	March 2018 Jane Murphy / Dave Pitchforth
The directorate will share best practice to ensure learning.	November 2017 Jane Murphy / Dave Pitchforth

8.2

Finding 5 - Directorate Database (Operating effectiveness)	Risk
The directorate office has an Excel document in place containing all staff within the directorate which records the dates of the most recent PADRs and the dates each statutory training module was completed. Audit found that the database was not kept up to date and did not contain new staff members, with old staff members for the directorate still held on the database. Also dates recorded for the mandatory training and PADRs were not reflecting the most recent completion dates.	Non-compliance with PADR or training requirements isn't identified or addressed.
Recommendation	**Priority level**
Management must ensure that the staff database is regularly maintained, with the deletion of staff that have left the directorate and the inclusion of new employees. Management must look to tie in the mandatory training dates with the ESR matrices to ensure they tie back to LED.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Role to be included in job description of Directorate Team	Cari Randall March 2018

8.2

Finding 6 - ESR (Operating effectiveness)	Risk
As part of the review the following issues were identified in relation to the use of ESR: • During the review Audit became aware that Internal Medicine were only placed on ESR as of the 1st July 2017. Since the introduction of the directorate onto ESR the ward managers and directorate office staff visited had stated that no training had been supplied by LED or Workforce on how to use ESR. They stated there was a power point training package available but were unsure how to access it; • Audit found that staff were having issues logging onto ESR with unknown user names and passwords. Once on ESR staff were having difficulty navigating the system and were unsure how to access the different functions; • Audit discovered during testing that a ward selected as part of the sample had not been assigned a hierarchy with both ward manager and deputy ward manager not having access to the staff's records. This was also the case for the senior nurse; and • Audit found that no areas within Internal Medicine were utilising the ESR function and were not uploading the PADR review dates.	Staff members are not appropriately trained.
Recommendation	**Priority level**
Management should ensure that all staff using ESR attends the training courses provided by LED/Workforce on how to use and utilise the ESR function. All ward managers and the senior nurse should check to see that there is a	**Low**

8.2

hierarchy in place within their area and that the hierarchy is correct and includes all members of staff under their management. The directorate should start uploading the review dates for individuals PADRs into ESR once they have been complete. This will assist Workforce when running compliance reports and also aid ward managers as it provides reminders when the next PADR review is approaching.	
Management Response	**Responsible Officer/ Deadline**
To be included in the reports for ESR to ensure all have access and training.	Cari Randall January 2018

8.2

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Discharge Planning – **Cardiff and Vale University Health Board**

Date issued: November 2017

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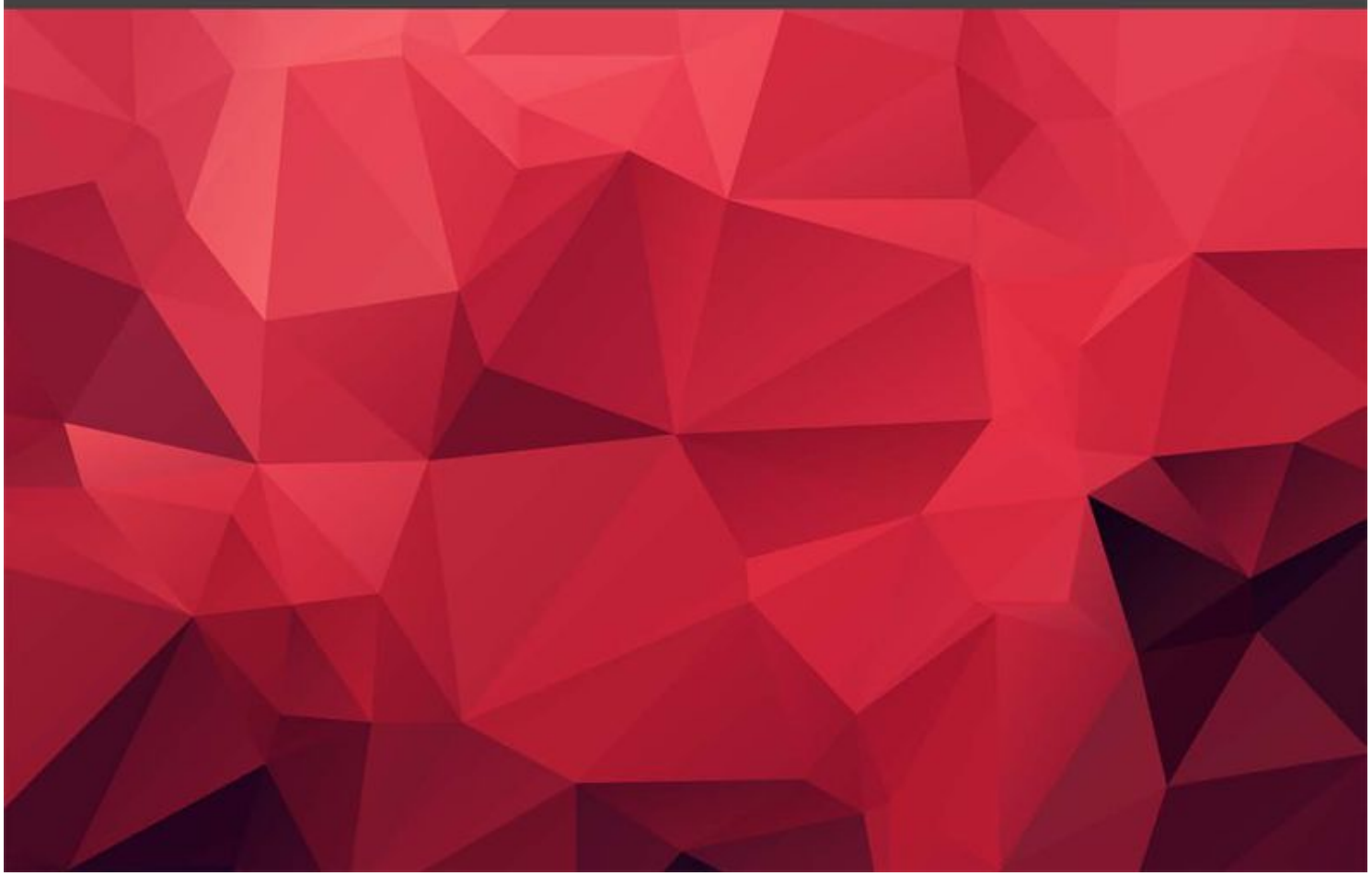

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

The team who delivered the work comprised Urvisha Perez and Matthew Brushett.

Contents

The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services.

9

Summary report

Background

1 Discharge planning is an ongoing process for identifying the services and support a person may need when leaving hospital (or moving between hospitals). The aim is to make sure that the right care is available, in the right place and at the right time. An effective and efficient discharge process is an important factor in good patient flow and key to ensuring good patient care and the efficient and effective use of NHS resources. Patient flow denotes the flow of patients between staff, departments and other organisations along a pathway of care from arrival at hospital to discharge or transfer.

2 Hospital beds are under increasing pressure, not least because of the loss of 1,800 beds across Wales over the last six years. Poor discharge planning can increase lengths of stay unnecessarily, which in turn can affect other parts of the hospital leading to longer waiting times in accident and emergency departments or cancellations of planned admissions.

3 Every year across Wales, there are approximately 750,000 hospital admissions and discharges. The discharge process is relatively straight forward or simple for 80% of patients leaving hospital. These patients return home with no or simple health or social care needs that do not require complex planning and delivery. For the remaining 20% of patients, discharge planning is more complex because of ongoing health and or social care needs, whether short or long-term.

4 For individual patients, many of whom are aged 65 or older, delays in discharge can lead to poorer outcomes through the loss of independence, confidence and mobility, as well as risks of hospital acquired infections, re-admission to hospital or the need for long-term support.

5 Despite the multiplicity of guidance to support good discharge planning,[1] [2] [3] work undertaken in 2016 by the NHS Wales Delivery Unit (the Delivery Unit) at all Welsh hospitals showed that there are opportunities to improve the discharge planning process, release significant inpatient capacity and improve patients' experiences and outcomes. Specific areas for improvement included:

- better working with community services;
- clearer and earlier identification of the complexity of the discharge to enable better facilitation of the discharge process;
- greater clarity around discharge pathways; and
- better information and communication with patients and families.

[1] Welsh Health Circular (2005) 035, **Hospital Discharge Planning Guidance**, 2005

[2] National Leadership and Innovation Agency for Healthcare, **Passing the Baton**, 2008

[3] National Institute of Clinical Excellence (NICE), **Transition between inpatient hospital settings and community or care home settings for adults with social care needs**, 2015

6 The Delivery Unit assessed the written evidence in case notes against specific requirements set out in 'Passing the Baton'[2]. The findings for Cardiff and Vale University Health Board (the Health Board) show that the patient discharge process was variable and largely poor when assessed against expected practice. Appendix 1 sets out the findings in more detail.

7 Many of the issues highlighted by the Delivery Unit have been common themes for years with limited evidence to suggest that discharge planning processes are seeing any real improvement. Given the growing demand on hospital services and continuing reductions in bed capacity, the Auditor General decided it was timely to review whether governance and accountability arrangements are robust enough to ensure that the necessary improvements are made to discharge planning.

8 This review examined whether the Health Board has sound governance and accountability arrangements in relation to discharge planning. Appendix 2 provides details of the audit methodology. The work focused specifically on whether the Health Board has:

- a sound strategic planning framework in place for discharge planning;
- effective arrangements to monitor and report on discharge planning; and
- taken appropriate action to manage discharge planning and secure improvements.

9 In parallel with this work, the Auditor General has also been undertaking a review of housing adaptation. This review focuses primarily on local authorities and registered social landlords given their respective responsibilities for managing and allocating Disabled Facilities Grants, Physical Adaptation Grants and other funding streams used to finance adaptations. There are clear links with discharge planning given that delays to fitting or funding housing adaptations can lead to delayed discharges. In addition, the Healthcare Inspectorate Wales has been examining the quality of communication and information flows between secondary and primary care in relation to patient discharge. The reports, setting out the findings of these two reviews, are intended to be published in autumn 2017.

Key findings

10 Our overall conclusion is: **The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services**. In the paragraphs below we have set out the main reasons for coming to this conclusion.

11 **Planning**: The Health Board has clear plans for improving discharge planning supported by comprehensive policies and pathways. We reached this conclusion because:

- there are clear plans for improving discharge planning, which have been developed with partners.

- the Health Board has a well-developed draft discharge policy, reviewed with partners, however patient and carers have not been involved in its review.
- the recently revised discharge pathways are comprehensive and form part of the draft discharge policy.

12 **Arrangements for supporting discharge**: Multiagency and multidisciplinary teams are available to support discharge but only during the week; staff training and awareness of policies and community services needs improvement. We reached this conclusion because:

- the Health Board has dedicated discharge resources, which are multiagency and multidisciplinary but these are available weekdays only.
- there is scope to improve staff training and raise awareness of policies, pathways and access to information about community services.

13 **Monitoring and reporting**: Overall, performance is improving; the Health Board has strong scrutiny arrangements for discharge planning and is taking positive steps to capture more meaningful information. We reached this conclusion because:

- there are clear lines of accountability and regular scrutiny of discharge planning performance, which includes partners.
- Board members generally feel informed about discharge planning performance, with action being taken to develop further the range of information available.
- performance is improving but it is too early to comment on whether this is linked to improvements in discharge processes.

Recommendations

Exhibit 1: recommendations

The table sets out the recommendations arising from the audit on discharge planning at Cardiff and Vale University Health Board. The Health Board's management response detailing how it intends responding to these recommendations is included in Appendix 3.

Recommendations	
R1	**Information on community health and social care services:** We found the Health Board collates a comprehensive range of information about community services but there is scope to strengthen ward staff knowledge and extend the range of data collated. The Health Board should: a. develop a system where ward staff are able to access up-to-date information about community health and social care services. b. review the range and frequency of data collated about community health and social care services. For example, waiting times for some services

Recommendations	
	and the frequency data on services available through other NHS bodies and housing options is collated.
R2	**Policy review:** We found that recently revised discharge and transfer of care and choice of accommodation policies were part of partnership action plans but we found no evidence that patients and carers were involved in the process. The Health Board should seek to involve patients and carers when the next policy revisions are due.
R3	**Staff awareness of policies and pathways:** We found that ward staff were unaware of discharge policies and pathways. Whilst these documents were under review at the time of the audit, staff should have been aware of previous iterations. The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.
R4	**Discharge planning training:** We found that staff training on discharge planning is patchy and that the Trust does not monitor compliance with training. Plans to improve training is included on the discharge improvement plans but staff told us that a lack of capacity on the wards is a barrier to attending training. The Health Board should: a. explore developing an e-learning course for discharge planning which ward staff may find more accessible. b. ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.

Detailed report

Part 1: the Health Board has clear plans for improving discharge planning supported by comprehensive policies and pathways

There are clear plans for improving discharge planning, which have been developed with partners

14 In October 2016, the Cabinet Secretary for Health, Wellbeing and Sport wrote to all NHS Chairs making clear his expectation that unscheduled care improvement plans would incorporate plans to improve discharge processes. The NHS Wales Planning Framework[4] also makes clear that organisations should specify how their plans support and improve patient flow. The focus of which should be on reducing admissions for the frail elderly through pro-active assessment and intervention, and discharging patients as early as clinically appropriate without unnecessary waiting.

15 Our audit work assessed the extent to which discharge planning is part of a wider strategic approach to improve patient flow. The Health Board area has three main plans for improving patient flow and discharge planning. These are: the Home First Plan, the Unscheduled Care Improvement Programme and the Cardiff and Vale Integrated Winter Plan. There are links between all three plans but their focus differs.

- the Home First Plan is the region's delayed transfer of care (DToC) action plan. It was developed by the Cardiff and Vale Integrated Health and Social Care (IHSC) Partnership[5] following a peak in DToCs in February 2015. This plan provides the strategic overview for work underway to improve DToCs and overall care for people needing care and support.
- the Unscheduled Care Improvement Programme aims to improve hospital inpatient processes and discharge and transfer arrangements.
- Cardiff and Vale Integrated Winter Plan details actions to enhance discharge arrangements to better manage winter pressures. The Health Board, Cardiff and Vale local authorities, third sector organisations[6] and the Welsh Ambulance Services Trust (WAST) jointly agreed the plan.

16 The Unscheduled Care Improvement Programme is based on recommendations from several reviews[7], including the Delivery Unit's discharge audit and good

[4] Welsh Government, **NHS Planning Framework 2017/20,** 2016

[5] The partnership includes representatives from the Vale of Glamorgan Council, Cardiff Council, the Health Board and third and independent sectors. The partnership is part of the Regional Partnership Board governance structure.

[6] Glamorgan Voluntary Services (GVS) and Cardiff Third Sector Council (C3SC).

[7] The document states that the programme 'is based on the recommendations of the Welsh National Unscheduled Care programme, Welsh, Scottish and English NHS guidance/best practice and the results of the Day of Care Audits and the Delivery Unit's

practice identified by others. The programme was established in autumn 2016 and at the time of our audit was still in its infancy. Phase 1 of the programme concentrates on short to medium term (12-18 months) improvements to inpatient processes and discharge arrangements. Phase 1 initiatives are split under the themes of 'keeping people well' and 'home first'.

17 'Keeping people well' focuses on stabilising and reducing demand, for example by educating patients on how to better manage their own care, increasing out-of-hours primary care support to reduce accident and emergency referrals, and minimising admissions from care homes. In addition, the Health Board is making traditionally hospital-based services or treatments available in the community, for example intravenous (IV) antibiotics.

18 'Home first' focuses on improving patient flow once a patient is within the hospital system. For example, by admission avoidance at the accident and emergency department, improving waiting times within the accident and emergency department, reducing waiting times for beds once a decision is made to admit a patient and ensuring patients stay in hospital for an appropriate length of time. It also details specific actions to improve the management of discharges and transfers of care by relaunching the discharge support service and reviewing available community pathways[8], to support patients once discharged from hospital.

19 The second phase of the programme seeks to support a joined-up and sustainable health and social care system. Much of these discussions are already progressing through the IHSC partnership and detailed within the Home First Plan.

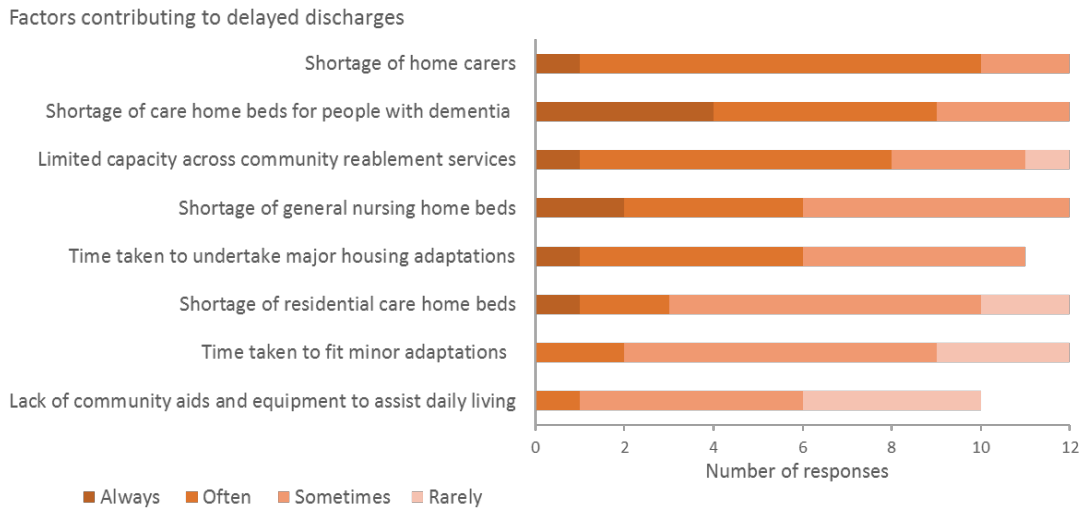
20 We asked NHS organisations what factors contribute to delayed discharges or transfers of care, to ascertain how well their plans seek to address the factors causing most problem. Exhibit 2 shows that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays to discharge or transfer of care.

Discharge Audit of Care at Cardiff and Vale Health Board. The programme 'has been informed by significant evidence on what works well and the damage caused by poor patient flow'.

[8] Community pathway include services such as community resource teams, acute response teams, palliative care teams and step-up and step down intermediate care facilities.

Exhibit 2: factors contributing to delayed discharges or transfers of care across NHS organisations

The chart shows the factors seen to contribute to delayed hospital discharges and transfers of care.



Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017[9]

21 The Health Board reported that the following issues always or often caused delays:

- a shortage of care home beds for people with dementia;
- the time taken to undertake major housing adaptations;
- a shortage of home carers; and
- a shortage of general nursing home beds.

22 In addition, the Health Board highlighted family issues such as disputes about choice of home or financial issues, or family (and staff) members being unavailable to take part in discharge planning meetings. Community service capacity, such as allocation of social workers, community nursing service provision, lack of suitable alternative accommodation and the integrated assessment process were cited as causing delays.

[9] We received responses from the seven health boards and Velindre NHS Trust. Betsi Cadwaladr and Hywel Dda University Health Boards organise discharge planning services on a locality or geographical basis and therefore we have more than one data return for these two health boards.

9

23 Actions included within the regions Home First Plan seek to address the issues highlighted by the Health Board. The plan, as mentioned above is the regions delayed transfers of care action plan. The plan aims to develop services that speed up the progress of people using acute or long-term care services, and reduce the number of people needing these services. The actions within the Home First Plan concentrate on key stages of a patients care journey when they need additional support. The aim at each point is to return patients home or as close to home as possible. The stages are:

- first contact – when people present with a potential need;
- ongoing support – when people have an ongoing, though relatively stable set of needs;
- crisis response – when people have a crisis or short-lived exacerbation of need; and
- comprehensive assessment – when people experience a significant and permanent change to their health and wellbeing.

24 In 2016, we conducted a review in Cardiff and the Vale of Glamorgan to find out whether partners were making sustainable improvements in relation to DToCs. We concluded that partners were working well together to manage DToCs whilst realising their plans for a whole systems model[10].

25 Over the years, the Welsh Government has released funding streams that aim to foster greater collaboration between services, the most recent of which is the Integrated Care Fund (ICF). The ICF, introduced in 2014-15 is a pooled resource and in terms of patient flow, funds initiatives that prevent hospital admission, supports the independence of older people and reduces DToCs. Initially, the fund was released on a one-off basis, but in 2015-16 was changed to a recurrent fund. Health Board and local authority directors in Cardiff and Vale told us that the Welsh Government has confirmed, in writing, that the fund is guaranteed for the next three years. This confirmation has given partners the confidence to plan long-term, for example, by recruiting permanent staff for some ICF funded posts, which in-turn will stabilise services. Partners, through the Regional Partnership Board governance structure, agree and evaluate ICF funded initiatives annually.

26 Long-term, the region has a strategy called Health Enterprise Alliance for Regional Transformation (HEART). This is the overarching blueprint for regional change over the next 10 years. The strategy includes plans for supporting an aging population in Cardiff and the Vale of Glamorgan, including dementia friendly initiatives and localities based service models. Currently, some of these initiatives are being piloted, with regular updates posted on the Integrated Health and Social Care Partnership website.

[10] A whole systems approach means putting the patient at the centre, by looking at what care a person needs instead of which organisation will deliver or pay for it. This way of working reduces duplication, can deliver cost savings, and ultimately ensures patients receive the right care, at the right time and by the right person.

The Health Board has a well-developed draft discharge policy, reviewed with partners, however patient and carers have not been involved in its review

27 The discharge process should be seen as part of the wider care process and not an isolated event at the end of the patient's stay. NHS organisations should have policies and procedures for discharge and or transfers of care, developed ideally in collaboration with statutory partners. In addition, NHS organisations should have a choice policy for those patients whose onward care requires them to move to a care home although in many areas choice may be limited.

28 We reviewed the organisation's policy on discharge and transfers of care using a maturity matrix[11]. The maturity matrix assesses 17 elements of the policy, with each element assigned a score from one (less developed) to three (well developed). At the time of our audit, the Health Board was in the process of reviewing its discharge policy. We reviewed a draft version dated February 2017. Exhibit 3 shows how the Health Board's draft discharge policy scored against the maturity matrix.

Exhibit 3: the Health Board's performance against discharge policy good practice checklist

The table shows that the Health Board's discharge policy is generally well developed scoring highly against the elements assessed by auditors.

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	2	Reviewing the policy is on the Home First Plan and its implementation is monitored at the Regional Partnership Board. However, there is no reference to patient/carer involvement in its development.
Policy reviewed within the last year	3	The policy was being reviewed at the time of our fieldwork. We reviewed a draft version dated February 2017.
Patient/carer involvement	3	The policy has a strong emphasis on involving patients and carers throughout the discharge process. For example, it mentions giving early information and advice and the importance of communicating to prevent misunderstanding.

[11] Our maturity matrix is based on the Effective Discharge Planning Self-Assessment Audit Tool developed by the National Leadership & Innovation Agency for Healthcare in 2008.

Elements assessed	Score	Auditor observations on the policy
Communication	3	Frequent reference to advocates throughout the policy and the choice of accommodation policy stresses the importance of communication with the individual, family and carers.
Information	3	Policy details actions to ensure patients get clear and accurate information about discharge processes. Such as: patient receiving a leaflet at an early stage detailing discharge planning process, meeting with patient/family or carer to explain restrictions on choice and the Discharge Support Officer ensuring accessibility to information.
Vulnerable groups eg patients who are homeless	3	Policy makes reference vulnerable groups such as people with learning disabilities, homeless people, people living with dementia and those who are old and frail. There are also links to protection of vulnerable adults (POVA) procedures.
Early discharge planning for elective admission	3	Policy states that 'predicted date of discharge for scheduled admissions should be set at the pre-admission clinic stage'.
Estimated discharge date set within 24 hours of admission	3	Clearly states that all patients will have a predicted date of discharge within 24 hours of admission.
Avoiding Readmission	1	There is no reference to avoiding admission.
Local Agreements and Protocols	3	Regional choice of accommodation policy forms part of the discharge policy. The policy also details process for when patients need equipment.
Assessment	3	Policy refers to integrated assessment, assessment of NHS funded nursing care and continuing health care a part of the complex needs pathway.
Discharge from A&E	1	Does not include discharge from A&E.
Discharge to care home	3	Clearly states that patients should not be directly admitted to a care home from acute hospital care.
Links to choice of accommodation policy	3	Policy makes reference to choice of accommodation policy, which is appended to the discharge policy.
Care Options	2	Policy refers to interim homes when first choice is not available.

Elements assessed	Score	Auditor observations on the policy
Escalation processes	3	Policy states that the Head of Integrated Care supports the IDS in complex discharge process. And a senior medical decision maker has to attend at all board rounds.
Accessible Discharge Protocols	3	Policy contains appendices showing different flow charts for pharmacy pathway, homeless patients and a clear discharge flowchart showing simple, complex and supported pathways.

Source: Wales Audit Office review of Cardiff and Vale University Health Board's discharge policy, 2017

29 Out of the 17 criteria we tested against, Cardiff and Vale's policy scored level 3 on 13 of the 17 elements, meaning that in general the Health Board has a well-developed discharge policy. We found some areas of the Health Board's discharge policy that were less developed. While the policy emphasises the need for prompt discharge, there is no specific reference to the risk of avoiding readmission. The policy also does not include information about discharging patients from accident and emergency.

30 The Health Board's draft policy is based on good practice and incorporates relevant elements of the Social Services and Wellbeing Act (2014). The revised policy aims to be an all-in-one reference for discharge planning. The policy includes relevant guidance material for example, discharge pathways, example discharge checklists and standard operating procedures for the clinical workstation[12]. The document also includes performance measures to monitor compliance with the policy.

31 The regional choice of accommodation policy, reviewed in October 2016, forms part of the draft discharge policy. Both policies make clear that the aim is to discharge patients to their normal place of residence. The choice of accommodation policy indicates that patients will not be discharged from an acute hospital to a permanent placement in a care home.

32 Reviewing both policies is an action within the Home First Plan, the implementation of which is overseen by the Regional Partnership Board. Whilst partners have been consulted on the revised policies, there is no evidence to suggest that patients and carers have been involved.

33 Roles and responsibilities for effecting safe and timely discharge should be clearly defined in policies and procedures. This is so skills and knowledge are used to

[12] The clinical workstation is a patient administration system. At the Health Board, it is used in conjunction with the patient record, which is a paper-based system.

good effect and individual staff held to account for the role they play in the process. The discharge policy should set the standards for all staff responsible for discharge.

34 At the Health Board, we found that a section within the draft discharge policy clearly outlines the roles and responsibilities of professions and teams involved in discharge planning. This includes the Health Board's chief executive, clinical staff, discharge support staff, social workers and allied health professionals (for example, therapies staff).

The recently revised discharge pathways are comprehensive and form part of the draft discharge policy

35 Hospital discharge planning should be seen as a continuous process that takes place seven days a week. Although not all staff involved in planning a patient's discharge will be available all of the time, communication, planning and coordination should continue. Defined discharge pathways that set out the sequence of steps and timing of interventions by healthcare professionals for defined groups of patients, particularly those with complex needs, can help ensure patients experience a safe and timely discharge.

36 As part of our work, we looked at the main discharge pathways in place. We assessed the extent to which there was clarity of purpose and use across the organisation, whether pathways were developed with local authority partners, supported by algorithms and standardised documentation and measures of quality.

37 We found that the Health Board uses three generic discharge pathways: simple, supported and complex, as well as a number of condition specific pathways that include parts of the discharge process. The supported pathway is a recent addition, which aims to differentiate between patients needing short-term assistance to reach pre-admission independence and those requiring long-term care. The Health Board's clinical workstation has been updated to include the additional pathway. The three pathways are presented in a single flow diagram within the draft discharge policy, which acts as a detailed reference guide.

38 We reviewed the three generic pathways against the criteria set out in Exhibit 4, which shows that generally, the Health Board has clear discharge pathways with most leading a patient back to their previous residence.

Exhibit 4: elements presented within the Health Board's generic discharge pathways

The table shows the Health Board's discharge pathways are generally comprehensive when assessed against a range of criteria.

Elements	Pathway		
	Simple	Supported	Complex
Flow diagram/decision tree for identifying appropriate patients	Yes	Yes	Yes
Specific discharge destination eg usual place of residence	Yes	Yes	Yes
Clear purpose	Yes	Yes	Yes
Generic or condition specific pathway	Generic	Generic	Generic
Transport or transfer logistics clearly acknowledged	Yes	Yes	Yes
Applies across all hospital sites	Yes	Yes	Yes
Applies 24 hours a day, 365 days per year	Unclear	Unclear	Unclear
Developed with NHS partners eg neighbouring LHBs, WAST or Velindre	No	No	No
Developed with local authority partners and applies equally across partners	Yes	Yes	Yes
Supported by generic discharge documentation	Yes	Yes	Yes
Supported by generic assessment documentation	Yes	Yes	Yes
Referral processes are clear	Yes	No	Yes
Agreed standards for response times for assessing need	Yes	No	Yes
Agreed standards for response times for service delivery	Yes	No	Yes
Agreed standards for quality and safety	No	No	No
Standards for information sharing with clinical/care staff in the community eg discharge letters	Yes	Yes	Yes

Source: Wales Audit Office review of Cardiff and Vale University Health Board's discharge pathways, 2017

39 The complex discharge pathway references the fast track policy, for patients who wish to die at home, and stages of the choice of accommodation policy. Whilst this pathway leads to a care home placement, as already stated, the draft discharge policy is clear that care/nursing home placement is a last resort. The pathways flow diagram also references discharge arrangements such as transport, take home medication, transfer of care information and sets out high-level timescales for processes.

40 The discharge pathways form part of the draft discharge policy, the review of which is part of the partnership's Home First Plan. However, there is no evidence to

suggest the pathways were developed with Velindre Cancer Care Trust or neighbouring health boards. It is unclear from the discharge policy whether the discharge pathways apply 24 hours a day, 365 days per year but we are aware that some discharges are reliant on the operational hours of the discharge support services, for example community resources teams.

41 The conventional approach to discharging patients, particularly the frail elderly, is to complete a series of ward-based assessments to identify the kind of support needed at home. These assessments are completed typically after the patient is declared 'medically' fit for discharge. Once assessments are completed, patients are then discharged when all appropriate support services or other resources are in place, which may take a significant amount of time. This is known as the 'assess to discharge' pathway or model.

42 Welsh Government has been encouraging a 'discharge to assess' pathway or model[13] [14]. This is where patients are discharged home once they are 'medically' fit for discharge and no longer need a hospital bed. On the day of discharge, members of the appropriate community health and social care team will then assess the patients' support needs at home. This enables patients to access the right level of home care and support in real-time, and removes the need for patients to be inappropriately kept in a hospital bed while waiting for assessments and services to be put in place.

43 The Delivery Unit found the use of 'discharge to assess' pathways was limited, and recommended that NHS organisations implement them. We found that half (4 out 8) of NHS organisations had implemented a 'discharge to assess' model, although in some organisations, the model had been implemented only at specific hospital sites. In Cardiff and Vale, the Health Board has recently introduced a residential 'discharge to assess' pathway where patients can recover away from an acute hospital bed. Using ICF monies, the partnership agreed to purchase beds (eight beds in Cardiff and six in the Vale of Glamorgan) in two residential homes to act as an intermediate care facility.

9

[13] Welsh Government, **Setting the Direction: Primary & Community Services Strategic Delivery Programme**, 2010

[14] Welsh Government, **Sustainable Social Services**, 2011

Part 2: multiagency and multidisciplinary teams are available to support discharge but only during the week; staff training and awareness of policies and community services needs improvement

The Health Board has dedicated discharge resources, which are multiagency and multidisciplinary but these are available weekdays only

The Health Board's discharge liaison team is multiagency and multidisciplinary; however like services at other health boards, it operates weekdays only

44 A discharge liaison team is a specialist team aimed at supporting the safe and seamless discharge or transfer of care of patients moving from hospital to community service provision. These teams can provide valuable support and knowledge to ward staff and offer help to facilitate complex discharges.

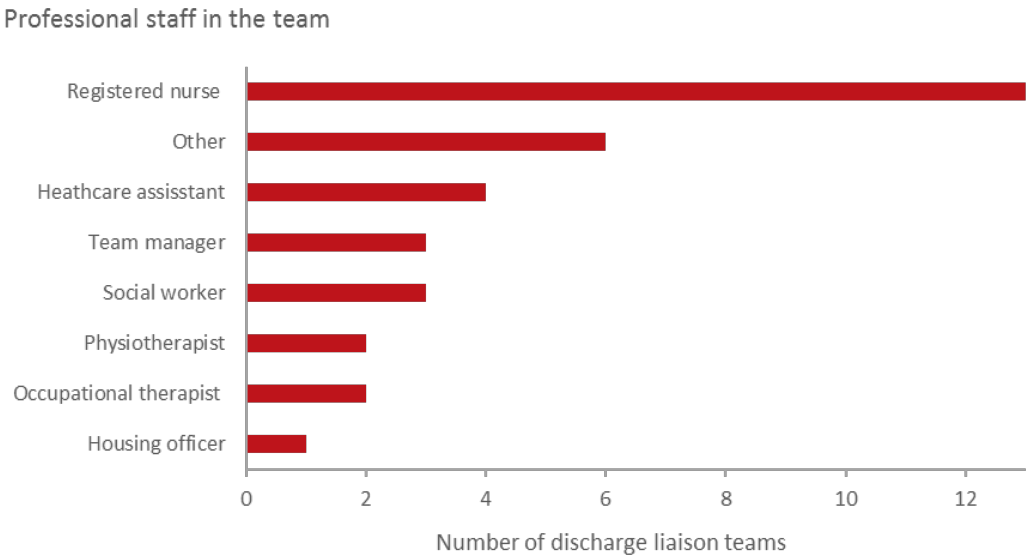
45 We sought information from every NHS organisation about whether they operate discharge liaison services and the scope of the services remit. Across Wales, we found that all NHS organisations, with the exception of Velindre NHS Trust, run one or more discharge liaison teams. All teams operate during weekday office hours only with the latest finishing time at 5.30pm. Seven out of the 15 teams reported that they manage both simple and complex discharges.

46 At the Health Board, we found it operates an Integrated Discharge Service (IDS), which covers all hospital sites. The Head of Integrated Health oversees the IDS, with health and local authority managers responsible for operational management. The IDS manages both complex and simple hospital discharges.

47 Typically, discharge liaison teams are made up of nursing staff, but to better manage complex discharges ideally teams should be multidisciplinary. Exhibit 5 shows the different professions within discharge liaison teams across Wales. The data shows fewer than half the teams are multi-disciplinary with most teams being nurse led. Discharge liaison teams range in size from two whole-time equivalent (WTE) staff to 29 WTE staff with bigger teams working across multiple hospital sites. The average was seven WTE staff.

Exhibit 5: different professional staff deployed across discharge liaison teams at 30 September 2016

The chart shows that across Wales discharge liaison teams are primarily nurse-led with very few multidisciplinary teams.



Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[15]

48 At the Health Board, the IDS is multi-disciplinary and multi-agency with staff from the Health Board, both local authorities and the third sector. The service includes nurses, social workers, housing officers and more recently discharge support officers. Discharge support officers are part of the IDS but employed by Age Connect. They help older patients and their families with discharge planning, for example by providing advice about available community services as well as offering emotional support. Staff we spoke to felt this was an invaluable service because discharge support officers can offer objective impartial advice, and can challenge clinical staff on behalf of the patient and family.

49 The combined cost of 13 of the 15 discharge liaison teams totalled £2.9 million between 1 October 2015 and 30 September 2016 with individual team costs ranging from £43,000 to £692,000. The average cost per discharge liaison team

[15] The seven health boards in Wales operate discharge liaison teams. We received 15 data returns from discharge liaison teams although not all data returns were complete. Most discharge liaison teams are managed as separate services although in some health boards the teams are managed as one integrated service.

was £244,000. At the Health Board, the cost of the discharge liaison team was £521,000.

50 Gaps in information on staffing, activity and service costs makes it difficult to establish the relative value for money of the discharge liaison teams between or within NHS organisations. Only four of the 15 discharge liaison teams across Wales provided the information that we requested. Based on the information provided by these four teams, we compared the number of discharges with the WTE number of staff. The number of discharges per WTE staff ranged from 50 discharges to 250; the average was 117 discharges per WTE staff. Please note that we do not have information on the number of discharges managed by the Health Board's discharge liaison team so we are unable to comment on the number of discharges managed by the team.

51 The Health Board has not evaluated the IDS since its implementation in 2013. However, there have been recent changes to the service, which form part of wider plans to improve patient flow. These include working with particular wards, expanding the team to include more social workers and a nurse to support education and development.

52 We asked discharge liaison teams to describe how frequently they carried out a range of activities to support discharge planning. Appendix 4 shows a summary of the types of activities carried out by discharge liaison teams across Wales. At the Health Board, the IDS always validate DToC data and provide training and development for clinical staff to effect timely discharge. The team also often undertakes the following activities, and this is broadly in line with other discharge liaison teams:

- participate in ward rounds and/or multi-disciplinary meetings;
- support staff to identify vulnerable patients whose discharge could be delayed;
- ensure individual discharge plans are in place for patients with complex discharge needs;
- liaise with other public bodies to facilitate successful hospital discharge and minimise readmission;
- provide a central point of contact for health and social care practitioners during discharge planning process; and
- provide housing options advice and support to patients and their families.

53 However, the IDS rarely update bed managers with information on hospital discharges, unlike 87% of other discharge liaison teams who always or often undertake this activity. However, the Health Board has a system in place to track patient flow (see paragraph 77) so the IDS does not need to undertake this activity. 60% of discharge liaison teams said they signpost patients and their families to advice and support for maintaining independence at home, the IDS sometimes does this. And just under half (47%) of discharge liaison teams work with

operational managers to develop performance measures on hospital discharge, whereas the IDS sometimes undertakes this activity.

Location and environment of discharge lounges were raised as concerns, but improving the lounges, which operate weekdays only, is part of the Health Board's improvement plan

54 A discharge lounge can also support effective discharge planning and patient flow by providing a suitable environment in which patients can wait to be collected by their families or by hospital transport. Thus releasing beds promptly for other patients being admitted. Some patients may also be sent to the lounge whilst they wait for medication to be dispensed.

55 We asked NHS organisations about their discharge lounge facilities. Across Wales, we found that all health boards, except Powys, operate discharge lounges in their acute hospitals. At the time of our audit work, discharge lounges had capacity to support 192 patients awaiting discharge; the average capacity per discharge lounge was 11. Discharge lounges operate for between 8 and 12 hours on weekdays and are generally staffed by registered nurses and healthcare support workers. There are also food and toilet facilities available for patients.

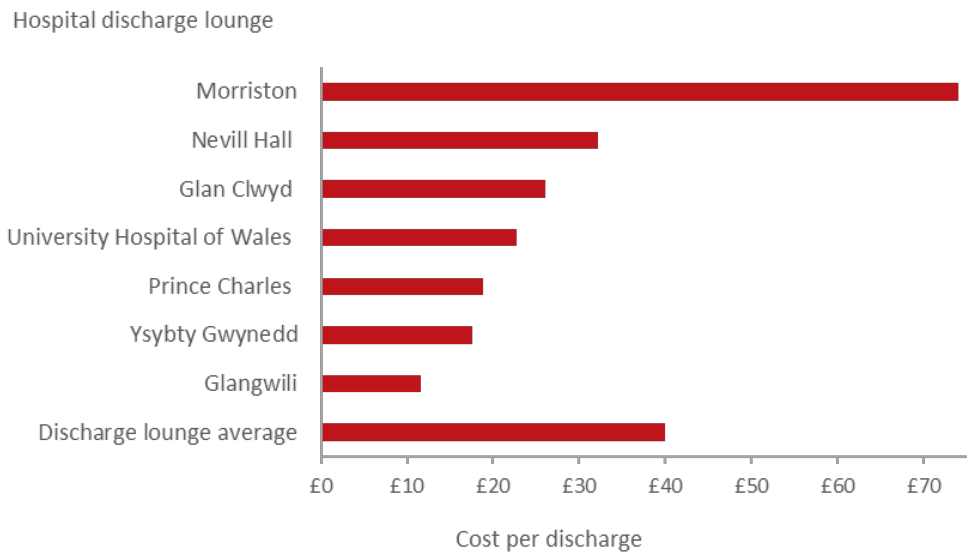
56 The Health Board runs discharge lounges at University Hospital of Wales (UHW) and University Hospital Llandough (UHL) during weekdays. Both lounges have capacity for 15 patients, and operate between 7am and 7.30pm at UHW and 8.30am and 5.30pm at UHL. Between October 2015 and September 2016, 5,337 patients were managed through the discharge lounge at UHW, the figure for UHL is unknown.

57 We also requested information on staffing, costs and activity for discharge lounges. This information was more complete. The number of staff deployed across hospital discharge lounges ranges from less than one WTE staff to five WTE staff; the average was three WTE staff. The combined cost for 12 of the 14 discharge lounges totalled £1 million with individual service costs ranging from £25,000 to £139,000. The average cost per discharge lounge was £86,600. We examined the cost per discharge supported through the discharge lounge. At Cardiff and Vale, the discharge lounge service cost £171,500. The cost per discharge for University Hospital Wales was £23 compared with the discharge lounge average of £40 (Exhibit 6).

58 Again, we compared the number of discharges supported through the discharge lounge with the WTE number of staff. Based on the information provided by eight of the 14 discharge lounges, the number of discharges per whole-time equivalent staff varied between 1 October 2015 and 30 September 2016 from just under 400 per WTE staff to just over 2000 per WTE. At the University Hospital of Wales, the number of discharges per WTE staff was 1067, which compares favourably with the discharge lounge average (1086 discharges per WTE) (Exhibit 7).

Exhibit 6: comparison of the cost per discharge managed by individual discharge lounges between 1 October 2015 and 30 September 2016

The chart shows the variation in the cost per discharge managed through the discharge lounge ranging from £12 to £74 per discharge.



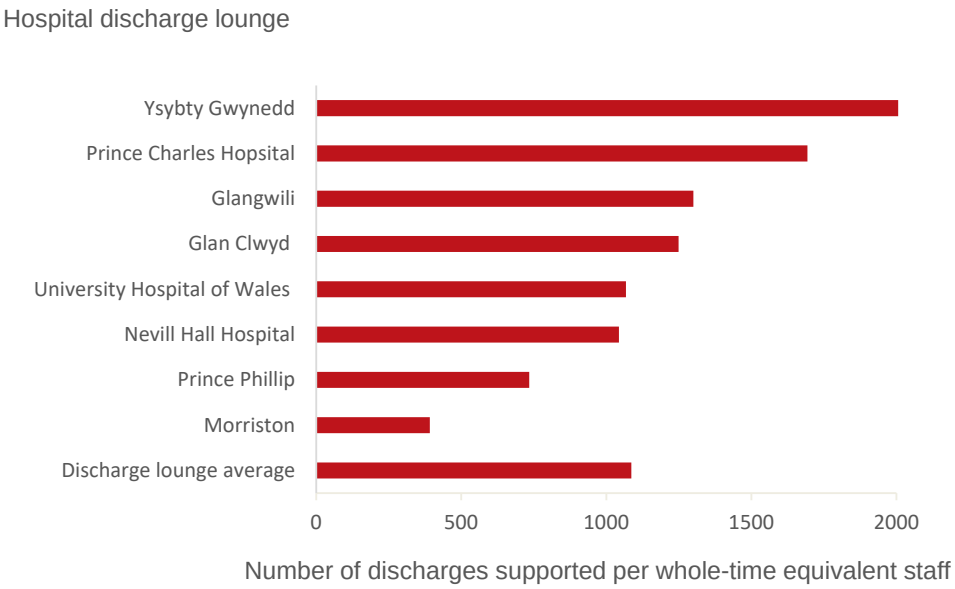
Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017[16]

[16] We received information from 14 discharge lounges but only eight returns provided all relevant information to compare costs per discharge from the discharge lounge.

9

Exhibit 7: number of discharges per whole-time equivalent (WTE) staff supported through hospital discharge lounges between 1 October 2015 and 30 September 2016

The chart shows the number of discharges per whole-time equivalent staff varies across hospital discharge lounges, from just under 400 per WTE staff to just over 2000 per WTE staff.



Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017 (See Footnote 16)

59 As part of this review, we met with a Community Health Council representative (CHC), who expressed concerns about the discharge lounges being uninviting, not located in visible places and a lack of things to do while waiting for transport. However, reviewing the discharge lounges at both hospitals is an action on the Unscheduled Care Improvement Programme. It is unclear if there is a set of standards for the discharge lounges, but the draft discharge policy refers to potentially appending the set criteria for discharge lounge patient access.

There is scope to improve staff training and raise awareness of policies, pathways and access to information about community services

60 Generally, responsibility for assessment and discharge planning rests with the ward team. Ward staff should be engaged in the discharge planning process and see it as part of the care continuum with ward staff and operational managers held

to account for effective discharge planning. This should be supported by clear awareness of policies and pathways, access to appropriate levels of training, and a good awareness of the range of services available to support discharge.

Training on discharge planning is patchy and ward staff capacity can prevent attendance while staff awareness of discharge policies and pathways is poor

61 As part of our audit work, we met with a mixed group of ward staff[17] to talk about a range of issues related to discharge planning. The staff that we met were clear about their role in discharge planning; however, they were not aware of the discharge policy or any written procedures for discharge planning. Each staff member worked to professional standards, but the different professional standards are not integrated. Whilst we accept that the discharge policy is currently under review, ward staff should be aware of and be working to the policy. We would also expect ward staff to know the policy is under review. The ward staff that we met were also unaware of any written discharge pathways but assumed they existed. The IDS staff were aware of the pathways as the team specialises in discharge.

62 Front line staff should receive regular training appropriate to their role in the discharge process. This training should be part of both induction programmes, and regular specific updates, particularly where related policies rely on assessment and care planning. Ideally, training is provided on a multi-agency and or multi-professional basis to ensure discharge planning is everyone's business.

63 Exhibit 8 shows that across Wales, only half of NHS organisations include discharge planning in nurse induction programmes and offer regular refresher training. At the Health Board, ward staff told us that training on discharge planning was patchy. We found induction programmes for nursing and medical staff did not include training on discharge planning, while it did for occupational therapists and physiotherapists.

[17] Participants included a senior nurse, ward sister, physiotherapist, occupational therapist, social worker, integrated discharge service manager, discharge support officer and a consultant.

9

Exhibit 8: availability of training on discharge planning for nursing staff

The table shows which NHS organisations provide training for discharge planning as part of nurse induction programmes and whether regular refresher training is provided for nursing staff.

NHS organisation	Training on discharge planning included in induction programmes for new starters	Refresher training on discharge planning provided regularly[1]
Abertawe Bro Morgannwg	No	Yes
Aneurin Bevan	No	No
Betsi Cadwaladr (hospitals)		
• Ysbyty Gwynedd	Yes	Yes
• Wrexham Maelor	Yes	Yes
• Glan Clwyd	Yes	No
Cardiff and Vale	**No**	**Yes**
Cwm Taf	No	Yes
Hywel Dda (county teams)		
• Pembrokeshire	Yes	No
• Ceredigion	No	No
• Carmarthenshire	No	No
Powys	No	No
Velindre	Yes	Yes
[1]Refresher training is provided at least annually or biennially for nursing staff		

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 9)

64 Ward staff interviewed felt training on discharge planning should be mandatory. Staff highlighted a lack of time and ward capacity as barriers to accessing training. Also, part of the IDS's role is to offer training and advice, but with the team taking on more discharge cases (simple and complex), there is less time for the team to perform this role. Staff suggested delivering training through an e-learning course, as a lot of training at the Health Board is already delivered this way. The Health Board does not monitor compliance with discharge planning training, but developing an e-learning course would allow easier compliance monitoring.

65 The Health Board recognises the lack of training on discharge planning with actions for staff training set out in the Home First Plan and Unscheduled Care Improvement Programme. The Home First Plan has an action to 'establish partner-wide training programme for discharge planning across the organisations'. The Health Board has appointed a nurse to support and develop an education and

training programme. The February 2017 update on the Home First Plan states that weekly advice and information session are held at both UHW and UHL but staff attendance is inconsistent.

There is a greater focus on discharge planning and some positive changes have been made, but there is some way to go before processes are efficient to allow timely discharge, patients receiving information and ward staff fully confident in handling more complex discharges

66 In its review, the Delivery Unit found a culture of risk aversion across Wales with staff speaking openly of a 'cwtch' culture[18] and insufficient time dedicated to managing the discharge process. Some nursing staff at the Health Board explained that they do not feel confident handling complex discharges because the majority of the time the discharges they manage are simple and routine. This chimes with the views of the IDS who feel that ward staff are becoming de-skilled and less confident in managing patient discharges. Staff told us that they feel that some patients could be discharged sooner but the risk averse culture within the organisation prevents it.

67 Ward staff also highlighted a number of barriers to timely discharge. Barriers were related either to processes or behaviour. Process barriers included:

- a lack of equipment in the joint equipment store;
- referral forms for occupational therapists being faxed instead of emailed;
- occupational therapists receiving referrals for assessment late, sometimes on the day of discharge;
- last minute visits by consultants who raise issues that have already been considered and addressed; and
- late medical assessments, which impacts on bed turnaround times.

68 Whilst procedural issues can be relatively simple to rectify, changing behaviour or perceptions can take longer. Ward staff spoke about families not respecting a patient's choice. For example, if a patient wants to go home and can with some support, family members may still insist on a nursing or care home placement. This was perceived to be the case when a doctor mentions admission to a residential care or nursing home as an option. We were told that in these cases, a social worker will spend considerable time with the family to talk through alternative support options that would help the patient to return home.

69 The Delivery Unit found limited evidence in patient records that patients' expectations of discharge were discussed with them. The Health Board has a 'Planning Your Discharge' leaflet (the version we reviewed was dated 2013), but

[18] The Delivery Unit described a cwtch culture ('cwtch' is the Welsh word for hug) whereby some staff were reluctant to discharge patients to their own home because they thought patients might be at risk. Whilst staff may be acting out of kindness, they may not be acting in patients' best interest.

not everyone we met was aware of it. The CHC representative expressed concerns that the patients and their families or carers receive little information about their discharge and that discharge information is not displayed on wards. Issues highlighted include:

- planned discharge dates are not always set or visible on the ward whiteboard;
- patients and their families or carers are not told when they can expect to be discharged;
- responsibility for organising transport is not always made clear; and
- contradictory views of different medical teams on whether a patient is ready for discharge.

70 In recognition of these issues, the draft discharge policy has a strong emphasis on communication and patient/carer involvement and the Health Board reported that the discharge leaflet is being updated.

71 Following the Delivery Unit review, the Health Board held a series of staff workshops to feedback the findings and to discuss how best to address them. The Health Board reported that the workshops were well attended. There was consensus amongst staff at both strategic and operational levels that recently there has been a greater focus on discharge planning and that a number of changes have been implemented. These changes included:

- staff appointed to support patient flow, with patient flow co-ordinators now in place in general surgery;
- better communication about discharge constraints, for example Clinical Boards implementing a regime of board rounds to identify constraints and weekly meetings held to review all patients who are medically fit but still in hospital;
- revised policies and procedures, including the introduction of a supported discharge pathway, and the inclusion of a ticket home and discharge checklist within the discharge policy; and
- improved data collection and monitoring systems with clinical workstation updates, measures to monitor policy compliance in development and a case review process established to learn from very complex cases.

Information about community services to support discharge is regularly collated but ward staff are unclear how to access it

72 Having a good understanding of the range and capacity of community health and social care services is an important part of ensuring timely discharge. Health bodies should hold up-to-date information about the availability of community services that can help patients once they have been discharged. These services can be available through NHS organisations, local authorities and third sector organisations. We asked health bodies the types of information they collated on

community services. Exhibit 9 shows that few organisations compile information about community services provided by other NHS organisations and housing options. In addition, relatively few collate information about waiting times for needs assessment and waiting times before services commence.

Exhibit 9: number of health bodies who reported collating a range of information on community services

Table shows the number of health bodies collating a range of information about community services.

	Range of services	Availability of services	Eligibility criteria	Referral process	Waiting time for needs assessment	Waiting time for services to commence
Health Board's/Trust's own community services	8	8	9	9	4	4
Community services provided by other NHS bodies	3	3	3	3	2	2
Social care services	9	9	9	10	6	3
Third sector	10	8	10	8	3	2
Housing options	4	2	4	6	2	2
Independent sector eg care home beds	7	6	9	9	2	2

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 9)

73 At the Health Board, the Primary, Community and Intermediate Care (PCIC) Clinical Board compiles information on independent, community and third sector services on a daily or weekly basis. The Integrated Discharge Service (IDS) also has available data on social work activity and housing provision[19], however housing options data are not formally collated. Whilst the Health Board collates information about community services provided by other NHS bodies, they were unsure how often this was undertaken.

74 We asked ward staff about their knowledge of the range of community services to support patients on discharge. Staff at the Health Board were unclear how to

[19] Housing Support Officers are part of the Integrated Discharge Service so have access to housing provision data.

access up-to-date information on community services, for example through a directory of community services. Some mentioned the 'Dewis Cymru'[20] website but the website is still in its infancy. Nursing staff were confident that they could get information if needed from therapy staff and the IDS, who both have up to date information about community services. However, therapy staff are not readily available on all wards and the IDS capacity is limited.

75 Ward staff should know how to access up-to-date information on community services to support patients on discharge. The Health Board has identified this issue, which is being addressed through the Unscheduled Care Improvement Programme. The plan details actions to map the range of available services and improve staff knowledge of available community resources.

Part 3: overall, performance is improving; the Health Board has strong scrutiny arrangements for discharge planning and is taking positive steps to capture more meaningful information

There are clear lines of accountability and regular scrutiny of discharge planning performance, which includes partners

76 If arrangements are to be effective, there needs to be clear lines of accountability, and regular scrutiny of discharge planning performance. This is important to ensure there is a sustained focus to improve discharge processes and to maintain patient flow through hospitals.

77 At the Health Board, operational responsibilities for discharge planning are clearly set out in the draft discharge policy. Day to day accountability for discharge planning lies with each of the eight Clinical Boards, which are subject to quarterly performance review meetings with Health Board executives. All Clinical Boards report directly to the Chief Operating Office.

78 In 2016, Cardiff and Vale Councils and the Health Board jointly appointed the Head of Integrated Care (October 2016) who reports jointly to the relevant Directors in each of the organisations, allowing strategic oversight across the region. The aim of the role is to improve patient flow and reduce levels of delayed transfers of care, and to lead the Home First Plan.

79 At the time of this review, the governance structure for the Unscheduled Care Improvement Programme was in development. However, the programme is supported by a weekly in-hospital working group, which at the time of our review was chaired by the Executive Lead for Unscheduled Care and attended by relevant

[20] Dewis Cymru is a website that was developed to help people find information about organisations and services that can help them take control of their own well-being.

heads of service, directors of nursing and heads of operational service for Cardiff and Vale local authorities. This group reviews performance but also monitors progress being made against actions in response to previous external reviews, including the Delivery Unit. At the time of our audit, the Chief Operating Officer and then Executive Lead for Unscheduled Care received daily updates on measures related to the status of hospital capacity.

80 Following previous concerns from the Delivery Unit in relation to how the Health Board manages its bed capacity, the Health Board introduced site meetings. These have now been in place for approximately 18 months and there is a strong performance management element to them. The meeting which is led by a band 7 nurse is attended by representatives from each of the Clinical Boards, WAST and emergency unit controller. The meetings take place four times per day (8.30am, noon, 3pm and 6pm) and at its centre is a detailed spreadsheet that captures:

- bed demand and capacity split by medical, surgery and specialist wards;
- patients waiting for a bed, prioritised by clinical concern;
- patients admitted to temporary wards, known as outliers;
- ward closures because of infection control and building issues; and
- action points for named staff which are reviewed at the next meeting.

81 The Health Board report that they have received positive feedback about site meetings from the Delivery Unit and is sharing their approach with other health boards.

82 At a higher level, board members receive an overall performance report as part of their board papers, which include some patient flow indicators (mainly tier one targets) and other updates as requested. The People, Planning and Performance committee also requests updates on particular areas of performance, for example updates on the Unscheduled Care Improvement Programme.

83 As part of our 2016 structured assessment work, we asked board members across the seven health boards and Velindre NHS Trust the extent to which they agreed with a number of statements about patient flow and discharge planning. Our board member survey found that 6 out of 9 of the board members (67%) who responded agreed or strongly agreed that the Board and its committees regularly scrutinises the effectiveness of discharge planning. This compares to 56% across Wales.

84 As good discharge planning relies on partner organisations working together, as well as internal challenge, joint scrutiny arrangements should also be in place. Cardiff and Vale's Regional Partnership Board oversees the work of the IHSC partnership and one of their priorities is improving patient flow. Delivery against regional priorities is reported at the quarterly Regional Partnership Board meetings and the monthly IHSC Strategic Leadership Group meetings. The IHSC Strategic Leadership Group has a particular focus on performance and discusses patient flow, DToCs, ICF funded projects, winter planning and the Health Boards big improvement goals (BIG). The relevant directors from each of the partner organisations attend these meetings. In addition, a scrutiny task group made up of

the Health Board's Chair and the two local authority cabinet leads for adult services meet on a quarterly basis to oversee progress against the Home First Plan. The Health Board's Chief Operating Officer holds responsibility for patient flow on behalf of the IHSC partnership, with delegated responsibility to the Head of Integrated Care.

Board members generally feel informed about discharge planning performance, with action being taken to develop further the range of information available

85 Having the right information on discharge planning performance is crucial for both monitoring and reporting. Delayed transfers of care is the only national measure, for both NHS organisations and local authorities, and as such is regularly monitored, reported and scrutinised. There are no other national measures related to discharge planning, and information about the quality and effectiveness of discharge planning is not readily available.

86 However, to understand delays in discharging patients from hospital, good practice dictates that NHS organisations should have a suite of performance measures, including information about patients' experience and outcomes from the discharge process. These can be a mixture of hard and soft measures.

87 As part of our review, we looked at the type of performance information reported to operational groups and the Board or its sub-committees which help inform discharge planning performance and how well patients are flowing through the hospital system. Exhibit 10 sets out the performance indicators and updates reported to the Board at Cardiff and Vale:

9

Exhibit 10: range of performance information reported to the Board during 2016-17

The table shows the information on performance related to discharge planning and patient flow presented to the Board at Cardiff and Vale University Health Board

Discharge planning	Patient flow
• patient experience performance; • numbers of complaints and incidents, of which some are related to discharge planning with evidence of lessons learned and changes to practice; • percentage of people over 65 who are discharged from hospital and referred to a nursing or residential home (new address); • delayed transfer of care measures;	• percentage of patients who had procedures postponed on more than one occasion for non-clinical reasons with less than 8 days' notice and are subsequently carried out within 14 calendar days or at patient's earliest convenience; • percentage of patients waiting 4 hours or less in accident and emergency; • percentage of patients waiting less than 1 hour for ambulance handover;

Discharge planning	Patient flow
• bed days lost for all patients still in hospital beyond date declared medically fit for discharge; • updates about how older peoples independences is supported and maintained; and • updates on how health care and support are delivered close to home.	• percentage patients waiting less than 26 weeks for elective treatment; and • timeliness of referrals for assessment.

Source: Wales Audit Office review of papers presented to the Board at Cardiff and Vale University Health Board

88 In response to our board member survey:

- 7 out of 9 board members (78%) agreed or strongly agreed that they received sufficient information to understand the factors affecting patient flow, compared to an all-Wales average of 75%; and
- 7 out of 9 board members (78%) agreed or strongly agreed that they understood the reasons for delays in discharging patients from hospitals within my organisation, compared to an all-Wales average of 82%.

89 Further information that would prove helpful to understand discharge planning performance in particular but not currently reported to the Board in Cardiff and Vale would include:

- number and percentage of patients who have an estimated discharge date;
- readmissions within 28 days of discharge from hospital;
- percentage of discharges before midday;
- percentage of unplanned discharge at night;
- percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.

90 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 11 shows that most organisation's patient administration systems have the ability to capture a range of data to aid discharge planning. However, less than half can record whether the discharge is simple or complex.

Exhibit 11: data fields on NHS organisations' patient administration systems related to the discharge process

The table shows that most NHS organisations' patient administration systems can record a small range of data related to the discharge process to support operational monitoring. However, less than half of the systems can capture whether the discharge is simple or complex.

Data fields on patient administration systems related to the discharge process	Number of NHS organisations responding positively
Expected date of discharge	12
Date of discharge from hospital	12
Time of discharge from hospital	12
Discharge destination eg home, residential, care home, etc.	12
Date the patient was declared medically fit for discharge	8
Whether the discharge is simple or complex	5

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 9)

91 The Health Board's clinical workstation can record all of the data presented in Exhibit 11. The Health Board is improving its clinical workstation both by making better use of it to monitor discharges (across multi-agencies) and system updates. One such improvement is to capture reasons for lengthened length of stay and delays to discharge. An algorithm has been developed, which calculates a patient's predicted length of stay and discharge date based on the clinical condition entered on the system. If staff change the predicted date of discharge or a medically fit patient is still occupying a bed, the system makes it mandatory for staff to log a reason. The stroke unit is piloting the system update. If rolled out to all wards the Health Board will have strong evidence on issues causing delays.

92 Since the Delivery Unit's review, the Health Board has also established a case review process to learn from very complex cases. Each week a patient's case is reviewed against the 'Passing the Baton' guidance. The case review form includes space for the patient's story and the potential number of bed days saved. At each stage of the discharge process, the form asks reviewers:

- What happened?
- What was the impact for the patient/family?
- What could have been done to make a difference?

Performance is improving but it is too early to comment on whether this is linked to improvements in discharge processes

93 The Delivery Unit undertook their review of discharge planning at the Health Board in January 2016. Since then the Health Board has developed robust plans and made a number of positive improvements. However, it is still early days for the Unscheduled Care Improvement Plan and the recently implemented changes (see paragraph 68) so it is too soon to comment on the overall impact on discharge planning.

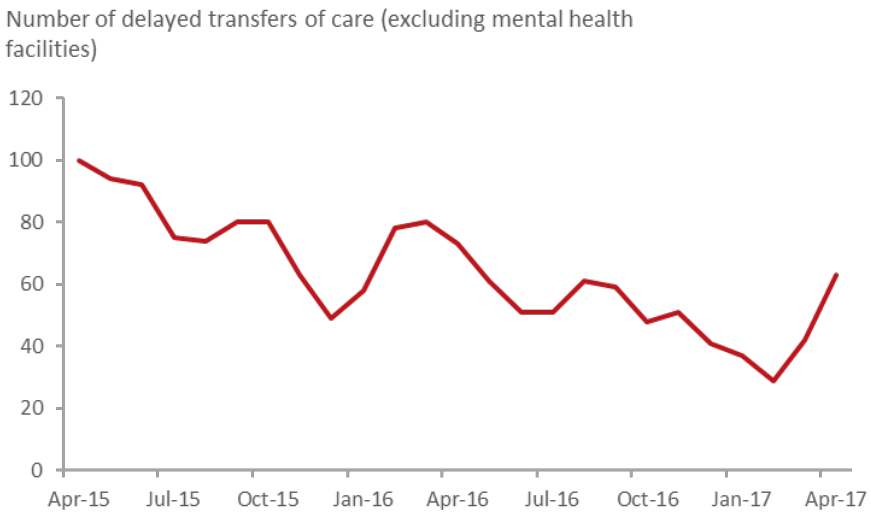
94 Nevertheless, some performance indicators are showing signs of improvement. Exhibit 12 shows a general downward trend in the numbers of DToCs reported each month between April 2015 (one year before the Delivery Unit's review of discharge planning) and April 2017 (one year later) with small fluctuations that could be attributed to seasonal pressures. The high number of DToCs in February 2015 (155 DToCs), led partners to take action and develop a DToC action plan (see paragraph 15).

95 The largest proportion of DToCs are attributed to Healthcare reasons and the proportion of delays attributed to these reasons has remained largely consistent at 38% in 2015-16 and 2016-17. However, the proportion of delays attributed to reasons related to selecting a care home or waiting for care home placement rose from 23% in 2015-16 to 28% in 2016-17. Positively, during the same time period, there was a 10% reduction in the proportion of delays attributed to community care reasons, from 27% in 2015-16 to 17% in 2016-17.

96 Although the total number of DToCs (excluding those in mental health facilities) reduced by 35% from 923 in 2015-16 to 604 in 2016-17, the number of patients delayed 13 or more weeks is rising (Exhibit 13).

Exhibit 12: trend in delayed transfers of care (excluding mental health facilities) between April 2015 and April 2017

The chart shows the general downward trend in delayed transfers of care from Cardiff and Vale University Health Board although there has been a small increase over the last two months.



Source: Wales Audit Office analysis of the NHS Wales delayed transfers of care database, May 2017

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Exhibit 13: change in number of delayed transfers of care (excluding mental health facilities) by length of delay between 2015-16 and 2016-17

The table shows the general downward trend in the number of delayed transfers of care (DToC) by length of delay at Cardiff and Vale University Health Board but an increasing proportion of patients delayed by more than three weeks.

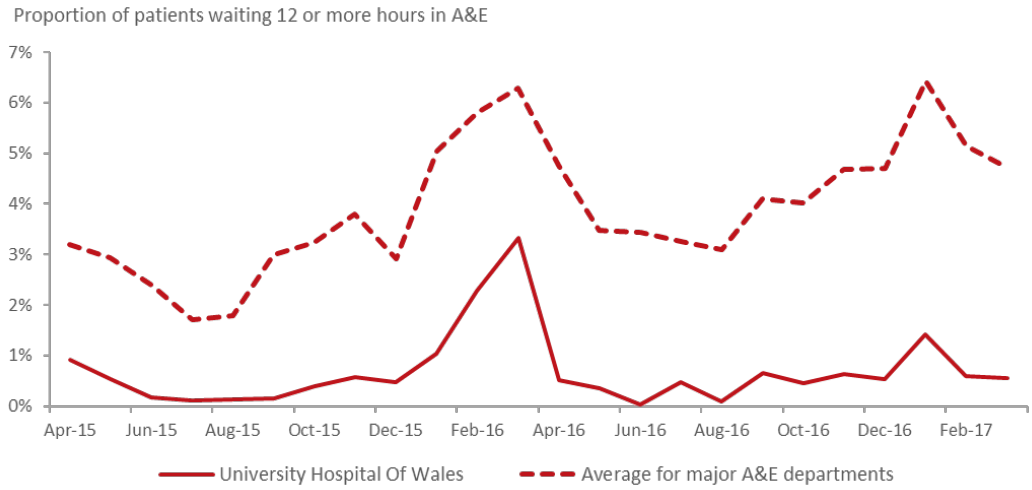
Length of delay	Percentage of delayed transfers of care (DToC)	
	2015-16	2016-17
0-3 weeks	35%	25%
4-6 weeks	25%	19%
7-12 weeks	26%	28%
13-26 weeks	11%	22%
26+ weeks	2%	6%
Total DToCs	923	604

Source: Wales Audit Office analysis of the NHS Wales delayed transfers of care database, May 2017

97 During the same period, Exhibit 14 indicates that the proportion of patients waiting over 12 hours in accident and emergency has reduced and the number of breaches is low. The Health Board's performance is better than the Wales average. However, the percentage of 12 hour breaches increased over the winter months mirroring the all Wales trend.

Exhibit 14: proportion of Health Board patients waiting more than 12 hours in accident and emergency compared to all Wales average between April 2015 and March 2017

The chart shows the proportion of patient waiting 12 hours or more at Cardiff and Vale University Health Board's accident and emergency department is reducing. Whilst the Health Board's performance is better than the Wales average, the percentage of 12-hour breaches generally increased over the winter months mirroring the all Wales trend.



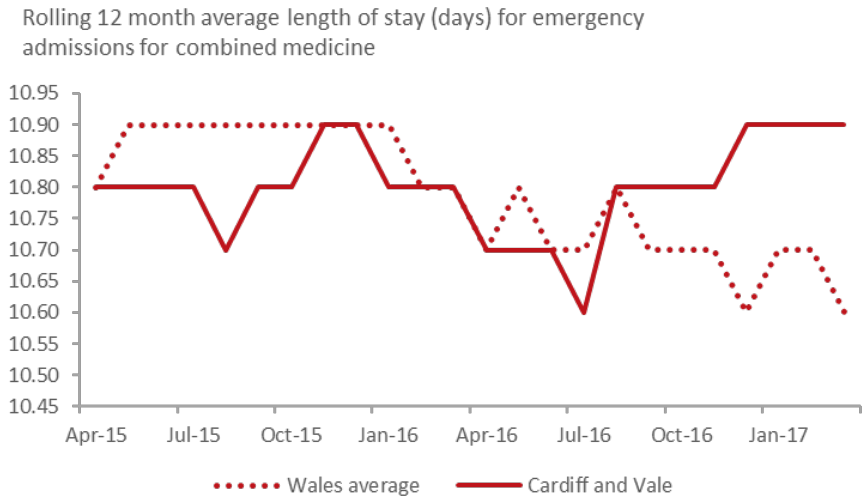
Source: Wales Audit Office analysis of the Time Spent in NHS Wales Accident and Emergency Departments: Monthly Management Information, NHS Wales Informatics Services, March 2017

98 NHS bodies are expected to reduce lengths of stay for emergency medical admissions. Performance is measured on a rolling 12-month basis (the performance reported for any single month therefore representing the average over the previous 12 months rather than the in-month performance). Exhibit 15 shows little change in the rolling average length of stay[21] for emergency medical admissions over the last two years with average lengths of stay starting to rise above the Wales average.

[21] The performance reported for any single month represents the average over the previous 12 months rather than the in-month performance.

Exhibit 15: trend in the 12 month rolling average length of stay (days) for emergency admissions for combined medical wards between April 2015 and March 2017

The charts shows small fluctuations in the rolling average length of stay for emergency medical admissions over the last two years with average lengths stay starting to rise above the Wales average.



Please note that the Y-axis does not start at zero.

Source: Wales Audit Office analysis of NHS Wales efficiency data provided by the NHS Wales Informatics Service, March 2017

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Appendix 1

NHS Wales Delivery Unit's quantitative findings from discharge planning audits at the Health Board's acute hospitals

Exhibit 16: the RAG status[22] of the Delivery Unit's assessment of written evidence in case notes against specific requirements set out in Passing the Baton[23]

The table shows that performance in relation to the patient discharge process was variable and largely poor when assessed against expected practice.

Discharge process	Expected practice	University Hospital of Wales	University Hospital Llandough
Stage 1 All discharges, within 24 hours of admission	Simple/complex discharge is identified on, or shortly after, admission to hospital.		
	A conversation will be had with the patient to establish how they were managing before admission, so that any discharge requirements can be identified, and planned for, from the admission date.		
	A conversation will be had with the patient's main carer (where appropriate) to establish any discharge requirements early in the hospital admission.		
	Long-term conditions will be identified on admission, and the patient's perception of their current status established.		
	Existing care co-ordination and support in the community is identified.		
	Patients and their families are provided with written information on what they should expect from the discharge process, and what is expected from them.		
Stage 2 Complex discharges	Early conversations take place with existing service provision to identify and pro-actively address any developing issues.		
	Existing care co-ordinator is identified.		
	In complex discharges, the patient and carer is given the contact details of the named professional who will act as their care co-ordinator.		
	In complex discharges, and MDT case conference is arranged to consider assessments and agree a discharge plan with the patient/carer.		

[22] The RAG (red, amber, green) traffic light system provides a simple colour-coding system to visualise where performance is less than optimal; for example, green would indicate that activities assessed were undertaken in all cases.

[23] National Leadership and Innovation Agency for Healthcare, **Passing the Baton**, 2008

Discharge process	Expected practice	University Hospital of Wales	University Hospital Llandough
Stage 3 All discharges	An estimated date of discharge (EDD) is set.		
	The EDD takes account of both acute and rehabilitation phases, where applicable.		
Stage 4 All discharges	The EDD is clearly communicated to the patient and their family/carers.		
	The EDD can be flexed according to an individual's response to treatment, in order to provide a realistic date for discharge.	Evidence this occurred but only 22% to 24% of case notes reviewed found evidence that the EDD had been recorded	
	Discharge plans are reviewed daily and there is evidence of actions completed.		
	Potential constraints are identified and actioned/escalated.		
	The patient and their family/carers are regularly updated on progress with the discharge plan.		
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.		
	The 'discharge/transfer' to assess model is considered in all complex discharges.		
	Timely MDT assessment is collated by the care co-ordinator.		
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.		
	Third sector provision is considered where appropriate.		
	Where required (eg to discuss onward placement or to determine CHC eligibility) MDT meetings are arranged in a timely manner.		
	If a care home placement is required, the patient and carer are provided with 'Clear information on the category of home they should by looking for.		Not applicable as none of the cases reviewed required a new care home placement.
	Information on care homes in the area.		
	Information on the Choice Policy.		
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).		
Stage 5 All discharges	A checklist is completed to ensure that the practicalities of discharge are addressed.		

Source: NHS Wales Delivery Unit, Discharge Audit at Cardiff and Vale University Health Board, February 2016

Appendix 2

Audit method

Our review of discharge planning took place across Wales between February and June 2017. Details of our audit approach are set out below.

Exhibit 17: audit methodology

The table shows the range of activities undertaken as part of the audit process.

Method	Detail
Data Collection Form – Discharge Planning (Health Board/Trust level information)	We sought corporate-level information about the extent of shared priorities for discharge and transfers of care; the services or teams available to support timely discharge; the landscape of community-based services; training to support discharge planning; performance management related to discharge planning; and the extent to which information about housing adaptation services is shared with NHS organisations. The information returned has supported both the discharge planning audit and the Auditor General's study on housing adaptations. The Health Board submitted the completed data collection form in March 2017.
Data Collection Form – Discharge Lounge	We asked NHS organisations that operated a discharge lounge services to tell us about each discharge lounge. We sought information about operational hours, the staffing profile, numbers of patients accommodated and the environment for patients. The Health Board submitted two forms, one for University Hospital of Wales and one for University Hospital Llandough.
Data Collection Form – Discharge Liaison Team	We asked NHS organisations to tell us about the discharge liaison team where these existed. We sought information about operational hours, the staffing profile, team/service costs and types of activities. Where multiple discharge liaison teams operate, one form was completed for each main acute hospital provided teams operated independently of each other. If the discharge liaison team service operated as a single integrated service, one form was completed. The Health Board submitted one form for the Integrated Discharge Service; the service covers all hospital sites.
Document request	We reviewed documents from the Health Board which covered strategies and plans for managing patient flow and unscheduled care, policies related to discharge and transfer of care and home of choice, discharge

Method	Detail
	pathways, action plans to improve discharge planning processes and patient flow, and performance reports, including those related to patient experience or information on complaints and incidents related to discharge processes. We also relied on information set out in the reports prepared for Welsh Government by each health board or regional partnership summarising how the Intermediate Care Fund was used and its impact in 2015-16.
Interviews	We interviewed a number of staff including: • Interim Chief Operating Officer • Executive Programme Director Unscheduled Care • Head of Integrated Care • Intermediate Care Liaison Manager • Head of Access Management (Patient Flow) • Independent Board Member (social services) • Community Health Council representative We also met with a group of mixed ward staff, the group included a: • Senior Nurse • Ward Sister • Ward Nurse • Intermediate Care Liaison Manager • Social Worker (Cardiff Council, part of IDS) • Occupational Therapist • Physiotherapist • Discharge Support Officer (Age Connects, part of IDS) • Consultant
Use of existing data	We used existing sources of information wherever possible such as the Delivery Unit's work on discharge planning from 2016, data from the StatsWales website for numbers of delayed transfers of care, hospital beds, staff, admissions, patients spending 12 hours or more in accident and emergency departments and lengths of stay.

Appendix 3

The Health Board's management response to the recommendations

Exhibit 18: management response

The table sets out the report's recommendations and the actions that the Health Board's intends to take to address them.

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1a	Develop a system where ward staff are able to access up-to-date information about community health and social care services.	Wider and up to date information on community services to help patients on discharge.	Yes	Yes	The Integrated Discharge Service is the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision. An Intranet Website is available currently and information on how to access the content is included within training programmes. Website address for DEWIS is also available. First Point of Contact and Single Point of Access, both ICF funded projects, are assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014.		Chief Operating Officer/ Head of Integrated Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact. A review of the web site is planned to ensure that information is current and accessible to all UHB staff. Reinforcement of available information sources will continue to be included in ongoing training programmes.	Ongoing December 2017 Ongoing	
R1b	Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated.	Ward staff are better informed and know where to find information about community services.	No	Yes	Information relating to how to access community services is available on the UHB intranet site. The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of information and data. How staff can access the current information on the UHB website and its content will be reinforced during training programmes.	Ongoing	Chief Operating Officer/ Head of Integrated Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	The Health Board should seek to involve patients and carers when the next policy revisions are due.	Patients and carers have a say in policy reviews and development meaning they are equal partners in the process.	Yes	Yes	The draft Choice Protocol and Discharge Policy are currently out for consultation. The current draft Discharge Policy and Choice protocol has been provided to South East Wales Carers Trust, Engagement Project for comment.	End October 2017	Chief Operating Officer/ Head of Integrated Care
R3	The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	Staff are well informed, leading to a consistent application of the discharge policy and pathways across the Health Board.	Yes	Yes	There is now a well-developed training and development plan in place. **Short-term Plan** **Discharge Planning** Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service; Care Homes; CRT; CWS and its use purpose. (20 session completed to date 64 staff attended) **"Get me Home"** 3 monthly workshops have been held which focus on the Home First principles. The HB has also embarked on an organisation wide De-conditioning	Ongoing	Chief Operating Officer/ Head of Integrated Care

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Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (two workshops held to dates with two further dates agreed – 120 staff attended). **SNAP Training** Daily for 2 weeks – 30min sessions, ward-based Topics: Discharge Policy Choice Protocol simple/supported complex; Integrated discharge Service; Care Homes; CRT; CWS and its use purpose; Fast Track CHC. (160 session delivered to date 280 staff attended) **Longer-term Plan** Work ongoing with Learning and Development department to facilitate Discharge Planning within undergraduate Therapy and Nurse training programmes. Work is progressing with LED colleagues to formalise the monthly multidisciplinary training programme.	Campaign Launch October 2017 Ongoing November 2017	

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Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Work is ongoing to include discharge planning in Induction programmes for all professional staff. Arrangements are in place to include specific discharge planning in the foundation course for newly qualified nurses. Collaborative work is ongoing with Cardiff University to support the inclusion of discharge planning as part of the academic curriculum for undergraduates.	November 2017 October2017 December 2017	
R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Training delivery method, which is convenient for ward staff with limited time.	No	Yes	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	TBC	Chief Operating Officer/ Head of Integrated Care
R4b	Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	Better discharge planning because staff are well trained, offered regular refresher courses and the Health Board has a record of training compliance.	Yes	Yes	Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training. Formal workshops are also recorded on the ESR system.	Ongoing	Chief Operating Officer/ Head of Integrated Care/ Clinical Boards

Appendix 4

Activities undertaken by discharge liaison teams

As part of this review, we asked health boards to what extent their discharge liaison teams undertake a range of discharge planning activities, from always to never. Exhibit 19 shows the reported frequency with which the 15 discharge liaison teams across Wales undertake these activities.

Exhibit 19: frequency with which the discharge liaison teams undertake a range of activities

The table shows the frequency with which the 15 discharge liaison teams undertake a range of activities.

Discharge planning activities	Reported frequency with which discharge liaison teams undertake the following activities				
	Always	Often	Sometimes	Rarely	Never
Participate in ward rounds or multi-disciplinary meetings.	33%	40%	20%	7%	0%
Support staff to identify vulnerable patients who could be delayed.	53%	40%	7%	0%	0%
Ensure individual discharge plans are in place for patients with complex needs.	60%	27%	13%	0%	0%
Liaise with other public bodies to facilitate hospital discharge and avoid readmission.	60%	27%	7%	7%	0%
Provide a central point of contact for health and social care practitioners.	67%	33%	0%	0%	0%
Work with operational managers to develop performance measures on hospital discharge.	27%	20%	40%	7%	7%

Discharge planning activities	Reported frequency with which discharge liaison teams undertake the following activities				
	Always	Often	Sometimes	Rarely	Never
Validate data on delayed transfers of care.	87%	7%	0%	0%	7%
Provide training and development for clinical staff to effect timely discharge.	33%	13%	40%	13%	0%
Update bed managers with information on hospital discharges.	67%	20%	0%	7%	7%
Provide housing options advice and support to patients and their families.	27%	27%	20%	7%	20%
Signpost patients and their families to advice and support for maintaining independence at home.	33%	27%	27%	7%	7%

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 9)

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Review of GP Out-of-Hours Services – **Cardiff and Vale University Health Board**

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10

Purpose of this document

This document is a draft supplied in confidence solely for the purpose of verifying the accuracy and completeness of the information contained in it and to obtain views on the conclusions reached.

Handling prior to publication

This document has been prepared as part of work performed in accordance with statutory functions.

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The work was delivered by Stephen Lisle and Anne Beegan.

Contents

The Health Board has strengthened the governance of GP out-of-hours but performance is mixed and risks remain in relation to the sustainability of the service.

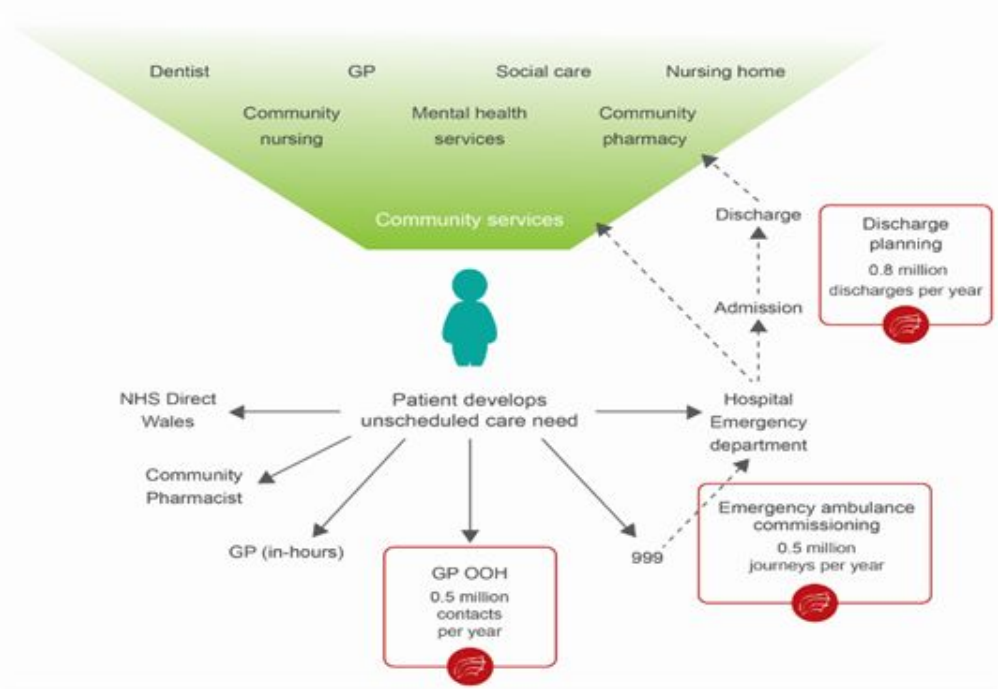
10

Summary report

Background

1 General practice out-of-hours (GP out-of-hours) services provide healthcare for patients with urgent (but not emergency) medical problems outside normal surgery hours[1]. These services manage more than 0.5 million patients every year in Wales[2] and are a key component of the wider unscheduled care system (Exhibit 1). When GP out-of-hours services struggle to meet demand, this can have knock-on impacts on the rest of the system, causing increased pressure on ambulance services, hospital emergency departments and in-hours primary-care services.

Exhibit 1: GP out-of-hours services within the wider system of unscheduled care



Source: Wales Audit Office

2 Health boards are responsible for ensuring their resident populations have access to high-quality GP out-of-hours services. Some health boards provide these

[1] The out-of-hours period runs from 6:30pm until 8:00am on weekdays, as well as weekends and public holidays.

[2] Welsh Government, Wales Quality and Monitoring Standards for the Delivery of Out-of-Hours Services, May 2014.

services by employing GPs on a sessional or salaried basis[3], while other health boards choose to commission services from private companies.

3 In 2012, a ministerial review led by Dr Chris Jones, concluded that GP out-of-hours services across Wales were unsustainable in their current form[4]. The report highlighted a lack of investment, opportunities for economies of scale, a lack of comparable data and a shortage of medical staff.

4 Our previous work on unscheduled care in 2009[5] and in 2013[6] also identified specific problems in GP out-of-hours services across Wales. These problems included recruitment and retention of GPs as well as scope to improve integration and information sharing with other unscheduled care services.

5 In May 2014, Welsh Government published its national standards for GP out-of-hours services with the intention of developing a common framework for performance management and governance. All health boards are expected to have implemented the standards by March 2018.

6 In 2015, the Welsh Government's Delivery Unit (DU) reviewed health boards' preparedness to implement the standards. Across Wales, they found that work was underway to achieve the standards but:

- gaps were apparent in performance reporting;
- there remained difficulties recruiting GPs;
- there was a need to standardise clinical pathways; and
- there was a need to better understand capacity and demand.

7 In March 2015, a conference of Welsh Local Medical Committees voted to support a motion calling for an urgent review of the sustainability of GP out-of-hours services. The conference warned that services were becoming unsustainable due to difficulties in filling GP rotas and changes in triage processes that were resulting in an increase in demand.

8 Furthermore, a May 2015 report on GP out-of-hours services at Betsi Cadwaladr University Health Board highlighted a number of problems with the service across North Wales including inadequate staffing levels, long waiting times and a lack of clinical leadership. There was also potential to improve staff training, monitoring and clinical governance.

9 The Public Accounts Committee (PAC) expressed its concerns about the failings of GP out-of-hours services across North Wales as part of its review of governance

[3] Salaried staff are directly employed by the service and are paid a regular salary. Sessional staff work for the service as and when required and are paid depending on the number of sessions they work.

[4] Dr Chris Jones, Primary Care Out of Hours Review, Interim Report, July 2012.

[5] Auditor General for Wales, Unscheduled care: Developing a whole systems approach, 15 December 2009.

[6] Auditor General for Wales, Unscheduled care: An update on progress, 12 September 2013.

arrangements at Betsi Cadwaladr University Health Board and across NHS Wales more widely.

10 The Welsh Government has provided updates to the PAC on health boards' actions to embed the national standards for GP out-of-hours services. But it was not clear whether the problems experienced at Betsi Cadwaladr University Health Board were prevalent elsewhere in Wales. The Auditor General therefore decided it was timely to review GP out-of-hours services across Wales to examine this, and broader aspects of the management of GP out-of-hours services as part of the wider unscheduled care system.

11 The review aimed to establish whether Cardiff and Vale University Health Board (the Health Board) is ensuring that patients have access to effective and resilient GP out-of-hours services. Appendix 1 provides details of the audit methodology. The work focused specifically on the:

- overall governance arrangements;
- financial and clinical sustainability of services; and
- performance and patient experience.

12 As part of our methodology, we carried out a postal survey of a sample of patients who had contacted the out-of-hours services across Wales. We did not receive enough responses to our patient survey to allow robust comparisons across health boards, however the results of our survey at an All-Wales level are included in Appendix 2 of this report.

Key findings

13 Our overall conclusion is: **The Health Board has strengthened the governance of GP out-of-hours but performance is mixed and risks remain in relation to the sustainability of the service.** In the paragraphs below we have set out the main reasons for coming to this conclusion.

Governance arrangements

14 The GP out-of-hours service has strengthened its monitoring and leadership arrangements and has recently written a business case to improve its strategic planning. We reached this conclusion because:

- the Health Board does not have a GP out-of-hours strategy but is planning change to the service through an action plan and a new business case;
- there are good arrangements for clinical and operational leadership of the GP out-of-hours service; and
- the Health Board has strengthened the way it monitors GP out-of-hours performance and learns from incidents but the approach to clinical audit and patient feedback is limited.

Financial and clinical sustainability

15 There are risks to the sustainability of the service because problems remain in filling GP shifts and spending is comparatively low. We reached this conclusion because:

- the service has increased its skill mix but remains fragile because there is no workforce plan and there are frequent problems filling shifts; and
- the Health Board's expenditure on GP out-of-hours has decreased and in 2015-16 its spending was the lowest per contact in Wales. Since our fieldwork, the Health Board has increased funding for GP out-of-hours services.

Performance and patient experience

16 Call taking performance is comparatively good but there is scope to improve the timeliness of home visits, appointments and especially call backs. We reached this conclusion because:

- the Health Board works in a range of ways to inform the public about out-of-hours services but there is scope to improve signposting from its website and practice answerphone messages;
- the service answers calls more quickly than other services in Wales and whilst there appear to be no call terminations, there may be inaccuracies in the data;
- timeliness of call backs to patients remains one of the service's most stubborn problems with performance remaining below the all-Wales average;
- timeliness of home visits and appointments is mixed compared with the average performance across Wales; and
- problems with data consistency make it difficult to compare referral patterns and whilst the out-of-hours service does not have a directory of services, it does have protocols with emergency departments.

Recommendations

17 As a result of our work, we make the following recommendations in relation to GP out-of-hours services.

Exhibit 2: recommendations

Recommendations	
R1	**Planning:** the Health Board does not have a GP out-of-hours strategy or workforce plan. Expenditure on out-of-hours in 2015-16 was comparatively low, although the Health Board has since increased its spending. The Health Board should: a. Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance; and b. develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service.
R2	**Performance management:** the Health Board has strengthened the way it monitors GP out-of-hours performance. Some weaknesses remain in clinical audit for GPs and learning from patient feedback. The data considered in our review also suggested that there had been no call terminations to the GP out-of-hours service during the sample period, which may suggest data accuracy problems. The Health Board should: a. introduce processes for learning from patient feedback to improve GP out-of-hours services; b. prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards; and c. check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate.
R3	**Public messaging:** we found large variation in the public messages about GP out-of-hours on practice answerphone messages. We also found scope to improve messaging on the Health Board website. The high rate of referrals from GP out-of-hours to other services further suggests scope to do more to ensure patients are accessing the most appropriate service. The Health Board should: a. improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. b. work has already been undertaken to try to ensure all GP practices have a standard answerphone message that provides appropriate information about the out-of-hours service. The Health Board now needs to ensure this is rolled out and implemented in all practices.

Recommendations	
	c. as part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours.
R4	**Interface with other services:** the Health Board's data suggests that in some practices there are high numbers of patient contacts with the out-of-hours service soon after it opens. We also found that the out-of-hours service has difficulties in accessing the in-hours GP Record system. The Health Board should: a. share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand; and b. identify and address the reasons that are preventing out-of-hours staff from accessing the GP record.

Detailed report

The GP out-of-hours service has strengthened its monitoring and leadership arrangements and has recently written a business case to improve its strategic planning

The Health Board does not have a GP out-of-hours strategy but is planning change to the service through an action plan and a new business case

18 GP out-of-hours services are an essential part of the unscheduled care system. The national review into these services in 2012, led by Dr Chris Jones, urged health boards to consider the development of GP out-of-hours services as a key component of their strategic vision for unscheduled care.

19 We assessed the Health Board's plans, looking for a documented plan for GP out-of-hours services that identified and addressed the key risks related to the service. We also reviewed the Health Board's wider plans for unscheduled care, to assess whether GP out-of-hours features prominently and coherently. We found that the Health Board does not have a specific strategy for GP out-of-hours but it does have an action plan. The action plan contains around 50 actions aimed at solving specific issues within the service.

20 In summer 2016, the GP out-of-hours service experienced a weekend of significant operational problems which has prompted changes to service planning. The weekend involved an acute shortage of GPs which resulted in a complete one-night closure of the service. Patients contacting the service heard an answerphone message diverting them to in-hours primary care, NHS Direct Wales or 999.

21 Since summer 2016, the Health Board has updated its action plan and developed a specific business case for GP out-of-hours services. The business case identified problems with the service's workforce model, problems filling shifts, and recommends the Health Board increases its expenditure on GP out-of-hours. The business case proposed an increases in expenditure of between £78,000 and £158,000 in the current financial year, plus a recurrent increase of between £374,000 and £731,000, depending on different options for staff pay rates.

22 Since our fieldwork, the Health Board has agreed to fund an additional GP to work in the out-of-hours service every night, and for an additional 18 hours throughout the weekends. The business case had also recommended an increase to GP pay rates but the Health Board did not support the recommendation, pending the conclusion of work on pay rates at an all-Wales level. The Health Board did, however, agree in-year funding for a bundling approach that provides enhanced payments to GPs willing to cover a number of less attractive shifts.

23 Our document review also looked at the Health Board's broader plans, to see if they focus sufficiently on GP out-of-hours. We found that some of the problems being experienced by GP out-of-hours are referred to in the Health Board's

Integrated Medium Term Plan (IMTP). The IMTP states that GP out-of-hours is 'fragile' and mentions recruitment difficulties. Senior staff also told us that GP out-of-hours regularly features in discussions within the Health Board's Big Room[7] approach to planning unscheduled care.

24 Our survey of GP out-of-hours staff[8] asked whether the Health Board had consulted staff in relation to the planning of the service. In the survey, 30% of the Health Board's respondents agreed or strongly agreed with the statement 'I was given ample opportunity to give my opinions to inform the development of the plan for GP out-of-hours services'. The equivalent figure in Wales as a whole was 24%.

25 Health boards are required to implement the national GP out-of-hours standards by March 2018. In late 2015, the Delivery Unit (DU) asked health boards to self-assess their readiness to implement each of the standards. Appendix 3 shows that the Health Board believes it is towards the middle of the pack when compared with other health boards in the extent of implementation of the 34 standards. The Health Board gave itself a 'limited development' rating for one performance standard and a 'work underway' rating for another six standards. Every month, the Health Board monitors performance against these standards and agrees a set of actions to address any performance issues.

26 Our previous work on unscheduled care across Wales found that health bodies were planning services without a comprehensive understanding of demand. This was contributing to problems in meeting demand, such as delays in patients receiving their care. The Health Board carried out analysis of capacity and demand in 2014 and again in 2016, with the focus being on meeting the national performance standards. The work carried out in partnership with the Health Board's Performance Department suggested a significant increase in capacity was required to meet demand and to meet the national performance standards. This analysis was used to inform the business case referred to earlier in this section.

27 Planning work is ongoing at an all-Wales level to put in place a new care coordination service called 111. This service will be a single point of access for unscheduled care services including GP out-of-hours and will provide integrated call taking, clinical assessment, information provision, signposting and referral. The Health Board is scheduled to be the last area in Wales to roll out the 111 service, so at the time of our fieldwork there was not a clear timescale or plan for implementation.

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[7] The Big Room is an approach to whole-system planning, involving weekly and high-profile discussions among staff from across the organisation, led by the chief executive.

[8] We carried out an online survey of all staff that work in the GP out-of-hours service. We received 73 responses from across the Health Board. The Health Board have not reported to us how many whole time equivalents they have working in the GP out-of-hours service

There are good arrangements for clinical and operational leadership of the GP out-of-hours service

28 Effective leadership and clear lines of accountability are vital components of any healthcare service. Our scoping work for our review on GP out-of-hours services suggested there was a risk that the leadership arrangements for GP out-of-hours services in health boards are unclear or distant from the actual delivery of services.

29 In common with all health boards, we found that the Health Board has a specific executive member directly responsible for GP out-of-hours. In some health boards, more than one executive member shares responsibility for out-of-hours. This is the case for Cardiff and Vale where the Chief Operating Officer is the named executive with operational responsibility for GP out-of-hours service, while the Medical Director maintains professional responsibility. Below the executive team, the next tier of management responsibility for GP out-of-hours lies with the Primary, Community and Integrated Care (PCIC) Clinical Board.

30 During our fieldwork we were told that the Health Board's leadership arrangements were contributing to a fairly high profile for GP out-of-hours. Senior managers are regularly involved in meetings to discuss GP out-of-hours and the PCIC has taken a proactive involvement in the service through its risk log and its service monitoring arrangements.

31 The self-assessments against implementation of the national standards submitted to the DU showed health boards across Wales had taken a variety of approaches to providing clinical leadership within GP out-of-hours services. The Health Board has made changes to address issues with its clinical leadership arrangements. A new clinical director has been put in place, with the support of two medical advisers. At the time of our work, a third medical advisor was being brought in because the leadership team remained short of time and capacity.

32 In response to our staff survey, 63% of the Health Board's respondents agreed or strongly agreed that GP out-of-hours is 'effectively managed by the service's clinical leaders' (the figure across Wales was 48%). 14% of the Health Board's staff disagreed or strongly disagreed (compared with 26% across Wales). During our fieldwork, we were also told positive things about the service's operational leadership. Staff told us that the management team was visible, and readily available on-call.

The Health Board has strengthened the way it monitors GP out-of-hours performance and learns from incidents but the approach to clinical audit and patient feedback is limited

33 A key part of the governance of GP out-of-hours services is the monitoring and review of performance. The national review into GP out-of-hours services in 2012 highlighted issues with monitoring performance, including a lack of consistent and comparable data across Wales.

34 At the Health Board, we found that the introduction of the national standards, and the national requirements to collect and report data, have contributed to better, more routine monitoring. GP out-of-hours performance data is considered monthly by the PCIC Service Delivery Group, monthly by the Health Systems Management Board, and also monthly in performance meetings between the PCIC and the Executive Team. The out-of-hours action plan is monitored weekly as part of operational management meetings.

35 Whilst it is a positive finding that the Health Board has increased its monitoring of out-of-hours, we were told by some staff that the service is now busy generating reports and data. The Health Board should ensure it has struck the right balance between regular reporting and over-production of reports, to ensure it is making the best use of its staff and data. Since our fieldwork, the Health Board has carried out work to rationalise reporting on GP out-of-hours services.

36 The Health Board carried out considerable work some two years ago to cleanse the performance data it was getting from the Adastra computer system. However, whilst the Health Board is now more confident in the accuracy of its data, there are remaining problems in other health boards, leading to difficulties in benchmarking.

37 The service would benefit from learning more from patients' feedback. Patient surveys, or information from interviews and focus groups is an important aspect of service improvement. However, in common with many GP out-of-hours services across Wales, the Health Board's service has not surveyed patients for several years.

38 A key part of performance management of GP out-of-hours services is regular clinical audit, to provide clinicians with feedback on their work. At the Health Board, and in common with most other health boards, GPs are not having their clinical contacts regularly audited. This is due to time constraints within the clinical leadership team. We were told however, that nursing staff have regular clinical audits, although this work is time-consuming.

39 We were told in interviews that there is large variation in productivity within the service's clinical staff. For example, some clinicians can triage ten cases an hour, whilst some other staff can only triage three cases. The service's management has been reluctant, so far, to challenge this variation because it does not want to deter any staff from working for the service.

40 If governance of GP out-of-hours is to be effective, Board and committees should routinely consider high-profile information on performance. At the Health Board, the Executive Team considers out-of-hours data every month, which is more frequent than in most other organisations. Exhibit 3 shows that in response to our Structured Assessment survey[9], Board members in the Health Board agreed more

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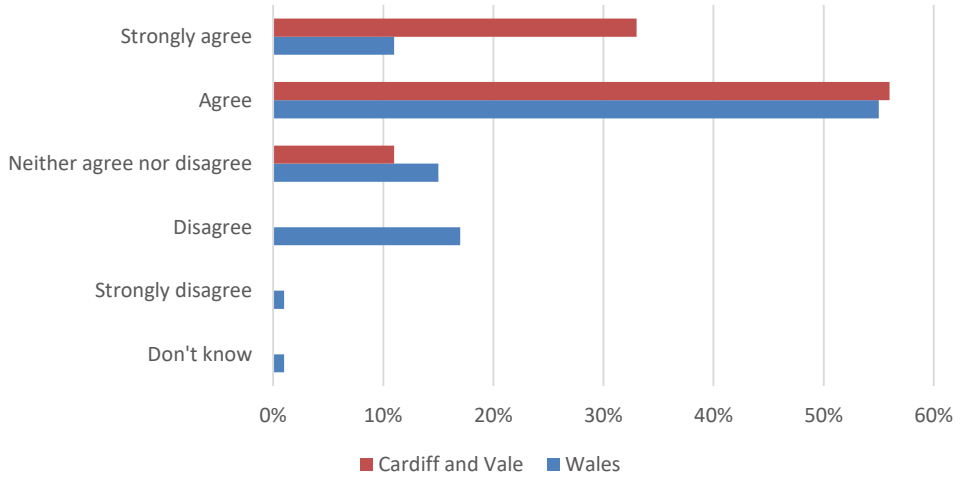
[9] As part of our 2016 structured assessment work, we surveyed all Board members on a number of aspects of governance. The survey included a number of questions specifically relating to GP out-of-hours services. We received responses from 16 board members in Hywel Dda University Health Board.

strongly than in other health boards that the Board and its committees regularly scrutinise the performance and quality of the GP out-of-hours service.

Exhibit 3: percentage of Board Members who agreed with the following statement 'The Board and its committees regularly scrutinise the performance and quality of GP out-of-hours services'.



Source: Wales Audit Office survey of Board Members.

41 Where health boards identify errors or incidents in relation to GP out-of-hours services, they should report the incidents to the National Reporting and Learning System (NRLS). Exhibit 4 highlights considerable variation between health boards in the number of incidents reported to the NRLS within GP out-of-hours services. The Health Board did not report any incidents in 2013 and 2014, but in 2015, did report four incidents.

Exhibit 4: number of incidents reported to the NRLS between 2013 and 2015

	Number of incidents reported		
Health Board	**2013**	**2014**	**2015**
Aneurin Bevan	83	92	136
Betsi Cadwaladr	15	10	1
Cwm Taf	2	4	3
Cardiff and Vale	**0**	**0**	**4**
Abertawe Bro Morgannwg	0	0	2
Powys	0	1	0

	Number of incidents reported		
Health Board	**2013**	**2014**	**2015**
Hywel Dda	0	0	0

Source: NRLS, NHS Commissioning Board Special Health Authority.

42 In our survey of GP out-of-hours staff, 62% of the Health Board's respondents agreed or strongly agreed with the statement 'Information obtained through complaints, incidents and error reporting is used to make care safer'. 15% neither agreed nor disagreed, 8% said they disagreed or strongly disagreed, and 15% said they did not know. These results were more positive than the results for the rest of Wales.

43 During our fieldwork, senior staff told us that the service had made marked improvements to its complaints handling and learning from incidents. Previously, the service did not have a set process for investigations, and complaints handling was taking a long time. The incident learning process is now being owned and driven by a Band 5 member of staff. The Community Health Council told us it has recognised improvements in the handling of complaints.

44 Another key aspect of reviewing GP out-of-hours services is through health boards' monitoring and management of risks. Whilst the Health Board does not have a specific risk register for out-of-hours, the PCIC Clinical Board Risk Register identifies the GP out-of-hours service as its highest service risk. This in turn feeds into the Health Board risk register. The risk rating reflects problems in filling shifts and in ensuring timely performance.

There are risks to the sustainability of the service because problems remain in filling GP shifts and spending is comparatively low

The service has increased its skill mix but remains fragile because there is no workforce plan and there are frequent problems filling shifts

45 Our scoping work across Wales highlighted considerable risks regarding the sustainability of GP out-of-hours services. The national review of GP out-of-hours services in 2012 stated that there was a manpower crisis in Wales and drew attention to some services struggling to ensure adequate staffing.

46 We requested from health boards documentation setting out their workforce plan for GP out-of-hours services. We were looking for clear plans for the future, setting out required skills and resources, based on a good understanding of demand. The Health Board does not have a workforce plan for GP out-of-hours although the service's business case does include some limited aspects of workforce planning. For example, it identifies gaps in capacity that it plans to fill with GPs in the short term, but then by increasing the skill mix of the service in the next two to three years. The Health Board told us that since our fieldwork, the service has increased its skill mix of new roles and is in the process of developing an overall workforce plan.

47 When deciding their ideal mix of salaried and sessional staff, health bodies have to weigh up the pros and cons. For example, whilst salaried staff can provide more stability, sessional staff may provide greater flexibility. The Health Board's GP out-of-hours service has no salaried GPs. The service has tried to recruit salaried GPs in the past but they have not been able to fill the posts due to lack of interest.

48 Traditionally, GPs provide the direct patient care in GP out-of-hours but staffing models are gradually changing. The national Primary Care Plan[10] states that 'No GP should routinely be undertaking any activity which could, just as appropriately be undertaken by an advanced practice nurse, a clinical pharmacist or an advanced practitioner paramedic'. As such, health bodies are gradually trying to move towards GP out-of-hours teams that supplement GPs with specialist nurses, paramedics and pharmacists. Following a skill mix review, the Health Board has recruited the following staff into the GP out-of-hours service: triage nurses, advanced nurse practitioners, advanced paramedic practitioners, minor illness nurses, prescribing pharmacists and dental nurses. During interviews, staff told us that the skill mix of the service was a real strength. However, some interviewees told us that the new staffing model was still in its infancy, with non-medical staff not

[10] Welsh Government, **Our plan for a primary care service for Wales up to March 2018**, February 2015.

being a perfect replacement for GPs because they require considerable supervision from GPs.

49 Staffing and capacity within GP out-of-hours services should be flexible enough to be able to respond to seasonal spikes in activity, such as the pressures experienced in April and December each year because of respiratory viruses. The Health Board does attempt to flex its capacity at peak times by increasing the resource available for call handling, triage and face-to-face consultations. At peak times, the Health Board also flexes its approach by asking GPs to swap between triage and consultation work, depending on the demand. Some GPs are allowed to work from home at peak times, as an incentive to recruit to shifts when the service is very busy. The Health Board often decides to close its GP out-of-hours centre at Barry or at University Hospital of Wales to centralise its resource at Cardiff Royal Infirmary.

50 During 2016, the service amended its escalation policy following a particularly difficult weekend where 280 patients were awaiting triage. The policy now considers the number of staff working during a shift, in addition to the number of callers waiting. Staff told us that the escalation policy is now better but could be further strengthened. For example, some staff felt the policy focuses on informing senior staff that the GP out-of-hours service is under pressure, rather than being focused on taking specific actions to deal with the pressure. Staff also felt that the policy could be improved by strengthening links with neighbouring health boards, to ask neighbours to help out when the GP out-of-hours service is under strain. The Health Board's escalation policy is now being shared as good practice with other health boards in Wales.

51 Even when health boards have a robust workforce plan, there can still be problems in ensuring appropriate staffing of GP out-of-hours services. For example, there may be difficulties in recruiting staff to posts, and difficulties in filling shifts. The Health Board recognises that filling shifts is one of the service's biggest challenges. Operational staff told us about very frequent difficulties in filling GP shifts. The Health Board would like to have two doctors covering night shifts at weekends, instead of one doctor, but it recognises that it may struggle to fill the additional shift. Exhibit 6 shows the staffing position in the Health Board compared with the rest of Wales. The data suggests that the Health Board has a smaller pool of GPs to draw upon, that filling shifts can be a problem and that staff had comparatively negative views about the service's staffing levels.

Exhibit 6: measures comparing staffing resources across Wales

Aspects of staffing	Health Board	Across Wales
Size of list of GP pool to draw upon per 1000 population	0.18	Ranging from 0.17 in Betsi Cadwaladr to 0.25 in ABM.
GP shifts unfilled rate (2015-16)	12%	7% (average) Ranging from 0.5% in Powys to 20% in Aneurin Bevan

Aspects of staffing	Health Board	Across Wales
Percentage of staff		
• agreeing or strongly agreeing that their workload was manageable	69%	66%
• agreeing or strongly agreeing that the current staffing levels in the GP out-of-hours service are sufficient to meet demand	15%	21%

Source: Self-assessments submitted to the Delivery Unit, Wales Audit Office survey of GP out-of-hours staff, Wales Audit Office health board questionnaire.

52 The staff that work in GP out-of-hours services are essential to the success of patient care. Health boards, therefore, need to support these staff to engender positive morale and to ultimately ensure they are happy to continue to work within the service. Exhibit 7 suggests the Health Board's staff wellbeing and support arrangements are more effective than the average position across Wales. However, during our fieldwork we were told about some problems with morale and disagreements amongst the call taking and administrative staff which has led to the development of a staff charter.

Exhibit 7: staff support arrangements and measures of staff wellbeing

Percentage of staff:	Health Board	Across Wales
agreeing or strongly agreeing that they received a comprehensive induction when they started work for the out-of-hours services	73%	64%
agreeing or strongly agreeing that they get sufficient training, learning and development within the out-of-hours service to carry out their role	80%	57%
agreeing or strongly agreeing that morale in the out-of-hours service is good	43%	31%
agreeing or strongly agreeing that they will still be working in the out-of-hours service in a year's time	81%	73%

Source: Wales Audit Office survey of GP out-of-hours staff.

The Health Board's expenditure on GP out-of-hours has decreased and in 2015-16 its spending was the lowest per contact in Wales

53 Exhibit 8 compares the amount of funding that Welsh Government notionally allocates to GP out-of-hours services with the actual expenditure on GP out-of-hours services in each health board. Cardiff and Vale paid £720,000 more on GP out-of-hours services in 2015-16 than the notional allocation it received from Welsh Government[11].

Exhibit 8: Health Board actual spend on GP out-of-hours service compared with the notional allocation from Welsh Government

Health Board	Notional allocation from Welsh Government 2015-16 (£000s)	Actual expenditure on GP out-of-hours services in 2015-16 (£000's)	Subsidy paid by health boards (£000's)	Subsidy paid by health boards as a percentage of notional allocation
Powys	1,980	2,543	563	28.4%
Aneurin Bevan	4,736	6,078	1,342	28.3%
Cwm Taf	2,447	3,064	617	25.2%
Hywel Dda	4,826	6,009	1,183	24.5%
Cardiff and Vale	**3,048**	**3,768**	**720**	**23.6%**
Abertawe Bro Morgannwg	4,533	4,905	372	8.2%
Betsi Cadwaladr	7,169	7,222	53	0.7%
WALES	28,739	33,589	4,850	16.9%

Source: Wales Audit Office analysis of Welsh Government data and health board local financial returns. Subsidy = Actual expenditure minus Notional allocation.

54 Exhibit 9 shows that whilst the total GP out-of-hours expenditure by health boards in Wales increased in cash terms by 6% between 2009-10 and 2015-16, when we took inflation into account, there was a real-terms reduction of 3%. Over the same period in the Health Board, there was a 2% decrease in cash terms, and an 11% decrease in real terms. The Health Board is one of four health boards that has decreased its expenditure on GP out-of-hours in real terms.

[11] The funding for the area covered by Hywel Dda increased in 2008-09 by £0.22 million, although we have been unable to ascertain the specific reasons for the increase.

Exhibit 9: change in GP out-of-hours expenditure between 2009-10 and 2015-16

	Expenditure on GP out-of-hours services (£000)		Change in expenditure between 2009-10 and 2015-16	
Health Board	**2009-10**	**2015-16**	**Cash terms**	**Real terms**
Hywel Dda	4,738	6,009	27%	16%
Cwm Taf	2,657	3,064	15%	5%
Abertawe Bro Morgannwg	4,238	4,905	16%	6%
Powys	2,534	2,534	0%	-8%
Cardiff and Vale	**3,847**	**3,768**	**-2%**	**-11%**
Aneurin Bevan	6,005	6,078	1%	-8%
Betsi Cadwaladr	7,632	7,222	-5%	-14%
WALES	**31,651**	**33,581**	**6%**	**-3%**

Source: Wales Audit Office analysis of health board local financial returns. To calculate the real terms changes we used the Gross Domestic Product deflators published by HM Treasury. GDP deflators measure inflation across the whole economy. We used the deflators issued in December 2016 to put all figures into 2015-16 prices.

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55 Exhibit 10 shows how the Health Board's expenditure on GP out-of-hours services compares with other bodies across Wales when considering its catchment population. Cardiff and Vale is the lowest spending health board in relation to cost per contact and is also lowest spending health board in relation to out-of-hours expenditure per 1,000 population. Cardiff and Vale is also the lowest in Wales for out-of-hours expenditure as a percentage of total GMS expenditure. During interview, staff told us that the service's budget is frequently underspent due to difficulties in filling GP shifts.

Exhibit 10: GP out-of-hours expenditure across Wales, 2015-16

Health Board	**Out-of-hours expenditure per 1000 population (£)**	**Cost per contact (£)**	**Out-of-hours expenditure as % of total GMS expenditure (2015-16)**
Abertawe Bro Morgannwg	9.33	36.07	6.7%
Aneurin Bevan	10.45	68.88	7.0%
Betsi Cadwaladr	10.40	50.36	6.2%
Cardiff and Vale	**7.77**	**34.63**	**5.5%**

Health Board	Out-of-hours expenditure per 1000 population (£)	Cost per contact (£)	Out-of-hours expenditure as % of total GMS expenditure (2015-16)
Cwm Taf	10.33	50.65	6.8%
Hywel Dda	15.68	93.32	9.8%
Powys	19.17	71.63	7.4%
WALES	**10.84**	**52.74**	**6.9%**

Sources: Local Health Boards' LFRs; Mid-Year Population Estimates, Office for National Statistics.

56 A key aspect of the financial sustainability, as well as the clinical sustainability, of GP out-of-hours services is the approach the Health Board takes to paying GPs. Whilst staffing models are gradually changing, GPs remain essential in leading GP out-of-hours services. Health boards need to strike a balance between paying enough to attract GPs to work in the service whilst also ensuring value for money. Exhibit 11 shows how the Health Board approach to GP sessional pay compares with other bodies across Wales. The Health Board has agreed a shift bundling approach that incentivises staff to commit to working for more than one shift at a time. The Health Board has also attempted to agree a standard rate of pay with neighbouring health boards and have been keen for an all-Wales agreement on pay rates. However, staff told us that the other health boards are continuing to increase their rate of pay at pressured times, perpetuating competition between health bodies. We were also told that the Health Board's previous efforts to improve bank holiday shift filling by increasing pay rates have come too late, due to delays in the decision making and approval process. The Health Board believes it has now resolved this issu.

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Exhibit 11: approach to sessional pay across Wales

	This Health Board	All health boards	
		Yes	No
Increased rate of pay for filling shifts at late notice.	No	3	4
Increased rate of pay for filling shifts well in advance (thereby incentivising early sign up to shifts.	No	0	7
Increased rate of pay for committing to more than one shift (incentivised bundling model).	Yes	3	4
Increased rate of pay for completing shifts as intended (thereby incentivising staff to work the shifts they agreed to fill).	No	0	7

	This Health Board	All health boards	
		Yes	No
Standardised rates of pay agreed with neighbouring health boards.	Yes	2	5
Standardised rates of pay agreed with all health boards in Wales.	No	0	7
Sessional rates in the out-of-hours service are identical to in-hours locum rates for GPs.	No	1	6

Source: Health Board Questionnaire

Call taking performance is comparatively good but there is scope to improve the timeliness of home visits, appointments and especially call backs

The Health Board works in a range of ways to inform the public about out-of-hours services but there is scope to improve signposting from its website and practice answerphone messages

57 Our previous work on unscheduled care showed that patients can find it difficult to decide how best to access unscheduled care services. If GP out-of-hours services are to succeed in managing demand appropriately, the public needs to be informed about the real purpose of GP out-of-hours and how to access the service appropriately.

58 Health boards have tried a range of actions to inform the public about GP out-of-hours services. The Health Board told us it informs the public through the work of its Communications Team, using the Choose Well campaign and social media. The Primary Care Team also runs a multidisciplinary access group to review frequent attenders and holds patient case conferences. The team is also linking with 1000 lives regarding behavioural insights training.

59 We reviewed health board websites to assess the extent of information on GP out-of-hours services for the public. Exhibit 12 shows how the results for the Health Board compared with the rest of Wales. We were only able to find two pieces of information about GP out-of-hours services on the Health Board's website that we were looking for.

Exhibit 12: comparison of GP out-of-hours information available on Health Board websites

	This Health Board	All health boards	
		Yes	No
Is there any information on the landing page about GP out-of-hours services?	No	4	3
Is there any information on the landing page about the Choose Well campaign?	Yes	7	-
Does the website have a page on GP out-of-hours services?	Yes	7	-
Does the GP out-of-hours page provide a description of the GP out-of-hours service?	No	3	4

	This Health Board	All health boards	
		Yes	No
Does the GP out-of-hours page provide examples to illustrate conditions/circumstances where it is appropriate to access GP out-of-hours services?	No	1	6
Does the GP out-of-hours page provide the opening hours of the GP out-of-hours service?	No	2	5
Does the GP out-of-hours page provide the locations of the GP out-of-hours primary-care centres?	No	2	5

Source: Wales Audit Office review of health board websites.

60 We reviewed a sample of GP practice websites and carried out 'mystery shopping' calls to GP practice phone lines, outside normal working hours, to assess how well they signpost patients to GP out-of-hours services. Exhibit 13 shows how GP practices in the Health Board compared with those across Wales. Importantly, the answerphone messages in the Health Board area varied considerably in their descriptions of the GP out-of-hours service. Some messages described the purpose of GP out-of-hours as 'urgent medical advice' or 'in emergencies'. Other messages simply told patients to contact GP out-of-hours 'if you want a consultation with the out-of-hours service' or 'if you require to speak to a doctor urgently'. Further descriptors were used on GP websites. The Health Board's Access group has promoted the use of standardised messages, but our work has found that many GP practices are not complying with this guidance.

Exhibit 13: comparison of GP out-of-hours information available on practice websites and automated messages

	This health board (10 practices)		Wales (70 practices)	
Practice websites	**Yes**	**No**	**Yes**	**No**
Does the practice have a website?	9	1	59	11
Does the landing page signpost patients to GP out-of-hours services?	5	4	31	29
Does the website give patients the telephone number for the GP out-of-hours service?	8	1	57	3
Does the website state that GP out-of-hours services are for 'urgent' cases only?	8	1	34	26
Does the website state that GP out-of-hours services are not for 'emergency' cases?	2	7	22	38

	This health board (10 practices)		Wales (70 practices)	
Practice websites	**Yes**	**No**	**Yes**	**No**
Does the website signpost patients to NHS Direct Wales (and other services)?	6	3	44	16
Practice phone lines	Yes	No	Yes	No
Was the call answered?	10	-	69	1
Was the call automatically diverted to the GP out-of-hours service?	3	7	16	53
Did the answerphone message give the phone number of the out-of-hours service?	7	2	49	18
Did the message say that out-of-hours services are not for 'emergency' cases, or explain what to do in an 'emergency'?	1	8	32	36
Did the message state that GP out-of-hours services are for 'urgent' cases only?	4	5	35	33
Did the message signpost patients to NHS Direct Wales (and other services)?	5	4	47	20

Source: Wales Audit Office review of GP practice websites and phone lines.

10

61 Our mystery shopping showed that there are at least five different phone numbers for GP out-of-hours services across the Health Board, three promoted through GP answerphone messages, and a further two promoted through GP websites[12]. The Health Board may want to consider whether this is overcomplicating patient access to the GP out-of-hours service.

62 Our scoping suggested that problems in accessing in-hours primary care may be driving additional demand for GP out-of-hours services. The Health Board recognises this issue and regularly monitors the number of contacts with the out-of-hours service, by practice, between 6.30pm and 7.30pm as a proxy measure for problems accessing in hours services. The data show large variations by practice, suggesting scope to improve in-hours access in some practices.

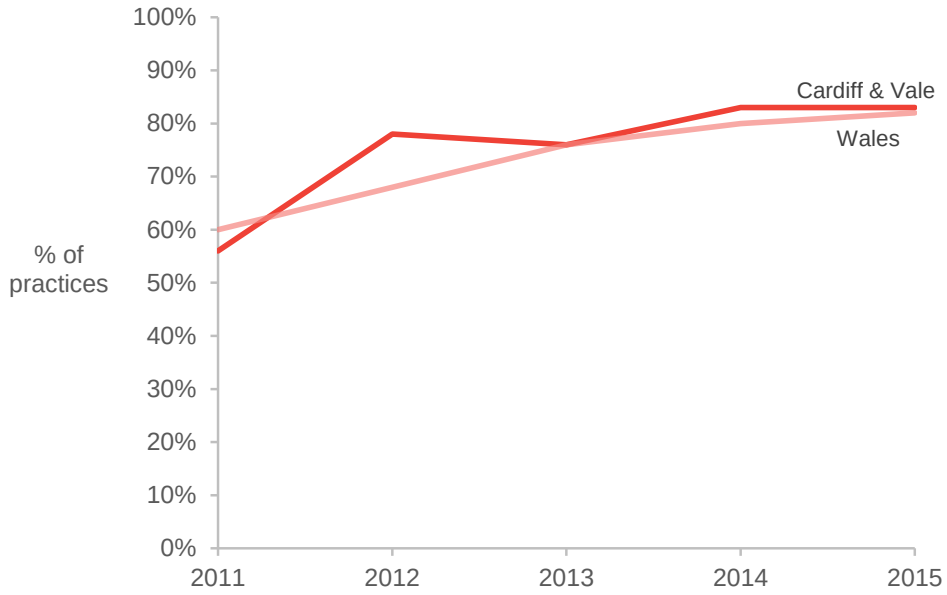
63 Exhibit 14 shows an increase across Wales in the percentage of GP practices that are open for the entirety of their core hours[13]. The definition of 'open' in this instance is that the practice's doors are physically open and a patient can have

[12] The phone numbers were 01446 729562, 01446 704666, 02920 44450, 01446 744877 and 01446 735365.

[13] Under the General Medical Services (GMS) contract (the UK-wide contract between general practices and primary care organisations for delivering primary care services to local communities), GP practice core hours are Monday to Friday, between 08:00 and 18:30 (except on Good Friday, Christmas Day and Bank Holidays).

face to face contact with a receptionist. The exhibit shows that performance in surgeries across the Health Board is marginally better than the all-Wales average.

Exhibit 14: percentage of GP practices open for their entire core hours



Source: Wales Audit Office analysis of data from My Local Health Service, NHS Wales.

64 There has been an increase across Wales in the percentage of practices that offer appointments between 5.00pm and 6.30pm, on at least two days per week. All practices across the Health Board now offer such appointments, making the health board one of the best performing for this measure.

65 Exhibit 15 shows less progress across Wales in ensuring practices offer appointments before 8.30am on at least two days a week. The Health Board's performance is comparatively better with 24% of practices offering such early appointments. This is the highest performance in Wales.

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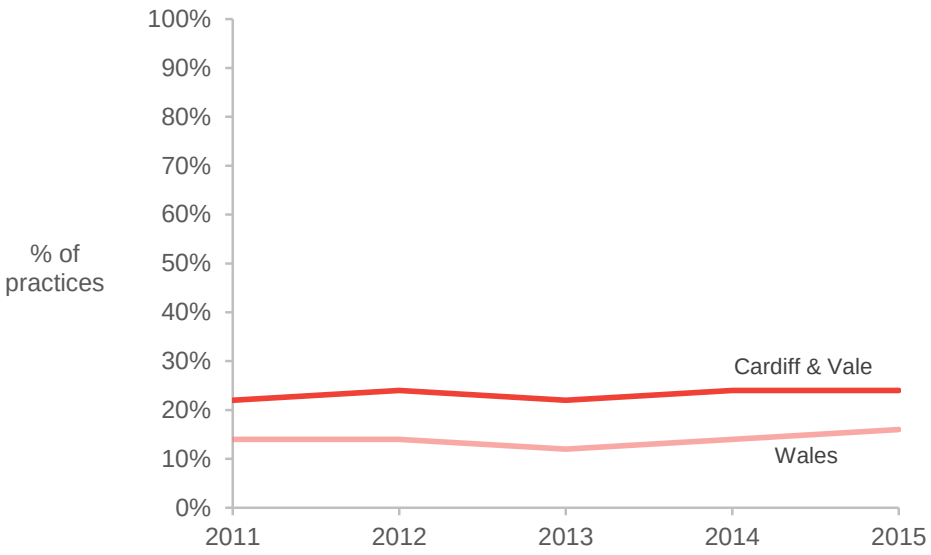
Exhibit 15: percentage of GP practices that regularly offer early appointments



Source: Wales Audit Office analysis of data from My Local Health Service.

10

The service answers calls more quickly than other services in Wales and whilst there appear to be no call terminations, there may be inaccuracies in the data

66 Most GP out-of-hours services use an automated system to answer calls so that patients hear a pre-recorded message. If the message is too long or complicated, or if it takes too long for the message to begin, patients may decide to terminate the call. The Health Board's data suggests no calls to GP out-of-hours were terminated[14] in this way. This seems unlikely and the Health Board should review its data to ensure they are accurate (Exhibit 16).

67 After the answerphone/automated message, patients will typically speak to a call taker. If there are delays at this stage, patients may choose to abandon the call. In the Health Board, 6% of calls were abandoned[15] at this stage, which is lower than

[14] Definition of terminated calls: Calls terminated by the caller before or during the pre-recorded message. If there is no pre-recorded message, a call is classed as terminated if the caller has hung up within 30 seconds of the call being recorded on the service's telephony system. The data cover April 2016 to September 2016.

[15] Definition of abandoned calls: Calls where the caller hung up before the call was answered by a call handler after the pre-recorded message (or after the initial 30

the all-Wales average. The data also show that between April and September 2016, the Health Board's GP out-of-hours service answered nearly 90% of calls within 60 seconds of the end of the answerphone message. This is the highest across Wales, however the national standards for GP out-of-hours services state that health boards should be achieving 95%.

Exhibit 16: call handling performance, April to September 2016

	Health Board	Wales
Percentage of calls terminated	0.0	14.6
Percentage of calls abandoned in 60 seconds or less	3.8	7.0
Percentage of calls abandoned after 60 seconds	2.2	5.3
Percentage of calls answered within 60 seconds (after the pre-recorded message)	89.8	74.3
Percentage of calls answered after 60 seconds (after the pre-recorded message)	10.2	25.7

Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to Welsh Government by the health boards.

10

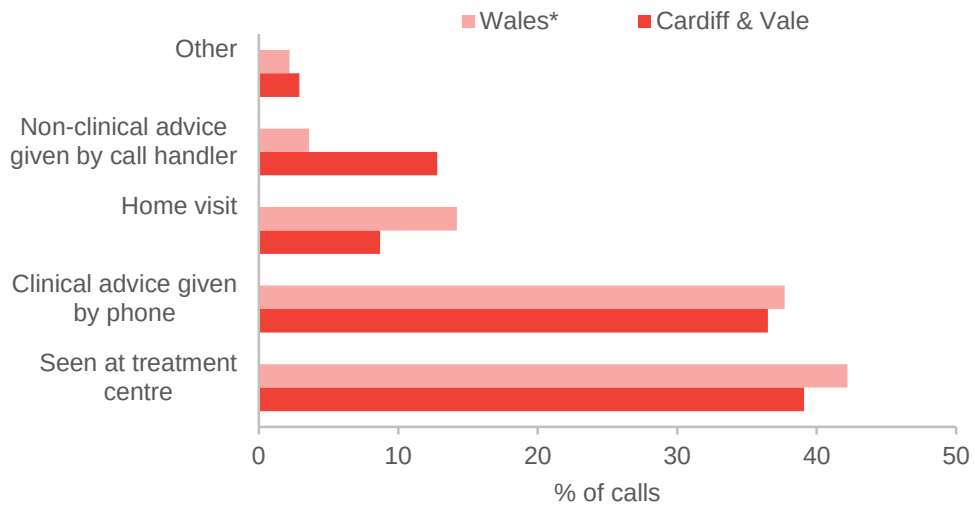
Timeliness of call backs to patients remains one of the service's most stubborn problems with performance remaining below the all-Wales average

68 Once the GP out-of-hours service has taken a call from a patient, the call taker may choose to manage the patient in one of several ways. Exhibit 17 shows how the Health Board handled calls[16] between April 2016 and September 2016. It shows that the Health Board's patients were more likely than in Wales as a whole to receive the entirety of their treatment through non-clinical advice given by a call handler. Cardiff and Vale patients were marginally less likely to have a home visit or an appointment at the GP out-of-hours facility.

seconds, if there is no pre-recorded message). The data cover Apr 2016 to September 2016.

[16] We have excluded calls where the patient had a life-threatening emergency.

Exhibit 17: the way in which the GP out-of-hours service manages calls, April to September 2016



Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to the Welsh Government by the health boards.

10

69 Telephone triage is the process that GP out-of-hours services use to assess the immediate needs of patients. The Health Board used to run an 'expert triage' model where additional emphasis and resource was focused on triage, to stop as many contacts as possible from progressing beyond the triage stage. The service now uses a direct booking model, where clinicians go through the details of the patients awaiting a call back, to directly book them into appointments where necessary. This aims to avoid an unnecessary telephone contact with the clinician. Since moving away from the expert triage model, GPs are no longer trained in triage. Instead, they shadow another GP for one shift. The Health Board's GP out-of-hours service also includes a dental triage service. This involves dental nurses fielding calls from patients.

70 After a patient has described their symptoms to the call taker, the GP out-of-hours service may decide that the patient needs a call back from a clinician. The national standards state that 98% of urgent calls should receive a call back within 20 minutes. Between April and September 2016, 71.6% of urgent calls in the Health Board received a call back within 20 minutes (compared with 78% across Wales as a whole). The national standards also state that 98% of 'routine' calls should receive a call back within 60 minutes. Between April and September 2016, 80.4% of routine calls to the Health Board received a call back within 60 minutes. The equivalent figure in Wales as a whole was 82.3%.

71 The Health Board's service has been criticised by the Community Health Council in the past for the timeliness of its call backs. Staff told us that the service is now making more effort to give patients a true indication of the delay they are likely to

experience in receiving a call back. Staff told us that timeliness of call backs has improved but remains a problem, particularly at weekends. The Health Board's business case for GP out-of-hours recognises that at peak times, between 50 and 200 patients may be awaiting a call back from the service, which can 'result in risks to patient safety, avoidable harm and outcomes'.

72 In our survey of GP out-of-hours staff in the Health Board, 69% of respondents said they were comfortable with the proportion of calls dealt with entirely on the telephone (sometimes referred to as 'hear and treat'). 15% were not comfortable. Across Wales, 54% were comfortable whilst 25% were not.

73 For hear-and-treat to be most effective, it helps if the clinician has access to a summary of the patient's medical history through a computer system called the GP Record. In the Health Board, 2.7% of the patients that contacted GP out-of-hours had their GP Record accessed by the service. This compares with 5.6% across Wales. The out-of-hours action plan recognises a particular issue with 'poor access' to the record.

Timeliness of home visits and appointments is mixed compared with the average performance across Wales

74 If the service deems a patient's condition serious enough, the telephone consultation may result in an appointment with a clinician in a GP out-of-hours treatment centre or a visit to the patient's home.

75 If the patient's condition is 'very urgent', the national standards state that 90% of patients should be seen at an appointment or through a home visit within an hour. 90% of 'urgent' patients should be seen within two hours and 90% of 'less urgent' patients should be seen within six hours. Exhibit 18 suggests that the Health Board's GP out-of-hours service is generally providing more timely home visits than in Wales as a whole, other than for 'less urgent' cases. However, the Health Board is performing less well for face-to-face appointments at treatment centres, other than for 'urgent' cases.

Exhibit 18: percentage of patients seen within the relevant time targets, April to September 2016

	Health Board	Wales[1]
Home visits		
Percentage of 'very urgents' seen within one hour	71.1	59.9
Percentage of 'urgents' seen within two hours	77.0	69.2
Percentage of 'less urgents' seen within six hours	77.9	92.7
Treatment centre		
Percentage of 'very urgents' seen within one hour	68.3	85.7
Percentage of 'urgents' seen within two hours	81.6	80.9

	Health Board	Wales[1]
Percentage of 'less urgents' seen within six hours	96.1	97.2

Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to Welsh Government by the health boards.

[1] The figures for Wales exclude Abertawe Bro Morgannwg University Health Board and Cwm Taf University Health Board.

76 In the Health Board between April 2016 and September 2016, 2.1% of patients that had an appointment booked at the GP out-of-hours treatment centre did not attend their appointment. This equates to an approximate cost of £10,200 between April 2016 and September 2016[17].

Problems with data consistency make it difficult to compare referral patterns and whilst the out-of-hours service does not have a directory of services, it does have protocols with emergency departments

77 Our scoping work suggested that GP out-of-hours services may be experiencing demand from patients that were suitable for other services. Out-of-hours services are for urgent cases but not emergencies, therefore the life-threatening emergency cases seen in GP out-of-hours services represent misplaced demand. Across Wales, 3.5% (6,756 cases) of all calls to GP out-of-hours services between April 2016 and September 2016 were life-threatening emergency cases. In the Health Board, the corresponding figure was 2.5% (929 cases).

78 If a patient contacts GP out-of-hours and is subsequently referred to their GP, it could be argued that the patient should have seen their own GP in the first instance. This is not true in all cases but we present the data here for discussion purposes. Across Wales, 17.6% (33,747 cases) of all calls to GP out-of-hours services between April 2016 and September 2016 resulted in referrals to the patient's own GP. In the Health Board, the corresponding figure was 26.6% (10,057 cases).

79 Across Wales, 40.8% of patients that contacted GP out-of-hours between April 2016 and September 2016 required a referral to a different service. In the Health Board, the corresponding figure was 60%. Exhibit 19 shows that the pattern of referrals made by the service in the Health Board varies considerably to the all-Wales position in a number of indicators. This may reflect differences in data collection processes.

[17] We calculated the cost per appointment by dividing the total cost of out-of-hours services by the number of appointments in 2015-16.

Exhibit 19: pattern of referrals made by GP out-of-hours services, April to September 2016

	Health Board	Wales
Category: Hear-and-treat patients		
Received a telephone assessment only and the call was closed	50.6	54.7
Referred to emergency ambulance service	0.2	5.7
Referred to hospital emergency department or minor injury unit	8.6	10.6
Referred to hospital admission or assessment on a hospital ward	1.2	2.9
Referred to their own GP	18.5	14.4
Referred to district nursing	0	2.6
Referred to dentist	0	0.3
Other	21.0	8.9
Category: Patients seen at treatment centres		
Did not attend the appointment or left before the appointment took place	2.1	1.0
Treated and discharged	32.2	61.1
Referred to emergency ambulance service	0.2	0.1
Referred to hospital emergency department or minor injury unit	1.7	1.8
Referred to hospital admission or assessment on a hospital ward	11.2	9.1
Referred to their own GP	45.3	23.4
Other	7.3	3.6
Category: Patients seen at home		
Treated and discharged	19.7	60.4
Referred to emergency ambulance service	0.2	0.6
Referred to hospital emergency department or minor injury unit	0.6	2.1
Referred to hospital admission or assessment on a hospital ward	13.6	7.9
Referred to their own GP	32.2	17.0
Other	25.4	6.2

Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to the Welsh Government by the health boards.

80 Where GP out-of-hours refers emergency cases to the ambulance service, the national standards state that the service should transfer all such calls within three minutes. Between April 2016 and September 2016, the Health Board transferred 100% of such calls within three minutes. There was insufficient data available to calculate an all-Wales position for this measure.

81 A potential barrier to effective referrals is the availability of other services outside normal working hours. During fieldwork staff told us about good availability of the district nursing service and the acute response team. In our survey of GP out-of-hours staff, the services that staff felt were least available related to:

- mental health crisis;
- frail person with diarrhoea and vomiting who needs hydration; and
- frail person found on the floor and lives alone.

82 Even when alternative services are available to take referrals from GP out-of-hours services, there is a risk that GP out-of-hours staff will not make referrals because they do not know about these alternative services. The Health Board's GP out-of-hours services do not have access to an up-to-date directory of service, which is likely to limit their ability to make appropriate referrals. However, the out-of-hours service triage suites do have reference packs which provide telephone numbers of other services.

83 A key relationship within the unscheduled care system is that between GP out-of-hours and the hospital emergency department. When patients access emergency departments and their needs can be appropriately met by GP out-of-hours, there needs to be robust processes for referring these patients to GP out-of-hours. The Health Board is one of six health boards across Wales that has a written protocol that covers all GP out-of-hours services, setting out how emergency departments should refer patients to GP out-of-hours services when clinically appropriate. The Health Board also has a protocol that applies in some of its emergency departments, setting out how the GP out-of-hours service should routinely in-reach to the emergency department, to identify patients suitable for GP out-of-hours.

84 During fieldwork staff told us that relationships between the out-of-hours service and the emergency departments are improving. The clinical directors for these services now meet regularly and a working group has been set up to improve working practices. A particular driver for this work has been the problems experienced by the out-of-hours service in summer 2016.

Appendix 1

Audit methodology

Our review of GP out-of-hours services took place across Wales between June and November 2016. Details of the audit approach are set out below.

Exhibit 20: audit methodology

Method	Detail
Health board questionnaire	The questionnaire was the main source of corporate-level data that we requested from the Health Board.
Document request	We reviewed documents from the Health Board which covered: • The GP out-of-hours Action Plan and Business Case • IMTP Operational Plan • Presentation showing capacity and demand analysis • Minutes and papers of the PCIC • PCIC risk register
Interviews	We interviewed a number of staff including: • Interim Chief Operating Officer • PCIC Director of Operations • PCIC Head of Primary Care Services Operations and Delivery • Head of Primary Care Improvement/GP out-of-hours • Operational Manager for GP out-of-hours • Clinical Director of GP out-of-hours • Deputy Clinical Shift Lead for GP out-of-hours • Community Health Council
Surveys of GP out-of-hours staff	We carried out an online survey of all staff that work in the out-of-hours service. We had 72 responses at the Health Board.
Survey of patients	We carried out a postal survey of 1,990 randomly selected patients in Wales that had contacted the out-of-hours service on any of the following dates: 12, 13, 16, 17, 18 July 2016. We received responses from 330 patients, giving a response rate of 16.6%.
Survey of Board members	As part of our structured assessment work, we surveyed NHS Board members. We included a small number of questions relating to out-of-hours services. At Cardiff and Vale we had responses from 9 members.
Review of health board websites	We reviewed the health board's website to assess the effectiveness of information provided on how and when to access out-of-hours services.
Mystery shopping: GP practice phone lines and websites	We made telephone calls, after practice closing times, to a sample of 10 practices in each Health Board. We assessed the answerphone message for effectiveness in information provision to patients. We also assessed GP-practice websites to assess the signposting to the out-of-hours service.

Method	Detail
Use of existing data	We used existing sources of data such as incident data from the National Reporting and Learning System, data from the Delivery Unit's 2015 work on out-of-hours, data from the My Local Health Service website and data submitted by health boards to the Welsh Government.

Appendix 2

All-Wales patient survey results

85 We did not receive enough responses to our patient survey to allow robust comparisons across health boards. The data we present from the patient survey are therefore a picture of opinions (from 330 respondents) from across Wales.

86 When asked about their overall level of satisfaction, 77% of respondents said they rated the GP out-of-hours service as 'excellent' or 'very good'. We also asked patients whether the advice or treatment provided by the GP out-of-hours service had had a positive impact on their symptoms. Exhibit 21 shows the results from across Wales.

Exhibit 21: percentage of patients who said the GP out-of-hours service had a positive impact on their symptoms

Please indicate how much impact the out-of-hours service had on your overall symptoms	Percentage of respondents
My symptoms improved a lot	43%
My symptoms improved a little	22%
My symptoms did not improve	13%
My symptoms got worse	9%
It is too soon to tell	2%
Don't know / Not applicable	11%

Source: Wales Audit Office survey of patients.

87 Our scoping work suggested that patients may be confused about how and when to access out-of-hours services. A proxy measure of whether patients are confused about how and when to access GP out-of-hours services is the percentage of patients that accessed a different service before accessing the GP out-of-hours service. Our patient survey showed that 66% of respondents across Wales had accessed one or more different services before accessing GP out-of-hours services. Exhibit 22 shows which services they accessed.

Exhibit 22: Range of services accessed by patients before contacting GP out-of-hours services

Service	Percentage of respondents
GP surgery	32%
NHS Direct Wales	18%
Pharmacy / Chemist	6%
Accident and Emergency department or minor injuries unit	5%
District nurse / community nurse	4%
Ambulance service / 999	4%
Other	8%

Source: Wales Audit Office patient survey. Note: the right hand column does not add up to 100% because some patients accessed more than one service, while some patients accessed none.

88 When we asked patients whether they were satisfied that GP out-of-hours services had been the right service for their needs, 87% of respondents said 'Yes', 8% said 'No' and 5% said 'Don't know'.

89 We also asked how patients found the telephone number for the GP out-of-hours service. Exhibit 23 shows the results from across Wales.

Exhibit 23: mechanism by which patients access the GP out-of-hours phone number

How did you find the number of the GP out-of-hours service?	Percentage of respondents
I got it from my GP surgery	45%
I already had the number	37%
I looked it up on the internet	7%
I asked a healthcare professional	4%
I asked a friend / relative /carer	3%
I looked it up in the telephone directory	1%
Other	4%

Source: Wales Audit Office survey of patients.

90 Once a patient has decided to contact the GP out-of-hours service, it is important that the service answers calls quickly. In our survey, 9% of respondents across Wales said it took 'longer than I expected' for their call to be answered, 56% said it took 'about what I expected' and 35% said it took 'less time than I expected'.

91 After a patient has their initial call answered, it is common for the GP out-of-hours service to arrange to call the patient back at a later time. In our survey, 288 respondents received a call back from the GP out-of-hours service. Of these respondents, 16% said it took 'longer than I expected' to get a call back, 50% said it took 'about what I expected' and 34% said it took 'less time than I expected'.

92 If a patient needs to be seen by a clinician face to face, the GP out-of-hours service may offer an appointment or a home visit. In our survey, 61 patients said the out-of-hours service did not offer them a face-to-face appointment or home visit. Of these respondents, around one-third would have preferred a face-to-face appointment or a home visit.

93 Exhibit 24 shows the survey results from in relation to appointments and home visits. The findings suggest largely positive patient experience, particularly for face-to-face appointments.

Exhibit 24: measures of patient experience of GP out-of-hours appointments and home visits across Wales

Face-to-face appointments (180 respondents)

- 85% of patients who responded to our survey said that they waited as long as they had expected or less time than they had expected, whilst 15% of respondents waited longer than they had expected.
- 82% of respondents said that the location of their appointment was convenient, whilst 10% of respondents said it was inconvenient.
- 97% of respondents said the service treated them with respect during their appointment and 98% said that the healthcare professionals listened to them carefully.
- 91% of respondents said that their appointment with the healthcare professionals was at least as long as they had expected, whilst 9% of respondents said that their appointment had been shorter than expected.

Home visits (73 respondents)

- 62% of respondents said the service told them the time that they should expect their home visit, 22% said they were not told and 16% couldn't remember.
- 74% respondents said that they waited as long as they had expected or less time than they had expected for their home visit, whilst 26% of respondents said that waited longer than they had expected.
- All respondents, except one, said that during the home visit, the healthcare professional listened carefully and treated them with respect.
- 96% of respondents said that their home visit was at least as long as they had expected.

Source: Wales Audit Office survey of GP out-of-hours patients.

94 78% of respondents to our survey said that after accessing GP out-of-hours they needed to access another service to have their needs met. This may suggest

patients are not accessing the right service for their needs, or it may reflect that patients are contacting GP out-of-hours with complex problems that are not easy to solve in the out-of-hours environment.

Appendix 3

Health boards' self-assessment against the national standards

Exhibit 25: Health Board self-assessment against the national standards

Aim		Performance Standard	Health Boards						
		Achieved	CT	BCU	CV	AB	ABMU	HD	Powys
		Work Underway							
		Limited Development							
		No response							
To ensure that services respond in a timely manner	1.1	Introductory message should include signposting to emergency services for clearly identifiable life-threatening conditions.							
	1.2	All patients receive a prompt response to their initial contact.							
	1.3	Patients will receive a timely, co-ordinated clinically appropriate response to their needs.							
	1.4	Referrals to other services are appropriate.							
Accessible	2.1	A single point of access in place.							
	2.2	Services are planned across organisational boundaries							
	2.3	Language							
	2.4	Disability							
	2.5	Signposting							
Knowledgeable	3.1	The service will be staffed by appropriately skilled and trained clinical and non-clinical staff.							
	3.2	Relevant medical history is considered to support the consultation.							
Effective	4.1	Patients receive clinical assessment in line with current national standards and guidelines.							
	4.2	Quality improvement methodology used to continually develop local services and share good practice.							
	4.3	Significant event analysis is in place.							
	4.4	Serious incidents are reported through LHB processes to ensure reporting in line with Putting Things Right and Datix guidelines.							
	4.5	Clinician audit in place using a recognised and accredited template e.g. RCGP toolkit.							
Care is Safe	5.1	Risk Management in place and lines of accountability are clear.							
	5.2	Efficient transmission of OOH data to GP Practices.							
	5.3	Communicating effectively internally and externally with patients, service users, carers and staff							
	5.4	Clear governance and accountability frameworks in place							
	5.5	Prescribing formulary agreed, with particular attention to antibiotics							
	5.6	Controlled drugs policy and procedures in place & controlled drugs are available for OOH services to dispense							
	5.7	Effective complaints handling and compliments reporting processes in place							
	5.8	Effective Serious Incident reporting processes in place							
	5.9	Relevant safety alerts are highlighted							
Consistent	6.1	The service will be able to flexibly adjust to meet periods of high demand without detriment to service provision							
	6.2	Systems, capacity and workload planning takes into account variation in demand, to allow for 4 consultations per hour for face-to-face consultation within a Primary Care Centre setting							
	6.3	Common framework of standards and governance across urgent and unscheduled care provision							
Acceptable	7.1	Equality, Diversity and Human rights policies and procedures in place in line with Equality Act 2010 and local HB policies							
	7.2	Dignity and respect policies in place							
	7.3	Information and consent issues addressed							
Relevant	8.1	Development of clinical pathways							
	8.2	Working with other services to develop a Locality based approach to unscheduled care e.g. WAST, Care Homes, Prisons, Patient Groups							
Efficient	9.1	Financial probity assured							

10

Source: Delivery Unit, Key findings from the Health Boards' baseline assessment of GP Out-of-Hours Services, October 2015.

Appendix 4

Management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1a	Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance	Appropriate, sustainable funding for the GP out-of-hours service	Yes	Yes	Historically the Cardiff and Vale Out of Hours service benchmarked the lowest in Wales in terms of investment per patient.; however due to significant investment , this has increased. C&V will look to review funding per 1000 population, and compare against the Welsh average if this information is available and reliable from other Health Boards. All Wales expenditure to be reviewed through the Out of Hours QSE group,	Oct 2017 (but reviewed at the PCIC Q,S&E committee on an ongoing periodic basis)	Jane Brown

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					taking into account the difference in Health Board population, and where possible service skill mix.		
R1b	Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service	Better strategic and workforce planning to ensure appropriate staffing levels to cope with demand	Yes	Yes	Workforce and governance reviews currently being undertaken to inform the future workforce development prior to the implementation of 111. 111 may have signifant implications for the C&V workforce which will have to be taken into account as and when more information is known. Work has already been undertaken to identify those shifts that are regularly difficult to fill considering alternative clinical cover. It has been acknowledged that the traditional GP OOHs model is not necessarily	November 2017 – long term workforce plan developed (based on what is currently known re 111)	Jane Brown

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					sustainable in the current climate, with ongoing difficulties in filling core shifts, as such skill mix will be a key factor moving forward. This includes consideration of salaried GPs as well the wider workforce.		
R2a	Introduce processes for learning from patient feedback to improve GP out-of-hours services	Improved service performance and patient experience		Yes	Develop more patient feedback mechanisms in conjunction with corporate services to for use by OOHs patients. Analysis with themes and trends to be discussed at Out of Hours QSE meeting. Produce information leaflets and posters for patients, along with a section on the service webpage to promote selfcare.	End Sept 2017 – Patient experience feedback mechanisms in place to be mapped and introduced. Learning and feedback to be routinely collected and analysed.	Ailsa Pritchard

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2b	Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards	Assurance that clinical contacts are of high quality	Yes	Yes	Agreed audit process in place; feedback to OOHs QSE meeting.	Process in place by September 2017. Continual review at OOHs QSE meeting.	Helen Earland/ Sherard Lemaitre
R2c	Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate	Better data quality, leading to better performance management		Yes	Work is underway to review this information working with the Vale Local Authority who provide some of the telephony statistics. Further work on an All Wales basis is taking place to review OOHs telephony statistics which Cardiff and Vale are leading on.	October 2017	Ailsa Pritchard
R3a	Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the	Better public understanding and use of GP out-of-hours services		Yes	This information has been updated on the intranet for GP OOHs. The internet information is being led by a primary care group, which is also looking at GP OOHs. The	December 2017	Ailsa Pritchard

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	conditions and circumstances in which patients should use it				refreshed GP OOHs internet site will include all information about the service and advice for the public on self care and other services that can be accessed.		
R3b	Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service	Better public understanding and use of GP out-of-hours services		Yes	A standardised message was promoted `through the primary care access group, of which 27 practices used a standardised message. However, this cannot be enforced with the practices. Work is ongoing with practices to improve the uptake rate to ensure that a consistent message is provided to patients.	October 2017	Jane Brown
R3c	As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours	Better public understanding and use of GP out-of-hours services		Yes (but dependent on 111 roll out)	Work towards rationalising the numbers down to one number, impact on stakeholders will need to be assessed	November 2017	Jane Brown

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					during this change process. The Head of OOHs is a member of the Directory of Services group, which is looking at this issue longer term, and will continue to work to ensure a single point of access.		
R4a	Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand	Reduced demand on GP out-of-hours from certain GP practices		Yes	Information included in the desktop assessment of practice sustainability as an additional indicator of performance. Send out monthly to practices and clusters. To be included in the information shared and discussed at annual Practice Development Visits as well as sharing through CD forum.	In place and will be refreshed as part of the PDPs in Sept 17. In place and will continue monthly.	Jane Brown

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4b	Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record	Better clinical information to inform contacts within the GP out-of-hours service		Yes	Ongoing issues with IHR have impacted on the ability for staff working in the Out of Hours service in being able to acess the GP record; This has been raised with NWIS and C&V IT colleagues as a priority area for change. A meeting with the C&V IT dept arranged for August 2017 to review IT related issues and agree actions to address these.	August 2017 – Meeting with IT dept and action plan to be produced to track and address issues.	Jane Brown/ Gareth Bulpin

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Auditor General for Wales

Review of follow-up outpatients – assessment of progress – **Cardiff and Vale University Health Board**

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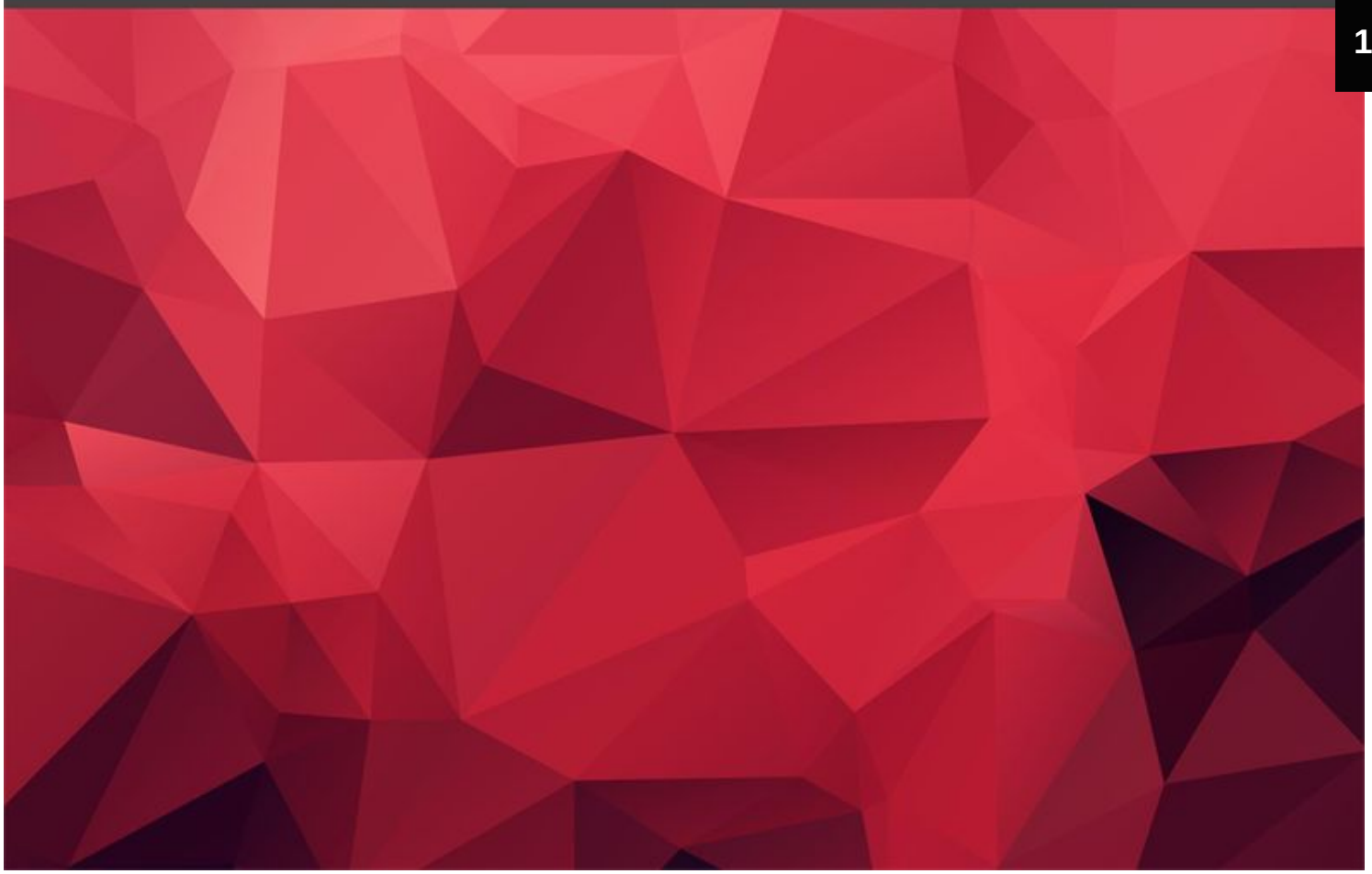

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The person who delivered the work was Katrina Febry.

Contents

The Health Board has made progress in addressing the recommendations made in our 2015 report, and, with the Outpatient Transformation Programme (under the remit of the Planned Care Board), is well placed to meet all recommendations.

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Summary report

Introduction

1 Outpatient services are complex and multi-faceted and perform a critical role in patient pathways. The performance of outpatient services has a major impact on the public's perception of the overall quality, responsiveness and efficiency of health boards.

2 Outpatient departments see more patients each year than any other hospital department with approximately three million patient attendances a year[1], in multiple locations across Wales. A follow-up appointment is an attendance to an outpatient department following an initial or first attendance.

3 Over the last 20 years, follow-up outpatient appointments have made up approximately three-quarters of all outpatient activity across Wales. Follow-up outpatients are the largest part of all outpatient activity and have the potential to increase further with an aging population which may present with increased chronic conditions and co-morbidities. Follow-up appointments that form part of the treatment package itself, for example, to administer medication, or to review a patient's condition, are not subject to timeliness targets set by the Welsh Government. Instead, these are managed within the context of clinical guidelines and locally determined target follow-up dates.

4 Since January 2015, each health board has been required to submit a monthly return to the Welsh Government detailing the number of patients waiting (delayed) at the end of each month for an outpatient follow-up appointment based on their target date[2]. As part of its NHS Outcomes Framework 2016-17[3], the Welsh Government has included a revised outcome target to reduce the numbers of patients waiting for an outpatient follow-up that have exceeded their agreed target date.

5 As part of the 2015 audit programme the Auditor General carried out a review of follow-up outpatients across all seven health boards in Wales. The review sought to answer the question 'Is the Health Board managing follow-up outpatient appointments effectively?'

6 We reported our findings for Cardiff and Vale University Health Board (the Health Board) in October 2015 and concluded that 'from a difficult starting point, the Health Board is taking appropriate action to identify the volume of its outpatient follow-up need but too many patients are delayed, the trend is worsening and it needs to do a lot more to develop sustainable follow-up outpatient services'. In making this conclusion, we found that:

[1] Source: Stats Wales, Consultant-led outpatients' summary data.

[2] Target date is the date by which the patient should have received their follow-up appointment.

[3] Welsh Health Circular (2016) 023

- the Health Board has taken a pragmatic approach to determining the volume of outpatient follow-up demand, but it needs to better understand clinical risks to patients;
- while follow-up waiting lists are more accurate, too many patients are delayed, the trend is worsening, and scrutiny and assurance arrangements need strengthening; and
- the Health Board is improving the administration of follow-up waiting lists but needs to develop a planned approach to modernise outpatient services.

7 In 2015, our report made the recommendations set out in Exhibit 1.

Exhibit 1: recommendations made in 2015

2015 Recommendations
Follow-up outpatient reporting
R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.
Clinical risk assessment
R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.
Outpatient transformation
R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways. R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider: • the clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; • internal and external engagement with stakeholders; and • primary and community care capacity to support outpatient modernisation.

Source: Wales Audit Office

8 As part of the Audit Plan for 2016, the Auditor General has included local work to track progress made by the Health Board in addressing the recommendations made in the 2015 Review of Follow-up Outpatient Appointments. This progress update commenced in February 2017 and asked the following question: **Has the Health Board made sufficient progress in response to the findings and recommendations made in the original review?**

9 In undertaking this progress update, we have:

- reviewed a range of documentation, including reports to the board and committees;
- undertaken some high-level analysis of recent Health Board data submitted to the Welsh Government in relation to follow-up outpatient appointments; and
- interviewed a number of Health Board staff to discuss progress, current issues and future challenges.

10 A summary of our findings is set out in the following section with more detailed information provided in the appendices.

Our findings

11 Our overall conclusion is that the Health Board has made progress in addressing the recommendations made in our 2015 report, and with the Outpatient Transformation Programme (under the remit of the Planned Care Board), is well placed to meet all recommendations.

12 In our previous report we highlighted that the Health Board's outpatient follow-up list contained a number of erroneous inclusions. Whilst our report made no recommendation on the validation of the list, we have highlighted progress made in reviewing the inclusions on the list in Appendix 1.

13 Exhibit 2 summarises the status of progress against our 2015 recommendations.

Exhibit 2: status of 2015 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
5	1	4	–	–

Source: Wales Audit Office

14 We found that the Health Board has fully implemented one recommendation, and made progress against all other recommendations. The Health Board is well placed to increase the pace of improvement:

- the People, Planning and Performance Committee receives information and focuses on outpatient follow-up risks and the progress made in validating the waiting list.

- clinical boards are required to set out how they will validate their waiting lists, target high-risk patients delayed beyond their target date and how they will modernise outpatient services. Performance against plans is monitored.
- the Health Board has completed the clinical risk assessment to identify conditions across all specialties where patients could come to irreversible harm due to delays in follow-up appointments.
- the Health Board has identified no patients experiencing harm as a result of a delay in their follow-up appointment.
- work is continuing to identify and target high-risk patients experiencing a delay in their follow-up appointment.
- some specialities have taken steps to modernise outpatient services, including shifting follow-up care into the primary care service (where appropriate).
- the Health Board's Outpatient Transformation Programme, under the remit of the Planned Care Board, will provide corporate oversight and management to outpatient modernisation across the Health Board.
- whilst transformation observed and progress made are positive, the Health Board can use the Outpatient Transformation Programme to drive transformation across specialities where progress has been slower.

Recommendations

15 The Health Board needs to continue to make progress in addressing recommendations that still require completion. These recommendations are set out in Exhibit 3.

Exhibit 3: 2015 recommendations that still require completion

Outstanding recommendations
Follow-up outpatient reporting
R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.

Outstanding recommendations	
Clinical risk assessment	
R3	Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.
Outpatient transformation	
R4	Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.
R5	Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider: • the clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; • internal and external engagement with stakeholders; and • primary and community care capacity to support outpatient modernisation.

Source: Wales Audit Office

Appendix 1

Assessment of work undertaken to review and validate the entries on the outpatient follow-up waiting list

Exhibit 4: assessment of progress to validate the waiting list

Area	Finding
Validation of patients on the follow-up waiting list	In our previous report we highlighted that the Health Board recognised that there were two issues with the follow-up outpatient waiting list: • a significant proportion of patients did not have a documented target date; and • an unknown proportion of the patients without a target date did not need to be on the follow-up list. Many of these unnecessary inclusions on the list related to patients included as a result of error, or related to pathways that were several years old. We reported that the Health Board had developed an automated IT tool to remove obvious erroneous inclusions on the follow-up outpatient waiting list. The approach used algorithms to match patients on the list against a range of data sources, such as discharge letters, other correspondence and patient data. The IT tool identified patients that the Health Board had already discharged or that had deceased and then automatically 'off-listed' them. The IT tool also off-listed patients where the lapsed time since their procedure was so great, that if any problems were to arise as a result of the procedure, they would have done so already. The Health Board had taken a cautionary approach by undertaking an initial pilot of the IT tool in ophthalmology, and ensured that clinicians were involved in developing the algorithm rules. Using the IT tool and clerical validation, the Health Board reduced the number of patients on the follow-up waiting list from 778,000 in April 2014 to 340,000 in June 2015. At that time, of the 340,000 patients remaining on the list, 70% (238,000) did not have a target date. In terms of continuing to review and cleanse the list to include only those patients genuinely in need of a follow-up appointment, our report outlined that clerical and automated validation of the follow-up list was ongoing, and that the Health Board needed to increase clinical validation[4].

[4] Clinical validation involves a consultant reviewing the medical notes of the patient to establish whether the patient still requires a follow-up appointment, or whether the consultant is able to discharge the patient based on his/her review.

Area	Finding
Validation of patients on the follow-up waiting list	In 2014, the Health Board set up the Outpatient Improvement Group (the Improvement Group), reporting to the Planned Care Board and including representatives from all Clinical Boards[5]. In November 2015, the Health Board agreed an Outpatient Follow-up Appointment Strategy (the Follow-up Strategy), and the Improvement Group was tasked with ensuring the implementation of the Follow-up Strategy and to oversee a programme of work to improve outpatient follow-up care. One of the four strands of work set out in the Follow-up Strategy is to improve data quality. The Improvement Group was tasked with putting in place organisation-wide arrangements to improve the quality of the data and ongoing administration of waiting lists. The Health Board identified a two-fold approach to improving data quality, consisting of reviewing the existing waiting list and looking for mechanisms to ensure that all new entries on the list are appropriate. The Health Board has undertaken automated off-listing across all specialties. All Clinical Boards, via the Improvement Group, were tasked with developing off-listing rules. Automated off-listing is now run on a weekly basis. Manual clinical validation of the outpatient follow-up list across all specialties is still underway. Specialties where the risk to patients experiencing a delay is the greatest were targeted first for clinical validation; the specialties being ophthalmology, cardiology, gynaecology and gastroenterology. Also, due to the dentistry department being very engaged in reviewing outpatient treatment, the dentistry team has also undertaken clinical validation of their lists too. The Health Board identified additional funding to help undertake clinical validation in cardiology and gastroenterology in terms of both referral to treatment and follow-up appointment waiting lists, which has helped speed up the process in these areas. The Health Board told us that that the clinical validation of patients on the list is taking longer than expected. The Health Board told us that so far, automated off-listing and clinical validation have led to approximately 15% of patients on the list being off-listed, and a further 15% being allocated a target date. In February 2017, there were 357,000 patients on the follow-up list. In the previous 12 months, the number of patients on the list has stayed at around 350,000, with small variations each month. The data does not suggest that large numbers of patients have been off-listed as a result of validation in the previous 12 months, however, it is possible that the number of off-listed patients has been offset by increasing demand.

[5] The Clinical Boards which provide outpatient follow-up appointments to patients are Children and Women, Dental, Medicine, Specialist Services and Surgical Services.

Area	Finding
Validation of patients on the follow-up waiting list	In addition to running the automated off-listing tools on a weekly basis, the Health Board has identified further actions required to ensure patients who no longer require a follow-up appointment are removed from the list: • some patients that are discharged to their GP are not automatically being removed from the list, and the Health Board is working to identify how to stop this. • the Health Board has identified that when patients attend an outpatient follow-up appointment and mistakenly walk away with their outcome form[6] rather than hand it in for reconciliation, the patient may remain on the list unnecessarily. The Health Board is developing a report to identify such occurrences. In April 2017, an additional validator was appointed to help progress the actions identified above, and any further actions to help maintain the robustness of the outpatient follow-up list. Alongside the work undertaken to validate patients currently on the list, the Health Board has also been working to provide target dates for existing patients on the list. The percentage of patients with a target date has increased each month since February 2015. In our previous report, we highlighted that in June 2015 only 30% of patients had a recorded target date. In February 2017, 47% of patients either had a target date or were classed as 'see on symptom'[7]. The Health Board is working to ensure that going forward all patients added to the lists are automatically allocated a target date, by ensuring that a target date or see on symptom classification is a mandatory field to be completed on the patient record. The Health Board's information systems provide Clinical Boards with the data used to produce the Welsh Government outpatient follow-up data return[8]. The Health Board's information systems currently provide the data to specialty level, and the Health Board would like to be able to provide data at clinic level to better help the Clinical Boards identify any problem areas.

[6] Clinicians complete an outcome form for every patient attending an outpatient appointment. The clinician will specify on the form the outcome of the appointment, for instance, the patient is discharged from further care or needs to be referred for diagnostic tests or alternate care.

[7] Patients without a target date can be classed as 'see on symptom' by a consultant, this means that the patient will only be seen by a consultant for a follow-up appointment if certain symptoms present, or based on the outcome of monitoring tests. In terms of the Welsh Government data submission, the number of patients classed as 'see on symptom' was a new field in April 2016; prior to this, in terms of the data submission, such patients would have been counted as a patient without a target date.

[8] The Welsh Government outpatient follow-up data includes the number of patients on the list, the number of patients with a target date, the number of patients with a booked appointment and the number of patients delayed beyond their target date.

Area	Finding
Validation of patients on the follow-up waiting list	It is pleasing to note that the specialities that are both high risk and high volume have undertaken validation of the outpatient follow-up lists. The Health Board needs to ensure now that all Clinical Boards focus on list validation, the development of off-listing rules, and ensure that all new additions to the list are appropriate and allocated a target date.

Appendix 2

Progress that the Health Board has made since our 2015 recommendations

Exhibit 6: assessment of progress against recommendations

Recommendation	Target date for implementation	Status	Summary of progress
Follow-up outpatient reporting			
R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.	December 2015 (for the January 2016 report to the People, Planning and Performance Committee).	In progress	In our previous report, we found that the Board had not received information on the volume of delayed follow-up appointments. The People, Planning and Performance Committee (the PPP Committee) is responsible for the oversight of outpatient follow-up care. We found that the PPP Committee had received information about delayed ophthalmology appointments, and updates on the progress of outpatient follow-up waiting list improvement actions. However, the PPP Committee did not receive information about specialties beyond ophthalmology, nor receive adequate assurance on the clinical risks associated with delayed appointments. Since our review, the Board and the PPP Committee have received regular progress reports on the steps taken to validate the outpatient follow-up list and to modernise outpatient services. The PPP Committee has also monitored closely the progress of the Clinical Risk Assessment (see recommendation two). After our report, initially, the PPP Committee were provided with updates on progress with transforming outpatient care every meeting, although the committee members now feel that twice-yearly updates are more appropriate. Performance information reported to the PPP Committee includes the number of patients on the outpatient follow-up waiting list by month, the percentage of patients with a target date, and the percentage of patients experiencing a delay.

Recommendation	Target date for implementation	Status	Summary of progress
Follow-up outpatient reporting			
R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.			Each year, the Clinical Boards are required to produce an Improvement Plan covering all areas of care. In terms of outpatients, the Clinical Boards are required to set out the actions they are taking to validate their outpatient waiting list, the interventions they are taking to ensure high-risk patients are being seen quickly, how they are managing risk and the planned changes to service models. The Clinical Boards are required to produce an annual Performance Report (due May/June) to report progress against the Improvement Plan. Clinical Board performance reviews are also produced eight times a year and include reporting of the number of patients on the follow-up outpatient waiting list (and the percentages of the patients with a target date and delayed). The Health Board's Integrated Medium Term Plan 2016-17 to 2018-19 (the IMTP) sets out a key measure of outpatient transformation which was a reduction in the number of outpatient appointments taking place in a hospital setting. With the Outpatient Transformation Programme (see recommendation 4) now in place, and with a real focus on service modernisation, it would be timely for the Health Board to review the performance indicators required to measure the Health Board's progression.

Recommendation	Target date for implementation	Status	Summary of progress
Clinical risk			
R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments.	November 2015	Implemented	Our 2015 review identified that the Health Board did not have a process to identify the conditions where the clinical risk to patients experiencing a delay in their follow-up appointment is the highest. Following our review, the Health Board asked each Clinical Board to identify the specialties or clinical conditions that carry a risk of patients coming to irreversible harm as a result of a delay to their follow-up appointment. The Clinical Boards were asked to complete this work by 21 April 2016. The resulting list of conditions and specialties (the Clinical Risk Assessment) was endorsed by the Health Board's Planned Care Board on 20 May 2016. Due to the volume of patients experiencing a delay in their treatment, the November 2015 PPP Committee requested that a report advising whether or not patients had suffered irreversible harm be presented to a future meeting. The Clinical Risk Assessment was presented to the PPP Committee on 12 July 2016 and the Board on 28 July 2016. Using the Clinical Risk Assessment to focus attentions, it was subsequently reported to the PPP Committee on 6 September that the Health Board had identified no patients experiencing harm as a result of a delay.

Recommendation	Target date for implementation	Status	Summary of progress
Clinical risk			
R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.	January 2016	In progress	The second strand of the Health Board's Follow-up Strategy is clinical risk assessment and the need for Clinical Boards to lead on: • improving knowledge of the clinical risks associated with delays; and • identifying targeted interventions where the greatest assurance is required. The Clinical Risk Assessment has set out the high-risk conditions where interventions are required most urgently. All Clinical Boards can review dashboards of aggregated follow-up data at specialty level that provides the number of patients delayed beyond their target date. The Health Board would like to develop this further to provide the data at clinical condition level to help target interventions. However, individual patient and clinic level data can also be accessed via the Clinical Portal[9]. The work to clinically validate the outpatients' follow-up list has helped identify the patients most in need of a targeted intervention in those areas where validation has been undertaken. Targeted interventions have taken place in some specialties to ensure that high-risk patients are seen quickly, including ophthalmology. In our previous review, we reported that the number of patients delayed beyond their target date was 44% (in June 2015). In February 2017, the number of patients delayed beyond their target date was 37%. It is encouraging to note that there has been a reduction in the number of patients delayed, although caution must be applied, because the action taken to remove erroneous inclusions on the list and to allocate target dates to patients will impact on the comparability of the data between the two periods.

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[9] The Clinical Portal is an electronic window that allows clinicians to view defined information about individual patients in a virtual electronic patient record drawn from information held in different clinical systems.

Recommendation	Target date for implementation	Status	Summary of progress
Clinical risk			
R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.			Whilst work is continuing to target patients delayed beyond their target date, the speed of progress is being hampered by; • the need to identify the erroneous inclusions on the list, so as to avoid wasting an outpatient appointment slot on them; • the number of patients on the list without a target date or newly allocated a target date; and • the time and resource required to clinically review the list to determine where interventions are required. However, work to improve the quality of the outpatient list has been targeted at the high-risk areas and there is data indicating the degree of the delay experienced by each patient. In addition, as highlighted in recommendation 1, Clinical Boards are required in their Improvement Plans to specify how they intend to target the patients most in need of an intervention to ensure they receive a timely outpatient follow-up appointment. The Health Board told us that the next steps are for the Information Department to work with the Clinical Board representatives to extract the number of patients classed as high risk and to develop service plans to target these patients. The Health Board has revised the target date for delivery of the recommendation to June 2017.

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient transformation			
R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.	An Outpatient Follow Up Strategy and proposal on the structure and shape of an Outpatient transformation programme will be considered at the next Planned Care Board on 6 November 2015.	In progress	In our previous report, we highlighted that the Health Board recognised that outpatient follow-up improvement work to date had been focused on improving the accuracy and management of the waiting list. The Health Board told us it had taken this approach to better understand true demand to enable the development of appropriate modernisation plans. Our report identified that the Health Board did not have a clear strategic plan for modernising outpatient services. However, we highlighted that some specialties were making progress with service modernisation, for example, where appropriate, patients were being discharged into, or seen in, a community setting instead. The third and fourth strands of the Health Board's Follow-up Strategy are to improve productivity and efficiency, and outpatient transformation. The Improvement Group set up in 2014, was responsible for overseeing outpatient follow-up improvement work. Subsequently, the Health Board has established an Outpatient Transformation Programme, under the remit of the Planned Care Board, which will be responsible for building on all ongoing work to transform and improve all areas of outpatient care, including follow-up work. The Outpatient Transformation Programme has been developed as part of the Health Board's recently established Transformation Board. Whilst there is significant work to do, there is a structure in place, with responsibilities allocated, and an initial action plan has been agreed. In terms of looking at future demand for outpatient services, the Health Board reviews referral to treatment outpatient demand and capacity on an annual basis. Progress still needs to be made in modelling demand and capacity for outpatient follow-up appointments. To date, the Health Board has concentrated efforts on cleansing the current outpatient follow-up list, as it wants to ensure that data on the list is robust prior to using it for demand modelling. The Health Board told us that it will pilot demand and capacity modelling in one area, prior to rolling it out to all specialties, and whilst there is no timeframe for this work, it is likely to be undertaken as part of the Outpatient Transformation Programme.

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient transformation			
R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.			A number of projects have focused on modernising outpatient services across the Health Board, including: • Leaner and Fitter Outpatient projects, supported by GE Healthcare Finnamore have been undertaken in dermatology, gastroenterology and urology. The overarching objectives of the projects were to improve clinic utilisation, reduce DNAs[10], support the achievement of referral to treatment times and optimise the use of electronic referrals or e-advice. In May 2016, the Health Board reported the following key achievements: – Gastroenterology – 0 patients waiting longer than 36 weeks (the lowest level in six years and a reduction from 190 patients in July 2015); a 2% reduction in new DNAs; an additional 51 patients booked per month when compared to July 2015; – Dermatology – 74% teledermatology referral rate resulting in a 'saving' of 230 appointments per month; an additional 374 patients booked per month when compared to July 2015; the downgrade of urgent suspected cancer referrals by 33% as a result of teledermatology; – Urology – a 4% reduction in the number of patients waiting longer than 26 weeks; and an additional 124 patients booked per month when compared to July 2015. • The Health Board launched the Bold Improvement Goal Programme (the BIG Programme) in 2016-17. One of the aims of the BIG Programme is to reduce waste, harm and unwarranted clinical variation. The initial pathfinder projects are in ophthalmology and musculoskeletal care. Patient pathways will be reviewed to identify where more care can be delivered in the primary sector, whether a follow-up appointment with a consultant is really necessary in all circumstances, and identify where follow-up appointments can be done virtually instead of in a hospital environment.

[10] Patients that did not attend their appointment

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient transformation			
R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.	.		• The Health Board's IMTP sets out the intention to identify opportunities to shift outpatient services from secondary care into primary care settings, including: – undertaking post-operative cataract follow-ups in the community; – providing wet AMD services in the community; – setting up a musculoskeletal community assessment service in the community as an alternative to secondary care clinics; and – the development of community-based audiology services in three community practices; and – embedding and strengthening community diabetes services to continue to increase provision of care and support in the community to reduce outpatient demand in secondary care.

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient transformation			
R4 Develop an outpatient transformation programme to create sustainable, efficient and good quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.			In addition, the Health Board has implemented efficiency improvements in outpatient care: • Fully Automated Booking has been implemented for all new outpatient appointments and the intention is to roll it out to automate follow-up bookings following further system development. This system should help to reduce DNAs. • E-advice services providing GPs with swift access to secondary care specialist expertise across high referral speciality services is being rolled out to include cardiology, ophthalmology, rheumatology, respiratory, gastroenterology and child health services. • electronic referral systems enabling GPs to refer directly into secondary care have been implemented. • outpatient clinic templates are being reviewed to deliver better scheduling and enhanced clinic utilisation. The Health Board is also leading on the orthopaedics work stream of the national programme to transform outpatient care, and is committed to incorporating recommendations from each of the five work streams of the national programme (audiology, dermatology, ophthalmology, orthopaedics and urology).

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient transformation			
R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider: • the clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; • internal and external engagement with stakeholders; and • primary and community care capacity to support outpatient modernisation.	This will be considered following agreement of the proposal on the Outpatient Transformation Programme.	In progress	In our previous report we said that without a robust whole-system approach to outpatient modernisation, it was not clear that: • there will be sufficient project management capacity, resource planning and service modelling across all specialties, to ensure that service modernisation takes place at the pace required; and • the interrelationship between its specialties and with primary care providers, which is necessary for effective pathway design, can be co-ordinated. As set out against recommendation 4, the Health Board's Outpatient Transformation Programme will be responsible for building on all ongoing work to transform and improve outpatient care, including follow-up work. The Outpatient Transformation Programme and the Transformation Board already have key members of staff in place. The Outpatient Transformation Programme has an agreed action plan, and work is ongoing to identify the clinical resources required to accelerate the pace of long-term outpatient transformation. The Planned Care Board, via the Outpatient Transformation Programme will be responsible for the corporate oversight and management of transforming outpatient services. However, the Clinical Boards will be required to lead on outpatient service modernisation. As set out in recommendation 1, each Clinical Board is required to produce an Improvement Plan setting out the steps that the Clinical Board will take to modernise service delivery, including the resources required and how the Clinical Boards will work with primary and community care to bring about change. Finding capacity to undertake the work, however, will be a challenge. Clinical resources continue to be stretched, and those areas that most need improvement are often those areas where clinical capacity is a concern. The implemented efficiency improvements in outpatient care set out in recommendation 4 demonstrate that significant engagement with internal stakeholders and primary care has already taken place in some specialties.

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Collaborative Arrangements for Managing Local Public Health Resources – **Public Health Wales NHS Trust**

Date: October 2017

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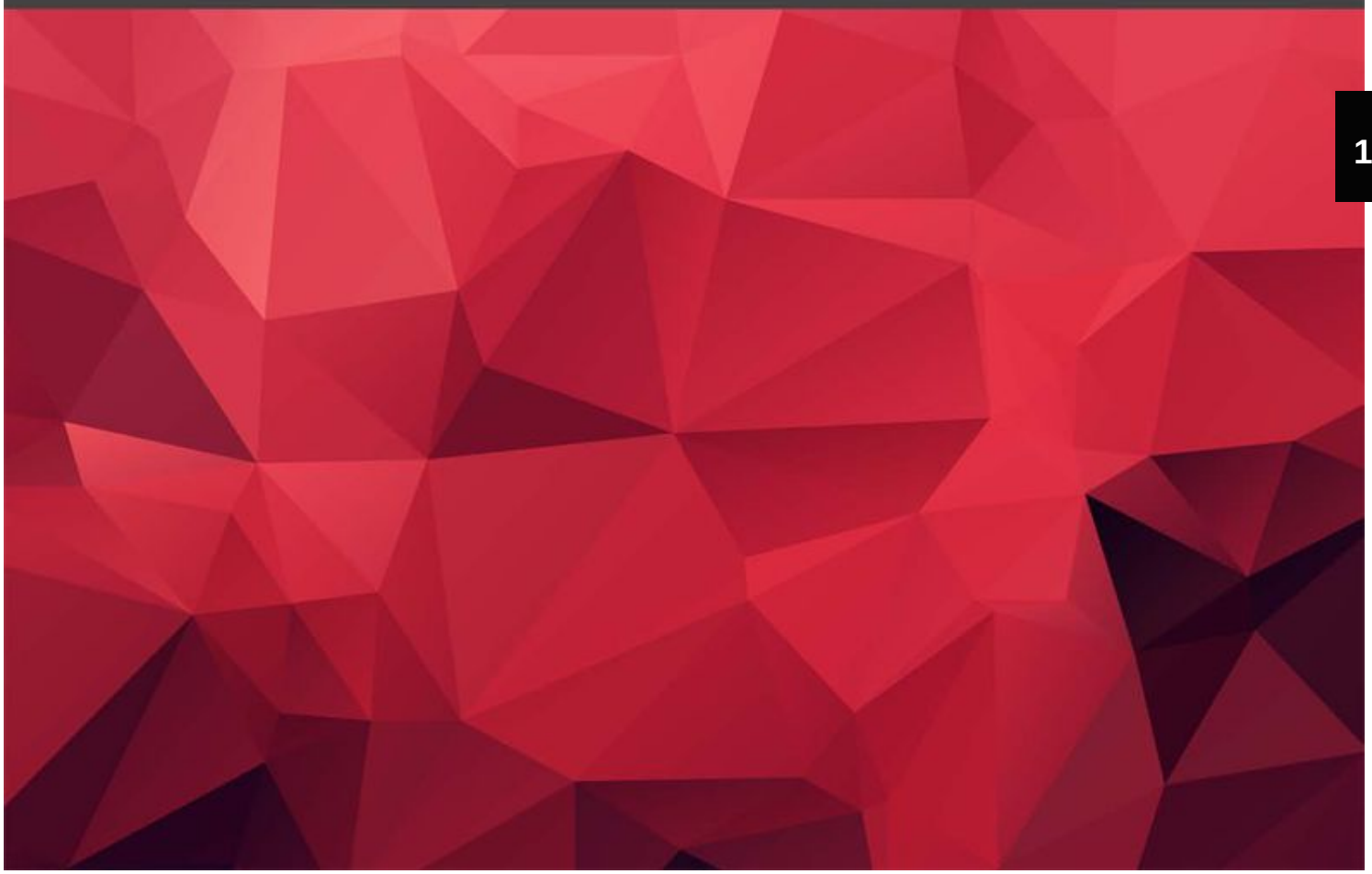

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The team who delivered the work comprised Gabrielle Smith and David Rees.

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

Summary report

The public health system in Wales

1 The UK Faculty of Public Health defines public health as 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society'[1]. This definition means that, 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.

2 There are three domains of public health practice: health improvement, health protection and healthcare public health. These areas of practice are underpinned by health intelligence functions. (Appendix 1 sets out a short description of the domains of public health practice. This report focuses on the health improvement domain.)

3 Public Health Wales NHS Trust (the Trust) was established as part of the wider reforms of the NHS in Wales in 2009. The Trust provides a range of public health services for the protection and improvement of the health and wellbeing of the people of Wales. It also provides evidence-based information and expert advice to a range of stakeholders, including NHS organisations, local authorities and the Welsh Government, on matters related to health and wellbeing. (Appendix 2 sets out the Trust's four statutory functions.)

4 The Trust has a key role in the system by virtue of the fact it is the national public health organisation and is recognised as an international public health institute[2]. The Trust's wide-ranging functions include providing and managing public health services for the people of Wales, delivering health improvement information to the public and the collection and dissemination of information on health. (Appendix 3 shows pictorially the breadth of work carried out by the Trust.)

5 The 2009 NHS reforms also led to the creation of seven local health boards responsible for commissioning and delivering healthcare services and for promoting and protecting public health across a defined geographical area. These organisations included an officer responsible for public health, the Director of Public Health (DPH). The Directors of Public Health (DsPH) are employees and Executive Directors of their respective organisations and with these organisations are responsible collectively for the health of the population they serve.

6 The Trust provides specialist public health resources[3] at a national, regional and local level, including to local health boards and their DsPH. Each DPH is responsible for directing and managing the work of the local public health team

[1] www.fph.org.uk

[2] Public Health Wales, like Public Health England, is a member of the International Association of National Public Health Institutes

[3] In the context of this audit, specialist public health resources relate to the specialist public health workforce

(LPHT). LPHTs were established largely on the historical legacy of staff numbers and skill mix at the time of the NHS reforms. Currently, LPHTs comprise public health consultants and specialists, public health practitioners and administrative staff. Teams vary in size and the majority of LPHT staff are employed by the Trust and organisationally part of its Health and Well Being Directorate. Several LPHTs include staff who are funded and employed by the health board.

7 In 2015-16, the Trust deployed 155 whole-time equivalent staff, equivalent to 12% of its specialist public health workforce, across the seven LPHTs. The budget for these staff, including the salaries of six of the seven DsPH for which the Trust is responsible, totalled £9.26 million or 9% of the Trust's overall budget.

8 Although employees and Executive Directors are accountable to their own respective health boards, all DsPH have an honorary contract with the Trust to direct and manage the work of LPHTs. The DsPH are accountable to the Trust for the use of the specialist public health resources provided to them. The Trust, meanwhile, is accountable for securing value for money from its resources, including those provided to and managed by the DsPH. The Trust describes itself as a professionally rich organisation[4] [5] so it must demonstrate that its resources are achieving improvements to population health and wellbeing.

9 The Trust provides the health intelligence, knowledge and evidence-base which the LPHTs require to function. These centrally organised and performed functions are also important in enabling the DsPH to discharge their statutory responsibilities. The Trust also provides centrally coordinated screening and health protection services for local health board populations; note that these services were outside the scope of this audit.

10 Crucially, no one organisation has been given the leadership role within the public health system. This means that the Trust and health boards, through their DsPH, must agree common goals and a collaborative approach for delivering public health work for improving population health and wellbeing.

11 The Welsh Government's vision for public health was articulated in 'Our Healthy Future'[6] and 'Fairer Outcomes for All'[7], which set the strategic direction for public health to 2020. This means there is a common national framework and outcomes which all in the public health system should be working to deliver.

12 The Trust is dependent upon working collaboratively with health boards, as well as a broad range of other stakeholders to discharge its functions as a national public health organisation. Furthermore, recent legislation[8] requires public bodies to work

[4] Public Health Wales, Our Strategic Plan 2016-2019, March 2016

[5] Public Health Wales, Our Strategic Plan 2017-2020, March 2017

[6] Welsh Assembly Government, Our Healthy Future, 2009

[7] Welsh Assembly Government, Fairer Outcomes for All, 2011

[8] Social Services and Well-being (Wales) Act 2014; Well-being of Future Generations (Wales) Act 2015; Public Health Wales Bill

collaboratively either in support or as members of statutory partnerships. In view of the potential complexities around governance and accountability for the use of resources to improve local population health and wellbeing, the Auditor General considered it an opportune time to assess the effectiveness of the Trust's arrangements for collaborating with DsPH and whether these are conducive to delivering health improvement work across Wales more generally.

Scope of the audit

13 The audit focused on the arrangements for delivering services for health improvement through LPHTs, which we were informed was the main function of most staff working in these teams. The audit focused primarily on the relationship between the Trust's national (corporate-based) teams, the LPHTs and DsPH. Although we recognise that public health work is multi-sectoral, the audit did not focus on the views of local authorities or other agencies.

14 The aim of our audit was therefore to provide a high-level view of how the Trust's current collaborative arrangements with LPHTs and DsPH work in practice. The objectives of our audit work were:

- to gain an understanding of the framework for alignment of priorities for local delivery of services to improve health and wellbeing;
- to form a view of the effectiveness of collaborative working and the adequacy of governance arrangements to deliver common public health objectives; and
- to identify any obstacles that may prevent effective collaboration.

15 While the audit focused primarily on the arrangements relating to health improvement, work related to the health protection domain are referred to for comparative purposes within the report. Although we did not assess the work undertaken by the Trust or LPHTs, there is undoubtedly good work taking place by the dedicated staff that we met.

16 The audit looked at the Trust's arrangements for collaboration. We did not assess the extent to which health boards' priorities for public health aligned with those of the Trust nor did we examine the extent to which health boards discharge their statutory responsibilities for improving the health of the populations they serve. Furthermore, we did not examine the role of the Welsh Government in setting direction, leadership and performance management.

17 We visited every LHPT and talked to public health consultants and specialists, public health practitioners and administrative staff, including team members employed by health boards. We also talked to all DsPH, two health board Chief Executives and a small number of Trust officers. In total we interviewed more than 100 people. We reviewed pertinent documents produced by the Trust, health boards and the Welsh Government. At various places in the report direct quotes from the staff that we interviewed are used to illustrate the themes to emerge strongly from the audit.

18 The participant information sheet detailing the scope of the audit is presented in Appendix 4. This was shared with all teams in advance of the interviews.

19 We gratefully acknowledge the assistance and cooperation of staff from LPHTs, DsPH and officers at both the Trust and health boards.

Main audit findings

20 The staff that we met within LPHTs are dedicated professionals undertaking crucial work across Wales. Many staff told us that they valued being part of a national public health organisation although a small number did not hold a strong preference as their day-to-day interactions with the Trust were limited. They did however see themselves as serving their local population. The benefits of being part of a national organisation frequently cited by staff included:

- a degree of independence from health boards that stops them getting drawn into secondary care issues;
- expertise that is appreciated by local partners and the public because it is seen to be objective; and
- a dedicated infrastructure with the knowledge and expertise that can be shared across Wales.

21 It was clear from our meetings with staff that they want to work within a public health system where there is a common vision and everyone knows what their relative role is in relation to health improvement regardless of where they work. To meet these aspirations requires consensual leadership within a public health system with shared priorities and strong collaboration between the Trust, DsPH and LPHTs.

22 However, our audit work found that the collaborative arrangements for managing local public health resources do not work as effectively as they should do. We reached this conclusion because:

- effective collaboration in relation to health improvement work is dependent upon consensual leadership but this was not always evident;
- the Trust has not established effective arrangements to ensure that it is securing value for money from the resources allocated to LPHTs;
- there is a lack of meaningful dialogue between the Trust and LPHTs about respective roles, responsibilities and priorities and an agreed framework about what work is best done collectively;
- the Trust does not have robust methods for allocating or changing resources of LPHTs;
- although the Trust has strengthened arrangements for appraisals and personal development planning, it can do more to assess the needs of local public health teams to support professional development and career progression; and

- the mechanisms for communicating and sharing information between the Trust and LHPTs are under developed.

Next steps

23 Although this report identifies a number of weaknesses with the current collaborative arrangements between the Trust and LPHTs in respect of health improvement work, it should not be seen as a criticism of the work or professionalism of staff. The issues identified, however, point to a need for improvements.

24 We recognise, in part, that the problems identified in this report relate to matters that are the responsibilities of the Welsh Government and local health boards, as well as the Trust. The Auditor General is therefore minded to undertake an examination of all three roles in local public health arrangements. We are therefore not making firm recommendations in this report.

25 In the meantime, however, it is appropriate for the Trust to consider how improvements to collaborative working could be made, including:

- continued working with health boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally;
- developing effective arrangements to demonstrate that it is securing value for money from the specialist public health resources allocated to LPHTs;
- clarifying the roles and responsibilities of the Trust's national and local teams in relation to developing and delivering health improvement programmes;
- progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice, including healthcare public health;
- agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs;
- agreeing a mechanism whereby workforce planning discussions take place on a more formal basis between the Trust and DsPH;
- clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite
- clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles; and
- collating information on the collective training and development needs of local public health teams to address skills gaps.

26 The Trust's management response is included in Appendix 5.

Detailed report

Effective collaboration in relation to health improvement work is dependent upon consensual leadership but this was not always evident

27 There will always be inherent tensions in a public health system where individual stakeholders have different priorities and accountabilities, particularly when seen from a national versus local organisational perspective. To manage system tensions, there needs to be clarity about who is leading the system, who has the authority to make decisions, either locally or nationally, and who is accountable for the decisions made. If there is a question mark over who the systems leaders are, then there may be confusion over which stakeholders' priorities matter while nobody knows who to follow. To mitigate these risks, organisations need to agree collectively the parameters of who does what and why.

28 The Trust's first Integrated Medium-Term Plan (IMTP) in 2014 indicated that attempts to describe the public health system had not been wholly successful with relationships within the system described as largely implicit, complex and evolving. The Trust recognised that:

- different perspectives and priorities needed to be reconciled;
- leadership roles were not explicitly defined and were contested;
- accountabilities for taking action and achieving outcomes were confused and challenged;
- cross-organisational performance management arrangements and responsibilities were unclear or disputed; and
- the mechanisms for aligning priorities and action across organisations were inadequate.

29 LPHTs and DsPH were clear that the public health system needs effective mechanisms for: leadership, advocacy, standards setting, health intelligence and evidence base. There were suggestions that these components were not always in place to ensure effective collaboration between the Trust and LPHTs.

30 The Trust acknowledged that relationships with DsPH are strained, particularly around health improvement. One reason for the strain was perceived to be the Trust 'not doing what health boards want it to do'. One interviewee commented that 'it feels like health boards need to be a grateful beneficiary but the Trust never asks us what would be helpful to support our local public health agenda'. The Trust told us that it wants to 'do the things only we can do; we don't want to be seen as treading on others toes'.

31 We found lots of rhetoric about system leaders without a clear consensus about who should lead. There is a perception amongst some DsPH that the Trust does not see them as equal partners in leading the public health system. This may be due in part to the Trust's description of its leadership role in its two most recent

IMTPs[9]. These descriptions read, 'we lead the public health system to define effective services and prioritised actions' and 'the Trust has a vital role to play through our system leadership'. However, when asked who the system leaders are, the Trust told us that all partners with responsibilities for public health, including the Welsh Government, have a role in leading the system.

32 It was not the purpose of this audit to consider relationships other than those between the Trust and DsPH to manage local public health resources collaboratively. However, the role of the Welsh Government in setting direction, leadership and performance management, was raised by staff on several occasions. In relation to the public health system, LPHTs and DsPH perceive the Welsh Government has high expectations that senior leaders will make it work. They were less clear, however, about what the Welsh Government expected in terms of the Trust's role in the delivery of health improvement programmes.

33 The Trust's Statutory Instruments[10] describe the functions of the Trust as 'managing public health services' rather than leading. This raises the issue of who has system leadership responsibility, the Trust or the DsPH in their statutory role for local public health.

34 While increasingly the Trust is seen by some as the system leader, this, in the view of others, is in conflict with the statutory duties placed on the health board based DsPH. Whilst 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.

35 Staff we spoke to during the audit commonly talked about confusion over leadership and 'who does what' leading to compromised collaborative activities between the Trust and LPHTs. This was seen as compromising the ability to tackle thorny challenges such as:

- securing agreements on what the health improvement priorities are in the face of competing local demands;
- ensuring that the 'population health' focus is not lost as a result of health boards chasing secondary care performance targets; and
- identifying incentives or sanctions to make the system work differently and to avoid a sense of 'inertia' across the system.

36 LPHTs frequently cited the need for mutual trust to ensure effective collaboration but a small number of staff reported feeling more recently that the Trust wanted to exercise a style of 'command and control'. LPHTs were confident that collaboration could be more effective provided there is:

- 'a willingness and maturity to accept the grey areas around organisational boundaries'; and

[9] See Footnotes 4 and 5

[10] The Public Health Wales National Health Service Trust (Establishment) Order 2009

- ‘a system that is less personality driven and where individual leaders are helped to let go (of control)’.

37 Staff frequently raised the issue of national versus local roles and responsibilities. LPHTs and DsPH see the Trust as providing the leadership and advocacy for public health at a national or all Wales level, while they fulfil these roles at a local level. Some DsPH were confident that the Trust should have a lead role in influencing and helping to frame a national public health strategy given its role in public health research and intelligence while they and their teams are better placed to lead local delivery.

38 However, the Trust, LPHTs and DsPH referred to the current system being one of contested leadership in respect of public health practice related to health improvement. One individual described the relationship as ‘parents pulling in different directions’.

39 We are of the view that there is a need to do more to incorporate Prudent Healthcare principles and for the Trust and the LPHTs to do ‘only what they can do’, and agree what they are best placed to do. Examples were cited where this has happened successfully in the health improvement arena. The Trust has brought together all the organisations in Wales that have a role to play in improving health and wellbeing at a national level through Cymru Well Wales[11]. This work is something that several DsPH acknowledged they could not have done. The Trust was also seen as being best able to converse and connect different stakeholders across Welsh Government departments.

40 Although this audit focused primarily on the relationship between the LPHTs, DsPH and the Trust’s Health and Wellbeing directorate, staff were keen to tell us of other parts of the Trust’s responsibilities which worked well and where the quality of working relationships and collaboration was better. All LPHTs teams and DsPH cited the good working relationships with the Trust’s Health Protection Team and staff indicated that they would like see these relationships replicated more generally.

41 The Health Protection Team, which is centrally coordinated has both an all Wales and local presence. We were told that there are well established arrangements and well established teams with clear roles and responsibilities with many, but not all, LPHT consultants taking part in the on-call rota. In the event of a health protection incident, there is a managed and coordinated approach to the work needed. ‘It’s clear who does what, nationally and locally.’

42 As well as clear roles and responsibilities, the Trust, LPHTs and DsPH identified a number of other factors thought to enhance positive collaboration with the Trust’s Health Protection Team. These factors included:

- ‘good structures and coordination in place ensuring effective communication between the national team and health boards’;

[11] www.wales.nhs.uk

- ‘a level of mutual respect based on well established relationships going back 20 years; there is a level of confidence that services will continue as before’; and
- ‘we’re kept in the picture by the local (Health Protection) team, who make it clear where the health board needs to support health protection functions’.

43 The issue of vacant or unfilled DPH posts was raised with us on a number of occasions given recent turnover and impending retirements amongst DsPH. This situation risks: (i) loss of leadership for public health locally; (ii) no oversight and management of the LPHT and work programme; and (iii) no channel for communication and collaboration with the Trust. We were assured to learn that these risks are increasingly recognised and that arrangements for mitigation are being put in place.

The Trust has not established effective arrangements to ensure that it is securing value for money from the resources allocated to local public health teams

44 No one organisation is wholly responsible for achieving improvements in population health and wellbeing. The Trust and health boards are accountable to the Welsh Government for delivering against the outcomes and indicators set out in the NHS Outcomes and Delivery Framework. These accountability arrangements were not within the scope of this audit but achievement is also predicated on effective collaboration.

45 DsPH hold honorary contracts with the Trust to enable them to direct, manage and appraise specified Trust staff based within the LPHTs. Our interviews with DsPH confirmed that these agreements have never been reviewed. These contracts are one of the mechanisms whereby DsPH can account for the use of resources allocated to the LPHTs. DsPH acknowledged their accountability for the use of these resources but for some there were concerns that the Trust wants to direct how they use them.

46 Based on interviews with both the Trust and DsPH, meetings to discuss how resources are deployed to meet the needs of both the Trust and the DsPH do not take place. This means that there is no understanding on how the funding for LPHTs is used to deliver shared priorities and whether it is delivering the intended benefits. The Trust has a duty to ensure where it is providing resources to LPHTs that its resources provide value for money because it is accountable to the Welsh Government, and the people of Wales, for the funding it receives (see also Paragraph 62).

47 The Trust is strengthening accountability arrangements with health boards where services are delivered in partnership. Over the last two years, the Trust has been working to formalise these arrangements through a Memorandum of Understanding (MOU). The MOU aims to articulate the specific arrangements and management of services by clearly defining relationships and mutual expectations.

The MOU will eventually cover all services and functions that the Trust provides, including LPHTs. The MOU could satisfy DsPH requests for clarity about what resources they can expect to receive to support them discharge their public health responsibilities.

48 As part of audit work, we looked to see what arrangements were in place to monitor and report on the collective delivery of local public health services. LPHTs described the governance arrangements between themselves and the Trust as 'loose' because there is no clear agreement about 'who does what' and how work will be monitored and reported outwith the team. Accountability for delivery of local work plans is to the DPH. It was clear from our visits to local teams and from the documents they shared with us that reporting lines ran from the DPH to their respective Boards and not to the Trust.

49 Locally, LPHTs had varying arrangements in place to monitor progress against their work plans using a range of key milestones and performance measures. One team told us it was moving to a more formal programme management model for developing its work plan so that the appropriate systems and processes are in place to support delivery and the right information is available to monitor progress and performance.

50 Despite the varying arrangements in place to monitor work plans, several staff commented that:

- 'there seems to be no consequences if milestones are missed'; and
- 'there is no real accountability for what the team delivers'.

There is a lack of meaningful dialogue between the Trust and local public health teams about respective roles, responsibilities and priorities and a formal framework about what work is best done collectively

There is a lack of meaningful dialogue about what is best delivered collectively

51 As part of our audit we discussed the extent to which shared priorities were seen to be in place in respect of local health improvement work and the arrangements for developing LPHT work plans to deliver the shared priorities. We did not explore the content or delivery of work plans. We were solely interested in the arrangements to facilitate and resource the work planning process.

52 When the Trust was first established, the position for the Executive Director with responsibility for health improvement remained vacant for many months. This was seen by some DsPH as hindering early communication between the Trust, LPHTs and DsPH. Teams told us that at that time there were no or limited discussions with the Trust to identify or agree priorities for public health work. Instead, teams told us they 'just got on with the work in hand' to deliver on priorities and targets set by Welsh Government as part of the NHS Wales' annual operating framework.

53 The introduction of the NHS integrated planning framework in 2014 helped sharpen the Trust's focus on planning[12]. It provided a renewed impetus for the Trust to work with DsPH to collectively identify and agree a small number of core public health priorities that everyone could focus on as a 'whole system'. We did not find, however, a framework setting out: (i) how these shared public health priorities would be delivered collectively through the individual contribution of the Trust and the LPHTs; and (ii) a shared view about what success would look like and how this might be monitored and reported by both the Trust and LPHTs.

54 The Trust continues to work with DsPH to strengthen and align organisational plans around key public health issues to enable complementary action by health boards and LPHTs in relation to each priority. It is also clear from minutes of the DPH peer group meetings that the need for common goals and priorities are discussed.

55 Although aware of the ongoing work to align public health priorities, LPHTs were less confident about the extent to which everyone was working to achieve the same goals. One team saw the priorities belonging to the Trust and not the system, commenting 'Trust's priorities are not always a comfortable fit for our local population'. The Trust regularly shared its draft IMTP with health boards during the annual refresh process, which LPHTs and DsPH told us they welcomed. The Trust's IMTP maps alignment of 'shared priorities' based on information in health boards' IMTPs.

56 The lack of clarity around roles and responsibilities within the public health system has not helped. As one individual commented, 'if there was a seamless public health system, then public health priorities would be the same across the seven health boards and Trust and we would work to one plan of action'.

57 To make the public health system work in relation to health improvement will require more than simply aligning the DsPH and their teams to the Trust. There needs to be agreement on the priorities that these two parts of the system need to deliver collectively, as well as agreeing individual contributions and measures of success to be monitored and reported.

58 LPHTs told us that work plans are designed to address local public health priorities articulated in the health boards' IMTPs and to support delivery of public health targets set out in the NHS Outcomes and Delivery Framework[13]. LPHTs design and implement their work plans with the balance of work agreed by the DsPH. LPHTs largely organise their work around public health topics like tobacco control or themes such as 'early years'. Staff are allocated work based on their expertise and experience as well as interest and development needs.

59 LPHTs told us that local work plans are not generally designed to support delivery of the Trust's IMTP priorities, nor do the Trust and LPHTs collaborate with each

[12] Wales Audit Office, **Public Health Wales Annual Audit Report 2014**, January 2015

[13] Welsh Government, **NHS Outcomes and measures guidance, WHC(2016)023**, March 2016

other when developing their work plans to agree approaches to common issues. A number of different views were expressed including:

- 'if it's not in the IMTP (the Trust's), we shouldn't do it';
- 'the senior management team (of the LPHT) should align our work retrospectively to the Trust's plan';
- 'whose IMTP are we delivering?'; and
- 'we don't know what the Trust expects us to do'.

60 Teams were confident that if asked, they could demonstrate how their work plan supported delivery of the Trust's IMTP. One team commented that the Trust's IMTP was 'so high level that you couldn't disagree with it but we can't see the thread that connects it with what is done locally'.

61 The Trust is largely unsighted of the content of local work programmes. One team reported that 'until recently, we were never asked about our work plan or what resources are needed to deliver it'. Others reported that in the past they had been asked about their work and that teams willingly shared information but this had ceased with the departure of one of the Trust's Executive Directors. The Trust told us that recent attempts to find out more had been met with resistance by some DsPH. The Trust's comments chime with comments from some DsPH who were unclear why the Trust wanted to see local work plans.

62 Based on our interviews, there are widely held views amongst LPHTs and DsPH that the Trust wants to direct and manage their work. However, when we put this question to the Trust, it acknowledged that DsPH and LPHTs were best placed to understand the needs of their local populations and it 'doesn't want to tell them what to do'. For some staff, it felt as if they had 'two masters'.

63 In our view, it is reasonable for the Trust to want an understanding of the work delivered by LPHTs, not least because the Trust is accountable for securing value for money from the resources it provides, as well as a duty of care to its employees. In addition, the Trust needs to ensure that levels of resourcing are appropriate for the delivery of evidence-based and safe public health interventions across Wales.

64 The Trust describes itself as a professionally rich organisation[14], which chimes with comments from some staff in LPHTs. Nearly half (48%) the Trust's staff (excluding medical and dental staff) are paid at pay band 6[15]. Information available for two health boards shows that one-third of staff are paid at pay band 6 or above. Given the rich grade mix and potentially limited specialist public health resource as

[14] See Footnotes 4 and 5

[15] Agenda for Change is the NHS pay and grading system that covers all staff except doctors, dentists and very senior managers. The grading system uses nine bands with one the lowest and nine the highest. There are a number of pay points within each band. The first pay point within band 6 starts at just over £26,500 while the top pay point in band 9 is just over £100,000.

described in its IMTP, the Trust needs to understand what its staff are doing and whether they are doing the right things.

65 Furthermore, the Trust needs to understand the nature of the work carried out by LPHTs to underpin resource allocations for delivering local public health services. Healthcare public health was seen by LPHTs and DsPH as an important element of public health practice. Organisationally, healthcare public health sits within the Trust's Directorate for NHS Quality Improvement and Patient Safety/1000 Lives Improvement Service. However, national support by the Trust for this aspect of practice was described as having 'withered on the vine'.

66 It is evident from our interviews that there is a lack of clarity about how this element of public health practice should be supported by the Trust, both at an all Wales level and locally. As the Trust does not have a full picture of the work done by its staff, it cannot appreciate the extent to which they support health boards in this area of practice, for example in relation to service reviews or Individual Patient Funding Requests.

The various documents setting out roles and responsibility for public health services in Wales fail to clearly articulate how the Trust and the Directors of Public Health should work together

67 Effective collaboration requires clarity about roles, responsibilities and leadership in the public health system. Notwithstanding the functions and responsibilities set out in the legislation, there is no single definitive document setting out how the Trust and the health boards should collaborate to discharge their public health functions.

68 Based on our interviews, there is no common agreement around what the system should look like and what it means to have one single public health system, particularly in relation to health improvement. A number of documents that we examined have attempted to set out the context for partnership working in the public health system in Wales. The evidence suggests however, that these have been only partially effective or even ineffective in practice.

69 For example, the generic job description for DsPH clearly states that DsPH are an integral part of public health services in Wales. DsPH are responsible for public health advocacy, leadership and action, working with the Trust as part of a unified public health system. The Trust would support DsPH to fulfil their roles by providing specialist public health resources

70 A tripartite agreement between the Trust, health boards and local authorities was developed in 2010. This agreement was intended to put the relationship between these organisations on a firm foundation, setting out clear expectations and responsibilities for organisations to work together. One of the principles set out in the document is that local and national activity would be integrated such that each supported the other across all domains of public health practice. The 2010-11

annual operating framework[16] indicated that this agreement provided the firm foundation for all organisations to work together in a mutually supportive way to tackle the public health challenges facing Wales. There is no evidence, however, that this agreement was shared with the Boards of individual health boards or ever reviewed to ensure it was 'fit for purpose'.

71 Meanwhile, the Welsh Government's 2011 long-term agreement (LTA) with the Trust set out the services to be provided to stakeholders, reflecting the Trust's statutory functions. The LTA made clear that the Trust would work in partnership with DsPH as part of a public health system. The Trust would have a key role in implementing the health board's local public health delivery plans through the seven LPHTs and the delivery of a range of centrally managed services and programmes. As the LTA was an agreement between the Welsh Government and the Trust, DsPH would have been unsighted of the detail. The LTA ended in 2014 when all NHS bodies moved to the three-year integrated planning framework.

The Trust does not have robust methods for allocating or changing resources of local public health teams

72 To be successful, the public health system requires a prudent workforce that is, people with the right combination of skills and experience, the right competencies and in the right place.

73 At the time of the 2009 reforms to the NHS, there were 19 LPHTs aligned to the 22 former local health boards. These teams comprised a public health director and a small team of at least three public health practitioners, who largely delivered health promotion programmes. The 19 teams were subsequently organised into seven local public health teams, which varied in size.

74 In 2011, the Trust reviewed the allocation of local resources[17] to strengthen under-resourced teams over time. The aim was to fund additional investment in those teams seen as under-resourced with no reduction in the size of larger teams. Information produced by the Trust at that time shows that it funded 82 WTE posts across LPHTs compared with the 155 WTE staff in post in 2015-16. Although the WTE number of staff has nearly doubled, team size still varies.

75 In addition to Trust funded staff, some LPHTs include a small number of staff who are funded in whole or in part by several health boards. The Trust employs some of these health board funded staff, who make up a small proportion (3%) of the staff deployed across LPHTs.

76 A consistent perception amongst LPHTs and DsPH is that the Trust is expanding to the detriment of local investment. Some interviewees went so far as to describe this expansion as 'empire building'. This perception is not borne out by our analysis

[16] Welsh Government, NHS Wales Annual Operating Framework 2010/11, January 2010

[17] The majority of the resource allocated by the Trust to LPHTs is in the form of staff with very little non-pay funding.

of the Trust's workforce information which shows that the Trust's workforce increased by 15% between 2015-16 and 2016-17[18]. This increase was due to a substantial number of staff transferring into the Trust from the NHS clinical networks and diabetic retinopathy screening service and recruitment to two of its directorates (Policy, Research and International Development and Operations and Finance). A handful of staff were recruited to the Trust's Health and Wellbeing Directorate.

77 LPHTs held varying views on whether teams were adequately resourced. Some LPHTs, including the DPH, were confident that numbers of staff were 'about right' while others complained of being under resourced. Irrespective of numbers of staff, LPHTs were less confident about whether teams had the range of skills needed for the future and 'whether the right staff were doing the right things'.

78 Strategic workforce planning documents for the Trust's Health and Wellbeing Directorate in March 2016 indicated no requirement to increase numbers of public health professionals until at least 2019. It is clear from our work that there is still a need to develop a method for effectively allocating resources to LPHTs, including determining the minimum number of staff needed to deliver the same set of functions.

79 When we visited LPHTs in autumn 2016, we learned that the Trust had begun to review resource allocations across teams. LPHTs were anxious that any rationale for allocating local resources should take into account factors, such as local deprivation, geography, rurality and population density. In addition, there were concerns that the Trust might consider reallocating funding for vacant posts in teams described as 'over-resourced' to those teams considered under-resourced.

80 The Trust has indicated that it wants to move away from resourcing LPHTs based simply on inputs or activity and move towards funding for outcomes. It intends to develop a formulae or clear rationale for allocating local resources that takes into account multiple factors like deprivation.

81 DsPH rely on the Trust for the specialist resources to deliver their public health responsibilities across all three domains of public health practice. It was clear from our interviews that DsPH want greater clarity about the allocation of resources from the Trust in relation to the three domains of public health practice.

82 We found that regular discussions about the numbers of staff needed to deliver local public health services or to support wider public health practice locally do not take place between the Trust and DsPH. Instead, discussions are ad hoc, taking place when vacancies arise within the team. Consequently, for those teams where turnover is low, there are limited opportunities to stimulate workforce planning discussions.

83 Some LPHTs acknowledged that they were 'top heavy' in relation to senior pay bands and welcomed the opportunity from staff turnover to establish new roles

[18] See Footnote 5

more suited to the changing nature of their work, as well as lowering salary costs. Where teams want to recruit to new roles, they told us discussions are held with the finance team in the first instance. Recent examples of new roles include communications officers with social marketing skills, analysts to increase local analytical capacity and programme managers to improve planning and performance monitoring of the local work plan.

84 Although supportive of LPHTs looking to create new roles, the Trust does not believe that these roles should be replicated across all teams. For example, in relation to social marketing, the Trust plans to establish a central Behaviour Change and Public Information team to support social marketing and public awareness. This could go some way to supporting the skills LPHTs are looking for provided there is sufficient capacity and clarity about how the Behaviour Change and Public Information team will support LPHTs. One DPH welcomed this addition but sounded a note of caution reporting that, historically, the Trust's central communications team was not always responsive to the needs of LPHTs. Equally, the Trust and DsPH could explore opportunities for LPHTs to host posts for pan Wales work.

Although the Trust has strengthened arrangements for appraisals and personal development planning, it can do more to assess the needs of local public health teams to support professional development and career progression

85 As part of the audit we examined how the Trust and LPHTs worked together in relation to staff appraisal and training and development. We thought this of importance to effective collaboration between the Trust and the LPHTs.

Arrangements are in place to support professional registration but more clarity is needed on how this is used to demonstrate professional competence and career progression

86 The UKPHR is a voluntary register accredited by the Professional Standards Authority. It was established in 2003 to regulate all multi-disciplinary public health specialists and practitioners from backgrounds other than medicine and dentistry. In 2011, the UKPHR started to regulate public health practitioners[19]. UKPHR registration is intended to show that public health specialists and practitioners have

[19] There are four routes to specialist registration enabling staff to work as consultants, standard route (completion of a five-year public health training programme), assessment of defined specialists (portfolio route), dual registration (for those already on the Specialist register of either the General Medical Council or General Dental Council) and recognition of specialist status (exceptionality). Public health practitioners are drawn from multidisciplinary backgrounds bringing a range expertise to their roles and work across the full breadth of public health practice. Practitioner registration is via a portfolio route.

attained appropriate standards of competence and to provide recognition and status as a member of the public health workforce.

87 The Trust has a Professional Development Team that supports national workforce and professional development across the whole public health sector, including the NHS in Wales, local government, the third sector, academia and Welsh Government. It hosts the local assessment scheme for all public health practitioners in Wales. The scheme supports individuals working across the public health sector to develop portfolios of evidence against the UKPHR's Practitioner Standards and to apply for registration.

88 The Trust and DsPH are supportive of staff wanting to develop portfolios of evidence and at the time of our audit work, the Trust was running introductory events about the process. The Trust indicated that few staff starting a portfolio of evidence complete the process while some staff felt 'pushed down the portfolio route'. LPHTs described the process as 'hard and time consuming' and one which needed them 'to stay motivated'. Practitioners are expected to complete the process within 12 months. One positive benefit cited by some staff of developing a portfolio of evidence was the opportunity to collaborate with colleagues in other teams.

89 Staff indicated that they would welcome guidance from the Trust setting out the minimum level of competence required to work as a public health practitioner because 'not everyone wants to pursue the portfolio route to register with the UKPHR'. Our interviews found no obvious incentives for staff to complete the process and register with the UKPHR. The Trust needs to clarify its expectations in relation to voluntary registration with the UKPHR and whether it is or should be a requirement to undertake particular roles.

90 The Trust's 2016 IMTP indicated that it would be assessing the requirement to fund postgraduate degrees in public health to ensure public health professionals have the necessary theoretical knowledge. Staff, however, were confused about whether this postgraduate degree was needed for career progression. Staff told us that in the past a postgraduate degree in public health was seen as the gateway to more senior roles but less so nowadays because there was less money available to fund such courses. Recent advertisements for senior posts indicate that postgraduate qualifications in public health or equivalent are required. However, there is no explicit reference that registration with the UKPHR is desirable or essential to the job.

New arrangements are 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

91 In 2016, the Trust implemented a new appraisal and performance and development review (PADR) process called My Contribution. The policy applies to all staff, except medical and dental staff registered with the General Medical Council or General Dental Council who take part in a separate appraisal process.

The first full cycle of the process concluded at the end of March 2017. LPHTs were positive about the new process describing the previous appraisal and PADR process as 'patchy'. At the time of our audit work, staff were taking part in mid-year performance reviews with the Trust seeking information on levels of compliance with the process. According to staff, it is only in the last few years that the Trust has sought information on compliance with the appraisal process.

92 Some staff with line management responsibility in the LPHTs reported using the recently revised Public Health Skills and Knowledge Framework as the basis for agreeing individual personal development plans for non-consultant staff. Staff from all teams told us, however, that they have never been asked to share their personal objectives or individual development plans with the Trust. This means that the Trust cannot form an objective view of the training and development needs of its staff to progress their careers and to address gaps in capacity and capability across LPHTs. Unlike their colleagues, consultants within the LPHTs reported routinely sharing PADRs and job plans with the Trust's Executive Director for Public Health Services/Medical Director.

93 Although critical appraisal and interpreting data are core competencies for specialists in public health, some staff questioned whether teams had sufficient levels of expertise or experience to apply these skills to underpin their practice. Other staff described the changing nature of their work and the perceived need for new skills, such as social marketing. Local team training and development plans were intended to address these perceived skills gaps but there were no mechanisms to help teams collaborate with each other around common training and development needs.

94 Instead, training and development needs are managed and coordinated by individual teams. A public health consultant or principal practitioner generally takes responsibility for designing the team training and development programme. One team intended carrying out a training needs analysis to ensure training and development was appropriate and targeted. LPHTs will seek support from the Trust's People and Organisational Development team if needed or will invite colleagues from the Trust's corporate-based teams to present their work or provide training.

95 The Trust has made significant investment in leadership and management capability having identified weaknesses in management development several years ago[20]. A number of staff across the LPHTs told us that they could, if they wanted, take part in the leadership and management development training programme that the Trust was running. Those staff participating were positive about the experience.

96 However, we found that administrative staff had very different training and development opportunities, depending upon their local team. Administrative staff felt 'boxed in and capable of doing so much more to support the public health

[20] Wales Audit Office, **Annual Audit Report 2015 Public Health Wales**, January 2016

agenda locally'. These staff also see local health boards implementing administration apprenticeships and feel that the Trust could consider similar schemes to support their career development.

97 Recent recruits to LHPTs, who had joined the Trust from local public health teams in England, were positive about the public health system in Wales compared with their experience in England. The system in Wales was seen as providing more opportunities for career and professional development, largely because Trust staff could work at an all Wales level or locally within LPHTs.

98 Staff acknowledged personal responsibility for maintaining professional competence and performance but reported that it is often difficult to find opportunities for work-based learning, such as shadowing colleagues or secondments with other teams. There are no shadowing opportunities and no real capacity to rotate through other LPHTs or the Trust's national teams.

99 Secondments of less than one year are seen as unattractive by staff not least because of the time needed to backfill their post. Staff felt that the Trust did not appreciate the impact and risks to teams' work plans should individuals take up a secondment. For other staff, secondments were seen as a way of connecting the LPHT with the Trust's national teams.

100 The Trust's 2016 IMTP highlighted its intention to increase collaborative working and engagement between all directorates, divisions and LPHTs by providing opportunities for staff to work across different areas. Our interviews found that the Trust has no easy way to do this or to draw in expertise from LPHTs. We were concerned to hear from several individuals in LPHTs that opportunities to work with the Trust's national teams had been denied. The reasons suggested include the Trust not involving the DPH in the initial approach to staff, a lack of clarity about the likely time commitment or no backfill for their post. As part of its arrangements for increasing collaborative arrangements between teams, the Trust will need to liaise with DsPH to see whether such arrangements are mutually compatible for both the individual concerned in respect of development needs and the needs of the LPHT and its programme of work.

The mechanisms for communicating and sharing information between the Trust and local public health teams are under-developed

101 Effective collaboration requires clear channels for communication with flows of information, such as national and local work programmes or evidence underpinning local public health services, both timely and in an agreed and easy to use format. The information should add value and be directed to those who need it.

102 Theoretically, it should be easy for the Trust to share information with LPHTs as the Health and Wellbeing Directorate, of which LPHTs are a part, includes the Observatory and Library and Knowledge service and the teams responsible for all Wales health improvement programmes. Our interviews with LPHTs identified that

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.

103 Other than the Trust's staff bulletin, there were no regular channels of communication between the Trust and LPHTs in relation to delivering local public health services for health improvement. We were told of examples of good practice in relation to communication and information sharing around immunisation where there is effective and regular communication between the Welsh Government, the Trust, LPHTs and the health boards' immunisation co-ordinators.

104 Based on our interviews, there is no mechanism to coordinate work being developed or carried out by the Trust's national teams and LPHTs or between one LPHT and another. An example was cited of how a local team working on substance misuse discovered that they were mirroring work on the same topic being carried out concurrently by one of the Trust's corporate teams, leading to wasted time and effort. LPHTs also cited a lack of clarity from the Trust about what health campaigns it planned to support during the year. The lack of coordination may be due in part to the Trust's lack of understanding of local work plans. One possible channel for greater coordination in this area is the DPH peer group meetings.

105 Greater clarity about the roles and responsibilities of the Trust's national teams for health improvement and LPHTs is needed to improve understanding and mutual respect. LPHTs were often unfamiliar with who worked on the various all Wales health improvement programmes. Teams were frustrated that it was not easy to find out, relying instead on personal relationships where these existed.

106 Consistently across the LPHTs, there was an expectation that the Trust's national teams would engage with them as all Wales health improvement programmes were developed. Many staff in the LPHTs felt that national teams could do more to work with them. However, we were informed that attempts by national teams to engage and share work with LPHTs had been rebuffed in the past because LPHTs felt they were already doing the work.

107 A small number of staff that we met had experience of working across both the Trust's national and local teams. These staff told us that colleagues based nationally were wary of approaching LPHTs with LPHTs described as unwelcoming. LPHTs were equally irritated that the Trust, as they saw it, failed to acknowledge successful initiatives in place locally. LPHTs frequently referred to the Trust taking initiatives 'in-house and claiming them as their own'.

108 We concluded that variability in information flow is influenced by the working styles of the Trust's corporate leads. It is important to say that there were exceptions and that relationships with national teams were seen as improving particularly where there is a common purpose or a willingness to engage with LPHTs. For example, one team indicated that the engagement team within the Screening Division is working with them to improve the uptake of screening services across their local population. In relation to work on health improvement, all LPHTs cited the good working relationships with the Trust's national team for tobacco control. What

seems to set apart this team is its regular communication and forum for regular meetings.

109 The Trust's latest IMTP indicates that for each of the health harming behaviours, such as smoking and alcohol consumption, it has established, in partnership with LPHTs mechanisms for the leads in each area to come together to discuss common priorities and shape work programmes. This should address many of the concerns raised by LPHTs during our interviews, not least providing a better understanding of all Wales programmes and providing a mechanism for leads with LPHTs to connect with each other.

110 The size of the Trust and the geographic dispersal of staff means that 'bumping into people, corridor chats and informal conversations' do not take place. However, where there is a degree of co-location, staff remarked that communication and working relationships were improving. LPHTs felt the Trust could do more to locate staff working on all Wales health improvement programmes with local teams as a way of improving communication and building trust and mutual respect.

111 While LPHTs praised the Library service for quick and timely responses to requests for help, there was criticism of the health intelligence function, where requests for data and support for analysis from the Observatory were not met in a timely fashion. LPHTs reported that the Observatory provides a 'gold' standard service but this meant the speed of response was too slow. LPHTs wanted a service that was 'good enough'.

112 Despite issues around timeliness, the LPHTs describe the Observatory as being 'worth its weight in gold' and that the quality of its products lent credibility to their work. We were also told that when the Observatory received ad hoc requests seen to be beneficial to all LPHTs, it would produce outputs on a 'once for Wales' approach. However, LPHTs complained of sometimes feeling overwhelmed with the volume of information and felt the Observatory could provide more support to interpret it.

113 The Observatory has a number of systems in place to communicate with LPHTs. These include:

- attending the DPH peer group meetings to share their annual programme of work and proposed data products with the aim of agreeing priorities;
- a single point of contact within the Observatory for each LPHT; and
- a liaison group at which a LPHT representative attends and where the plan of proposed products is also shared. LPHT representatives on the group told us that they had no real ability to influence the work but meetings provided opportunities to network with colleagues in other teams.

114 There was a perception amongst some LPHTs that programmes of work of the Trust's different corporate and national teams were not always joined up. For example, staff were unclear how the emergent work of Adverse Childhood Events

(ACE)[21] linked with current programmes around the early year's theme or how 'First 1000 Days'[22] links with the work on ACEs. Staff were confused over this disconnect and although LPHTs described the work around ACEs as 'brilliant', they had no idea what it meant for their local work.

115 Some staff commented on poor levels of communication on decisions to disinvest in specific programmes, such as the MEND[23] programme for childhood obesity. LPHTs reported that the programme had not been replaced leaving a void or lack of direction about what they should be doing in terms of obesity programmes for children and young people.

116 Both the Trust and LPHTs need to manage a number of relationships with the same local authority and third sector partners. However, there are no arrangements for coordinating communication or information sharing with these partners by the Trust or LPHTs. LPHTs frequently reported 'always tripping over other colleagues' outside their team or seeing others as 'on my patch'. LPHTs reported being caught by surprise when partners referred to meetings or events organised by the Trust's corporate teams to which they were unsighted. LPHTs also reported having to 'pick up the pieces' if the Trust did not follow up on 'its promises'. We found that in most LPHTs, senior staff – consultants and principal practitioners – managed the relationship with individual local authorities on behalf of the team. A simple solution to improve coordination might be a single point of contact within each LPHT with whom Trust corporate teams could liaise and share information.

[21] www.wales.nhs.uk

[22] www.wales.nhs.uk

[23] MEND stands for Mind, Exercise, Nutrition, Do it

Appendix 1

Domains and functions of public health practice

Exhibit 1: description of domains and functions of public health practice

The table describes the domains and functions of public health practice.

Descriptions of public health practice	
Health improvement	• This domain covers wide ranging action to improve health and wellbeing of local populations and to reduce health inequalities including: – assessing health and wellbeing needs of local populations; – developing effective initiatives and interventions to improve health and wellbeing; – building strategic partnerships; and – enabling and supporting local communities.
Health protection	• This domain covers wide ranging action including: – ensuring the effectiveness of immunisation programmes; – ensuring the safety and quality of food, water, air and the general environment; – preventing the transmission of communicable diseases; – managing outbreaks and the other incidents which threaten public health; and – ensuring emergency and major incident preparedness.
Healthcare public health	• This domain covers the planning and development of services to ensure they meet population needs including: – ensuring equity of service provision, clinical governance, safety of services and quality improvement; and – screening services to detect changes indicative of specific health problems.
Health intelligence	• This function underpins all of the above three domains of public health practice and includes: – surveillance and monitoring of population health and assessment of the determinants of health and wellbeing; – support for evidence-based practice; and – assessing the effectiveness of policies, programmes and services.

Source: Faculty of Public Health, **Functions of the local public health system,** 2014

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Appendix 2

Public Health Wales Statutory Functions

Public Health Wales National Health Service Trust (Establishment) Order 2009, SI 2009/2058 sets out the Trust's four statutory functions. These are:

- to provide and manage a range of public health, health protection, healthcare improvement, health advisory, child protection, microbiological laboratory services, and services relating to the surveillance, prevention and control of communicable diseases;
- to develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;
- to undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales, including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and
- to provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.

Appendix 3

Public Health Wales – what it does

The infographic shows the broad range of work carried out by Public Health Wales.

Source: Public Health Wales

Appendix 4

Participant information sheet

Review of collaborative arrangements for managing local public health resources

Why we are doing the audit?

The Auditor General is the public sector watchdog for Wales, which includes examining how NHS bodies manage and spend public money. Wales Audit Office staff carry out this work on behalf of the Auditor General.

The review of collaborative arrangements for managing local public health resources is part of the Auditor General's programme of external audit work at Public Health Wales. In 2015-16, the amount funded for local public health teams was in excess of £9 million, representing approximately 9% of the Trust's budget.

It is important that the Auditor General satisfies himself that these resources are well spent. In order to do this, it is necessary to look at the collaborative arrangements through which these funds are administered.

Why we want to meet with staff from local public health teams?

Our audit focuses on Public Health Wales' arrangements to provide and account for local public health resources. We are not auditing the work or performance of local public health teams.

In order to provide a high-level, factual picture of how the current collaborative arrangements work between Public Health Wales and local health boards, we need to understand what local public health teams do and the support they receive to do their work. When we meet with individuals or groups of staff, we want to cover a number of themes. These themes are:

- Individual roles and responsibilities within the team; and
  - how these roles and responsibilities are agreed;
  - the extent of support that individuals or teams receive from Public Health Wales (ie the corporate centre) to fulfil these roles and responsibilities or to do your jobs; and
  - activities that individuals undertake on behalf of Public Health Wales.
- The work programme or work plan that the team is responsible for delivering, including how the programme or plan is developed, resourced, monitored and reported; and
  - the extent of Public Health Wales' support, input or oversight of the team's work programme or work plan;

  - the extent of investment in local teams to deliver work programmes or work plans;
  - any requirements to report to Public Health Wales.
- Individual/personal objectives and how these link to the team's work programme/plan and the arrangements for training and development; and
  - the extent of Public Health Wales' input to or oversight of personal objectives and personal development plans.
- The level of interaction individuals or the team have on a day-to-day basis with Public Health Wales; and
- Mechanisms individuals or teams have to share work or expertise with the wider team, other local public health teams or nationally.

Appendix 5

The Trust's management response

The table sets out the report's recommendations and the actions that the Trust intends to take in partnership with the public health system to address the issues raised. The detailed actions fall within three main themes: roles, responsibilities and accountability; relationships; and system capacity and capability.

Improvement action	Management response	Lead	Completion date
1. Collaborative arrangements for managing local public health resources do not work as effectively as they should do. The Wales Audit Office recognises, in part, that the problems identified in this report relate to matters that are the responsibilities of Welsh Government, Health Boards and Public Health Wales.	**1a)** In the context of the Well-being of Future Generations FG Act, WG to establish a mechanism to describe the public health system leadership, including the respective roles and responsibilities for the specialist public health system and to develop options for consideration by all relevant bodies on an operational model for specialist public health at a local level. *Theme: roles, responsibilities and accountability*	Welsh Government	20 April 2018
	1b) In the meantime, Public Health Wales and Health Boards will strengthen the existing arrangements for the governance, assurance and reporting arrangements in relation to the management of LPHTs. An overarching governance framework will be developed and will clarify and optimise accountability and reporting arrangements, thereby ensuring that the Board of Public Health Wales can account for the appropriate use of the local public health resource. The work will build on the current MoU	Task and Finish Group led by PHW	31 January 2018

Improvement action	Management response	Lead	Completion date
	and ensure that governance and accountability arrangements can be tailored for local circumstances. *Theme: roles, responsibilities and accountability*		
	1c) To discharge its duties in relation to accounting for the local public health resource, Public Health Wales will meet Local Health Board DsPH at least annually. Escalation of issues will be through existing Executive to Executive meetings and, in future, Board to Board meetings. *Theme: relationships*	PHW	First round of PHW/DPH meetings completed by 31 March 2018
2. Continued working with Health Boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally.	**2)** Public Health Wales, Health Boards and Welsh Government will, through the Public Health Directors' Group, build on existing arrangements and establish a more strategic and planned approach - aligned to Integrated Medium Term Plans - securing a collective focus on a number of evidence-based priorities. The agreed approach will clarify roles and responsibilities, reporting mechanisms; include agreed output and outcome measures of both national and local programmes; and feed into refreshed accountability mechanisms (1b). *Theme: roles, responsibilities and accountability*	PH Directors Group	31 January 2018
3. Developing effective arrangements to demonstrate that PHW is securing value for money from the specialist public health resources allocated to LPHTs.	**3a)** Public Health Wales will establish a transparent mechanism to agree a fair distribution of resources between LPHTs. *Theme: relationships*	PHW	28 February 2018
	3b) PHW will establish a transparent mechanism for how value for money will be measured through the use of these and central resources. *Theme: relationships*	PHW	30 April 2018
4. Clarifying the roles and responsibilities of the Trust's national and local teams in	**4a)** As part of action 1a, Public Health Wales will work with Welsh Government and Health Boards to clarify the respective roles and responsibilities for health improvement. This will include clarity in relation	Welsh Government	30 April 2018

Improvement action	Management response	Lead	Completion date
relation to developing and delivering health improvement programmes.	to what is developed nationally by Public Health Wales and what is delivered locally by Health Boards. *Theme: roles, responsibilities and accountability*	PHW Health Boards	
	4b) In developing and implementing its long term strategy, Public Health Wales will work with Health Boards to maximise improvements in public health. *Theme: roles, responsibilities and accountability*	Welsh Government PHW Health Boards	30 April 2018
5. Progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice including healthcare public health.	**5)** The distribution of resource is included as part of action 3 above. In support of the output of action 1a, Public Health Wales will work with the Public Health Directors' Peer Group to define and agree: ● the respective roles for healthcare public health at a local level ● the required support/resource from by PHW ● the required support/resource from Health Boards. *Theme: roles, responsibilities and accountability*	PHW	28 February 2018
6. Agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs.	**6a)** Public Health Wales, in collaboration with DsPH, will improve the existing mechanism for effective communication and knowledge sharing across the public health system. *Theme: relationships*	PHW	31 January 2018
	6b) DsPH and Public Health Wales to commit to ensuring that all LPHT staff have fair access to staff development and engagement processes organised by Public Health Wales. *Theme: System capacity and capability*	PHW and DsPH	Immediate effect
7. Agreeing a mechanism whereby workforce planning discussions take place on a	**7a)** The Director of People and Organisational Development and other relevant Directors of Public Health Wales will regularly meet DsPH to discuss immediate and medium term workforce needs and skill gaps for each LPHT.	PHW	Commence by 31 December 2017

Improvement action	Management response	Lead	Completion date
more formal basis between the Trust and DsPH	*Theme: System capacity and capability*		
	7b) As part of the PHW 10 year strategy development and in the context of the WFG Act, PHW will collaborate with DsPH and LPHTs on developing and implementing a strategic workforce plan for LPHTs as a more integral plan for the specialist public health system. (This will include understanding the current skill gaps to deliver such a workforce plan.) *Theme: System capacity and capability*	PHW supported by DsPH	31 January 2018
8. Clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite.	**8)** Public Health Wales to establish a further Task and Finish Group with DsPH, Health Education and Improvement Wales and WG to develop and implement a programme for personal and professional development, leadership and management development and career progression. This will include the professional qualifications and registration required for specialist public health roles. *Theme: System capacity and capability*	PHW supported by DsPH	31 January 2018
9. Clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles.	**9)** Included as part of action 7 above.		

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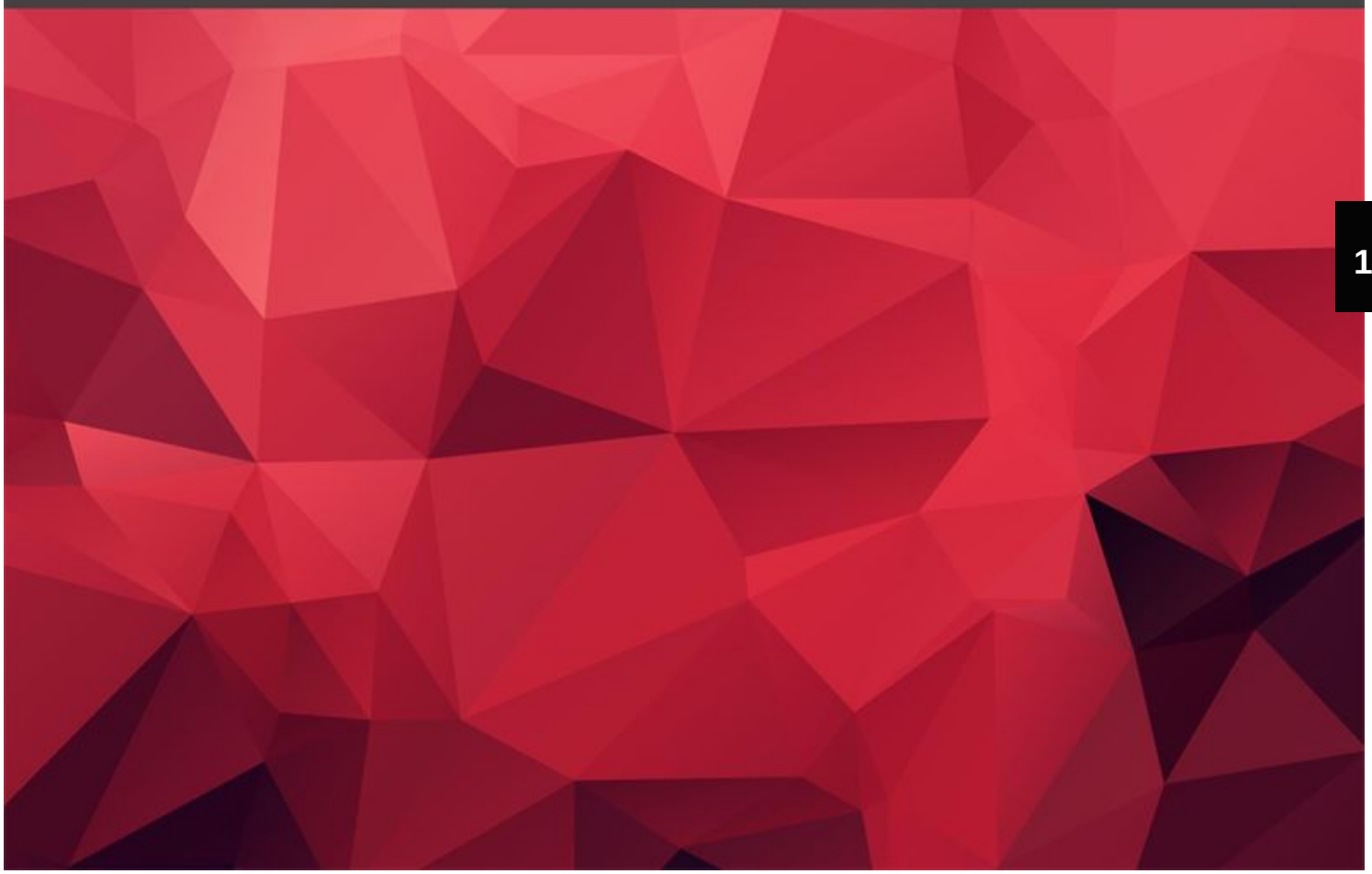
Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Cardiff and Vale University Health Board**

Date issued: December 2017

Document reference: CVACU2017



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Summary report

About this document

1 This document provides the Audit Committee of Cardiff and Vale University Health Board (the Health Board) with an update on current and planned Wales Audit Office work. Financial and performance audit work is considered and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

Exhibit 1: Financial audit update

Work area	Progress	Conclusions
Annual Accounts and other financial-audit work		
We have concluded the audit of the Health Board's grants. We are finalising the audit of the Health Board's 2016-17 Funds Held on Trust Account, which is scheduled to be signed and certified in January 2018. In December we will be commencing our planning of the 2017-18 financial audits. This work will be covered in our 2018 Audit Plan, which the Audit Committee will consider in early 2018.		

Performance audit update

Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

Topic (year of Audit Plan)	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
Thematic review – patient flow (out-of-hours) (2016)	The Health Board has strengthened the governance of GP out-of-hours but performance is mixed and risks remain in relation to the sustainability of the service. • The GP out-of-hours service has strengthened its monitoring and leadership arrangements and has recently written a business case to improve its strategic planning. • There are risks to the sustainability of the service because problems remain in filling GP shifts and spending is comparatively low. • Call taking performance is comparatively good but there is scope to improve the timeliness of home visits, appointments and especially call backs.	Final report	Steve Curry	December 2017	Developed and appended to final report
Thematic review – patient flow (discharge planning) (2016)	The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services.	Final report	Steve Curry	December 2017	Developed and appended to final report

Topic (year of Audit Plan)	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
	• The Health Board has clear plans for improving discharge planning supported by comprehensive policies and pathways • Multiagency and multidisciplinary teams are available to support discharge but only during the week; staff training and awareness of policies and community services needs improvement • Overall, performance is improving; the Health Board has strong scrutiny arrangements for discharge planning and is taking positive steps to capture more meaningful information				
Local project – progress update on the management of follow-up outpatients (2016)	The Health Board has made progress in addressing the recommendations made in our 2015 report, and, with the Outpatient Transformation Programme (under the remit of the Planned Care Board), is well placed to meet all recommendations: • the People, Planning and Performance Committee receives information and focuses on outpatient follow-up risks and the progress made in validating the waiting list. • clinical boards are required to set out how they will validate their waiting lists, target high-risk patients delayed beyond their target date and how they will modernise outpatient services. Performance against plans is monitored. • the Health Board has completed the clinical risk assessment to identify conditions across all specialties where patients could come to irreversible harm due to delays in follow-up appointments.	Final report	Steve Curry	December 2017	Not applicable

Topic (year of Audit Plan)	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
	• the Health Board has identified no patients experiencing harm as a result of a delay in their follow-up appointment. • work is continuing to identify and target high-risk patients experiencing a delay in their follow-up appointment. • some specialities have taken steps to modernise outpatient services, including shifting follow-up care into the primary care service (where appropriate). • the Health Board's Outpatient Transformation Programme, under the remit of the Planned Care Board, will provide corporate oversight and management to outpatient modernisation across the Health Board. • whilst transformation observed and progress made are positive, the Health Board can use the Outpatient Transformation Programme to drive transformation across specialities where progress has been slower.				

Work currently underway

Exhibit 3: Work currently underway

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Structured Assessment (2017)	This work will continue to assess the robustness of NHS bodies' arrangements for corporate governance and financial management, and the progress that is being made in addressing issues and concerns identified in previous years' structured assessments. The work will also include an assessment of arrangements to deliver financial efficiencies, as aspect of governance which has presented challenges to most NHS bodies. The area of comparative analysis is currently being considered. This work will also be used to start to build up a picture of how NHS bodies are responding to their statutory requirements under the Well-being of Future Generations (Wales) Act 2015. This work will inform a national 'year-one commentary' across all relevant public sector bodies.	Report currently being drafted	Peter Welsh	~~December 2017~~ Amended to February 2018 to allow for clearance and discussion with full Board
Local project (2017)	This work will examine the progress made by the health board in relation to our recommendations raised in relation to our previous work of medical equipment.	Fieldwork underway	Fiona Jenkins	April 2018

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Thematic review – primary care (2017)	This work is being delivered in two phases. The first phase will build on existing data to provide an all-Wales data rich picture of primary care. Phase 2 will then focus on the work being undertaken by Health Boards to implement the strategic vision for primary care, drawing on the commitments set out within the 2014 Plan for Primary Care Services for Wales and other relevant national delivery plans, together with key enablers of change such as the development of primary care clusters and mechanisms to increase capacity and capability within primary care services.	Phase 1 underway. Phase 2 due to commence in February 2018	Steve Curry	~~April 2018~~ Amended to September 2018 as work now not due to commence until February
Thematic review – integrated care fund (2017)	This work will focus on the Integrated Care Fund (ICF) which is available to health boards and local authorities to develop integrated services. The exact focus of this work is still to be confirmed but is likely to examine whether the fund is being use to the best effect. The work will examine both a national and regional perspective and is likely to result in a single national report.	Early scoping.	TBC	~~April 2018~~ Amended to September 2018

Other Auditor General studies

Since the last Audit Committee we have published the following reports which are of relevance to the NHS.

Exhibit 4: Auditor General Reports published since last audit committee

Product	Summary
Collaborative arrangements for managing local public health resources November 2017	This audit focused on the arrangements for delivering services for health improvement through local public health teams, which we were informed was the main function of most staff working in these teams. The review concluded that collaborative arrangements for managing local public health resources do not work as effectively as they should do. We came to this conclusion because: • Effective collaboration in relation to health improvement work is dependent upon consensual leadership but this was not always evident. • The Trust has not established effective arrangements to ensure that it is securing value for money from the resources allocated to local public health teams. • There is a lack of meaningful dialogue between the Trust and local public health teams about respective roles, responsibilities and priorities and an agreed framework about what work is best done collectively. • The Trust does not have robust methods for allocating or changing resources of local public health teams. • Although the Trust has strengthened arrangements for appraisals and personal development planning, it can do more to assess the needs of local public health teams to support professional development and career progression. • The mechanisms for communicating and sharing information between the Trust and local public health teams are underdeveloped. The report can be found at http://www.audit.wales/system/files/publications/collaborative-arrangements_managing_public_health_resources_public_health_wales.pdf
Public procurement in Wales October 2017	We have examined whether there is evidence that current procurement arrangements in Wales are helping to deliver value for money in public spending and are fit for the future. We have concluded that national governance arrangements for procurement could be strengthened and there is clear scope for improvement in procurement arrangements at a national and local level. Public bodies also face challenges in balancing potentially competing procurement priorities, responding to new policy, legislation and technology, and in the recruitment and retention of key personnel.

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Product	Summary
	• The principles governing public procurement are set out in a range of legal and policy frameworks but national governance arrangements could be strengthened. • In 2015-16, public bodies in Wales spent around £6 billion through procurement on a range of goods, services and works. • Procurement consortia and public buying organisations are reporting financial savings, although there are mixed views on the effectiveness of some of these arrangements. • There is clear scope for improvement in public bodies' procurement arrangements and additional challenges arising from new policy and legislation. The report can be found at http://www.audit.wales/system/files/publications/Public-Procurement-in-Wales-2017-English_0.pdf

Good Practice Exchange

The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table below lists recent and forthcoming events.

Exhibit 5: Good Practice Exchange

Recent and forthcoming events
Recent events
How different methods of engagement can help involve the citizen in public service delivery – September 2017 (past) This seminar focused on the important of engaging with citizens and shared examples of how organisations in Wales have done this, using very different and innovative methods.
How understanding Adverse Childhood Experiences (ACEs) can help integrated service delivery – November 2017 (past) Through scenario based discussions, this webinar helped delegates understand the impact of ACEs, how ACEs underpin the work of public services, how the five ways of working can be applied to take an approach that seeks to prevent ACEs and how working together in this way can fulfil the spirit and intention of the Well-being of Future Generations Act.
Forthcoming events
Using alternative delivery models to deliver public services – 22 November 2017, and 7 December 2017.
The role of scrutiny in relation to the WFG Act – 16 January 2018, and 25 January 2018.

Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

AUDIT OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S CONTRACTUAL RELATIONSHIPS WITH RKC ASSOCIATES LIMITED AND ITS OWNER	
Name of Meeting: Audit Committee	**Date of Meeting:** 5 December 2017

Executive Lead: Chief Executive
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the "Values" element of the Health Board's Strategy.
Financial impact: As identified in the Wales Audit Office report
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Governance, leadership and accountability and Standard 7.1 Workforce
CRAF Reference Numbers: 8 and 9
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The progression of the Action Plan provided in Appendix 1 and ongoing monitoring by this Committee.

RECOMMENDATION

The Committee is asked to:

- **NOTE** the contents of this report;
- **MONITOR** the progress of the Action Plan and
- **PROVIDE** the Board with the assurances required.

SITUATION

Further to the critical report of the Auditor General for Wales dated July 2017 relating to the UHB's contractual relationships with RKC Associates Ltd and its Owner, the UHB developed a comprehensive action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future.

BACKGROUND

This report follows that provided to the Committee on 26 September 2017, and contains the updated version of the Action Plan (Appendix 1).

It was agreed at Board on 27 July 2017 that the Audit Committee would monitor the progress of actions and provide the Board with the assurances required.

The Chair and Chief Executive attended the Public Accounts Committee on 25 September 2017 to discuss the Wales Audit Office report, and the Action Plan was provided to that Committee. Correspondence has now been received from the Chair of the Public Accounts Committee confirming that it is reassured by the UHB's response to this matter.

The Public Accounts Committee requires an update on the implementation of the Action Plan in April 2018 and has requested specific assurance around improving the culture within the Health Board for staff to feel comfortable in raising concerns.

Following the Wales Audit Office report, the UHB has engaged with Internal Audit to carry out a review of procurement. This is focusing on contracts that have been let to gain assurance that there are no further instances of poor practices. The outcome of that audit is awaited and the Public Accounts Committee has asked for sight of the completed Internal Audit report.

In addition the Health Board has also carried out an internal review of all manual payments made to Consultants or individuals in the period 2014-17, with an invoice value greater than £5k. A total of 227 contractors / suppliers have been reviewed. Two of these contracts have been referred to NHS Counter Fraud Service Wales and the Public Accounts Committee has also asked for an update on these referrals once the investigations have been concluded.

The updated Action Plan has been shared with Wales Audit Office.

ASSESSMENT AND ASSURANCE

The Action Plan reflects the progress that has been made since the last report to the Committee.

Of the 26 actions contained within the Action Plan, only 9 remain outstanding. The updates provided in the Action Plan provide assurance that good progress is being made in relation to these outstanding actions, including those that require input at an All Wales level.

It is proposed that a closure report, containing the completed Action Plan, be provided to the Board meeting on 29 March 2018.

In addition, an action plan has been developed by the Head of Procurement Services with actions to address each of the criticisms within the Wales Audit Office report, and this has been reviewed by NHS Wales Audit and Assurance Services.

Appendix 1

Action Plan in Response to the Wales Audit Office Report in Respect of Cardiff and Vale University Health Board's Contractual Relationships with RKC Associates Ltd and its Owner

Conclusion 1 - The way in which the Cardiff and Vale University Health Board (UHB) procured and managed HR consultancy contracts awarded to RKC Associates fell well short of the standard that the public has a right to expect of a public body
a) The UHB failed to comply with its own procurement procedures when it awarded consultancy contracts to RKC Associates in November 2014 and June 2015 and in consequence both the contracts and payments made under them are potentially unlawful. b) The award of consultancy contracts to RKC Associates breached public procurement rules. c) The UHB failed to undertake due diligence checks of RKC Associates resulting in the UHB being exposed unnecessarily to financial and reputational risk. d) The UHB was in breach of its own Standing Financial Instructions when it agreed contracts with RKC Associates which had been drafted by the owner of RKC Associates. e) The UHB appointed the owner of RKC Associates to deliver consultancy projects, but the UHB utilised her as a senior member of staff and, in consequence, has potentially over-claimed VAT amounting to £58,162. f) As the Officer who signed the contracts with RKC Associates in November 2014 and June 2015, the UHB's Chief Operating Officer had a duty to ensure proper process had been followed. The failure to do so has cast doubt on whether the decisions to award these contracts were based entirely on valid considerations. g) The UHB did not exercise effective financial monitoring of its contracts with RKC Associates, with payments exceeding the contracted value and contractual expenses not being verified.

Dated: 20 November 2017

Appendix 1

UHB Response to Conclusion 1

Following publication of the Wales Audit Office report, a full report was received at the UHB's Board meeting on 27 July 2017 and discussion conducted in the public session of that meeting. In addition, the report has been raised at the meetings of our Management Executive (ME) and Health Systems Management Board (HSMB), and discussed with Senior Trade Union / Staff Side representatives and at our Local Partnership Forum (LPF).

As acknowledged by the Wales Audit Office, the UHB has a number of detailed policies and procedures covering this area. These have been developed to standardise processes based on best procurement practice and set out the governing principles for public procurement, for example, the Scheme of Delegation, Standing Orders, Standing Financial Instructions and Financial Control Procedures. Regrettably, these processes were not followed on this occasion, and there was no reference to the UHB's Head of Procurement as provided for in our Scheme of Delegation.

The Procurement Guide for Staff which was developed in conjunction with NHS Wales Shared Services Partnership Procurement Services, and approved through the All Wales Directors of Finance Sub Group in 2015, is provided to UHB staff as part of the training delivered by the UHB Procurement Department and will be further reinforced throughout the UHB.

Prior to the Wales Audit Office report, a review of our processes was already in train in response to changes to the IR35 legislation[23] relating to off-payroll working in the public sector. In addition, the process around requesting approval of contracts has been changed, a procurement checklist that sets out a defined approval hierarchy has been implemented to ensure compliance with Standing Orders and EC Regulations and that more than one signatory is obtained. All external Consultancy contracts are now signed off by the CEO.

The UHB, in conjunction with its colleagues in Procurement and Human Resources / Workforce, has developed this action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future. The Action Plan will be presented to the UHB Board on 28 September 2017 and its Audit Committee on 26 September 2017 and will thereafter be monitored by the Audit Committee. The Action Plan has also been shared with Wales Audit Office.

1 Her Majesty's Revenue and Customs (HMRC) introduced the 'intermediaries legislation' commonly known as IR35or off-payroll rules in April 2000. This legislation is intended to combat tax abuse by an individual who would be treated as an employee were it not for the fact that they provide their services via their own company, called 'disguised employees' by HMRC. From April 2017, where a public sector organisation engages an off-payroll worker through their own limited company, that organisation will become responsible for determining whether the rules should apply, and, if so, for paying the right tax and National Insurance Contributions.

Dated: 20 November 2017

Appendix 1

Conclusion 1 Action Plan	Lead	Completion	Update	Status
Training 1. Provide training for all Board members on the law, rules and regulations relating to employment and procurement at the August Board Development Day.	Director of Corporate Governance	August 2017	**Complete** Training delivered on 31/08/17.	
2. Cascade the training provided at Clinical Board senior management teams and throughout the organisation to Directorate Management level.	Executive and Clinical Board Directors	October 2017	**Complete** Discussed at ME on 04/09/17 & cascaded.	
Review 3. Undertake review of external consultancy categories in the purchase to pay system for period 2014-2017 to ensure compliance with procurement rules.	Head of Procurement	August 2017	**Complete** Reports received by CEO and Director of Finance.	
4. Review the Procurement Guide for Staff and revise to reflect process changes connected with the IR35 legislation.	Head of Procurement	September 2017	**Complete**	
Process 5. Provide the Procurement Guide for Staff to the Management Executive Team meeting for cascading to Clinical Boards, and Corporate Departments.	Director of Finance	September 2017	**Complete** Approved by ME on 25/09/17	
6. Publish the Procurement Guide for Staff across the UHB and place on intranet and internet for ease of staff access.	Director of Corporate Governance	October 2017	**Complete**	
7. Implement a no purchase order, no payment system to prevent the processing of manual payments.	Head of Procurement	March 2018	Site visits underway, approval received from All Wales Directors of Finance & draft policy prepared. Full implementation by March 2018.	
8. Develop and cascade process guidance for off-payroll working.	Head of Procurement	August 2017	**Complete** Approved by ME on 14 August 2017, taken to HSMB on 17 August 2017 for cascading by Clinical Board Directors.	

Dated: 20 November 2017

Appendix 1

Conclusion 2 - The way in which an HR consultancy contract was awarded to RKC Associates in February 2016, along with the actions of key decision-makers, compromised the integrity of the procurement process
a) The UHB embarked upon a procurement process for a contract and invited and evaluated tenders for that contract, despite the fact that RKC Associates had been engaged in advance of the tender process. b) The robustness and integrity of the advertised procurement process was compromised in several key respects and the UHB's Chief Operating Officer participated in the process despite knowing that RKC Associates had already been engaged in advance of the procurement process commencing. c) The Procurement Department failed to keep adequate documentation of the procurement process. d) The UHB delayed seeking formal written approval for the fixed-term appointment of a new Director of Workforce and Organisational Development, resulting in the UHB incurring unnecessary expenditure on a consultancy contract.
UHB Response to Conclusion 2 The UHB has taken steps to strengthen its existing processes and extend training at all levels to reinforce the requirements in relation to these areas. We recognise however that policies / procedures and training, whilst the foundation of good practice, are part of a bigger picture that includes a culture of sound behaviours and values, adherence to the rules at all levels of the organization, checks to ensure this is happening and an environment that enables individuals to confidently highlight departure from any rules no matter how senior those involved. As part of the communication with the UHB following receipt of this report, the CEO has asked staff to share any concerns they may have with him and provided assurance that anything raised will be explored to provide reassurance regarding our systems / processes and decisions made. Procurement compliance reports are already presented to the UHB's Audit Committee outlining for example Contract Extensions and Single Quotation or Single Tender Actions. Steps are also being taken to put in place more vigorous checks around our processes to flag potential issues and to achieve more robust oversight and business scrutiny by our Management Executive Team, Board and its Committees. We are committed to utilising temporary employment contracts rather than consultancy contracts wherever possible.

Dated: 20 November 2017

Appendix 1

Conclusion 2 Action Plan	Lead	Completion	Update	Status
Training 1. Develop and deliver an enhanced training programme for procurement staff focusing on the conclusions of the Wales Audit Office report.	Head of Procurement	September 2017	**Complete** All training complete, refresher sessions will continue.	
2. Obtain quality management accreditation for the Procurement Department in respect of its tendering processes.	Head of Procurement	November 2017	Assessment postponed to early January 2018 due to departure of Assessor.	
3. Develop a Procurement flowchart for use by Board and Senior Managers.	Head of Procurement	October 2017	Draft to be considered by ME on 11/12/17.	
Audit 4. Enhance existing audit processes within the Procurement Department to verify compliance with contract procedure.	Head of Procurement	September 2017	**Complete** Forward programme for audit planned & training of Clinical Boards & departments to continue.	
5. Review Internal Audit Programme to include audits relevant to the issues highlighted in this report and to test compliance with new processes.	Director of Finance	September 2017	**Complete** Specific audit included in 2018 plan, to look at overall progress of action plan & review in detail a sample of actions.	
Assurance 6. Enhance the statutory compliance report provided at each Audit Committee to include our compliance with and exceptions to recruitment requirements, Standing Orders and Standing Financial Instructions.	Directors of Finance and Workforce and Organisational Development	September 2017	**Complete** Standing agenda item with first report received at Audit Committee on 26/09/17.	
7. Review the Terms of Reference for the Remuneration and Terms of Service Committee to include a requirement to report any Executive level secondments and Consultancy appointments for approval to this Committee.	Director of Corporate Governance	October 2017	**Complete** Presenting to Board on 30/11/17.	

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Appendix 1

Conclusion 3 - The process followed by the UHB that led to the appointment of the owner of RKC Associates to the position of Director of Workforce and Organisational Development in April 2016 was fundamentally compromised, lacked transparency and was poorly documented.
a) It is unclear why the UHB decided to proceed with a recruitment process for a Board level position with only a single candidate who had not applied for the position when it was originally advertised. b) The recruitment process was poorly documented and, as a consequence, it is not clear when the person who had been overseeing the recruitment exercise became a candidate. c) The integrity of the recruitment process was compromised because the sole candidate had access to some of the assessment questions in advance of being interviewed for the position. d) The information provided to the Board and its Remuneration and Terms of Service Committee regarding the appointment was inaccurate, incomplete and inconsistent.
UHB Response to Conclusion 3 High level appointments are not as frequent as other positions within the UHB and are often challenging to recruit due to small numbers of applicants with the relevant skills and experience. As a result of this report, the UHB has looked at how these senior appointment processes are conducted and how the office of the Chief Executive and Director of Workforce and Organisational Development can work better together to ensure compliance with processes and that satisfactory documentation is maintained. We also recognise that we can better support our Independent Board Members in relation to their Committee roles, to equip them to confidently scrutinise decisions and hold us to account.

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Appendix 1

Conclusion 3 Action Plan	Lead	Completion	Update	Status
Review 1. Review the procedures used to recruit Executive Directors and other Senior Managers.	Assistant Director of Workforce and Organisational Development	July 2017	**Complete** To be reflected in the updated Recruitment and Selection Policy & Procedure.	
2. Review the quality of information and its presentation to the Remuneration and Terms of Service Committee.	Chair and Director of Corporate Governance	September 2017	Introducing new process in January 2018 whereby all papers will be assured by Chair & Director of Corporate Governance prior to publication.	
Process 3. Revise the Executive recruitment process to include a clear defined role for the Director of Workforce and Organisational Development which can be delegated to their Deputy or Director of Corporate Governance if circumstances require or a conflict arises.	Chief Executive	August 2017	**Complete** To be reflected in the updated Recruitment and Selection Policy & Procedure.	
Training 4. Arrange training for Independent Board Members, including those sitting on the Remuneration and Terms of Service Committee, covering their roles and responsibilities. This should also provide them with example questions they may wish to ask and the minimum information they may require to assist them in discharging their role.	Director of Corporate Governance	August 2017	**Complete** Included in the programme for the August Board Development Day.	
5. Provide legal and governance training for all Board members on their roles and responsibilities at the October Board Development Day.	Director of Corporate Governance	October 2017	**Complete** Included in the programme for the October Board Development Day.	

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Appendix 1

Additional Improvements				
Action Plan	**Lead**	**Completion**	**Update**	**Status**
Whistleblowing 1. Review current Procedure for NHS Staff to Raise Concerns which includes whistleblowing to ensure it is fit for purpose and easy for staff to raise any concerns regarding non-compliance.	Director of Workforce and Organisational Development	October 2017	All Wales Procedure under review, comments being provided by the UHB Employment Policy Sub Group to the Welsh Partnership Forum.	
2. Develop an internal protocol providing a system for senior leaders to raise concerns, with clear lines of reporting should a concern relate to the Chair, Vice Chair or Chief Executive.	Director of Corporate Governance	October 2017	Discussions underway & further meeting arranged for 10/01/18 to look at Standard Operating Procedure.	
Governance and Accountability Framework 3. Revise the UHB Governance and Accountability Framework to reflect any amendments by the Directors of Finance All Wales Group to the Standing Financial Instructions and Standing Orders.	Director of Corporate Governance	March 2018	Model Standing Financial Instructions and Standing Orders being developed on an All Wales basis.	
4. Review and revise the UHB's Scheme of Delegation.	Director of Finance	October 2017	Review underway, to be presented to Audit Committee on 27/02/18.	
5. Circulate a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance and duties of probity / candour and the Values and Standards of Behaviour Framework.	Directors of Corporate Governance and Communications	October 2017	The Academi Wales Good Governance Pocket Guide will be considered in the development of a bulletin for wider circulation by December 2017.	
Communication 6. Communicate openly and transparently with staff about the findings of this report, the actions being taken by the UHB and their progress. This will include public meetings of Board / Audit Committee and meetings of LPF, Clinical Board Directors, HSMB and publishing of the action plan on the intranet for access by all staff, supplemented by other communication bulletins.	Chief Executive and Chair	October 2017	**Complete** Reports at Board, ME, HSMB, LPF. Continued dialogue with Senior Trade Union / Staff Side representatives, CEO communication placed on intranet and internet. Action plan monitored by Audit Committee & closure report anticipated for March Board.	

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Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Jan 2014	Combined follow-up review of progress made against recommendations relating to disaster recovery, data back-up arrangements, Caldicott and data quality (Local Work 2013)	The WAO work summarised the key messages and recommendations raised from their previous work on waiting lists, data quality, disaster recovery and business continuity, Caldicott, and data backup and recovery arrangements. It also concluded that there are a number of issues facing the UHB's IM&T service: • Financial investment in IM&T has been low historically, and the UHB's own figures indicate it compares unfavourably with the Welsh NHS as a whole. As a result, much of the IT infrastructure is now approaching the end of its useful life. • The IM&T risk assessment process does not seem to be escalating risks appropriately to a corporate level. WAO recent work in several areas had highlighted this issue. • The structure of the IM&T Department is uneven, with a concentration of expertise residing in a small number of individuals. • The replacement programme for aging servers is not keeping pace with need so the volume of obsolete and unsupported equipment is rising. • The UHB's strategic approach to IM&T is unclear. There is an Implementation programme but this has not been formally agreed and falls between the functions of a strategy and an operational plan, in WAO view satisfying neither. Without such a strategy, it will be difficult both to prioritise work and to evaluate progress.	Director of Therapies and Health Science and IT	Action Plan produced and received by PPD Committee in January 2014. Recognised that there was a need for additional investment which were captured in the Integrated Medium Term Plan and Capital Plan as appropriate. The IM&T Programme Board and the Information Governance (IG) Group were both re-established in 2014/15 as sub-Committees of the PPD Committee under the Chair of the Independent Member - Information, Communication and Technology. This has ensured that appropriate scrutiny has started to be provided. A follow up review has been undertaken and the final report was received on 10 February 2015 (see below) 28/09/17 - There were 14 recommendations within this report – 12 of which have been completed entirely, the remaining two (these were bother investment dependant) have partially been completed with a target date to be completed December 2017.	On-going	Strategy and Engagement John Antoniazzi Information Governance & Technology sub-Committee - Eileen Brandreth	28/01/2014 - initial report 26/02/2015 - (PPP) Follow-up Report See below for update. IGSC 23.03.16 Presented to IT&GSC Oct 17
01 Jan 2015	Structured Assessment (2014)	The UHB's Medium Term Plan addresses the £19.177 million deficit incurred in 2013-14, but operational pressures and a failure to deliver planned cost savings mean it is now forecasting a deficit of £24.9 million at the end of 2014-15 Overall governance arrangements have continued to evolve and mature, although some aspects of arrangements need to be further improved - The UHB has adopted a clear and robust approach to strategic planning although a slow pace of change and financial constraints is affecting its delivery - The organisational structure is maturing but there are a number of risks which impact on its effectiveness to support operational delivery - Board effectiveness, assurance and internal controls continue to be strengthened and are largely effective although there remain some important areas which need to be addressed - Performance management arrangements have been strengthened with a specific focus on the top five priorities but some services are becoming disengaged and there is a need for the organisation to more explicitly challenge its performance and delivery - The UHB continues to focus positively on quality and safety but there remains a number of issues to address, including capacity to support shared learning and responding to concerns in a timely manner. - The UHB has continued to provide the mechanisms to facilitate change but the ability to sustain change is a concern. - The Board is now much better informed of the significant risks associated with its assets but resources are limited.	Board Secretary	The majority of actions have been completed and previously reported to the Audit Committee. Only outstanding actions relate to the role of the People, Planning and Performance Committee re monitoring performance and the resources within the Governance Team. Both were highlighted in the 2015 Structured Assessment (see below). The Committee will be appraised of action under that report in future.	On-going	Chair of Board and Committees	To be reported to the Audit Committee and relevant Committees of the Board. Audit 12.04.16 **COMPLETE**
01 Jan 2015	Arrangements for responding to and tracking progress against recommendations (2014)	This work sought assurance that the UHB has appropriate corporate processes for responding to Wales Audit Office reports, tracking implementation of audit recommendations and reporting to the appropriate committee. It found that there are generally effective arrangements in place to manage and respond to audit recommendations although there are opportunities for a more consistent approach to the management responses, and not all action plans are monitored through to completion. Good progress is being made against audit recommendations with many of them completed in a timely manner, however as some recommendations are not always tracked through the committees, particularly in relation to my recommendations relating to ICT arrangements, we are unable to comment on whether all of previous recommendations are being actioned.	Board Secretary	Report considered by Board on 27th January 2015 as part of Structured Assessment. Action Plan drafted and shared with Executive leads. Discussions held with the Chair and Board Secretary to discuss and agree a more robust approach to tracking. The reports are not "Complete" until all actions have been completed or a position has been reached where no further action is possible and the resulting risk will be assessed and if appropriate tolerated. The Board Secretary and the Committee secretariat ensure, as far as is practicable that Committee's are clear and record when they expect to receive assurance reports. 14.11.17 - Improvements in tracking now implemented	On-going	Audit - John Antoniazzi	As above 12.04.16 **COMPLETE**
01 Feb 2015	Orthopaedics (2012)	Orthopaedic services are generally coping with demand, which is consistently low, but MRI waits are long, the inpatient pathway needs to be improved to make better use of resources and although outcomes are generally positive, revision rates and missed follow-up appointments are some of the highest in Wales - Investment in primary care services is increasing and there is a consistently lower rate of GP referrals, although the impact of the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is unclear. - Outpatient and physiotherapy services are generally meeting demand, although a reduction in did not attend rates for outpatient appointments and the availability of direct access to physiotherapy could further improve waiting times. Access to MRI for GP referred patients is problematic. - More timely pre-operative assessment, increased day surgery rates, maximised bed occupancy and a reduction in prosthetic costs could improve the use of inpatient resources; and - Patients generally have positive outcomes with the exception of revision rates, which are some of the highest in Wales and not all patients are followed-up.	Chief Operating Officer	Report received and action plan approved by PPP Committee in July 2015. Interim report received in January 2016 and a full report in 12 months February 2017) R&D 7.11.17 - A revised model of care was being piloted in CMATS and indicated a significant impact on outpatient demand. Substantial work had been undertaken to reduce the waiting list. This remained challenging as there were pockets with significant demand but was confident this would continue to improve which had been reflected in the RTT position over the last few quarters. In regard to prosthesis costs; the service with NWSSP had negotiated the lowest cost of knee replacement in Wales. The Planned Care Programme had been rolled out to spinal surgery and achieved an 84% response rate for this year. This had allowed only 5-6% of patients to require follow-up stating clinical outcomes were better than the UK average.	On-going	Resource and Delivery - Charles Janczewski	21/07/2015 (PPP) 18.01.16 (PPP) R&D 7.11.117
01 Feb 2015	Combined follow-up review of Informatics and Communication Technology Audits (2013)	The combined follow-up review examined progress against recommendations relating to the WAO previous work on disaster recovery and business continuity, data back-up arrangements, Caldicott and data quality (see above). The UHB has made progress in addressing some of the issues raised in previous reviews but the WAO have made seven new recommendations to ensure that key areas continue to be addressed - The Information Governance Committee and Data Quality Group are in their infancy but provide a good foundation to provide the Board with assurance on data quality - The UHB does not have a standard approach to disaster recovery and business continuity planning, with plans less established in clinical departments, than in the ICT department. Testing of disaster recovery and business continuity plans and training in clinical areas is also limited - Caldicott governance arrangements have been strengthened but there remains a need to develop training on Caldicott, data protection and information confidentiality - Clinical departments and ICT have agreements in place to identify data owners and responsibilities for backups but some agreements remain unsigned and the testing of backups remains ad hoc	Director of Therapies and Health Science (IM&T)/Director of Public Health (Data Quality)/Director of Strategic Planning (Business Continuity Planning)/Medical Director (Information Governance and Caldicott)	As the report related to a number of different areas of work agreement of the action plan took longer than anticipated. The PPP Committee received and approved the action plan on 10 November 2015. It was agreed that responsibility for monitoring the implementation of the actions would be remitted to the Information Governance sub-Committee and the Information Management and Technology sub-Committee as appropriate.	On-going	Information Governnance andTechnology sub-Committee - Eileen Brandreth	10/11/2015 IM&T 7.03.16 IM&T 10.06.16 IGSC 18.12.16
01 Jun 2015	Medicines Management (2014)	The work reviewed medicines management arrangements in the acute sector to assess scope for making improvements in relation to the quality and efficiency of services. The review concluded that there are strengths in the way the Health Board managed medicines but there were also issues associated with the strategic approach, storage facilities, transfer of medicines information and performance monitoring. - There was clear executive leadership, regular financial monitoring and improved clinical engagement but there was scope to raise pharmacy's profile, clarify accountabilities and strengthen the strategy. - Pharmacy staff costs per bed day were lower than the Welsh average and workload pressures were similar to the rest of Wales. There was scope to dedicate more resource to training and improve access to the pharmacy team outside normal hours. - Pharmacy facilities largely comply with key requirements although there were risks associated with storage of medicines, monitoring the temperature of ward fridges and infrequent audit of injectable medicine preparation on the ward. - There were some strengths to medicines management processes but there were risks related to information transfer between primary and secondary care, timeliness of reconciliations, non-medical prescribing and supporting patients to take their medicines properly. - There is scope to improve performance reporting, mixed evidence about the effectiveness of learning processes and a need to understand more about the root causes of the pharmacy team's safety interventions.	Medical Director	Report agreed and action plan developed. Action plan presented to and agreed by the PPP Committee in January 2016. Whilst the Committee did not agree when a follow-up would be received it will be added to the workplan for February 2017 by which time most actions will have been completed. Report to be presented to Committee, 7 November 2017 7.11.17 - The Nurse Executive Director was pleased to see there was improvement and progress being made. This was endorsed by the Chair in light of looking at the action plan. It was agreed for further assurance that recommendations were being acted on, a report would be brought back to the Committee on an annual basis for an update on progress but would be monitored through the Medicines Management Group.	On-going	Resource and Delivery - Charles Janczewski	18.01.16 (PPP) R&D 7.11.17

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Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Oct 2015	Management of follow-up of outpatient appointments (2014)	The WAO review concluded that from a difficult starting point, the Health Board was taking appropriate action to identify the volume of its outpatient follow-up need but too many patients are delayed, the trend is worsening and it needs to do a lot more to develop sustainable follow-up outpatient services. The reason for their conclusion was that: - The Health Board has taken a pragmatic approach to determining the volume of outpatient follow-up demand, but it needs to better understand clinical risks to patients. - While follow-up waiting lists are more accurate, too many patients are delayed, the trend is worsening, and scrutiny and assurance arrangements needs strengthening - The Health Board is improving the administration of follow-up waiting lists but needs to develop a planned approach to modernise outpatient services.	Chief Operating Officer	Action plan approved by the PPP Committee on 10 November 2015. The Committee received a further report regarding Outpatients Follow-ups in March 2016 where it was agreed to receive a report at every meeting. The Committee has been advised that further work is required regarding pathway redesign and the Committee will be kept appraised of this via the regular reports. To report to Private Session of Board 28 July 2016 Reported to QSE on 20 June 2017. Minute QSE 17/105	On-going	Resource and Delivery - Charles Janczewski	10/11/2015 & 15/03/16 (PPP) 12.07.16 (PPP) QSE 20.06.17
01 Nov 2015	Diagnostic review of IT capacity (2014)	This high-level diagnostic work assessed whether budgetary pressures were affecting capacity within informatics teams and the IT infrastructure, and provided an independent comparative analysis of the capacity of IM&T teams and resources across Wales. Despite above-average investment in ICT, their diagnostic work indicated that there were some weaknesses in the Health Board's arrangements and its clinical ICT infrastructure was not fully effective in supporting the delivery of healthcare. - Overall spend on ICT is just above the all-Wales average but remains below the recommended level of spend despite substantive additional funding in the past year. - Staffing levels for ICT are some of the lowest in Wales. - The Health Board is committed to ICT but there is a mixed level of integration of both systems and resources, and doctors' perception of IT facilities is not as positive as others across Wales. - The Health Board has a low number of devices and access to PCs was perceived as problematic. - A considerable amount of ICT equipment has reached its end of life and, although systems were generally reliable, downtime records were incomplete for many systems. - Despite some positive aspects, refresher information governance training was not mandated and training arrangements for some temporary staff were weak. - The mainstream clinical ICT systems were not fully effective in supporting doctors to provide patient care.	Director of Therapies and Health Science	Report received by UHB on 24 Nov 2015. Management response has been developed and considered by the Information Management and Technology sub-Committee. It will be received by the PPP Committee in May 2016 when the arrangements for receiving assurance regarding completion of all action highlighted will be agreed. There will be a workshop at end of September 2016 for all clinicians	On-going	Information Governnance andTechnology sub-Committee - Eileen Brandreth	02.05.16 (PPP)
26 Jan 2016	Review of Operating Theatres (Jan 2016)	1) The theatre improvement project is driving change through a clear focus on improving processes and performance management to improve efficiency 2) Theatre utilisation and productivity have improved but the Health Board has not clearly demonstrated that its investment has led to cashable financial savings. 3) Problems with staff engagement and workforce capacity mean there are risks to maintaining momentum 4) The focus on utilisation has not been matched by a strong enough focus on quality, although staff have positive views about surgical safety.	Chief Operating Officer	To be considered by the PPP Committee in May 2015 To report to PPP Committee January 2017 meeting. 10.01.17 - The report from WAO was responded to and an action plan developed, 86% of which was now green. This prompted the Theatre Strategy work and out of this five workstreams had been created. 16.05.17 - • Theatres had received £860k of replacement equipment but faced a backlog of £3m. • The metrics were looked at in relation to the utilization of theatres. This provided visibility to what was happening across the patch. They were able to predict what would happen with the ability to track all categories. • There were issues with a few of the theatres. These were currently addressed and a plan was in place. • An theatre estates plan was being developed to refurbish the wards at UHW and UHL. 7.11.17 - THEATRE UTILISATION • In order to strengthen areas key strategies were put in place such as; a workforce plan to improve staffing levels; to strengthen governance and accountability with the clinicians; to look at systems reviewing whole pathways around the surgical stream• The position has increased to 78-79% utilisation with a stretch target of 83% being the national standard. Bookings have reached 86% compliance; this was an 8% improvement. Improvements in CAVOC had shown 92% of theatre utilization. Work had commenced with the Children's Hospital predominantly to do with the use of theatres for elective and emergency surgery. There has also been improved trajectory for day units on both the UHL and UHW sites.	On-going	Resource and Delivery - Charles Janczewski	02.05.16 (PPP) 12.07.16 (PPP) 10.01.17 (PPP) 16.05.17 PPP 7.11.17 - R&D
27 Jan 2016	Structured Assessment 2015	1) Further refine the People, Planning and Performance Committee to strengthen its ability to provide appropriate levels of assurance to the Board. 2) The Health Board should review its governance capacity, to ensure that there is sufficient capacity to enable the governance team to provide greater support to Clinical Boards around risk management, to ensure that all external action plans are appropriately monitored and that written assurances are provided to the Board on key matters arising from Committees. 3) Attendance by the nominated Executive Officer at Clinical Board meetings needs to be improved to ensure that in their capacity as 'Independent Member' they provide appropriate scrutiny and challenge at a Clinical Board level. 4) The condition of the Health Board's estate is a significant risk. The Health Board now needs to accelerate its actions to ensure that its estate is fit-for-purpose and specifically, that it is compliant with statutory requirements.	Director of Governance	Management response was presented to the Audit Committee on 12 April 2016.	On-going	Audit - John Antoniazzi	12.04.16
01 Sep 2016	Consultant Contract: Follow-up of previous audit recommendations	1) Processes to review job plans annually 2) Guidance and training 3) Appropriate involvement 4) Information and outcome setting 5) Appraisal 6) Monitoring arrangements 7) Service improvement 8) Supporting processional activities 9) Wider benefits realisation	Medical Director	Draft being prepared. To go forward to PPP in May 2017	Ongoing	Resource and Delivery - Charles Janczewski	Audit 28.02.17
01 Nov 2016	Review Delayed Transfers of Care	1) Discharge Planning Audit - address the findings from the Delivery Units discharge planning audit either by: developing an action plan; or incorporating actions into existing service improvement action plans. 2) Imtermediate Care Fund (ICF) - Explore ways of mainstreaming services funded through the ICFG to ensure services remain resilient	Chief Operating Officer	Draft being prepared. To go forward to next QSE meeting in April 2017. Asked when it was anticipated that progress would be seen (the UHB had the third highest number of delayed transfers of care) in Wales, it was noted that Mrs Alice Casey was taking the lead on length of stay through the transformation work and this would be reported to the UHB Board through the Transformation Board.	Complete	Resource and Delivery - Charles Janczewski	Audit 28.02.17 18.04.17 - QSE
01 Jan 2017	Review of Estates	1) To ensure thte estates service is represented at board level, priortise recruiting an independent board member for estates. 2) Create a central log of estates related issues and actions resulting from Clinical Board meetings. 3) Develop a fully costed Estates Management Strategy. 4) Develop a zero based estates budget that makes provision for likely revenue costs arising from changes to the Health Board estate, such as new buildings. 5) Introduce a system to inspect a percentage of repairs each month. 6) Strengthen performance management by: extending the performance dashboard to include Key Performance Indicators (KPIs) for the other serices covered by the Service Board; and making greater use of the data captured through the Backtraq repairs maintenance system. 7) To ensure repairs are correctly priortised: run Backtraq refresher training for helpdesk staff; and review questions on call handlers' script	Director of Strategic Planning	1) An Independent Member with responsibility for Capital & Estates has been appointed. 2) This can be achieved by our Backtraq Maintenance System. All actions can be logged on this system. 3) Estate Strategy ready for launch, also Modernisation programme near completion. 4) Exec Teams to consider options. 5) Full KPI pack for Estates in place and being measured. 6) KPI's completed and communicated each month. Content covers all of Service Board responsibilities. 7) Refreshers completed and Backtraq has multi levels dedicated for prioritisation. Teams manage all tasks by priority on a daily basis. Levels 1 to 5. (Immediate to Planned Work within 28 days).	Ongoing	Strategy and Engagement John Antoniazzi	Audit 28.02.17 Audit 5.12.17

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01 Jan 2017	Structured Assessment 2016	1) Financial Reporting - strengthen financial reporting arrangements: a dashboard summarising performance against against key financial perfromance indicators and the issues and detail of actions being taken to manage overspend and deliver necessary savings by clinical area 2) Development of Plans: clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans 3) Monitoring and scrutiny of plans 4) Planning capacity 5) Board and assurance framework 6) Transparency of public reporting 7) Board membership, vacancies to be filled and support quorate running of committees 8) Scrutiny of performance: Establish new Resources and Delivery Committee as a matter of urgency to ensure robust scrutiny is given to HBs performance and ensure relevant information is provided to Committee including sharing of clinical board reviews to focus attention on areas which need greatest scrutiny. 9) Governance capacity: to undertake further evaluation. The views of IMs on what assurances are needed should be sought as part of evaluation 10) Tracking arrangements: Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee	Director of Governance	Draft being discussed by the Management Executive and prsnted to Audit Committee in April	Ongoing	Audit - John Antoniazzi	28.02.17 24.04.17
01 Jan 2017	Annual Audit Report	Key findings from the Annual Report included: 1) Comments on financial management 2) Governance and assurance arrangements 3) Performance audit reviews 4) Internal controls 5) Arrangements for securing efficiency , effectiveness and economy in the use of services 6) Issues relating to estates management 7) Capacity of the corporate governance team 8) Monitoring of previous recommendations	Director of Governance	Management Executive provided comments on the draft report and two meetings were arranged to discuss with WAO. Final version agreed. Presented to the Board 30 March 2017 and to be 'tracked ' by Committees	Ongoing	Audit - John Antoniazzi	28.02.17 30.03.17 - Board
01 Feb 2017	Discussion Paper: The Governance Challenges Posed by Indirectly Provided, Publicly Funded Services in Wales	No recommendations Its contents are relevant to policymakers, officials, practitioners and academics, as well as those who oversee, provide and receive indirectly provided services that are funded with public money. This paper will help to spread good practice, generate new ideas, support beneficial change and so contribute to the good governance of public services in Wales		To be taken to the Management Executives Team to note and consider.		Audit - John Antoniazzi	24.04.17
01 Feb 2017	Radiology Services	1) Develop an action plan detailing how reporting backlogs will be managed sustanability. 2) Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff. 3) Over the next year, increase mandatory training rates for all radiology to staff at least eh Health Board target of 85%. 4) Liaise with referring clinicians when developing and reviewing referral guidance. Ensure all referring clinicians know ehre to access up to date versions of guidance. 5) To develop a radiology strategy over the next 12 months. 6) Develop a workforce plan alongside the radiology strategy which identifies the baseline capacity needed to sustainably meet radiology demand in a timely and safe way. 7) By mid-way 2017 develop an equipment replacement plan. 8) Strengthen directorate performance management	Chief Operating Officer	To be reported at Resource and Delivery Committee 7 November 2017 the Radiology Strategy is a complex piece of work and in the main actions were being progressed as intended. • Would like to see an indication of the timeframe with milestones finalised and how this would fit in with the IMTP process. • Over the next few months this piece of work would continue, with more specific timelines as this will be a part of the IMTP document. Once this was complete it would be shared with the Committee. •To have a brief update presented to the Committee of what was being put in place in regard to the recommendation that had not been accepted		Resource and Delivery - Charles Janczewski	7.11.17 - R&D
01 Jul 2017	Contractual Relationships with RKC Associates Ltd and its Owner	1) Board members and senior officials with significant financial responsibility should be on the organisations payroll, unless there are exceptional circumstances - in which case the Accounting Officer should approve the arrangements - and such exceptions should exisit for no longer than six months. 2) Engagements of more than six months in duration for more than a daily rate of £220, should include contractual provisions that allow the department to seek assurance regarding the income tax and NICS obligations of the engagee - and to terminate the contract if that assurance is not provided; and 3) These measures should be implements within three months - and implementation will be monitored after one year, reporting back to hte Chief Secretary to the Treasury and the Minister for the Cabinet Office; and if it emerges that any departments have not abided by these rules, sanctions will apply - wiht departmental resource budgets reduced by up to five times the payment in question	Medical Director	Action plan to be presented at Audit Committee 26.09.17 and Board Meeting 28 September will be a standing agenda item for Audit Committee until all actions complete.		Audit - John Antoniazzi	Audit - 26.09.17 Board - 28.09.17
01 Nov 2017	Discharge Planning	R1: Health Board collates a comprehensive range of information about community health and social care services. a) develop a system where ward staff are able to access up-to-date information about community health and social care services b) review the rnage and frequency of data about community health and social care services. For example, waiting times for some services anfd the frequency data on services available through other NHS bodies and housing options is collated. R2: We found that recently revised discharge and transfer of care and choice of accommodation policies were part of partnershipa ction plans but we found no evidence that patients and carers were involved in the process. The HB should seek to involve patients and carers when the next policy revisions are due. R3: we found that ward staff were unaware of discharge policies and pathways. The HB should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in dishcarge planning understand how to use it. R4: We found that staff training on discharge planning is patchy and that the HB does not monitor compliance with training. Plans to improve training is included on the discharge improvement plans but staff told us taht a lack of capcaity on the wards is a barrier to attending training. The HB should: a) explore developing an e-learning course for discharge planning which ward staff may find more accessible. b) ensure that attendance at training is captured on the ESR, which will help to improve compliance and monitoring.	Chief Operating Officer				

Wales Audit Office Tracking Report December 2017

Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Sep 2017	Review of GP Out of Hours Service	R1 the Health Board does not have a GP out-of-hours strategy or workforce plan. The HB should A) Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance; and b. develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service. R2 the Health Board has strengthened the way it monitors GP out-of-hours performance. Some weaknesses remain in clinical audit for GPs and learning from patient feedback. a. introduce processes for learning from patient feedback to improve GP out-of-hours services; b. prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards; and c. check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate. R3 Public messaging: a) improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. b. work has already been undertaken to try to ensure all GP practices have a standard answerphone message that provides appropriate information about the out-of-hours service. The Health Board now needs to ensure this is rolled out and implemented in all practices. c) as part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours. R4 Interface with other services: a. share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand; and b. identify and address the reasons that are preventing out-of-hours staff from accessing the GP record.	Chief Operating Officer				
01 Oct 2017	Review of Follow-up Outpatients - Assessment of Progress	R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: a) covers a broader range of specialities; and b) clearly reports clinical risks associated with delayed follow-up appointments. R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation.	Chief Operating Officer				
01 Oct 2017	Collaborative Arrangements for Managing Local Public Health Resources	R1 Collaborative arrangements for managing local public health resources do not work as effectively as they should do. The Wales Audit Office recognises, in part, that the problems identified in this report relate to matters that are the responsibilities of Welsh Government, Health Boards and Public Health Wales. R2 Continued working with Health Boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally. R3 Developing effective arrangements to demonstrate that PHW is securing value for money from the specialist public health resources allocated to LPHTs. R4 Clarifying the roles and responsibilities of the Trust's national and local teams in relation to developing and delivering health improvement programmes. R5 Progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice including healthcare public health. R6 Agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs. R7 Agreeing a mechanism whereby workforce planning discussions take place on a more formal basis between the Trust and DsPH R8 Clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite R9 Clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles.	Director of Public Health				

CAPITAL ORDERING AUTHORISATION PROTOCOL	
Name of Meeting : Audit Committee	**Date of Meeting:** 5th December 2017

Executive Lead : Executive Director of Finance
Author : Head of Financial Accounting & Services
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact : The procedure presented has been developed to ensure that the University Health Board has appropriate management and governance arrangements in place around capital expenditure. These will determine how capital is planned, prioritised and managed in line with the Health Board's Strategy and Values**.**
Health and Care Standard Number The contents of the report and the attached appendix cut across multiple health standards. Where merited, specific issues will be brought to the committees attention via separate papers.
CRAF Reference Number The contents of the report and the attached appendix cut across multiple corporate risks. Where merited, specific issues will be brought to the committees attention via separate papers.
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

The fact that the attached protocol has been scruitinised and endorsed by the Group with delegated authority for the management and governance of the Health Board's Capital Programme (Capital Management Group).

The Audit Committee is asked to:

- **APPROVE** the protocol which will govern how the UHB places capital orders and **REQUEST** that the UHBs capital scheme of delegation is updated to include the Executive Director of Therapies, the Head of Procurement and the Head of Compliance and Discretionary Capital.

SITUATION

As defined in the Standing Financial Instructions, the Chief Executive is responsible to implement appropriate management and governance arrangements around the UHB's Capital Programme. To assist the Chief Executive with this task, the UHB has established a Capital Management Group, under the chairmanship of the Director of Planning. This panel meets

monthly and will assist the Director of Planning in all areas of the UHB's capital programme and other asset management issues. This will include ensuring robust financial management and governance arrangements are in place in respect of the capital programme. It will be charged with reviewing the benefits realisation of completed capital schemes and in determining how the use of capital funding can help shape better service delivery

BACKGROUND

To enact appropriate governance and management arrangements around the Capital Programme, the Capital Management Group produced and Published "The Capital Ordering Authorisation Protocol" in September 2014. This procedure was subsequently refreshed in September 2016. The attached draft has now been updated in November 2017 to reflect the current Governance Framework in place around placing expenditure orders for Capital Schemes.

ASSESSMENT AND ASSURANCE

By implementing this procedure, this will help the UHB ensure that it has a robust capital governance regime in line with its standing financial instructions, standing orders and the requirements of The Welsh Ministers Guidance.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board	**Reference Number: UHB TBA** **Version Number: 3** **Next Review Date: October 2020** **Previous Trust/LHB Reference Number: N/A**

Capital Ordering Authorisation Protocol

Introduction and Aim

This protocol has been developed to ensure that the University Health Board (the UHB) has appropriate management and governance arrangements in place around the process by which orders are raised to commit capital expenditure.

The UHB's Standing Financial Instructions (SFI's) and Scheme of Delegation and Earned Autonomy Framework are the key policy documents for this area. This protocol; should be read in conjunction with the UHB's capital management procedure. This protocol provides further details on operational arrangements which underpin this

Each year the UHB receives a capital resource allocation from the Welsh Government (WG). The UHB has an annual statutory financial duty to ensure that its capital expenditure does not exceed this resource allocation. The funding comprises two elements:

- **Discretionary Capital.** This is a one off annual allocation given to the UHB by WG. As the title implies, the UHB is free to prioritise the sum allocated as it best sees fit.
- **Capital funding issued by WG for a specific purpose**. WG has a number of capital budgets (the All Wales Capital Building Programme, the Health Technology Fund, Invest to Save Funding) which the UHB can bid against in order to obtain capital funding which often, as a result of the size of the projects involved, cannot be accommodated from within the discretionary programme. Section 3.3 of this procedure outlines the principles such bids should follow and the governance regime that applies to their submission.

In addition to the above the UHB can internally generate capital funding by means such as property disposals or encouraging charitable donations.

Objectives

This procedure sets out the management and governance arrangements that need to be in place in respect to the authorisation of capital orders. It recognises that a one fit for all process for capital orders is not appropriate Specifically it addresses the following:

- The authorisation process which the UHB places follows when placing estates

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works orders for discretionary schemes.

- The authorisation process which the UHB places follows in placing orders for all emergency capital expenditure requirements.
- The authorisation process which the UHB follows in placing orders for equipment (incl IM&T) for equipment only schemes.
- The authorisation process which the UHB follows in placing orders for All Wales Capital schemes.

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Scope

This procedure applies to all of our staff in all locations including those with Honorary Contracts who are involved in either bidding for, or the use of capital funding.

In addition to the responsibilities detailed within the protocol staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

Equality Impact Assessment	An Equality Impact Assessment has not been completed. The UHB will, however ensure that an Equality Impact Assessment is undertaken annually when it is prioritising its capital programme.
Documents to read alongside this Procedure	Standing Financial Instructions The UHB Scheme of Delegation UHB Capital Management Procedure
Approved by	Capital Management Group
Accountable Executives or Clinical Board Director	Executive Director Of Finance/Executive Director of Planning
Authors	Head of Financial Accounting & The Business Manager (Capital, Estates & Facilities)

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1		September 2014	This is a new protocol.
2		September 2016	Minor amendments to job titles

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As per the UHB's Scheme of Delegation and Earned Autonomy Framework, the Director of Capital, Estates and Facilities is the delegated budget holder responsible for ensuring that the UHB stays within its Capital Resource Limit on an annual basis.

While the Director of Capital, Estates and Facilities) will be the delegated budget holder for the capital programme as a whole, the Executive Director of Planning and Executive Director of Finance will delegate responsibility for individual capital schemes (including those funded directly by WG) to nominated budget holders. The below sections outline the processes budget holders must follow in order to get capital orders raised & approved.

Budget holders are reminded that any budgeted discretionary funds not required for their designated purpose(s) revert to the UHB Capital Contingency Budget, subject to any authorised use of virement and subject to the Board's scheme of delegation

In addition any likely overspending or reduction of income that cannot be met by virement must not be incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation

1.0 The Authorisation of Discretionary Funded Estates Works Orders

Capital requisitions up to £5,000 (incl VAT) may be approved by either the Head of Compliance and Discretionary Capital or the Head of Capital Planning.

Capital requisitions for values between £5,000 and £25,000 (incl VAT) may be approved by the Director of Capital, Estates and Facilities.

Where requisitions exceed £25,000 the following applies:

All orders are to be raised within procurement. In order for the order to be raised the relevant procurement officer will need to be e-mailed with the following confirmation(s) of approval:

- For orders higher than £25,000 but up to a value of £125,000 (incl VAT) a requisition form signed by the Director of Capital, Estates and Facilities plus a capital approval form (CAPR) signed by the Executive Director of Planning or the Executive Director of Finance.

- For orders higher than £125,000 but up to a value of £500,000 (incl VAT) a requisition form signed by the Director of Capital, Estates and Facilities plus a capital approval form (CAPR) signed by the Executive Director of Planning and the Chief Executive.

- For orders higher than £500,000 (incl VAT) a requisition form signed by the Director of Capital, Estates and Facilities) plus a capital approval form (CAPR) signed by the Chair on behalf of the Board

Note: this process encompasses equipment bought as part of a discretionary works scheme.

2.0 The Authorisation of Emergency Equipment Replacement Orders

As outlined in the UHB's Capital Management Procedure, where a clinical board needs to make an emergency request for capital to address an urgent medical equipment, IM&T,estates maintenance or statutory compliance issue then a standard form designed for this purpose needs to be completed. The forms are available from the Business Manager (Capital, Estates & Facilities). Once complete, for estates maintenance or statutory compliance issue the forms should be returned to the Business Manager (Capital, Estates & Facilities). In the case of urgent medical equipment bids, the forms should initially be sent to the Assistant Director of Therapies, who will review the bid before forwarding on to the Business Manager (Capital, Estates & Facilities). The Business Manager (Capital, Estates & Facilities) will advise the Director of Capital, Estates & Facilities on the level of contingency funding available to support the request The Director of Capital, Estates & Facilities will then forward the details of the bid (including the level of funding available to support it) to the Executive Director Of Therapies, the Chief Operating Officer and the Executive Director of Planning who will decide if the bid is to be supported or not.

In circumstances where the value of the equipment exceeds £0.125m (but not £0.5m) then additional authorisation would be required by the Chief Executive in line with the scheme of delegation

In respect of equipment bids supported as part of the above process, to enable an order to be raised the Assistant Director of Therapies must forward a signed

requisition form to the relevant procurement officer, together with copies of the e-mails where authorisation has been given by the Executive Director of Therapies, The Executive Director of Planning, the Chief Operating Officer and where necessary The Chief Executive.

In the case of urgent IM&T bids, the forms should initially be sent to the Head of IM&T, who will review the bid before forwarding on to the Business Manager (Capital, Estates & Facilities). The process then follows that outlined for urgent medical equipment bids except that in respect of IM&T bids supported as part of the above process, to enable an order to be raised the Head of IM&T must forward a signed requisition form to the relevant procurement officer, together with copies of the e-mails where authorisation has been given by the Executive Director of Therapies, The Executive Director of Planning, the Chief Operating Officer and where necessary The Chief Executive

Note: In years in which the UHB's contingency for such items has been exhausted then the UHB will approach WG directly for the funding for such items. The Business Manager (Capital, Estates & Facilities) will be responsible for notifying the procurement team when this occurs and where it is the case the relevant procurement officer must obtain confirmation from either the Business Manager (Capital, Estates & Facilities) or The Head of Financial Accounting, Financial Information & Services that the necessary WG funding has been obtained before an order can be placed.

3.0 The Authorisation of Equipment Orders to be placed for equipment only discretionary schemes:

The responsibility for the delivery of these schemes will be delegated each year to nominated budget holders. As part of this the budget holder will be required to draw up a costed list of the items to be purchased. The total cost of this list must not exceed the annual budget designated to the scheme by the UHB's Board. Once the list is prepared it should be approved by the UHB Board in line with the UHB's scheme of delegation as follows:

For Non IM&T Schemes:

- For equipment schemes totalling up to a value of £25,000 (incl VAT) the list can be approved by the Director of Capital, Estates and Facilities.

- For equipment lists having a combined value of more than £25,000 but less than £125,000 (incl VAT) these can be approved by the Executive Director of Planning, The Executive Director of Therapies or the Executive Director of Finance.

- For lists with an overall value higher than £125,000 but up to a value of £500,000 (incl VAT) may be approved by the Executive Director of Planning and the Chief Executive.

- For equipment lists costing higher than £500,000 (incl VAT) approval by the Chair on behalf of the Board is required.

All orders are to be raised within procurement. In order for the order to be raised the relevant procurement officer will need to be e-mailed with approval in line with the above:

For IM&T Schemes:

- For equipment schemes totalling up to a value of £25,000 (incl VAT) the list can be approved by the Head of IM&T

  Where requisitions exceed £25,000 the following applies:

  All orders are to be raised within procurement. In order for the order to be raised the relevant procurement officer will need to be e-mailed with the following confirmation of approval.

- For equipment lists having a combined value of more than £25,000 but less than £125,000 (incl VAT) these can be approved by the Executive Director of Planning or the Executive Director of Therapies.

- For lists with an overall value higher than £125,000 but up to a value of £500,000 (incl VAT) may be approved by the Chief Executive on the recommendation of the Executive Director of Therapies.

- For equipment lists costing higher than £500,000 (incl VAT) approval by the Chair on behalf of the Board is required.

4.0 The Authorisation of Orders for All Wales Capital Schemes:

The initial Budget for such schemes shall be determined by the approval letter received from WG. The signing of the acceptance letter for the funding provided by the chief executive shall serve as authorisation to the Director of Planning and the Executive Director of Finance to appoint devolved budget holder to utilise the funding in the way intended:

In respect of contractor costs and the fees of external advisors, schedules should be obtained from the Health Board Cost advisors which reconcile to the WG approved sums. Copies of this schedule, the WG approval letter and a signed requisition by the budget holder need to be supplied to the relevant procurement officer in order for them to raise the appropriate orders. In respect of equipment, again a costed list of the items to be purchased should be produced by the budget holder. The value of this list should not exceed the value of equipment approved for the project by WG. Once in receipt of this list the relevant procurement officer can raise equipment orders on the written instruction of the budget holder.

The budget holder may choose to delegate some of the above tasks to members of their team. The relevant procurement officer may act on instruction from the person to whom the budget holder has delegated responsibility as long as they have been provided with written confirmation of the delegation by the budget holder.

Due to the nature of these schemes it may become necessary to vire funding between the different categories of expenditure within the one capital project. These virements can only be authorised by the project director (who will keep Capital Management Group and the Scheme's project Board briefed on the reason for and the effect of any such changes). Where this results in additional orders needing to be placed, the budget holder will advise the relevant procurement officer of the changes together with correspondence from Capital Management Group and the Project Board where the virements were discussed. As long as these virements are within the approved cost envelope of the scheme then this will allow the relevant procurement officer to place the additional orders on receipt of written instruction from the budget holder.

Occasionally the UHB may decide to allocate additional discretionary funds to a project to help it achieve its aims. Where this occurs the budget holder must again provide appropriate documentary evidence to support this decision to the relevant procurement officer (together with a list of what the additional funding is to be spent on). The UHB's scheme of delegation requires the following in respect of capital budgetary adjustments:

- Amendments greater than £1.0m require UHB Board approval
- Amendments greater than £0.5m; but less than £1m require Chief Executive Approval (based on the recommendation of CMG)
- Amendments up to £0.5m may be authorised by the Executive Director of Planning, Executive Director of Finance & Chief Operating Officer via the Capital Management Group.

These only apply to adjustments within the overall approved annual capital budget; any overcommitment on budget requires Board approval (or Chief Executive in emergency)

5.0 The Authorisation of Orders for Capital Schemes Funded outside of the Capital Resource Limit.

In certain instances funding will be contributed to capital schemes by external bodies. Before orders can be placed in respect of such funding, the relevant procurement officer must be provided with the following:

a) Written confirmation from the donating body of the sum to be donated.
b) Written confirmation from the Director of Finance that we are to take the money.
c) A costed list of items to be purchased from this money (which does not exceed in value the sum to be donated) – supplied by the budget holder.

Where this funding is contributing to the funding of an existing scheme, then the existing budget holder will be allocated this additional funding. Where the capital scheme is new and to be solely funded from this additional funding, the Executive Director of Finance and the Executive Director of Planning will appoint a budget holder.

Once in receipt of these, the relevant procurement officer should take advice on whether a VAT exemption certificate can used to avoid VAT being charged on any of the equipment. They may than place orders on receipt of a signed requisition from the budget holder.

6.0 Conclusion.

By implementing the above protocol; the UHB should ensure it has a robust governance regime in place for the authorisation of capital orders which is in line with its standing financial instructions, standing orders and the requirements of The Welsh Ministers Guidance.

REPORT OF THE DIRECTOR OF CORPORATE GOVERNANCE	
Name of Meeting : Audit Committee	**Date of Meeting:** 5 December2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well : This paper supports our Value and Behaviors which is an integrated part of our Strategy
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number …
CRAF Reference Number : 1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE
is provided by:

- Report requested by the Chair of the Audit Committee

The Committee is asked to:

- **NOTE** the paper

SITUATION

Following discussion with the new Chair of the Audit Committee, it has been agreed that we introduce a Report from the Director of Corporate Governance at each meeting of the Audit Committee. This is the second report presented to the Audit Committee.

BACKGROUND

The Audit Committee received regular reports on governance at each meeting of the Committee. Traditionally this has been provided in the sections of the Agenda for the meeting called “Committee Governance”. This includes:

- The Corporate Risk and Assurance Framework
- External Audit Tracking Reports
- Reports on Hospitality Registers and Declarations of Interest
- Wales Audit Office Reports.

The Chair of the Audit Committee has requested a report from the Director of Corporate Governance in this section as a standing agenda item.
In summary this report will:

- Strengthen the governance reporting to the Committee
- Escalate relevant governance issues to the Audit Committee in an open and transparent manner
- Provide a forward plan for key governance issues and provide the Committee the opportunity to influence these
- Ensure greater linkages and connectivity on governance issue between the Audit Committee and other Committee of the Board.

ASSESSMENT AND ASSURANCE

The purpose of the Report of the Director of Corporate Governance is summarized below.

The report will provide the opportunity for the Director of Corporate Governance to raise any concerns/issue directly to the Committee. The introduction of this is also in line with the White paper service. Fit for the Future – Quality in Governance in Health and Care in Wales" and the role of the Board Secretary:

The following issues are brought to the attention of the Committee

1. Deloittes Financial Governance Review

The Action Plan has been up dated and will be brought to the Finance Committee in December. The Audit Committee should note progress is being made on implementing the agreed actions.

2. Wales Audit Office Report on the Contractual Relationship with RKC Associates Ltd and its Owner.

This is a separate item on the agenda and very good progress on implementing the action plan should be noted. The Public Accounts Committee (PAC) wrote to the Chair of the UHB on 31st October 2017, thanking the Chair and Chief Executive for attending the P.A.C. on the 25th September 2017 to discuss the Public Interest Report on the above. The Committee acknowledged the frank and open answers provided by the Chair and Chief Executive and gave the assurance required on the response of the UHB to this serious matter. They welcomed the Action Plan and requested an update on the implementation of the Action Plan in April 2018.

3. Independent Members Vacancies on the Board

The following appointments have been made:

- Independent Member (Cardiff University)
- Independent Member (Trade Union)
- Associate Board Member (Social Services)

These appointments were made prior to current post holders leaving office to ensure the Board has no delay in filling posts.

4. Visit to Canterbury HealthCare, New Zealand

A visit was made to the above at the end of November 2017 for an intensive three day programme. This follows a visit by Canterbury in September 2017. A Strategic Alliance between the two organisations is being progressed and has been reported to the Board. Arrangements for the trip were compliant with UHB current policies.

5. End of Year Reporting

Work has already commenced on the above with particular reference to the Annual Governance Statement. This ensures sufficient time is scheduled for discussion with the Wales Audit Office.

6. Structured Assessment 2016

A progress report on the above will be brought to the Audit Committee meeting in February.

7. Board / Committee Working

A review of the above will be discussed at Board Development Day in February 2018. This is very important for effective Board / Committee working and gives the number of changes in Membership of the Board in 2017.

8. The Good Governance Pocket Guide for NHS Wales Board

The above document was published in November 2017 by Academia Wales and each member of the Board has now received a copy.

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT
Name of Meeting: Audit Committee **Date of Meeting:** 5 December 2017

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number: 2.1
CRAF Reference Number: Not applicable
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Assignment of risks to a Lead Executive and Committee
- The CRAF being a standard agenda item at Board and its Committees
- The review of the CRAF that is currently taking place recognises that this area can be strengthened to provide better assurance and is aimed at achieving this.

The Committee is asked to:

- **NOTE** proposed next steps in the CRAF review
- **AGREE** to receive a report on risk reference 8.2.3 around relevant up to date policies at its next meeting.

SITUATION

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight.

BACKGROUND

The review of the overall Risk Management process, including the CRAF that is maintained, published and provided to the Board and its Committees continues.

Next steps

- An integral part of the review is engagement with the Clinical Boards and Corporate areas and a program of further visits to ensure all areas are covered and all registers reviewed with key individuals is planned.

- Existing systems in other organizations have been reviewed and a new template register is being developed to include an “open date” for risks, together with initial and current ratings and a target risk score. Smart capturing of existing controls and further mitigating actions together with due dates, review dates and key indicators are to be included to make the CRAF the live document it should be with more meaningful, measurable content.

- The revised CRAF will align with our current strategic objectives as set out in our IMTP.

- Once the proposed new format has been consulted on with Clinical Boards, Corporate areas and Board members, it will be presented at the April Board Development Session with launch to take place the same month.

- The procedural guide has been further refined following feedback to include more examples of good practice. This will help structure review of the current registers and CRAF, improve content and achieve transfer to the new system.

- A template report for Board/Committee/Group reporting on risk is being developed to assist risk owners in providing updates and assurance to these meetings. This is to be tested with a report to the Health and Safety Committee on risk 6.4.5 “Compliance with fire safety requirements” which is currently scored at 20. This report will include a review of how this risk is currently captured in the CRAF and propose any necessary changes to meet the requirements of the new system.

ASSESSMENT AND ASSURANCE

The latest version of the full CRAF (updated 13 November 2017) can be found at: http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865

It is to be noted that the overall CRAF format and content remains unchanged other than being updated to reflect information being provided by our areas. There has been no change in the profile of risks currently assigned to the Committee.

The highest risk assigned to the Committee is risk reference 8.2.3 around relevant up to date policies; this is a Corporate level risk and is also recorded as a risk in the Specialist Services Clinical Board, with an overall risk score of 20. It is proposed that an update report focusing on this risk be provided to the next Committee to include a review of how this risk is currently captured in the CRAF and propose any necessary changes to meet the requirements of the new system.

REPORT OF THE LOSSES AND SPECIAL PAYMENTS PANEL	
Name of Meeting : Audit Committee	**Date of Meeting:** 5th December 2017

Executive Lead : Director of Finance
Author : Head of Financial Accounting and Financial Services
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : £ 3.761m (actual figure)
Quality, Safety, Patient Experience impact: The appendix to the report outlines those agreed actions by panel members which will attempt to reduce the numbers of similar instances occurring in the future and hence reduce any impact on quality, safety and patient/carer experience.
Health and Care Standard Number: The contents of the report and the attached appendix cut across multiple health standards. Where merited, specific issues will be brought to the committees attention via separate papers.
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Audit Committee is asked to:

- **APPROVE** the write off of the losses and special payments outlined in the assessment section shown below:
- **NOTE** the minutes of the 22nd November 2017 meeting of the Losses and Special Payments Panel.

SITUATION

As defined in the Standing Financial Instructions, the Audit Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit Committee with this task, the UHB has established a losses and special payments panel, under the chairmanship of the Director of Finance (delegated to The Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the committee.

The work of the panel supports the UHB's sustainability and ensures that we make the best use of the resources that we have.

BACKGROUND

The Losses and Special Payments Panel last met on 22nd November 2017 to consider the 6 month period April 1st 2017 to September 30th 2017. This report informs the Audit Committee of the items considered at this meeting and the recommendations made for formal Audit Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Attachment 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the audit committee for approval.

ASSESSMENT

For the period in question the following losses have been identified for write off:

- £91,330 in respect of bad debt write offs for the period 1 April 2017 to 30 September 2017;
- Clinical negligence claims of £2.982m and personal injury claims of £0.260m for the period 1 April 2017 to 30 September 2017;
- Small Claims Panel Losses of £2,190 for the period 1 April 2017 to 30 September 2017;
- £1,950 in respect of Ex Gratia Payments made during the period 1 April 2017 to 30 September 2017;
- £61,625 settlement costs re Employment Tribunal cases for the period 1 April 2017 to 30 September 2017;

Attachment One

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 22nd NOVEMBER 2017.

PRESENT:

Mr C Lewis (Chair)
Mr A Crook
Mr S Monk
Mrs F Gregory
Mrs S Wicks
Mr R Hurton

APOLOGIES:

Mr C Greenstock
Mrs A Hughes
Mr R Cockayne
Mr A Williams

Minutes of Last Meeting

The minutes of the last meeting were reviewed and the group endorsed them as an accurate record.

Agenda Items

1. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury losses for the six months to 30th September 2017.

The income and expenditure effect re the six months to September 30th 2017 was described as shown below: For comparison, the figures for the same period in 2016/2017 were also discussed

SUMMARY OF LOSSES

	2017/2018 £'000		2016/2017 £'000
Clinical Negligence	77,794	**Note 1**	34,873
Personal Injury	257	**Note 2**	564
Total Loss	78,051		35,437
Less WRP Receipts	-77,017		-34,749
Total Net Cost to the UHB	**1,034**		**688**

Note 1

48 new cases	1,375	(64)	9,178
19possible/remote moved to probable/certain	4,073	(24)	26,393
2 probable/certain moved to possible/remote	-278	(5)	-1,101
Movement in quantums	72,877		1,383
36 Clin Neg cases settled and closed	-312	(36)	-793
28 Clin Neg cases cancelled/withdrawn	-66	(23)	-225
5 new PTR cases	9	(7)	11
Movement in PTR quantums	82		14
2 PTR cases settled and closed	30	(9)	13
3 PTR cases cancelled and closed	4	(0)	0
	77,794		**34,873**

Note 2

30 new cases	41	(23)	30
4 possible/remote moved to probable/certain	36	(2)	18
0 probable/certain moved to possible/remote	0	(1)	-7
Movement in quantums	72		593
22 cases settled and closed	115	(18)	-23
11 cases cancelled/withdrawn	-7	(7)	-47
	257		**564**

With respect to clinical negligence claims, Mr Monk advised that the revised in gross expenditure was linked to the change in The Lord Chancellor's Personal Injury Discount Rate which had been announced in February 2017. He noted that the UHB had now been informed by NWSSP Legal and Risk that all the UHB's outstanding claims had been assessed and if relevant amended to reflect this change. Mrs Wicks confirmed that there would be no further change to this rate before the end of the year.

Mr Hurton described that the increase in expenditure compared to the same period in 17/18 consisted of 3 elements:

(i) An increase in putting things right cost of £0.083m. The UHB would receive additional funding from WG to cover this cost.
(ii) An increase in personal injury costs of £0.170m. £0.094m of this related to cases were Legal & Risk had assessed them as being only possible to succeed at the end of £2016/17.
(iii) An increase in clinical negligence costs of £0.093m. This was largely due to an increase in the number of new cases assessed as being certain/probable to succeed that we have seen this year.

Recommendation

The Panel recommended that the Audit Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £1.034m for the six months ending 30th September 2017.

Finalised Clinical Negligence (including Redress) Claims

During the six months ending 30th September 2017, there were 38 claims (where liability had been conceded and settlements paid) which had concluded at a total cost of £3.108m (£2.982m re settlements and £0.126m re defence fees).The UHB was successful in recovering £2.327m from the Welsh Risk Pool for these claims, resulting in a net cost to the UHB of £0.781m.

Finalised Personal Injury Claims

During the period, 22 claims where liability had been conceded and settlements paid have concluded at a total cost of £0.324m (£0.260m re settlements and £0.064m re defence fees).The UHB was successful in recovering £0.064m from the WRP for these claims, resulting in a net cost to the UHB of £0.260m

Mr Monk reminded the group that expenditure on defence fees was not treated as a loss and also that it should be remembered that the net loss is accrued over the lifetime of a claim which can span many years.

Recommendation

The Panel recommended that the Audit Committee approve the write off of the settlement costs of claims finalised in the period 1st April 2017 – 30th September 2017. The value of these claims finalised was - Clinical Negligence - £2.982m. Personal Injury - £0.260m.

2. Debt Write Offs

Mrs Gregory presented a report on proposed invoice write offs for the period 1st April 2017 to 31st March 2017.

These were as follows

Category of Debt	Value	Number
Dental	148	11
Medical Records	207	10
Payroll	6,857	11
Private Patients	13,976	23
O/Seas Patients	47,306	29
Misc	22,835	25
Total	**91,330**	**109**

Mrs Gregory also presented the group with a table comparing the amount to be written off in 2017-18 to amounts written off in previous years.

	2012/13		2013/14		2014/15		2015/16		2016/17		2017/18 (6m)	
	Value	No	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	1,821	7	1,598	5	0	0	8	1	1,049	8	0	0
Dental	195	14	629	35	90	7	130	10	81	6	148	11
Medical Records	360	20	2,127	75	1,182	48	360	22	650	35	207	10
Payroll	27,250	36	32,629	46	15,229	18	2,004	7	20,025	53	6,857	11
Private Patients	12,243	10	2,675	22	4,573	18	4,578	32	24,325	28	13,976	23
O/Seas Patients	3,363	7	62,700	23	24,761	38	53,011	48	16,475	10	47,306	29
IVF Wales	150	1	825	5	0	0	0	0	31,026	24	0	0
Misc	63,101	98	9,860	65	122,466	68	17,787	50	78,685	61	22,835	25
	108,484	**193**	**113,043**	**276**	**168,301**	**197**	**77,877**	**170**	**172,315**	**225**	**91,330**	**109**

The invoices relating to private patient charges had been put forward for write off by the Private and Overseas Patient Manager as all avenues for collecting the debt have been exhausted. Where possible, all debts had been referred to CCI Credit Management.

Again all overseas patient invoices had been referred to CCI Credit Management where possible. As well as being referred to CCI Credit Management, all overseas debts over £500 were referred to Data Share which is monitored by the Home Office, and therefore any person with an outstanding invoice trying to enter the UK will be flagged and payment demanded before entry/visa is granted.

The following debts were included in the miscellaneous category:

- A Cardiff University invoice dated July 2009 for £3,879.14 for the supply of HIV packs. Numerous queries had been raised by CU in relation to this invoice for which we were unable to provide sufficient information to enable the invoice to be authorised for payment

- A further Cardiff University invoice dated March 2012 for £16k. This charge was in relation to clinical trials work re Professor Burnett. Professor Burnett has now retired and the trial has closed. Hence it had proved impossible to satisfy Cardiff University on the disputes they have raised.

Recommendation

The Panel recommended that the Audit Committee approve the write off of £92,546 in respect of Bad Debts for the period 1st October 2016 to 31st March 2017.

3. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the first six months of the financial year 2017-18.

He explained that permanent injury allowances were approved by the NHS Pensions Agency and the long term costs were picked up by the UHB. The costs must be treated as losses and should be noted by the Panel. The UHB made payments on a quarterly basis to the Pensions Agency based on bills received from them.

There were a total of 26 cases ongoing, which in expenditure terms had cost the UHB £0.033m. There were payments made in the same period of £0.098m

As none of the cases had met the requisite criteria to be thought of as concluded in the period, there was no loss as such to consider.

Recommendation

The Panel recommended that the Audit Committee be asked to note the impact on expenditure of £33,091 (for the period 1st April 2017 to 30th September 2017.

4. Employment Tribunal Costs

Mr Crook presented a paper outlining the claims and costs for the period 1st April 2017 to 30th September 2017.

During the period, Cardiff and Vale University Health Board had been involved with thirteen Employment Tribunal claims.

Five of these cases had previously been reported to the Losses and Special Payments Panel, and the remaining eight cases had been submitted to the Employment Tribunal since 1st April 2017.

During the period £61,625 had been paid in settlement costs. £50,000 of this related to one particular case for unfair dismissal for which the UHB had obtained written approval from WG before making the settlement payment.

Recommendation

The Panel recommended that the Audit Committee approve the write off of £61,625 in respect of Employment Tribunal Settlements for the period 1st April 2016 to 30th September 2017.

5. Ex Gratia Payments and Other Losses

Mr Monk presented a report on costs for the period 1 April 2017 to 30 September 2017.

Mr Monk noted that there were 7 ex-gratia losses totalling £1,950 made in the six months under consideration.

All of the cases were the result of the independent review/ombudsman process.

Recommendation

The Panel recommended that the Audit Committee approve the write off of the losses incurred in the period 1st April 2017 to 30th September 2017 amounting to £1,950.

6. Security Losses

Mr Cockayne was not able to attend the meeting; but had e-mailed that no incidents had been reported for the period under consideration. He would produce a full report for the year to 31st March 2018 for the meeting to be held in May.

7. Small Claims Panel Losses

Mr Monk presented a report on costs for the period 1 April 2017 to 30 September 2017. During that period 14 claims had been settled at a total cost of £2,190.

The report explained that lack of accurate record keeping is still a problem across most clinical boards which has resulted in 9 claims being paid as the investigation has shown that they are unable to account for the loss. Four claims were paid as items were lost while changing bed sheets or when they had been sent to the laundry by mistake. Accidental damage resulted in the final claim.

No one clinical area seemed to have a major problem with claims which the panel found to be encouraging.

Recommendation

The Panel recommended that the Audit Committee approves the write off of the £2,190 in respect of compensation payments which had been paid over the first 6 months of 2017-18.

8. Report of the Counter Fraud Manager

A report on fraud investigations undertaken during the first six months of 2017/18 was received in the absence of Mr Greenstock.

The panel noted that all potential fraud and irregularity investigations were regularly discussed with the Finance Director and then reported to the Audit Committee. An update on the current position of fraud cases under investigation would be reported to the Audit Committee on December 5th.

As at 30th September 2017, there are no cases reported, which have been closed in the period, from which the Health Board were then not able to recover any of its costs. However, there are a total of thirty three (54) cases still under investigation and which have an estimated potential total loss of approximately £61k.

Recommendation

The Panel asked The Audit Committee to note that there were no losses to report for the period.

9. Voluntary Early Release Payments

Mr Crook reminded The Panel that payments under a Voluntary Early Release Scheme were classified as "ex-gratia" payments and were managed in accordance with the Losses and Special Payments procedure. All such payments would require the approval of the Remuneration and Terms of Service Committee.

Where any compensatory payments were over £50,000, under the terms of the scheme, the Welsh Assembly Government would be required to provide approval for such payments to be made.

The Panel was asked to note the total payments figure shown below. However no recommendation for approval was required, since these would be approved by the appropriate committee.

There had been 2 payments during the first 6 months of the year totalling £0.058m.

Recommendation

The Panel recommended that the Audit Committee note the £58,261 paid in Voluntary Early Release Payments made during the first 6 months of 2017/18.

10. Salary Payments paid to the Wrong Bank Account

At the May meeting of the panel Mrs Gregory had presented a paper asking the group to endorse the action of the financial services team in preparing a draft protocol to address the above situation. This endorsement had been given.

Mrs Gregory bought the updated paper back to the November meeting which in the intervening period had also been shared with payroll colleagues (who also had agreed with its contents.

To help enact the protocol , Mr Crook agreed to look at the wording on staff changes and enrolment forms to see if this could be edited to make clear to all that they could suffer financial loss if they don't enter bank details correctly on these forms. Before doing this however, Mr Crook would check the contents of the protocol with NWSSP Legal Services **(Action Mr Crook).**

11. Any Other Business

Mr Hurton confirmed that the next meeting of the panel would be in May, the timing of which would need to be determined by the date of that months Audit Committee.

22.1

Cardiff and Vale University Health Board

Welsh Risk Pool Concerns & Compensation Claims Management Standard: Claims Reimbursement

Final Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

22.1

Contents **Page**

Review reference:	C&V-1718-03
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Auditor/s:	Ross Hughes (Internal Auditor) Ian Virgill (Deputy Head of Internal Audit)
Executive sign off:	Ruth Walker (Executive Nurse Director)
Distribution:	Angela Hughes (Asst Director of Nursing) Suzanne Wicks (Claims Manager) Karen Lewis (Claims Manager)
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of the claims reimbursement process was completed in line with the Internal Audit Plan. The review seeks to provide the Health Board with assurance on compliance with Area for Assessment 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard.

The relevant lead Executive Director for the review is the Executive Nurse Director.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of claims reimbursement, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to provide assurance to the Audit Committee that the claims reimbursement process is in compliance with Welsh Risk Pool Standard.

The main areas that the review sought to provide assurance on were:

- Appropriate and accurate completion and authorisation of Appendix U Cost Schedules by the Claims Manager.
- Appendix S Checklists are completed by the Claims Manager and signed by the Chief Executive and Nurse Director (or a delegated person); and forwarded to the Welsh Risk Pool.
- All claims submitted are accurately entered onto the DATIX Risk Management Database.

3. Associated Risks

The potential risks considered in this review are as follows:

- Claims costs reimbursed from Welsh Risk Pool are inaccurately recorded and are not appropriately authorised by Health Board senior management.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the

effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated **Claims Reimbursement** is substantial assurance.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

In accordance with WRP Claims Management Standard Assessment Area 23 requirements, the Auditor sampled 25% of the total number of claims submitted (12 claims sampled) for reimbursement.

Review of the sampled claim files confirmed that each reimbursement had been appropriately undertaken and was supported by a properly completed and authorised Appendix U cost reimbursement schedule and a fully completed and authorised Appendix S. All The claims were also uploaded onto the Datix system.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and are not appropriately authorised.				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

22.1

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Claims Reimbursement.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weakness in the operation of the designed system/control for Claims Reimbursement.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk: Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and are not appropriately authorised.

The following areas of good practice were noted:

- All closed claims reimbursed by the Welsh Risk Pool that were sampled, held on file a completed and authorised Appendix U form. All forms were signed and dated by the Corporate Service Manager.
- All closed claims reimbursed by the Welsh Risk Pool that were sampled, held on file a completed and authorised Appendix S Summary Checklist. All Checklists were signed as authorised by the Claims Specialist Manager, the Governance Declaration was signed as authorised by the relevant individuals and the Responsible Body Declaration and each appendix was signed as authorised by two Executive Directors; and
- All claims had been forwarded to the Welsh Risk Pool for approval and reimbursement.
- All claims were uploaded onto the Datix system.

There were no significant findings identified.

7. Summary of Recommendations

There were no recommendations arising from this review.

22.1

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

22.2

IM&T
Welsh Patient Referral System

FINAL INTERNAL AUDIT REPORT
2017/18

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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Management response received:	13 November
Final report issued:	21/11/17
Auditors:	Martyn Lewis

Executive sign off: Director of Therapies and Health Sciences
Distribution:

Committee: Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the C&V University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

In accordance with the 2017/2018 internal audit plan, a review of the Welsh Patient Referral System was undertaken. The assignment originates from the internal audit plan and the subsequent report will be submitted to the Audit Committee.

The relevant lead Executive Director for the assignment is the Director of Therapies.

The Welsh Patient Referral Service (WPRS) enables electronic referrals to go directly from GPs to consultants. The consultants can carry out a number of electronic actions with each referral, including prioritising, returning to the GP (with an explanation), and redirecting to non-consultant services or clinics. The introduction of WPRS allows for faster processing of referrals and a corresponding reduction in consultant clinic attendance – freeing up appointments and leading to shorter waiting lists for patients.

WPRS is currently being deployed across the UHB, with full deployment planned for March 2018.

2. Scope and Objectives

The objective of the audit is to evaluate and determine the adequacy of the systems and controls in place for the management of the WPRS, in order to provide reasonable assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review is to provide assurance that that the WPRS is subject to appropriate governance and testing and that data is securely transferred between systems.

The main areas that the review will seek to provide assurance on are:

- An appropriately resourced plan for roll out of the WPRS is in place and monitored;
- Appropriate testing is performed prior to roll out, including system capacity;
- Appropriate training on the use of the system is provided to users prior to roll out;
- Data transferred between systems is complete, accurate and secure with no duplicates or errors and that an appropriate audit trail is maintained.

3. Associated Risks

The potential risks considered in the review are as follows:

I. The project does not meet its deadlines;
II. Transfer of data is incomplete or contains errors.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report.

An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

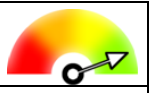
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the WPRS is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

The WPRS is an established system part developed by C&V IM&T. The roll out process is governed by a formal process and progress is regularly monitored along with identified risks. Changes to the process are formally approved and subject to testing and data is subject to logging and most data transfer is encrypted. There were minor weaknesses identified relating to the attendance of some services at ISEC (Informatics Services E-Communications Project Board) and one transfer process is not encrypted.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	*The project does not meet its deadlines;*				✓
2	*Transfer of data is incomplete or contains errors.*				✓

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weaknesses in the system control/design for the WPRS.

This is identified in the management action plan as (D).

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for the WPRS.

This is identified in the management action plan as (O).

6. Summary of Audit Findings

The key findings are reported in the section below with full details in the Management Action Plan under Appendix A.

Risk: The project does not meet its deadlines.

The following areas of good practice were noted:

- There is a local project plan in place for each speciality;
- The plan breaks down the tasks to be undertaken and has identified leads;
- There is an overall roll out plan in place;
- There is a project structure in place for WPRS;
- Progress on the project is regularly monitored;
- Project risks are identified and managed via a risk log;
- Progress is also communicated to all stakeholders via regular bulletins;

- The project is regularly reviewed at the Informatics Services E-Communications Project Board (ISEC);
- Readiness assessments are undertaken on each area before they go live;
- Testing is undertaken appropriately with identified issues raised and tracked.
- User guides are available for staff;
- Training is provided online, with the option of face to face training if required.

The following significant findings were noted:

- Although the WPRS project is regularly reviewed at ISEC, attendance at this is poor for some individuals (9 of the 20 members). This means that not all service groups have consistent visibility of the project.

RISK: Transfer of data is incomplete or contains errors.
The following areas of good practice were noted:

- The process is set out within formal documentation;
- there are mandatory fields defined within the process, as are duplicate checks;
- Most data transfer is encrypted using AES256;
- There is an application change advisory board for all the systems leads. This means that cross-system issues are identified and integrity maintained;
- The process is fully audited.

The following significant finding was noted:

- Due to historical reasons, data sent from the Welsh Clinical Communications Gateway (WCCG) to the Welsh Admin Portal (WAP) are not encrypted.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**0**	**2**	**0**	**2**

Finding 1	Risk
Although the WPRS project is regularly reviewed at ISEC, attendance at this is poor for some individuals (9 of the 20 members). This means that not all service groups have consistent visibility of the project. (O)	The project does not meet its deadlines.
Recommendation 1	**Priority level**
The membership of ISEC should be reviewed to ensure it is still valid. Subsequently the Chair should remind members to attend or send a representative.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Agreed. The membership of ISEC has been recently reviewed to ensure validity.	NWIS Programme Lead Completed

22.2

Finding 2	Risk
Due to historical reasons, data sent from WCCG to WAP are not encrypted. (D)	Transfer of data is incomplete or contains errors.
Recommendation 2	**Priority level**
Encryption should be applied to all data transfers.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
The feasibility of applying encryption to this data transfer will be raised / discussed with NWIS as lead providers.	NWIS Programme Lead April 2018

22.2

Welsh Patient Referral System

Cardiff & Vale University Health Board

22.2

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

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 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

22.3

IM&T
MTeD Deployment

FINAL INTERNAL AUDIT REPORT
2017/18

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

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Auditors:	Martyn Lewis

Executive sign off: Director of Therapies
Distribution:

Committee: Audit Committee

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1. Introduction and Background

In accordance with the 2017/2018 internal audit plan, a review of the deployment of MTeD (Medicines Transcribing and e-discharge) was undertaken. The assignment originates from the internal audit plan and the subsequent report will be submitted to the Audit Committee.

The relevant lead Executive Director for the assignment is the Director of Therapies.

MTeD is part of the Welsh Clinical Portal and has two functions: Medicines Transcribing (MT) will enable a clinician to transcribe patient medications electronically. This will improve medicines management throughout the patient's stay in hospital from admission through to discharge; and eDischarge (eD) will allow a clinician to electronically record a summary about the patient's stay in hospital on a Discharge Advice Letter or DAL. Patient demographic details will be automatically populated from our patient management system and the discharge medication list will be imported from the medicines transcribing part of the system. MTeD is needed as the current process for making information available to GP practices regarding the outcome of patient admissions is untimely and unreliable. Information on the current TTH can be illegible, incomplete and inaccurate, thus creating avoidable clinical risk. The aim of the MTeD project is to establish consistency and timeliness of discharge communication from secondary care teams to GP practices, thus improving patient safety and supporting a more positive patient experience.

MTeD is currently being deployed across the UHB, with full deployment planned for March 2018.

2. Scope and Objectives

The objective of the audit is to evaluate and determine the adequacy of the systems and controls in place for the deployment of MTeD, in order to provide reasonable assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review is to provide assurance that that the roll out of MTeD is subject to appropriate governance and testing and that anticipated benefits are realised.

The main areas that the review will seek to provide assurance on are:

- An appropriately resourced plan for roll out of MTeD is in place and monitored;

- An assessment of readiness for roll out is undertaken;
- Appropriate testing is performed prior to roll out, including system capacity;
- Appropriate training on the use of the system is provided to users prior to roll out;
- Benefits of the system are clearly defined and a mechanism in place for ensuring realisation of these.

3. Associated Risks

The potential risks considered in the review are as follows:

I. The project does not meet its deadlines;
II. The UHB does not gain the benefits from MTeD.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

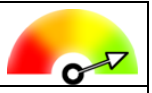
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the MTeD Deployment is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

MTeD is an established system part developed by C&V IM&T. The roll out process is governed by a formal process and progress is regularly monitored along with identified risks. There were minor weaknesses identified relating to the attendance of some services at ISEC (Informatics Services E-Communications Project Board) and the lack of a formal benefits realisation / assessment process.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	*The project does not meet its deadlines;*				✓
2	*The UHB does not gain the benefits from MTeD.*			✓	

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weaknesses in the system control/design for MTeD Deployment.

This is identified in the management action plan as (D).

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for MTeD Deployment.

This is identified in the management action plan as (O).

6. Summary of Audit Findings

The key findings are reported in the section below with full details in the Management Action Plan under Appendix A.

Risk: The project does not meet its deadlines.

The following areas of good practice were noted:

- There is an overall roll out plan in place;
- There is a project structure in place for MTeD;
- Progress on the project is regularly monitored;
- Project risks are identified and managed via a risk log;
- Progress is also communicated to all stakeholders via regular bulletins;
- The project is regularly reviewed at the Informatics Services E-Communications Project Board (ISEC);
- Readiness assessments are undertaken on each area before they go live;

- Testing is undertaken appropriately with identified issues raised and tracked.
- User guides are available for staff;
- Training is provided online, with the option of face to face training if required.

The following significant finding was noted:

- Although the MTeD project is regularly reviewed at ISEC, attendance at this is poor for some individuals (9 of the 20 members). This means that not all service groups have consistent visibility of the project.

RISK: The UHB does not gain the benefits from MTeD.

The following significant finding was noted:

- Although MTeD is known to provide benefits, in particular patient safety and efficiency improvements, there has been no full formal assessment of the benefits associated with MTeD within the UHB.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**0**	**2**	**0**	**2**

Finding 1	Risk
Although MTeD is known to provide benefits, in particular patient safety and efficiency improvements, there has been no full formal assessment of the benefits associated with MTeD within the UHB. As part of the pilot project evaluation of MTeD in 2014 the project employed Metrics Based Process Mapping (MBPM) to identify tangible measurement of process performance indicators for current state and future state processes. It was recognised that this MBPM could be repeated following rollout to the UHB's In Patient Wards. (D)	The UHB does not gain the benefits from MTeD.
Recommendation 1	**Priority level**
Repeat the benefits measurements (MBPM described above) which was carried out as part of the MTED Pilot Project Evaluation.	**Medium**

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Management Response 1	Responsible Officer/ Deadline
The benefits measurements carried out as part of the MTED Pilot Project and set out in the Evaluation Report will be repeated following the recent completion of the rollout of MTED to all 72 In Patient wards (excluding Mental Health). The UHB has expended resource on the implementation of the system having recognised and endorsed the benefits, some of which are listed below: • Fast electronic transmission and receipt of patient's Discharge Advice Letter (DAL) by the patient's GP as the patient leaves the ward • Reduction in postage costs of sending paper DALs. • Reduction in paper letters received, opened and filed or scanned to the electronic record by GP staff. • Reduction in phone calls by GP staff regarding the patients stay in hospital as DALs are provided in real time. • Timely transfer of the patients' discharge prescriptions back into primary care. • Access to the Welsh GP Record by secondary care clinicians. Telephone calls to GP Practices are minimised.	NWIS Programme Lead April 2018

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Finding 2	Risk
Although the MTeD project is regularly reviewed at ISEC, attendance at this is poor for some individuals (9 of the 20 members). This means that not all service groups have consistent visibility of the project. (O)	The project does not meet its deadlines.
Recommendation 2	**Priority level**
The membership of ISEC should be reviewed to ensure it is still valid. Subsequently the Chair should remind members to attend or send a representative.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Agreed. The membership of ISEC has been recently reviewed to ensure validity.	NWIS Programme Lead Completed

22.3

MTeD Deployment

Cardiff & Vale University Health Board

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Cardiff and Vale University Health Board

Children & Women Clinical Board – Medical Staff Rotas and Study

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Steve Curry – Chief Operating Officer.
Distribution:	Rachel Burton – Director of Operations. Jennifer Thomas – Clinical Director. Diane Rogers – Directorate Manager. Rose Whittle – Directorate Manager.
Committee:	Audit Committee.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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1. Introduction and Background

The review of Medical staff rotas and study within the Children & Women Clinical Board was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board.

All National Health Service organisations rely on a level of Medical locum cover in order to maintain service continuity. The inherent nature of providing health services, with the variations in demand, capacity and workforce availability dictate that such expenditure is unavoidable. However, an organisation can influence the demand for locums via a flexible, efficient and robust rota system.

Study leave for medical and dental staff was determined in the Terms and Conditions of Service as leave granted for postgraduate purposes and approved by the employer and includes study (usually but not exclusively or necessarily on a course) research, teaching or taking examinations, visiting clinics and attending professional conferences.

CPD is not only a pivotal component of both clinical governance and clinical standards activity but is one of the key elements to revalidation. It is important that individuals are able to demonstrate to their appraiser compliance with the requirements of their Royal College / speciality body in order to be in a position to revalidate. Study leave aims to satisfy the needs of not only the individual doctor but also those of the Health Board in improving patient care.

Previous Internal Audit reviews of Medical Staff Study Leave carried out during 2016/17 identified that the Health Board's 'Study Leave Procedure for Medical and Dental Staff' is out of date. Management actions have been agreed to address this issue.

The relevant lead Executive Director for this review is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Children & Women Clinical Board for the management of Medical Staff Rotas and Study, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to provide assurance that Medical staff rotas are effectively developed to ensure appropriate coverage and hours worked and study leave provided to Medical Staff complies with BMA guidance, is of value to the Doctor and the UHB and is processed appropriately.

The areas that the review sought to provide assurance on are:

- The Clinical Board has appropriate processes and procedures in place for the drawing up of Medical staff rotas;
- Medical Staff rotas are drawn up to reflect workload and breaks and they are fair, consistent and ensure that staff members work their contracted hours;
- Appropriate processes and procedures are in place for the booking of locum doctors against demand and usage is appropriate and authorised;
- An appropriate Policy or Procedure is in place for the assessment and approval of study leave that complies with BMA guidance;
- Study leave is appropriately approved and is relevant;
- All Medical Staff undertake study / professional leave within the BMA guidelines;
- The costs associated with the study leave are identified and processed appropriately.

It was originally agreed that the review would be undertaken within the following 3 Directorates:

- Acute Child Health;
- Obstetrics & Gynaecology; and
- Community Child Health.

However due to delays in receiving the required information from the Obstetrics and Gynaecology Directorate, the work could not be completed within the required timescales and the scope of the review was therefore limited to the Acute Child Health and Community Child Health Directorates.

3. Associated Risks

The potential risks considered in this review were as follows:

- Staff rota's are not drawn up in advance.
- Inappropriate shift patterns mean staff do not work their contracted hours or do not have appropriate breaks.
- Unnecessary usage of locums.
- Unnecessary / inappropriate expenditure.
- Medical staff do not stay up to date within their field / lower quality care provision.

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OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of Medical Staff Rotas and Study within the Children & Women Clinical Board is **Reasonable assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The review noted good practice within the Clinical Board via the timely issue of the staff rota's sampled, standardised templates in operation and good communication between the Clinical Board and medical workforce. These practices ensure that medical staff rotas are being appropriately managed and staff members are working their required sessions.

The review did however identify a number of issues in relation to both Medical staff rotas and study leave. These relate to the availability and appropriateness of procedural guidance within all the areas sampled, the level of compliance with procedures for locums and study leave and the generally low take up levels of study leave by the medical staff.

It should be noted that there were delays in receiving information within one of the directorates and testing was curtailed in this area.

There was one high priority finding noted within this report; From the audit sample, the combined percentage of study days taken, compared to their allowances, was less than 50%.

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5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Staff rotas are not drawn up in advance.				✓
2	Inappropriate shift patterns mean staff do not work their contracted hours or do not have appropriate breaks.			✓	
3	Unnecessary usage of locums.			✓	
4	Medical staff do not stay up to date within their field/ lower quality care provision.		✓		
5	Unnecessary/ Inappropriate expenditure			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for the management of medical staff rotas and study within the Children & Women Clinical Board.

Operation of System/Controls

The findings from the review have highlighted six issues that are classified as weakness in the operation of the designed system/control for the management of medical staff rotas and study within the Children & Women Clinical Board.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISKS 1 & 2: Staff rotas' are not drawn up in advance & Inappropriate shift patterns mean staff do not work their contracted hours or do not have appropriate breaks.

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We identified the following areas of good practice:

- There is a guidance document (June 2016) available on the intranet surrounding the General Paediatrics and sub-speciality rota's at UHW. The guidance document sates a minimum of 2 individuals to cover night shifts.
- In general, the rota's sampled were issued in advance.
- Standardised templates are used for populating Rotas' (supplied by medical workforce).
- Medical Workforce undertakes bi-annual reviews within the Clinical Board to ensure compliance to the New Deal/ EWTD. The process involves junior doctors completing an on line assessment of their exact working times, over a 2-week period within the (Allocate System).
- Results are generated and a compliance spread sheet of results (including breaches) is sent to the directorates.

We identified two significant findings in relation to these risks:

- Procedural guidance for rotas was found to be in need of standardisation and enhancement.
- The controls in place to ensure compliance with working time policies, surrounding taking appropriate breaks and maximum length of shifts, need enhancement.

RISK 3: Unnecessary usage of locums.

We identified the following areas of good practice:

- The Health Board has in place a procedure for the recruitment of locum doctors and dentists and this was available on the Health Boards intranet.
- This procedure is supported by the Medical Locum's Decision Tree and Approval Thresholds which details local framework rates and out of hours' request escalation process.
- The Health board has an extra duty claim form that must be completed in line with procedure and states timescale for completion.
- Authorisation of claim forms was appropriate.

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We identified two significant findings in relation to this risk:

- From the audit sample of 20 locum shifts, testing identified the following issues;
  1. Submission of three claims was outside the required time period (1 Month),
  2. Two shift lengths were greater than the maximum allowed under the policy.
  3. There was no formal assurance on any of the forms to evidence what alternative cover arrangements had been sought prior to the locum shifts being agreed. It should be noted that verbal assurance was given to the auditor that checks had been undertaken.
- The extra duty claim form does not have a print name section, therefore making it difficult to identify the individual who is approving the shifts and the associated costs.

RISKS 4 & 5: Medical staff do not stay up to date within their field/ lower quality care provision & Unnecessary or Inappropriate expenditure.

We identified the following areas of good practice:

- Study Leave is covered by the All Wales Study Leave Policy which was last updated in January 2015, and the Cardiff & Vale Study Leave Procedure.
- The Intrepid system is now used to submit and approve applications for study leave and to record all reclaimed expenses.
- Courses applied for, were found to be generally appropriate and in line with requirements.
- Expenses reclaimed were found to be appropriate.

We identified three significant findings in relation to this risk:

- During fieldwork there was found to be an absence of knowledge around the study leave procedure.
- The percentage of study leave take up was found on average to be less than 50%. It was also identified that one consultant had taken 7 days more than their entitlement over the period.
- A sample of applications and expenses was tested for accuracy and appropriateness and the following issues were identified:
  1. Estimated costs were not always supplied;
  2. Study leave request timeframes were not always adhered to; and
  3. One instance of retrospective approval of leave.

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7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**5**	**1**	**7**

Finding 1 - Study leave rates (Control Design)	Risk
A sample of 20 doctors and consultants was selected from across the Clinical board in order to establish compliance with study leave procedures. From this sample, the combined percentage of study days taken by the Medical Staff compared to their allowances, was less than 50% uptake. The individual take up percentages ranged from 10% - 98% (excluding the below). Testing subsequently identified that one consultant had taken 7 days more than entitlement, for study leave period ending 31/10/2016.	Medical staff do not stay up to date within their field/ lower quality care provision.
Recommendation 1	**Priority level**
The Clinical Board will monitor the number of study days taken by medical staff in order to ensure that there is an improvement in the percentage uptake. Controls will also be established to prevent individuals exceeding their allowances.	**High**
Management Response	**Responsible Officer/ Deadline**
Directorate Management Teams will be reminded to monitor the requests and approval of study leave for all medical staff. This will be reviewed as part of the monthly Directorate Performance Reviews and will provide an opportunity for Clinical Board involvement as necessary.	DMT Starting October 2017

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Finding 2 - Study leave guidance (Operating effectiveness)	Risk
The study leave procedure for medical and dental staff was issued on the 8th June 2006 and was due for review in June 2008. However, the Procedure has not been subject to review and consequently is now out of date. Previous Internal Audit reviews of Medical Staff Study Leave carried out during 2016/17 identified that the Health Board's 'Study Leave Procedure for Medical and Dental Staff' is out of date. Management actions have therefore already been agreed to address this issue. However, during the fieldwork for this review there was also found to be an absence of knowledge around the study leave procedure and accountability, throughout the clinical board.	Medical staff do not stay up to date within their field/ lower quality care provision.
Recommendation 2	**Priority level**
The profile and accountabilities in relation to study leave requirements needs to be reinforced.	Medium
Management Response	**Responsible Officer/ Deadline**
Updated study leave procedures will be circulated to DMT and onwards to all medical staff in the Clinical Board. All staff will be reminded of their responsibilities in relation to this policy.	Rachel Burton – Director of Operations/Jennifer Thomas – Clinical Director. November 2017

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Finding 3 - Consultant study leave (Operating effectiveness)	Risk
12 Consultant study leave applications were sampled, to verify the correct procedure had been followed and that expenses were appropriate. The following results were highlighted: 1. Within 4 applications, no estimated costs had been supplied prior to undertaking study leave. The total costs involved in these 4 claims was circa £3200 with 1 of these claims costing £ 2215. 2. There were also 4 occasions that breached the study leave approval timeframe (6 weeks in advance of course attendance), although it should be noted that on 1 of these occasions, reasons for the breach were stated on the application. 3. One application showed that study leave was retrospectively approved after the course was attended.	Medical staff do not stay up to date within their field/ lower quality care provision.
Recommendation 3	**Priority level**
Staff will be reminded of their responsibilities when requesting and approving study leave.	Medium
Management Response	**Responsible Officer/ Deadline**
Updated study leave procedures will be circulated to DMT and onwards to all medical staff in the Clinical Board. All staff will be reminded of their responsibilities in relation to this policy.	Rachel Burton – Director of Operations/Jennifer Thomas – Clinical Director. November 2017.

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Finding 4 - Study leave electronic system (Operating effectiveness)	Risk
The monitoring arrangements for study days taken by consultants (30 days over 3 years, in accordance with Health Board policy) was limited within the Community Child Health Directorate. This was due to the manual process operating at the time that did not have the mechanism to proactively monitor such details. However, from May 2017, consultants within Community Child Health have been moving onto the Intrepid system that has better tools to proactively monitor study leave going forward.	Medical staff do not stay up to date within their field/ lower quality care provision.
Recommendation 4	**Priority level**
Proactive monitoring will be undertaken to ensure all appropriate staff are utilising the Intrepid system.	Low
Management Response	**Responsible Officer/ Deadline**
Assurance to be provided through Directorate Performance Reviews from each DMT that Intrepid is being used appropriately throughout each Directorate	DMT November 2017

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Finding 5 - Locum Testing (Operating effectiveness)	Risk
Audit sampled 20 occasions where locums had been utilised for both doctor and consultant graded staff. Compliance to procedures were tested and the following was noted: 1. On 3 occasions the submission of claims was outside the required time period (1 Month); 2. On 2 occasions the shift length being claimed was greater than the maximum allowed under the policy, (13 Hours claimed where maximum shifts 12.5 Hours); 3. Within the standard Locum claim form currently in use, there is no "print name section" for authorising the form. This made establishing the appropriateness of the approvals difficult. On no occasion was there any formal assurance written on the forms as to what alternative cover arrangements had been sought prior to locum shift being agreed. It should be noted that verbal assurance was given to the auditor that checks had been undertaken.	Unnecessary usage of locums.
Recommendation 5	**Priority level**
Staff will be reminded of the procedural requirements and updates to standard forms will be undertaken, where appropriate.	**Medium**

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Management Response	Responsible Officer/ Deadline
A review of the format of the claims forms used within C&W Clinical Board will be undertaken and changes made as required. All staff within the Clinical Board and Directorates will be reminded of the need to comply with procedures. Directorates have already been asked to remind all consultants to comply with timescales and a reminder will also be sent to junior staff reiterating the need to comply with timescales.	Rachel Burton – Director of Operations/Jennifer Thomas – Clinical Director. November 2017.

Finding 6 Staff rota procedure (Operating effectiveness)	Risk
There was no corporate policy available for the rostering of medical staff. However, within the Clinical Board, there was a guidance document (June 2016) available on the intranet surrounding the General Paediatrics and sub-speciality rota's at UHW. However, there was no standardised guidance for the production of rotas throughout the Clinical Board The guidance document states a minimum of 2 individuals to cover night shifts, however, it does not state the minimum staff level required for alternative shifts e.g. Daytime ward cover etc. The auditor was also informed that the usual night shift length (in terms of consecutive nights) was 4; however, no guidance within procedures / policies was evident.	Inappropriate shift patterns mean staff do not work their contracted hours or do not have appropriate breaks.

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Recommendation 6	Priority level
Guidance should be produced and made available throughout the Clinical Board and this should reflect minimum personnel per shift and skill mix requirements.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The current document will be reviewed and consideration given to broadening its scope to include all specialties within the Clinical Board. This will cover the skill mix and number of personnel required per shift.	Rachel Burton – Director of Operations/Sarah Evans – Head of Workforce and Organisational Development. November 2017

Finding 7 – Staff rota compliance (Operating effectiveness)	Risk
The audit sampled 10 individuals from Acute Child Health and Community Child Health to ensure appropriate staffing levels on wards and appropriate shift pattern had been undertaken in line with policy requirements. The following was noted; 1. No evidence was available as to the length and frequency of staff breaks within Acute Child Health. 2. Within PICU, there were 2 instances where no cover for shifts was evident; 7/4/2017 (standard Day) and9/4/2017 (standard weekend Day). 3. It is stated within the Working time policy that Shift lengths should not	Inappropriate shift patterns mean staff do not work their contracted hours or do not have appropriate breaks.

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normally be longer than 12 hours (12 ½ to include handover time), and should not exceed a total of 12 ½ hours apart in very exceptional circumstances e.g. in a medical emergency (8.2.14 Page 9 of working time policy). However, within the duty detail of the "neonates" rota the "Max continuous duty length" is 13 Hours e.g. night and long day shift.	
Recommendation 7	**Priority level**
Management should remind staff around the requirements of the working time policy.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The current requirements of the working time policy will be shared with all DMT and compliance will be managed through Directorate Performance Reviews.	Rachel Burton – Director of Operations/Jennifer Thomas – Clinical Director. November 2017

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Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Cardiff and Vale University Health Board

Serious Incidents Management

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Carol Evans, Assistant Director Patient Safety and Quality Maria Roberts, Patient Safety Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of the management of Serious Incidents (SIs) was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board.

Organisations and services should put in place systems and procedures to ensure that there is appropriate management and reporting of all Serious Incidents.

"Putting Things Right- Guidance on dealing with concerns about the NHS from April 2011", defines a Serious Incident as "an incident that occurred during NHS funded healthcare (Including in the community), which resulted in one or more of the following:

- Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- a never event- all never events are defined as serious incidents although not all never events necessarily result in severe harm or death (see Never Events Framework);
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations, or incidents, of physical abuse and sexual assault or abuse;
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation".

The Health Board is required to report all serious incidents to the Welsh Government within 24 hours of the incident taking place, where possible. Welsh Government will then grade the incident and provide a timescale within which the Health Board must submit a completed investigation.

Compliance with the serious incident reporting process is considered as part of the NHS Delivery Framework monitoring arrangements.

Welsh NHS Bodies are also required to report all patient safety incidents (irrespective of seriousness and degree of harm) to the National Reporting and Learning System (NRLS).

The UHB utilises DATIX, an electronic risk management database for recording and reporting incidents, concerns, claims and inquest management.

The relevant lead Executive Director for this review is the Executive Nurse Director.

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2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of Serious Incidents, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that all recorded Serious Incidents are appropriately investigated, acted upon and reported.

The areas that the review sought to provide assurance on are:

- The UHB has appropriate documented policies and procedures in place which reflect the requirements of the 'Putting Things Right Regulations', issued 1st April 2011;
- Serious Incidents are appropriately identified and are subject to an appropriate investigation within the required timescale;
- Action Plans are developed, approved and implemented where issues have been identified;
- Feedback is provided to individuals involved and lessons learned are shared across the organisation;
- Periodic reports on Serious Incidents are produced and communicated to Clinical Boards and appropriate Health Board Groups / Committees and Serious Incidents are reported to the Board in an open and transparent way;
- Reporting of Serious Incidents complies with all external requirements (including Welsh Government); and
- Serious Incidents are subject to appropriate closure in accordance with Welsh Government timescales.

As part of the review, testing was carried out on a sample of SIs from the following 4 Clinical Boards:

- Medicine;
- Mental Health;
- PCIC; and
- Specialist Services

3. Associated Risks

The potential risks considered in this review were as follows:

- Serious Incidents are not effectively managed within the UHB;
- Lessons are not learnt and actions are not taken to prevent reoccurrence of incidents; and
- The UHB fails to comply with reporting requirements.

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OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Serious Incidents Management is **Reasonable Assurance.**

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Serious Incidents are being appropriately identified within the Health Board and processes are in place to ensure required actions are identified and implemented. The Health Board also has robust reporting processes in place to ensure that lessons are learnt.

Datix is utilised effectively and the 'Putting Things Right' guidance is followed when dealing with serious incidents. CAV web has a dedicated page available for incident reporting, which includes links to Datix for the reporting and management of all incidents. A document outlining Severity Descriptors is also available for staff completing Datix, as well as RIDDOR guidance which will assist if relevant. The pages on CAV web are user friendly and well laid out.

The Health Board's Incident Reporting policy is currently out of date but is in the process of being reviewed and updated.

Testing identified that the Health Board is not always completing the review and closure of SIs within the timescales stipulated by WG. However we did note that there are often extenuating circumstances that prevent the required investigations from being completed within the timescales.

All four sampled Clinical Boards have a Quality, Safety and Experience committee in place which monitors the progress against their SI's. Each

Clinical Board also has their own dedicated Patient Safety Team Facilitator allocated to them. Improvements could be made with regards to the completion of action plans and ensuring they are more readily available via the Datix system.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Serious Incidents are not effectively managed within the UHB			✓	
2	Lessons are not learnt and actions are not taken to prevent reoccurrence of incidents			✓	
3	The UHB fails to comply with reporting requirements			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as a weakness in the system control/design for Serious Incidents Management.

Operation of System/Controls

The findings from the review have highlighted 4 issues that are classified as weakness in the operation of the designed system/control for Serious Incidents Management.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK 1: Serious incidents are not effectively managed within the UHB.

The following areas of good practice were noted:

- The incident reporting pages on CAV web contain policies and procedures as well as guidance and contact details for staff to use. These are extremely user friendly, laid out into sections and contain links to useful information and contacts.
- Procedures are available for completing Root Cause Analysis investigations as well as flowcharts to advise staff on how to carry out investigations into serious incidents.
- Incidents occurring within the Health Board are reported and managed via the Datix system. The user profiles within Datix ensure that access to the system and individual incidents is appropriately controlled. Datix also provides a unique identification number for each incident along with an audit trail of any additions or changes made. Datix will also prevent the reporter submitting the incident form unless all the required fields are completed.

The following significant finding was noted:

- The Incident Reporting policy is currently out of date as it was due for review in August 2015. A revised copy of the policy, which has been drafted by the Health and Safety team, is currently out for consultation. The Patient Safety Team are also working on updating procedural documents to supplement the policy.

RISK 2: Lessons are not learnt and actions are not taken to prevent reoccurrence of incidents

The following areas of good practice were noted under:

- Effective processes are in place to ensure that relevant incidents are appropriately identified as SIs and are then communicated to all required staff members within the Health Board.
- The Patients Safety Team carries out monthly reconciliations between the SIs that have been reported to WG and the responses received to ensure no SIs have been missed or unreported. In addition to this the System development analyst for the patient safety team maintains a deletion database which records all incidents that have been removed and the reason why.
- Action plans are developed within the Clinical Boards to address issues associated with reported SIs. Where possible, evidence was provided to support the completed actions identified in the action plans for the Clinical Boards reviewed.

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- Closure forms that are completed for WG describe the actions that have taken place to reduce the likelihood of the incident reoccurring. This could be found on all 9 closure forms reviewed.
- There is evidence to show that discussions regarding Serious Incidents and the Welsh Government Closure forms are taking place within all four of the Clinical Board QS&E Committees reviewed. Some of the clinical boards have a standard agenda template for this meeting, which includes Serious Incidents. We have also found examples of good practice and lessons learnt being shared during these meetings.
- Each directorate within the Clinical Boards have their own Quality and Safety meeting which is held each month and discusses SIs.
- All four Clinical Boards have their own Patient Safety Facilitator allocated to them who attends all meetings.
- Due to the sheer number of SI's for Medicine and Mental Health, both Clinical Boards have a Clinical Governance Lead who has overall responsibility for monitoring and managing the incidents. For PCIC and Specialist Services the Directors of Nursing have overall responsibility.

The following significant findings were noted:

- Action plans are rarely uploaded onto Datix and are only accessible directly from the Clinical Boards. This can create delays in accessing, especially if individuals are absent from work.

  Action leads or approval of the action plan is also not always shown on the plans.

RISK 3: The UHB fails to comply with reporting requirements

The following areas of good practice were noted:

- Welsh Government are made aware of all serious incidents which are reported through Datix, via a Notification of Serious Incidents form (SI1). This could be found for all 15 SI's reviewed.
- All serious incidents are also reported through Datix to the National Reporting and Learning System. The Patient and Safety Team will run a monthly report to inform them of all the serious incident reported within the organisation that month.
- It was also noted through testing that where necessary, reporters and line managers are informing other parties of the incident occurring, i.e. HM Coroner, Police.

The following significant finding was noted:

- The Health Board is not always reporting serious incidents to WG within the required 24 hours of the incident occurring.

- Serious Incident closure forms are not always being completed and submitted to WG within the required timescales.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**3**	**1**	**5**

Finding 1 - Time scales for closing SIs (Operating effectiveness)	Risk
A sample of 15 serious incidents were chosen and reviewed to ensure they had been processed within the required timescales and to establish if they were compliant with the requirements of the Welsh Government guidance 'Putting Things Right'. Once WG are notified of the serious incident they respond with an email and provide the organisation with a timescale in which they expect the closure form to be received. All serious incidents should be subject to a root cause analysis (RCA) investigation, which is included as part of the WG closure form. Some incidents may require a full RCA whereas others such as pressure damage have tool kits provided, to aid investigating officers. Review of the 15 sampled SIs identified that for 7 the closure forms had not been submitted to WG within the stipulated timescales. For 5 of theses the closure form is yet to be submitted to WG as the investigation is still ongoing. For the other 2 the closure forms were submitted to WG after the required timescale. One of these remains open as WG are not happy to close the SI.	The UHB fails to comply with reporting requirements.
Recommendation	**Priority level**
Management must ensure that closure forms are submitted to WG within the required timescales.	**High**

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Management Response	Responsible Officer/ Deadline
Welsh Government have set an All Wales target of 90% compliance in closing all Serious Incidents within the prescribed timescales. The UHB had made significant progress in reducing its backlog over the last 12 months from a position where we were reporting 230 serious incidents open in October 2016 to a position where we now have 74 open. The UHB has an agreed trajectory for improvement and each Clinical Board has agreed targets for serious incident closures which is monitored at Monthly Executive Performance reviews and is reported into regular meetings with the Delivery Unit. **Action:** Maintain current monitoring arrangements for performance against agreed Clinical Board KPIs.	Assistant Director Patient Safety and Quality / monthly.

Finding 2 - Incident Reporting Policy (Control Design)	Risk
The Incident Reporting policy is currently out of date as it was due for review in August 2015, however a revised copy of the policy is out for consultation. The Patient Safety Manager hopes to present the documents at the Quality, Safety and Experience committee in December 2017. Due to the way in which incidents are now reported via the Datix system and as help is available through each stage of the process this reduces the risk.	Serious Incidents are not effectively managed within the UHB.

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Recommendation	Priority level
Management must ensure that the policy is up to date and available to all the relevant staff.	Medium
Management Response	**Responsible Officer/ Deadline**
The Incident Reporting Policy was approved at the July 2017 Health and Safety Committee. **Action:** The Patient Safety Team will develop the supporting procedures to support implementation of the policy.	Patient Safety Manager – all completed by March 2018.

Finding 3 - Action Plans (Operating effectiveness)	Risk
There is a section within Datix that allows action plans to be included and uploaded onto the system. From the original sample of 15 SI's only nine should have had an action plan in place, however we could only locate two out of nine action plans within Datix. We were however able to trace six out of the seven missing action plans directly from the Clinical Boards. At the time of the audit Specialist Services was unable to provide a copy of the action plan due to annual leave within the department. From the action plans reviewed we could see that an action lead had not been identified for any of the Mental Health action plans. We were also unable to identify if any of the action plans had been formally approved.	Lessons are not learnt and actions are not taken to prevent reoccurrence of incidents.

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Recommendation	Priority level
The Patient Safety team should communicate the importance of uploading the action plans onto Datix so that they are easily accessible. All action plans should have an identified lead and signed approval.	Medium
Management Response	**Responsible Officer/ Deadline**
Action plans will have been developed and signed off as part of the investigation process and these will be held within the Clinical Boards. However we agree that the complete audit trail needs to be maintained within the Datix system.	
Action: The Clinical Boards will be reminded of the importance of uploading associated action plans for all Sis	Assistant Director Patient Safety and Quality / End October 2018
Action: The Patient Safety team will put in place a programme of quarterly audits to ensure that all Sis that have been closed in the previous quarter have the associated action plan uploaded on Datix. Results of the audit will be shared with Clinical Boards for discussion at QSE meetings	First quarterly audit to be completed by end of January 2018 (to check all closed SIs in previous quarter) and to establish quarterly thereafter. End November 2017
Action: The team will consider, in the medium term, whether the action planning field becomes mandatory on Datix.	Review March 2018

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Finding 4 - Time scale for reporting SIs to WG (Operating effectiveness)	Risk
The Putting Things Right guidance states that *where possible* Welsh Government (WG) should be notified within 24 hours of the serious incident taking place. From the 15 serious incidents we reviewed, 9 were not reported to WG within 24 hours of the incident occurring. Further investigation identified that there were explanations for the delays in reporting as follows; • 3 of the incidents required a Coroner's report; • 4 were re-graded from either a low or moderate harm to severe; and • 2 required further investigation before clarification could be made on the grading of the incident.	The UHB fails to comply with reporting requirements.
Recommendation	**Priority level**
Management should ensure that SIs are reported to WG within the required 24 hours wherever possible.	Medium
Management Response	**Responsible Officer/ Deadline**
Whenever possible the Patient Safety team will attempt to report within 24 hours. The Datix system has been set up to trigger an email to the Patient Safety team if anything reported is graded at severity of 4 or 5 or is flagged as a potential SI. There are many reasons why this is often not possible: • Delay in reporting from the clinical area	

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• Lack of clarity at the outset in relation to the level of harm • A serious incident becomes apparent through a later complaint or as a result of audit and requires retrospective reporting The team would prefer to report accurate information at the outset as once they are reported they will be treated as a Si by WG. This is important for both families and staff also this features in published statistics. Although this is a standard set by WG, it is indicative and not performance monitored. An explanation of any delay in reporting is always included in the WG SI form **Action:** the Patient Safety team will monitor compliance with this standard on a quarterly basis and discuss whether any 'delayed' reporting could have been avoided and whether a reasonable explanation for the delay was included on the SI form.	Patient Safety Manager / First audit to be completed by end of January 2018 and quarterly thereafter

Finding 5 - Feedback (Operating effectiveness)	**Risk**
A field is available on Datix for line managers to complete to state whether feedback has been given to those involved in the incident. This is not a mandatory field to be completed within the form. It gives the option of selecting either 'yes' or 'no'. If 'yes' is selected, no further information is input into the form, however if 'no' is answered there is the option to complete a field stating why feedback has not been given to the staff involved. The sample of fifteen serious incidents was reviewed to identify whether feedback had been given to the staff involved with the incident. For 6 of the SIs the field had not been completed on Datix to confirm that feedback had been given to staff involved. Of the 6, 3 were closed SI's but	Lessons are not learnt and actions are not taken to prevent reoccurrence of incidents.

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for 1 of these separate feedback had not been given to staff involved due to the nature of the case. All who were involved with the investigation would have attended the PRUDIC meetings and therefore notified of any outcomes and feedback given. Management do ensure that verbal feedback is provided but there is currently a lack of evidence to support this.	
Recommendation	**Priority level**
The Patient Safety Team should encourage management to use the feedback field within Datix to ensure an audit trail is available to show feedback has been provided. The Patient Safety Team may want to consider changing this to a mandatory field.	Low
Management Response	**Responsible Officer/ Deadline**
It is well recognised that the success of a reporting system depends on the level of feedback given to staff who report incidents so this is an important area for attention. The Patient Safety team have audited 20,267 reported patient safety incidents over a 12 month period; of those 17,614 indicated that staff had received feedback (86%) which we consider to be very high compliance. The Patient Safety team will consider whether to make the relevant field mandatory or not and this will be added to the Datix workplan The Patient Safety team will consider whether to carry out a random survey of staff who have reported incidents to validate they have had the feedback as indicated.	Patient Safety Manager / End November 2017 Patient Safety Manager / End March 2018

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Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Cardiff and Vale University Health Board

Nurse Revalidation

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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1. Introduction and Background

The Audit review of Nurse Revalidation has been completed in line with the 2017/18 Internal Audit Plan.

The relevant lead Executive Director for the review is Ruth Walker, Executive Nurse Director.

The primary purpose of revalidation is to improve public protection by making sure that registered nurses and midwives can demonstrate their continued ability to practice safely and effectively throughout their careers.

Revalidation gives registered nurses and midwives in Wales the opportunity to continue to develop their professional knowledge and show their professionalism to those with whom they come into contact with throughout their working lives.

From April 2016, all registered nurses and midwives have to revalidate every 3 years. Health Boards and Trusts need to demonstrate they have robust internal processes that ensure their employees meet the requirements of the NMC revalidation process.

The NMC hold a register of every nurse and midwife who has fulfilled the NMC registration requirements and is therefore eligible to practice in the UK.

Failure to successfully complete the revalidation process will result in the registered nurse being lapsed from the NMC register.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place for the management of nursing staff revalidation, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system's objectives are managed appropriately.

The purpose of the review was to provide assurance to the Audit Committee that there are adequate processes in place within the Health Board for monitoring Nurse Revalidation compliance for registered nurses.

The main areas that the review sought to provide assurance on were:

- There is an appropriate process in place for supporting nurses to revalidate with the NMC;
- Guidance is in place for managers and registered nurses; and
- There are arrangements in place for monitoring and reporting.

The scope of the current review focussed on the revalidation process and did not extend to the nurse registration process. We did not therefore consider any lapses in registration that may have occurred.

3. Associated Risks

The potential risks considered in the review were as follows:

- Registered nurses practice without current registration with the NMC; and
- Nurses temporarily are not able to practice leading to increased financial pressures due to a temporary need to employ bank and/or agency nurses.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of Nurse Revalidation is **Reasonable assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The Health Board has made considerable progress embedding procedures in relation to the NMC revalidation process even though they have made the decision not to adopt the NHS Wales Nursing and Midwifery Council Revalidation and Registration Policy.

Whilst many areas of good practice have been demonstrated, that have sufficiently mitigated the risk of lapse from the register due to failure to revalidate, there are opportunities to build on the processes to align with other Health Boards where we have undertaken similar reviews. Examples

of these improvements include adopting the All Wales policy, or inclusion of revalidation in the existing Professional Registration Policy, and embedding the nurse revalidation process into the annual Personal Appraisal Development Reviews.

5. Assurance Summary

The summary of assurance given against the individual risks is described in the table below:

Assurance Summary					
1	Registered nurses practice without current registration with the NMC			✓	
2	Nurses temporarily are not able to practice leading to increased financial pressures due to a temporary need to employ bank and / or agency nurses				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the system control/design for Nurse Revalidation.

Operation of System/Controls

The findings from the review have highlighted 1 issue that is classified as a weakness in the operation of the designed system/control for Nurse Revalidation.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK 1: Registered nurses practice without current registration with the NMC.

The following areas of good practice were noted:

- When the new process was enforced, the HB had an interim 12 month role to lead the NMC revalidation. The Nurse Revalidation Lead informed/educated both registrants and assessors of the new

process via 1:1 and group workshops and made available templates and guidance where appropriate.

- The All Wales policy states that 'Health Boards and Trusts will record the minimum data set of renewal and revalidation information on the registered nurse or midwives Electronic Staff Record', C&V UHB complies with this, where a position in ESR requires a pin number (ie. for practicing nurses), revalidation and registration dates are automatically populated from the NMC therefore the live register is reflected in ESR.
- ESR also provides a notification to the 'supervisor' listed in the hierarchy of any approaching revalidation dates.
- The C&V intranet provides a direct link to the NMC website where there is a wealth of information provided for Nurse Revalidation, this includes checklists to follow and example templates for the portfolios. The intranet also provides a list of 'link' nurses who have received training and are available for each Clinical Board for advice and support as required.

The following significant findings were identified:

- The All Wales policy, 'NHS Wales Nursing and Midwifery Council Revalidation and Registration Policy', has not been adopted by C&V UHB following a decision by the Nursing and Midwifery Board; In absence of this, the local Professional Registration policy does not currently contain enough detail regarding the HB arrangements for nurse revalidation.
- The current PADR process does not provide sufficient confirmation that appropriate revalidation evidence is being gathered and produced as part of each annual appraisal.

RISK 2: Nurses temporarily are not able to practice leading to increased financial pressures due to a temporary need to employ bank and/or agency nurses.

The following areas of good practice were noted:

- All sampled registrants were identified as live on the NMC register therefore confirming the accuracy of data in ESR
- All sampled confirmers have received adequate training or have sufficient guidance available to them to enable effective sign-off of registrant's revalidation submissions.
- All confirmers/discussion partners sampled were deemed to be appropriate for the role, in accordance with the All Wales Policy and had no conflict of interest with the registrant.
- All sampled confirmers/discussion partners were able to give detailed descriptions of their portfolio review including following the NMC templates and checklists. This gives confidence that reviews

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are following NMC guidelines.

- Despite it not being a requirement, 5 of the 12 sampled confirmers keep a copy of the signed evidence of confirmation that is retained on the registrant's portfolio.
- No issues or lapses were identified and raised by any of the confirmers/discussion partners sampled. All staff felt that the new process was a positive change and provided a valued opportunity to reflect of practice, encourage training and receive feedback, however, there is still anxiety amongst staff that are yet to undergo the process.
- There have been no lapses in revalidation since the new process was implemented.

No significant findings were identified under this risk heading.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**1**	**1**	**3**

Finding 1 - Policy (Control design)	Risk
There is an All Wales policy, 'NHS Wales Nursing and Midwifery Council Revalidation and Registration Policy', available for each Health Board/Trust to adopt. This has not been adopted by C&V UHB as decided by the Nursing and Midwifery Board. The Health Board's 'Professional Registration policy' does not currently contain enough detail of the arrangements regarding nurse revalidation.	Registered nurses practice without current registration with the NMC
Recommendation	**Priority level**
The All Wales policy should be adopted by the Health Board and adapted to include local arrangements regarding the NMC revalidation process, or the Professional Registration policy should be supplemented to include this.	**High**
Management Response	**Responsible Officer/ Deadline**
The All Wales Policy is currently under review by Welsh Government expected date for completion December 2017. The Nursing and Midwifery Board will consider the revised policy as soon as available from Welsh Government. The policy will either be adopted at this point or discussions will take place between Head of Workforce Governance and the Senior Nurse for Professional Standards to determine if the UHB Professional Registration Policy needs to incorporate NMC Revalidation.	Executive Director of Nursing March 2018

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Finding 2 - Revalidation embedded in Appraisal (Control design)	Risk
The collection of appropriate evidence should be a continual process and be taking place over the whole three year cycle prior to each revalidation date. The All Wales policy therefore states that 'Registered nurses and midwives will therefore be expected to produce evidence in relation to revalidation at each annual appraisal.' The C&V PADR form has a tick box for: 'Has Nurse revalidation been discussed?' however it does not provide the opportunity to encompass discussion of how much evidence has been gathered to complete the portfolio. In some cases an objective has been set: 'Met their professional/regulatory CPD requirements, eg. NMC Revalidation, HCPC registration etc.', however this is also a tick box exercise.	Registered nurses practice without current registration with the NMC
Recommendation	**Priority level**
The C&V UHB PADR form should be revised for Nursing Staff to include an appendix to ensure Nurse revalidation portfolio completion is discussed at each annual appraisal during the 3 year cycle.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Senior Nurse for Nurse Education will work with the lead for PADR to create a section for revalidation for nurses within the pay progression document. Pay progression training continues, to assist nurses in the completion of documentation (through enhanced communication and coaching workshops).	Senior Nurse for Nurse Education March 2018

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Finding 3 - ESR Notification of due revalidations (Operating effectiveness)	Risk
Each confirmer was questioned to see how they were made aware that the revalidation of the registrant was imminent. Only 5 of the 12 sampled confirmers correctly received the notification from ESR. 4 of the confirmers were reliant on lists of revalidation dates provided during implementation, whilst this has not resulted in a lapse of registration thus far, these lists will expire in the near future (due to the end of the first 3 year cycle) and they do not encompass new staff. 3 confirmers were reliant on the staff to make them aware that their revalidation is due.	Nurses temporarily are not able to practice leading to increased financial pressures due to a temporary need to employ bank and/ or agency nurses.
Recommendation	**Priority level**
Where nurses are using their line manager as their confirmer, the confirmers should be reminded of ESRs capability to make them aware that staff members in their hierarchy are approaching their nurse revalidation date.	**Low**
Management Response	**Responsible Officer/ Deadline**
An email via the Directors of Nursing will be issued to remind staff of ESR capability re revalidation/registration.	Executive Nurse Director January 2018

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Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Cardiff and Vale University Health Board

Research & Development

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	Ian Virgil – Deputy Head of Internal Audit. Murray Gard – Principal Auditor.
Executive sign off:	Graham Shortland – Medical Director.
Distribution:	Christopher Fegan - Consultant Hematologist. Jane Jones – Research and Development Manager. Lee Hatheway – Research and Development Facilitator.
Committee:	Audit Committee.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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1. Introduction and Background

The review of the management of Research & Development (R&D) within the UHB was completed in line with the Internal Audit Plan.

The relevant lead Director for the assignment is the Medical Director.

R&D is essential for the advancement of healthcare and wealth creation through the development of intellectual property. The UHB is committed to:

- Playing a leading role in NHS R&D;
- Encouraging staff to pursue high quality, ethical and relevant R&D;
- The pursuit of evidence-based clinical practice and management, in a research-aware environment.

The R&D Office is a central corporate function within the UHB. The Office supports the development of high quality R&D within Cardiff and Vale University Health Board. The R&D Office takes an organisation level lead in ensuring that research is conducted and managed to high scientific, ethical and financial standards, prepares all submissions to the Welsh Assembly Government to secure and account for R&D Support Funding and contributes to developing an active research organisation.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of arrangements for the management of R&D in order to provide assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The scope of the review was to establish if there is an appropriate process that ensures that guidance is in place for R&D and that research is approved and of an appropriate quality and relevance to the UHB.

The main areas that the review will seek to provide assurance on are:

- The UHB produces appropriate guidance and training for the management of research & development studies/trials which is distributed appropriately throughout the UHB;
- Approval processes ensure that research is of appropriate quality, and relevant to the UHB; and
- All R&D projects in the UHB are appropriately peer and risk reviewed, approved by a Research Ethics Committee, comply with research governance standards and statutory requirements.

3. Associated Risks

The potential risks considered in the review were as follows:

- R&D is of poor quality.

- R&D does not deliver work aligned to the overall strategic objectives of the UHB;
- Patient harm due to poor management of trials / research
- Breach of data protection / confidentiality.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Research & Development is **reasonable assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The review noted good practice within Research and Development via the linkage to the IMTP and wellbeing objectivise which demonstrates that the Health Board is attempting to embed research into the culture of the organisation. Also the research departments have strong procedural guidance in place and standard file management arrangements.

However, the review did identify issues within the governance arrangements and also the individual research files.

There was one high priority finding noted within this report relating to the fact that the required Clinical and Directorate lead reviews are not being completed for all projects.

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5. Assurance Summary

The summary of assurance given against the individual risks is described in the table below:

Assurance Summary					
1	R&D is of poor quality			✓	
2	R&D does not deliver work aligned to the overall strategic objectives of the UHB			✓	
3 & 4	Patient harm due to poor management of trials / research & Breach of data protection / confidentiality.			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Research & Development.

Operation of System/Controls

The findings from the review have highlighted six issues that are classified as weakness in the operation of the designed system/control for Research & Development.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk 1 - R&D is of poor quality:

The following areas of good practice were noted:

- Policies and procedures covering research and development are available on the Health Boards Internet;
- The Research Governance policy was approved by the Quality, Safety and Experience Committee in 2016 and sets out a framework for the governance of research in health and social care;
- The Health Board has a Research Development and File Management standard operating procedure which is in date and provides guidance on the documentation that should be retained in the course of research and how it should be maintained;

- The Health board has produced job descriptions that show responsibilities for both Clinical Board and Directorate R&D leads;
- The main monitoring and discussion forum for R&D within the Health Board is the Research Governance Group. This group Meets quarterly, has a dedicated terms of reference, and reports via the Chair to the Medical Director;
- Reporting to the Research Governance Group is the Cardiff and Vale Research Review Service (CaRRS) Panel. This panel also reports to the Cardiff University Research Committee and has defined terms of reference.
- The UHB's Quality and Safety Committee oversees R&D within the Health board with an R&D division research report noted in the December 2016 papers.
- The board received 3 performance reports during 2016/17; one in September 2016, showing the comparison between 2014/15 and 2015/16 performance, another in November 2016 highlighting on-going performance issues during 2016/17 and a larger mid-year performance reports was submitted in the January 2017 committee meeting.
- A Quarterly performance report detailing the summaries of progress against welsh government key indicators and targets is produced.

The following significant findings were noted:

- 60% of the project files sampled had not received feedback from either the R&D clinical lead, R&D directorate lead, or both, prior to the outcome of the CaRRs panel being decided.
- The Women's and Children Clinical Board does not currently have a clinical board R&D Lead.

RISK 2 - R&D does not deliver work aligned to the overall strategic objectives of the UHB:

The following areas of good practice were noted;

- Research and Development is embedded within the IMTP for 2015/16 – 2017/18 and also has its own specific section around expanding research and development.
- The 2017/18 IMTP summary plan, builds on this via sharing and being fully engaged with Welsh Government's research and development ambitions, to bring patient and economic benefit to Wales through increasing R&D activity.
- During 2015 the UHB approved a 3-year R&D plan; this was reviewed, amended and approved by the UHB Executive Board in September 2016. The plan is aligned to the UHB strategic themes.

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- The R&D Office has a standing agenda item to report to the Research Governance Group on its' Risk Register and, in accordance with the UHB Risk Assessment and Risk Register Procedure (UHB 024), risks scoring more than 15 are included in the Corporate Risk Assurance Framework (CRAF).

The following significant findings were noted:

- Declarations of interest were not evident at the Research Governance Group and representation from clinical boards was low.
- The Health Board's performance against R&D targets set by Welsh Government are generally below the required level.

RISK 3 & 4 - Patient harm due to poor management of trials / research & Breach of data protection / confidentiality:

The following areas of good practice were noted;

- A tracker has been established by the R&D departments to ensure all files are dealt with in accordance procedures.
- Generally, all project files followed a logical approach and were adequately documented, notwithstanding the findings identified below.
- All principal investigators were found to be appropriately Good Clinical Practice (GCP) trained.
- The relevant UHB Finance representative reviews all governance review projects and identified costs.
- The R&D checklist was contained within all files.

The following significant finding was noted:

- Data protection roles had not been defined leading to differing approaches in the projects sampled.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**4**	**1**	**6**

Finding 1- Research Review Service (Operating Effectiveness)	Risk
The Cardiff and Vale Research Review Service (CaRRS) carries out a science and governance review of all R&D projects, as appropriate. The terms of reference states that "*Each project requiring governance review will be reviewed by one Lead Reviewer assigned by the R&D Office to provide an assessment of clinical risks, and by the relevant Directorate R&D Lead".* From the 15 project files reviewed there were only 6 instances where both the lead clinical and Directorate reviewer assigned had completed and returned the documentation. There were 4 projects where the lead Clinical review had not been completed and a separate 4 projects where the lead Directorate review was missing. There was also 1 project where both individuals had not returned the documentation. The TOR for the CaRRs committee does not state the minimum requirements for progression through the governance review.	R&D is of poor quality.
Recommendation 1	**Priority level**
Lead officers will be required to provide an assessment of the research projects assigned to them.	High

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Management Response	Responsible Officer/ Deadline
The R&D Office accepts the concerns raised. There are several issues with the system currently in place as follows: 1) Some Directorate R&D Leads have raised that they do not have dedicated protected time in their Job Plan to carry out the responsibilities of this role. 2) Because of the Welsh Government metric of 40 days to approve a project, reviewers are requested to turn around their review within 10 days. Thus there is currently a balance required in ensuring an adequate governance review and compliance with Welsh Government metrics. In the medium term, governance review will no longer be undertaken by C&V UHB as Wales, along with the rest of the UK, is moving towards a centralised governance review model, where this responsibility will be carried out by the Health and Care Research Wales Support Centre for projects led from Wales, by the Health Research Authority for studies led in England, and by equivalent bodies in Scotland and Northern Ireland for studies led by these devolved nations. These changes could be introduced as early as January 2018 but more realistically towards March 2018. However, a short term solution needs to be found immediately. Thus the following actions have been taken: 1) The Medical Director has written to all R&D Leads and Lead Clinical	<u>R&D Director</u> Emails sent by Medical Director to reviewers on 09/10/2017 Third reviewer included from 3/10/2017. No study to be approved without at least one independent governance review (apart from the Chair) initiated on 3/10/17.

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Reviewers, reminding them of their responsibilities and the need to return reviews allocated to them 2) All projects will be sent to an additional reviewer 3) Whilst the 10 day deadline to review will remain, approval will not be given until at least one review is returned. Longer term, where there will still be a requirement for a small number of studies led and Sponsored by C&V UHB to have a ***scientific*** review (rather than a governance review), a revised process will be put in place, based on the current robust UHB 'Sponsor Assessment Process' used for Clinical Trials of Investigational Medicinal Products (see Guideline GR-RG-008). The R&D Director is in discussion with the Medical Director about the role of Directorate R&D Leads moving forward in the medium term. It is felt that an alternative model of paying a Directorate/Clinical Board per review may work better than the current model.	

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Finding 2 - Research Governance Group (Operating effectiveness)	Risk
Audit reviewed the Research Governance Group minutes from 2016/17 and identified the following areas for improvement; 1. There was no declaration of interest section within either the agenda or minutes, throughout 2016/17. 2. Attendance at meetings by Health Board representatives was generally low, with no attendance at any of the 2016/17 meetings from the following Group members; • Research Governance Lead for Mental Health Clinical Board; • Research Governance Lead for Dental Services Clinical Board; • Research Governance Lead for Medicine Clinical Board; • UHB Deputy Director of Nursing; • UHB Assistant Director of Innovation and Improvement.	R&D does not deliver work aligned to the overall strategic objectives of the UHB.
Recommendation 2	**Priority level**
Declarations of interest should be added as a standard agenda item and minuted appropriately. Management will also ensure that there is wider representation from Clinical Board staff.	Medium

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Management Response	Responsible Officer/ Deadline
A Declaration of Interest has been added as a standard agenda item to the Research Governance Group (RGG) meeting agenda and will be minuted appropriately. The Medical Director has written to all members of the Research Governance Group reminding them of their responsibility to attend the quarterly Research Governance Group meetings. Meeting dates are always circulated well in advance and were re-circulated as part of this correspondence. The Clinical Board R&D Leads were instructed to ensure if they were not able to attend, then a Directorate R&D Lead from their Clinical Board should represent them at the meeting. They were reminded that it was not appropriate to send a junior member of staff to represent them.	R&D Manager October RGG meeting has additional agenda item added Medical Director sent emails to all RGG members on 09/10/17 to remind them of the need to attend on a regular basis.

Finding 3 - Data Protection (Operating effectiveness)	Risk
From the 15 projects sampled, the data protection officer had not completed an assessment on 7 occasions. However, on all these occasions, the data protection review had been undertaken by the research department. The R&D department are not experts in data protection but do have significant experience of research projects in order to make a general assessment. It should be noted that when occasions arise that are out of the ordinary the R&D department will query with the data protection officer for clarification.	Breach of Data Protection / confidentiality.

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Recommendation 3	Priority level
Management will ensure data protection checks are undertaken by appropriate individuals. This will be increasingly important as the new general data protection regulations come into force (May 2018).	Medium
Management Response	**Responsible Officer/ Deadline**
A guidance document written by the R&D Office on how the data protection checks will be undertaken, has been approved by the Data Protection Manager (DPM) and is an agenda item for the October Research Governance Group. The data protection checks will be undertaken by R&D Office staff (Band 6 and Band 7 grade) in accordance with the guidance document. Any concerns or issues with studies will always be escalated to the DPM for review. The DPM will check a random selection of 10% of projects on a monthly basis to ensure the data protection checks are being carried out appropriately by R&D Office staff. If the DPM has any concerns, re-training will take place, and the percentage of projects selected on a monthly basis will be increased. In the medium term, as part of the UK wide changes in the R&D permissions process, it is likely that the Data Protection checks will become global checks carried out once on behalf of all research sites by the centralised review function (HCRW Support centre in Wales, HRA in England and equivalent bodies in Scotland and Northern Ireland). It is not clear yet whether there will be any need for any form of local check to remain.	R&D Manager and Data Protection Manager On approval of the Guidance document by RGG, the new process will be put in place with immediate effect (expected timeline November 2017)

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Finding 4 - Welsh Government Targets (Operating effectiveness)	Risk
The Welsh Government has produced national R&D objectives, key indicators and targets. Quarter 4 of the Health Boards (2016/17) performance report, shows that, whilst they are not being fully met, positive progress has been made on the majority of targets (80%) within the *"Permissions/ Study Set-up/ Research Delivery Summary indicators"* when compared to the 2015/16 results. i.e. 1. Percentage of Health and Care Research Wales Clinical Research Portfolio Studies receiving NHS research permission within 40 calendar days have increased from 32% in 2015/16 to 65% in 2016/17. 2. Percentage of Health and Care Research Wales Clinical Research Portfolio Studies recruiting the first patient within 30 calendar days of approval/ site initiation has increased from 37 % to 58%. However, the welsh government also set a target for increasing the number of Health and Care Research Wales Clinical Research Portfolio Studies (CRP) by 10%. The results have shown a 3% decrease in the number of projects during 2016/17.	R&D does not deliver work aligned to the overall strategic objectives of the UHB.
Recommendation 4	**Priority level**
Management will ensure increased compliance to welsh government targets during 2017/18.	Medium

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Management Response	Responsible Officer/ Deadline
The Senior Management Team at C&V UHB has completed and submitted a Narrative Plan for 2017/18 to Health and Care Research Wales Support Centre on 31/5/17 (attached). This outlines the main actions being taken to address Welsh Government performance metrics.	R&D Director These actions will be ongoing through the year and the Forward Plan and Performance Metrics Report from HCRW are standard agenda items at the quarterly RGG meetings.

Finding 5 - Clinical Board Lead (Operating effectiveness)	Risk
Strong research and development leadership at a Clinical Board level is necessary for the UHB to achieve the aims of NHS Wales to make R&D a core activity. Within the Health Board, each Clinical Board should have appointed an R&D lead and there is a developed job description that shows their responsibilities. However, this is not the case for the Children and Women's Clinical Board who has no such representative.	R&D is of poor quality.
Recommendation 5	**Priority level**
Management will ensure that all clinical boards have appropriate leads for R&D.	Medium

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Management Response	Responsible Officer/ Deadline
The Medical Director has written to the Children and Womens Clinical Board Director to remind them of their obligation to appoint a Clinical Board R&D Lead with the expectation that this position will be appointed to by December 2017. The Job Descriptions for both Directorate and Clinical Board R&D Leads have been updated and are an Agenda item at October Research Governance Group.	Clinical Board Director Children and Women / R&D Director. Requested to ensure a Clinical Board R&D Lead is in post by December 2017. Updated Job Descriptions for R&D Lead posts will be approved in October 2017 at RGG, assuming no changes are required.

Finding 6 - Policy (Operating effectiveness)	Risk
Policies and standard operating procedures covering R&D were available on the Health Boards internet, however, the following was noted; • The "Research, Consent and Mental Capacity Standard Operating Procedures" was established to ensure that consent and capacity issues in research are dealt with appropriately, in accordance with the legal and regulatory framework. This procedure was last approved in April 2014 and requires review. • The "Research Audit Procedure" was also outside its review period, having been ratified in April 2014.	R&D is of poor quality.

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Recommendation 6	Priority level
Policies and standard operating procedures surrounding research and development will be updated and approved by an appropriate forum, as appropriate.	Low
Management Response	**Responsible Officer/ Deadline**
The R&D Office maintains its own Document Version Control System currently holding the following documents: 2 Policies, 22 Standard Operating procedures, 7 Guidelines, 21 Information Sheets, 42 Office Workplace instructions & 28 Forms. Policies requiring review/approval are submitted to Research Governance Group and upwards to Quality and Safety Committee. Standard Operating Procedures with an impact wider than the R&D office are also reviewed at RGG, undergo a two week UHB wide consultation before approval. Information sheets with an impact wider than the R&D Office are also sent to RGG for information, and discussion if required. The progress on the two out of date Standard Operating Procedures mentioned in this report is as follows: The "Research, Consent and Mental Capacity Standard Operating Procedure" was reviewed at the last Research Governance Group on 11 July 2017 and was	<u>R&D Manager</u> The Research Audit Standard Operating Procedure, SR-RG-012 will be published once it has been approved by RGG and undergone the standard UHB two week consultation period (November 2017 assuming there are no issues raised by RGG or the UHB community). The 6 month pre-review list of documents will be brought to the next Team Brief on 19/10/2017 and monthly thereafter

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subsequently approved for release on 11 September 2017. The Research Audit Standard Operating Procedure, SR-RG-012, is an agenda item for the next Research Governance Group meeting on 17 October 2017. The current process for ensuring all documents are reviewed in a timely manner is for a list of documents due for review in the following **3 months** to be brought as an agenda item at each fortnightly R&D Office Team Brief where a decision is made on responsibility to review. To ensure that wherever possible all documents get reviewed and sent to RGG/UHB wide consultation prior to their 3 year review timeline, documents due for review in the following **6 months** (rather than the current 3 months) will be brought to Team Brief.	

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Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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CRC Energy Efficiency Scheme

Final Internal Audit Report

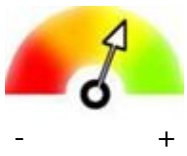
Cardiff & Vale University Health Board

2017/18

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

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Executive sign off	Abigail Harris, Executive Director of Planning
Distribution	➢ Geoff Walsh, Assistant Director of Planning ➢ Jon McGarrigle, Head of Performance & Energy
Committee	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The CRC Energy Efficiency Scheme (CRC) is a UK Government initiative to reduce carbon dioxide (CO2) emissions from large and medium-sized organisations meeting certain qualification criteria.

Participation for these organisations is mandatory. The first phase of the scheme ran from April 2010 to the end March 2014. The second phase (which all NHS Wales Health Boards joined) runs from 1 April 2014 to 31 March 2019.

The UK government announced in 2016 that the CRC energy efficiency scheme will be abolished following the 2018/19 compliance year.

Health Boards are required to submit their annual report for the third year of participation by 31 July 2017.

The CRC guidance states a requirement for participants to be subject to an annual internal audit review to ensure compliance with guidance.

2. Scope and Objectives

The assignment originates from the 2017/18 internal audit plan.

The overall objective of the review was to assess compliance with CRC requirements and guidance.

The scope of the audit review was limited to the following aspects:

- Follow up: Assurance that recommendations made in prior audits had been appropriately addressed;
- A review of the 2016/17 annual report (due for submission by 31st July 2016), to assess:
  - Accuracy of reported figures/totals;
  - Correct treatment of data including actuals/estimates, inclusions/exclusions etc.; and
  - Audit trail to supporting evidence;
- Assessment of the management of the purchase of allowances; and
- Sufficiency of the Evidence Pack.

This review drew on the findings of any relevant audit assignments undertaken within the reporting year to prevent any duplication.

3. Associated Risks

The potential risks considered in the review were as follows:

- Failure to implement previously agreed recommendations;
- CRC guidance was not being followed;
- Reported data was inaccurate, which may incur financial penalties;
- Failure to sufficiently budget for, or achieve value for money from, the purchase of allowances; and
- Evidence pack was not appropriately maintained.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

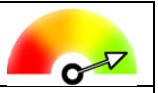
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the CRC Energy Efficiency Scheme is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Follow up				✓
2	Annual Report Data			✓	
3	Purchase of Allowances			✓	
4	Evidence Pack				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted **1** issue that is classified as a weakness in the system control/design for managing the requirements of the CRC Scheme.

Operation of System/Controls

The findings from the review have highlighted **2** issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the CRC Scheme.

6. Summary of Audit Findings

Follow Up

We sought assurance that previously agreed management actions had been implemented. The status of agreed management actions arising from previous reviews is as follows:

Closed	Outstanding	Total
4	0	4

Detail behind this summary is included at **Appendix B**.

Annual Report Data

Data System

The UHB appointed a specialist consultant to advise and assist the UHB with regard to the CRC scheme and the European Emissions Trading Scheme (EU ETS); including assistance in the preparation of the final submissions.

The difficulties experienced in 2015/16, regarding the robustness of consumption information, have eased for data reported in 2016/17. Whilst some difficulties were noted in obtaining complete data from the utilities supplier, it was eventually obtained. Furthermore, the UHB had been able to independently verify the majority of the data provided against its own operational energy database; populated from either automatic meter readings (AMR) or manual meter readings.

Data Accuracy

Supplies in relation to University Hospital Wales (UHW) were appropriately excluded from reported totals, noting that the site was included within the EU ETS and was therefore exempt from CRC reporting.

We sampled 75% of the reported gas consumption figures and 85% of the reported electricity consumption figures, confirming reconciliation to data taken from statements and/or the UHB's energy bureau database.

It was confirmed that the majority of the reported figures sampled were supported by working papers, with all calculations correct. However, some errors/anomalies were noted: a reduction of 4,327,313 kWh [gas consumption] reported and an increase of 20,143 kWh [electricity consumption] reported: a net reduction in cost of £12,648 for the UHB (using the 2016/17 forecast sale allowance price) **(Recommendation 1).** These were discussed with the UHB; and amended prior to submission of the evidence pack Refer to **Appendix C** for details of the amendments.

It was noted for one meter sampled (Lansdowne) there was no supporting supplier information or meter readings; and that 2016/17 was the first year of inclusion on the gas listing [NB: electricity had been included in previous years]. In the absence of meter readings, a reasonable estimate had been determined based on the floor area of the site, compared to similar sized properties; and reflecting the consumption of similar provisions. Management should work with the Estates team to determine the ownership of the gas meter at the Lansdowne site to facilitate accuracy of reporting in future years **(Recommendation 2).**

Furthermore, the reported figure did not incorporate a 10% uplift required for estimated figures **(Appendix C)**, but this was addressed by management at the time of fieldwork.

Estimated Data

The UHB reported 1.43% of total gas and 2.60% of the total electricity consumption as estimated at the 2016/17 CRC report. As estimated supplies incur 10% uplift by way of penalty for failing to hold accurate data, this incurred £420 in additional costs for the UHB (using the 2016/17 forecast sale allowance price).

The decision to report some of these supplies as estimated was made noting some significant decreases in the 2016/17 consumption data compared to the 2015/16 data, as reported by the supplier. Having ruled out any justified reason for the decreases (such as decommissioning / installation of energy saving measures), it was therefore concluded by management that reliance could not be placed on the 2016/17 data, with the 2015/16 data used instead. For other supplies, the decision was made noting fewer days (than expected) reported by the supplier and no independent data recorded by the UHB for the given meter.

100% of both the estimated gas and electricity consumption was assessed, for accuracy of calculations and compliance with CRC guidance, confirming calculations were compliant and correct.

Corporate Responsibility Questions

The UHB answered positively to the four corporate responsibility questions, and had sufficient evidence to support these answers (retained within the evidence pack), in accordance with the CRC guidance.

Report Submission

Calculated totals were correctly uploaded to the CRC Registry, in advance of the deadline of 31 July 2017.

Annual Report Data: Conclusion

Whilst noting the improved robustness of data, discrepancies were still noted between reported figure and supporting documentation. We have raised one recommendation to review the ownership of one gas meter (accounting for 3% of the total consumption reported). Therefore, we have determined **reasonable assurance** in this section.

Purchase of Allowances

Each year the UHB is required to purchase sufficient allowances to cover their CO_2 emissions. Purchase can either be in the forecast sale at the lower rate at the start of the year or retrospectively at year end at a higher rate. Unused allowances can be rolled over into future years.

The UHB purchased 11,000 allowances (including an element purchased via the University Hospital Llandough (UHL) energy management

company) in the forecast sale in April 2017, at a total cost of £182,600, i.e. taking advantage of the lower allowance rate offered through early purchase. This approach yielded a reduction of circa £12k, compared with the cost of having to purchase these allowances in the buy-to-comply sale at year end.

There was a robust forecasting methodology utilised to determine the number of allowances required. The methodology included the utilisation of 13,500 surplus allowances held from purchases in 2016/17 – allowances, over-purchased [at a lower forecast sale price], to offset against future years costs

The UHB takes advantage of the forecast sales to purchase allowances; there is the expectation that approval for purchases is sought. It was noted that approval sought from Executive Management for the purchase of allowances in April 2017 was retrospective; purchases which were part of the management strategy for the concluding years of Phase 2 of the CRC scheme **(Recommendation 3).** Whilst the purchases were not outside of delegated authority, their strategic implication was not appropriately considered.

Noting the retrospective approval sought for allowances in the forecast sale, we determine **reasonable assurance** appropriate for this area.

Evidence Pack

There was a comprehensive electronic evidence pack retained in line with CRC requirements. We therefore determine **substantial assurance** in this area.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	-	2	1	**3**

Finding: Accuracy of reported data	Risk
We sampled 75% of the reported gas consumption figures and 85% of the reported electricity consumption figures, confirming reconciliation to data taken from statements and/or the UHB's energy bureau database. It was confirmed that the majority of the reported figures sampled were supported by working papers, with all calculations correct. However, some errors/anomalies were noted: a reduction of 4,327,313 kWh [gas consumption] reported and an increase of 20,143 kWh [electricity consumption] reported: a net reduction in cost of £12,648 for the UHB (using the 2016/17 forecast sale allowance price). Refer to **Appendix C** for details of the amendments.	Incorrect consumption figures reported; and risk of financial penalties if errors identified at external audits.
Recommendation 1	**Priority level**
Management will amend the evidence pack for the errors / anomalies identified. **(O)**	**Low**
Management Response	**Responsible Officer/ Deadline**
The evidence pack was amended for the errors / anomalies at the date of the audit.	Head of Energy & Performance Date: Already actioned

22.8

Finding: Lansdowne site: ownership of meter	Risk
Review of the total reported gas figure for the Lansdowne site (912,000 kWh) noted that there was no supporting supplier statement or UHB recorded meter readings for this site. Management advised that this is the first year the site has been included on the gas listing, whilst noting that electricity has been recorded in previous years. Recognition for inclusion was only highlighted following issues reported to Estates regarding the boilers at the site. Management were on the understanding that the supply had previously been paid for by the occupant (GP) and no invoice had been received by the UHB. Given the uncertainty, the UHB determined it was prudent to include an appropriate consumption estimate based on the floor area of the site, compared to similar sized properties, and the delivery of similar provisions (noting the absence of meter readings and invoices). Consumption data had also been shared with finance for inclusion of an accrual relating to the site. The estimate figure recorded had not reflected the 10% uplift as per CRC guidance. This was addressed at the time of the audit and a revised figure of 1,003,200 kWh included in the final submission **(refer to recommendation 1)**.	Risk of financial penalties if errors identified at external audits.

Recommendation 2	Priority level
Management will work with the Estates team to determine the ownership of the gas meter at the Lansdowne site to facilitate accuracy of reporting in future years. In the interim, a meter reading will be taken to ensure the database reflects a more accurate consumption reading **(O)**	**Low**
Management Response	**Responsible Officer/ Deadline**
The ownership of the Lansdowne gas meter will be progressed with our current UHB gas supplier (British Gas). Meter readings will be taken to establish a datum point to determine historic and future usage.	Head of Energy & Performance Date: April 2018

22.8

Finding: Purchase of Allowances – Refund due	Risk
The purchase of the units for 2017/18 had taken place during the course of the year under review. Review of the report issued to the Assistant Director of Planning noted that retrospective approval was requested as forecast sale purchases [11,000 allowances at a cost of £182,600] had to be made by 28/04/2017. It was noted that the content of this report set out the strategy for purchasing in light of the forthcoming closure of Phase 2 of the scheme. The detail of this strategy had not been approved prior to the purchases being made. Whilst the purchases were not outside of delegated authority, their strategic implication was not appropriately considered.	The UHB may be left with surplus allowances at the end of Phase 2 with loss of financial investment.
Recommendation 3	**Priority level**
Approval will be sought in advance of all future purchases being made. Should timing available not permit presentation of a full report to the management executive group for approval, email communication will be issued to the relevant officers to facilitate approval in advance of the purchase cut-off date. **(D)**	**Low**
Management Response	**Responsible Officer/ Deadline**
Future carbon credit purchases will only be required for the final year of the scheme. The UHB shall purchase these allowances through the 'buy to comply' process versus the advance purchasing programme and approval will be sought through the appropriate management arrangements.	Head of Energy & Performance Date: April 2018

22.8

Follow up of previously agreed recommendations

Ref	Recommendation made at 2015/16 audit	Priority Rating	Status at 2016/17 audit	Updated Responsibility & Timescale
1	Management will ensure that, for the 2016/17 reporting year, data controls are enhanced through the use of data taken from the new energy database, populated from AMR data and other sources.	Medium	**Closed** The energy database has been populated appropriately from manual readings as well as AMR data to ensure there is supporting information for consumption figures and a verification tool against the supplier statements received from British Gas to facilitate a more appropriate reconciliation process for consumption levels. Internal procedures have been established noting that where energy database and CRC supplier statement figures materially agree, the statement figures are used. Where there are discrepancies, the larger figure is used for prudence.	n/a
2	Where supplier statements do not provide sufficient information to accurately determine whether a supply is actual or estimated (in line with CRC guidance), it would be prudent for such supplies to be reported as estimated.	Low	**Closed** There are significantly less estimates included as reported figures in the 2016/17 return. Reference has been made to both the energy database and the supplier statements. In the majority of cases, the two sources of	n/a

22.8

Ref	Recommendation made at 2015/16 audit	Priority Rating	Status at 2016/17 audit	Updated Responsibility & Timescale
			information reconcile. Where there are differences, which are not material, the supplier statement has been used as the more accurate of reading. In the instances where no information is provided, the UHB has adopted the approach to reflect the prior year reported figure as an estimate and apply the 10% uplift accordingly.	
3	The UHB will develop a strategy for the purchase of allowances over the remainder of the Phase, and to address how the final year will be managed. The strategy will be appropriately approved in advance of any future purchases.	Low	**Closed** Whilst not a formal strategy, the report prepared for approval of purchase of allowances (2017/18) sets out the plans to ensure the UHB does not over commit in the purchase of allowances leaving the UHB unable to use or sell back at the end of the current scheme.	n/a
4	The UHB will ensure it receives the refund due from the UHL energy management company in respect of the 2015/16 CRC pricing error.	Low	**Closed** The Head of Performance & Energy has obtained the invoice from Veolia relating to the centralised boiler house at UHL for 2015/16. It has been confirmed with finance that this invoice has not been paid; therefore a refund is not due.	n/a

Summary of errors / anomalies amended prior to submission of evidence pack

	Site / Meter	Consumption: energy bureau database	Consumption: Supplier Statement	Reported consumption figure	Amended consumption figure	Explanation for amendment
Gas						
1	Whitchurch Road Park [77764201]	9,108,653	4,604,565	9,108,653	4,604,565	Database had been updated in May 2016 for 5.0m consumption. UHB confirmed this consumption related to 2015/16 therefore incorrectly reflected in the reported figure for 2016/17.
2	Lansdowne	912,000	-	912,000	1,003,200	Estimated consumption figure which had not reflected the 10% uplift. Also refer to recommendation 1.
3	Gabalfa Clinic [8926715708]	80,928	85,575	0	85,575	Consumption figure incorrectly classified as below the 73,00kwh threshold and exempt from reporting.
Electricity						
4	Whitchurch Park Road [2199993414923]	2,528	5,872	16,472	5,872	Incorrect consumption figure taken from supplier statement.
5	Whitchurch Park Road [2100040881037]	16,472	18,550	18,550	20,226	Reported figure did not reflect consumption for the whole year.
6	Iorwerth Jones Home [2199989676841]	226,651	206,619	206,619	226,651	Reported figure did not reflect consumption for the whole year.
7	Loudoun Square Medical Centre [2100041036647]	112,661	102,596	102,596	111,901	Reported figure did not reflect consumption for the whole year.

22.8

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment

22.9

Clinical Diagnostics and Therapeutics (CD&T) Neuroradiology Additional Payments Follow-Up

FINAL INTERNAL AUDIT REPORT 2017 /2018

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Committee :	Audit Committee

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Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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22.9

1. EXECUTIVE SUMMARY

The follow-up review of Neuroradiology Additional Payments within the Clinical Diagnostic & Therapeutics (CD&T) Clinical Board has been completed in line with the Internal Audit Plan.

The original CD&T Additional Neuroradiology Sessions Internal Audit objective was to review the claims submitted for payment following the increased costs associated with these sessions as requested by the Clinical Board. The review was finalised in October 2016 and highlighted a total of five findings.

The risk considered in the previous review was as follows:

- Unnecessary/ inappropriate expenditure.

The purpose of the follow-up review was to provide assurance whether progress/ full implementation has been made relating to the following agreed actions:

- Issues previously identified have been raised and investigated by the Counter Fraud Department;
- Erroneous claims have been fully quantified by the Clinical Board;
- Consultants have been reminded of their contractual responsibilities and provided with guidance and procedures on what work is claimable as an additional payment;
- Control processes have been enforced to ensure claim forms are verified prior to authorisation for payment by the Clinical Director;
- A log of claims is maintained and cross-referenced to new claims to avoid duplication;
- Claims are being reviewed to ensure there is no overlap with job plans; and
- The above processes are checked prior to authorisation by the Clinical Board Director.

2. CONCLUSION AND FINDINGS

In summary, progress against the seven actions that required implementation was as follows:

No of Management Actions to be implemented	Fully Actioned	Partially Actioned	Not Actioned/ Alternative Action
7	5	1	1

22.9

The follow up review concluded that based upon discussions with relevant management and review of the evidence provided good progress has been made and controls have significantly improved.

The management actions completed to date can be summarised as follows:

- Issues previously identified have been raised with the Counter Fraud Department and there is an on-going investigation (Fully Actioned);
- Consultants have been reminded verbally of their contractual responsibilities and what work is claimable as an additional payment. A draft policy on Waiting Lists Initiatives (WLI) has been written encompassing this but it has not been formally circulated yet (Partially Actioned);
- All claims submitted by the Neuroradiology Consultants are now checked by the Clinical Director (CD) prior to authorisation and recorded on an approved spreadsheet. Testing confirmed the reports tested were accurate as per RADIS (the radiology patient record system) and signed & dated by the CD (Fully Actioned);
- The Director of Operations for CD&T keeps a summary of all claims that are submitted for approval, new claims are manually cross-referenced to this when they are submitted to avoid duplication of payments (Fully Actioned);
- Claims are being reviewed to ensure there is no overlap with job plans, testing confirmed the sampled additional payments made related to un-contracted time (Fully Actioned); and
- After approval from the Clinical Director, claims are submitted to the Clinical Board for authorisation prior to payment. These are reviewed by the Director of Operations (DofO) as opposed to the Clinical Board Director due to the volume of claims. Testing confirmed that all the sampled claims were signed and dated by the DofO (Fully Actioned).

Due to the on-going investigation by Counter Fraud, no separate review has been undertaken by the Clinical Board to quantify the loss to the Health board as a result of the erroneous claims.

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