Bundle Audit Committee Part 1 11 February 2019

0 AGENDA
Agenda Part 1 Audit Committee 11 February 2019.docx
1 PART 1 PRELIMINARY MATTERS
1.1 Apologies for Absence
1.2 Welcome & Introductions
1.3 Declarations of Interest
1.4 Unconfirmed Mintes of the meeting held on 14 January 2018
1.4 Unconfirmed Minutes of the PART 1 meeting held on 14 January 2019.docx
1.5 Action Log
1.5 Audit Committee Action Log 11 February 2019.docx
1.6 Matters Arising not contained within the Action Log
2 PART 2 INTERNAL CONTROL AND RISK MANAGEMENT
2.1 Audit Recommendations Tracker
2.1 Audit Recommendations Tracker CT AC 11 Feb 2019 Final.docx
3 INTERNAL AUDIT
3.1 Internal Audit Progress Report
3.1 Internal Audit Progress Report.pdf
3.2 Internal Audit Report - Common Issues identified with Directorate Reviews
3.2 Internal Audit Report Common issues identified within Directorate Reviews.pdf
3.3 Internal Audit Report - Medical Equipment & Devises - Limited Assurance
3.3 Medical Equipment & Devices.pdf
3.4 (CLOSED) Internal Audit Report - Management of Major Capital - PCH - Limited Assurance
3.4 (CLOSED) Management of Major Capital PCH.pdf
3.4.1 (CLOSED) Appendix 1 Management of Major Capital PCH
3.4.1 Appendix CTUHB_Client Questionnaire_PCH_1819 IA plan.docx
3.4.2 (CLOSED) PCH GFF Cover Report
3.4.2 (CLOSED) PCH GFF IA Cover Report.docx
3.4.3 (CLOSED) PCH GFF Annex A
3.4.3 CLOSED Annex A - v1.0 FINAL PCH PAR (003).docx
3.4.4 (CLOSED) PCH GFF Annex B
3.4.4 Annex B - v1.0 FINAL PCH AAP.docx
3.4.5 (CLOSED) PCH GFF Annex C
3.4.5 Annex C - Progress against PAR Gateway recommendations v5.docx
3.5 Internal Audit Report - IT Systems
3.5 IT Systems.pdf
3.6 Internal Audit Report - Directorate Reviews – Primary Care Management Arrangements
3.6 Primary Care Management Arrangements Final report.pdf
3.7 Internal Audit Report - Mandatory Training
3.7 Mandatory Training Final Internal Audit Report.pdf
3.8 Internal Audit Report - management of Absence Target
3.8 Absence Management Final Internal Audit Report.pdf
3.9 Internal Audit Report - Private & Overseas Management - Follow Up
3.9 Follow Up Private and Overseas Patients Final report.pdf
4 PART 4 EXTERNAL AUDIT
4.1 Wales Audit Office Update Report
4.1 WAO Progress Update Report.pdf
4.2 Wales Audit Office Report - All Wales Review on Follow Up Outpatients Not Booked

4.2 WAO Report Follow Up Outpatients Not Booked AC 11 February 2019.pdf

4.2.1 Appendix 1 WAO response to WG

4.2.1 WAO Response to WG FUNB AC 11 February 2019.pdf

4.3 Wales Audit Office Report - All Wales Review on Radiology Services

4.3 WAO Report Radiology Services AC 11 February 2019.pdf

4.3.1 Appendix 1 WG Response Letter

4.3.1 WG Response Radiology Service AC 11 February 2019.pdf

4.4 Wales Audit Office - Recent Publication Agency Staff in Wales

4.4 WAO Report Agency Staff in Wales AC 11 February 2019.pdf

5 ITEMS FOR INFORMATION

5.1 Committee Forward Work Plan 2018/19

6.1 Forward work plan AC 11 February 2019.doc

6 PART 6 ANY OTHER URGENT BUSINESS

6.1 Items for Referral to other Committees

6.2 Close of Part 1 of the meeting - Date and time of next meeting

CWM TAF UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING

11 February 2019

A meeting of the Audit Committee will be held on Monday 11 February 2019, at Ynysmeurig House, Navigation Park, Abercynon commencing at 9.00am.

This meeting will include a private meeting with the Auditors between 8.30 – 9.00am

MR PAUL GRIFFITHS
CHAIRMAN

PART ONE – CWM TAF UHB

AGENDA

		LEAD / ATTACHED
PART 1. PRELIMINARY MATTERS		
1.1	Apologies for Absence	Chair/Oral
1.2	Welcome and Introductions	Chair/Oral
1.3	Declarations of Interest	Chair/Oral
1.4	Unconfirmed Minutes of the Audit Committee meeting held on 14 January 2019	Chair **Attachment**
1.5	Action Log	Chair **Attachment**
1.6	Matters arising not contained within the Action Log	Chair/Oral
PART 2. INTERNAL CONTROL AND RISK MANAGEMENT		
2.1	Audit Recommendations Tracker	Interim Board Secretary **Attachment**
PART 3. INTERNAL AUDIT		
3.1	Internal Audit Progress Report	**Attachment**

3.2	Internal Audit Report – Common issues identified within Directorate Reviews	**Attachment**
3.3	Medical Equipment & Devices – Limited Assurance	**Attachment**
3.4	Management of Major Capital – PCH – Limited Assurance (CLOSED ITEM)	**Attachments**
3.5	IT Systems	**Attachment**
3.6	Directorate Reviews – Primary Care Management Arrangements	**Attachment**
3.7	Mandatory Training	**Attachment**
3.8	Management of Absence Target	**Attachment**
3.9	Private & Overseas Management – Follow Up	**Attachment**

PART 4. EXTERNAL AUDIT

4.1	Wales Audit Office update Report	Wales Audit Office **Attachment**
4.2	Wales Audit Office Report – All Wales Review on Follow Up Outpatients Not Booked https://www.youtube.com/watch?v=41FySJfbM3w&feature=youtu.be	Wales Audit Office **You Tube Link**
4.3	Wales Audit Office Report – All Wales Review on Radiology Services	Wales Audit Office **Attachment**
4.4	Wales Audit Office – Recent Publication Agency Staff in Wales http://audit.wales/publication/expenditure-agency-staff-nhs-wales	Wales Audit Office **You Tube Link**

PART 5. ITEMS FOR INFORMATION

5.1	Committee Forward Work Plan 2018/19	Chair **Attachment**

PART 6. ANY OTHER URGENT BUSINESS

6.1	Items for referral to other Committees	Oral/Chair
6.2	Close of **Part 1** of the meeting – Date and time of next meeting. • 09.00am Monday 1 April 2019	Oral/Chair

In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960 it has been resolved that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

CWM TAF UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 14 JANUARY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

Paul Griffiths	-	Independent Member (Chair)
Maria K Thomas	-	Independent Member
Jayne Sadgrove	-	Independent Member
Dilys Jouvenat	-	Independent Member

IN ATTENDANCE

David Jones	-	Local Counter Fraud Specialist
Huw Evans	-	Head of Corporate Finance
Dave Thomas	-	Wales Audit Office
Sara Utley	-	Wales Audit Office
Steve Webster	-	Director of Finance
Gwenan Roberts	-	Interim Board Secretary
Paul Dalton	-	NHS Wales Shared Services Partnership (NWSSP) – Head of Internal Audit & Assurance
Emma Samways	-	NWSSP – Internal Audit & Assurance
Emma Walters	-	Committee Secretariat
Hywel Daniel	-	Assistant Director of Workforce & OD (In part)
Scott Lavender	-	NWSSP, Post Payment Verification Location Manager (in part)
Sarah Jeremiah	-	NWSSP, Post Payment Verification (In part)
Kelechi Nnoaham	-	Director of Public Health (in part)
Angela Hopkins	-	'Interim' Director of Nursing (in part)
Alan Lawrie	-	Director of Primary, Community & Mental Health Services (in part)
Sarah Bradley	-	Primary Care & Localities Manager (in part)
John Palmer	-	Chief Operating Officer (in part)

AC/19/001 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair, **welcomed** everyone to the meeting.

AC/19/002 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Gareth Lucey, Robert Williams and Joanna Davies.

AC/19/003 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interests, to those previously notified.

AC/19/004 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 8 OCTOBER 2018.**

The minutes of the meeting held on 8 October 2018, were **CONFIRMED** as a true and accurate record.

AC/19/005 **AUDIT COMMITTEE ACTION LOG**

The Committee Action Log from the meeting held on 8 October 2018 was reviewed by Members and the following was **NOTED**:

17/130 – Hywel Daniel advised that there were two documents used within the organisation which provided guidance to staff in relation to Time off in Lieu (TOIL), one of which was the organisational Roster Policy and the other the Overtime Policy which would be presented to the next Quality, Safety & Risk Committee for approval. Members **NOTED** that there would be a need to ensure that guidance was fully accessible shared with managers in order that all staff were clear related to the requirements across the health board. **(Added to Action Log)**

18/026 – Members **NOTED** that the Medical Variable Pay Financial Control Procedure would be presented to the February meeting. (**Added to Forward Work Plan)**

18/077 – Steve Webster advised that he would circulate an update to Members on progress made to address the significant variations within dental services **(Added to the action log)**.

18/097 – Huw Evans confirmed that this action related to capital assets and advised that a general email had been circulated following the last meeting asking Directorates to ensure their capital asset registers were up to date and that this action was now complete. (**Remove from Action Log).**

18/099 – Maria Thomas questioned when the Committee would receive an update in relation to JAG accreditation. Paul Dalton confirmed that Internal Audit had undertaken a follow up review

following the initial review undertaken in 2017/18. Gwenan Roberts **AGREED** to confirm the latest position at the next meeting. (**Update Action Log)**

18/100 – Huw Evans confirmed that he had spoken to Angela Hopkins and that this action was now complete. Members **NOTED** that a report was being presented to the February meeting of the Finance, Performance & Workforce Committee in relation to the increase in claims expenditure. (**Update Action Log).**

18/102 – Paul Griffiths advised that it had been agreed to discuss a more detailed review of plans and priorities at the October 2019 meeting following the Bridgend transition **(Added to the Forward Look)**.

18/103 – Paul Griffiths advised that he felt that this action had not been completed and that the action log should be amended; Paul Dalton advised that there was still a delay being experienced in relation to submission of management responses and timescales were slipping, the reasons for which were varied. Members **NOTED** that management responses tended to be more detailed against limited assurance reports. Gwenan Roberts confirmed that this issue had been discussed at length with the Executive Team and that an escalation process had been put in place. (**Update Action Log).**

AC/19/006 **MATTERS ARISING**

AC/18/099 – Page 5 – Maria Thomas advised that JAG Accreditation had been discussed at Quality, Safety & Risk Committee and the closure report would be critical to enable the discussion to be closed.

Paul Griffiths advised Members that the Corporate Team were working towards a quicker turnaround of the minutes and action log which should enable officers early sight of the actions to be taken forward.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/007 **POST PAYMENT VERIFICATION PROGRESS REPORT**

Scott Lavender and Sarah Jeremiah were in attendance for this item.

Scott Lavender presented the update report which was provided every six months to the Committee.

Members **NOTED** that a number of initiatives had been put into place since the last update report was presented to the Committee, which included the development of revised ophthalmic protocols which had now been published and a revised medical protocol which had been

submitted to the British Medical Association (BMA) for further consideration.

Members **NOTED** that a training event would be taking place in April where a discussion would be held as to what the patient record should be. Members **NOTED** that training had previously been undertaken with Practice Managers within the Cwm Taf area and that there were plans to undertake refresher training as a result of the Bridgend boundary change.

Members **NOTED** that the Team wished to undertake further work with community pharmacies as a high percentage of administration errors had been identified. Members **NOTED** that a working group had been established to review the new specifications.

Maria Thomas advised that she found the report very interesting to read and advised that it would be helpful if some benchmarking could be included in future iterations of the report. Scott Lavender confirmed that this could be considered by the Team moving forward.

Maria Thomas questioned whether the team were identifying any areas of concern in relation to quality & safety issues for contracted professionals. Members **NOTED** that there were no immediate issues identified at present and that if any issues were identified these would be referred into the Primary Care and Counter Fraud teams. Maria Thomas requested that the report was shared with the Primary & Community Care Committee for further discussion **(Referral made to Primary and Community Care Committee)**.

A discussion was held in relation to the significant variation in administration error rates, with some areas at 40%. Steve Webster asked whether a yearly comparison update could be presented to a future meeting so that a discussion could be held on whether any trends had been identified. Members **NOTED** that an annual update would be presented to the April meeting of the Audit Committee, which would include an update on the plan for next year **(Added to the Forward Look)**.

Members **NOTED** that Internal Audit at NHSWSSP were well prepared in relation to the Bridgend boundary change and regular meetings were being held to ensure processes were in place.

Members **RESOLVED** to **NOTE** the report.

AC/19/008 **SCHEME OF DELEGATION REPORT**

Huw Evans presented the report which provided an update in relation to the transactions approved as "exceptions" within the Scheme of Delegation for the period 1.9.18 to 30.11.18.
An update was provided on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NHSWSSP).

Members **NOTED** that there had been no engagements or contracts entered during the period and it had been identified that some small payments had been made to 3 individuals that had been identified through the Creditors system (as opposed to payroll) during this period. Members **NOTED** that consideration was being given to what future engagement was being planned for the individuals, two of which had been previously been considered within the requirements of IR35. One of these had since been assessed and was found to be out of the scope for IR35.

Members **NOTED** that there were no single tender actions to consider and no contracts requiring ministerial approval. Huw Evans advised that Purchase to Pay continued to meet its 95% target of paying non-NHS invoices within 30 days.

Members **RESOLVED** to:

- **NOTE** the position on procurement matters for the period 1.9.18 to 30.11.18
- **NOTE** the update regarding Purchase to Pay.

AC/19/009 **LOSSES AND SPECIAL PAYMENTS**

Huw Evans presented the report which provided Members with an update on the losses and special payments made to the UHB for the period 1 September 2018 to 30 November 2018, as required in the Standing Financial Instructions. Members **NOTED** that the net claim expenditure to date for the financial year 2018/19 was £1,318k, which equated to a monthly expenditure of £164k. Members **NOTED** that this was higher than the previous financial year's monthly expenditure of £133k.

Members **NOTED** that the annual budget for net claim expenditure for 2018/19 was £1.334m (year to date £889k). Members **NOTED** that there was therefore a month 8 overspend on claims of £429k which had been included within the Health Board's position, which meant that the full year budget had been expended within the first 8 months.

Members **NOTED** that in relation to the case relating to a Permanent Injury Benefit claim, the case was in the process of being challenged

and the Welsh Government had agreed to under write anything over £1m, which the UHB had already made provision for.

Members **RESOLVED** to:

- **NOTE** the losses and special payments made for the period 1 September 2018 to 30 November 2018.

AC/19/010 **STANDARDS OF BEHAVIOUR POLICY**

Gwenan Roberts presented the report which provided the Committee with the reviewed and updated Standards of Behaviour Policy for approval.

Members **NOTED** that the policy had been updated to reflect the need to make staff aware that the information contained within their declarations, sponsorship and gifts would be made public.

Members **NOTED** that the Cwm Taf UHB Intranet site was being used to electronically record declarations, this would take place in March and that steps were being taken to move towards an electronic reminder system for all senior clinical staff and those at band 8 or above, or those with business interests.

Members **RESOLVED** to:

- **APPROVE** the updated policy and supporting appendices in relation to the Health Board's Standards of Behaviour Policy.

PART 3. CHARITABLE FUNDS

AC/19/011 **CHARITABLE FUNDS**

Huw Evans presented the report which provided Members with an update of the activity and balances on charitable funds for the period 1 September 2018 to 30 November 2018 and provided a progress update on other matters of interest.

Members **NOTED** that the balance as at the end of November was £1.842m which was a reduction of £9k since the last report and that the number of funds had reduced by 4 since year-end following closure of some funds.

Members **NOTED** that in relation to investments, the market value as at 30 November was £1.810m compared to the £1.5m invested. Members **NOTED** that there had been a deterioration in the market since November and the forecast income for 2018/19 was currently £62k.

In relation to the Bridgend boundary change, Members **NOTED** that work was in progress to identify the funds to transfer and that this work could not be completed until the name of the new organisation had been confirmed.
Members **RESOLVED** to:

- **NOTE** the report;
- **REQUEST** that a discussion was held at the October Charitable Funds Committee in relation to the Charitable Funds plan and priorities for investment.

PART 4. INTERNAL AUDIT

AC/19/022 **INTERNAL AUDIT PROGRESS REPORT**

Paul Dalton, Head of Internal Audit & Assurance, presented the Internal Audit & Assurance progress report. Since the October meeting, Members **NOTED** that the following 5 reports had been finalised.

Retention of Staff	**Limited**
Directorate Review – Facilities Management Arrangements	**Part Limited/ Part Reasonable**
Raising Concerns	**Limited**
Well-being of Future Generations Act (2015)	**Reasonable**
Continuing Healthcare	**Reasonable**

Members **NOTED** that management responses had now been received for the reviews undertaken into Medical Equipment and Devices and Major Capital and that both reports would be presented to the February meeting.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/023 **INTERNAL AUDIT & ASSURANCE AUDIT REPORTS**

Retention of Staff – Limited Assurance
Emma Samways presented the report which had been given a limited assurance rating, with 3 high and 3 medium priority recommendations made. Members **NOTED** that the recommendations mainly related to the Retention Strategy and that the action plan was still in draft at the time of the audit, with no clear alignment or flow between both documents. Members **NOTED** that the exit interviews process could not be evidenced. Emma Samways advised that the review identified that a lot of proactive work had been undertaken including the use of pulse surveys.

Hywel Daniel advised that work was being undertaken to align the retention strategy and action plan and that work was also being undertaken to strengthen the exit interview process.
Members **NOTED** that exit interviews were now being undertaken within nursing and medical staff which would provide improved data as to the reasons why staff were leaving; work was being undertaken to triangulate the pulse surveys, staff surveys and wellbeing surveys.

Paul Griffiths questioned whether the team were confident in meeting the deadlines set within the report, with most actions due for completion in January. Hywel Daniel advised that the report was first issued to the Team in October and that a significant amount of work had been undertaken since the report had been issued. Members **NOTED** that a number of issues highlighted in the report were regularly being discussed at clinical business meetings.

A discussion was held in relation to retention and whether the retention issue was just within nursing or other areas also. Hywel Daniel advised that this review focussed on nurse retention and that a review was also being undertaken of the high turnover of healthcare scientists and medical workforces.

Members **NOTED** that as the report had been given a limited assurance rating, a follow up review would be undertaken by internal Audit in quarter 1 of 2019/20. Members **AGREED** to monitor progress via the Audit Tracker and **AGREED** to refer the report to the Finance, Performance & Workforce Committee for information **(Referral made to the Finance, Performance and Workforce Committee)**.

Members **RESOLVED** to:

- **NOTE** the report;
- **REFER** report to the Finance, Performance & Workforce Committee for information.

Raising Concerns – Limited Assurance

Emma Samways presented the report which focussed on the policies and procedures in place for raising concerns also known as whistleblowing. Members **NOTED** that the report had been given a limited assurance rating with 3 high and 4 medium priority recommendations made. Members **NOTED** that the high priority findings related to lack of training. There were also concerns in relation to raising awareness of the policy to existing staff, particularly those without IT access. The review identified issues in relation to how the health board was maintaining a central log when informal concerns were being raised and there were contact details within the policy which were out of date.

Hywel Daniel advised that the Team fully accepted the findings within the report and that work was being undertaken to improve systems and processes. Members **NOTED** that a telephone line was now live where staff could contact to raise any whistleblowing concerns, policies and procedures had now been updated and a tracker had now been put into place to capture the formal concerns.

Members **NOTED** that further consideration would need to be given as to how informal concerns raised could be captured. A discussion was held as to whether consideration could be given to introducing a nominated person who would receive protected disclosures. Following discussion, it was **AGREED** that this matter was referred to the Executive Team for further consideration.

Members **RESOLVED** to:

- **NOTE** the report;
- **REQUEST** that the Executive Team consider the suggestion to introduce a nominated person for capturing concerns raised by staff.

Wellbeing of Future Generations Act (Wales) 2015 – Reasonable Assurance

Kelechi Nnoaham was in attendance for this item.

Paul Dalton presented the report which had been given a reasonable assurance rating, with 2 high, 1 medium and 1 low priority recommendations made. Members **NOTED** that a lot of good practice had been identified during the review, with objectives being integrated into the IMTP. The review did identify that there was further work to be undertaken in relation to ownership of the Act.

Kelechi Nnoaham advised that he accepted the content of the report and that additional work would be undertaken to strengthen processes over the next few months. A discussion was held as to when the Health Board would be required to report formally to Welsh Government on the targets contained within the Act. Members **NOTED** that there were no specific targets for the UHB to report against and that the UHB was required to publish an annual report.

Members **NOTED** that the Act would be monitored moving forward by the Wales Audit Office and would feature in next year's Audit plan where overall reporting lines would be reviewed. Kelechi Nnoaham advised that it would be a challenge to complete all actions by the

target dates set within the report and added that a discussion would need to be held with the Executive Team in relation to resourcing.

Members **RESOLVED** to:

- **NOTE** the report.

Continuing Healthcare (CHC) – Reasonable Assurance

Angela Hopkins was in attendance for this item.

Paul Dalton presented the report which had been given a reasonable assurance rating, with 1 high and 4 medium priority recommendations made. Members **NOTED** that the high priority finding related to the appropriate authorisation of funding decisions, and that sample testing identified that some CHC forms had not been appropriately authorised in line with the Scheme of Delegation. Members **NOTED** that this issue had now been addressed by the Team, with all forms now being presented to the Director of Finance for sign off.

Members **NOTED** that an action plan was now in place which was being monitored on a monthly basis, with good progress being made against a number of actions.

Members **RESOLVED** to:

- **NOTE** the report.

Facilities Directorate Review Management Arrangements – Reasonable Assurance

John Palmer was in attendance for this item.

Emma Samways presented the report which had been given a part limited and part reasonable assurance rating. Members were reminded that the report had been presented in draft to the October meeting and this final version now included a more streamlined and refined management response.

Members **NOTED** that the review had been split into 3 areas of focus, with a limited assurance rating being given to the workforce element of the review. Members **NOTED** that the Directorate were in the process of addressing the issues identified, with work being undertaken to ensure the workforce redesign work was being implemented.

Paul Griffiths advised that he was pleased that the Committee had received the report and was surprised to see the issues that had been flagged were basic and straightforward and had not been addressed

previously by management. Paul Griffiths also stated that the implementation dates identified were ambitious and questioned whether the Team were confident that these would be met.
John Palmer provided assurance that the team were now addressing the issues and that regular discussions were being held at clinical business meetings in relation to the controls in place.

Members **RESOLVED** to:

- **NOTE** the report.

PART 5. EXTERNAL AUDIT

AC/19/024 **WALES AUDIT OFFICE UPDATE REPORT**

Dave Thomas presented the report and advised that a number of All Wales Audit reports would be presented to the February meeting. Members **NOTED** that the review into Orthopaedics would take longer than initially anticipated.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/025 **WALES AUDIT OFFICE REPORT – STRUCTURED ASSESSMENT 2018**

Sara Utley presented the report which followed on from similar themes identified in previous year's reports. Members **NOTED** that the review identified that the UHB continued to have significant workforce challenges and quality governance issues. The report identified that the UHB's financial position was robust and that positive work had been undertaken in relation to prudent healthcare.

Members **NOTED** that a number of recommendations had been made in relation to quality governance, concerns had been raised in relation to timely reviews being undertaken of directorate risk management registers and the need to triangulate audit trackers. Members **NOTED** that 9 recommendations had been made in total and that the WAO were working with the UHB in relation to the management response, which would be presented to the February Audit Committee.

Paul Griffiths questioned what response rate was received from the Board survey that had been undertaken. Dave Thomas advised that in comparison with other Health Board's, the response rate from the UHB had been positive. A discussion was also held in relation to the reference made to a performance report on one particular date. Dave Thomas advised that he felt it was justified that the performance report had been reviewed at one point in time and the most recent data available would always be reviewed during the audit.

Paul Griffiths advised that in reading the report, he felt that there were more than 9 recommendations made. Dave Thomas agreed that there were more than 9, with most recommendations being grouped together. Dave Thomas added that he felt that the recommendations highlighted were the areas where it was felt the UHB needed to make most progress against. Paul Griffiths advised that the Committee would need to be assured that all of the issues identified were being addressed.

Members **NOTED** that some of the recommendations made were already being considered and that the work being undertaken would need to align with the enhanced monitoring that was now being undertaken by Welsh Government.

Dave Thomas agreed to consider the views expressed by Paul Griffiths in relation to the content of the management response and of the need to see a review of the full breadth of recommendations made. Members **NOTED** that a discussion would be held with the Executive Team in relation to the content of the response.

Members **RESOLVED** to **NOTE** the report.

AC/19/026 **WALES AUDIT OFFICE REPORT – PRIMARY CARE SERVICES**
Alan Lawrie and Sarah Bradley were in attendance for this item.

Sara Utley presented the report which reviewed the sustainability of Primary Care and focussed on 5 key areas. Members **NOTED** that the review concluded that the UHB had a robust plan in place for Primary Care and was making reasonable progress, with further scope to continue to raise the profile of primary care services and move resources. Members **NOTED** that a management response had been provided by the Team.

Alan Lawrie welcomed the report and advised that it presented a good overview of the service. Members **NOTED** that the report identified that good governance processes were in place, with a need to further emphasise the role of the Primary & Community Care Committee.

A discussion was held in relation to investment into Primary Care Services, with the accounts suggesting an overall real term decrease of investment. Dave Thomas advised that it had been difficult to track the funding when the review was undertaken. Steve Webster advised that primary care investments were very transparent with the only element that could not be reported on being Primary Care

prescribing. Members **NOTED** that all primary care funding was proactively scrutinised at the Primary & Community Care Committee.

Members **RESOLVED** to **NOTE** the report.

AC/19/027 **WALES AUDIT OFFICE ANNUAL REPORT**

Dave Thomas presented the report which provided an update on the work undertaken during the last 12 months and summarised the remaining ongoing work.

Members **RESOLVED** to **NOTE** the report.

Dave Thomas left the meeting at 12.03pm.

AC/19/028 **COMMITTEE FORWARD WORK PLAN 2018-19**

Members **RECEIVED** and **NOTED** the Forward Work Plan. Members **NOTED** that the Audit Tracker update report would be presented to the February meeting.

AC/19/029 **ITEMS FOR REFERRAL TO OTHER COMMITTEES**

Members referred the Internal Audit Report on Retention of Staff to the Finance, Performance & Workforce Committee.

AC/19/030 **CLOSE OF PART 1 OF THE MEETING – DATE AND TIME OF NEXT MEETING:**

In closing part 1 of the meeting, Members **RESOLVED** that in accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960, that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

The next meeting of the Committee would be held at 09:00hrs on Monday 11 February 2019.

…….

Paul Griffiths, Chair

Date ……

AUDIT COMMITTEE ACTION LOG
FOLLOWING MEETING ON 14 JANUARY 2019

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT February 2019
17/130	11/09/ 2017	Directorate Review (Pathology)	Members agreed that the issue of Time Off In Lieu (TOIL) which had featured within a number of Directorate Governance Reviews, be raised with the Director of Workforce & OD as there was a concern that if allowed, there did not appear to be a consistent UHB wide approach. Mr M Thomas suggested that a discussion needs to take place with Internal Audit in relation to the balance of the Audit Plan with regards directorate reviews with only 2 or 3 undertaken each year.	October 2017	Board Secretary / Director of Workforce & OD Director of Finance	**Completed** The Assistant Director provided an update at the January 2019 meeting and advised that there were policies and procedures in place which provided guidance to staff in relation to TOIL. Progress to continue to be monitored via the Audit Tracker process with an invite extended to the Director of Workforce & OD if actions remained outstanding.
18/026	16/4/ 2018	Procurements & Scheme of Delegation	Finance version of the Medical Variable Pay Financial Control Procedure (FCP) to be presented to the May Audit Committee once finalised.	May 2018	Director of Finance/ Director of Workforce & OD	**Due April 2019** (was February 2019) FCP drafted and in the process of being reviewed by the Assistant Director of Finance & Director of Workforce & OD. Will be presented to Audit Committee 1 April 2019.

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT February 2019
18/028	16/4/ 2018	Audit Recommendations Tracker	Amend Audit tracker template to include specific dates for Director updates and to stipulate that if no progress made within a 3 month period the Director should attend an Audit Committee meeting to explain why limited progress made	May 2018	Board Secretary/ Director of Governance & Corporate Services	**On agenda** Executive Directors are invited to attend the Committee within 3 months for high risk actions and 6 months for medium and low risk actions.
18/028	16/4/ 2018	Audit Recommendations Tracker	Application of workforce policies in relation to • time off in lieu (TOIL) – • pre-employment screening. Director of Workforce and Development Services to provide update at future meetings.	May 2018	**Director of Workforce & Development Services**	**Completed** On Forward Look
18/077	09/07/ 2018	Draft Annual Accounts 2017/18	Assistant Director of Finance to discuss with the Director of Finance the significant variations year on year concerning dental services. Director of Finance to provide an update at the October meeting.	October 2018	**Director of Finance**	**Verbal update at Meeting** Steve Webster to request that Mark Thomas provide an update by email to Members on progress made to address the significant variations.
18/081	09/07/ 2018	Standards of Behaviour Report	Board Secretary to undertake a review of the Declarations of Interests received to ensure all submissions had been captured.	October 2018	Board Secretary	**Due April 2019**
18/081	09/07/ 2018	Standards of Behaviour Report	Board Secretary to undertake a benchmarking exercise against other Health Board's in relation	October 2018	Board Secretary	**Completed**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT February 2019
			to Gifts & Hospitality submissions.			Report considered by the Audit Committee 14 January 2019.
18/084	09/07/ 2018	Charitable Funds	Discussion to be held at the Annual Meeting of Trustees scheduled to take place in October, in relation to distribution of the capital to individual funds should the market value exceed 20% of cost	October 2018	Director of Finance	**Completed**
18/097	8/10/ 2018	Matters Arising – Internal Audit Directorate Review into Anaesthetics, Critical Care & Theatres	Mr S Webster to write to Directorates asking for an update on whether their asset registers were up to date.	January 2019	Director of Finance	**Completed**
18/099	8/10/ 2018	JAG Accreditation	Closure report to be presented to a future meeting.	January 2019	Deputy Chief Operating Officer	**In progress** Gwenan Roberts to confirm when a closure report would be available for the Audit Committee to review. Internal Audit had undertook a follow up review following the initial review undertaken in 2017/18.
18/100	8/10/ 2018	Losses & Special Payments	To discuss with Angela Hopkins of the need to • remind staff of the correct procedures to follow when	January 2019	Director of Finance	**Completed** Report being presented to the February 2019 meeting of the Finance,

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT February 2019
			handling cash brought into hospital by patients and what actions had been taken to learn lessons from this. • Review the increasing claims			Performance & Workforce Committee in relation to the increase in claims expenditure.
18/102	8/10/ 2018	Charitable Funds	A review of the Charitable Funds plan and priorities to be undertaken at the October Charitable Funds Committee meeting.	October 2018	Director of Finance	**In progress** Discussion held at the October 2019 meeting
18/103	8/10/ 2018	Internal Audit Progress Report	Discussion to be held with the Executive Team regarding concerns raised by Committee members on the delays being experienced in submitting management responses for Internal Audit reviews.	January 2019	Interim Board Secretary/ Deputy Director of Finance	**In progress** Delays still being experienced in relation to submission of management responses. Noted that a discussion had been held with Executives and an escalation process had been put into place.
19/007	14/1/ 2019	Post Payment Verification Progress Report	Consideration to be given to including benchmarking information in future iterations of the report.	April 2019	Post Payment Verification Manager	**In Progress**
19/023	14/1/ 2019	Internal Audit Report – Retention of Staff	Report to be shared with the Finance, Performance & Workforce Committee for information	January 2019	Interim Board Secretary	**Completed** Report presented to the January 2019 Finance, Performance & Workforce Committee
19/023	14/1/ 2019	Internal Audit Report – Raising Concerns	Discussion to be held with the Executive Team in relation to introducing a nominated person	February 2019	Interim Board Secretary	**In progress**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT February 2019
			who would be responsible for receiving any protected disclosures.			
19/025	14/1/ 2019	WAO Report – Structured Assessment 2018	Discussion to be held with the Executive Team in relation to the content of the management response	February 2019	Interim Board Secretary	**In progress**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.1** **11 February 2019**

Audit Committee Report
AUDIT RECOMMENDATIONS TRACKER

Executive Lead: Board Secretary / Director of Corporate Services
Author: Interim Board Secretary
Contact Details for further information: Gwenan.roberts@wales.nhs.uk

Purpose of the Audit Committee Report
To update the Audit Committee on reported progress with implementation of Audit report recommendations.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2018-2021, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives.
Supporting evidence	• Wales Audit Office (WAO) Reports • Internal Audit Reports

Engagement – Who has been involved in this work?
Executive Director and Officer leads for each of the Wales Audit Office (WAO) and Internal Audit (IA) reports have been involved in providing updates on progress where appropriate.

Audit Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	√
Recommendation	The Audit Committee is asked to: • **DISCUSS** and **NOTE** the contents of the report; and • **ENDORSE** the actions in place to monitor progress with all outstanding Audit recommendations.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No impact						
Legal implications	There may be an adverse effect on the organisation if the UHB does not fully implement learning and improvements identified as part of Audit arrangements.						
Population Health	Ensuring a robust governance framework as documented and supported by Audit review will have a positive impact on the population that we serve.						
Quality, Safety & Patient Experience	Robust internal processes aligned with a strong governance framework is essential to ensuring patients experience the greatest possible levels of safety and quality.						
Resources	Many of the Audit reviews assess the strength of internal control. Failure to ensure recommended actions are implemented could adversely impact on the organisation's resources.						
Risks and Assurance	The related risks and assurance implications are captured within individual audits and feature within the related recommendations. The development of this system of tracking progress with implementation of recommendations is a mitigating action to ensure recommendations from Internal Audit reviews are implemented.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources. Link to Health & Care Standards Welsh Government web site The work reported in this summary and related annexes take into account many of the related quality themes.						
Workforce	No impact						
Freedom of Information Status	Open						

AUDIT RECOMMENDATIONS TRACKER

1. SITUATION / PURPOSE OF REPORT

The main purpose of this report is to present an update to the Audit Committee on reported progress with implementation of Audit report recommendations. This report relates to both internal and external audit review recommendations.

2. BACKGROUND / INTRODUCTION

Ensuring the organisation learns from and implements recommendations arising from Audit reports is an essential component of a strong organisational governance framework.

Tracking progress with implementation of Audit recommendations against agreed timescales is also an important assurance tool to support the work of the Committee and to provide assurance into the Board.

It is also important to consider why implementation of some recommendations has been delayed against the original agreed timescales and management response.

The attached summary table and supporting documents (Internal Audit – **Appendix 1**) make reference to 15 of the 55 Internal Audit reports received by the Audit Committee primarily since April 2017, and 2* of the 25 Wales Audit Office reports received since January 2014 (including National reports). In relation to Internal Audit, the summary table only references audit activity from mainly April 2017 to date, as all except 2 audits from pre April 2017 reports have reportedly been implemented.

A judgement on completion / partial completion has been made where progress is reported in this way.

Of the 55 Internal Audit report updates summarised and included in this report:

- 299 recommendations have been made;
- 257 recommendations have been reportedly implemented, although it is important to note that some of these require ongoing action;
- 42 recommendations are reportedly outstanding; and of these
    - 35 are overdue their original date for implementation (although a number are partially implemented or related work is progressing). Of these, there are ten High Risk rated recommendations (a number of which relate to reports received at the January 2019 Audit Committee meeting).

Progress with reported completion of recommendations continues to improve and this update report focuses on the 'overdue' or ongoing recommendations reported as outstanding within the updates sought from officer leads. A summary of updated actions against outstanding recommendations is attached as **Appendix 1a**.

Of the 25 Wales Audit Office reports (External Audit **Appendix 2**) covered within the Audit Tracker:

- 194 recommendations have been made;
- 164 recommendations have reportedly been implemented, although it is important to note that some of these require ongoing action;
- 30 recommendations are outstanding with 17 overdue their originally agreed completion date and relate mainly to Follow Up Outpatients Not Booked (FUNB)), Discharge Planning and Structured Assessment 2017, although it is important to note that some actions have taken place to progress implementation whilst some remain ongoing. Members will note the close and ongoing scrutiny at Finance, Performance & Workforce Committee and Quality, Safety & Risk Committee on actions to address the issues associated with FUNB.
- Members have agreed to receive the management response relating to the 2018 Structured Assessment, received by the Board in January 2019 at the April 2019 meeting of the Audit Committee. This will also aim to update on progress with the partially completed actions from the 2017 Structured Assessment.

A summary of updated actions against outstanding recommendations is attached at **Appendix 2a**.

In order to try and avoid duplication, Members will note discussion regarding the follow up outpatient not booked review and related actions being reported through Quality, Safety & Risk Committee (in May & September 2018) and Finance, Performance & Workforce Committee in October 2018.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Where there are actions outstanding within the tracker log, the related updates are referenced below for consideration of the Audit Committee. The Audit Committee has agreed that where High and/or medium risk related recommended actions fall outside a 6 months timescale, the lead Director (s) will be asked to present an update on the related reasons for the slippage in timescales and intended action to address the recommendation to the Committee.

Members may wish to consider the outstanding recommendations and their related timescales, particularly with High and/or Medium risk rated recommendations, and arrange for the lead Director to attend the next Audit Committee meeting in order for Members to be updated on related progress / intended actions.

4. RECOMMENDATION

Members of the Audit Committee are asked to**:**

- **DISCUSS** and **NOTE** this update report and the attached summary of progress;

- **ENDORSE** the progress made to date and agree any related further actions, particularly relating to the High Risk recommendations, where action has been significantly delayed beyond originally intended completion dates.

Freedom of Information Status	Open

Appendix 1

Summary of Outstanding Internal Audit Recommendations (January 2019)

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Corporate Legislative Compliance	Board Secretary / Director of Corporate Services & Governance	Reasonable	Jul-16	Jul-16	4	3	1	0	1
Complaints Management - Follow Up	Director of Nursing, Midwifery & Patient Services	Reasonable	Jan-17	Feb-17	7	6	1	0	1
Clinical Coding	Director of Planning & Performance	Limited	May-17	May-17	5	5	0	0	0
Corporate Risk Management	Director of Corporate Services & Governance	Reasonable	May-17	May-17	6	6	0	0	0
Mental Health Act Aftercare	Director of Primary, Community & Mental Health	Reasonable	May-17	May-17	7	7	0	0	0
Electronic Discharge Advice Letter (EDAL)	Director of Primary, Community & Mental Health	Reasonable	May-17	May-17	5	5	0	0	0
Financial Systems	Director of Fiancé	Reasonable	May-17	May-17	3	3	0	0	0
Occupational Health	Director of Workforce & OD	Reasonable	May-17	May-17	9	7	2	0	2

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
IT (Maternity Information Systems)	Director of Primary, Community & Mental Health	Reasonable	May-17	May-17	6	6	0	0	0
Recruitment Vacancy Management	Director of Workforce & OD	Reasonable	May-17	May-17	4	4	0	0	0
Public Sector Prompt Payment	Director of Finance	Substantial	May-17	May-17	2	2	0	0	0
DOLS Follow Up	Director of Nursing, Midwifery & Patient Services	Substantial	May-17	May-17	5	5	0	0	0
Recruitment	Director of Workforce & OD	Reasonable	Sep-17	Sep-17	4	4	0	0	0
Environmental Sustainability	Chief Operating Officer	Reasonable	Sep-17	Sep-17	3	3	0	0	0
Health and Care Standards	Director of Nursing, Midwifery & Patient Services	Substantial	Sep-17	Sep-17	1	1	0	0	0
Paeds, Obs, Neonates Capital Scheme PCH	Director of Planning & Performance	Reasonable	Sep-17	Sep-17	10	10	0	0	0
Patient Property & Monies	Director of Nursing, Midwifery & Patient Services	Reasonable	Sep-17	Sep-17	8	8	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Safeguarding	Director of Nursing, Midwifery & Patient Services	Reasonable	Sep-17	Sep-17	4	4	0	0	0
Directorate Governance - Pathology	Chief Operating Officer	Reasonable	Sep-17	Sep-17	8	8	0	0	0
Directorate Governance - Medicines Management	Director of Primary, Community & Mental Health	Reasonable	Sep-17	Sep-17	7	7	0	0	0
Directorate Governance - Acute Medicine and A&E (Follow Up)	Chief Operating Officer	Reasonable	Sep-17	Sep-17	12	12	0	0	0
Carbon Reduction	Director of Planning & Performance	Reasonable	Oct-17	Nov-17	3	3	0	0	0
Data Quality Monitoring	Director of Planning & Performance	Reasonable	Oct-17	Nov-17	5	5	0	0	0
Clinical Coding (Follow Up)	Director of Planning & Performance	Reasonable	Oct-17	Nov-17	5	5	0	0	0
Safety Bulletin Alerts	Director of Corporate Services & Governance	Reasonable	Oct-17	Nov-17	3	3	0	0	0
Nurse Staff Revalidation	Director of Nursing, Midwifery & Patient Services	Substantial	Oct-17	Nov-17	2	2	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
CAMHS Data Quality	Director of Primary, Community & Mental Health	Reasonable	Nov-17	Nov-17	5	5	0	0	0
JAG Accreditation Endoscopy **(See Follow Up review below)**	Chief Operating Officer	Limited	Dec 17	Jan 18	(was 7)	-	-	-	-
Clinical Audit	Director of Nursing, Midwifery & Patient Services	Reasonable	Dec 17	Jan 18	4	4	0	0	0
Risk Management	Medical Director	Reasonable	April 18	April 18	5	5	0	0	0
Performance Management	Deputy Chief Executive/Director of Planning & Performance	Limited	Mar 18	April 18	8	8	0	0	0
Governance Arrangements Hosted Bodies	Director of Corporate Services & Governance/ Board Secretary	Reasonable	April 18	April 18	3	3	0	0	0
IM&T Strategy	Chief Operating Officer	Reasonable	Mar 18	April 18	7	5	2	0	2
Core Financial Systems	Director of Finance	Substantial	Feb 18	April 18	2	2	0	0	0
Scheme of Delegation Review	Director of Finance	Reasonable	Feb 18	April 18	3	3	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Health Roster Review	Director of Workforce & OD	Reasonable	April 18	May 18	6	6	0	0	0
Private & Overseas Patients	Director of Finance	Limited	May 18	May 2018	6	4	2	0	2
EASC Commissioning	Chief Ambulance Services Commissioner	Reasonable	April 18	May 18	1	1	0	0	0
Fire Management	Director of Corporate Services & Governance/ Board Secretary	Reasonable	May 18	May 18	7	4	3	0	3
Governance Arrangements with Local Authorities & Third Sector Partners	Deputy Chief Executive/Director of Planning & Performance	Reasonable	May 18	May 18	5	5	0	0	0
ACT Management Arrangements	Interim Chief Operating Officer	Reasonable	July 18	July 18	16	15	1	0	1
ACT Compliance	Interim Chief Operating Officer	Reasonable	July 18	July 18	5	5	0	0	0
Healthcare Standards	Director of Nursing	Reasonable	July 18	July 18	3	3	0	0	0
Annual Quality Statement	Director of Nursing	Reasonable	July 18	July 18	2	2	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
JAG Accreditation Endoscopy follow up	Chief Operating Officer	Reasonable	Sept18	July 18	11	8	3	0	3
General Data Protection Regulation	Board Secretary	Reasonable	Sept 18	Oct 18	8	7	1	0	1
Performance Management Monitoring and Reporting follow up	Deputy Chief Executive / Director of Planning and Performance	Reasonable	Aug 18	Oct 18	8	6	2	0	2
CRC Energy Efficiency	Deputy Chief Executive / Director of Planning and Performance	Substantial	Jul 18	Oct 18	3	3	0	0	0
Governance Arrangements Primary and Community Care Committee	Director of Corporate Services and Governance / Board Secretary	Substantial	Aug 18	Oct 18	4	1	3	0	3
Facilities Compliance	Chief Operating Officer	Reasonable	Sept18	Oct 18	2	2	0	0	0
Facilities Management	Chief Operating Officer	Reasonable	Sept18	Oct 18	15	14	1	0	1
Retention of Staff	Director of Workforce and OD	Limited	July 18	Jan 19	6	1	5	0	5
Raising Concerns	Director of Workforce and OD / Board Secretary	Limited	Oct 18	Jan 19	7	1	6 (partial)	0	6 (partial)

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Future Generations and Well-being Act	Director of Public Health	Reasonable	Aug 18	Jan19	4	0	4	4	0
Continuing Healthcare	Director of Nursing Midwifery and Patient Care	Reasonable	Oct 18	Jan19	5	0	5	3	2
Totals					**299**	**257**	**42**	**7**	**35**

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Corporate Legislative compliance	The Health Board will firstly complete a risk assessment of all corporate legislative requirements and then maintain a tracker for those identified as high risk.	Medium	Board Secretary	Head of Corporate Services	November 2018 Betsi Cadwaladr Health Board presented to Board Secretaries a comprehensive approach to corporate legislative requirements - this system will be shared in due course across Wales and will provide an All Wales approach. January 2019 – awaiting progress to share system, being actively pursued.	In progress – should be available in 2019
Complaints Management - Follow Up	Management should review the current procedures for completing responses to ensure that they are being consistently completed by the most appropriate staff in order to minimise any delays whilst ensuring a high quality response.	Medium	Director of Nursing Midwifery and Patient Services	Heads of Nursing / Team Manager Complaints / Senior Manager for Investigations & QI	January 2019 remains in progress timescales not yet as desired	In progress Awaiting agreement of funding as part of IMTP.
Occupational Health	There should be a policy in place for the Occupational Health and Wellbeing Service and links to the policy should be available on the Intranet.	Medium	Director of Workforce & OD	Occupational Health & Wellbeing Manager	September 2018 update-Further comments and feedback received on additional inclusions post policy review group meeting. Amended OHWB policy on the agenda for the Policy Review group meeting 25th October 2018. January 19 – comprehensive SharePoint site for Health and Wellbeing; Health and Wellbeing month January 2019; Emotional wellbeing directory of services available	In progress
	The services provided by the OH Doctor should be formalised in a SLA.	Medium	Director of Workforce and OD	Occupational Health & Wellbeing Manager/Head of Operational HR/Assistant Director of Workforce & OD	December 2018 - meeting held on 20th December with the ABMU OHP to progress discussions around longer term OHP provision for CTUHB.	In Progress
IM&T Strategy	The strategy should be formally communicated to staff and included within the Plans and Reports section of the website.	Low	Chief Operating Officer	Assistant Director of IM&T	December 2018 Update - Executive Board has now approved the elements of the strategy for 2019. These will be published in January.	In progress
	Any future revision of the Strategy should ensure that the quoted organisational objectives and vision replicate those within organisational strategies.	Low	Chief Operating Officer	Assistant Director of IM&T	December 2018 Update - Exec Board has now approved the elements of the strategy for 2019. These updates will be made in the corporate IMTP.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Private & Overseas Patients	a) Following the development of procedures for overseas patients, the Health Board should ensure that all relevant staff are made aware of the need to identify those patients that are potentially from overseas. b) Management should ensure that those staff who are more likely to encounter overseas patients should have appropriate training and awareness incorporated into their induction process.	High	Director of Finance/Chief Operating Officer/Director of Planning & Performance	Directorate Manager & Head of Medical Records	December 2018 update - This post was submitted to the Agenda for Change team to review, it has been passed and the post is currently out to advert.	In progress
	a) Management should produce documentation for members of the public that provides information on their rights and responsibilities as an overseas patient and the expectations that will be placed upon them in order to determine eligibility for free health care provision. b) Information relating to potential charges that an overseas patient may incur should be made publically available. c) Information relating to potential charges that a private patient may incur should be made publically available.	Medium	Director of Finance/Chief Operating Officer/Director of Planning & Performance	a) Directorate Manager & Head of Medical Records b) Head of Financial Planning	a) Agreed. This will be actioned with support from the Commissioning and Communication teams. b) Agreed Sept 2018 update - Documentation located on DOH website. This will be circulated and put up in patient areas once Overseas Manager in post. December 2018 update - The post is currently out to Advert and once the candidate is in post and training received, the documentation we have located from the DOH website will be circulated to all patient areas. c) Private Patients are provided with details of the charges made by the Health Board for their 'hotel services costs' prior to their admission. It is important to note that the Health Board does not charge for any clinical staff costs etc., as these are charged directly by the clinician concerned. *Audit comment: While we note the management response to recommendation 'c', at the time of the audit fieldwork we were not aware of the details of charges provided to private patients prior to their admission. We consider this process appropriate to address the recommendation.*	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Fire Management	Opportunities will be explored to better capture information, including developing the NWSSP: SES database and improve reporting from Divisions and Directorates. (D)	High	Director of Corporate Services & Governance/Board Secretary	Head of Operational Health, Safety & Fire Director of Corporate Services & Governance	Agreed. The key issue is the absence of meaningful management information and the limitations of a national software system, which results in workarounds being developed. Significant effort is made to ensure that the fire risk assessments are completed adequately; however, the 'Fire Auditing and Reporting System' cannot provide accurate/ up-to-date information for discussion with directorate managers. Noting the limitations of the national system, there are a number of local systems in place as a workaround, however this results in duplication. In the first instance, the issue will be raised with NWSSP: SES to request improvement of the national system, and advise on what action can be taken nationally to address this concern.	Ongoing The limitations of the national system have been raised but the matter is not in the control of the UHB.
	Updated DSEAR reviews will be conducted in accordance with HSE requirements. (O)	Medium	Director of Corporate Services & Governance/Board Secretary	Head of Health, Safety & Fire	Update December 2018 - Capital monies have now been allocated for this work and tenders are being prepared.	In progress
	Fire folders be reviewed on a regular basis and out of date information removed and updated.(O)	Low	Director of Corporate Services & Governance/Board Secretary	Fire Safety Manager	Update December 2018 - The Audit of the 400+ Fire folders across the UHB was commenced in 12/18 and is due for completion 03/19.	In progress. Audits will commence in Autumn 2018 - Now due for completion in March 2019
ACT Management Arrangements	The directorate should ensure that all staff required to complete DoI do so in a timely manner. The Health Board should ensure that the Standards of Behaviour Policy is updated to reflect the amendments agreed at the September 2017 Audit Committee in relation to the requirement for Nil Returns and returns for staff Band 8 and above to make returns. The Health Board should review the policy and clarify how directorate / line managers are made aware of the declarations made by their	Medium	Chief Operating Officer	Directorate Manager/Services Leads/Head of Corporate Services/Board Secretary	January 2019 Standards of Behaviour Policy updated. Corporate Team working on an automated process to take place in March 2019 for all Declarations of Interest and provide directorate level reports during May 2019	Ongoing

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	staff. A report provided to directorate managers of returns made and nil returns, would allow due consideration to be given to declarations and would also allow directorate managers to chase those staff who have failed to make a return.					
JAG Accreditation Endoscopy - Follow Up	Approval of the Terms of Reference for the JAG working group should be documented to ensure it has been approved by an appropriate group or committee.	Low	Chief Operating Officer	Senior Nurse Medical Specialities	Update December 2018 - Terms of Reference now being reviewed and will be submitted to the Endoscopy Steering Group for approval.	In progress
	Management should ensure that a project plan is in place that incorporates all the actions that are required to meet the JAG accreditation status by a required date. Each action identified should include reference to the domains and standards that it refers to, an identified lead, and the timescale for completion.	High	Chief Operating Officer	Demand and Capacity, waiting times management – Ruth Morrissey, continual. JAG accreditation plan - Neil Hawkes & Carolyn John, in place and being used.	There has been significant progress made on the timeliness of delivery of the service over the last year, not just in preparation for an improved position for JAG accreditation but to improve the quality of service for our patients. In addition, there has also been the development of a delivery plan for each site for JAG accreditation which is a live document for each site that is maintained via each JAG accreditation meeting. Within the plan each domain and progress is clearly shown. These plans will be used as the foundation for each JAG accreditation meeting. It will be used to focus the agenda and report progress. December 2018 update - Work in this area continues and is ongoing	In progress
	Review by the relevant consultants of the supporting appendices to the Operational Policy should be completed as soon as practically possible to allow for final approval of the Operational Policy.	Low	Chief Operating Officer	Consultant Gastroenterologist	December 2018 update - Diabetes guidelines received, for final approval & sign off in January 2019 ESG meeting.	In progress January 2019
GDPR	An assessment of the departments included on the IAR should be undertaken to identify those who have not completed the IAR exercise. As part of this a timetable for all departments to have submitted entries should be set out.	Low	Board Secretary	Information Governance/Data Protection Officer	This is difficult to collate due to the way that the REDCap system is set up. However, the IG team will export into excel and filter to review potential gaps. December 2018 update - Work has commenced in this area although has not yet been fully completed - this will be undertaken by the end of February 2019	Part completed

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Performance management monitoring and reporting follow up	**Updated Recommendation**. Management should continue to review the levels of support provided to directorates to ensure demand and capacity planning is embedded within their working environment. We note the need to analyse and manage the resource implications of the merger with Bridgend on the current demand and capacity work, to ensure the progress that has been made continues.	Medium	Deputy Chief Executive/Directorate of Planning & Performance	Assistant Director of Performance & Information	**Updated Management Response**. This is an ongoing challenge, with renewed efforts being made to recruit skilled individuals to join the Directorate, in parallel with the development and retention of existing analytical staff. The demand and capacity work related to Bridgend will be integrated into the Cwm Taf led IMTP process for 2019/20. The demand and capacity work will therefore be led by Cwm Taf, but supported by ABMU staff who currently hold the data. The Directorate is fully engaged in the Transition Programme to ensure the appropriate level of resource transfer for April 1st 2019.	Ongoing. Recruitment and retention of key staff remains a key challenge, with a further recruitment drive underway.
	Updated Recommendation - The Health Board should consider whether phasing of demand and capacity plans would be beneficial in terms of providing a more co-ordinated planning approach.	Low	Deputy Chief Executive/Directorate of Planning & Performance	Assistant Director of Performance & Information	The next iteration of the plans will look to incorporate a way of dynamically updating the assessment every month. Whilst the phasing suggested is sensible, the time constraints associated with dedicating analytical resource to coincide with the IMTP process may not facilitate such a change to the current process. The regular updating of demand and capacity plans in a dynamic way will be the UHB approach to phasing, which will highlight changes in any one Directorate that other Directorates will be able to take account of in their planning.	Ongoing. This remains a medium term objective for the P&I directorate.
Governance arrangements primary and community care committee	The Committee should ensure that training and development requirements are documented in the Terms of Reference to satisfy the requirements of the Health Board's Standing Orders.	Low	Board Secretary	Head of Corporate Services	Following discussion with the Committee Chair, the Terms of Reference will be amended in line with Standing Orders.	TOR updated – to be agreed with Chair - for ratification at the April meeting
	The Primary & Community Care Committee should clarify in their Terms of Reference the required Members to be present at each meeting.	Low	Board Secretary	Head of Corporate Services	Following discussion with the Committee Chair, the Terms of Reference will be amended in line with Standing Orders and will include specifically the requirement for executive directors to be present. The TOR will also be amended to clarify that the Chair is included in the number of Independent Members at the meeting.	TOR updated – to be agreed with Chair - for ratification at the April meeting
	The Committee should review the Terms of Reference to correct any duplications of responsibilities and text.	low	Board Secretary	Head of Corporate Services	Following discussion with the Committee Chair, the Terms of Reference will be amended in line with Standing Orders and to correct the duplication of responsibilities and text.	TOR updated – to be agreed with Chair - for ratification at the April meeting

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Facilities management	The review of the historical roster templates that are being used should be progressed with revised rosters realigned to meet the current demands of the services at both hospital sites. It should be ensured that suitable systems are in place to accurately capture the work undertaken by the porters, to better inform future roster amendments and to allow monitoring of staff productivity. Rosters should be prepared further in advance in order for staff to know their core shifts and overtime shifts, if any, thus reducing the need for staff to swap shifts if they are unavailable for the overtime they have been allocated. Where there is a need to make use of overtime, efficient use should be made of all available staff.	High	Chief Operating Officer	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers.	Will be fully completed when the Porter redesign scheme is fully implemented. Currently in stage 2 grievance process. Porter redesign includes rota design that will complement existing staff establishment and support services trends and demands. Porter Trac utilised to support trends for this	In progress
Retention of staff	The objectives recorded in the 'Our Nurse Retention' Strategy and the actions in the Retention Strategy Action Plan should be aligned. All actions outlined in the Action Plan should contribute to the achievement of an objective. Both the 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan should be finalised. The Engagement Strategy, Leadership Strategy and Nurse Retention Strategy should be aligned, avoiding duplication between the three documents.	High	Director of Workforce & OD	Phillippa Doble Head of Operational HR	The 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan will be finalised and in so doing the actions in the Retention Strategy will be aligned to objectives in the 'Our Nurse Retention' Strategy. As the Engagement and Leadership Strategies are currently in draft, work will be undertaken to ensure that the Nurse Retention Strategy, which relates to the substance of this audit, aligns to the draft Engagement and Leadership Strategies in their current form. Areas of duplication and opportunities for synergies will be identified and any actions included in the Nurse Retention Strategy Action Plan.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	The exit questionnaire and interview process should be reviewed, with a view to implementing a comprehensive process across the Health Board that will allow the effective gathering of data for analysis and presentation to relevant groups. While this process is being formalised managers should be reminded of the importance of encouraging staff to complete exit questionnaires and to have an exit interview, with outcomes reported centrally.	High	Director of Workforce & OD	Phillippa Doble Head of Operational HR	A review of the exit questionnaire and process has been undertaken. This has resulted in a new process which was presented to the Nursing Workforce Group in September. The group suggested changes to the questions, which will be amended and finalised in a meeting being held on 12 October. The process has been piloted within nursing during October – December 2018. Alongside this an entry survey has also been developed to capture data on days 1, 30 and 90 which will also be piloted during the same period. All data captured from both exit and entry questionnaires will be presented to the Nursing Workforce Group monthly meeting. The importance of exit interviews is enforced at both the Senior Nurse Forum and the Nursing Workforce Groups meetings which meet on a monthly basis. This is not a specific action of this audit, and occurs in any event. Once pilot is completed and evaluated, the process will be rolled out across all staff groups.	In progress
	Where surveys are undertaken, results should be analysed and reported in a timely manner to ascertain if there are any trends or themes that need to be acted upon. The perceived lack of action may discourage staff from completing surveys in the future. 'Pulse surveys' should be carried out on a regular basis with nursing staff to assess the opinions of staff and ascertain if they have any concerns in work.	Medium	Director of Workforce & OD	Karen Vaughan Occupational Health & Wellbeing Manager	The staff Health and Wellbeing survey, which was the All Wales staff survey has recently closed. High-level feedback was received on 12 November 2018. Regular pulse surveys will be conducted as part of the Engagement strategy.	In progress
	Personal Development Reviews (PDRs) should be undertaken on an annual basis with staff so that ongoing development can be captured to help retain staff including setting key objectives for the following year. PDRs should also be carried out to identify if there are any fundamental issues with the staff.	Medium	Director of Workforce & OD	Janet Gilbertson Interim Assistant Director Organisational Development	A new draft PDR form has been designed as part of the Engagement Strategy but further work is required for finalisation at the beginning of 2019	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	When developing the Retention Strategy Action Plan a clear set of initiatives should be included, linked to each of the actions, that will assist in the retention of nurses. Initiatives should have measurable targets attached to them that can be assessed.	Medium	Director of Workforce & OD	Phillippa Doble Head of Operational HR	As per Finding 1, the action plan will be reviewed, with appropriate milestones and target timescales included. This will drive the development and implementation of new initiatives, such as the rotational posts, in a measureable manner. The action plan will be reported via the Nursing Workforce Group before the end of the year and that Group can drive communication across the nursing workforce within the Health Board.	In progress
Raising Concerns	The Health Board should ensure that appropriate training is provided to those staff involved with investigating concerns so that the Policy / procedure is consistently applied and that concerns are correctly classified in the first place. Management should consider providing awareness training to staff who do not have responsibility for investigating concerns on when and how concerns should be raised to ensure that the staff understand when it is appropriate to raise a concern.	High	Director of Workforce & OD	Claire Nicholas (Head of Workforce and Improvement Efficiency)	Staff involved in formal investigations across the Health Board undertake Investigating Officer training, and are supported by an HR professional, who will advise on the relevant considerations. The Health Board will arrange to provide information to individuals who undertake informal investigations of incidents and concerns to enable them to appropriately classify where an issue has arisen under the Raising Concerns Policy, and making it clear who they may seek advice from in those circumstances. The Health Board does not believe it is practical or necessary to include Raising Concerns training as part of the mandatory training at this stage. January 2019 - A comprehensive SharePoint (intranet) page has been developed which provides supplementary information to the Policy including information on how it is appropriate to raise a concern, to be disseminated to staff via internal communication channels. Investigating officer sessions continue to be provided; More work required to raise awareness; more resources available - some actions completed.	In Progress Completed in part
	The Health Board should ensure that there is a process in place so that staff without IT access are made aware of their responsibility to raise concerns; this may be through team meetings, induction training and publicity campaigns.	High	Interim Board Secretary	Interim Board Secretary	January 2019 – now plan to use social media channels and the Chief Executive's blog to raise awareness of the policy, how to raise a concern, and when it might be appropriate to do so, across the Health Board. We will also remind all senior managers of the policy and ask that they ensure that appropriate arrangements are in place for staff without access to IT to be aware of it, including team meetings. We will provide materials (e.g. leaflets and posters) to raise awareness across the Health Board.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	The Public Concerns at Work (PCaW) Best Practice guidance recommends: Keep the message fresh: update poster campaigns and intranet resources regularly. New colours, designs, and formats help keep them fresh so staff continue to notice them. Lead from the top: use written and verbal messaging from senior staff members to promote the arrangements.				As part of the induction process, new staff are currently advised of where they can find policies, although the Raising Concerns Policy is not specifically mentioned. They also have information included in their contract advising them if they ever have a concern that something untoward is happening at work and wish to report this to the Organisation in a confidential manner to refer to the Policy. We will repeat these steps periodically to ensure that awareness of the Raising Concerns Policy continues. January 2019 – work relating to the Bridgend Boundary Change includes the updating of key policies and procedures which will be disseminated to staff before 1 April. This will include the Raising Concerns Policy.	
	The Health Board should ensure that there is a named individual responsible for maintaining a central log of all formal concerns raised via all routes detailed in the policy. In addition, the Health Board should consider maintaining a log of informal concerns raised to enable them to identify trends or reoccurring themes. We acknowledge that the new Employee Relations system may be an appropriate method of logging concerns raised to ensure that the concern has been fully considered and recorded in line with the policy. A trend analysis should be carried out on both formal and informal concerns raised to help identify recurring themes. We accept that this may not be possible until the Health Board has a procedure in place for logging all concerns raised.	High	Director of Workforce & OD	Hywel Daniel (Deputy Director of Workforce and Organisational Development)	The Directorate of Workforce & OD will be responsible for maintaining a central log of all formal concerns raised via the Raising Concerns Policy on the ER Tracker system. Any informal concerns which are notified to the Directorate will be included on the same system. The ER Tracker system has been built to include the timeframes outlined within the Raising Concerns Policy. Data including a trend analysis will be included in the Employee Relations Report which goes to the 'in Committee' Health Board meeting every other month.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	The Health Board should ensure that the policy correctly details key contacts to ensure that concerns are raised with the correct person in line with the requirements of the policy. The Health Board should consider whether additional professional heads should be considered. The Raising Concerns telephone hotline automated message should be updated to provide a message that confirms that the caller has reached the Raising Concerns telephone hotline; the information required from the caller, and what will happen next.	Medium	Director of Workforce & OD/Interim Board Secretary	Gwenan Roberts/ Claire Nicholas	January 2019 update - Policy has been amended to ensure the key contact details are correct. Additional professional heads have been considered but it was felt that the key relevant contact details are available. Within the SharePoint page external bodies and information is provided for all staff groups. The telephone hotline with fail safe email reminders has been put in place and tested for robustness. Further work to raise awareness is also planned	In progress
	The Health Board should ensure those responsible for investigating and reporting concerns are provided with supplementary procedure notes to ensure that when a concern is raised that these are consistently and appropriately dealt with in line with the requirements of the policy. The Public Concerns at Work (PCaW) Best Practice guidance recommends: Gauging the seriousness: Provide clear guidelines to managers around how to understand the nature of the concern and when and how to keep a written record of it. Introduce whistleblowing resources: Consider specific resources, training, forums or surveys for managers around receiving, handling and recording concerns.	Medium	Director of Workforce & OD/Interim Board Secretary	Gwenan Roberts/ Claire Nicholas	January 2019 update - The guidance for undertaking an investigation is available on the SharePoint page. Further resources will be developed at the same time as a communication drive to raise awareness of the policy. The timing is crucial to have maximum impact	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Engage with the key whistleblowing contacts for their feedback on receiving concerns and the effectiveness of arrangements generally.					
	The Policy includes two forms for completion when dealing with formal concerns. Form WB1 'Recording a concern raised under the procedure', and Form WB2 'Concerns Raised Under the Procedure: Summary of findings and outcome of investigation'. The Health Board should ensure that when the Employee Relations software is used for recording concerns it includes all required fields as detailed on forms WB1 and WB2 which would assist in ensuring that concerns are fully and appropriately investigated, reported and completed in line with the policy.	Medium	Director of Workforce & OD	Hywel Daniel (Deputy Director of Workforce and Organisational Development)	The new ER Tracker system will be utilised to record concerns, the nature of concern raised on the WB1 form will match the categories in the case opening reasons on the ER Tracker. The timelines on the ER Tracker are in line with those detailed in the policy e.g. 28 days for an investigation. Forms WB1 and WB2 are able to be uploaded onto the ER Tracker system against the specific case. January 2019 – Tracker now in operation Additional information provided to managers on the SharePoint Site	Complete
	The Health Board should ensure that there is an appropriate process in place for reporting all concerns raised. The Health Board should consider what information should be reported. This could include Performance figures on progress against investigating concerns. For example, Number of days from receiving the concern to appointing an investigating officer; Number of days from appointing an investigating officer to completing the investigation;	Medium	Director of Workforce & OD	Hywel Daniel (Deputy Director of Workforce and Organisational Development)	As mentioned in the response to Finding 3, data and trend analysis on concerns raised via the Raising Concerns Policy will be included in the Employee Relations Report. The Health Board intends to develop standard operating procedures as part of its wider work to reduce the length of time taken to process employee relations activity, not specifically connected to this audit. This work will include specific metrics for Raising Concerns cases. This information will be used as part of the routine management of ER cases within the Directorate of Workforce & OD.	

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Number of days spent investigating the concern; Percentage of concerns investigated and concluded; Percentage of concerns by directorate / department / service area.					
Continuing Healthcare	Whilst it may be beneficial for the CHC Unit Panel to see the daily or weekly cost of care for a patient, it should be ensured that that annual cost of service provision is calculated and recorded on the panel form as the Scheme of Delegation authorisation limits are based around the annual cost. All CHC Unit Panel forms should be appropriately authorised in line with the Scheme of Delegation.	High	Director of Nursing	Sian Lewis (Lead Nurse for CHC and NHS Funded Care)	The responsibility for the Financial Sign Offs has now returned to the central CHC Team and a new process has been introduced. The new Financial Sign Off form has been reviewed in line with the new scheme of delegation and will include: · Annual Cost; Weekly Cost; Existing Package plus the additional request being presented to Panel. This is currently being piloted with full implementation in early 2019. All forms will be authorised in line with the Scheme of Delegation.	In progress
	The CHC Unit Panel should be made aware of the full package of care that is currently being funded for an individual as each new panel form is considered. The panel form should also include confirmation that a Nursing Assessment and Decision Support Tool form have been completed and the relevant dates. The CHC Unit Panel form should be reviewed to ensure all elements of the form remain applicable and to ensure that the authorisation elements of the form are consistent with the most up to date version of the Scheme of Delegation	Medium	Director of Nursing	Sian Lewis (Lead Nurse for CHC and NHS Funded Care)	The responsibility for the financial sign offs have now returned to the central CHC team and a new process identifying appropriate sign off in line with the scheme of delegation has been introduced. The checklist for quality assurance process will provide reassurance that DST and Nursing Assessments has been completed. The new Financial Sign Off has been reviewed in line with the new scheme of delegation. The existing package plus the additional request being presented to Panel will be included on the form.	In progress

Appendix 2

Summary of Outstanding External (Wales Audit Office) Audit Report Recommendations Updated January 2019

Report Title	Lead Director (s)	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Clinical Coding	Director of Performance & Planning	Jan-14	Apr-14	4	4	0	0	0
Operating Theatres	Chief Operating Officer	Jan-14	Apr-14	9	9	0	0	0
Primary Care Fraud arrangements	Director of Primary Care, Community & Mental Health	Mar-14	Apr-14	6	6	0	0	0
Follow Up Review Ward Staffing	Nurse Director	Sep-14	Oct-14	2	2	0	0	0
Financial Statements Memorandum	Finance Director	Sep-14	Oct-14	7	7	0	0	0
Annual Audit Report 2014	Board Secretary	Jan-15	Apr-15	5	5	0	0	0
District Nursing Review	Nurse Director	Mar-15	May-15	7	7	0	0	0
Historical Waiting List Anomalies	Director of Planning & Performance / Chief Operating Officer	Mar-15	May-15	3	3	0	0	0
Medicines Management in Acute Hospitals	Board Director	Jun-15	Jul-15	9	9	0	0	0
Orthopaedic Services	Chief Operating Officer	Oct-15	Oct-15	4	4	0	0	0
Financial Statements Memorandum	Director of Finance	Oct-15	Oct-15	7	7	0	0	0
Hospital Catering Follow Up Report	Board Director / Director of Nursing, Midwifery & Patient Services	Jan-16	Jan-16	10	10	0	0	0
Follow Up Outpatients Not Booked * see Below	Chief Operating Officer	Jan-16	Jan-16					

IM&T Audits	Board Director / Director of Finance & Deputy Chief Executive	Jan-16	Jan-16	21	21	0	0	0
Structured Assessment 2015	Board Secretary / Chief Executive	Jan-16	Jan-16	17	17	0	0	0
ICT Capacity & Resource	Director of Primary Care, Community & Mental Health	Apr-16	Apr-16	4	4	0	0	0
Consultant and SAS Contract	Medical Director	Sep-16	Oct-16	16	16	0	0	0
Radiology Review	Chief Operating Officer	May-17	May-17	10	10	0	0	0
Structured Assessment 2016	Board Secretary / Chief Executive	Jan-17	Feb-17	8	8	0	0	0
GP Out of Hours	Director of Primary Care, Community & Mental Health	Sep-17	Sep-17	9	9	0	0	0
Follow Up Review of Outpatient Follow Ups Not Booked *	Chief Operating Officer	Nov 17	Nov 17	5	2	3	0	3
Discharge Planning	Chief Operating Officer	Dec 17	Jan 18	4	0	4	0	4 (partially completed)
Structured Assessment 2017	Board Secretary / Chief Executive	Jan 2018	April 2018	7	1	6	0	6 (partially completed)
Primary Care	Director of Primary Care, Community & Mental Health	Dec 2018	Jan 2019	11	3	8	8	0
Structured Assessment 2018	Board Secretary / Chief Executive	Dec 2018	Jan 2019	9	0	9	**(Management response to be presented to April 2019 AC meeting)**	
Totals		**25**		**194**	**164**	**30**	**17**	**13**

Internal Audit Report & Recommendation	Recommendation	Priority / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Review Report Follow Up OPs Not Booked Rec 1	Ensure that there is sufficient information on the clinical risks of delayed follow-up outpatient appointments reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.	Mar-16	Chief Operating Officer	Chief Operating Officer	The Chief Operating Officer (COO) has presented a detailed report to the Quality, Safety & Risk Committee in May 2018. The Finance, Performance & Workforce Committee is also periodically receiving update reports on the volume of patients in this category. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard.	In progress
Review Report Follow Up OPs Not Booked Rec 2	Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	Apr-16	Chief Operating Officer	Assistant Director of Operations (Scheduled Care)	In general, positive progress has been made with ensuring revised booking processes are consistently applied across the Health Board. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard.	In Progress
Review Report Follow Up OPs Not Booked Rec 4	Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.	March 2016	COO	AD Ops Unscheduled Care	The Chief Operating Officer (COO) presented a detailed report to the Quality, Safety & Risk Committee in May 2018. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance.	In Progress

Internal Audit Report & Recommendation	Recommendation	Priority / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
					For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard.	
Discharge Planning Rec 01	Discharge Planning Policy: Our assessment of the Health Board's policy indicates that it could be strengthened when it is next reviewed. The Health Board should include: • a patient discharge leaflet; • the discharge checklist; • the escalation procedures; • arrangements for patients discharged from A&E departments or medical/ clinical assessment units; • electronic links to the Hospital Discharge Protocol for Patients in Housing Need, the Choice of Accommodation Protocol and the Continuing NHS Care Framework; • and a flow chart or decision tree to support decisions on whether discharges are simple or complex and the pathway to follow.	Dec 2018	Chief Operating Officer	Deputy Chief Operating Officer	The Discharge Planning Policy is due for review in September 2019. However, we will complete an early review and revise the document in order to reflect upon the audit recommendations. December 2018 update - The Discharge Planning Policy is currently in final draft format. As part of the partnership agenda the policy has been reviewed with Local Authority colleagues and includes the Choice Process. A pilot is underway in Ysbyty Cwm Rhondda (YCR) which supports families through the Choice process and monitors the time frame.	In Progress, likely to complete early 2019.
Discharge Planning Rec 02		Dec 2018	Chief Operating Officer / Director of Nursing	Deputy Chief Operating Officer	The Discharge Planning Policy is due for review in September 2019. However, we will review and revise the document early in order to reflect upon the audit recommendations December 2018 update - The Discharge Planning Policy is currently in final draft format. As part of the partnership agenda the policy has been reviewed with LA colleagues and includes the Choice Process.	In Progress, likely to complete early 2019.

Internal Audit Report & Recommendation	Recommendation	Priority / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Discharge Planning Rec 03	Patient leaflet: Adapt the community hospital patient leaflet so it is relevant for patients staying in acute hospitals, setting out • information about the discharge process, • how the patient and family will be kept informed of the discharge process; • arrangements that the patient may need to make (such as arrange transport); • information about follow-up care; and • the complaints process.	Sept 2018	Chief Operating Officer	Deputy Chief Operating Officer	Progress is being made with engagement, to develop a revised leaflet to better inform discharge planning and address the issues recommended for improvement. It is anticipated this will be progressed to completion during quarter 3.	Ongoing
Discharge Planning Rec 04	Monitoring performance or compliance: Although, the Health Board's Discharge Planning Policy and draft Discharge Protocol include a range of both qualitative and quantitative measures to monitor compliance, these performance measures have yet to be reported systematically to the Board or its committees. The Health Board should regularly report on these measures.	Sept 2018	Chief Operating Officer	Deputy Chief Operating Officer	Performance monitoring around discharge planning (and Delayed Transfers of Care) is reported to F,P & W Committee via the Performance Dashboard and also to Board although related data is being developed further.	Ongoing
Structured Assessment 2018	The Management Response to the report's recommendations, finalised and received by the Board in January 2019, will be considered by the April 2019 meeting of the Audit Committee.	April 2018/2019	Chief Executive / Interim Board Secretary	Interim Board Secretary	-	To Follow

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Shared Services
Partnership
Audit and Assurance Services

Cwm Taf University Health Board

INTERNAL AUDIT PROGRESS REPORT

Audit Committee - February 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction 1
2. Outcomes from completed audit reviews 1
3. Delivery of the 2018/19 Internal Audit plan 1

Appendix A:

Table 1: Status of 2018/19 assignments

Please note:

This audit progress report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, 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 Cwm Taf 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 (the 'committee') with the current position regarding the work undertaken by Internal Audit as at 1 February 2019.

1.2. The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the 2018/19, and any required updates.

2. Outcomes from completed audit reviews

2.1 Since the January meeting of the committee six assignments have been finalised, and one has been issued as a 'final draft'. The finalised and 'final draft' reports identified in the table below along with the allocated assurance rating. The full versions of these reports are included in the committee's papers as separate items.

Assignments 2018/19	Assurance rating
Directorate review – Primary Care – management arrangements	Risk & governance - Reasonable Performance & plan - Substantial Workforce - Reasonable
Mandatory training	Reasonable
Management of absence target	Reasonable
Private and overseas patients – Follow up	Reasonable
Medical equipment and devices	Limited
Management of major capital (final draft)	Limited
IT continuity	Reasonable

3. Delivery of 2018/19 Internal Audit plan

3.1 The detail of the scheduling and current progress of the audit work is outlined in the assignment status schedule, which is included at Appendix A.

3.2 The schedule includes the timing of the audits. These dates may be subject to change as the audit work progresses, and any alterations will be communicated to the committee via future progress reports..

Table 1: Status of 2018/19 assignments to be reported in February Audit Committee or later

Assignment	Days in plan	Status	Assurance	Timing	Notes
Medical equipment and devices	15	Final	Limited	Q2	-
Management of major capital	25	Final draft	Limited	Q4	Draft report issued 20.11.18
IT systems	10	Final	Reasonable	Q2	-
Directorate reviews – Primary Care - Management arrangements	30	Final	-	Q2	-
• Risk management and governance			Reasonable		
• Performance and planning			Substantial		
• Workforce			Reasonable		
Mandatory training	15	Draft	Reasonable	Q2	Draft report issued 18.01.19
Management of absence target	15	Final	Reasonable	Q3	-
Private & Oversea patients – Follow up	N/A	Final	Reasonable	-	-
Directorate reviews – Primary Care - Compliance	15	Drafting	-	Q2	Fieldwork completed and being reviewed.

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
Directorate reviews – Surgery - Management arrangements	30	WIP	-	Q3	Fieldwork on going
Directorate reviews – Surgery - Compliance	15	WIP	-	Q3	Fieldwork on going
Risk management	10	WIP	-	Q3	Fieldwork on going
Commissioning	15	WIP	-	Q4	Fieldwork on going
Patient experience	15	WIP	-	Q3	Fieldwork on going
Service Change Plans	15	WIP	-	Q3	Fieldwork on going
Cyber security	15	WIP	-	Q3	Fieldwork on going
Water safety	15	WIP	-	Q3	Fieldwork on going
Directorate reviews – Radiology - Management arrangements	30	WIP	-	Q4	Fieldwork on going
Directorate reviews – Radiology - Compliance	15	WIP	-	Q4	Fieldwork on going
Core financial systems	10	WIP	-	Q4	Fieldwork on going
Welsh risk pool	2	WIP	-	Q4	Mandatory review – Scheduled to start 04.02.19

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
Data quality review	15	Scoping	-	Q4	Planned start in March. Scoping meeting held 24.01.19
Health & Care standards	20	Scoped	-	Q4	Mandatory review
GP OOH	20	-	-	Q4	-
WHSSC					
Risk management	10	WIP	-	Q3	Fieldwork on going
Governance arrangements	10	Scoped	-	Q4	ToR issued 18.12.18
EASC					
Governance and performance	15	WIP	-	Q2	Fieldwork on going
Additional work					
Bridgend project	15	Ongoing	-	Q2	HoIA attending governance work stream
Review not taken forward in 2018/19					
Consultant job planning	15	-	-	Q3	Agreed at October 2018 Audit Committee that this review will be rescheduled for 2019/20

Reviews already reported

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Sustainability reporting	10	Final	Substantial	Q1	-
Annual Quality Statement	7	Final	Reasonable	Q1	-
JAG accreditation – Follow up	5	Final	Reasonable	Q1	-
General Data Protection Regulation (GDPR)	15	Final	Reasonable	Q1	-
Governance arrangements of Board committees	15	Final	Substantial	Q1	Focus on Primary Care committee
Carbon reduction commitment	10	Final	Substantial	Q2	Mandatory review
Directorate reviews - Facilities – Compliance	15	Final	Reasonable	Q1	-
Performance management – follow up	5	Final	Reasonable	Q2	-
Retention of staff	15	Final	Limited	Q1	-
Directorate reviews: Facilities - Management arrangements	30	Final	-	Q1	Reported as 'draft' at the October 2018 committee

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
• Risk management and governance			Reasonable		
• Performance and planning			Reasonable		
• Workforce			Limited		
Raising concerns	15	Final	Limited	Q1	-
Well-being of Future Generations Act (Wales) 2015	10	Final	Reasonable	Q2	-
Continuing Health Care	15	Final	Reasonable	Q2	-
WHSSC					
High cost drugs	15	Final	Reasonable	Q1	-
Review of network groups and advisory boards	10	Final	Reasonable	Q2	-
EASC					
EASC - Non-Emergency Patient Transport Service – Follow up of baseline position review	N/A	Final	N/A	-	Additional review requested by EASC

Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Partneriaeth
Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

Cwm Taf University Health Board

Directorate reviews – summarised analysis

Audit Committee - February 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents

		Page
1.	Introduction	1
2.	Summarised analysis of findings	1
3.	Conclusion	3

Appendix A: Findings in directorate reports

Please note:

This audit progress report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, 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 Cwm Taf 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 paper set out the common themes that we have identified in our directorate reviews within the Health Board. This paper captures information from our reports issued between 2016/17 and 2018/19. However, working with the Health Board, we have developed our approach to the directorate reviews in recent years so that more aspects of a directorate's operations are covered by our fieldwork.

1.2. We have reviewed the findings that have been reported to Audit Committee in our last nine directorate review reports. A table showing all of the summarised findings, and their priority rating is attached as Appendix A.

2. Summarised analysis of findings

2.1 Our directorate reviews are cover four common areas of function within each directorate. The number of findings in relation to these areas are summarised in the table below:

Internal Audit area of focus	Total findings
Risk management and governance	28
Planning and performance	9
Workforce	46
Compliance with financial control procedures*	9
Total	**92**

**Two directorate reviews have included this area of focus and have been reported to the Audit Committee at the time of this report.*

2.2 In the table below we have summarised the top six common themes of the findings that we have identified in our directorate reports across the four areas of focus.

Top six common themes across the directorate reviews

Theme of finding	Total findings
Risk recording, reporting and monitoring	10
Annual leave	9
Flexi-time / Time off in lieu (ToIL)	8
Sickness/ absence management	8
PDR compliance	8
Terms of reference for directorate groups/committees	6

2.3 In the tables below we have summarised the common themes of the findings that we have identified within our areas of focus that had four or more findings when we looked across our directorate reviews.

Common themes by area of focus (more than four findings)

Risk management and governance	
Theme of finding	**Total findings**
Risk recording, reporting and monitoring	10
Terms of reference for directorate groups/committees	6
Declarations of Interest	4

Planning and performance	
Theme of finding	**Total findings**
IMTP	5
Performance reporting	4

Workforce	
Theme of finding	**Total findings**
Annual leave	9
Flexi-time / Time off in lieu (ToIL)	8
Sickness/ absence management	8
PDR compliance	8

3. Conclusion

3.1 The finding summarised above show that the most common theme of findings related to the recording and reporting of risk within directorates.

However, the largest number of findings falls within the Internal Audit review objectives relating to workforce, such as annual leave, ToIL and sickness management.

3.2 We would encourage the Health Board to consider sharing this report across directorates so that the recurring themes identified in our reviews can be proactively considered by management to reduce the chance of related risks materialising.

Table 1: Findings per directorate report

	2018/19	2018/19	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17	2016/17	
	Primary care	**Facilities**	**ACT**	**Medicines management**	**Pathology**	**Therapies**	**Acute medicine and A&E**	**C&YP**	**CAHMS**	**No**
	-	Risk records	Risk records	Risk records	-	-	Risk records	-	-	4
	Risk register reporting	Risk reporting and monitoring	Risk reporting and monitoring	-	-	-	risk register monitoring	risk register monitoring	-	5
	Risk register monitoring			-	-	-			-	1
	Terms of reference of CBM	-	Terms of reference of DIGBM and CBM	Terms of reference of directorate groups	-	-	Quality & Safety forum ToR	Governanc e of Q&S committee	Review of ToR for directorate governance groups	6
	-	-	-	-	Integrated governance meeting	-	Cancelled CBM	-	-	2
	-	-	-	-	Attendance at CBM	-	Directorate Integrated Governance meetings cancelled	-	-	2

Appendix A

	-	Comms. plan	-	-	-	-	-	-	-	1
	DoI	-	Declarations of interest	Declarations of interest	Declarations of interest	-	-	-	-	4
	-	-	Dissemination of alerts	-	-	-	-	-	-	1
	-	Up to date policies and procedures	Up to date policies and procedures	-	-	-	-	-	-	2
	-	IMTP monitoring	Tracking performance against IMTP	-	IMTP planning	-	IMTP development process	-	IMTP planning	5
	-	-	Tracking performance for Service Change plan and workforce	-	-	-	Introduction of Qlik Sense for performance reporting	Introduction of Qlik Sense for performance reporting	Introduction of Qlik Sense for performance reporting	4
	-	Annual leave process - porters	-	-	-	-	-	-	-	1
	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	9
	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	-	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	8

Appendix A

	-	-	-	-	-	-	Flexi leave - operational	-	-	1
	Absence management	Absence management	Absence management	Absence management	Absence management		Absence management	Absence management	Absence management	8
	PDR	PDR	PDR	PDR	PDR	-	PDR	PDR	PDR	8
	Mandatory training	Mandatory training	Mandatory training	-	-	-	-	-	-	3
	Rostering guidance	Rostering guidance	-	-	-	-	-	-	-	2
	-	Rostering doc.	-	-	-	-	-	-	-	1
	-	-	Future staffing plans	-	-	-	-	-	-	1
	-	-	Consultant job planning - sign off	-	-	-	-	-	-	1
	-	Rostering effectiveness	Rostering effectiveness	-	-	-	-	-	-	2
	-	Rostering review process	-	-	-	-	-	-	-	1
	-	Inventory of non-	Inventory of non-capital assets	-	-	-	-	-	-	2

		capital assets								
-		Budgetary control	asset register verification	-	-	-	-	-	-	2
-		Cash & banking process design	Capital asset disposals	-	-	-	-	-	-	2
-		Cash limits - cash held before banking	Stores - design	-	-	-	-	-	-	2
-	-		Additional staff payments	-	-	-	-	-	-	1
Total findings	**10**	**19**	**21**	**7**	**8**	**1**	**12**	**7**	**7**	

Note:

Colour coding represents the priority rating given to the original finding:

- Red – High priority finding
- Amber – Medium priority finding
- Green – Low priority finding

Medical equipment and devices

Internal Audit Report

Cwm Taf University Health Board

February 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 6
5. Assurance Summary 8
6. Summary of Audit Findings 9
7. Summary of Recommendations 13

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-17
Report status:	Final Internal Audit Report
Fieldwork commencement:	30 August 2018
Fieldwork completion:	30 November 2018
Draft report issued:	4 December 2018 & 15 January 2019
Management response received:	29 January 2019
Final report issued:	4 February 2019
Auditors:	Emma Samways Martin Lewis Johanna Butt Jon Morris
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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.

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1. Introduction and Background

In line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board') a review of the procedures around the arrangements for managing medical equipment and devices was carried out.

The term 'medical equipment or device' includes all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. The range of products is very wide; it includes dressings, tubing, syringes, infusion pumps, heart valves, surgical instruments, resuscitators, radiotherapy machines, wheelchairs, and walking frames or other assistive technology products.

A systematic approach to the acquisition, deployment, maintenance (preventative maintenance and performance assurance), repair and disposal of medical devices and medical device training ensures that medical devices are used safely, competently and effectively for the best care of patients and to comply with all relevant legislation and guidance.

Growing numbers of medical devices such as patient monitors, infusion pumps, ventilators, pacemakers and imaging modalities, many of which are life-sustaining or life-supporting, incorporate wireless capabilities and complex software. However, these networked medical devices and other mobile health technologies have the potential to play a transformational role in health care but also may expose patients and health care organisations to safety and security risks. Among the unintended consequences of health care digitisation and increased networked connectivity are the risks of being hacked, being infected with malware, and being vulnerable to unauthorised access.

The Health Board uses the (Real Asset Management) RAM system as its Medical Equipment Management system. This was implemented in August 2017.

The Clinical Engineering department uses the RAM5000 system to record medical equipment and devices, and the Finance department uses the RAM4000 system as their Fixed Asset Management System. At the time of our audit fieldwork, the two systems were not linked so Clinical Engineering Department provides Finance with information relating to items greater than £5,000 for capital asset recording, this information includes the lifespan of the device. We understand that it is the Health Board’s intention to have the two systems linked at some point.

The relevant lead for the review is the Interim 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 in relation to the Health Board's management of medical equipment and devices. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

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

- Relevant Health Board policies and procedures are up to date, clear in respect of roles and responsibilities, and available to staff.
- The Health Board medical devices and equipment register is up to date and reviewed and the information required, including equipment lifespan, is recorded.
- There is compliance with Health Board procedures for the addition and removal of assets from the register, including recording the loaning of equipment between wards and the loaning of equipment from the Clinical Engineering equipment library.
- Accurate records are maintained of the servicing and maintenance of medical equipment and devices.
- Risk assessments are completed on devices and equipment that may pose a risk to patients or staff.
- Incidents, defects and faults relating to medical devices and equipment and recorded on the Datix incident reporting system.
- Where necessary, staff are appropriately trained before using medical devices and equipment.
- Adequate information is reported to relevant groups.
- Appropriate security processes are enabled in order to secure network or Wi-Fi enabled medical devices.

The management of hospital beds has not been included within our review. Our sample selection was from the two main acute sites, namely Royal Glamorgan Hospital and Prince Charles Hospital.

3. Associated Risks

The potential risks considered in the review were as follows:

- Insufficient maintenance of medical equipment and devices may lead to failures.
- Replacement of equipment may not comply with policy and therefore may result in risk to patient/staff safety.
- Inadequate training or knowledge regarding the appropriate use of equipment and Health Board processes may result in risks to patient safety.
- Incidents are not monitored so they may be repeated and underlying issues continue unaddressed.
- Inadequate record-keeping could undermine management monitoring arrangements, and hinder the ability of the Health Board to demonstrate its management of devices to external bodies.
- Policies are out of date risking a lack of clarity in respect of roles and responsibilities.

- Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.
- Risk of patient harm or unauthorised access to data due to poor security controls on medical devices.

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 establishment controls within the Medical equipment and devices 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 a policy in place for the management of medical devices, namely, the 'Medical Device Management Policy' (the 'Policy'). The Policy covers the period to 2014, and as such is out of date. In 2015, the Medicines and Healthcare products Regulatory Agency (MHRA) provided guidance for healthcare and social services organisations on managing medical devices, including what a device management policy should include. However, our review of the Health Board's Policy confirmed that it does not consider all of the requirements set out in the MHRA guidance.

The Health Board condemns equipment that it is unable to locate after three attempts of looking. At the time of our audit fieldwork, the RAM inventory system appears to list 11,351 condemned items, with a purchase cost of £10.6m that the Clinical Engineering Department had been being unable to locate. We since understand that a number of these items have been incorrectly classified as items not found following the migration of data to the new inventory system in August 2017. However there remains the risk that some of these items may still be in use within the Health Board but would not be subject to planned preventative maintenance (PPM). At the time of the audit fieldwork, this information is not escalated to any of the Health Board's committees. Given that these items, while recorded as

condemned, could still be being used, the Health Board may be unnecessarily purchasing new equipment that it already has, but is unable to locate.

The inventory, as at August 2018, included 15,774 items with a total purchase cost of £33m. However, not all of the information fields for around 10,000 items of equipment have been completed, such as the 'Model Life' field. Including the 'Model Life' could assist the Health Board with effective equipment life-cycle planning. We acknowledge that the RAM system was not implemented until August 2017 and as such is evolving. Once all fields are completed on the RAM system this will provide the Health Board with more meaningful reporting and provide better assurance to the Board on the financial implications associated with managing medical equipment and devices, which could assist with forecasting and future decision-making.

The Planned Preventative Maintenance system provides a good audit trail including what work was undertaken, and by whom. We also note that the Clinical Engineering Department actively checks for medical device alerts and investigates and logs Datix incidents relating to medical devices, where appropriate.

A training needs assessment should be completed and training provided, either internally or by the manufacturer, before medical equipment and devices are released and used on patients. The Clinical Engineering Department require that a Statement of Need (SON) is completed for all items of medical equipment and devices prior to procurement so that all elements can be fully considered prior to procurement – including training. We understand from our sample testing and from discussions with Clinical Engineering staff that the SONs are not always received and as such equipment can be installed in the ward / department without the Clinical Engineering Department being aware of the equipment. As such, our review confirmed that the paperwork relating to training required was not fully recorded and at the time of our review was not up to date. We would expect as a minimum that a training needs assessment is completed and logged for all items of equipment, which should document whether or not training is necessary and that a central log of these should be maintained.

The IT security of medical devices is generally good, with passwords changed, access to the Health Board network controlled, and wireless connectivity and physical port access restricted unless required. We note some weaknesses in that the procedures do not always document the actions taken. In addition, there are flaws within pacemakers that could allow unauthorised access, and patient data is not always secured. This issue is not unique to the Health Board. At present, these are not actively exploited and although the current risk exposure is low, this is likely to increase in the future.

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. To this end, while the assurance summary in section 5 shows the majority of the areas

reviewed as either in the reasonable or substantial assurance, the number of findings identified during the audit fieldwork, and the significance of the high priority findings means that, in our judgement, an overall assurance rating is considered to be limited.

5. Assurance Summary

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

Assurance Summary					
1	Policies and Procedures			✓	
2	Medical Equipment Register		✓		
3	Addition & Removal of Assets from Register		✓		
4	Servicing and Maintenance				✓
5	Risk Assessments Completed on Devices			✓	
6	Incidents Reported on Datix				✓
7	Staff Training		✓		
8	Meeting / Reporting Arrangements			✓	
9	Security Processes - Secure Network			✓	

** 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 three issues that are classified as weakness in the system control/design for medical equipment and devices.

Operation of System/Controls

The findings from the review have highlighted eight issues that are classified as weakness in the operation of the designed system/control for medical equipment and devices.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Relevant Health Board policies and procedures are up to date, clear in respect of roles and responsibilities, and available to staff.

We note the following area of good practice:

- The Clinical Engineering Department have procedures in place, which have been recently reviewed and include references to the RAM system, which was implemented in 2017. The procedures include a version control, which details the reason for any updates to the procedures. The procedures detail the day-to day processes that the Clinical Engineering Department should follow.

We identified the following findings:

- The Health Board's 'Medical Device Management Policy' was due for review in February 2014. In April 2015 the Medicines and Healthcare products Regulatory Agency (MHRA) issued guidance on what should be included in an organisation's policy. The Health Board's current Policy does not fully address all the requirements as detailed in the guidance. We acknowledge that the Health Board's Policy was produced prior to the issue of the MHRA guidance.

Objective 2: The Health Board medical devices and equipment register is up to date and reviewed and the information required, including equipment lifespan, is recorded.

We note the following area of good practice:

- The RAM system sequentially numbers all assets added to the system. When equipment is returned to the Clinical Engineering Department for Planned Preventative Maintenance (PPM), the new RAM inventory number sticker is attached to the piece of equipment.

We identified the following finding:

- The RAM system includes a field for 'Model Life', which records how long the equipment is expected to last. This field is not completed in all instances.

Objective 3: There is compliance with Health Board procedures for the addition and removal of assets from the register, including recording the loaning of equipment between wards and the loaning of equipment from the Clinical Engineering equipment library.

We note the following areas of good practice:

- A user manual has been produced and is available on the Health Board's intranet on the process to follow for loaning out and returning equipment to the equipment library.
- Access to the equipment library is restricted, via swipe card, to staff who need to access the library to collect or return equipment.
- The Clinical Engineering Management System assigns a sequential number to the loan reference and details the name and contact retails of the person requesting the equipment, the equipment requested and the location that the equipment is going.

We identified the following findings:

- The Health Board condemns items that it cannot find after the third attempt to locate it. However, the equipment could still be in use and may not receive the appropriate servicing and maintenance. In addition, the Health Board may purchase similar / identical equipment as it considers the equipment condemned. We understand that these items are communicated to ward managers and items are listed. However, at the time of our review the total number of items and the purchase cost of these items were not being reported upwards to a relevant committee within the Health Board.
- The equipment libraries are unmanned. The Clinical Engineering Department does not routinely undertake a reconciliation between the inventory available in the library and the inventory on loan. We understand that a reconciliation is undertaken when stock levels are low. However, waiting until the equipment levels are low could adversely affect patient care. We were informed that the Clinical Engineering Department does not have the capacity to undertake a routine reconciliation.
- A Statement of Need form, which sets out a risk assessment relating to the equipment, should be completed before equipment is added to the inventory. We selected a sample of 30 items of equipment from the inventory. For 16/30 of these a SON had not been completed prior to the equipment being purchased.
- The RAM system details the location of the equipment. We selected a sample of 30 items of equipment. For 10/30 of these we were unable to sight the equipment at the location recorded on the RAM system. We acknowledge that reasons were provided for the equipment not being available and these reasons are detailed on the finding.

Objective 4: Accurate records are maintained of the servicing and maintenance of medical equipment and devices.

We note the following areas of good practice:

- Since the implementation of the RAM system, when equipment is returned to the Clinical Engineering Department a new RAM asset number and next service date sticker is placed on the item, which is colour coded and relates to the year of the next Planned Preventative Maintenance (PPM). This highlights to staff when the medical equipment and device is due for service, which is an extra control in addition to the Clinical Engineering Department's PPM schedule.
- We reviewed a sample of 30 items of Medical equipment and devices selected from the RAM inventory as at August 2018 against the PPM schedule, which confirmed that, 29/30 of the items selected were listed on the PPM schedule.

We did not identify any findings relating to this objective.

Objective 5: Risk assessments are completed on devices and equipment that may pose a risk to patients or staff.

We did not identify any areas of good practice or specific findings in respect of risk assessments.

However, the Statement of Need form, as referenced above under objective 3 (Appendix A – finding 5), includes a risk assessment and we identified a number of instances where this form had not been completed.

Furthermore, a risk in relation to pacemakers (objective 9, below) should be formally recorded on a risk register.

Objective 6: Incidents, defects and faults relating to medical devices and equipment are recorded on the Datix incident reporting system.

We note the following area of good practice:

- The Clinical Engineering Department actively checks for medical device alerts and investigates and logs Datix incidents relating to medical devices, where appropriate.

We did not identify any findings.

Objective 7: Where necessary, staff are appropriately trained before using medical devices and equipment.

We identified the following finding:

- There does not appear to be a structured approach to recording training needs in line with the Health Board's procedures. At the time of our audit, there was a 12-month backlog of entering manufacturer provided training information onto the training database due to a lack of administration support. The evidence provided in respect of some of the training was in the form of handwritten notes from departments that were produced upon audit request.

- We would expect as a minimum that a training needs assessment is completed and logged for all items of equipment, which should document whether or not training is necessary. We understand that TNA's are completed for equipment that the Training Manager is aware of but for the sample of 30 items appropriate evidence of a Training Needs Assessment (TNA) was not available for all items selected, as highlighted above.

Objective 8: Adequate information is reported to relevant groups.

We note the following area of good practice:

- Reporting at an operational level was found to be appropriate. This included: providing updates to the Quality, Safety and Risk Committee; the Capital Monitoring Group; and the Facilities Operational Group.

We identified the following finding:

- We note that at the time of our review there was no reporting in respect of the total number and costs of equipment that has been categorised as condemned following the Clinical Engineering Departments inability to locate the items after the third attempt. We have indicated on the relevant finding where we would consider reporting / escalation appropriate and as such, a specific finding has not been raised under this objective. We acknowledge that the RAM system is evolving and will enhance reporting when all relevant fields are completed.

Objective 9: Appropriate security processes are enabled in order to secure network of Wi-Fi enabled medical devices.

We note the following areas of good practice:

- There is a requirement that devices meet minimum standards before being connected to the Health Board's network, which is controlled by the IT department.
- As part of the device commissioning process, the passwords to devices are changed. Additionally, wireless connectivity is only turned on if it is going to be used.
- The passwords used are good in that they are long and complex.
- USB ports on devices are locked to prevent unauthorised access.
- Medical devices are updated following an alerts and this information pertaining to updates is held on the RAM system.

We identified the following findings:

- The device configuration management procedures do not fully cover the actions that are undertaken as part of the device commissioning process as they do not refer to password changes or wireless connectivity.

- There are weaknesses within the pacemakers used by the Health Board, and the associated programmer units (units held in the department used to define the settings for pacemakers). None of the devices can be password protected, the data held on the programmer units is not encrypted and there is no process to ensure data sanitisation / removal. In addition, these records (patient data) are not held on any Information Asset Register.
- There is no standard process in place to ensure that medical devices are updated to the latest version of the relevant software.
- There is a security flaw in some pacemakers, which allows an unauthorised user to access a device using commercially available equipment and reprogram it. At the time of our audit fieldwork, this affects about 435 patients. These have not been updated due to the clinical risk associated with the process and the resource requirement to mitigate this. Whilst this decision may be appropriate, it has not been formally recorded, and the risk has not been included on the Cardiology departmental risk register.

7. Summary of Recommendations

The audit findings and 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**	**6**	**3**	**11**

Finding 1 - Items condemned due to failure to locate (Operating effectiveness)	Risk
The Health Board condemns equipment that it is unable to locate after the third attempt. When condemning an item we understand that the Clinical Engineering Department inform the user or manager at the relevant ward or department when they have been unable to locate the item, and that it is the responsibility of the ward/department to inform finance that an item has been condemned. At the time of our audit fieldwork, the copy of the Real Asset Management (RAM) inventory that we were provided with included 19,644 condemned items. Of these items, 11,351, with a total purchase cost of approximately £10.6m, were classified as items that the Clinical Engineering Department were unable to locate after the third attempt, and as such had been condemned. Of these, 440 items had a purchase costs ≥£5,000 with a total value of around £3.5m. The Head of Clinical Engineering confirmed that some of these items may still be in use within the Health Board, but would no longer be subject to planned preventative maintenance (PPM). We also note that if these items are still in use the Health Board may be purchasing equipment that it already has, but is unable to locate. We have since been informed that some of the 11,351 may have been incorrectly classified as "unable to locate at third attempt" when data was transferred from the old inventory database to the current RAM system. As such a true picture of the items that have actually been condemned if not found after three attempts cannot be obtained.	Financial and reputational implications associated with the failure to effectively manage medical devices and equipment. Medical Equipment and devices are being used which are no longer subject to Planned Preventative Maintenance which may result in risks to patient safety. Disposal of Medical Equipment and devices is not in line with relevant regulations.

Furthermore, at the time of our audit fieldwork information in relation to the number and value of items condemned when not found is not escalated to any of the Health Board's committees, though as stated, ward managers are informed.	
Recommendation	**Priority level**
The Health Board must ensure that where medical equipment and devices are being moved from their current location that the Clinical Engineering Department is informed to ensure that the RAM system can be appropriately updated. The Health Board should ensure that the data within the RAM system is accurate in order for it be used to report the number and value of items that it is unable to locate after the third attempt. This information should be escalated to Board via the appropriate committee so that they are fully aware of the financial implications and potential patient safety issue.	**High**
Management Response	**Responsible Officer/ Deadline**
• Moving forward data is recorded on system to enable necessary reports to be provided and would be scrutinised for accuracy before sending. • Individual missing items are reported to ward managers/responsible person following Planned Preventive Maintenance on an almost monthly basis depending where those checks were scheduled to take place • High-level report of quantity and value is now reported through Quality Safety & Risk Committee exception report. (Last provided 12 Nov 2018).	Wayne Goodfield, Head of Clinical Engineering – Closed High level Reports are now provided to Safety, Quality & Risk Committee.

• Pilot RF-ID project from WG funding to analyse whether this can assist in tracking equipment and aiding locating devices.	

Finding 2 - Evidence of training (Operating effectiveness)	Risk
The Clinical Engineering Department's 'QP_02 Medical Devices Training Procedure' details the process to follow in respect of Medical Devices and equipment training. The procedure details that: • *The Head of Clinical Engineering has the overall responsibility for the delivery and compliance of medical devices training, provided by Clinical Engineering and the manufacturers.* • *The Medical Devices Trainer is responsible for the construction and delivery on internal approved courses and is also responsible for the co-ordinated and management of Manufacturers courses.* • *All attendance records are produced by the responsible trainer and maintained for training audits by the Medical Devices Trainer.* *Once a training need has been identified, a Training Needs Analysis (TNA) CT03 form is completed by the medical devices trainer as a result of one of the four factors listed below:* • *New equipment* • *User requests* • *Statutory alerts* • *Mandatory requirements of the Health Board*	Inadequate training or knowledge regarding the appropriate use of equipment and Health Board processes may result in risks to patient safety. Inadequate record-keeping could undermine management monitoring arrangements, and hinder the ability of the Health Board to demonstrate its management of devices to external bodies.

There are different methods of delivering training on medical devices, including in-house from the Medical Devices Trainer and manufacturer training. It is noted that the procedure does not make a distinction between the two training methods and as such we would expect a central log of all training, as required by the procedure regardless of delivery method. It is acknowledged that some training may be delivered by manufacturers directly to staff, where equipment is obtained without Clinical Engineering involvement, due to lack of a SON. However our sample was taken from the RAM inventory, therefore equipment known to Clinical Engineering. We requested evidence of training for the sample of equipment and devices that we selected and note the following: • There was no evidence of training needs analysis forms being completed before medical equipment is procured and released to the department. • There is a 12-month backlog on entering the training attendance information onto the training database. As such, any reporting from the training database system does not accurately reflect the current situation in respect of training received or required. We were informed that the backlog relates to manufacturer training only. We understand that this is due to a lack of administrative support. • Due to the backlog in updating the training database with the training records, it was not possible to confirm that in all cases staff using the medical equipment/devices have been adequately trained before the equipment is provided and used on patients. We were provided with attendance records to show that training had been delivered for some of the medical equipment selected in our sample. However, some of the evidence provided for	

manufacturer training was in the form of handwritten notes from departments that were produced on upon audit request and state "there is e-leaning available on YouTube and a user manual is available if required" • For those records that were available the date that the training was delivered was not always completed on the records. We understand that training is delivered on various dates and as such, the dates are not recorded on the attendance sheet. The procedure notes include a 'Competence Flow Chart for All Users of Medical Devices', which indicates that a frequent user should have their competency assessed annually and non-frequent users should undertake refresher training. However, if the date is not recorded then it is not possible to undertake the appropriate monitoring. Given that there is a backlog in updating the training database with the attendance sheets it is unlikely that they will accurately recall the date that the training had been provided which could impact on carrying out the appropriate monitoring. • Attendance sheets that have not been entered onto the training database are held in an unsecured desk drawer, which may not be appropriate under GDPR, given that they detail personal sensitive information.	
Recommendation	**Priority level**
The Health Board must ensure that the procedure in respect of Medical Devices training is followed to ensure that it can demonstrate that staff have been appropriately trained on Medical Equipment and Devices prior to it being used on patients.	**High**

Management Response	Responsible Officer/ Deadline
While the equipment has been logged on RAM this does not necessarily mean we were aware of the purchase of the equipment prior to purchase to ensure training was performed, TNA's etc completed. Equipment may have been delivered directly to user department and not Clinical Engineering. The sample selected contained equipment for which we did not have awareness of prior to purchase or delivered directly to user. An IMTP plan for additional training support has been submitted which will reduce backlog of paper information being transferred to database and capture and provide monitoring of manufacture supplied training. It is acknowledged that currently Clinical Engineering do not and cannot provide the competency and update training of specific equipment in specific departments for individual staff. The departments have their own responsibility to monitor and assess training requirements, such as when staff leave and new staff are enrolled. Evidence of training was provided for the samples requested, however they are not yet updated on database. New equipment for which we had direct control of, were withheld from use until the training records were provided to enable release of the equipment. TNA documents were also provided for new equipment purchases which we had available. TNA were not specifically requested for all samples. Any TNA's we have on file is available upon request. Exact dates of the training were not individually entered as manufacture training of equipment may span a month or two. (Reliant on supplier/manufacturer completing this date).	Wayne Goodfield, Head of Clinical Engineering /Russell Hoare, Acting Assistant Director 01/08/2019

Competence and update training is not performed on manufacturer provided training. Dates would be spanned possibly over a month or two to capture 70% or more staff before equipment release. It would also be the responsibility of the user department and staff member to keep a log of their training, however the original paper documentation is available upon request. Training provided by Medical device trainer have firm dates and competence workbooks and are updated on the training database in timely manner. Reports on competencies are reported to director of nursing, heads and senior nurses. Monitoring is therefore provided for these courses. Keys have been obtained and lockable cabinets are now in use for paper records which are in the Head Of Clinical Engineering /Medical Device Trainer's office, which is locked when unattended.	Robert Matthews – Medical Devices Trainer. Completed

Finding 3 - Model life (Operating effectiveness)	Risk
The Health Board uses the Real Asset Management (RAM) system as its Medical Equipment Management system; this was implemented in August 2017. The inventory, as at August 2018, included 15,774 items with a total purchase cost of around £33m. The RAM5000 system, used by the Clinical Engineering Department, does not currently link directly with the RAM4000 system, used by the Finance Department. However, the Clinical Engineering Department provides Finance with information relating to items greater than £5,000 for capital asset recording, this information includes the lifespan of the device. We understand that it is the intention to have the two systems linked at some point. Our review of the inventory on the RAM system confirmed that not all fields were completed. For 10,054 items of equipment, with a total purchase cost of approximately £25.5m, the 'Model Life' field, which records how long the device or equipment is expected to last, had not been completed. Of the 10,054 without the model life recorded, 1,185 items had a purchase cost of ≥£5,000, with a total value of approximately £19m. Including the 'Model Life' could assist the Health Board with equipment life-cycle planning. We understand that going forward, all new models recorded on RAM will have the model life data input. We acknowledge that the Health Board uses medical equipment and devices that are past their notional useful life, if they are still in good working order, which we consider a prudent use of resources.	Inadequate record-keeping could undermine management monitoring arrangements. Financial implications associated with the failure to effectively monitor medical devices and equipment.

Recommendation	Priority level
The Health Board should ensure that the 'Model Life' field is completed on the RAM system and use the reporting functionality of the system to forecast and assist in effective equipment life-cycle planning. The Health Board should ensure that all relevant fields are completed on the RAM5000 system to facilitate the process when the system is linked to the RAM4000 system. The Health Board should ensure that it effectively escalates any forecasting reports on equipment life cycle planning, both number of items and estimated purchase cost of replacing the equipment, if required. This would provide the Board with greater clarity on future costs and equipment issues to facilitate planning.	**Medium**
Management Response	**Responsible Officer/ Deadline**
There are currently 4,767 models listed on RAM, 2,328 are obsolete models which must remain on database for condemned devices. These records will not be updated with model life as they are not active. 2,439 models of active equipment. 131 models have a projected lifespan associated with them. This leaves 2,308 models to be updated. This information was not available on old database and will be an on-going update as and when we review devices/models. Purchase/install dates of individual devices are entered on all active equipment records which gives an indication to age of device. The Head Of Clinical Engineering provides guidance where required at Capital Monitoring Group and	Wayne Goodfield, Head of Clinical Engineering 01/08/2019

any reports provided regarding suggested replacement of devices. Lists of all equipment have been provided to directorate managers with install dates for Capital and IMTP planning as a result of Capital Workshop with guidance to contact Head Of Clinical Engineering for any advice regarding the list. While model life will be updated in future, these are just guidance values as equipment replacement would be reviewed. Each individual model would have any other update of information also added. Any new model added has the required information included. In general medical devices are given 5, 7 or 10 year lifespans.	

Finding 4 - Medical equipment and devices policy (Control design)	Risk
The Health Board's current 'Medical Device Management Policy' (the 'Policy') approved by the Quality, Patient Safety and Public Health Committee in January 2011, was due for review in February 2014, and as such was out of date at the time of our audit fieldwork. In addition, we note that there are multiple versions of the Policy on the Health Board's intranet. In April 2015 the Medicines and Healthcare products Regulatory Agency (MHRA) issued guidance for healthcare and social services organisation on managing medical devices. Section 2.3 of this guidance relates to 'Device Management Policy', which details what a policy should address. We reviewed the Health Board's policy (which it is acknowledged pre dates this guidance) to confirm that it included the relevant sections in accordance with the MHRA guidance. The Health Board's policy is clear on roles and responsibilities, but it does not include clear sections on the following: • The equipment life cycle (selection, acquisition, acceptance, maintenance, repair, monitoring, traceability and disposal/replacement). • Risk management including adverse incident reporting and actions required on MHRA's Medical Device Alerts and manufacturers' field safety notices. • Training and access to manufacturer's instructions – While the Health Board's policy details training, it does not refer to accessing manufacturer's instructions. However, we acknowledge that the Clinical Engineering intranet page includes links to the relevant manufacturer's instruction.	Policies are out of date risking a lack of clarity in respect of roles & responsibilities. The Health Board's Policy does not address the requirements of the MHRA guidance.

• Records, including device inventory – While the Policy refers to records and inventory throughout the document, there is no specific section for records and device inventory as suggested by the MHRA guidance. • Outsourcing - this is not included on the Health Board's policy. However, we understand that some devices are serviced, and training delivered, by the manufacturer. • Equipment deployment, tracking and utilisation. We acknowledge that section 6 of the Health Board's policy provides examples of existing supporting procedures. Some of these procedures may already address the MHRA requirements and as such, whilst the current policy does not provide detail in relation to the bullet points listed above, there are some procedures in place that may already address the requirements.	
Recommendation	**Priority level**
The Health Board's `Medical Device Management' policy should be updated in line with the requirements as set out in the MHRA's 'Managing Medical Devices' guidance. All historical versions of the Policy should be removed from the Health Board's intranet to ensure all staff adhere to the correct version of the Policy. Clinical Engineering procedure should also be reviewed to ensure that they fully address the requirements of any revised and updated Policy in accordance with MHRA guidance.	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed the policy and associated procedures are out of date. A review was started and should be updated in line with new organisation structure and rationalisation of the documents to simplify. We are lacking a multidisciplinary 'Medical Device Group' which was planned and will be developed to ensure the policies/procedures are updated to enable ratification at board level and for it to be communicated throughout HB. A group will be developed with TOR as part of the merging of CTUHB and Bridgend district which will include monitoring of need, quality and standard of medical devices proposed for purchase, training compliance and records. Clinical Engineering internal policy/procedure will be reviewed and updated in line with any new HB policy/documents developed. Document review is part of internal quality procedure.	Wayne Goodfield, Head of Clinical Engineering 01/08/2019

Finding 5 - Statement of Need (Operating effectiveness)	Risk
The Health Board's 'Purchase and Acquisition of Medical Devices / Equipment Procedure' requires that "*all requisitions placed for medical equipment should be accompanied by a Statement of Need (SON). The department must include the clinical governance statement and risk score together with approval from the Head of Clinical Engineering to ensure consistency across the organisation of intended purchases whatever the source of funding*". The Health Board has produced a SON template to be completed prior to procurement to ensure that procurement of medical equipment and devices is fully considered. We tested a sample of 30 items of medical equipment from the RAM inventory as at August 2018 to confirm that the SON had been completed. The sample included 15 items located in Royal Glamorgan Hospital (RGH) and 15 items located in Prince Charles Hospital (PCH). We note that SONs had not been received / completed for 16/30 of the items tested. We note the following: • 2/16 - Clinical Engineering were unable to locate the SON. • 2/16 - Were approved through the Executive Capital Management Group (ECMG) via the Integrated Medium Term Plan (IMTP). • 6/16 - Were purchased as part of a major scheme. • 3/16 - Were agreed as replacement items through Executive Capital Management Group End of Year (EOY) funding. • 3/16 - were agreed through Single Quote Tender (SQT) ECMG EOY funding.	Replacement of equipment may not comply with policy and therefore may result in risk to patient/staff safety.

Furthermore, while the RAM system includes a field for 'SON Reference' the Head of Clinical Engineering confirmed that this field is not populated.	
Recommendation	**Priority level**
In accordance with procedures the Health Board must ensure that a Statement of Need is completed, submitted and appropriately reviewed by the Head of Clinical Engineering to ensure that consideration has been given, for example, as to whether: • Devices already exist within the ward or department. • Devices already exist in other wards or departments that are surplus to requirements. • The device is a replacement or additional (new) to existing equipment. • What is the source of the funding. • Does the device meet the safety requirements for its type. • Do other departments and wards need to procure the same device - enabling economies of scale. The Health Board should ensure that the SON reference is recorded on the RAM system as a matter of course.	**Medium**

Management Response	Responsible Officer/ Deadline
Clinical Engineering attempts to ensure a SON is provided for all purchases. If purchases are made without our authorisation or are purchased through other mechanisms, Clinical Engineering will have no control. This has been raised previously by Head of Clinical Engineering with Procurement and Capital. Clinical Engineering suggest that with the new policy a new SON process is developed as a web page for both revenue and capital purchases with approval hierarchy. Procurement have a fundamental role in ensuring process is followed. The SON reference is an additional field developed for RAM in an attempt to identify which SON's relate to which equipment purchased. Any new devices added to RAM should have this added by the technician booking the device on the system. Once established, a Medical Devices Group would in theory view any device suggested for purchase or donation before it is considered for the HB.	Wayne Goodfield, Head of Clinical Engineering /Russell Hoare, Acting Assistant Director 01/08/2019

Finding 6 - Pacemakers (Control design)	Risk
There are software weaknesses within the pacemakers that are provided to patients by the Health Board, and the associated programmer units (hardware units held in the department used to define the settings for pacemakers), these are: • none of the devices can be password protected; • the programmer units in the department hold patient data, which is never deleted; • the data held on the programmer units is not encrypted; • disposal of the programmer units is undertaken by the supplier. However, there is no process to ensure data sanitisation / removal; and • these records (patient data) are not held on any Information Asset Register (IAR). However, we acknowledge that these weaknesses are inherent within the devices, and is not unique to the Health Board.	There is a small risk of unauthorised access to pacemakers. In addition, there is a risk of data leakage on disposal of programmer units, the process for which does not comply with the Health Board procedures for disposal of ICT equipment and media. There is also a risk of legislative non-compliance as these patient records are not recorded on an IAR.
Recommendation	**Priority level**
The risks associated with pacemakers should be recorded on the Cardiology Departments risk register. The records should be recorded on the Cardiology Departments IAR.	**Medium**

The supplier should be asked to confirm that when programmer units are disposed of, the patient data is appropriately sanitised using a process, which would enable the Health Board to ensure compliance with GDPR (General Data Protection Regulations).	
Management Response	**Responsible Officer/ Deadline**
Risk assessment to be completed and added to risk register. Programmers are stored in locked store room in Cath lab and device clinic room which is locked during non-office hours. All software updates are carried out by manufacturer representatives on hospital sites. Medtronic and Boston Scientific programmers do not contain a hard drive so no patient data is stored on programmer. St Jude (Abbott) and Biotronik patient data is stored on programmer hard drive. This information is accessed as part of clinic review of patient's device interrogation. Patient data can be cleared manually prior to the programmers being return to manufacturer for repair. A department protocol to be completed and staff made aware of process prior to return of programmers. Capital bids submitted to acquire cardiac device central storage and reporting system. This system would be a donated asset as part of a purchase agreement within current resource. This would considerably reduce the risk associated with data transfer, storage & access. Using this system data would deleted from	Dave Tyler Head of Cardiopulmonary Diagnostics / Victoria Brooks Head of Cardiac Device Service. 01/04/19

programmers transfer. The Cardiology department Information Asset Register (IAR) will be updated to record that patient data is held on pacemaker software.	

Finding 7 - Reconciliation of Equipment Library inventory (Control design)	Risk
The Health Board has a Clinical Engineering equipment library at Royal Glamorgan Hospital and at Prince Charles Hospital, which is stocked with commonly used medical devices such as infusion pumps and syringe pumps. Access to these rooms is restricted to porters and some ward staff via swipe card access. The equipment library rooms are not manned and are reliant on staff using a bar code reader to scan items in or out of the library. To facilitate this the Health Board has produced guidance, which is available on its intranet. No routine inventory check is undertaken to confirm that the loan process is followed, so that items listed as being available for loan are in stock. We understand that a reconciliation is undertaken when stock levels are low. However, waiting until the equipment levels are low could adversely affect patient care is if equipment is left on wards longer than necessary.	Inadequate record-keeping could undermine management monitoring arrangements, and hinder the ability of the Health Board to demonstrate its management of devices to external bodies.
Recommendation	**Priority level**
While we understand that currently, the department does not have the resources to undertake a reconciliation, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	**Medium**

Management Response	Responsible Officer/ Deadline
An IMTP submission is in place which includes the requirement for Equipment library staff. A system has been initiated in PCH where porters are making regular evening walks of wards and collecting equipment. Clinical Engineering Staff are reviewing the equipment returned to check Planned Preventative Maintenance status and update library system. Currently the option for doing this is not possible in RGH. Pilot RF-ID project from WG funding to analyse whether this can assist in tracking equipment and aiding locating devices/auto updating of locations. Bid within IMTP for further coverage if the pilot proves successful.	Wayne Goodfield, Head of Clinical Engineering /Russell Hoare, Acting Assistant Director 01/09/2019

Finding 8 - Incorrect location recorded on RAM or unable to sight sample items (Operating effectiveness)	Risk
The RAM system includes a field for recording the location of the medical equipment and devices. We tested a sample of 30 items of medical equipment from the RAM inventory as at August 2018. The sample included 15 items located in RGH, and 15 items located in PCH, across wards and departments. We were unable to sight the equipment at the location listed on RAM system for 10/30 items selected. Of these, the following is noted: • 1/10 - the equipment was locked away and the member of staff with the key was on leave. • 1/10 - the theatre where the equipment was located was in use and as such not available to view. • 3/10 - the items were sighted but not at the location listed on the inventory. • 1/10 - the item was being serviced - this was verified to a Job Report from the PPM system. • 3/10 - these were listed as defibs for resus training - despite four attempts to sight these items, they were not available to view. • 1/10 - the equipment related to a Diabetic Pump, which was out in the community with a patient. The department listed on the RAM system was Speech Therapy - which is incorrect.	Inadequate record-keeping could undermine management monitoring arrangements, and hinder the ability of the Health Board to demonstrate its management of devices to external bodies. Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

During our testing we identified one item of equipment, relating to a Dysphagia Swallow Station with a purchase cost of £92k, that has not been used since purchased (Its statement of need was completed in 2015). The item held in a storage room whilst, out of preference, staff continue to use older equipment. This does not appear to be an appropriate use of resources.	
Recommendation	**Priority level**
The RAM system should be updated to reflect the correct and current location of the medical equipment and devices. Wards and departments must ensure that, where equipment has been removed from its current location, it is communicated to the Clinical Engineering Department. Management should consider an appropriate course of action to address the new unused equipment.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Clinical Engineering updates database as and when we are aware of equipment movements or errors noted on database. In the transcription from the old database the location was incorrect which was corrected immediately on the database when noted. Pilot RF-ID project from WG funding to analyse whether this can assist in tracking equipment and aiding locating devices/auto updating of locations. Bid within IMTP for further coverage if the pilot proves successful.	Wayne Goodfield Head of Clinical Engineering 01/08/2019

Clinical Engineering would welcome enhanced scrutiny over device purchases through capital or revenue process, where Clinical Engineering have concerns prior to purchase.	

Finding 9 - Device set-up (Operating effectiveness)	Risk
The device configuration management procedures do not cover the following actions that are undertaken as part of the device commissioning process: • ensuring passwords to devices are changed; and • ensuring wireless connectivity is only 'turned on' if required. In addition, our testing identified that the RAM system is not always fully updated with password information, neither is the master password list always updated.	There is a risk that security may not be maintained.
Recommendation	**Priority level**
These IT security related items should be specifically included within the procedures. The RAM system, and the password list, should be updated to ensure records are complete.	**Low**
Management Response	**Responsible Officer/ Deadline**
Clinical Engineering will review and update 'QP04 Configuration management procedure' and 'QP21 Acceptance Procedure for medical devices' accordingly. Staff are reminded regularly to ensure data is updated on database with required information.	Wayne Goodfield Head of Clinical Engineering 01/08/2019

Finding 10 - Device updating (Operating effectiveness)	Risk
There is no standard process in place to ensure that medical devices are updated to the latest version of the relevant software. For example: • Devices managed by clinical engineering are updated when the supplier contacts them to make them aware of an update, if there is a formal MHRA's medical device alert, or if a manufacturers' field safety notice is issued for a device. • There is a security flaw in some pacemakers, which using commercially available equipment, allows an unauthorised user to access and reprogram the device. At the time of our audit fieldwork, this affects about 435 patients. These have not been updated due to the clinical risk associated with the process and the resource requirement to mitigate this. Whilst this decision may be appropriate, it has not been formally recorded, and the risk has not been included on the departmental risk register. We note that at present, the IT security risk associated with medical devices is low as there are no commonly available active exploits (computer scripts); however, this risk is likely to increase in the future.	There is a risk of unauthorised access to patient information and devices.

Recommendation	Priority level
The risk associated with the pacemakers should be formally recorded. The Health Board should start to consider a process for ensuring medical devices are updated appropriately in order to future proof the processes and prevent future risks from materialising.	**Low**
Management Response	**Responsible Officer/ Deadline**
Clinical Engineering have a formal process for dealing with device alerts via MHRA and Manufacturers. (QP11) which would include software updates. Only if the software is of a mandatory update in nature will this process be enacted. Some software updates are available as enhancements to operation and not necessarily security, which would have costs and further training implications. Compatibility of systems also have to be considered when software versions are implemented and compatibility of interchangeable monitor modules/networks etc. A log of the software version is updated on RAM for the associated equipment by the technicians. Clinical Engineering disseminate Medical Device alerts relating to internal pacemakers/internal defibrillators to named contacts in Cardiology. The risk associated with not updating the software in pacemakers will be recorded on the Cardiology department's risk register.	Wayne Goodfield Head of Clinical Engineering 01/03/2019 Dave Tyler Head of Cardiopulmonary Diagnostics /

	Victoria Brooks Head of Cardiac Device Service. 01/04/19

Finding 11 - Items recorded as installed and condemned on the same day (Operating effectiveness)	Risk
The RAM system includes fields for equipment 'Installation Date' and 'Condemned Date'. We reviewed the RAM inventory as at August 2018, which included a total of 15,774 items, and note that it included 22 items that were installed and condemned on the same day. In addition, there were 57 items that had a condemned date, which was earlier than the installation date. The Health Board was not aware of this issue and did not know the reason for this anomaly. These items were still 'active' on the RAM system and as such, had not been condemned.	The integrity of the RAM system is compromised resulting in unreliable reporting.
Recommendation	**Priority level**
The Health Board should investigate the reason for this anomaly and rectify to ensure that the integrity of the RAM system is maintained.	**Low**
Management Response	**Responsible Officer/ Deadline**
Clinical Engineering are aware of the issue since providing the inventory to the auditor, and have reported to RAM to correct. This field however is actually a hidden field and when producing reports, this field is not actually used. The condemned job date would be used, so this is not an issue in the meanwhile. Informed colleague Nathan of problem 30/08/2018. RAM call log 02480972 to rectify issue when making other corrections.	Nathan Merchant Senior Clinical Technologist 01/03/2019

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.

Prince Charles Hospital Redevelopment

Final Draft Internal Audit Report

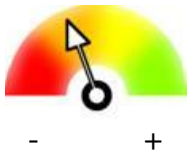
2018/19

Cwm Taf University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Limited Assurance

Previous rating (2016/17) **Reasonable Assurance**

Contents

Page

1. Introduction and Background 4
2. Audit Scope and Objectives 6
3. Risk Assessment 7

Opinion and key findings

4. Overall Assurance Opinion 8
5. Summary of Audit Findings 12
6. Summary of Recommendations 27

Appendix A	Management Action Plan
Appendix B	Audit Assurance Ratings
Appendix C	Prioritisation of Recommendations
Appendix D	Audit Objectives
Appendix E	Status of Previously Agreed Audit Recommendations
Appendix F	Investment Objectives
Appendix G	Time Performance
Appendix H	Cost Performance
Appendix I	Target Costs
Appendix J	Governance
Appendix K	Glossary of Terms

Review reference:	SSu_CTU_1819_01
Report status:	Draft
Interim feedback:	May 2018
Increased scope agreed:	August 2018
Fieldwork:	September – October 2018
Draft report issued:	20th November 2018
Draft report meeting:	24th and 30th January 2019
Management sign-off:	3rd February 2019
Management response received:	Deferred
Final Draft report update issued:	4th February 2018
Final report issued:	
Auditor/s:	A&A: Specialist Services Unit
Executive sign off	Chief Executive/ Director of Planning & Performance
Distribution	➢ Chief Executive ➢ Director of Planning & Performance ➢ Assistant Director of Planning (Capital & Estates) ➢ PCH Programme Director
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 Cwm Taf 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

1.1 Introduction

An initial audit review of the Prince Charles Hospital Development was undertaken in Quarter 4 of 2017/18, the output of which was reported in draft form to Cwm Taf University Health Board (the "UHB") in May 2018.

It was agreed to extend the review to undertake a more in-depth review of the key areas of concern, to gain a wider understanding of the key events affecting the delivery of the Project/Programme since the approval of the Outline Business Case (OBC) to date. This was to allow fuller consideration of the contributing factors, issues and management actions taken to manage/mitigate the same.

It was jointly agreed that this was deferred to allow a dove-tailed approach with the Gateway Review team to minimise duplication and reduce the impact on UHB staff.

The audit also seeks to review progress made to address previously agreed audit recommendations arising from the prior audit review. The scope of the that review was limited to a review of the Programme Business Case and Phase 1a Business Justification Case and provided a *"Reasonable"* level of assurance (see **Appendix B & C** for definitions). A summary of the audit findings is provided at **Appendix A**.

1.2 Investment Objectives and Regulatory Requirements

The investment objectives area outlined at **Appendix F**.

The Outline Business Case (OBC) stated that:

> *"failure to complete the associated and necessary permanent works within the timescales as defined in the Business Case would ultimately result in the (fire) enforcement notice (FEN) being enacted with resultant prosecution and potential closure of Prince Charles Hospital."*

At the time of this audit, the UHB was still in the position of having a fire enforcement notice served on the Prince Charles Hospital.

There is a positive working relationship with the South Wales Fire & Rescue Service, evidenced by the incremental extension of the FEN to reflect work undertaken to date.

However, it is recognised that the continued extension of the FEN is reliant upon the continued demonstration of progress, which can now be further demonstrated with the recent approval of Phase 1b that should be concluded on site in early 2021.

The fire enforcement notice is the important driver to the programme of works and has meant that, following OBC approval, the UHB has needed to commit to demonstrating continuous fire safety improvement.

It is also noted that there is clear support from the Welsh Government to work with the UHB to resolve the fire safety issues at the site in a timely manner.

1.3 Background & Current Status

a. The Programme as a whole has a long history and is summarised at **Appendix G**. The Outline Business Case (approved February 2013) outlined the current requirement and assumed progression via a single Full Business Case (FBC) and following the 5-case model methodology (utilising a three contract strategy).

With Welsh Government agreement, a mini-FBC was completed in May 2015 for Phase 1 enabling works only. A key change from the OBC was the UHB preference for a permanent, rather than a temporary, decant facility.

In dialogue with NWWSP: SES and Welsh Government concerns were raised with the indicative programme length (and cost) to see if there were alternative, quicker remediation options to lift the Fire Enforcement Notice. The Welsh Government instructed the UHB to undertake a 'do minimum' review. This review was undertaken jointly by the UHB, NWSSP: SES and the Fire Authority, taking 12 months to conclude.

A meeting was held with Welsh Government on the 24th May 2016 to discuss the outcome of the review, where it was accepted that the 'do minimum' option was not feasible. It was suggested, based on NWSSP: SES advice, that work should be re-phased in response to concern over the delay of the 'do minimum' review, to accelerate an area of highest risk (i.e. the kitchen area).

The Welsh Government confirmed, in June 2016, the expected business case approach to facilitate delivery of the Programme as follows:

- **Phase 1 - Business Justification Case:** Later split into Phase 1a: Decant for kitchens and Phase 1b: New permanent kitchen, pharmacy & infrastructure;
- **Phase 2 - Full Business Case:** Remaining ground & first floor main areas;
- **Programme Business Case** – to capture all phases and set out Phase 1 and 2 with fully tendered costs and include 'cost not to exceed' for the further phases, namely Phase 3 and Phase 4.
- **Phase 3 and 4** - these works are still subject to finalising detailed design. The approval and documentation required for Phase 3 and 4 will be subject to confirmation from Welsh Government, but are envisaged to be in the BJC format as per Phase 1 elements.

The June 2016 direction from Welsh Government is accepted as re-setting the targets in the original approved OBC.

b. As noted, the primary driver has been the need to demonstrate progress in addressing the Fire Enforcement Notice (FEN).

At various points, this has required the revisiting of the delivery strategy, impacting negatively on the delivery programme e.g. a permanent decant solution at the original mini FBC (May 2015), the 'do minimum' review and subsequent division of Phase 1 (supporting quicker commencement of works, as Phase 1a could be priced quickly whereas Phase 1b required additional work before it could be priced sufficiently).

The overall delivery programme has also been significantly reshaped to allow resequencing of works to satisfy the South Wales Fire & Rescue Service that there is incremental progress in addressing the significant risks identified under the FEN. For fuller details see **Appendix G**.

c. The current cost profile of the Programme has been summarised by the Cost Adviser at the "Overview of Budget Movements from Submission of the Original OBC" report in August 2018:

Figure 1	£	£
Approved OBC	**119,750,347**	
PUBSEC index adjustment to OBC	59,834,550	
Adjusted OBC	**179,584,897**	
Changes to Methodology, Technical Scope & Programme	59,708,256	
Total ECA Assessment of Cost	**239,293,153**	
Current SCP Forecast		**263,031,635**

The ECA has applied an inflationary uplift to the OBC approved sum of £59.834m. Additionally, changes to methodology, technical scope and Programme have been assessed as £59.708m. These are being reviewed in conjunction with NWSSP: SES on behalf of Welsh Government.

For fuller details see **Appendix H**.

2. Audit Scope and Objectives

This audit was commissioned to evaluate:

- Cost Control Systems;
- Programme/Project Management;
- Project Governance;
- Appointments and Contract; and
- Previously Agreed Audit Recommendations.

Further details on the specific objectives are outlined at **Appendix D** and summarised appropriately within the report.

3. Risk Assessment

We additionally sought the mitigation and management of negative impacts to time, cost and quality objectives of the sampled projects.

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.

Assurance Summary

It is important to recognise that all parties accept the Programme has not followed a conventional route. It is clear, in our view, that this has had a significant impact on certain processes applied and the outcomes to date.

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

Assurance Summary					
1	Cost Management	✓			
2	Programme Management	✓			
3	Programme Governance		✓		
4	Appointments and Contract			✓	
5	Status of Previously Agreed Recommendations			✓	

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

The three areas that have been assessed as providing negative assurance to date may be summarised as:

4.1 Cost Management:

Key deficiencies in cost management contributed to the Programme's financial challenges that emerged in the Autumn of 2017. The impact on the cost position may be summarised as at August 2018 as:

- The adjusted sums (£118m) applied to the approved Outline Business Case needs to be confirmed and accepted/ rejected; and
- Additionally, the £24m variance between the External Cost Adviser and Supply Chain Partner assessments need to be similarly resolved.

Since the UHB became aware of the deficiencies in the financial reporting and monitoring of the Programme, together with NWSSP: SES, management has sought to start to address relevant matters directly with their advisers.

We recognise that approximately £44m of the £239m at Figure 1 above relates to the approved Business Justification Cases for Phases 1a and 1b. Therefore, approximately £195m remains to be formally approved and committed via the Full Business Case process – demonstrating the importance at this stage of the need and benefit in reviewing lessons to date so that robust processes are implemented going forward.

4.2 Programme Management:

In concluding on the performance of programme management to date, we noted various limitations in the current arrangements implemented at the Programme.

In our view, these have impacted on the ability of the UHB to successfully discharge its informed client role. A number of issues have been raised within this report which include:

- An activity based resource schedule not being applied to confirm the current and future internal resource requirements, including fully dedicated operational leadership;
- The performance levels of the external advisers; and
- The overall Programme not being completely reset at the relaunch/re-phasing of the Programme to effect the realisation of revised phase targets.

To balance this observation, we recognise that management has supplemented its internal resource with specialist advisory support from NWSSP: SES, which was formally requested in writing via its Director in February 2018. Additionally, the UHB is currently bringing in further specific and dedicated expertise in the form of a Deputy Senior Responsible Officer.

An additional standalone factor, is the continued potential risk of contractor failure on the Programme, and the potential that subcontractor costs have been inflated to reflect this risk (we acknowledge this is a national issue and that the UHB is monitoring and consulting appropriately). Subsequent to the audit, we are advised that a paper was tabled at an in-committee meeting of the UHB to discuss the risk rating of the Supply Chain Partner. The Health Board subsequently endorsed the decision of the Project Board to continue to contract with the existing Supply Chain Partner for Phase 1b, whilst also continuing to monitor the situation closely.

4.3 Governance:

Noting the context of the Programme observations, and the agreed approach with the Welsh Government to the approved phases, management has implemented an adequate structure, and associated governance arrangements to facilitate the effective delivery of Phases 1a and 1b post business case (BJC) approval.

However, as noted, moving forward, there will be benefit in building on the current arrangements to implement a further strengthened Programme structure to introduce more control for Phase 2 and onwards.

As outlined there was, however, importantly insufficient cost and programme reporting to both the Project Board and the Capital Programme Board, especially on the performance of the overall Programme budget, impacting on the ability of the UHB to discharge the informed client role.

This has been accepted by management, who have already committed to, and demonstrated certain early actions to strengthen arrangements.

4.4 Overall Opinion:

The Assurance Summary table above outlines that three of the five key areas assessed impacted negatively on the Programme; with one being assessed as *'Limited Assurance'* and two assessed as providing *'No Assurance'*.

As noted, it is important to recognise that all parties accept the Programme has not followed a conventional route. It is clear, in our view, that this has had a significant impact on certain processes applied and the outcomes to date.

We are also cognisant that approximately £195m of the Programme remains to be formally approved. This will be committed via the Phase 2 Full Business Case and assumed BJCs for subsequent Phases 3 and 4. There is a recognition that the experiences gained on Phases 1a and 1b may be applied positively to improve control on Phase 2.

In our view, this demonstrates the importance of ensuring that action is taken at the Programme to bring it within satisfactory parameters to ensure the whole control framework is fit for purpose going forward.

We also acknowledge that 40% of the High priority recommendations outlined to management in the interim position reviewed in the Spring of 2018 are either closed or partially addressed.

We are therefore able to conclude the overall assessment for the current position of the Programme as:

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 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. Summary of Audit Findings

5.1 Cost Management



5.1.1 External Support – *the objective is to ensure the appointments/ framework requirements of the External Project Manager and External Cost Adviser (ECA) are discharged appropriately, including:*

- *content and accuracy – ensuring reporting is fit for purpose and reflective of the emerging Programme as a whole; and*
- *regularity and timeliness – ensuring information is received by the client in a timely manner to allow effective decision making.*

Period from the Relaunch of the Programme in June 2016 to November/ December 2017:

It was generally observed that the content and accuracy of reporting to the UHB was in line with guidelines, utilising established templates.

The ECA reporting in the period from relaunch in June 2016 to November/ December 2017 focused on the approved funding i.e.:

- Phase 1a: fees and construction costs, also evaluation of the Target Cost concluded at approval of the 14th September 2017;
- Phase 1b: fees only for the Business Case stage only; and
- Phase 2: fees only for the Business Case stage only.

However, the monthly cost reports, produced by the ECA, did not provide a full account of the remaining phases, overall expenditure profile and/ or overall Programme budget.

Overall Programme cost management and reporting was not recognised as a requirement by the advisers and not explicitly sought by the UHB in the period (ref. **recommendation 1 & 2**).

Furthermore, at relaunch in June 2016, having re-phased the Programme, relevant budgets were not derived or reconciled to the approved Outline Business Case to control the relevant phases and overall Programme (ref. **recommendation 4**). It is important to recognise that all parties accept the Programme has not followed a conventional route and that it would be usual to progress a Programme Business Case at this stage to capture this information and outline control requirements.

Period from Receipt of Most Recent Target Costs in November/ December 2017:

The receipt of the Phase 1b and Phase 2 initial Target Costs was in November/ December 2017. From this point the ECA continued to report as outlined above, but additionally produced ad-hoc reports on the progress to the

challenge and scrutiny of the individual Target Costs. The final Target Cost for Phase 1b was re-issued in May 2018.

The Phase 1b Target Cost scrutiny was concluded with the Welsh Government approval of the 31st October 2018. Scrutiny of the Target Cost for Phase 2 continued at the point of drafting this report (November 2018).

Further assessment of the Target Costs is considered at **Appendix I**. The balance of this section focuses on the overall Programme (see **recommendations 5-8**).

On the 26th March 2018, the ECA provided the UHB with the first update of the OBC Cost Plan schedules since the relaunch. This took account of approvals to date, Target Costs submitted and anticipated a forecast outturn cost position. Further iterations of the overall Programme cost reports were prepared in both May and August 2018.

The latest cost position is noted as (as at August 2018):

Figure 1	£	£
Approved OBC	**119,750,347**	
PUBSEC index adjustment to OBC	59,834,550	
Adjusted OBC	**179,584,897**	
Changes to Methodology, Technical Scope & Programme	59,708,256	
Total ECA Assessment of Cost	**239,293,153**	
Current SCP Forecast		**263,031,635**

The ECA has applied an inflationary uplift to the OBC approved sum of £59,834m. Additionally, changes to methodology, technical scope and Programme have been assessed as £59.708m. These are being reviewed in conjunction with NWSSP: SES on behalf of Welsh Government.

Approximately £44m of the £239m above relates to the approved Business Justification Cases for Phases 1a and 1b. Therefore, approximately £195m remains to be formally approved and committed via the Full Business Case process.

At the point of drafting this report, the overall position highlighted above shows there is currently a variance of £24m between the ECA assessment (£239m) and the SCP forecast (£263m) – (ref. **recommendation 9, 10 & 11**).

The above is still subject to further assessment, scrutiny and challenge. For example, the VAT assumptions made by the ECA were yet to be tested and confirmed, with a provision of 35% reclaim having been made (although a figure of 40% was agreed at the similar Ysbyty Glan Clwyd project) – (ref. **recommendation 12**).

5.1.2 Internal Financial Monitoring and Reporting - *the objective is to ensure that internal reporting is sufficient to support key decisions by the Board and/ or supporting groups, including:*

- *content and accuracy – ensuring reporting is fit for purpose and reflective of the emerging Programme as a whole; and*
- *regularity and timeliness – ensuring information is considered in a timely manner to allow effective decision making.*

a. The previous section reviewed the external expert advice provided to the UHB. This should be an important element of the overall cost management structure applied to the Programme. Outputs and advice should inform the UHB on a regular basis, as a key source of assurance and be a fundamental contribution to key decisions.

The output from the external advisers was directed and considered by the Project Team. The Programme Director then prepared a regular narrative update for the Project Board, summarising the external adviser reports (in narrative form).

The report did not contain an evaluation of probable outturn e.g. against commitments or the Programme.

Accordingly, the ongoing advice to the Project Board was limited by the restrictions outlined previously and the lack of direct accountability of the external expert advisers. Evidence of the ongoing visibility of the challenge and scrutiny provided was therefore restricted (ref. **recommendation 13**).

b. Separately, a narrative report was prepared by Finance on the in-year performance against the approved Capital Resource Limit (ref. **recommendation 13**).

5.1.3 External Reporting – *the objective is to ensure UHB compliance with Welsh Government reporting requirements.*

The Capital Programme Guidance available at the time of the review outlined:

> "To inform the Welsh Government of progress on NHS capital projects, all schemes funded from the AWCP are required to report on a monthly basis using the template……. reports are required for all schemes with SOC approval onwards."

It is noted, however, that it has been general custom and practice across NHS Wales for submissions to follow approved Outline Business Cases and a more flexible arrangement has been detailed at updated WG guidance issued in October 2018.

From the relaunch in June 2016, the Welsh Government dashboard reporting was prepared by the Programme Director for Phase 1a and directed through the Capital Planning Department for outward transmission to Welsh Government.

This was not presented to Project Board for consideration on an ongoing basis (ref. **recommendation 14**).

We were advised that there was no request for additional regular external reporting e.g. including an overall Programme forecast (ref. **Recommendation 15**).

In conclusion, the Programme currently needs to resolve the financial challenges that emerged in the Autumn of 2017, summarised as:

- The adjusted sums (£118m) applied from the approved Outline Business Case needs to be confirmed and accepted/ rejected (ref. 5.1.1 and **recommendations 9 & 10**); and
- Additionally, the £24m variance between the External Cost Adviser and Supply Chain Partner assessments need to be similarly resolved (5.1.1) – ref. **recommendation 11**.

Key deficiencies in cost management contributing to this include:

- At relaunch, having re-phased the Programme, relevant budgets were not derived or reconciled to the approved Outline Business Case to control the relevant phases and overall Programme (5.1.1 & **recommendation 4**);
- A lack of direct accountability of the external expert advisers to the Project Board (5.1.2);
- Reliance on narrative based reporting restricting accountability to the Project Board (ref. 5.1.2 and **recommendation 13**);
- An absence of checkpoint reporting to the budget and oversight of effective monitoring of the overall Programme cost being absent until March 2018 (5.1.1, 5.1.2 & 5.1.3); and ref. **recommendations 1 & 2**; and
- Evidence of the ongoing visibility of challenge/ scrutiny provided by the Project Board/ Team being restricted (5.1.1, 5.1.2 & 5.1.3) - ref. **recommendations 1, 2, 3, 4, 13**.

Since the UHB became aware of the deficiencies in financial reporting/ monitoring (particularly against the Programme budget), together with NWSSP: SES, management has sought to start to address certain of the above directly with the advisers.

However, in the context of the current financial challenge on the overall Programme, we have assessed that **No assurance** is appropriate until this is further resolved.

5.2 Programme Management



5.2.1 Resource Management - *assessment of performance monitoring and any associated issues.*

Internal Resource

a. It is usual for the resource requirement for a Programme of this nature to be determined from an activity based resource schedule.

However, the internal capacity at this Programme has been restricted by the incremental approvals associated with a phased approach and the submission of individual business cases; we understand that an activity based resource schedule has not been produced – ref. **Recommendation 16**.

b. For a Programme of this size and complexity, it would be usual to appoint a fully-dedicated Programme Director to provide operational leadership with the technical capacity to discharge the informed client role, including overseeing key external parties and managing the internal resource.

We have been advised that the UHB has unsuccessfully sought to appoint a Programme Director on a number of occasions. A full time Programme Director has been in place subsequent to the relaunch, we understand however given the individual does not have the full technical expertise, this requires the Assistant Director of Planning (Capital and Estates) (UHB) to supplement the assigned internal resource with the required technical support/ direction. This was also further strengthened, as referenced above in early 2018, with the formal request to NWSSP: SES for advice, with a member of the NWSSP: SES team joining the Project Board as an adviser. Therefore, certain parties were discharging their roles at the Programme in addition to other duties.

c. The core team establishment assessed for the Programme, including the Programme Director, equates to 4 whole time equivalent (WTE). However, we understand that due to working patterns and vacancy, only 2.2 WTE has been filled to date.

Management has been taking action to further strengthen the Programme Team:

- Appointing a Deputy Senior Responsible Officer with technical and framework expertise (full-time)
- Reviewing the Programme Director workload;
- Developed a Commercial Manager post; and
- Reviewing the potential for additional secretarial support (currently 0.6 wte).

See **Recommendation 16**.

Advisers

d. Key Performance indicators have been completed and returned to NWSSP: SES in accordance with Framework requirements for external advisers.

e. Capacity issues were raised with External Advisers in August 2017 and general performance issues have been raised throughout 2018 (ref. **recommendation 17**) i.e. in relation to:

- Absence of Programme Budget Cost;
- Inadequate Target Cost Reporting;
- Project Manager's Report lacking certain content and including contradictory contract references; and
- The need for additional capacity to be provided in support of the EPM and ECA.

f. Additionally, the UHB requested NWSSP: SES to provide expert advice to supplement this role and provide additional support to the UHB as referred to above.

g. The project structure was enhanced in the Autumn of 2017 by the introduction of the Principals meeting and the re-initiation of the Finance Review Sub Group to oversee the performance of external parties.

SCP

h. Key Performance indicators have been completed and returned to NWSSP: SES in accordance with Framework requirements for the SCP.

i. As background, the UK Cabinet Office reported in January 2018 that it was monitoring the financial health of the SCP at a national level, amid concerns regarding its level of debt and overall finance stability. It should be noted that NWSSP: SES also provide regular monitoring information on SCP performance to Local Health Boards, which in the case of Cwm Taf is shared with the Project Board.

j. As recently as 12th November 2018 The Guardian reported on the SCP: '…shares dip to lowest level in 30 years amid finance concerns', noting shares in the SCP are now worth about £60m, down by more than 90% in five years.

Given the same, the UHB has sought assurances from NWSSP: SES on the financial stability of the SCP. Whilst it is acknowledged that SCP financial performance is outside of the direct control of the UHB, the contract and associated potential risk rests with the UHB. A provision has been made at the risk register (e.g. Phase 2: risk T149: Unlikely and Catastrophic with a financial impact of £100k) – ref. **recommendation 18 & 19**.

Subsequent to the audit, we are advised that a paper was tabled at an in-committee meeting of the Health Board to discuss the risk rating of the Supply Chain Partner and the Health Board subsequently endorsed the decision of the Project Board to continue to contract with the existing Supply Chain Partner for Phase 1b, whilst continuing to monitor the situation closely.

Consideration should be given as to whether similar arrangements should be required for any relevant parties in the supply chain and the external advisers – ref. **recommendations 18 & 19**.

5.2.2 Business Case Delivery - *assessment of progress to:*

- *deliver the business cases to individual approvals; and*
- *achieve the approved business case objectives (Phase 1a).*

An outline of performance against the evolving business case strategy is provided at **Appendix G**.

If we assume the following against the last approved checkpoint:

- Green - Delivery up to 3 months of the approved target.
- Amber - Delivery 4 to 12 months of the approved target.
- Red - Delivery beyond 12 months of the approved target.

Original Targets	Position to 11/18	Assessment
• SOC	UHB achieved target submission date.	Reasonable progress
• OBC	UHB 1 month late.	Reasonable progress
• FBC	UHB submission target of 12/13 extended due to approval timeline to 08/14. Mini FBC submitted 05/15 with revised preferred option.	Progress 9 months late
Do minimum review	Instructed 06/15 and concluded 06/16.	Timetable not stated.
Relaunch (06/16):		
• Phase 1a BJC	02/17 target at relaunch, submitted 08/17.	Progress 4 months late
• Phase 1b BJC	02/17 target at relaunch, submitted 06/18.	Progress 16 months late

• Phase 2 FBC	08/17 target at relaunch, yet to be submitted.	Currently 15 months late to 11/18.
• PBC	08/17 target at relaunch, yet to be submitted.	Currently 15 months late to 11/18.
• Remaining Phases	Not formally re-set at the relaunch.	Timetable not stated.

Note: Management advise that the restart timescales were not set by the Project Manager and did not factor the level of reworking to achieve to desired outputs, accordingly the targets stated here were not reasonable in the UHB's view.

5.2.3 Programme/ Project Management Tools – *assessment of Programme/Project management tools utilised, including risk control*

The expected management tools were evidenced as:

	Prepared	Applied	Updated	Effective
Project Execution Plan	✓	✓	✓	In part
Risk Register	✓	✓	✓	In part
Management Control Plan	✓	✓	✓	In part

The effectiveness of the tools is cognisant of the issues noted within the cost and programme management sections (ref. **recommendation 20 & 21**).

In concluding on the performance of programme management we note:

Resource Management

- An activity based resource schedule has not confirmed the current and future internal resource requirements, including fully dedicated operational leadership (ref. **5.2.1 a, b, c** and **recommendation 16**);

  Limitations of current arrangement, in our view, has impacted on the ability of the UHB to discharge its informed client role;
- The UHB should continue to performance monitor the ECA and EPM to deliver the required level of service (ref. **5.2.1 d-g** and **recommendation 17**); and
- The Director of Finance should provide regular updates to the Project Board on the financial and operational risks arising (ref. **5.2.1 h, I** and **recommendation 18 - 19**).

Business Case Delivery

- The overall programme and phase targets was not completely reset at the relaunch/re-phasing of the Programme; and
- Formalised targets have been re-set on a regular basis, with delivery being negatively impacted (ref. **5.2.2** and **recommendation 4**).

Project Management Tools

- Implemented management tools have not assisted sufficiently in controlling the project objectives (ref. **5.2.3** and **recommendation 20 & 21**).

In assessing the processes and controls to deliver Programme/Project management, we note:

- Phase 1a – post approval of the BJC has been delivered to target;
- Phase 1b – 16 months late achieving approval;
- Phase 2 – as at 11/18, is 15 months beyond target;
- PBC - as at 11/18, is 15 months beyond target; and
- Remaining Phases – targets to be determined.

In the context of the current challenge to deliver the Programme objectives beyond Phases 1a and 1b, we have assessed that **No assurance** is appropriate until key issues are addressed.

5.3 Programme Governance



5.3.1 Stakeholder and User Sign-off – *appropriate engagement has been undertaken to establish user and stakeholder requirements against the current plans.*

Established working groups were identified to ensure that key stakeholders were engaged in the design and sign-off of the identified preferred option.

However, we are cognisant that the recent Gateway review considered this further.

5.3.2 Supporting Structures - *an appraisal of the supporting structure of work-streams, robustness of supporting information, and co-ordination, scrutiny and approval of outputs.*

The Programme Management section of this report addresses the capacity challenges and are not duplicated in this section.

This section therefore focuses on the internal structures put in place to drive forward the Programme.

It was observed that work streams have followed activity to date.

We have not evidenced:

- Work stream leads reporting or accounting directly to Project Team then to the Project Board; and
- A resource/activity plan to:
    - Identify the requirements for work streams at key intervals; and
    - Assist focus and prioritisation.

Ref. **recommendation 22 & 23**.

5.3.3 Scrutiny and Approvals - *assurance that appropriate scrutiny and approval processes are defined and applied at the Programme, including appropriately defined and operated delegations.*

a. Internal

Key internal approvals for the relevant phases and overall Programme were demonstrated.

The Cost Management and Programme Management sections of this report reviewed key factors contributing to the scrutiny arrangements at the Programme, including:

- accountability of externals to the Project Team;
- internal scrutiny requirements by the Project Board; and
- Project Board challenge and effectiveness.

Accordingly, these aspects are not duplicated in this section.

b. External

Noting the context to the Programme, and agreed approach with Welsh Government, key external approvals for the relevant phases have been demonstrated.

We have also observed positive engagement with both NWSSP: SES and Welsh Government through the scrutiny process. This included Chief Executive presentation of the case for change at the Welsh Government's Infrastructure Investment Board (a key forum/ group within Welsh Government's approval mechanism).

5.3.4 Organisational and Governance Arrangements – *an appraisal of organisational and governance arrangements.*

Established governance arrangements were evidenced that linked to the UHB Capital Programme Board.

The Chief Executive is the Senior Responsible Officer, attending the Capital Programme Board (originally chaired by an Independent Member but more recently chaired by the Chief Executive) and chairing the Project Board from its inception. The Project Board has regular Independent Member attendance (including UHB Chair attendance for key decisions) (further details are provided at **Appendix J.**

The UHB utilised existing reporting and accountability lines to keep Welsh Government abreast of progress to resolve the fire safety issues at the site in a timely manner.

There is also a positive working relationship with the South Wales Fire & Rescue Service, evidenced by the incremental extension of the FEN to reflect work undertaken to date.

Perhaps noting the phased approach to the Programme to date, there has been limited effective collaboration between the SCP, External Advisers and the UHB – a key principal benefit of the contract and procurement strategy adopted (ref. **recommendation 24**).

We note recent action taken to strengthen the Programme structure including the re-establishment of dedicated financial sub-group (within the Programme structure) and the introduction of the Principals meeting.

In conclusion, in assessing the governance arrangements applied at the Programme, we note:

- Decision-making and effectiveness of the governance arrangements has been negatively influenced by the weaknesses in cost management and Programme management (ref. 5.1 & 5.2);
- Stakeholder and user engagement was satisfactory (ref. 5.3.1);

- Upon the activity based resource schedule being established, there may be potential to review the timing and requirement for future work streams (e.g. benefits realisation, workforce, service modelling, decant etc.) and to re-affirm key roles (ref. 5.3.2 & ref. **recommendation 23**);
- Key work streams leads reporting to the Project Board/ Project Team would improve accountability through the structure. This would assist the driving forward of the project goals and objectives, potentially introducing more controls and mitigating unexpected events (ref. 5.3.2 & ref. **recommendation 22**); and
- Moving forward, efficiencies and improved effectiveness may be gained by introducing more collaborative arrangements between the Supply Chain Partner, External Advisers and the UHB (ref. 5.3.4 & ref. **recommendation 24**).

Noting the context of the Programme, and the agreed approach with Welsh Government to the approved phases, the Programme has implemented an adequate structure, and associated governance arrangements to date to facilitate the delivery of Phases 1a and 1b post business case approval.

Additionally, the External Project Manager Project Phase reports are now directly reported to the Project Board.

However, moving forward, there will be benefit in building on the current arrangements to implement a strengthened Programme structure to progress Phase 2 onwards.

There was, however, importantly insufficient cost and Programme reporting to the Project Board and the Capital Programme Group, especially on the performance of the overall Programme budget, impacting their ability to discharge the informed client role.

This has been accepted by management, who has already taken a number of actions and is committed to strengthening arrangements as previously outlined.

We have therefore determined **limited** assurance on the **effectiveness** of Programme/Project governance arrangements to date.

We are advised that, subsequent to the audit, the UHB has implemented a Gateway recommendation to re-assign the role of Senior Responsible Officer to the Deputy Chief Executive/Director of Planning & Performance.

5.4 Appointments and Contract



We sought assurance that parties contracted to the University Health Board had been appropriately appointed, including: the SCP; External Cost Adviser; EPM and that appropriate contract documentation has been completed in accordance with the current phase of the project.

5.4.1 Supply Chain Partner:

The SCP was appointed via the Designed for Life: Building for Wales 3 Framework arrangement. The Welsh Government confirmed the contract strategy approach in writing to the UHB in June 2016. Prior to the expiry of the framework in October 2017, the UHB sought legal and NWSSP: SES advice regarding the use of the appropriate framework and contract mechanism, and the associated implications (*this process was covered by our previous audit report issued in February 2017*).

It was reported that Phase 1a had commenced in October 2017 under a limited value *letter of intent*.

The contract documents (Deed of Variation and Confirmation Notices) were completed and signed in February 2018.

It has been recommended that contracts should be signed prior to the start of construction and that the use of *letters of intent* should be avoided; so as to ensure that the interests of the UHB are adequately protected (ref. **Recommendation 25**).

5.4.2 External Project Manager & Cost Adviser:

The contractual position for the EPM, ECA and other design team members was appropriately established.

As the contract strategy had been confirmed, and generally applied, **reasonable assurance** was assessed; but concern remained in respect of the delay in concluding the contracts.

Note: Section 5.2 separately addresses any performance issues in discharging responsibilities as defined at these appointments.

5.5 Status of Previously Agreed Recommendations



We sought to review the current status of management actions to address previously agreed recommendations.

The previous audit (fieldwork progressed during September and December 2016), was restricted to an assessment of the arrangements in place to deliver the Programme Business Case and Phase 1a BJC focusing on the arrangements then in place to cover:

- Governance;
- Approvals;
- Business case development;
- Selection, Appointment and Contract Methodology;
- UHB brief and Design Development; and
- Risk Management.

The status of agreed management action arising from the previous audit report (*which determined a "Reasonable" level of assurance*) is as follows:

Priority	H	M	L	Total
Number of Recommendations	**0**	**8**	**0**	**8**
Recommendations Implemented/Closed	**0**	**6**	**0**	**6**
Recommendations not Implemented	**0**	**2**	**0**	**2**

The two outstanding recommendations were:

- That business case delivery progress monitoring should be enhanced; and
- An Integrated Assurance and Approval Plan should be developed.

Appendix E outlines the status of individual recommendations.

Noting positive progress to implement previous recommendations, **reasonable assurance** was assessed.

6 Summary of Recommendations

6.1 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	**19**	**6**	**-**	**25**
Agreed recommendations outstanding.	11	6	-	**17**
Agreed recommendations partially implemented*	2	-	-	**2**
Closed recommendations*	6	-	-	**6**

The above has been prepared with cognisance to the recommendations produced from the Gateway review and looks to build on their recommendations rather than duplicate.

As noted at **1.1** above, interim feedback in the Spring of 2018 outlined 23 recommendations reported to management at an interim point. These have been re-assessed and re-profiled as appropriate within this report. When relevant, if issues have been addressed or moved-on, they have been denoted as *'closed'* at the above summary.

For * see 6.2 below.

We acknowledge that 40% of the High priority recommendations outlined to management in our interim position reviewed in the Spring of 2018 are either closed or partially addressed.

Design of Systems/Controls

The findings from the review have highlighted **9** issues that were classified as weakness in the system control/design for the Prince Charles Hospital Redevelopment.

Operation of System/Controls

The findings from the review have highlighted **16** issues that were classified as weaknesses in the operation of the designed system/control for the Prince Charles Hospital Redevelopment.

6.2 Status of Recommendations Closed or Partially Actioned

No	Recommendation	Status update on issue of Draft Report
1	The ECA cost reports should routinely provide a clear summary of the overall cost position on the Programme (including appropriate narrative)	Closed. ECA cost reporting on the overall cost position introduced.
2	The ECA should routinely report the SCP's estimates for respective phases and explain any variances as appropriate	Closed. ECA reporting includes SCP estimates where available.
3	The Project Board should ensure mechanisms are in place to allow it to effectively discharge its responsibility to confirm that the Programme delivers appropriate value for money	Partially addressed – see recommendations 9,10 & 11.
5	The ECA should report on the identified variances in respect of the Target Cost for Phase 1b, and provide an explanation for the reasons for the cost differences, with relevant recommendations	Closed. Target Cost on Phase 1b finalised and agreed.
6	The UHB should also consider alternative courses of action, if it becomes clear that the SCP will not agree to significantly revise its cost estimates for Phase 1b .	Closed. Closed with the approval of Phase 1b BJC.
7	The ECA should provide a full report on the current position on the overall Programme, reconciling against approved budgets	Closed. Reports produced in March, May and August 2018.
13	A regular report should be prepared and presented to the Project Board that shows the current and projected expenditure on all phases	Closed. Internal reporting to the finance sub-group now encompasses all cost

No	Recommendation	Status update on issue of Draft Report
	of the overall Programme reconciling to the total approved budget	information for the overall Programme.
21b	The risk register should include details of: b) quantify the financial value of the identified risks (see recommendation 21). (O).	Partially implemented.

Finding 1 & 2: Up-dated OBC Cost Plan Schedule	Risk
Following re-launch, the ECA provided the UHB with the first update of the OBC Cost Plan schedules on the 26th March 2018 – taking account of approvals to date, Target Costs and anticipated forecast outturn. Further updates were provided in May and August 2018. Prior to this, ECA reporting was primarily in relation to: • Phase 1a: fees and construction costs, also evaluation of the Target Cost concluded at approval of the 14th September 2017; • Phase 1b: fees only for the Business Case stage only, also evaluation of the Target Cost concluded at approval of the 31st October 2018; and • Phase 2: fees only for the Business Case stage only, also evaluation of the Target Cost yet to be concluded. Overall Programme cost management and reporting was not recognised as a requirement by the advisers during this period and not explicitly sought by the UHB in the period.	Inadequate cost management through deficient cost reporting.
Recommendations 1 & 2	**Priority level**
1. The ECA cost reports should routinely provide a clear summary of the overall cost position on the Programme (including appropriate narrative) *(D).*	**High**

2. The ECA should routinely report the SCP's estimates for respective phases and explain any variances as appropriate *(D).*	**High**
Management Responses 1 & 2	**Responsible Officer/ Deadline**
1. . 2.	

Finding 3: Budgets & Finance	Risk
The Project Team's responsibilities included: • To develop, agree and monitor project budgeting arrangements for project delivery; and • To identify and develop appropriate capital and revenue financing arrangements for the project ensuring both affordability and sustainability. The minutes of project team meetings demonstrated an insufficient coverage of budget/ financing arrangements and a lack of detailed reporting on the overall budgetary position on the Programme. As a result, the Project Team does not provide required support to the Project Board in this respect. See also **recommendations 9, 10 & 11**.	Risk of overspending on the Programme due to a failure to agree and/or monitor budgeting arrangements. Risk of inadequate development of appropriate capital and revenue assumptions.
Recommendation 3	**Priority level**
3. The Project Board should ensure mechanisms are in place to allow it to effectively discharge its responsibility to confirm that the Programme delivers appropriate value for money *(O).*	**High**
Management Response 3	**Responsible Officer/ Deadline**
3.	

Finding 4: Programme Business Case	Risk
A PBC was required in order to link all the phases together and provide a comprehensive account of the Programme. The Welsh Government confirmed the requirement for a PBC in a letter to the UHB in June 2016 as follows: *"It is my understanding that our teams have agreed a proportionate evidence based submission is needed to support the funding request for this initial phase rather than a full business case. Our respective teams have agreed that this will comprise of a short paper detailing scope of works, tendered costs, management and governance arrangements, the procurement strategy and a risk register.* *In terms of further fire safety works and asbestos removal, we will proceed using a Programme approach that allows you to identify the remaining phases of works and for us to consider in an incremental manner. To support this, we will require a Programme Business Case to be submitted which will build upon the preferred way forward in the approved OBC. This Programme Business Case will need to describe the overall phasing of the fire and asbestos works. It will need to clearly identify, cost and describe the benefits of the modernisation works required in addition to the fire safety and asbestos components. Our teams will continue to discuss the business case requirements as the proposals develop. I anticipate that the first version of the Programme Business Case will provide full tendered costs for the second phase of works and provide outline costs to inform a "not to exceed" budget for the remaining phases."*	Risk that the full extent of the financial and operational implications of the redevelopment Programme are not agreed and monitored as a whole. Risk of additional time and cost arising through the failure to agree/manage the Programme.

The Programme Business Case was deferred until the conclusion of the Phase 1a and 1b Business Justification Case. Whilst the submission of the PBC was not an explicit requirement of WG at the relaunch of the Programme in 2016, due consideration should have been given to the impact of the re-phasing on the overall cost and programme. The PBC is currently in draft format and should include a reconciliation of the changes in terms of content and associated cost impact from the original approved OBC – and some of the cost increases relating to inflation, re-phasing and additional works would have been known at the time.	
Recommendation 4	**Priority level**
4. The PBC should be prioritised for completion and submission to the Welsh Government *(O).*	**High**
Management Response 4	**Responsible Officer/ Deadline**
4.	

Finding 5 & 6: Agreement of Target Cost Phase 1b	Risk
The agreement of a Target Cost for Phase 1b has been severely delayed. However, a final version of the Target Cost Report for Phase 1b was presented to the UHB on 27th March 2018. This report confirmed that an original submission, by the SCP in the sum of **£29.9 million** had been revised, following scrutiny by the ECA to the present sum of **£26.2 million**. The ECA was of the opinion that certain costs, within the revised figure, were overstated. Therefore, they could not conclude that this offered value for money. The ECA also advised that their own assessment for Phase 1b (taking account of pricing up-lifts and scope changes from the original OBC) was in the sum of **£23.2 million**. However, we understand that the UHB team was of the opinion that the uplifted OBC figure for Phase 1b should be circa. **£21 million**. At the time of reporting audit findings, the ECA has not currently explained to the UHB the reasons for the former difference. The ECA suggested that a general value engineering exercise should be undertaken to establish savings.	Risk of agreement of inflated Target Cost following inadequate scrutiny.

Recommendation 5 & 6	Priority level
5. The ECA should report on the identified variances in respect of the Target Cost for Phase 1b, and provide an explanation for the reasons for the cost differences, with relevant recommendations *(O).*	**High**
6. The UHB should also consider alternative courses of action, if it becomes clear that the SCP will not agree to significantly revise its cost estimates for Phase 1b *(O).*	**High**
Management Response 5 & 6	**Responsible Officer/ Deadline**
5. 6.	

Finding 7 & 8: Cost Control – Agreement of Target Cost Phase 2	Risk
The latest draft estimate of the Target Cost for Phase 2 of the Programme was issued by the ECA on 20th April 2018. The same indicated that: • The SCP had issued their proposed Stage 4 Target Cost in December 2017 in the sum of £134,437,810 (excl. VAT); • This compared to the ECA's uplifted OBC sum of £110,534,049 together with scope changes incorporated into the Phase 2 works and inclusive of risk and design development; • The above represented a total variance of 21.6% or £23,903,761 (excl. VAT) between the SCPs proposed Target Cost and the ECA's uplifted OBC assessment; and • A risk reduction meeting took place between the ECA and SCP on 13th April 2018 to discuss outstanding information and a revised date of 25th May 2018 was identified for the issue of the final Phase 2 Target Cost Report. Therefore, noting the variance between the ECA and SCP's cost assessments at the time of assessing the Target Cost submission (25th May 2018), the ECA reported that they could not recommend that the SCP's Target Cost submission offered value for money.	Risk of agreement of inflated Target Cost following inadequate scrutiny.
Recommendation 7 & 8	**Priority level**
7. The ECA should provide a full report on the current position on the overall Programme, reconciling against approved budgets *(D).*	**High**

8. The UHB should also determine alternative courses of action, if it becomes clear that the SCP will not agree to significantly revise its cost estimates for Phase 2 or provide alternative solutions to deliver the Programme in accordance with approvals *(O).*	**High**
Management Response 7 & 8	**Responsible Officer/ Deadline**
7. 8.	

Finding 9, 10 & 11: Financial Assessment	Risk
The ECA's latest OBC Cost Plan schedules (August 2018), outlined the ECA's estimate of the cost of the required works to that point in time. This profiled the financial problem. We have summarised this further at **Appendix H**; in summary, this shows the ECA's draft schedules reporting: • The original OBC had been adjusted from **£119.750m** to **£179.585m (a difference of £59.835m)** by the ECA. The up-lift was attributed, by the ECA, to inflationary pressures. However, this methodology was yet to fully tested and confirmed by the UHB and NWSSP: SES; • A 'total development cost for additions since the OBC' was included in the sum of **£59.708m.** The additions did not currently have identified funding; and • The ECA has therefore forecast that the Programme delivery cost is currently estimated at **£239.293m.** The SCP assessment of the forecasts is **£263.031m**, representing a variance of approximately **£24m**. It is noted that approximately £44m of the £239m above relates to the approved Business Justification Cases for Phases 1a and 1b. Therefore, approximately £195m remains to be formally approved and committed via the Full Business Case process.	Scope creep is allowed. Approved costs are exceeded due to poor budgetary control.

Recommendations 9, 10 & 11	Priority level
9. The up-lift and indexing methodology (to assess inflationary costs) should be tested and either accepted/rejected (£59,835m) *(O)*.	**High**
10. The unapproved additions should be analysed and either accepted/rejected (£59.708m) *(O).*	**High**
11. The variance between the External Cost Adviser and Supply Chain Partner assessments should similarly be resolved (£24m) *(O).*	**High**
Management Responses 9, 10 & 11	**Responsible Officer/ Deadline**
9. 10. 11.	

Finding 12: VAT Assumptions	Risk
The latest ECA's draft OBC Cost Plan schedules (August 2018) assumes an increased VAT reclaim of 35% on works and fees. However, NWSSP: SES has advised, as a relevant comparator, that 40% was agreed between BCUHB and HMRC on the Ysbyty Glan Clwyd project. This requires confirmation by a professional VAT adviser.	
Recommendation 12	**Priority level**
12. Professional advice should be received on the VAT recovery assumptions for agreement with HMRC, and appropriately acted upon *(O).*	**High**
Management Response 12	**Responsible Officer/ Deadline**
12.	

Finding 13: Internal Financial Reporting	Risk
Project Board meetings regularly received a narrative Progress Report from the Assistant Director (Capital & Estates). This was drafted by the Project Director, based on information received from the EPM, ECA, Project Team and SCP. The report was largely narrative based; reflecting the assigned budgets covered by the ECA together with other expenditure heads managed internally. The Project Board also received a summary of the Risk Register and an internal Finance Report that focused on the current and projected expenditure profiles against the CRL – again primarily narrative based. However, a report was not presented to the Project Board that monitored the current and projected expenditure on all phases of the Programme against the overall approved budget for the Programme, based on the approved OBC, as uplifted for inflation. This information was also not reported on by the ECA – (ref. **recommendations 1 & 2**). Consequently, it was not possible for the Project Board to monitor the overall expenditure position against the approved Programme budget.	Project Board and Board are unable to effectively monitor expenditure on the individual phases of the Programme against the overall approved budget. Lack of control over costs against budget.
Recommendation 13	**Priority level**
13. A regular report should be prepared and presented to the Project Board that shows the current and projected expenditure on all phases of the overall Programme reconciling to the total approved budget (ref. **recommendations 1 & 2**). *(O)*	**High**

Management Response 13	Responsible Officer/ Deadline
13.	

Finding 14 & 15: Dashboard Reports	Risk
The mandated 'Dashboard Reports' for submission to the Welsh Government were produced periodically in respect of certain phases of the Programme. However, we did not evidence presentation of the same at Project Board. The 'Dashboard Reports' currently limit their financial and costing information to approved funding amounts and performance against the Capital Resource Limit (CRL). We have concluded that the UHB should enhance the requirement internally for 'Dashboard Reporting' to extend to cover all phases of the Programme and provide additional financial information prior to the approval of relevant OBC/FBC/BJC for internal reporting/control purposes – including an overall Programme/ PBC overview.	Poor financial control over individual phases within the Programme
Recommendation 14 & 15	**Priority level**
14. The Project Board should receive copies of the monthly Welsh Government 'Dashboard Reports' submissions for information and to enhance internal monitoring *(O).*	**Medium**
15. The internal requirements for 'Dashboard Reporting' should be extended to cover all phases of the Programme and provide additional financial information prior to the approval of relevant OBC/FBC/BJCs for internal reporting/control purposes *(O).*	**Medium**
Management Response 14 & 15	**Responsible Officer/ Deadline**
14. 15.	

Finding 16: Resource Requirement	Risk
The original OBC outlined that funding would be sought for a single FBC – with three individual contracts let within the overall approved sum. As would be expected, the OBC did not include a detailed resource schedule. In 2016, a revised multi-phased Programme approach was proposed by Welsh Government with individual business cases required for each phase (be they FBC, BJC or other): • Phase 1a; • Phase 1b; • Phase 2; and • Phases 3, 4 and 5. The phased approach carries with it phased approvals, with funding only approved as phases are progressed. Accordingly, the Programme resource has reflected the constrained approvals. At the time of the review, the Programme Director did not have a full assessment of the resource requirement for each phase or the overall Programme, but it was noted that of the current anticipated 4 whole time equivalent (WTE) in the project team, only 2.2 WTE were filled. It is concluded that a full activity based resource plan would be beneficial to determine the requirements for an effective project internal team, including fully dedicated operational leadership. Where skill shortages are identified these should be supplemented as appropriate (e.g. external appointments).	Sufficient and appropriate resource is afforded to support project progress.

We understand that this exercise is ongoing, evidenced by the introduction of a Commissioning Manager post which is currently being matched ready for advert. We are also advised that the UHB are in the process of appointing a Deputy Senior Responsible Officer with technical framework expertise. See also **recommendation 24** below considering opportunities for improved collaboration.	
Recommendation 16	**Priority level**
16 A full activity based resource plan should be developed for current and future internal resource requirements (including fully dedicated operational leadership) – see also **recommendation 23** *(D)*.	**High**
Management Response 16	**Responsible Officer/ Deadline**
16.	

Finding 17: Performance	Risk
Key Performance indicators have been completed and returned to NWSSP: SES in line with requirements. The March 2018 return from the UHB provided negative feedback on the performance of the EPM and ECA in respect of the "Timely Delivery of Services/Information". It was indicated that this assessment was derived from "timeliness of Target Cost review management, encountered re: Phases 1b and 2". These issues have been raised with the EPM and ECA at various meetings from August 2017 through to the most recent correspondence in June 2018 and October 2018 (please note that the EPM/ ECA have refuted the certain claims on timely performance). In addressing the above, the UHB sought advice from NWSSP: SES on the expected service of the EPM and ECA – to inform the agreed arrangements going forward. Some positive action has been taken in respect of the expected reporting and capacity, however, the UHB should continue to performance monitor the ECA and EPM to deliver the required level of service. The performance level of external advisers has adversely impacted on the ability of the UHB to discharge the informed client role.	Poor project team performance be may not adequately addressed. Programme/project delivery may be adversely affected by poor project team performance.

Recommendation 17	Priority level
17 The UHB should supplement existing arrangements with checkpoint stages to effect enhanced monitoring of the performance of the external advisers *(D).*	**High**
Management Response 17	**Responsible Officer/ Deadline**
17.	

Finding 18 – 19: Financial Stability	Risk
The Refurbishment of Prince Charles Hospital is a complex Programme of works extending over a number of years; this requires commitment from a reliable SCP. The UK Cabinet Office reported, in January 2018, that it was monitoring the financial health of the current SCP employed at the Prince Charles Hospital Redevelopment Programme amid concerns about its debt and finance stability. As recently as 12th November 2018, it was widely reported, including the Guardian, outlining that the SCP: '…shares dip to lowest level in 30 years amid finance concerns', noting shares in the SCP are now worth about £60m, down by more than 90% in five years. Currently, NWSSP: SES procure the financial vetting information on behalf of NHS Wales and a report is presented periodically to Project Board. A provision has been made at the risk register (e.g. Phase 2: risk T149: Unlikely and Catastrophic with a financial impact of £100k), however this assessment appears low given the value and complexity of the works and experience elsewhere. It is concluded that arrangements would be strengthened if the vetting information (while procured centrally by NWSSP: SES) was directed via the Director of Finance, so he provided ongoing advice to the Project Board in relation to the same. Consideration should be given to whether similar arrangements should be required for any relevant parties in the supply chain and/or the external advisers; including the adequacy of risk provisions.	Risk of financial instability of the SCP, leading to risk of delays and additional costs in delivering the Programme.

Recommendation 18 – 19	Priority level
18.1 The monitoring of the financial stability of the SCP should be the responsibility of the Director of Finance, so he provides ongoing advice to the Project Board in relation to the same *(D).*	**High**
18.2 The Director of Finance should determine whether similar arrangements should be required for other relevant parties in the supply chain *(D).*	
18.3 The Director of Finance should determine whether similar arrangements should be required for any of the external advisers *(D).*	
19 The risk provisions for the insolvency of key parties at each phase should be reviewed for adequacy*(D).*	**High**
Management Response 18 – 19	**Responsible Officer/ Deadline**
18. 19.	

<table>
<tr><th>Finding 20 & 21: Programme/ Project Management Tools</th><th>Risk</th></tr>
<tr><td>The expected management tools were evidenced at the project and the following was observed:
<table>
<tr><th></th><th>Prepared</th><th>Applied</th><th>Updated</th><th>Effective</th></tr>
<tr><td>Project Execution Plan</td><td>✓</td><td>✓</td><td>✓</td><td>Part</td></tr>
<tr><td>Risk Register</td><td>✓</td><td>✓</td><td>✓</td><td>Part</td></tr>
<tr><td>Management Control Plan</td><td>✓</td><td>✓</td><td>✓</td><td>Part</td></tr>
</table>
The assessment on the effectiveness of the tools is cognisant of the issues noted within the cost and programme management sections.

The risk register included details for each identified risk of the ‘risk owner’ and ‘mitigation action agreed’. However, no details of the individual(s) responsible for mitigation actions were stated and the financial impact had not been quantified.

Additionally, the fundamental risk of achieving the financial objectives of the OBC was not recognised and accordingly mitigating actions not identified/analysed.</td><td>Project Management tools prove ineffective and do not provide complete assistance to the Programme Director.</td></tr>
</table>

Recommendations 20 & 21	**Priority level**
20 Project Management Tools will be regularly reviewed at key checkpoints to ensure they remain effective *(O).*	**Medium**
21 The risk register should include details of: a. the individual(s) responsible for mitigation actions; and b. quantify the financial value of the identified risks (see **recommendation 19**). *(O).*	**High**
Management Response 20 & 21	**Responsible Officer/ Deadline**
20. 21.	

Finding 22 & 23: Work streams	Risk
It was observed that work streams have followed activity to date and are regularly chaired by the Programme Director. Best practice would observe work stream leads reporting and/ or accounting to the Project Team/Board on the performance of the respective work stream in achieving the assigned targets/ objectives. We previously noted at **recommendation 16,** the need to prepare a full activity based resource plan for the overall Programme. In preparing the same, due consideration should be given to the resource required to establish expected work streams to support the Project Board. This will also assist in focusing and prioritising activities.	Insufficient attention is maintained across all of the activities required to inform the Project Board.
Recommendations 22 & 23	**Priority level**
22 Work stream leads will be accountable to the Project Team/Board on performance to achieve outcomes/ products *(D).*	**Medium**
23 The resource/ activity plan will give due consideration to the required work streams *(D).*	**Medium**
Management Response 22 & 23	**Responsible Officer/ Deadline**
22. 23.	

Finding 24: Cost Control – Collaboration	Risk
A key benefit of the contract methodology adopted at the projects within the Programme includes Early Contractor Involvement and encourages collaboration throughout the delivery cycle. The intention is to reduce waste, assign risks to the party best placed to manage it, identify savings and provide greater cost/ programme certainty. We note that relationships between the SCP, external advisers and the UHB has been impacted by the issues highlighted at this report (e.g. **recommendation 17**). Moving forward, improved visibility of collaborative arrangements (e.g. a shared Programme office) should result in efficiencies and improved effectiveness. NWSSP: SES should be able to provide further guidance in this area based on experiences at other D4L:B4W Programmes/ projects.	Failure to collaborate effectively results inefficiencies.
Recommendation 24	**Priority level**
24 Opportunities should be explored to implement efficiencies through increased collaboration between the SCP, external advisers and the UHB *(O).*	**Medium**
Management Response 24	**Responsible Officer/ Deadline**
24.	

Finding 25: Contracts and Letters of Intent	Risk
The interests of the UHB should be protected through appropriately executed contract documentation, prior to the commencement of any contractual work. We therefore sought to confirm that appropriate contract documentation had been completed for the main construction contract. National capital guidance (WHC 2015-012) requires a contract, even where there are only advance (enabling) works. We additionally note the advice of NWSSP: SES being that: "letters of intent are not good practice within the NHS". There is no internal guidance within the UHB re: the use of letters of intent. Phase 1a was commenced in October 2017 under a limited value letter of intent. Contract documents were later completed and signed in February 2018. Letters of intent do not afford the UHB with the same legal protection as a contract, and in the event of a dispute are unlikely to provide sufficient detail to enable satisfactory resolution of issues (for example they do not specify the value of delay damages to be paid etc.). Similarly, key adviser appointments for the design stages for 1a, 1b and 2; and the construction phase for 1a were not completed until 2018 (although backdated to the contract commencement date).	Longer term liabilities are not adequately addressed until the main contract is finalised and executed. Letters of Intent do not afford the same legal/financial protection as an executed contract.

The risk in each of the above, is that the work is undertaken at risk to the University Health Board, with reduced recourse should performance issues arise. Particular cross reference is made to **recommendation 18** relating the current financial stability of the SCP reinforcing the need to proceed in a disciplined manner.	
Recommendation 25	**Priority level**
25 Contracts should be signed in a timely manner *(O).*	**High**
Management Response 25	**Responsible Officer/ Deadline**
25.	

Appendix B: 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.

Appendix C: 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.

Appendix D: Audit Objectives

- **Cost Control Systems**:

- content and accuracy – ensuring reporting is fit for purpose and reflective of the emerging Programme as a whole;
- regularity and timeliness – ensuring information is received by the client in a timely manner to allow effective decision making;
- external support – to ensure the appointments/ framework requirements of the External Project Manager and External Cost Adviser are discharged appropriately;
- internal reporting - to ensure that internal reporting is sufficient to support key decisions by the Board and/ or supporting groups; and
- external reporting - the objective is to ensure UHB compliance with Welsh Government reporting requirements.

- **Programme/Project Management**:

- assessment of progress to -
    - *deliver the business cases to individual approvals; and*
    - *achieve the approved business case objectives (Phase 1a).*
- assessment of time and cost performance;
- assessment of Programme/Project management tools utilised, including risk control; and
- assessment of performance monitoring and any associated issues.

- **Project Governance**:

- an appraisal of organisational and governance arrangements;
- an appraisal of the supporting structure of work-streams, robustness of supporting information, and co-ordination, scrutiny and approval of outputs;
- appropriate engagement has been undertaken to establish user and stakeholder requirements; and
- assurance that appropriate scrutiny and approval processes are defined and applied at the Programme, including appropriately defined and operated delegations.

- **Appointments and contract:**

- assurance that parties contracted to the UHB have been appropriately appointed, including: Supply Chain Partner (SCP); External Cost Adviser (ECA); External Project Manager (EPM); and
- assurance that appropriate contract documentation has been completed in accordance with the current phase of the project.

- **Previously Agreed Audit Recommendations**:

- We sought to review the current status of management actions to address previously agreed recommendations.

Appendix E: Status of Previously Agreed Audit Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
Medium Priority Recommendations					
1	The Project Execution Plan will be updated to reflect the re-configured project and current management arrangements.	Assistant Director of Planning (Capital & Estates March 2017	Closed	N/A	N/A
2	The proposed structure of the Project Team, including membership and reporting arrangements etc., will be formally agreed by the Project Board and details included within a revised Project Execution Plan.	Assistant Director of Planning (Capital & Estates March 2017	Closed	N/A	N/A
3	Reporting arrangements and frequency of reports will be determined and implemented as a matter of priority.	Assistant Director of Planning (Capital & Estates March 2017	Re-raised at the *Cost Management* section.	N/A	N/A
4	Time-bound deliverables and outputs will be established for each element of the business case as	Assistant Director of Planning (Capital & Estates	Outstanding		Assistant Director of Planning (Capital & Estates

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
	soon as possible and submitted to the Project Board for agreement. Business case delivery progress will be monitored by the Project Board in the form of dashboard reporting against the same.	Case 1a March 2017 (complete) Case 1b & 2 July 2017			
5	An appropriate IAAP will be developed to recognise the various assurance providers. Funding of costs of assurance providers, including internal audit will be recognised within the business case project costs.	Assistant Director of Planning (Capital & Estates (at appropriate stages linked to the Programme).	Outstanding *The implementation of an IAAP (as recommended within the NHS Wales Capital Programme guidance and at the previous audit), would assist in establishing the assurance points for each stage of the business case approval and delivery process. As a part of the same, the development of an integrated audit plan for the Programme would ensure sufficient audit resources and appropriate assurance activity at key stages of development are directed to the Programme and accordingly has been recommended.*		Assistant Director of Planning (Capital & Estates (at appropriate stages linked to the Programme).

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
6	The UHB will ensure that legal advice obtained (re framework banding) is fully applied and confirmation of the same provided to the Project Board as appropriate.	Assistant Director of Planning (Capital & Estates March 2017	Closed	N/A	N/A
7	The project brief will be reviewed and revised to reflect the current project requirements.	Assistant Director of Planning (Capital & Estates March 2017	Closed	N/A	N/A
8	The risk register will be reviewed and up-dated as necessary to reflect the current project status and will be reported to the next Project Board meeting.	Assistant Director of Planning (Capital & Estates March 2017	Closed	N/A	N/A

Appendix F: Investment Objectives

The audit was undertaken to evaluate the processes and procedures put in place to support the delivery of the Prince Charles Hospital Redevelopment Programme by the UHB).

The investment objectives for this FBC are as those set out in the OBC, with an emphasis on compliance with statutory fire safety and asbestos removal. The first of these is heightened by the Fire Enforcement Notice (FEN) placed upon the Health Board in December 2010 in respect of the core ground and first floor areas of the original hospital. This FEN has been subsequently extended on various occasions, both on the strength of completed interim temporary measures and via an ongoing annual review arrangement, between the UHB and South Wales Fire and Rescue Service, that is only extended dependant on satisfactory continued advancement of the planned works contained in this business case to deliver statutory conformity in the earliest timescale possible.

In summary, the objectives for this case are:

- *Statutory fire compliance with the Regulatory Reform (fire Safety) Order 2005, at the Prince Charles Hospital site;*
- *Removing the potential risk of asbestos exposure to patients, visitors and staff within the original building of the hospital, resulting in compliance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations, 1999 and Control of Asbestos Regulations 2006;*
- *To improve service efficiency, quality and productivity in line with the wider Cwm Taf UHB clinical and financial strategic direction;*
- *To redesign clinical areas, as currently provided from within the ground and first floor areas of PCH in line with accommodation standards, to provide flexible, safe and welcoming accommodation in support of improved productivity and future proofing against emergent strategies.*

Appendix G: Time Performance:

	Anticipated	Actual
Strategic Outline Case Development & Submission	SOC - March - October 2011	October 2011
Strategic Case Approval	SOC - November 2011	May 2012
OBC Development & Submission	SOC - May 2012 OBC - January 2013	February 2013
OBC Approval	SOC - June 2012 OBC - March 2013	December 2013
FBC Development & Submission	OBC - December 2013	May 2015 (mini FBC – Phase 1 works only)
FBC Approval	OBC – March 2014	Approval not provided
Conclude 'do minimum' review	N/A	March 2016
Do minimum review approval	N/A	June 2016
Phase 1a Development & Submission	re-launch target: February 2017	August 2017
WG Approval of Phase 1a		September 2017
Phase 1b Development & Submission	re-launch target: February 2017	June 2018
WG Approval of Phase 1b		October 2018
Phase 2 Development & Submission	re-launch target : August 2017	November 2018

Appendix H: Cost Performance

	March 2018 (£)		May 2018 (£)		Aug 2018 (£)	
Approved OBC	**119,750,347**		**119,750,347**		**119,750,347**	
PUBSEC index adjustment to OBC	59,834,550		59,834,550		59,834,550	
Adjusted OBC	**179,584,897**		**179,584,897**		**179,584,897**	
Changes to Methodology, Technical Scope & Programme:	48,187,708		48,187,708		59,708,256	
ECA Forecast	**227,772,605**		**227,772,605**		**239,293,153**	
SCP Forecast		**Not provided**		**266,842,361**		**263,031,635**

The ECA has assessed the current variance between their own assessment and that of the SCP as attributable to:

- Levels of SCP's Preliminary costs (32% of difference);
- Extent of SCP's Design development / risk allowances (7% of difference);
- SCP's Pricing levels within packages (47% of difference); and
- Increase in Fee percentage in Phase 2 (7% of difference).

Appendix I: Target Costs

Definition

Option C of the NEC3 suite of Contracts (being applied at the Prince Charles Hospital Redevelopment Programme) provides a Target Cost contract. This contains a mechanism for sharing risks and rewards.

The Target Cost is the SCP's estimate for the works plus the associated fee to cover the SCP's costs, overheads and profit.

The Target Cost should be agreed between the UHB and the SCP prior to the completion of the contract documentation and commencement of the works on site.

Target Cost – Phase 1a:

The Target cost for Phase 1a (£5,622,265) was agreed between the UHB and SCP, and subsequently approved by the Welsh Government via the BJC on the 14th September 2017.

Outturn costs anticipate a UHB gain share on the Phase 1a contract of £75k. The forecast cost assumes that the Health Board's share will be utilised on this scheme to fund additional asbestos work. However, this will require discussion and approval by Welsh Government.

Target Cost – Phase 1b:

The Target Cost was submitted by the SCP in November 2017, and the final iteration of the report (May 2018) appended at the BJC for Phase 1b outlining:

- the ECA's own assessment for Phase 1b (taking account of pricing up-lifts and scope changes from the original OBC) was in the sum of **£23.2 million**.
- the original submission by the SCP was in the sum of **£29.9 million**,
- revised downward following scrutiny by the ECA to the present sum of **£26.2 million**.

Whilst the ECA advised that the Target Cost issued by the SCP was considered excessive and did not offer value for money, WG approved the business case given the rationale provided by the UHB. Subsequent to the WG approval, NWSSP: SES has been arbitrator in negotiating the £3m variance between parties. We understand the significant element now sits within the Project Risk provision, as the UHB has assessed that it is willing to accept the risk. Had these remained within the Target Cost and not materialised, then any saving would be shared with the SCP based on the pain/gain clause defined within the contract.

Target Cost: Phase 2:

The Target Cost for Phase 2 was received in December 2017 with an interim Target Cost Report produced by the ECA in May 2018.

In summary the ECA reported that:

- the SCP had issued their proposed Target Cost in the sum of **£134,437,810** (exc. VAT).
- This is in comparison to the sum of **£110,534,049** which is the cost adjustment of the original OBC figure, updated by the ECA.

- The ECA had identified various information gaps and concerns on content producing a series of queries and challenges, which to date have not been accepted by the SCP resulting in a current total variance of 16% or **£23,903,761** (exc. VAT) to the adjusted OBC budget.

Accordingly, the ECA was not able to advise that the submitted Target Cost represented value for money.

Having had approval to Phase 1b, there is an opportunity to pause to consider the current variance in assessments. A similar assessment should be undertaken as per Phase 1b to determine whether the gap can be closed.

Target Cost Remaining Phases

The Target Costs had not been developed for the remaining phases at the time of the current review. The ECA has assumed a further 10% cost increase on their own assessment for the remaining phases – reflective of experiences at Phase 1b and 2.

Conclusions:

- A significant cost variance remains at Phase 2 whereby the ECA is unable to affirm value for money.
- It is anticipated that cost variances identified at Phase 1b and 2 will impact on the remaining phases of the Programme.

Noting the above, the procurement strategy for remaining phases will require revisiting/ ratification

Appendix J: Governance

Forum	Description
Project Board	The Project Board had appropriate terms of reference and membership, together with attendance by representatives of clinical departments as required. The Project Board is chaired by the Chief Executive/Senior Responsible Officer and membership includes an Independent Member, the Deputy Chief Executive/Director of Planning and Performance, Chief Operating Officer and other supporting officers. Project Board meetings have been well attended and have also on occasions also included the UHB's Chairman. However, it was noted that the meeting held in February 2018 had a large number of apologies; it was recognised by members that any decisions made at that meeting would need ratification at the next meeting.
Project Team	The Project Board was supported by a Project Team. This was chaired by the Programme Director and members include key internal estates, capital and finance staff, as well as the EPM. It was noted that the Project Team's responsibilities includes: - To develop, agree and monitor project budgeting arrangements for project delivery; and - To identify and develop appropriate capital and revenue financing arrangements for the project ensuring both affordability and sustainability. However, the minutes of meetings demonstrate insufficient coverage of the budget and financing arrangements and a lack of detailed reporting on the overall budgetary position on the Programme. As a result, to date the Project Team has not adequately discharged its defined role to support the Project Board.
Project Principals' Progress Review Group:	A further added layer of governance was provided by the Principals Progress Review Group that reported to the Project Board. This is chaired by the Assistant Director Capital & Estates and membership includes UHB project leads together with the EPM, ECA, SCP and NWSSP Specialist Estates Services. The group reviewed areas of possible impact or delay arising from the supporting Technical Team or Technical Design Team activities. The group had been operational since October 2017.
Capital Programme Group:	The Project Board reports, via the UHB's Capital Programme Board (CPB), to the Health Board. The CPB was originally chaired by an Independent Member but is now chaired by the Chief Executive. Membership includes the Chief Executive; Chairman; two Independent Members, the Deputy Chief Executive/Director of Planning and Performance, Chief Operating Officer and other supporting officers. Regular reports are provided on the project to the CPB as part of its reporting arrangements.

Forum	Description
Financial Review Group	The Financial Review Group meet monthly to review costs, budget reporting and CRL phasing and formally report into the Project Team.

Appendix K: Glossary of Terms

Definitions	
The Programme	The Prince Charles Hospital Refurbishment Programme (including contributing phases) is referred to within the report as 'the Programme'. *For clarity, any reference to 'programme' (in lower shift) therefore refers to the management of time performance against parameters/ milestones set-out during the business case process.*
Investment Decision Maker (IDM)	IDM role is held with the Health Board or its equivalent for other NHS organisations. IDM has the ultimate responsibility to invest in financial and human resources in any given project. Decisions will be based on the project's Business Case which provides a comparative assessment on the investments benefits and associated risks. The key responsibilities of the IDM are to: • ensure that a viable and affordable business case (cost vs. benefit) exists for the project, with the revenue impact of the project clearly identified; • ensure that the business case remains valid; • maintain visible and sustained commitment to project; • ensure that the role of project sponsorship is established and understood, with appropriate representation and commitment; • define the SRO/project owner's terms of reference; • authorise the allocation of funds to the project; • oversee project performance through cost and schedule performance; and resolve any issues which fall outside the SRO/project owner's delegated authority.
Senior Responsible Officer (SRO)	The Senior Responsible Officer (SRO) is the individual responsible for ensuring that a project, or Programme of change, meets its objectives and delivers the projected benefits. He/she should be the individual with overall responsibility for ensuring that a project or Programme meets its objectives and delivers the projected benefits. The SRO represents the Investment Decision Maker and is usually the Health Board's Chief Executive Officer. (There may be instances, at lesser projects, when the SRO role may be merged with the Executive/Project Owner role. In such cases suitable measures need to be enacted to ensure the Chief Executive will be appropriately informed and still able to be a key conduit and guide to the IDM).
Executive/Project Owner	The Executive (or Project Owner) should ensure that the project maintains its business focus, that it has clear authority, and that the work, including risks, is actively managed. The Executive is usually

Definitions	
	the chair of the Project Board. He or she represents the customer and is responsible for the Business Case. The Project Owner defines the project's objectives and will be responsible to the SRO for ensuring they are met to the agreed time, cost and quality constraints.
Programme Director	The Project Director is appointed by the UHB to represent and be responsible for the successful outcome of the Programme. The Project Director has direct responsibility to the IDM (usually via the Executive/Project Owner) and has defined delegated responsibility to manage the day to day issues of the project for example financial authority, decision making processes and the ability to deploy the necessary resources.
Programme/ Project Board	The Programme/ Project Board represents the wider ownership of interests with responsibilities of the Programme/ Project delegated to it by the IDM. Project Board will comprise of senior individuals who will have an interest and whose activities will have a direct affect from the project. The main aim of the Project Board is to maintain the delivery co-ordination of the Programme/ Project.
Project Team	The Project Team represents resources deployed internally and/or externally in order to achieve the Programme/ Project's outcomes. The Project Team will compromise of architects, cost advisers, contractors and others appointed by the Programme/ Project Director to manage, design and build the project.
Project Execution Plan (PEP)	Document prepared by the External Project Manager, under the direction of the Programme/ Project Director, setting out the scope, objectives, priorities and governance arrangements. The document evolves and is revised throughout the life of the Programme/ Project depicting all governance changes. The document must be formally approved by the Programme/ Project Board at each revision.
Designed for Life: Building for Wales Framework (D4L:B4W)	The Designed for Life: Building for Wales (D4L:B4W) frameworks are the NHS in Wales's construction procurement and delivery frameworks for major capital Programmes/ Projects. D4L:B4W (3) is the second national construction procurement framework. The framework commenced in has now completed, however there are still Programmes/ Projects in the design and construction stages which were commenced under this framework prior to its expiration.
Supply Chain Partner (SCP)	The Supply Chain Partner (SCP) is ultimately responsible for the design and construction of the Programme/ Project. The SCP employs and manages a team of designers to design the solution; it is a critical role of the SCP to manage the design team to ensure the final design is fully coordinated, this role is undertaken by the design manager. The SCP will work with the External Project Manager, External Cost Advisor and UHB/Trust to produce an agreed

Definitions	
	programme of works and cost plan to facilitate the design and construction stages of the Programme/ Project. A key role of the SCP is to manage the construction of the Programme/ Project; this will involve coordination of the entire supply chain and the delivery of quality requirements. The SCP has a key role in attaining the objectives.
External Project Manager (EPM)	The EPM acts for the UHB/Trust to manage and monitor the Programme/ Project from inception to completion. The successful delivery in terms of the key objectives, including time, cost and quality is the responsibility of the EPM. Administration of the NEC contract is also a responsibility of the EPM. The EPM is key to building a successful team and an important responsibility is to develop a cohesive team that work towards attaining the defined objectives.
External Cost Advisor (ECA)	The External Cost Advisor (ECA) is responsible for undertaking the cost planning and cost management on behalf of the UHB/Trust. The ECA provides independent cost advice throughout the duration of the Programme/ Project, during both the design and construction processes. The key objective of the ECA is to promote Best Value for Money and to help ensure the Programme/ Project is delivered on budget. The ECA also will support the EPM in the administration of the NEC contract.
Designed for Life: Building for Wales Process Map	To assist Health Boards, NWSSP: Facilities Services has prepared a process map to outline the key stages of the project life cycle under Designed for Life: Building for Wales. The key stages are: Stage 1: Strategic Outline Case Stage 2: Outline Business Case Stage 3: Full Business Case Stage 4: Design Completion and Construction Stage 5: Operational Commissioning Stage 6: Project Closure
Programme Business Case	The Programme Business Case is important because Programmes will only deliver their intended outcomes and benefits if they are properly scoped, planned and costs justified from the outset. A Programme Business Case should be developed using the Five Case Model providing decision makers and stakeholders with a proven framework for structured 'thinking' and assurance.
Strategic Outline Case (SOC) Stage 1	To support of an investment (project, procurement or scheme), that has been identified within a strategy and/or its supporting Programme. At an early stage, the main purpose of the SOC is to establish the need for investment; to appraise the main options for service delivery; and to provide management with a recommended – or preferred – way forward for further analysis.

Definitions	
Outline Business Case (OBC) Stage 2	In all cases, a Strategic Outline Case (SOC) should have been completed, prior to the submission of this document for approval. The main purpose of the OBC is to: revisit the case for change and the preferred way forward identified in the SOC; establish the option which optimises value for money; outline the deal and assess affordability; and demonstrate that the proposed scheme is deliverable.
Full Business Case (FBC) Stage 3	In all cases, an Outline Business Case (OBC) should have been completed and agreed, prior to the submission of this document for approval. Prior to contract signature, the main purpose of the FBC is to evidence that the most economically advantageous offer is being procured and that it is affordable. In addition, the FBC explains the fundamentals of the negotiated deal and demonstrates that the required outputs can be successfully achieved.
Target Cost (TC)	The contractual cost of the works as determine by the Supply Chain Partner (independently scrutinised by the External Cost Advisor). The Target Cost at Designed for Life Programmes/ Projects is subject to a pain/ gain mechanism whereby if costs come in under the Target Cost the benefit is shared between the Health Board and SCP – however if the Target Cost is exceeded, the additional cost is borne by the SCP only.
Client Brief	The Client Brief is prepared by a user panel overseen by the Programme/ Project Director. The brief should be developed in sufficient detail to allow the outline design and the budget cost to be drawn up. It normally comprises whole hospital policies, departmental policies and accommodation schedules.
Capital Resource Limit (CRL)	The Capital Resource Limit (CRL) controls the amount of capital expenditure a Health Board may incur in a year. Health Boards require capital resource to cover all capital expenditure and must not incur expenditure in excess of this limit. Each Health Board will be allocated an initial CRL based on planned capital expenditure. This will change during the year if additional capital resources are allocated from Welsh Government.
Gateway Reviews	The Gateway review process is a series of short, focused, independent peer reviews at key stages of a Project or Programme. The reviews highlight risks and issues, which if not addressed would threaten successful delivery. Reviews can take between 2 and 4 days and are usually undertaken by a team of 3 or 4 people, but each team is chosen to meet the requirements of the Project or Programme. The review team produces a report giving an overall assessment, summarised findings and recommendations. This is left with the senior responsible owner (SRO) of the Programme or Project at the end of the review before the team leaves.

Definitions	
	The Gateway Review Process looks at a Project or Programme at six key stages in the lifecycle and considers the readiness to progress to the next phase. The six stages, or Gates are: Gate 0 - Strategic Assessment Gate 1 - Business Justification Gate 2 - Delivery Strategy Gate 3 - Investment Decision Gate 4 - Readiness for Service Gate 5 - Operations Review and Benefits Evaluation

Client Organisation	Cwm Taf University Health Board
Audit title	PCH Redevelopment
Audit reference	SSU_CTU_1819_01
Final Report Date	4th February 2019
Auditor(s)	Eifion Jones

I would be very grateful if you would please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be also reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	Yes	No	Partially	n/a	Any further comments
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial eg providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Thank you very much for taking time to complete this questionnaire. Please return by email: steve.wood@wales.nhs.uk or post :**Steve Wood, Director (SSU), NWSSP Audit & Assurance, Floor 3, Companies House, Crown Way, Cardiff, CF14 3UB**
Alternatively, please feel free to call me on: **029 2090 5313**

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**CLOSED AGENDA ITEM 3.4**

Audit Committee Report
PRINCE CHARLES HOSPITAL REDEVELOPMENT INTERNAL AUDIT REPORT 2018/2019

Executive Lead: Chief Executive Officer , Senior Responsible Officer
Author: Director of Planning and Partnerships/Deputy Chief Executive
Contact Details for further information: ruth.treharne2'wales.nhs.uk

Purpose of the Audit Committee Report
The purpose of the report is to set some useful context and update for Audit Committee members to take into consideration when discussing the above internal audit report at their meeting in February 2019.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2015-2018 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A
Engagement – Who has been involved in this work?	
NHS Wales Shared Services Partnership	

Audit Committee Resolution to:							
APPROVE	√	**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The Audit Committee is asked to: • **NOTE** and **DISCUSS** this report, the two Gateway Review reports attached and the internal audit report. • **NOTE** the progress made in terms of actions taken to respond to the recommendations. • **AGREE** that the completed internal audit report action plan is brought back to the Audit Committee at its next meeting in April 2019 when this can be considered in full.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No specific impact						
Legal implications	Legal advice is taken on the project as required. The project is undertaken under the NHS Wales Designed for Life 3 Framework.						
Population Health	No specific impact						
Quality, Safety & Patient Experience	As a project, it should be noted that this is being delivered in a live hospital environment where the focus on safety, quality and patient experience is critical to maintain.						
Resources	This is a major capital project, with significant capital and some revenue consequences.						
Risks and Assurance	The refurbishment of PCH Ground and First Floor is required to address the fire enforcement notice which is currently in situ. This is a corporate risk which is registered on the Health Board's corporate risk register. The Health Board commissions both internal audits and Gateway reviews as part of undertaking its scrutiny and assurance measures for this major capital project.						
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources.						
Workforce	No specific impact although it should be noted that the refurbishment is taking place in a live, operational District General Hospital, where staff involvement in both the design, development and delivery of plans is crucial.						
Freedom of information status	Closed – commercial in confidence						

PRINCE CHARLES HOSPITAL REDEVELOPMENT
INTERNAL AUDIT REPORT
2018/2019

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to set useful context and update for Audit Committee members to take into consideration when discussing the above internal audit report at their meeting in February 2019.

2. BACKGROUND

The internal audit report under consideration, was based on work undertaken on the Prince Charles Hospital Ground (PCH) Ground and First Floor refurbishment project concluded in quarter 3 of 2018/2019.

The Health Board had also commissioned a Gateway Review of the project which was undertaken in September 2018.

By way of approach and process, it was therefore jointly agreed by the Audit team, the Health Board and Gateway Review team, that a dovetailed approach would be developed between the Audit team and Gateway Review team to minimise duplication and to reduce the impact of those reviews on UHB and other partners involved.

The result of the internal audit review was the 'PCH Redevelopment Internal Report 2018/19', which is on the agenda today for the Audit Committee to consider.

In order to support the discussion, attached at **Annex A** of this report, for member's attention, is the first Gateway Review report that was produced following the September review, containing six recommendations.

As part of their process, the Gateway Review team consequently carried out a follow-up review in January 2019 in order to assess progress made by the Health Board against the recommendations made. This report is attached for members' attention at **Annex B.**

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

At the conclusion of the first Gateway Review, there were six recommendations and the Review team provided a delivery confidence assessment of 'red'.

Since then considerable hard work has been undertaken by the Health board to address the recommendations. **Annex C** provides further detail on the actions that were taken as a result. This paper was presented to the PCH

Ground and First Floor Project Board on 3rd January 2019 and was then consequently updated for presentation to the Gateway Review team for their follow-up review, which we had agreed would take place in January 2019. This was completed on 18th January 2019 and a report issued to the Chief Executive/Senior Responsible Officer, which is the paper that is attached at **Annex B**.

In essence, the Gateway Review team provided a delivery confidence assessment of 'amber', made four additional recommendations and found that several significant issues raised in the September 2018 review had been addressed. They stated:

The Review Team finds the significant issues raised in the September 2018 PAR have been addressed robustly. There remain outstanding risks and issues in respect of commercial supply chain and CTUHB resources.

CTUHB maintains its quest to make continuous progress in satisfying the Fire Enforcement Notice and, in parallel, has undertaken significant work in ratifying the strategic alignment of Prince Charles Hospital within it portfolio. The options analysis confirming the way forward adds weight to the Phase 2 Business Case.

The Review Team is impressed by the efforts of the CTUHB Programme Team, assisted by their various colleagues in Welsh Government and is pleased to report an improvement in delivery confidence assessment.

In terms of the internal audit report presented today, members should note that this was substantially carried out in October 2018. Since then significant progress has been made in several areas, as can be seen from the above and two reports attached.

Members will also note that in the audit report management response that the internal audit team have already noted, that out of the 25 recommendations made, they have confirmed that 6 actions have already been completed and 2 actions have been partially implemented.

Unfortunately, due to time constraints, the time period between the draft audit report being produced and the Chief Executive/Senior Responsible Officer for the project being able to meet with the Audit team to discuss this, there has been insufficient time to fully complete the management action plan. Consideration was given to delaying the report going to the Audit Committee until the management response was complete, but on balance and in discussion with the Audit Committee Chair, it was considered best to present this to the February 2019 meeting.

However, Audit Committee members should be assured that this work is well underway and combined with the fact that several actions have already been completed, as can be seen from the report, it is recommended that

the fully completed action plan is brought back to the Audit Committee at its next meeting in April 2019 when this can be considered in full. It is also suggested that the management response when fully finalised, also incorporates the actions related to the follow-up Gateway review.

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** and **DISCUSS** this report, the two Gateway Review reports attached and the internal audit report.
- **NOTE** the progress made in terms of actions taken to respond to the recommendations.
- **AGREE** that the completed internal audit report action plan is brought back to the Audit Committee at its next meeting in April 2019 when this can be considered in full.

Freedom of information status	Closed – commercial in confidence

Llywodraeth Cymru
Welsh Government

Programme/Project Assessment Review (PAR)

Version 2.0 2017

Version number:	V1.0 FINAL
Senior Responsible Owner (SRO)	Allison Williams
Date of issue to SRO:	23/09/2018
Programme/Pproject Title:	Prince Charles Hospital Refurbishment
Department/Organisation of the programme/Project	Cwm Taf University Health Board
Programme/Project Director (or equivalent)	Bill Rogers
Business Case stage reached:	Phase 1B BJC Phase 2 FBC
Decision/approval point this report informs:	N/A
Review dates:	12/09/2018 to 14/09/2018
Review Team Leader:	David Wilkin
Review Team Member(s):	Peter Lloyd Jones Jayne Stokes
Departmental Representative:	N/A
Previous Review:	N/A
IAH ID number:	AH/18/09

Contents

1. Executive Summary 3
2. Delivery Confidence Assessment (DCA) 3
3. Summary of report recommendations 4
4. Areas of good practice and lessons learnt 5
5. Areas of concern 5
6. Acknowledgement 5
7. Comments from the SRO 6
8. Summary of the Programme/Project 7
Business Strategies 7
Local Strategies 7
The Case for Change 8
Business Need 9
9. Scope/Terms of Reference of the Review 10
10. Detailed Review Team findings 11
10.1 Strategic Position 11
10.2 Business Cases & Finance 12
10.3 Benefits & Stakeholder Engagement 14
10.4 Governance 15
10.5 Contract Management 15
10.6 Programme Management & Resources 16
11. Next assurance review 17
ANNEX A - List of Interviewees 18

About this report

This report is an evidence-based snapshot of the programme's/project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over the review period, and is delivered to the SRO immediately at the conclusion of the review.

This assurance review was arranged and managed by:

Welsh Government Integrated Assurance Hub (IAH)
Cathays Park 2
Cathays
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IAH helpdesk: ppmdevelopmentunit@gov.wales

1. Executive Summary

The pursuit of the Fire Enforcement Notice is being tackled with a sense of purpose and the SRO has a strong personal commitment to maintaining service delivery in a safe manner. The refurbishment of the Prince Charles Hospital has been progressed incrementally to ensure that addressing this prominent problem is undertaken as speedily as possible. This is being done whilst also endeavouring to refurbish the hospital in such a way that will derive improvements in healthcare outcomes and benefits.

It is without question that the leadership and management of the programme is being undertaken with the best intent, but it is not realistic to pursue the aspiration with the current level of resource or supply chain constraints. Additionally, since the programme's original inception, some 22 years ago, the strategic backdrop has changed and there could be potential to derive a better outcome at a lower cost and at the same time satisfy the requirements of the Fire Enforcement Notice.

2. Delivery Confidence Assessment (DCA)

Delivery Confidence Assessment:	**Red**
The Review Team finds that as currently constituted and resourced, successful delivery of the programme is unachievable. The skeleton team is performing to a high standard and looks likely to succeed in the short term, with the guidance of a strong SRO and executive leadership. There are significant deficiencies in supply chain management expertise, affordability of the current costings from a risk-averse marketplace, core financial and programme management expertise, and a high degree of focus on near-term financial arguments rather than the big picture. The programme may need re-baselining or overall viability (in its current form with current supply chain) re-assessed.	

The Delivery Confidence assessment RAG status should use the definitions below:

RAG	Criteria Description
Green	Successful delivery of the project/programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
Amber/Green	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.
Amber/Red	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
Red	Successful delivery of the project/programme appears to be unachievable. There are major issues which, at this stage, do not appear to be manageable or resolvable. The project/programme may need re-base lining and/or overall viability re-assessed.

3. Summary of report recommendations

The Review Team makes the following recommendations, which are prioritised using the definitions below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Classification
1.	**Ratify the strategic case for the Programme and the service mix required to be delivered by PCH whilst maintaining momentum in addressing the fire enforcement notice.**	**Essential**	**Dec 2018**	**12.1 Alignment to Strategy**
2.	**Resolve the apparent affordability gap and VfM debate, considering other, potentially new-build, options.**	**Critical**	**Oct 2018**	**8.2 Business Case**
3.	**Establish a business change network to inform solution design and implementation planning.**	**Essential**	**Mar 2019**	**4.2 Operational Readiness**
4.	**Simplify, clarify and communicate the various governance bodies, ensuring appropriate escalation relationships and clinical membership.**	**Critical**	**Oct 2018**	**1.1 Governance Structures and Processes**
5.	**Accelerate and strengthen activities to drive compliance with the Design for Life 3 Framework and instigate a robust cost management mechanism.**	**Critical**	**Oct 2018**	**7.1 Contract Management**
6.	**Establish a comprehensive appropriately skilled and experienced Programme Team, including robust commercial management capability.**	**Critical**	**Mar 2019**	**10.3 Skills Assessment and Management**

Critical (Do Now) – To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately

Essential (Do By) – To increase the likelihood of a successful outcome the programme/ project should take action in the near future.

Recommended – The programme/project should benefit from the uptake of this recommendation.

4. Areas of good practice and lessons learnt

- Community stakeholder communications and engagement.
- Skeleton team energy and commitment.
- SRO personal commitment.
- Clinical staff support and acceptance.
- Phased approach to dealing with near-term problems.
- Relationship with South Wales Fire & Rescue Service.
- Relationship with Welsh Government.

5. Areas of concern

- Ongoing strategic fit and future benefit realisation.
- Value for Money and affordability.
- Clarity of Governance.
- Processes for the Management of Risk.
- Readiness for Business Change.
- Financial management.
- Contract management.
- Market appetite.
- Programme Team Resources.

6. Acknowledgement

The Review Team would like to thank all participants for their contributions to this Review. In particular, the support provided by Bill Rogers prior to, and during, the Review was much appreciated.

7. Comments from the SRO

This Report is a fair reflection of the Project to date and the discussions that have taken place as part of the Gateway Review process.

The requirement to deliver changes to ensure that the Fire Enforcement Notice is lifted at the earliest possible opportunity has been (and will continue to be) the primary driver for this scheme. It is recognised that this time-pressure has a potential impact on consideration of other strategic options. Any further discussion on options arising from this Gateway Review will need to take full cognisance of the impact and potential challenges for the Health Board and Welsh Government of any potential delay in delivering fire compliance for the Prince Charles Hospital site.

All recommendations and their respective level of urgency are fully accepted.

Recommendations 3,4 and 6 are within the direct control of the Health Board to deliver and will be progressed immediately.

Recommendation 5 will require further support and expert advice from NHSWSSP and will be actioned as a matter of priority.

Recommendations 1 and 2 will require urgent discussion with Welsh Government and NHSWSSP in the context of the commitments made to deliver timely compliance with the extant Fire Enforcement Notice.

8. Summary of the Programme/Project

Background and context:

The Phase 2 Ground & First Floor FBC (v4) states that:

Business Strategies

The following business strategies were either included within the OBC and remain valid or have since OBC approval been issued and are pertinent to this business case; :

- *Setting the Direction - Primary and Community Services Strategic Delivery Programme;*
- *Prudent Healthcare (2016);*
- *Health and Care Standards (2015);*
- *Wellbeing of Future Generations (Wales) Act 2015;*
- *Social Services and Well-being (Wales) Act 2014;*
- *'A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26';*
- *Delivering Safe Care, Compassionate Care (2013);*
- *Working Differently, Working Together (2012);*
- *A Healthier Wales: Our Plan for Health and Social Care (2018).*

Local Strategies

- *Cwm Taf Area Plan (2018)*

Led by the Cwm Taf Regional Partnership Board, a regional plan has been produced to address the findings of the population assessment that was completed in Cwm Taf during 2017. The plan explains how the Health Board will deliver a range of services in accordance with the Social Services and Wellbeing (Wales) Act 2014, to meet care and support needs and improve wellbeing within local communities during 2018- 2023.

- *Cwm Taf Wellbeing Plan (2018)*

In 2015 the Wellbeing of Future Generations Act was passed. This new law puts the citizens of Wales in the centre of everything public services do to improve the economic, social, environmental and cultural well-being of Wales, and has the sustainable development principle at its heart to support:

  - *Tackling Loneliness and Isolation;*
  - *Thriving Communities;*
  - *Healthy People;*
  - *Strong Economy.*

- *Cwm Taf UHB Three Year Integrated Medium Term Plan 2018 – 2021*

This Integrated Medium Term Plan (IMTP) 2018-21 builds upon and refreshes the Health Board's approved Plan for 2017-20. The IMTP describes the entirety of the Health Board's business, describing how its budget and workforce will be deployed over the coming three year period.

A copy of the approved plan is attached as Appendix 1.

Aims & Objectives

The Phase 2 Ground & First Floor FBC (v4) states that:

> ***The Case for Change***
>
> *The investment objectives for this FBC are as those set out in the OBC, with an emphasis on compliance with statutory fire safety and asbestos removal. The first of these is heightened by the Fire Enforcement Notice (FEN) placed upon the Health Board in December 2010 in respect of the core ground and first floor areas of the original hospital. This FEN has been subsequently extended on various occasions, both on the strength of completed interim temporary measures and via an ongoing annual review arrangement, between the UHB and South Wales Fire and Rescue Service, that is only extended dependant on satisfactory continued advancement of the planned works contained in this business case to deliver statutory conformity in the earliest timescale possible.*
>
> *In summary, the objectives for this case are:*
>
> - *Statutory fire compliance with the Regulatory Reform (fire Safety) Order 2005, at the Prince Charles Hospital site;*
> - *Removing the potential risk of asbestos exposure to patients, visitors and staff within the original building of the hospital, resulting in compliance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations, 1999 and Control of Asbestos Regulations 2006;*
> - *To improve service efficiency, quality and productivity in line with the wider Cwm Taf UHB clinical and financial strategic direction;*
> - *To redesign clinical areas, as currently provided from within the ground and first floor areas of PCH in line with accommodation standards, to provide flexible, safe and welcoming accommodation in support of improved productivity and future proofing against emergent strategies.*

These investment objectives are driven by the existing issues:

- *The majority of the ground and first floor area is currently failing to comply with current fire legislation;*
- *Large areas of the ground and first floor building have either non-existent or insufficient levels of fire compartmentation and fire stopping. Furthermore, various other fire safety issues prevail in the form of inadequate fire doors, firefighting equipment and appropriate means of detection;*
- *Within the building asbestos coating has been used throughout to provide fire protection. Progressive deterioration and damage has resulted in widespread asbestos contamination within the ceiling voids and air currents have, over time, spread this into other connecting voids and cavities;*
- *In addition asbestos spray coating was used as fire protection to the structural steel frame of the building which has become friable over time and is deteriorating.*

In relation to the latent fire issues of the original hospital buildings, two Fire Enforcement Notices have been served upon on the Health Board, at Chief Executive level, for rectification as a matter of urgency. One of these, relating to the centre core of the hospital, was resolved on completion of the previous major capital scheme for the centre core and upper floor ward areas completed in 2013. However, the enforcement notice relating to the ground and first floor areas remains outstanding, and can only be resolved through permanent major capital works.

The related asbestos management issues have now reached the stage where basic maintenance of the building infrastructure is hindered through a requirement to test and rectify individual areas when undertaking essential maintenance tasks in voids, lift shafts or above ceilings and when undertaking even minor improvement works within departmental areas. Consequently, the costs of maintaining PCH are rapidly increasing and even the smallest of jobs now commonly have a wide impact on service delivery.

As the level of works to make these fundamental building fabric rectifications involves a complete strip back of the building to its steel frame across large areas of the whole site, it has afforded the UHB the opportunity to carefully plan and consider the future layout of existing services and provide these with realigned adjacencies to support improved patient flow and way finding across the site.

Business Need

The compelling reason for the works described within this FBC is to enable the Health Board to continue to meet its statutory obligations, without delay, to deliver the refurbishment works programme to address the live Fire Enforcement Notice (FEN). Works as part of this wider programme commenced in October 2017, under the approved BJC for phase 1a and are soon to move into phase 1b in October 2018, subject to pending Welsh Government approval. This FBC is submitted to provide continuity with the full programme of remediation works, in the optimum timescale, for early delivery against the requirements of the FEN.

The strategic fit for the continued refurbishment of PCH as a local acute care centre as part of the wider Cwm Taf direction is recognised within national and local strategic thinking and is at the forefront of the Health Board's future vision for core acute service provision.

The revised layouts of the existing services proposed within this business case also align to other recent major works completed such as the Emergency Care Centre and will see further alignment of "hot" (urgent / acute) and "cold " (elective / procedural) areas zoned together across the site.

The scope of core service areas that will be addressed within the FBC proposed works includes:

- *Main Theatres;*
- *Day Theatres;*
- *Critical Care;*
- *Radiology;*
- *Outpatients;*
- *Oral Maxillofacial Services;*
- *Endoscopy;*

- *Neurophysiology;*
- *Cardio Pulmonary Services (COPD);*
- *Diabetes Services;*
- *Therapies.*

It is of note that the above include a large element of core clinical areas that fundamentally support hospital wide patient care and delivery and as such explains the need to phase the works in such a way as to maintain service delivery at all times whilst undertaking the significant accommodation remediation.

Key Milestones:

Milestone	Date
Phase 1a BJC Approved	Sept 2017
Phase 1b BJC Submission	June 2018
Phase 2 FBC Submission	Oct 2018
Phase 1a works completion	Oct 2018
Phase 1b works completion	Jan 2021
Phase 2 works completion	Apr 2026

9. Scope/Terms of Reference of the Review

The Review Team has undertaken this PAR with a broad terms of reference, roughly aligned to a Gateway 0 Review, augmented by a number of requests submitted by the Programme Director, namely:

- *Programme review to date and consideration that the HB has continued to reasonably maintain progress to the best of its ability and has resources this appropriately.*
- *To consider and review that the OBC scope still remains consistent with current plans.*
- *To consider and review that the phased approach proposed is reasonable.*
- *To consider and review if the VfM opportunities have been fully explored/optimised.*

10. Detailed Review Team findings

10.1 Strategic Position

This Programme has been in existence, in one form or another, since 1996. In the intervening time, a number of National, Healthcare, and Local strategies have evolved, with implications for the strategic role of Prince Charles Hospital (PCH).

A Fire Enforcement Notice has been in place since 2010, with annual extensions being granted on demonstrable evidence towards addressing the issue.

Balancing the Strategic imperative to evolve and improve the hospital service mix at PCH, with the tactical and urgent need to tackle the fire safety issue presents a dynamic and ongoing challenge for Cwm Taf University Health Board (CTUHB).

CTUHB will absorb responsibility for healthcare in the Bridgend area, increasing its span of control by approximately one third. This also presents the opportunity to consider re-balancing the service mix across the enlarged CTUHB estate, potentially with implications for the role of PCH. Service provision in neighbouring Health Boards, and other factors such as the Heads of the Valley road shortening travel times, could also have an impact on the options for CTUHB and PCH in particular.

Merthyr Tydfil is considered to be an important geographical location serving the Urgent Care needs of the Heads of the Valleys area and Powys as well as the immediate locale, noting that the nearest alternative is some distance away. Maintaining A&E in this vicinity is therefore viewed as imperative.

The fire safety issue has been at the forefront of driving progress. The programme implementation planning has been shaped around the need to make incremental progress and demonstrate to South Wales Fire & Rescue Service (SWF&RS) that the continual extension of the Fire Enforcement Notice (FEN) can be justified. The Review Team is of the view that the ‘heads down’ pursuit of addressing the fire issue is to the credit of the conscientious leadership but is also potentially a distraction from delivering the appropriate service mix in the evolving strategic context.

Given the many years that have passed since the programme’s inception, and the urgent need to tackle the fire issue, the Review Team is concerned that although CTUHB might be ‘pursuing the programme right’, they might not be ‘pursuing the right programme’.

The Review Team was made aware of various possibilities having been investigated to tackle the fire safety issue. The incremental plan to tackle the high-risk areas first - the building core, the kitchens and a structured approach thereafter through to 2026 – appears to be the optimal approach, assuming that the programme is indeed ‘the right programme’.

The Review Team was also made aware of historic discussion surrounding the possibility of a new-build elsewhere, but not on the PCH site. In light of the Strategic backdrop and the potential impact on service mix, the Review Team believes that there could be scope for a new build on the PCH site, which would alleviate some of the complexity of refurbishing an operational hospital. Indications are that the anticipated cost of refurbishment has risen significantly over the years and it could well be cheaper to build new and demolish old. The Review Team did not have access to forensic financial analysis to support this argument, but it would be worthwhile making sure that a new-build on-site option is properly considered prior to progressing with the main works of the programme (referred to as Phase 2).

In the context of maintaining momentum in pursuit of the fire issue, the Review Team believes it is important to ratify the strategic case for the Programme (as currently scoped), make adjustments if necessary to fit with National Policy drivers and the CTUHB strategic position.

<u>Recommendation 1</u>: Ratify the strategic case for the Programme and the service mix required to be delivered by PCH whilst maintaining momentum in addressing the fire enforcement notice. (Essential – Do by submission of the Phase2 Business Case)

10.2 Business Cases & Finance

The approach to Business Case submission for this programme has deviated from the standard. This makes sense and supports the need to make progress on tackling the FEN issue, together with a phased approach to addressing an asbestos problem. It does, however, require that programme leadership maintain an eye on strategic programme direction when making proposals for incremental phase implementation. There is always the possibility that cost could be incurred on short-term progress, which then proves to have been misaligned with the overall picture. This should not be viewed as nugatory work, but rather a cost incurred for a quick-win benefit and the support of business continuity.

The Business Case status is as follows:

- Phase 1a: Decant for kitchens, £7.5m, approved WG Sept 2017, works underway and almost complete.
- Phase 1b: New permanent kitchen, pharmacy & infrastructure, £36m, WG submission June 2018, awaiting approval.
- Phase 2: Ground & First Floor main areas, £177m, WG submission Autumn 2018.
- Phases 3&4: Future phases, £42m.

The anticipated cost of the programme, as currently costed by the supply chain, is in the region of £263m. This compares with the original programme cost estimate of some £119m as approved by WG in a previous iteration of the business case in 2013. The reasons for this uplift are many and various, and some is attributable to the various false starts and delays imposed on CTUHB in the intervening years.

The Supply Chain Partner (SCP), Interserve, has submitted a costing for Phase 1b. This has been assessed by the Trust Cost Advisors (TCA), Gleeds, as being excessive and non-compliant with the Design for Life 3 Framework. There appears to be an empasse in this matter.

There is a difference of approx. £3m between the Interserve costing and the Gleeds assessment. This issue has consumed much management attention. The Review Team observed that the 'heads down' worrying about this £3m has perhaps been another distraction from the big picture. Phase 1b is £36m. Phase 2 is £177m. If the same percentage disagreement prevails there will be an affordability gap. There is also likely to be difficulty in demonstrating Value for Money (VfM) during the business case submission. This needs to be addressed promptly to ensure that the programme can maintain momentum through Phase 1b and be ready to roll into Phase 2 (whatever form that may take by then) and ensure continued demonstration of progress against the FEN.

Market forces have changed over the years, with a reduction in supply-side risk appetite (the Carillion effect), changed management structures and a more buoyant consumer base reducing competition for high-profile, high-risk projects. Additionally, the numerous delays to date have dented supply chain sub-contractor confidence.

Many interviewees drew comparisons between PCH and Ysbyty Glan Clwyd (YGC) as 'sister hospitals', built to the same blueprint. Questions were raised as to why the refurbishment of part of PCH is set to be so much more expensive than the complete refurbishment of YGC. Differing opinions were offered, but nonetheless the magnitude of difference is significant and appears to lack cogent argument. This VfM issue presents difficulty in maintaining momentum whilst avoiding being 'held over a barrel' by the SCP and failing to protect value for the public purse.

The complexity and risk, lack of supply chain interest and the apparent empasse in costing estimates serves to undermine the continuance of the programme in its current form. This reinforces the attractiveness of a new-build option, which would be simpler, have a lower impact on ongoing hospital operations and, the review team is led to believe, likely cost no more. Upon completion, a new, fit for purpose, functionally optimised facility is an attractive alternative to a compromised refurbishment at excessive cost. This warrants consideration.

<u>Recommendation 2</u>: Resolve the apparent affordability gap and VfM debate, considering other, potentially new-build, options. (Critical – Do Now)

10.3 Benefits & Stakeholder Engagement

Interviewees reported a positive relationship with Welsh Government (WG), regular meetings and strong support. Notwithstanding some frustration at perceived unnecessary pauses (e.g. the Do Minimum Review), CTUHB maintains a healthy working dynamic which balances challenge with support. This is encouraging.

SWF&RS has a firm and business-like, yet pragmatic, approach to supporting the progress of the programme. The Review Team believes that the Fire Service would be a willing partner to perform a more active role 'inside the tent' of the programme team and could be utilised to greater effect. They could be expert advisors during planning & options appraisal, design considerations and project phasing. Again, this is encouraging.

Community engagement has been strong, with regular public meetings in various locations across the CTUHB area, consultation events and Community Health Council (CHC) involvement. As well as a service provider, PCH is a major employer for the local area. Community interest is high. Car parking was cited frequently as a concern, but there is an acceptance that some interim inconvenience is a necessary factor in achieving the benefit of the refurbishment.

With previous service reconfigurations, there had been some community anxiety about the future of PCH. Whilst there is a preference for a new-build, there is also a preference for maintaining the PCH site. As discussed, the Review Team believes there might be potential to satisfy both.

Refurbishment of anything old usually results in a compromise, compared with the creation of something new. The Review Team observed several examples where the refurbished clinical facilities will be a huge improvement on the current status, but still be sub-optimal. There is also some concern that the design is constrained by the current infrastructure, perhaps limiting the ability to install optimised movement for both patients and equipment. This could impact clinical safety and potentially open PCH to potential non-compliance with future regulatory change. It would be unfortunate if the refurbishment were to be completed, only for CTUHB to need to embark on another wave of modifications.

Staff appear to be well informed, but on a just-in-time basis. Communication is largely one-way from the programme team, though there have been numerous fora where staff have had the opportunity to attend and receive updates and provide feedback via surveys. The programme team operates on a skeleton staffing, and it is therefore a credit to them that they have managed to achieve as much as they have. Moving forward, there will be a need to evolve communication into true engagement. This will underpin the design and business change aspects for the programme, particularly as Phase 2 progresses. Furthermore, this is a key plank of benefits realisation through effective change and programme delivery. The Review Team encourages building on the solid stakeholder support thus far by creating a formalised change network.

Recommendation 3: Establish a business change network to inform solution design and implementation planning. (Essential – Do by commencement of Phase 2)

10.4 Governance

The Programme is governed by a 'Programme Board'. Each phase is governed by a 'Project Board'. Additionally, there is the 'Capital & Estates Programme Board' and various 'business as usual' reporting lines. It is not clear to the Review Team, nor to many interviewees, how this governance map is intended to operate. The SRO (CTUHB CEO) has taken a strong personal interest in the programme, noting the prominence of the FEN, and has driven personally many of the necessary decisions.

With the changing strategic landscape and the transformation activities needing attention throughout CTUHB, it might be appropriate at the right time for the CEO to relinquish SRO responsibilities to an Executive Lead. This would be reliant on sufficient strength and depth being established in the delivery team for the challenge ahead and for there to be confidence that this critical issue is in good hands.

The Review Team observed that Programme Board meeting attendance is sporadic and lacks sufficient active membership of clinical colleagues. Moving forward, the governance arrangements would benefit from a 're-boot' to ensure solid membership, attendance and effective decision-making.

Recommendation 4: Simplify, clarify and communicate the various governance bodies, ensuring appropriate escalation relationships and clinical membership. (Critical – Do Now)

10.5 Contract Management

The programme is being delivered via the Design for Life 3 Framework (DfL3). The earlier works at PCH had been contracted with Laing O'Rourke, who had completed the refurbishment at YGC. Laing O'Rourke did not feature on the DfL3 Framework and therefore was not available to tender for the completion of the PCH refurbishment.

Market conditions have changed and there were only three Supply Chain Partners appointed to the DfL3 Framework. All three were interviewed by the Health Board and the limited competition resulted in the selection of Interserve as the SCP for PCH. Interserve will be contracted for the delivery of Phase 1b as well as the development of the business case for Phase 2. The delivery of Phase 2 is not yet contracted, but there is a working assumption that Interserve will progress from business case to delivery. Given media reports about Interserve refinancing earlier in 2018, it is not unreasonable for the Health Board to have raised questions about the financial stability of Interserve. Interserve's risk appetite is low and there is a general impression from interviewees that Interserve would potentially walk away from the programme if the profit margins do not

satisfy their risk exposure. It is not clear that there is a viable alternative and the sub-contract market is growing weary of continual delays, with many work packages receiving only a couple of bids. This does not paint a picture where CTUHB has many options, but neither does it sit comfortably with ensuring VfM.

If the cost empasse cannot be resolved, there is a risk to programme continuity. The option of re-competing is reputed to likely result in further delay and further increased cost. The Review Team was told of various behaviours that could be driving Interserve to inflate costs, including excessive inclusion of risk budgets within the target cost. There is a need to ensure that Interserve comply with the terms of DfL3. The responsibility for doing this appears to be falling through the cracks, with Shared Services (who control the Framework) potentially conflicted in their advice roles, Gleeds not in a position to exercise contract management (as opposed to Cost Advice) and CTUHB not resourced to undertake robust commercial discussions. The Review Team believes that Shared Services is best placed (as owners of the Framework) to insist on compliance. CTUHB needs to progress this matter with Shared Services to a satisfactory conclusion, otherwise the business case for Phase 2 will likely fail. It is not clear whether alternative procurement routes are available or are likely to result in a more favourable outcome, but it would be worthy of some consideration.

There is a need to differentiate between expected base cost and contingency/risk cost and to instigate a mechanism to trigger exception payments in the event of risk occurrence. This will rely on robust contract and financial management within the programme, neither of which is in evidence at present.

<u>Recommendation 5</u>: Accelerate and strengthen activities to drive compliance with the Design for Life 3 Framework and instigate a robust cost management mechanism. (Critical – Do Now)

10.6 Programme Management & Resources

The programme is documented and controlled in a manner that appears to have been adequate to date. It is not optimised and appears to lack (to varying degrees) a number of factors that the Review Team would expect, including a fully developed benefits management framework (though some benefits registers do exist), a business change plan, a resource plan, a contract management plan, fully developed Risk, Assumptions, Issues, Dependencies and Opportunities (RAIDO) approach, programme financial management and a strategic approach to transition management.

The programme appears to have been managed like a large project, not a programme, with the primary focus on meeting the near term needs (progressively working towards lifting the FEN), not the strategic outcomes (which are benefits-led). This is understandable given the pressing need to address the most urgent threat to continuity, but it is not sustainable with the level of resource currently allocated to the delivery of the programme. The skeleton programme team has done a very credible job under pressure and has demonstrated progress, span and work-rate normally associated with a team

twice its size, and the Review Team heard examples of similar programmes where the team is ten times the size.

Success to date is not an indication of success in the future. The Review Team believes strongly that the programme will fail beyond Phase 1b if the deficiencies in adequate resourcing are not addressed. This means undertaking a full resource requirement and planning activity to establish what skills and experience will be needed, something that CTUHB acknowledges and is already discussing. The Review Team understands that recruitment to Merthyr is a particular problem, but progressing without a properly constituted team is a route to certain failure.

Recommendation 6: Establish a comprehensive appropriately skilled and experienced Programme Team, including robust commercial management capability. (Critical – Do Now)

11. Next assurance review

The next Assurance Review should occur at the next strategic decision point, no later than September 2019. It should, by that time, be able to assess progress against Phase 1b and the preparations for whatever may follow.

In advance of that Review, an Assurance of Action Plan (AAP) will need to be completed to assess progress on the recommendations made in this report, together with the trajectory of Delivery Confidence. The AAP should be completed by January 2019.

ANNEX A - List of Interviewees

The following stakeholders were interviewed during the review:

Name	Organisation and role
Allison Williams	CEO CTUHB, SRO
Ruth Treharne	Deputy CEO CTUHB, Exec Lead
Mel Jehu	Independent Member, Project Board member
Bill Rogers	Programme Director PCH
Dominic Roche	Gleeds HB External Project Manager
Chris Edmonds	Interserve Project Lead
Huw Evans	Head of Finance
Dick Jones	SWF&RS
StJohn Towell	SWF&RS
Anthony Taylor	Senior Operating Dept. Practitioner
Cllr Clive Jones	Methyr County Borough Council
Nigel Watkins	Gleeds Director Cost Management
Mike Roberts	Gleeds Trust Cost Advisor
Mwoyo Makuto	Deputy Chief Officer CHC
Mark Allman	Chief Pharmacist, PCH
Suzanne Scott-Thomas	Clinical Director of medicine management

Llywodraeth Cymru
Welsh Government

OGC Gateway™ Assurance of Action Plan

Version number:	V1.0 Final
Senior Responsible Owner (SRO):	Allison Williams
Date of issue to SRO:	28/01/19
Programme/project Title:	Prince Charles Hospital Refurbishment
Department/Organisation of the Programme/project	Cwm Taf University Health Board
Review dates:	18/01/19
Review Team Leader:	David Wilkin
Review Team Members:	Leigh Dyas
Previous Review:	PAR 12/09/2018 to 14/09/2018 Delivery Confidence Assessment -Red
IAH ID number:	AH/18/09

This assurance review was arranged and managed by:

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This report is an evidence-based snapshot of the programme/project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over the review period, and is delivered to the SRO immediately at the conclusion of the review.

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1.0 Delivery Confidence Assessment (DCA)

Delivery Confidence Assessment:	**Amber**
The Review Team finds the significant issues raised in the September 2018 PAR have been addressed robustly. There remain outstanding risks and issues in respect of commercial supply chain and CTUHB resources. CTUHB maintains its quest to make continuous progress in satisfying the Fire Enforcement Notice and, in parallel, has undertaken significant work in ratifying the strategic alignment of Prince Charles Hospital within it portfolio. The options analysis confirming the way forward adds weight to the Phase 2 Business Case. The Review Team is impressed by the efforts of the CTUHB Programme Team, assisted by their various colleagues in Welsh Government and is pleased to report an improvement in delivery confidence assessment.	

1.1 Delivery Confidence Assessment

The Delivery Confidence assessment RAG status should use the definitions below:

RAG	Criteria Description
Green	Successful delivery of the programme/project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
Amber/Green	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.
Amber/Red	Successful delivery of the programme/project is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
Red	Successful delivery of the programme/project appears to be unachievable. There are major issues which, at this stage, do not appear to be manageable or resolvable. The programme/project may need re-baselining and/or overall viability re-assessed.

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2.0 Progress on Previous PAR Recommendations

Ref. No.	Recommendation	Urgency (C/E/R)	Progress since PAR
1.	Ratify the strategic case for the Programme and the service mix required to be delivered by PCH whilst maintaining momentum in addressing the fire enforcement notice.	Essential Dec 2018	CTUHB progressed this recommendation with vigour in several aspects. The strategic positioning of the healthcare service mix provision within the Cwm Taf area was confirmed. Additionally, SWFRS was consulted with respect to the ongoing momentum of addressing the FEN. The potential alternatives were discussed and the impact assessed. **ACTIONED**
2.	Resolve the apparent affordability gap and VfM debate, considering other, potentially new-build, options.	Critical Oct 2018	Detailed analyses have been conducted both in respect of Phase 1B and in preparation for the Phase 2 FBC. The affordability gap for Phase 1B has been reduced considerable from approx.. £3m to approx. 300k through allocation of risk pots both inside and outside cost, held by the contractor ant the Health Board. Those Risk costs can be retired as the phase progressed. Any residual additional costs can be absorbed by CTUHB Capital prioritisation. The Phase 2 FBC takes a similar approach. **ACTIONED**
3.	Establish a business change network to inform solution design and implementation planning.	Essential Mar 2019	Existing User Groups are being leveraged to articulate Benefit Profiles. Key Service Leads have been identified to act as a link between Major Projects and the various services. The Programme Director will be able to focus more on Business Change for the next

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			Phase, thus further strengthening the arrangements. The operation of the Business Change Network will need to be a continuous activity. **ACTIONED**
4.	Simplify, clarify and communicate the various governance bodies, ensuring appropriate escalation relationships and clinical membership.	Critical Oct 2018	A new organogram has been developed and a communications brief agreed. The documentary evidence is clear, though the Review Team has been unable to test understanding amongst a representative sample size during the AAP. The recommendation arose from significant interviewee misalignment of understanding during the original PAR. Governance will be examined again at the next PAR. This recommendation, per se, can be considered actioned. **ACTIONED**
5.	Accelerate and strengthen activities to drive compliance with the Design for Life 3 Framework and instigate a robust cost management mechanism.	Critical Oct 2018	Relationships with NHS Shared Service Centre have been beneficial in responding to this challenge. A form of words to clarify compliance was agreed between CTUHB and Interserve, bringing greater clarity to the control of costs within the DFL3 framework and the means by which additional costs would be handled. Thematically, however, maintaining adherence to DFL3 for Phase 2 remains a risk. **ACTIONED but the topic remains a theme**
6.	Establish a comprehensive appropriately skilled and experienced Programme Team, including robust commercial management capability.	Critical Mar 2019	A commercial management capability has been secured on secondment from NHS Shared Services. An advert has been posted (and is now closed) to recruit an additional team member for the programme team. The Review

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			Team is unconvinced that this is sufficient, though the arrival of the commercial manager (deputy SRO) may prove to release bandwidth elsewhere in the team to absorb the remainder of the workload. **ACTIONED but the topic remains a theme**

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3.0 Summary of AAP Report Additional Recommendations

The Review Team makes the following recommendations, which are prioritised using the definitions below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Classification
1.	**Engage NHS Wales Shared Services Partnership – Specialist Estates Service to critique the Phase2 Business Case prior to submission.**	**Critical**	**Feb 2019**	**8.2 Business Case**
2.	**Confirm the respective roles in the core programme team, specifically between service design/change and construction delivery.**	**Essential**	**July 2019**	**10.5 Organisation**
3.	**Develop jointly with WG a set of contingency plans to respond to possible scenarios arising from contractual difficulties with the supplier.**	**Critical**	**Feb 2019**	**9.2 Contingency Planning**
4.	**Profile the Project Management resource requirement for Phase 2 start-up.**	**Critical**	**Feb 2019**	**10.5 Organisation**

Critical (Do Now) – To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately

Essential (Do By) – To increase the likelihood of a successful outcome the programme/project/ project should take action in the near future.

Recommended – The programme/project should benefit from the uptake of this recommendation.

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4.0 Comments from the SRO

The PAR Gateway Review undertaken in September 2018 was an important catalyst for reviewing the strategic context, structures and processes underpinning the PCH Ground and First Floor Project.

As SRO, I believe that the progress made since that time is fairly and accurately reflected in this 'Assurance of Action Plan' review and I accept all the recommendations in full.

The very tight timescales for delivering on the 3 critical recommendations is in line with the timetable for submission of the Phase 2 Business case and will be addressed without delay.

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5.0 Background

The aims of the programme/project:

The Phase 2 Ground & First Floor FBC (v4) states that:

In summary, the objectives for this case are:

- *Statutory fire compliance with the Regulatory Reform (fire Safety) Order 2005, at the Prince Charles Hospital site;*
- *Removing the potential risk of asbestos exposure to patients, visitors and staff within the original building of the hospital, resulting in compliance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations, 1999 and Control of Asbestos Regulations 2006;*
- *To improve service efficiency, quality and productivity in line with the wider Cwm Taf UHB clinical and financial strategic direction;*
- *To redesign clinical areas, as currently provided from within the ground and first floor areas of PCH in line with accommodation standards, to provide flexible, safe and welcoming accommodation in support of improved productivity and future proofing against emergent strategies.*

The driving force for the programme/project:

These investment objectives are driven by the existing issues:

- *The majority of the ground and first floor area is currently failing to comply with current fire legislation;*
- *Large areas of the ground and first floor building have either non-existent or insufficient levels of fire compartmentation and fire stopping. Furthermore, various other fire safety issues prevail in the form of inadequate fire doors, firefighting equipment and appropriate means of detection;*
- *Within the building asbestos coating has been used throughout to provide fire protection. Progressive deterioration and damage has resulted in widespread asbestos contamination within the ceiling voids and air currents have, over time, spread this into other connecting voids and cavities;*
- *In addition asbestos spray coating was used as fire protection to the structural steel frame of the building which has become friable over time and is deteriorating.*

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Current position following previous assurance review:

The PAR from which this AAP flows was conducted in September 2018, returning a Delivery Confidence Assessment of RED, noting at that time that:

> *The pursuit of the Fire Enforcement Notice is being tackled with a sense of purpose and the SRO has a strong personal commitment to maintaining service delivery in a safe manner. The refurbishment of the Prince Charles Hospital has been progressed incrementally to ensure that addressing this prominent problem is undertaken as speedily as possible. This is being done whilst also endeavouring to refurbish the hospital in such a way that will derive improvements in healthcare outcomes and benefits.*
>
> *It is without question that the leadership and management of the programme is being undertaken with the best intent, but it is not realistic to pursue the aspiration with the current level of resource or supply chain constraints. Additionally, since the programme's original inception, some 22 years ago, the strategic backdrop has changed and there could be potential to derive a better outcome at a lower cost and at the same time satisfy the requirements of the Fire Enforcement Notice.*

And that:

> *The Review Team finds that as currently constituted and resourced, successful delivery of the programme is unachievable.*
>
> *The skeleton team is performing to a high standard and looks likely to succeed in the short term, with the guidance of a strong SRO and executive leadership. There are significant deficiencies in supply chain management expertise, affordability of the current costings from a risk-averse marketplace, core financial and programme management expertise, and a high degree of focus on near-term financial arguments rather than the big picture.*
>
> *The programme may need re-baselining or overall viability (in its current form with current supply chain) re-assessed.*

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6.0 Purposes and conduct of the AAP

The Assurance of Action Plan (AAP) review re-assesses a Delivery Confidence Assessment in the light of actions taken, following an assurance review, where Delivery Confidence has been assessed as Red or Amber/Red.

This AAP was undertaken as a one-day activity, on site at Prince Charles Hospital.

Annex A lists the people who were interviewed during the review.

7.0 Acknowledgement

The Review Team would like to thank all participants for their contributions to this AAP Review.

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8.0 Review Team findings and recommendations

Strategic Position

CTUHB has re-affirmed the strategic alignment of its plans for PCH within the HB. The service mix has been re-examined at a portfolio level, confirming that the needs are extant and that the full scope of the programme is required in order to maintain the full suite of healthcare required in the area.

The potential for a new-build hospital, on a new site, was examined, along with options for a complete or partial new build on the existing site. The options appraisal was proportionate to the time available and was sufficiently granular to identify indicative costs of the various options. Additionally, adherence to a progressive path of addressing the Fire Enforcement Notice was of prominent importance. Maintaining momentum towards fire safety compliance, balanced with cost and benefits led to confirmation of the current programme.

The Review Team believes that the re-visiting of strategic fit, together with a refresh of options, has served to strengthen the CTUHB Business Case for the PCH Refurbishment Programme. There is no doubt that a new build would be more likely to provide a future-proofed way forward, but the HB has balanced this against funding profile and maintaining the momentum towards fire safety.

Business Cases & Finances

The Value for Money (VfM) gap for Phase 1b has been significantly closed. The methodology developed and agreed for the handling of Risk Inside Cost and Risk Outside Cost has been taken forward and applied to the Phase 2 FBC.

The Phase 2 FBC is in development and is due to be submitted to WG in February 2019, with the expectation that it is approved by June, enabling contract signature around July.

The cost of Phase 2 is approximately £177m.

If the FBC is not approved by WG in this timeframe, there will be a direct impact of delay and additional cost. It is important that CTUHB makes it very clear to WG that this is the case. Not only should WG understand the cost and time impact of non-approval, but it should also be made aware of the financial profile so that the funding of

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PCH can be optimally granted in the overall NHS portfolio and smooth the profile across demand.

Additionally, if delays were to result in the build being undertaken under DFL4, rather than DFL3, this would further increase costs.

Whilst WG needs to be properly assured of the investment, and not be held over a barrel by CTUHB, there is a need for swift and decisive approval if the programme is to proceed at pace in pursuit of its objectives. CTUHB will need to make a compelling case to WG that there is an enduring need. It would be prudent to make sure that the FBC flies at the first attempt; NHS Wales Shared Services Partnership – Specialist Estates Service would make useful 'critical friends' in this regard and they could usefully be involved now I critiquing the FBC prior to submission.

Recommendation AAP1: Engage NHS Wales Shared Services Partnership – Specialist Estates Service to critique the Phase2 Business Case prior to submission. (Critical – Do Now)

Benefits & Stakeholder Engagement

The Business Change arrangements have evolved and the benefits have been articulated. The Benefits Profiles are impressive. The Review Team understands that the Programme Director is likely to take a greater role in driving service design and business change as core aspects of the programme going forward. This can only serve to strengthen the stakeholder engagement landscape and ensure that the delivery plans for the programme are optimally aligned with minimising disruptive impact on service delivery. Stakeholder engagement and communications will be prominent as Phase 2 ramps up. Arguably this is a Business Change Programme, with capital estates construction projects within it; not the other way around.

Governance

The Programme Board continues to govern the Programme, with each Phase designated a Project Board. The Review Team understands that the SRO role will shortly transition from the CE to the deputy CE (Director of Planning and Performance). This makes sense (especially in the context of a Business Change Programme) and releases the CE to concentrate on Portfolio matters for the CTUHB.

A commercial contracting expert is shortly to take up post on secondment from NHS Shared Services, bolstering experience and skills in that area, to complement the

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experience and skills of the Programme Director. The new arrival is also proposed to undertake a 'deputy SRO' role, though the Review Team (in the space of this one day AAP) was not fully able to assess how those duties would be positioned in the existing governance/delivery divide. If is deputy SRO is part of the governance, they ought not to be part of the delivery (and vice versa). The Review Team heard that this commercial role is to co-ordinate and deliver the construction projects through robust contractual commercial management. This seems, to the Review Team, at slight odds with the deputy SRO title.

Without wishing to debate job titles, on first impression the Review Team sees two complementary roles: Delivery Director and Change Director, both reporting to the SRO. It is clearly for CTUHB to decide how and where roles sit, and what labels they carry, so long as the job gets done. The Review Team believes that there could be merit in revisiting the division of responsibilities for the future construct to confirm that the current intention is optimal, or otherwise.

<u>Recommendation AAP2:</u> Confirm the respective roles in the core programme team, specifically between service design/change and construction delivery. (Essential – Do By Phase 2 commencement)

Contract Management

The arrival on secondment of the commercial expertise is good news.

The delivery chain for the project involves CTUHB managing Gleeds managing Interserve. The Review Team is unconvinced about the value being added by the middle man. With additional CTUHB commercial and contact management expertise in-house, does the role of Gleeds diminish, especially if they are dealing only with contractor delivered components of the projects, not in-house services (such as IT) or business change activities? It might be worth considering whether the expenditure consumed on this role might better be directed towards additional in-house project managers.

As the submission of the Phase 2 FBC, with subsequent approval, will enable contact signature. There remains a risk that Interserve could hold CTUHB to ransom by refusing the sign. The DFL3 / DFL4 history (as discussed in the original PAR report) prevails and the potential for re-tendering along with the attendant delays and cost increases remains a worry. It would be prudent to develop with WG a set of contingencies to cater for a number of scenarios should contractual difficulties arise with Interserve at that critical juncture.

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<u>Recommendation AAP3:</u> Develop jointly with WG a set of contingency plans to respond to possible scenarios arising from contractual difficulties with the supplier. (Critical – Do Now)

Programme Management & Resources

Programme management disciplines appear robust and the Programme Team is working tirelessly in pursuit of a positive outcome. The major focus recently has been the development of the Phase2 FBC and this is nearing readiness for submission. Leadership at the Executive level in CTUHB is clearly attentive and strong and there is an acute eye on the need to maintain progress towards fire safety. Pursing that FEN progress in parallel with a major programme is no small task and it is a credit to all involved so far that so much has already been achieved. That said, the core programme team remains very light and the recruitment of one additional staff member is, in the view of the Review Team, unlikely to be sufficient, especially when Phase 2 starts in earnest. It would be worthwhile profiling the Project Management demand, particularly for Phase 2 start-up, to make sure CTUHB can surge PM resource in line with the demand from the contractor side. Not only is it critical to have adequate resources to optimise delivery, but it is also critical to ensure avoidance of commercial compensation events arriving from client-side non-delivery.

<u>Recommendation AAP4:</u> Profile the Project Management resource requirement for Phase 2 start-up. (Critical – Do Now)

9.0 Next Assurance Review

The next Assurance Review should be another **PAR** with a bespoke Terms of Reference, after Phase 2 FBC approval and around the time of Phase 2 implementation start-up. On current plans, this is likely to be **late summer 2019**.

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ANNEX A

List of Interviewees

The following stakeholders were interviewed during the review:

Name	Organisation and role
Allison Williams	CEO CTUHB, SRO
Ruth Treharne	Deputy CEO CTUHB, Exec Lead
Dominic Roche	Gleeds HB External Project Manager
Chris Edmonds	Interserve Project Lead
Mike Roberts	Gleeds Trust Cost Advisor
Ian Gunney	NHS Wales Shared Services Partnership – Specialist Estates
Bill Rogers	Programme Director PCH
Iain Worby	Shared Svcs / Deputy SRO

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GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 5** **Appendix F** **Date of Meeting – 3rd Jan 2019**

PCH Ground and First Floor – Progress against Recommendations from the PAR Gateway Review

Executive Lead: Ruth Treharne, Director of Planning and Performance/Deputy Chief Executive.
Author: Bill Rogers, Programme Director, Prince Charles Hospital (PCH) Ground and First Floor Scheme and Tim Burns, Assistant Director, Capital and Estates.
Contact Details for further information: Bill.Rogers@wales.nhs.uk

Purpose of the Report
To update the PCH Ground and First Floor Project Board on the current position and progress in respect of the recommendations from the Progress Against Recommendations (PAR) Gateway Review undertaken in September 2018.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2015-2018 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are; • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses mainly on the progress against supporting Phase 2 elements progression to satisfy the requirements of the fire enforcement notice.
Supporting evidence	The papers attached provide a range of supporting evidence.

Engagement – Who has been involved in this work?
There are a range of partners involved in this work including Gleeds as the Health Board's expert project management and cost advisors, Interserve as the Supply Chain Partner, Shared Services (Estates), Welsh Government (WG) Capital Leads and other stakeholders including operational staff, engaged in the project as necessary.

Resolution (insert √) To;							
APPROVE		**ENDORSE**	X	**DISCUSS**	X	**NOTE**	X
Recommendation	Members of the PCH G&FF Project Board are asked to: • **NOTE** and **DISCUSS** the progress made against the recommendations and **ENDORSE** the recommendations against 3, 4 and 6 this time.						
Summarise the Impact of the Report							
Equality and diversity	Impacts are covered in the SBAR main body below						
Legal implications	Impacts are covered in the SBAR main body below						
Population Health	Impacts are covered in the SBAR main body below						
Quality, Safety & Patient Experience	Impacts are covered in the SBAR main body below						
Resources	Impacts are covered in the SBAR main body below						
Risks and Assurance	Impacts are covered in the SBAR main body below						
Health & Care Standards	Impacts are covered in the SBAR main body below						
Workforce	Impacts are covered in the SBAR main body below						
Freedom of information status	**CLOSED** - contains sensitive commercial / legal advice						

PRINCE CHARLES HOSPITAL GROUND AND FIRST FLOOR PROGRAMME
'PROGRESS AGAINST RECOMMENDATIONS' (PAR)
GATEWAY REVIEW REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to update the Prince Charles Hospital (PCH) Ground and First Floor (GFF) Project Board in respect of the current position and progress against the recommendations from the 'Progress Against Recommendations' (PAR) Gateway Review undertaken in September 2018.

2. BACKGROUND / INTRODUCTION

In response to the Project Board and Welsh Government (WG) recommendations a Gateway Review was held in relation to the planned programme of works related to the PCH Ground and First Floor refurbishment programme. These proposed works are required in order to satisfy the requirements of a live Fire Enforcement Notice (FEN).

The Gateway Review was externally facilitated by the 'assurance arm' of the Welsh Government and locally led by an Independent Review Team. The Review was undertaken over three days and involved 1-1 interviews of a cross section of parties, both internal and external to the Health Board, that have a key interest in the proposed development.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The final Gateway Review report was discussed in detail at an extra-ordinary Project Board meeting held on the 25th October 2018 with six recommendations having been made in total,

At the Project Board meeting, the following actions, in the 2nd column of the table, were agreed, as set out below against each of the recommendations, with this report providing an update on progress made.

Recommendation 1 - Ratify the strategic case for the Programme and the service mix required to be delivered by PCH whilst maintaining momentum in addressing the fire enforcement notice. (Essential – Do by submission of the Phase2 Business Case)	a) The SRO to hold a strategic review meeting with WG to discuss the feasibility of reopening any debate on a change in direction. b) Provide an update on the process and progress to consider the strategic options of new build and partial new-build in the manner such as discussed in the extra ordinary Project Board meeting i.e. part new build to the front elevations and then demolish existing.

Recommendation 2: Resolve the apparent affordability gap and VfM debate, considering other, potentially new-build, options. (Critical – Do Now)	An agreed form of words, with Framework support, that identifies what has been done in relation to the handling of the 1B 'affordability gap' and what further process will be followed to do the same for the Phase 2 business case.
Recommendation 3: Establish a business change network to inform solution design and implementation planning. (Essential – Do by commencement of Phase 2)	A description of the functions and proposed membership for the suggested Business Change Network
Recommendation 4: Simplify, clarify and communicate the various governance bodies, ensuring appropriate escalation relationships and clinical membership. (Critical – Do Now)	An updated organogram and draft communication brief agreed by the Director of Planning and Performance.
Recommendation 5: Accelerate and strengthen activities to drive compliance with the Design for Life 3 Framework and instigate a robust cost management mechanism. (Critical – Do Now)	An agreed form of words, with Framework support, in relation to framework compliance and the mechanism for dealing with any outlying issues; an outline of the revised cost management mechanisms that provide the assurance that they are fit for purpose going forward.
Recommendation 6: Establish a comprehensive appropriately skilled and experienced Programme Team, including robust commercial management capability. (Critical – Do Now)	The requirement for additional capacity and reinforcing the skills gap is currently being considered by the SRO.

The following therefore sets out the progress made against each of the actions.

Recommendation 1 - Ratify the strategic case for the Programme and the service mix required to be delivered by PCH whilst maintaining momentum in addressing the fire enforcement notice. (Essential – Do by submission of the Phase2 Business Case)	a) The SRO to hold a strategic review meeting with WG to discuss the feasibility of reopening any debate on a change in direction. b) Provide an update on the process and progress to consider the strategic options of new build and partial new-build in the manner such as discussed in the extra ordinary Project Board meeting i.e. part

	new build to the front elevations and then demolish existing.

With regard to action 1a) a meeting was held with Andrew Goodall, Director General, Simon Dean, Deputy Director General and other WG leads on the 14th November 2018, which was also attended by Allison Williams, Chief Executive, Ruth Treharne, Director of Planning and Performance/Deputy Chief Executive, Tim Burns, Assistant Director of Capital and Property Services and Bill Rogers the Programme Director.

Discussion was held around the strategic options and the merits of each in relation to the timing and potential for these, in light of the current, advanced position of the programme. It was agreed that the Chief Executive would discuss with the Chief Fire Officer for South Wales Fire and Rescue Services and feed back to the Director General, as this was a critical part of informing the way forward.

The follow up discussion with the Chief Fire Officer for South Wales Fire and Rescue Services, confirmed that whatever option is progressed, the Health Board will be required to show continued improvement at Prince Charles Hospital against the Fire Enforcement Notice, during any intervening or overlapping period. This need is accordingly factored into the alternative option considerations in 1b below.

With regard to action 1b), it was recommended to develop and present the high level options review for inclusion in the eventual Programme Business Case. A summarised paper and indicative plan detail is attached at **Appendix 1 and 2** which looks, at a high level, at the potential of new build options, as well as a considering a 'part new build and demolish' approach, including assessment of cost, timescale and service delivery impacts. The various pros and cons of each are then set out and compared to the current plan, including assessment of functionality and cost.

The summary finding of the option appraisal undertaken, identifies all options are possible, but both the 'part new build and demolish' and also the 'all new build options' extend the programme considerably, when compared to the proposed Full Business Case (FBC) approach. Added to this, other key elements around continuity of FEN improvements at PCH and needing to maintain the estate for a longer period, both alternatives to the FBC attract significantly greater cost (details provided at **Appendix 3**).

With this considered, and noting the significant additional cost of the new build options and sub-optimal service related issues of the 'part new build' option, the Health Board continues to prefer the Full Business Case (FBC) approach as the way forward for continuation of the programme.

The Project Board are asked to discuss these findings and provide a steer on the recommended way forward.

Recommendation 2: Resolve the apparent affordability gap and VfM debate, considering other, potentially new-build, options. (Critical – Do Now)	An agreed form of words, with Framework support, that identifies what has been done in relation to the handling of the 1B 'affordability gap' and what further process will be followed to do the same for the Phase 2 business case.

In line with recommendation 2, the narrative of the process undertaken to "safeguard" the described 'value for money' gap in relation to Phase 1b is provided at **Appendix 4**. From this, and at the request of the Project Board, a similar approach is now being applied in relation to the existing "value for money" gap in the draft Phase 2 FBC, with the intention that this be concluded prior to the formal submission of the business case into Welsh Government.

Recommendation 3: Establish a business change network to inform solution design and implementation planning. (Essential – Do by commencement of Phase 2)	A description of the functions and proposed membership for the suggested Business Change Network

The proposals for the proposed business change network will be to build on the work of the existing User Groups established for the now completed design development phase. It is proposed to use the identified key service leads, drawn from the individual service benefits realisation plans (attached at **Appendix 5**), to act as the link between the Major Projects team and the various services.

These leads (identified in the table below) will both act as owners of the benefits realisation plans for their specific area and co-ordinate activities as described below the table:-

Name / Designation	**Service Area**
Cheryl Davies – Senior Nurse Theatres /Day Surgery Unit/Pre-Assessment	Theatres (Main and Day) and Pre-assessment
Andrew Hermon – Snr Nurse Critical Care	Critical Care (ITU)
Dr Mark Allman – Dep Chief Pharmacist	Pharmacy
Dr Justin Taylor – Lead Cons Cardiologist	COPD
Gautam Das – Consultant Physician Diabetes & Endocrinology	Diabtetes
Jacqueline Price - Sister Endoscopy	Endoscopy
Steve Barnard – Catering Manager	Catering

Steve Evans – HSCP Neurophysiology	Neurophysiology
Sue Jones – Department Manager	Oral Max Facs
Deborah Evans – Outpatients Manager	Outpatients
Paul Johnston - Superintendent Radiographer	Radiology
Debbie Davies - Head of Physiotherapy Services	Therapies (Physio / Hydro)

Their role will be as follows:

1) **Represent the service at monthly project team meetings** in order to review and consider the actual/potential service delivery impacts of the current or upcoming works and provide input to the development of potential mitigation plans. These meetings are facilitated by Capital and Estates and are reported upon through to the Project Board. The reporting is also used to inform the planned continuity of CHC and Public Forum updates and site based works progress displays.

2) **Act as the Service Champion/co-ordinator** of their own Service User Group. In this capacity will both act as the focal point for disseminating progress information in order to keep their colleagues advised of the developments and also as a conduit to raise concerns or ask questions on their colleague's behalf.

3) **To facilitate the development of any service change processes** that may/will be required in order to deliver any new methods of working and or fit to suit the new accommodation and deliver upon the benefits realisation plans. Given the phased progression of works these activities will be convened at suitable points along the programme. As much as this third aspect is service focused, it will initially be facilitated by Capital and Estates and will draw in support services representation as may be required e.g. ICT, facilities, estates etc. in order that all aspects of the service change impacts can be picked up. For some of the more complex clinical areas further support will be drawn in from the Programme Management Office as required. Given the potential for service delivery change these meetings will be both reported upon to Project Team through 1 above and also by the lead through their existing Directorate CBM management process to ensure that a comprehensive understating of any changes taking place is maintained.

Once leads have been formally agreed, it is proposed to publicise their roles as service champions, in relation to the PCH works, alongside the Major Projects Team, across the Health Board so that colleagues from across the patch will know the respective points of contact.

As a supplementary note, the Programme Director will also be invited to attend the Operational Board Meetings to both provide updates on progress and receive updates of service change planning that may impact upon proposals and or works.

The Project Board are asked to endorse these proposals to enhance the Business Change Network arrangements for the project.

Recommendation 4

An updated organogram and draft communication brief agreed by the Director of Planning and Performance.

In relation to simplifying, clarifying and communicating the Governance structures, this is a timely opportunity over the coming months to consider a transitional change in the SRO at a point of moving into the construction phases, once the main business case is approved. In addition, it is acknowledged that it would be prudent to strengthen the Project Board, with greater clinical representation at this juncture, given the direct service impacts the works will have. With this in mind, work will also be undertaken to agree the revised core membership of the Project Board and also review the terms of reference to reflect the move into the construction phases.

Mindful that publicising the changes and the wider programme structure form part of this recommendation it would also be appropriate to discuss and agree the proposals above and those under recommendation 3 before briefs are prepared and shared.

The existing terms of reference for the Project Board include the following:-

The Terms of Reference for the Project Board is to formally support the timely delivery of the project by the Project Team. The Board will meet bi-monthly until December 2018 or at intervals to deal with specific issues.

This will be achieved through:-

- *Ensuring that the project scope remains consistent with the strategic programme.*
- *Provide formal approval at key stages to the project both in terms of business case development and formal submission to the Welsh Assembly Government.*
- *Provide the formal authority for committing resources to the project.*
- *Ensure that the scheme delivers appropriate value for money.*

It is proposed that these are updated at the point of FBC approval by Welsh Government to reflect the key shift into the construction phases of the project as follows:-

The Terms of Reference for the Project Board is to formally support the timely delivery of the project by the Project Team. The Board will meet bi-monthly or at intervals as required to deal with specific issues.

This will be achieved through:-

- *Ensuring that the project scope remains consistent with the strategic programme.*
- *Provide formal approval for any major variations arising against the approved FBC delivery approaches.*
- *Provide the formal authority for committing resources to the project.*
- *Ensure that the scheme delivers appropriate value for money.*
- *Ensure that progress against Benefits Realisation plans are routinely monitored and maintained.*

In terms of the review of Project Board membership, the current membership is set out below:-

Name	Position	Organisation	Role
Allison Williams	Chief Executive	Cwm Taf UHB	Chair SRO
Ruth Treharne	Director of Planning and Performance / Deputy Chief Executive	Cwm Taf UHB	Vice Chair – Exec Lead
Mel Jehu	Non-Officer Member – Independent	Cwm Taf UHB	Member
John Palmer	Chief Operating Officer	Cwm Taf UHB	Member
Steve Webster	Director of Finance	Cwm Taf UHB	Member
Tim Burns	Assistant Director Capital Planning	Cwm Taf UHB	Member
Bill Rogers	Project Director	Cwm Taf UHB	Member
Rosie Cavill	Head of Capital	Cwm Taf UHB	Member
Various	Clinical Leads (as required)	Cwm Taf UHB	Member
Huw Evans	Head of Capital Finance	Cwm Taf UHB	Member
Iain Worby	Head of Design for Life	NWSSP	Advisor

Aligned to the point of FBC approval, the suggestion is to revise this membership and key responsibilities as follows, to reflect the key shift to operational delivery:-

Name	Position	Organisation	Role
Allison Williams	Chief Executive	Cwm Taf UHB	Chair
Ruth Treharne	Director of Planning and Performance / Deputy Chief Executive	Cwm Taf UHB	SRO
Mel Jehu	Non-Officer Member – Independent	Cwm Taf UHB	Member
John Palmer	Chief Operating Officer	Cwm Taf UHB	Member – Exec Lead
Steve Webster	Director of Finance	Cwm Taf UHB	Member
Tim Burns	Assistant Director Capital Planning	Cwm Taf UHB	Member
Bill Rogers	Project Director	Cwm Taf UHB	Member
Rosie Cavill	Head of Capital	Cwm Taf UHB	Member

Angela Hopkins	Interim Executive Director of Nursing and Midwifery	Cwm Taf UHB	Member
Kamal Asaad	Medical Director	Cwm Taf UHB	Member
Huw Evans	Head of Capital Finance	Cwm Taf UHB	Member
Iain Worby	Head of Designed for Life	NWSSP	Advisor (as and when)

These proposed changes and the actions being taken in regard to recommendation 3 should help to address the communication and clarification of the management and governance structures for the project, as it moves into the major construction phases**.**

Project Board are asked to discuss and endorse the recommended changes to the Terms of Reference and Membership of the Project Board, as described above.

Recommendation 5: Accelerate and strengthen activities to drive compliance with the Design for Life 3 Framework and instigate a robust cost management mechanism. (Critical – Do Now)	An agreed form of words, with Framework support, in relation to framework compliance and the mechanism for dealing with any outlying issues; an outline of the revised cost management mechanisms that provide the assurance that they are fit for purpose going forward.

Updates including legal advice in regard to the framework compliance matters is provided in the main project update paper this time.

Recommendation 6: Establish a comprehensive appropriately skilled and experienced Programme Team, including robust commercial management capability. (Critical – Do Now)	The requirement for additional capacity and reinforcing the skills gap is currently being considered by the SRO.

The requirement for additional capacity and reinforcing the skills gap has been considered by the SRO and Director of Planning and Performance, and also the Assistant Director of Capital and Estates and Programme Director.

In terms of early decisions made, a secondment has been agreed with Shared Services Estates to bring in a Deputy Senior Responsible Officer to strengthen leadership support and expertise to the project. This will include providing expert contracts advice and management, supporting on professional contract

management, Designed for Life frameworks and interfacing with contractors and expert cost advisors and project managers. He will also provide an expert link between the current programme lead and the Assistant Director of Estates and Capital and will be accountable directly to the Director of Planning and Performance.

This role will maintain day to day direct oversight and steerage for the programme in conjunction with the Assistant Director of Capital and Estates and the Programme Director and provide specialist advice into Project Board and provide invaluable timely support recognising the complexity of setting up the programme, across Phase 2, with the various planned sectional completions this contract will encompass. This also recognises and reflects the recent additional pressures placed upon the available time of the current technical lead (Asst Dir Cap & Estates) since the decisions made around the Bridgend changes.

Recruitment to the other posts within the project structure are now under way, with the commissioning role and replacement admin roles both being out to advert currently.

The Project Board are asked to endorse these proposals to enhance the capacity and skills to help support the project.

4. RECOMMENDATION

Members of the PCH G&FF Project Board are asked to;

- **NOTE** and **DISCUSS** the progress made against the recommendations, and **ENDORSE** the three recommendations made in the body of the report made against recommendations 3, 4 and 6 this time.

Freedom of information status	Closed – sensitive commercial discussion included

IT Systems Continuity

Final Internal Audit Report

Cwm Taf University Health Board

February 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 4

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 9

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-21
Report status:	Final Internal Audit Report
Fieldwork commencement:	November 2018
Fieldwork completion:	5 December 2018
Draft report issued:	10 December 2018
Management response received:	5 February 2019
Final report issued:	5 February 2019
Auditor:	Martyn Lewis
Executive sign off:	John Palmer, Chief Operating Officer
Distribution:	Richard Cahn, Assistant Director of ICT
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.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, 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 Cwm Taf 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 line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board') a review of the continuity processes in relation to IT was carried out.

IT continuity is a subset of Business Continuity Planning (BCP) and encompasses IT disaster recovery planning and wider IT resilience planning. It also incorporates those elements of IT infrastructure and services, which relate to communications such as (voice) telephony and data communications.

It is a systematic process to prevent, predict and manage Information and Communications Technology (ICT) disruption and incidents which have the potential to disrupt ICT services, and should result in a more resilient IT service capability aligned to wider organisational requirements.

Alongside this, IT service users should understand that disruptions may still occur and should develop their own continuity plans to maintain operations in the event of a loss of IT service.

The relevant lead for the review is the Interim 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 in relation to IT continuity. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

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

- appropriate backup and continuity arrangements are in place within ICT;
- the level of dependency on NWIS is fully quantified and included in appropriate risk management process;
- departments understand their responsibilities and have continuity arrangements in place to cope with the loss of IT functions; and
- department plans are achievable, tested and consider the potential time lag for reinstating IT service provision.

3. Associated Risks

The potential risks considered in the review were as follows:

- the Health Board cannot provide an adequate service in the event of a loss of IT services; and
- loss of Health Board data.

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 IT continuity 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 Health Board has a resilient architecture in place, with separately located server rooms, over which there is good control to protect the servers from unauthorised access, fire, and overheating. The servers have been recently upgraded and there is a virtualised environment in place to improve resilience. Backups are taken on a regular and structured basis, although we note that the testing of these has fallen behind recently.

There are IT disaster recovery (DR) plans in place for systems managed by ICT and these consider key risks, and include contacts for enacting the plans. However, we note that some of these plans are out of date and do not reflect the improved configuration.

Furthermore, there is no overarching BCP for ICT, which covers all systems, and provides for prioritisation of system recovery based on a Business Impact Analysis (BIA), and with consideration of departmental needs for an appropriate recovery time.

In addition, the dependency on NWIS, although generally understood by management, has not been fully articulated and defined as we would expect.

Throughout the Health Board overall, directorates are generally aware of their responsibility to ensure an appropriate plan is in place to provide continuity of their services in the event of a loss of IT, and generally understand that there may be a 'lag' in recovery. However, not all

departments have plans in place, and some of the plans that are extant are incomplete and lack the detail to fully allow for continuity to be enacted.

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	Backup and continuity arrangements are in place within ICT;			✓	
2	Dependency on NWIS is fully quantified		✓		
3	Departments understand their responsibilities and have continuity arrangements in place which are achievable			✓	

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

Design of Systems/Controls

The findings from the review did not identify any issues classified as weakness in the system control/design for IT Continuity.

Operation of System/Controls

The findings from the review have highlighted six issues that are classified as weaknesses in the operation of the designed system/control for IT Continuity.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Appropriate backup and continuity arrangements are in place within ICT.

We note the following areas of good practice:

- there is a Backup Policy in place;
- tapes are stored offsite;
- the backup process is monitored and test restores are undertaken and recorded;
- there is a business continuity plan for IT to deal with service provision;
- there is a resilient architecture in place with servers recently upgraded to windows 2012;
- servers are virtualised using Hyper-V, which enables geographical resilience to be provided;
- server rooms are generally well protected and locked with UPS, fire detection (suppression), air conditioning and alarmed;
- disaster recovery (DR) plans are in place for systems;
- DR plans include consideration of risk and mitigation of these;
- DR plans include contacts and numbers for IT staff; and

We identified the following findings:

- Although there are individual system plans, there is no overall BCP/DR plan for IT as a whole that considers all of the systems that are supported, or the controls in place to provide resilience and recovery mechanisms.

  As a result, there has been no full business impact analysis with IT focussing on their perception of the higher risk systems without any engagement with the system users / business. In addition, there is no consideration of the time that departments can acceptably cope without IT Services within the plans with IT taking a 'do the best' approach.

- We note some areas of weakness in relation to the IT DR plans:
  - hard copies of plans are not always available;
  - some of the plans instructions (for fix or restore) are high level with no detail;
  - contact names and numbers in departments are not always included;

  - some of the plans are out of date with old configurations noted; and
  - there is no consideration of RTO /RPO and no contact with departments to properly assess this.
- Although these is a process in place for testing backups and restores, this has fallen behind, and the record of tests is missing.

Objective 2: The level of dependency on NWIS is fully quantified and included in appropriate risk management process.

We identified the following finding:

- The Health Board is reliant on NWIS for the provision of key national systems and networking. This dependency extends to preventing alternative site DR or network resilience as NWIS control the national active directory and would need to authorise new network addresses. However, there has been no work to develop a record of what NWIS provide together with the risks of failure and associated mitigation, and the impact of NWIS is not on the IT risk register.

Objective 3: Departments understand their responsibilities and have continuity arrangements in place to cope with the loss of IT functions which are achievable.

We note the following areas of good practice:

- IT make explicit the requirement for departments to have their own plans;
- generally, departments are aware of the responsibility and the concept of DR lag (the fact that there will always be a certain amount of time needed to restore services after a failure);
- some departments do have IT continuity plans, in particular the Pathology department plan is a good example, with detailed instructions for staff to follow;
- where plans exist they include record keeping for later entry; and

We identified the following finding:

- We identified weaknesses in departmental continuity planning with regards to loss of IT:
  - not all departments have continuity plans in place to enable them to effectively deliver services in the event of a loss of IT;
  - where departments do have plans, some of these were very basic and do not provide detail of steps to be undertaken or key individuals to contact; and
  - Where plans exist, they do not consider differing types and lengths of IT service loss.

7. Summary of Recommendations

The audit findings and 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**	**5**	**1**	**6**

Finding 1 – Overarching IT Continuity (Operating effectiveness)	Risk
Although there are individual system DR plans, there is no overall BCP/DR plan for IT as a whole that considers all the systems supported, the controls in place to provide resilience, and recovery mechanisms. As a result, there has not been a full business impact analysis. IT are focussing on their perception of the higher risk systems without any feed in from the system users / business. In addition, there is no consideration of RTP / RPO within the plans with IT taking a 'do the best' approach. Without consultation with the business there is a risk that the plans in place do not fully meet the business needs.	The organisation cannot provide an adequate service in the event of a loss of IT services.
Recommendation	**Priority level**
The organisation should develop an overarching BCP / DR process. This should consider all the systems and use a business impact analysis to prioritise the systems for recovery. The business (Directorates / Departments) should be involved in the process and should be consulted in order to define appropriate RTO / RPOs.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The organisation will look to develop an overall BCP/DR plan for ICT services. This would require senior management within ICT and the Civil Contingencies Manager to drive this with the co-operation of the various stakeholders within	Richard Cahn 30/04/19

the Health Board. This should be overseen by the Digital Strategy Group.	

Finding 2 –IT DR Plans (Control design)	Risk
We note some areas of weaknesses in relation to the IT DR plans: • hard copies of plans are not always available; • some of the plans instructions (for fix or restore) are high level, with no detail; • contact names and numbers in departments are not always included; • some of the plans are out of date with old configurations noted on 4 out of the 12 plans reviewed; and • there is no consideration of RTO /RPO and no contact with departments to properly assess this. These issues may make recovery processes longer than necessary.	The organisation cannot provide an adequate service in the event of a loss of IT services.
Recommendation	**Priority level**
As part of the review process for DR plans, the identified weaknesses should be addressed, with up to date configurations included, along with all relevant contact names and numbers. The plans should also consider the RTO / RPO needed by the user departments and instructions should be complete. Hard copies of the plans should be stored so they are accessible in the event of network loss.	**Medium**

Management Response	Responsible Officer/ Deadline
This would be part of the review process in Finding 1.	Richard Cahn 30/04/19

Finding 3 – Departmental Continuity Plans (Operating effectiveness)	Risk
We sampled 9 departments over a range of directorates and we identified weaknesses in departmental continuity planning with regards to loss of IT: • not all departments have continuity plans in place to enable them to effectively deliver services in the event of a loss of IT, with 5 departments unable to provide a plan; • where departments have plans, some of these were very basic and do not provide detail of steps to be undertaken or key individuals to contact; and • Where plans exist, they do not consider differing types and lengths of IT service loss. For example, there is no consideration of the impact of losing network access or system access individually.	The organisation cannot provide an adequate service in the event of a loss of IT services
Recommendation	**Priority level**
As part of the process for reviewing IT DR plans, contact should be made with departments to ask them to establish their required RTO (the time for which they could acceptably work without the IT service being considered). This process should then push departments into developing their own plans for service provision without IT. The plans should consider varying scenarios covering lengths of outage. e.g. 1hr, 4hr, 1day etc. and also the different aspects of IT e.g. network loss, system loss etc.	**Medium**

Management Response	Responsible Officer/ Deadline
This is not the responsibility of the ICT Department but the individual Departments under the organisations Business Continuity Procedure. The IT Team will work with the Civil Contingencies Manager to review the BC plans with each Department.	Richard Cahn & Andrew Francis 30/04/19

Finding 4 – NWIS Dependencies (Control design)	Risk
The Health Board is reliant on NWIS for the provision of key national systems e.g. LIMS and networking. This dependency extends to preventing alternative site DR or DHCP resilience as NWIS control the national active directory and would need to authorise new network addresses. However, there has been no work to develop a record of what NWIS provide, together with the risks of failure and associated mitigation. In addition, the impact of NWIS is not recorded on the IT risk register.	The organisation cannot provide an adequate service in the event of a loss of IT services
Recommendation	**Priority level**
A single record of services provided by NWIS to the Health Board should be developed. In addition, an analysis should be undertaken of the impact of failure, and the extent that the Health Board would need NWIS support should an internal continuity event occur. Appropriate mitigations should be developed and the risks should be included on an appropriate risk register.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The ICT Department holds this as part of its Service Level agreement with the various Departments within the Health Board. The ICT Service Manager to review this with other senior members of the ICT Department. Any identified risks will be added to the ICT Department's Risk Register.	Mark Evans 30/04/19

Finding 5 – Backup Testing (Operating effectiveness)	Risk
Although there is a process in place for testing backups and restores to ensure the validity of the data, this has fallen behind and the record of tests is missing detail since April.	Loss of Health Board data
Recommendation	**Priority level**
The backup tests should continue and these should be recorded.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Server team did have records in place however, these have recently not been updated. The Head of Server Management will ensure that these tests are regularly recorded.	Paul Chilcott 28/02/19

Finding 6 – Server Room (Operating effectiveness)	Risk
The main server room (and IT Dept.) is held in a porta cabin which is at least 15 years old. Although it is secure, there is a risk that the building infrastructure will start to break down which leads to a risk of leaks. In addition, the backup server room does not have fire suppression in place, given the distance from the majority of IT staff, any fire would be hard to contain.	Loss of Health Board data
Recommendation	**Priority level**
The Health Board should consider putting plans in place to relocate the server rooms to a more stable environment. The Health Board should consider installing fire suppression in the backup room.	**Low**
Management Response	**Responsible Officer/ Deadline**
The issue with the porta cabin has been recorded on the ICT Department's Risk Register for over 15 years. Replacement of the porta cabin is part of the Health Board's refurbishment of the ground and first floor at PCH. The Server team has over the years taken measures to introduce contingency measures such as having backup services at the backup site at Blaenavon Data Centre. In terms of the backup room this area is part of the refurbishment project at PCH. Due to this project it is unlikely that the Health Board would provide finance to install a fire suppression system.	Chris Ball 30/06/19

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.

Primary Care Directorate review – Management Arrangements

Internal Audit Report

Cwm Taf University Health Board

February 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 6

Opinion and key findings

4. Overall Assurance Opinion 6
5. Assurance Summary 10
6. Summary of Audit Findings 10
7. Summary of Recommendations 15

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-23
Report status:	Internal Audit Report
Fieldwork commencement:	29 August 2018
Fieldwork completion:	15 January 2019
Draft report issued:	22 January 2019
Management response received:	4 February 2019
Final report issued:	5 February 2019
Auditors:	Emma Samways, Stuart Bodman
Executive sign off:	Alan Lawrie, Interim Director of Primary, Community and Mental Health
Distribution:	Craige Wilson, Assistant Director, Primary Care, Children and Community Sarah Bradley, Directorate Manager Primary Care & Localities Manager Merthyr/Cynon
Committee:	Audit Committee

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1. Introduction and Background

Our review of the Primary Care Directorate management arrangements was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation').

As part of the current year's Internal Audit programme, we reviewed the management arrangements for a number of Directorates and it is anticipated that all Directorates will be audited over a three year period.

In addition to this review of management arrangements within Primary Care, a separate piece of audit work was undertaken within the Directorate to establish the level of compliance within the Scheme of Delegation and a number of the most relevant/highest risk Financial Control Procedures applicable to the Primary Care Directorate.

As such we will produce two reports, one focussing on Compliance with financial governance arrangements, and one focussing on Management Arrangements.

As part of our audit planning we spoke with members of the Finance team, the Deputy Director of Finance, the Directorate Manager and the Directorate's business partners.

The areas sampled for testing within the Directorate included the GP Out Of Hours Service and the Primary Care Support Unit (PCSU) that included the two GP Managed Practices at Ferndale and New Tynewydd, Treorchy.

The relevant lead for the assignment is the Director of Primary, Community and Mental Health.

2. Scope and Objectives

The overall objective of our audit was to evaluate and determine the adequacy of the systems and controls in place in relation to governance, 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 areas we sought to provide assurance on were:

Governance Arrangements

- Appropriate governance structures, committees and groups are in place with clear reporting lines that support the key operational functions of finance, workforce and planning and performance.
- Business partners provide appropriate support for the Directorate's key organisational functions.
- Directorate policies and procedures are owned and are up to date.
- There are appropriate mechanisms in place to ensure new legislative and regulatory information received is disseminated and actioned on a timely basis.

Risk Management

- A risk management process is in place that ensures risks are appropriately identified, assessed, recorded, monitored and reported on.
- Risk owners are identified for each risk and mitigation plans are in place where appropriate.
- Risks associated with future demand planning associated with GP services are appropriately captured.

Workforce Management

- Annual leave is appropriately planned, requested, recorded and authorised.
- Flexi time and Time Off in Lieu (TOIL) is appropriately recorded, monitored and managed in accordance with local procedures and processes.
- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Sickness Management Policy.
- Staff and management appropriately complete PADRs in good time.
- Staff complete mandatory training in line with specific timeframes.
- Staff rosters are planned and approved in line with the template.
- Systems are in place to ensure amendments to rosters that deviate from the template roster are appropriately reviewed and approved to ensure optimum workforce deployment and minimal use of overtime.
- Workforce planning arrangements exist to establish and plan for known future changes to the Directorate. For example, key staff due to retire within three years.
- Timely references are obtained as part of the recruitment process.

Planning and Performance

- The Directorate has appropriate arrangements in place to ensure its Integrated Medium Term Plan (IMTP) is developed in accordance with the Health Board's corporate framework.
- Budget holders and other relevant staff are appropriately engaged in the development of the Directorate's IMTP and there is integration with the cluster arrangements.
- Budget holders within the Directorate monitor budgets and take action as appropriate.
- The Directorate has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery including cluster working and cross-cutting themes such as workforce.

- The Directorate has appropriate action and recovery plans and mechanisms in place, where required in relation to both financial and non-financial activities.

Standards of Conduct

- Declarations of Interest (or Nil Returns) are submitted for all relevant staff and the Directorate is aware of the declarations made.

3. Associated Risks

The potential risks considered in the review are as follows:

- The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Risks materialise as they have not been identified and/or addressed.
- Reduced service provision/additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.
- Directorate objectives are not achieved as a result of demand capacity data failing to be properly used and monitored.

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. Previous Directorate reviews have given one overall opinion for the scope of work covered as the objectives were considered in aggregate. However, as we have increased the both the scope and number of objectives under each of the areas that align with assurance domains, it is now more appropriate to report against each of these domains individually. This review, focussing on management arrangements, covers risk management and governance (which includes the objectives for standards of conduct), performance and planning, and workforce, giving three separate opinions relating to the relevant domain areas.

The opinions are based on the work performed as set out in the scope and objectives within this report. An 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 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.

Risk management and governance

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with risk management and governance 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.

Governance arrangements

The Directorate holds an up to date organisational chart that reflects the current governance structure and the committees/groups in place that are served by clear reporting and information lines.

The Directorate has excellent working relationships with its Business Partners and this was evidenced through its Clinical Business Meetings (CBMs) and the support they provided during the IMTP development process.

Good practice is also noted in the Directorate's creation and ongoing use of a RAG rated IMTP Monitoring Report and detailed action plan which is discussed during its Directorate Business Meetings.

Risk Management

The Directorate uses the Datix Risk Management database to record, monitor and update its risks accordingly on a regular basis. However, there is no evidence of the CBM being presented with the Non-Patient Safety Incident, Risks and Claims during 2018/19 and the action logs of other groups are not explicit in stating that the risk register has been discussed.

Standards of Conduct

Whilst the Directorate has an annual process to request Declarations of Interest, these are not being submitted by all appropriate staff and this may be fuelled by the lack of clarity within the current Policy as to how Directorate Management are made aware of any declarations made.

Performance and planning

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with performance and planning 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.

Planning and Performance

The Directorate has used the Health Board's Local Planning Framework to develop its 2018-21 IMTP and all draft submissions were made to the Planning Department in accordance with the Health Board's timetable. Additionally, evidence was seen of engagement with stakeholders from across other Directorates and with the relevant Business Partners.

Monitoring of the overall financial position and non-financial performance measures takes place during the Directorate Business Meetings and the Clinical Business Meetings and through weekly meetings with the Finance Business Partner. Additionally, recurrent overspends are being monitored, managed and reported appropriately within these meetings.

Workforce

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with workforce 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.

Our workforce testing focused on the PCSU, the two GP Managed Practices at Ferndale and New Tynewydd, Treorchy and the GP Out Of Hours Service.

Our workforce testing was split into six key areas; annual leave, flexi-time and Time of in Lieu (TOIL), sickness management, PDRs, mandatory training and staff rosters and we identified examples at all areas where the management of annual leave, absence, PDRs and training was not full in accordance with policies. More detail regarding these findings is in section 6 of this report, and full commentary regarding individual findings is within Appendix A.

Our key concerns relate to the absence of local procedures in place for the management of annual leave, TOIL, rotas and inconsistent completion of documentation and/or submission to the Directorate Manager in respect of authorisation to carrying over annual leave from one financial year to the next.

Testing of the workforce processes identified good practice whereby all sampled annual leave is appropriately approved by line management and documented in an appropriate diary and/or rota, though ESR is not consistently used to record annual leave. Sickness absence levels are reported to and monitored by the Primary Care & Localities Business Meeting and CBM as a standing agenda item and sickness 'trigger point' and long term sickness management is undertaken in compliance with the All Wales Sickness Policy.

Additionally, PADR Compliance rates are also reported to these meetings on an ongoing basis and all PADRS were completed according to planned timescales and entered onto individual's ESR accounts. Reporting and monitoring of CSTF Mandatory Training is likewise sound and staff are reminded by line management to undertake online training once their expiration dates have been reached.

5. Assurance Summary

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

Assurance Summary					
1	Governance				✓
2	Risk Management			✓	
3	Workforce Management			✓	
4	Planning and Performance				✓
5	Standards of Conduct			✓	

** 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 issues that are classified as weakness in the system control/design for management arrangements within Primary Care.

Operation of System/Controls

The findings from the review have highlighted seven issues that are classified as weakness in the operation of the designed system/control for management arrangements within Primary Care.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Governance Arrangements

We note the following areas of good practice:

- The Directorate has an up to date organisational chart in place, in addition to a Primary Care & Localities Governance structure. These clearly identify the committee structure and the various groups within the directorate and the reporting lines and flow of information between each group is clear.
- CBM were seen to review at each meeting workforce issues, including mandatory training, PDR compliance rates and sickness rates. Vacancies and recruitment are also highlighted at this meeting.
- The financial position is discussed at every CBM and 'signed off date' for the Financial Budgets was brought to the attention of the group in May 2018.
- Evidence was seen of early discussions and preparation in relation to the transfer of services from Bridgend to the Health Board.
- The Directorate has created an IMTP monitoring report that has a detailed action plan which is RAG rated and therefore an easy way to monitor progress. This is felt to be good practice and as such should be shared with other Directorates.
- The Finance and Workforce Business Partners regularly attend the directorate's CBM and the Planning Business Partner attends on alternative months.
- Directorate Business Meetings are well attended on an ongoing basis by various relevant staff groups.

Objective 2: Risk Management

We note the following area of good practice:

- The Directorate uses the Datix Risk Management database to record all of its risks and all risks are attributed to a suitable risk handler.
- The Directorate's top risk relating to the difficulties in the recruitment and retention of primary care GPs is recorded on the risk register with evidence of regular review.

We identified the following findings:

- Four of the Directorates risks had not been reviewed for over a year, though it is acknowledged that these are longer term risks to the directorate.
- The Non-Patient Safety Incident, Risks and Claims report has not been presented at the CBM to date and we could only see limited evidence of the risk register being discussed at the directorates other key groups.

Objective 3 - Workforce Management

We note the following areas of good practice:

Sickness Absence

- Sickness absence levels are reported to and discussed at the bi-monthly Primary Care & Localities Business Meeting and CBM as a standing agenda item.

PDRs

- The Directorate PDR compliance rates are reported to and discussed at the bi-monthly Primary Care & Localities Business Meeting and at CBM as a standing agenda item.
- All sampled departments have a means by which they can identify when their respective staff are due to have their annual PDR. The GPOOH Manager also keeps an annual PDR database that RAG rates completion and aids monitoring.

CSTF Mandatory Training

- For the directorate as a whole, the average compliance rate across the 11 modules was 79% in April, increasing to 84% in December 2018. For all three areas where testing was undertaken, the average compliance rates for the 11 modules was 80% or above.
- The Learning and Development Department CSTF compliance reports received monthly by the Directorate management are disseminated to senior management to highlight any shortfalls in compliance. Compliance rates are also a standing agenda item at the bi-monthly Primary Care & Localities Business Meetings and CBMs.
- Departmental managers monitor their staff compliance rates and act accordingly to remind staff of the need to undertake the training and this is evidenced by the generally high compliance rates and that of the Directorate compliance rate as a whole. It was noted that one Managed Practice Manager was very proactive in the monitoring and supporting of staff to attend training and as result have 100% compliance.

Staff Rosters

- All rotas are compiled manually by departmental managers or the GP Practice Managers on the basis of ensuring sufficient staff coverage to meet service provision, though it should be noted that no template rotas are in place which state minimum staff coverage as would be found in the e-rostering system.
- Changes to shifts can only be made by line management and the processes in place only allow these to be made where there is sickness and/or annual leave absence.

Workforce Planning

- The Directorate 2018/21 IMTP acknowledges and documents future staffing changes and known retirements to its workforce. It also includes the key risks and actions pertaining to workforce planning in respect of anticipated changes.

We identified the following findings:

Annual Leave

- None of the four areas have local documented procedures or guidelines in respect of their processes for requesting, recording and subsequent management of annual leave.
- Annual leave requests are not made in a consistent way across the four areas tested and ESR is used to differing extents.
- The Health Board's Scheme of Delegation had not been followed in all instances when annual leave was carried over from prior years.

Flexi Leave and TOIL

- An isolated incidence of TOIL was identified through testing of annual leave and this was not supported by a departmental procedure for use and not formally recorded and authorised by the Practice Manager at New Tynewydd GP Managed Practice.

Sickness Absence

- No central record is kept of any team sickness absence or individual sickness summary records at either of the managed practices. These help facilitate monitoring of absence and aid reconciliation.
- Out of date return to work forms are used by one practice and therefore the absence commencement dates weren't recorded.
- There were solitary incidences of non-completion of various sections of self-certification and return to work forms at both GP Managed Practices and within the PCSU.

PDRs

- Solitary incidences were identified at both GP Managed Practices relating to incompletion of PDR documentation.

CSTF Mandatory Training

- Within the areas tested, a small number of staff were identified who were non-compliant with nearly all modules. In some cases these were new employees who have not yet had the time to undertake training, though other cases relate to staff who have been in post longer and previous training has expired. Staff shortages, shift patterns and limited time and ability to access ESR are contributing to the non-compliance.

Staff Rostering

- No documented procedures are in place for the creation and ongoing management of rotas at either GP Managed Practice or for those relating to the PCSU GP process.
- None of the sampled departments retained copies of their 1st draft rotas so it was not possible to undertake comparative testing between these and the final issued versions of rotas.

Objective 4 - Planning and Performance

We note the following areas of good practice:

- The Directorate Manager attended the formal IMTP engagement session with Executive Directors, Assistant Directors, Directorate Teams and Business Partners that was held in October 2017.
- Directorate Manager liaised with all business partners and other directorates whose own services feed into the Primary Care Directorate during the compilation process that supported the creation of the IMTP.
- Budgetary monitoring takes place formally on a bi-monthly basis via the Localities & Primary Care Business Meetings and on a monthly basis within the Directorate CBM. Weekly meetings take place between the Finance Business Partner and the Directorate Manager.
- Service Leads receive monthly budgetary reports from the Directorate Manager to aid local monitoring.
- Whilst there are recurrent overspends within the Directorate, these are being actively managed and reported accordingly.
- Performance monitoring of the IMTP key priorities, performance measures, service change plans and workforce metrics is undertaken as a standard agenda item on a bi-monthly basis within the Directorate Business Meetings Minutes and within monthly Directorate Clinical Business Meetings.

We did not identify any findings under this objective.

Objective 5: Standards of Conduct

We identified the following findings:

- A number of key staff have not completed a declaration of interest or nil return.
- Those declarations of interest that are made by Primary Care staff are being retained centrally by the Head of Corporate Services. There appears to be some confusion and a lack of clarity within the Policy regarding how Directorate Managers (or line managers) are made aware declarations that have been made.

7. Summary of Recommendations

The audit findings and 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
Risk management and governance	0	2	1	**3**
Planning and performance	0	0	0	**0**
Workforce	1	0	5	**6**
Total number of recommendations	**1**	**2**	**6**	**9**

Risk management and governance

Finding 1 - Risk reporting (Operating effectiveness)	Risk
The Directorate receives a Non-Patient Safety Incidents, Risk and Claims report on a quarterly basis from the Patient Safety and Care team. At the time of the audit we could not see evidence of these reports being presented at the Directorate CBM. We understand that going forward the reports will be presented at this meeting and we acknowledge that patient and non-patient safety incidents are reported via the Primary Care and GP Out of Hours Quality and Safety Group. The terms of reference for the Primary Care and GP Out of Hours Quality and Safety Group state that this group has responsibility for risk management monitoring within the Directorate. A risk register report is a standing agenda item. The agendas for the June and October 2018 meetings did not contain an attached risk register report. The Directorate Manager has provided assurance that the risk register was discussed at both of these meetings, but acknowledges that the action log / minutes need to better reflect this. The agenda for January 2019 was also sighted and it was confirmed that this did contain a copy of the risk register and narrative report. The risk register is also reviewed at the Primary Care and Localities Business Meeting and the high level risks are reviewed and the Primary Care Committee.	Risks materialise as they have not been identified and / or addressed.

Recommendation	Priority level
Management should ensure that the Non-Patient Safety Incidents, Risk and Claims report that contains amongst other things risk register information is presented at each CBM meeting and if necessary at the Primary Care and Out of Hours Quality and Safety group. The action log / minutes of the Primary Care and Out of Hours Quality and Safety group should accurately reflect discussions held in relation to the risk register.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The non-patient safety incident, risks and claims report has been recently (January 2019) added as a standard agenda item for CBM. The implementation overlapped with the review. For noting it is already a standing agenda item for the Primary Care Quality and Safety Group and the bi monthly Primary Care and Localities Business Meeting (senior managers/nurse meetings). Although lengthy discussions about the risk register take place at the Quality Safety and Risk Group and the Primary Care and Localities Business Meetings, the detail of these discussions is not captured in the notes. The Directorate Manager will ensure that future notes are scrutinised to ensure they clearly reflect the discussions, which took place.	Sarah Bradley, Directorate Manager End of February 2019

Finding 2 - Declarations of Interest (Operating effectiveness)	Risk
The Health Board's Standards of Behaviour policy requires all staff band 8a and above to complete a Declaration of Interest (DoI) or 'nil return'. We obtained a list of staff within the directorate that met this criterion to ensure a DoI or 'nil return' had been completed. Of the six employees listed as band 8a and above, there had been one DoI and two 'nil returns'. Therefore, half of the required staff had not complied with the policy. We acknowledge that the Directorate Manager had reminded staff in July 2018 to return outstanding DoI's or 'nil returns'. We understand that the Directorate Manager is not informed of the declarations that are made.	The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendation	**Priority level**
The Directorate should ensure that all relevant staff complete a declaration of interest or 'nil return' in line with the Health Board's Standards of Behaviour policy.	**Medium**
Management Response	**Responsible Officer/ Deadline**
All staff will be reminded of their responsibilities to complete the declaration of interest in a timely manner and a process will be established to follow up and	Sarah Bradley Directorate Manager

chase those who fail to complete.	End of February 2019

Finding 3 - Risk monitoring (Operating effectiveness)	Risk
The Directorate uses the Datix to record risk. We obtained a risk report for the directorate as at November 2018. Of the 57 risks recorded, four (three Low and one Moderate) had not been reviewed for over a year. We note that all four risks were longer-term risks such as the development of a new housing estate, and the impact on the demand for GP services. Whilst we acknowledge that while these risks remain there may be little change to them, the Datix records should still be reviewed and updated on a periodic basis to confirm the risks remain relevant.	Risks materialise as they have not been identified and / or addressed.
Recommendation	**Priority level**
Proactive monitoring of all risks should take place even if it is known that the risks may remain for the long term. Datix should be updated to show periodic review with future action dates recorded.	**Low**
Management Response	**Responsible Officer/ Deadline**
A process will be put in place to ensure all risk, even those which are rated as low and which are long term, are reviewed regularly. The owner of the risk will be made aware of their responsibility to review in a timely manner.	Sarah Bradley Directorate Manager 1 April 2019

Workforce

Finding 4 - Annual Leave (Operating effectiveness)	Risk
We undertook annual leave testing in four areas within the directorate: the GPOOH Service; New Tynewydd GP managed practice; Ferndale GP managed practice; and PCSU GPs. We note the HB does not have an annual leave policy. The key findings identified were as follows: • None of the four areas have local documented procedures or guidelines in respect of their processes for requesting, recording and subsequent management of annual leave. • There are inconsistent practices across the four areas for requesting annual leave. The GPOOH and PCSU do not use ESR for recording annual leave. It is unclear as to why PCSU is not using the functionality in ESR. In addition, while ESR is used at the Ferndale managed practice, it is not used at New Tynewydd as leave requests are made in paper form and not consistently input on ESR. We saw evidence of this when trying to reconcile the annual leave balances recorded in ESR to the paper records, where a number of discrepancies were identified. • Testing identified five members of staff who carried forward annual leave into 2018/19. Only in one case was there evidence of Directorate Manager approval in line with the Health Board Scheme of Delegation to carry the leave forward.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

Recommendation	Priority level
Directorate Management should ensure that procedures/guidelines are documented in respect of the local processes in place for the requesting, recording and subsequent management of annual leave. The functionality for recording requesting and approving annual leave via ESR should be fully utilised in all areas of the directorate. This will allow more efficient monitoring of leave and prevent discrepancies on paper records. The Directorate should ensure that they are following the Health Board's scheme of delegation when authorising carried forward leave. All forms should be authorised by the Directorate Manager or above.	**High**
Management Response	**Responsible Officer/ Deadline**
The Directorate does not have an annual leave policy as managers are required to follow the 'All Wales' Attendance at Work Policy and this applies to the Managed Practices and the OOHs, as it does across the Directorate. Some staff, especially within OOH, do not use ESR because they are part time and may only undertake a couple of hours work each monthly and there may be logistical issues preventing access. E.g. access to a PC at home or within their working schedule, for example dispatch drivers. It is appreciated that there are logistical issues around bringing staff in outside of their work time, however, this issue will be reviewed and a solution will be explored. The Directorate Manager will look to standardise the process for request,	Sarah Bradley Directorate Manager Immediate

recording and the monitoring of annual leave across the whole portfolio. At the same time all staff will be reminded of the UHBs process for the requesting and authorising of carried forward leave. A Managed Practice Steering Group has been established over the last couple of months to oversee areas for improvement and this will be added to the agenda and action plan.	

Finding 5 - TOIL process and procedures at GP managed practices (Control Design)	Risk
Whilst our discussions with managers and testing of rotas did not identify any regular use of Time Off In Lieu (TOIL) within the Directorate, it can be used. Our testing of annual leave identified one instance where TOIL was offered to a member of staff but this was not substantiated by any procedure/guidelines or documentation to record its accrual and use. Additionally, during our fieldwork we saw rotas that requested staff to complete a TOIL sheet, implying that TOIL is utilised.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Recommendation	**Priority level**
The Health Board should ensure that relevant polices are in place to clarify and address the use of TOIL within the directorate. If appropriate management should provide localised guidance in line with the Health Board's policy.	**Low**
Management Response	**Responsible Officer/ Deadline**
TOIL is in use in the directly managed practice at times by administrative staff when there is staffing shortage due to sickness or other absence and it is essential the reception cover is maintained at all times. Experience is essential within a GP practice and there is not the opportunity for bank staff to be accessed. The procedure of requesting TOIL should only be used by exception and a review	Mark Gall – Deputy Manager May 2019

has commenced and a process will be implemented across the Directorate. A Managed Practice Steering Group has been established over the last couple of months to oversee areas for improvement and this will be added to the agenda and action plan.	

Finding 6 - Sickness absence (Operating effectiveness)	Risk
The key findings arising from our review of 25 episodes of sickness across the four sampled areas were as follows: <u>New Tynewydd GP Managed Practice</u> • No central record is kept of team sickness absence, and no individual sickness record is kept to help monitor absence triggers and aid the reconciliation to information posted onto ESR. • There was one instance of a self-certification form and a return to work form that did not include the start or finish date of the sickness. <u>Ferndale GP Managed Practice</u> • No central record is kept of team sickness absence and no individual sickness summary record is kept to monitor absence triggers and aid reconciliation to information posted onto ESR. • Outdated return to work forms are in use at the practice, and as such no sickness start dates are recorded. • There was one instance of a self-certification form not being dated by the Practice Manager or the employee, and two instances where the form was not dated by employees. Furthermore, there was one instance of a return to work form not signed by an employee.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

PCSU • Our testing identified one instance of a self-certification form not signed and dated by the PCSU Manager and a further instance where the return to work form which was not completed by the GP and the PCSU Manager until three weeks after re-commencement of duty. GPOOH Service No issues were identified in the GPOOH Service.	
Recommendation	**Priority level**
At the managed practices consideration should be given to introducing an individual sickness record which would provide an 'at a glance' aid to monitoring of absence and any potential triggers hit, and aid accuracy checks to the information recorded on ESR. It should be ensured that the most up to date forms and documents, in line with the All Wales Attendance at Work Policy, are used by the GP Managed Practices when completing return to work interviews. Managers should remind staff that all self-certification and return to work forms are fully signed and dated by both parties at the time of completion, and that both of these exercises are undertaken as soon as practicable upon an employee's return to work.	**Low**

Management Response	Responsible Officer/ Deadline
When reference is made to no central record being held this is referring to a record being held within each managed practice as all sickness records are held on ESR and are monitored by the Primary Care Support Unit Managers. A Managed Practice Steering Group has been established over the last couple of months to oversee areas for improvement and this will be added to the agenda and action plan.	Mark Gall – Deputy Manager May 2019

Finding 7 - Mandatory training (Operating effectiveness)	Risk
Whilst we note managers monitor their staff compliance, and at the time of the audit fieldwork were all above 80%, within the OOH Service there are a small number of staff (approximately six) who are non-compliant in the majority of modules.	Staff performance is not effectively assessed and addressed.
Recommendation	**Priority level**
The Directorate should ensure that all staff, including new starters, are provided with the opportunity to undertake their mandatory training and ESR should be updated accordingly to reflect the training undertaken.	**Low**
Management Response	**Responsible Officer/ Deadline**
The overall compliance rate is high but as noted previously some staff within the OOH service work very few hours a month and do not have access to a PC. Ways will be explored as to how we can overcome this problem. All staff will be reminded of their responsibility to undertaken mandatory training.	Martine Randall - OOH Urgent Primary Care Service May 2019

Finding 8 - Rota procedures (Design of control)	Risk
Only one of the four areas tested (GPOOH Service) has documented procedures for rota creation and management. At the time of our fieldwork New Tynewydd and Ferndale GP managed practices, and the PCSU did not have documented procedures in place outlining the process to follow when compiling staff rotas. Such documents could aid the completion of rotas during times of absence and aid succession planning.	Services are not effectively planned.
Recommendation	**Priority level**
The PCSU GP service and the two GP managed practices (New Tynewydd and Ferndale) should introduce formal documented procedures for the creation and active management of their rota processes and ensure that these are disseminated to staff.	**Low**
Management Response	**Responsible Officer/ Deadline**
A new OOH on-line rota (rotamaster) has been introduced for OOH and this is working well. This has already been highlighted as an issue by the management team. An agreed rota and job planning for clinical staff in each of the directly managed practices has recently been discussed and prioritised as part of the Managed	Mark Gall – Deputy Manager May 2019

Practice Steering Group and this will be monitored as part of the Group's action plan going forward.	

Finding 9 - PDR compliance (Operating effectiveness)	Risk
As at December 2018 the PDR compliance for the directorate was 82% and the Health Board target is 85%. Within the three areas that we reviewed compliance rates at that time were: • GPOOH Service - 99% • New Tynewydd GP Managed Practice - 72% • Ferndale GP Managed Practice - 84% We tested a sample of staff from each of these areas and identified the following: <u>New Tynewydd GP Managed Practice</u> • 5/6 sampled staff held an up to date PDR. • 1 member of staff only held a post-commencement 3 monthly PDR for 2017/18 and the full annual PDR could not be located or provided. • 1/5 PDRs was a draft handwritten version which was unsigned by either parties - the completed version could not be located. • 1/5 PDRs was not signed by the employee. <u>Ferndale GP Managed Practice</u> • 1/6 PDRs did not state the reviewers name, job title, review period and progress review dates.	Staff performance is not effectively assessed and addressed.

• 1/6 PDRs did not state the review period and progress review dates. • 1/6 PADRs was not signed by the reviewing manager. GPOOH Service - 14 staff sampled and no issues identified.	
Recommendation	**Priority level**
In line with Health Board targets, all staff should be subject to a PDR on an annual basis. PADR documentation should be fully completed and forms signed by both the manager and employee.	**Low**
Management Response	**Responsible Officer/ Deadline**
The service managers and senior nurses will be reminded of their responsibility to ensure that all staff have a PDR and that the appropriate paper work is completed to support the PDR process.	Sarah Bradley Directorate Manager May 2019

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.

Mandatory Training

Internal Audit Report

2018/19

Cwm Taf University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 10

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-31
Report status:	Internal Audit Report
Fieldwork commencement:	3 October 2018
Fieldwork completion:	14 December 2018
Draft report issued:	23 January 2018
Management response received:	4 February 2019
Final report issued:	5 February 2019
Auditors:	Olubanke Ajayi Olaoye (Senior Internal Auditor) Emma Samways (Deputy Head of Internal Audit)
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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.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, 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 Cwm Taf 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 line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation') a review of the process around the arrangements for mandatory training was carried out.

Welsh Government (WG) requires monitoring for all NHS Wales employees compliance against 'level one' training in ten core modules including Health and Safety, Information Governance, Safeguarding and Infection Prevention and Control. A compliance target of 75% has been set. As at July 2018, the Health Board was reporting a compliance rate of just under 73%, which is an improvement from the position in July 2017, when compliance stood at 55%. At the time of reporting, compliance levels had further improved to 75%.

The Health Board has undertaken work to identify roles that require the post holder to undertake further training modules at levels two and three. For example as part of their role, nursing staff are required to undertake infection control training at level two. These additional requirements have recently been input against each employee's ESR account to allow future monitoring.

The relevant lead for the review is the Director of Workforce and Organisational Development.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's management of the mandatory training process. The review sought to provide assurance to the Health Board's Audit Committee that risks material the system's objectives are managed appropriately.

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

- Appropriate and up to date documents exist outlining the Health Board's strategic approach for the completion of mandatory training.
- Staff complete mandatory training in line with agreed timeframes and accurate records are maintained on ESR. Reasons for non-compliance are understood, and actions are identified to address issues.
- Staff have access to the appropriate training platforms in order to undertake the mandatory training that has been attributed to their post (level one, and levels two and three, where appropriate).
- There is regular monitoring and reporting of compliance and non-compliance at appropriate committees and meetings throughout the Health Board.

3. Associated Risks

The potential risks considered in the review were as follows:

- Staff competencies do not meet the requirements of their role.
- Patient and staff safety is compromised.
- Non-compliance is not identified and therefore not addressed.
- Litigation charges brought against the Health Board should incidents occur.

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 established controls for mandatory training 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.

Overall the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard. We identified good practice within the central Learning and Development team, with regular and detailed reports provided to all directorates on compliance rates, and to the Health Board's Executive team and Finance, Performance and Workforce Committee.

While the department has a broad range of documents available on their intranet pages to support staff and managers, and have developed a variety of techniques to support directorates such as 'train the trainer' sessions, the Health Board does not have an overall policy in relation to mandatory

training.

In addition, the Health Board does not have a plan in place to improve compliance against WG targets at level one, or internal targets for level two and three, especially in those departments and directorates currently poorly performing.

Our testing within departments identified an inconsistent approach to overseeing mandatory training compliance. Whilst all were seen to be using the reports provided by the Learning and Development department to monitor compliance, the level of uptake of training varied greatly.

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	Policies and procedures			✓	
2	Completion and recording of training			✓	
3	Training		✓		
4	Reporting and monitoring			✓	

** 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 Mandatory training.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weakness in the operation of the designed system/control for Mandatory training.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Appropriate and up to date documents are in place outlining the Health Board's strategic approach for the completion of mandatory training

We note the following good practice:

- The Learning and Development intranet site has various relevant information and useful documents available to staff such as:
    - explanation of what mandatory training is, including the UK Core Skills Training Framework;
    - lists of the training requirements;
    - how ESR competencies are awarded;
    - training briefing presentation;
    - how to book a training course with a user guide attached; and
    - e-learning guidance.

We identified the following finding:

- The Health Board does not have an overarching policy that outlines the overall approach to statutory and mandatory training.

Objective 2: Staff complete mandatory training in line with agreed timeframes and accurate records are maintained on ESR. Reasons for non-compliance are understood, and actions are identified to address issues

We note the following areas of good practice:

- Volunteers are required to undertake the mandatory training during their induction and are not allowed to commence their role until training has taken place. This is managed by the Patient Safety and Care team. Although the training department is not responsible for volunteers, they give advice when required and ensure they are up to date with any changes. There are also good practices such as:
    - An induction pack designed to fit the needs of Volunteers. This has been in use since 2017.
    - A slide presentation has been prepared and approved by the relevant subject matter leads.
    - Refresher courses are provided.

- Monitoring of training compliance rates take place in all directorates and departments that we visited, with reports disseminated down to Heads of departments.
- The Estates department has good processes for recording and monitoring staff training requirements (not just mandatory training) and has administration support to maintain records and prompt staff. Compliance rates for the directorate were high, at 77%.

We identified the following findings:

- Managers can classify staff as competent in a module on ESR if it is deemed their professional, or other qualifications, exceed the mandatory training level. It is unclear how well this is promoted, the guidance for managers is not very detailed and there is no monitoring of if this process.
- We undertook testing within four departments from three different directorates and identified vast differences in the approach to managing mandatory training. These differences are reflected in the compliance rates, with those departments who adopt a more proactive approach having higher compliance rates.

Objective 3: Staff have access to the appropriate training platforms in order to undertake the mandatory training that has been attributed to their post (level one, and levels two and three, where appropriate).

We note the following areas of good practice:

- A variety of platforms are used by the Learning and Development department to generally communicate with staff in order to provide appropriate and adequate information, including presentation to line managers to convey changes, attendance at the fortnightly corporate orientation sessions, weekly e-Learning support training for level two and three courses.
- The Learning and Development department have delivered a 'Train the Trainer' programme to prepare responsible managers to provide training courses in their relevant areas for level one courses. This approach has been implemented for specific staffing groups within the Facilities directorate, with a positive effect on compliance rates.
- The Health Board is developing training for members of the Board as they may require a different bespoke level of training. We understand that each subject matter lead is to develop a training package to suit the Executives.

We identified the following finding:

- The Health Board does not have a plan in place to increase mandatory training compliance rates at each level to desired targets. However, we acknowledge that work is underway to develop a plan.

Objective 4: There is regular monitoring and reporting of compliance and non-compliance at appropriate committees and meetings throughout the Health Board.

We note the following areas of good practice:

- The Learning and Development department has a robust process in place to produce monthly training compliance reports, with members of the department allocated directorates for which they are responsible. As monthly reports are distributed, narrative information is included to draw recipient's attention to any potential issues.
- Level two and three training requirements were uploaded into ESR in June 2018. The first compliance report to include all training levels was produced in October 2018.
- Overview reports are produced and presented at the following meetings:
    - Finance, Performance and Workforce (FP&W) Committee;
    - Executive Board;
    - The Health & Safety group once a year or on an *ad hoc* basis; and
    - Clinical and Corporate Business Meetings.
- Compliance rates for specific modules are produced and reported to the following committees:
    - Safeguarding Children Committee;
    - Safeguarding Adult Committee; and
    - Infection prevention and control committee.
- Processes have been put in place to ensure that monitoring is not just at the high level. Detailed information is available to Managers at various levels via monthly reports and all line Managers have ESR access and staff's compliance rate is readily available for viewing.

We identified the following finding:

- There are some groups of individuals who undertake work for the Health Board that are not direct employees and therefore ESR does not contain training data for them. These include agency staff, contractors and volunteers. Monitoring processes were seen to be in place for volunteers, though we were unable to establish how the monitoring of compliance for agency and contractors takes place.

There are approximately 900 bank staff who do not hold also substantive posts within the Health Board. The training compliance rate for this group is poor at only 9% according to ESR. A proportion of this group may no longer undertaken work for the Health Board or may have paper based training records, however there will be a large number who are non-compliant with their training requirements.

7. Summary of Recommendations

The audit findings and 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**	**3**	**0**	**5**

Finding 1: Access to training (Operating effectiveness)	Risk
During 2018 the Learning and Development department have worked with subject matter experts from within the Health Board to determine the level of training required of each post for each of the mandatory training modules. Data in relation to level two and three training requirements has been uploaded to ESR records. The majority of level two and three training is provided in a classroom as opposed to e-learning. Since the need for this training has become apparent, existing sessions have become fully booked. Trainers have tried to manage the demand by organising additional training times. Using the additional data in ESR, information was extracted by the Learning and Development department to show the number of training places that would be required for all staff within the Health Board to become 100% compliant in all mandatory modules up to the level required of their post. Based on the available training capacity, there is a shortfall of approximately 28,000 training places. This was reported to the Finance, Performance and Workforce Committee in September 2018. We recognise that the Health Board is faced by a limitation of supply in training resources compared to the training need. While at the time of the audit fieldwork there was no plan in place for delivering the additional demand for level two and three training in-house, or for procuring training from external providers we note that management acknowledge that a plan will need to be developed if the Health Board is going to achieve compliance rates. We understand that work has	Staff competencies do not meet the requirements of their role.

commenced on capturing data on the demand and current capacity for each module. Further work is needed to determine the target percentage increases in compliance for each module per year, the staff that will need prioritising for training (based on risk) and the monitoring arrangements.	
Recommendation	**Priority level**
Management should ensure a plan is developed outlining the target compliance rates that the Health Board is striving to achieve for each level of training and the plans in place in order to help achieve those targets.	**High**
Management Response	**Responsible Officer/ Deadline**
The recent uploading of higher levels of mandatory training requirements into ESR coupled with new ESR functionality is, for the first time, allowing the production of a detailed TNA and a forecast of required face-to-face training demand. The majority of work required for the production of a training plan based on the information currently held within ESR is already complete. However the impending Bridgend boundary changes will make this information and any plan based on it obsolete on the 1st April 2019. Consequently the analysis of training requirements and the subsequent uploading into ESR undertaken for CTUHB will need to be replicated for all staff transferring from Bridgend County area into the new CTMUHB. Once this work has been undertaken ESR will once again provide a true reflection of the new	CSTF Task and Finish Group L&D Manager CSTF SMEs – 01 October 2019

organisations mandatory training needs. L&D will then work with each of the CSTF mandatory training SMEs to develop a training delivery plan. Each plan will consider; the training demand indicated by ESR against the UHBs capacity to deliver training; agree incremental improvement targets in compliance percentages for each level/competency of all 10 CSTF subjects and rationalise training delivery to ensure that best use is made of available e-learning packages to replace face –to-face training delivery. Each plan will be presented to the UHBs CSTF Steering Group for sign off and subsequent monitoring of implementation. L&D are already working with CSTF SMEs to scrutinise and refine the training requirements uploaded into ESR, to reduce the requirement for face to face training and ensure that e-learning is used as the preferred mode of training delivery wherever possible. In tandem with this, considerable effort is being put into making access to e-learning far simpler for those staff that need to maintain compliance through this route.	

Finding 2: Monitoring arrangements (Operating effectiveness)	Risk
The Learning and Development team provide monthly reports from the data contained within ESR to allow mandatory training compliance at each of the training levels to be monitored. Monitoring takes places at the Finance, Performance and Workforce Committee, in directorate Clinical and Corporate Business Meetings, and during team meetings within directorates. Individuals not directly employed by the Health Board are not enrolled on ESR and therefore monitoring of their compliance rates is not part of the remit of the Learning and Development department. These individuals include, but are not limited to: • contractors not employed by the Health Board; • agency staff; and • volunteer staff. The Patient Care and Safety team are responsible for volunteers working in the Health Board, and we saw evidence that processes were in place to ensure the required mandatory training was undertaken when a volunteer began working in the Health Board. However, we were unable to find out the numbers of individuals engaged in each of the above areas and the means by which the Health Board monitors, or ensures that agency and contractors have the right level of CTSF training. For agency and contractors, the Health Board expects and assumes that individuals have undertaken the appropriate level of training as required for the	Non-compliance is not identified and therefore not addressed.

role that they are being employed to undertake. Some assurances can be sought from the nurse revalidation process as this requires mandatory training completion to be in place. Furthermore, we have sighted HIW GP Inspection reports where contractors training compliance in certain modules is reported upon. However, there does not appear to be a complete overview of the assurances provided. Compliance data relating to bank staff was obtained. It was identified that over 900 individuals are registered on ESR as bank staff, who do not have substantive posts elsewhere in the Health Board. The compliance rate for this group is low at only 9%. Evidence was seen of compliance reports being provided to managers within Workforce and to the Bank Staff Manager. We understand from the Learning and Development Manager that work is underway by the Bank Staff Manager to remove Bank staff from ESR who have not undertaken any shifts for the Health Board for a number of years, as they will have a detrimental impact on compliance rates. It is not known how many staff will be removed via this process. It is also known that paper training records exist for some of this group and there are plans to transfer this data to ESR. Again, it is unknown how much of an impact this will have on the compliance percentage. However, it is clear that this is a large group of individuals with a low compliance that needs addressing.	

Recommendation	Priority level
Assurances should be sought that individuals working on behalf of the Health Board, but that are not direct employees, are participating in mandatory training relevant to the role that they are providing. A means of monitoring the training compliance of such staff groups should be put in place. An action plan should be developed in relation to bank staff that includes cleansing the data in ESR and establishing a process to ensure this group of staff participate in training. Monitoring of compliance rates should be undertaken.	**High**
Management Response	**Responsible Officer/ Deadline**
For agency workers, the UHB's providers manage compliance as part of their contractual obligations. To ensure the UHB is sighted on compliance, at the point of candidate submission the agency is required to submit a number of personnel documents, including a mandatory training certificate. Candidates' documents are reviewed upon presentation. Any gaps in compliance are identified, discussed with the booking department and a risk assessment and a waiver form completed if the level of risk is deemed to be acceptable. For Bank Staff, an action plan is being developed to resolve identified issues, which includes:- • Arrange ESR accounts for all bank workers to access e-learning modules. • Validate and cleansing the staff bank register (commenced). • Validate ESR training records for existing bank staff.	Sarah Quirk, Staff Bank Manager, January 2020

• Issue of remuneration to be considered as part of this work. • Consider an agreed penalty for non-compliance (e.g. restriction from duties, possible de-registration in line with All Wales Terms of Engagement. • L&D CSTF Strategy to include Bank workers.	

Finding 3: Mandatory training policy (Control design)	Risk
The UK Core Skills Training Framework (CSTF) is available for staff to view on the Health Board's intranet. The framework comes with a guide which specifies the mandatory training that each member of staff is expected to undertake. The Learning and Development department intranet pages provides detailed information to staff on the CSTF. This includes individual subject guides for each of the mandatory modules, ESR log on guides for staff and managers, CSTF briefing dates and a list of 'useful documents'. However, unlike some other health boards, the organisation does not have an overarching training policy that outlines their approach to statutory and mandatory training. Such a policy may include: • Who the policy applies to, and the organisation's scope of responsibility around permanent, agency, bank, volunteer, contractor staff and any other groups of staff. • The importance of undertaking training and the implications of not participating in mandatory training. • The timeframe within which new starters should undertake mandatory training. • The responsible executive lead and the responsibilities of individuals and line managers, and the role of the learning and development team in supporting the training provision. • The system of compliance, monitoring and reporting.	The Health Board's stance and the roles and responsibilities of staff in relation to mandatory training are not outlined.

Recommendation	Priority level
Management should ensure a policy in relation to mandatory training is produced to include relevant information to guide members of staff and managers.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Since the Core Skills Training Framework (CSTF) was mandated by Welsh Government CTUHB has relied on the accompanying CSTF Manuals to determine training requirements and responsibilities. Elements of these manuals have been "translated" into numerous documents and guides to make their meaning more relevant to CTUHB staff and these are readily available to staff and managers through the UHBs Intranet site. However, the UHB accepts that an overarching Core Mandatory training policy is required to clearly state its stance and to highlight the roles and responsibilities of its staff. A policy will be developed which will be applicable to the new Cwm Taf Morgannwg University Health Board, with a draft ready for consultation in May 2019, which will subsequently run through the Health Board's approval mechanisms.	Mark Gibbs, L&D Manager, May 2019

Finding 4: Training completion (Operating effectiveness)	Risk
Our testing to ensure staff complete mandatory training in line with agreed timeframes and that accurate records are maintained on ESR was undertaken in four departments across three directorates. We explored the reasons for non-compliance with mandatory training requirements. We confirmed that all of the directorates that we tested receive monthly compliance reports from the Learning and Development department. These are used within the directorate as a monitoring tool and are disseminated as appropriate. However, it is clear that there are very different approaches within departments to ensure that staff participate in training. This may be a reflection of the differing staff types and administrative support available. <u>Head and neck directorate – PCH speciality Dental staff</u> The compliance level at the time of the audit fieldwork was 46% for the directorate, and 18% for PCH speciality dental, well below the Welsh Government target of 75%. However, throughout 2018 the directorate had seen its compliance rising slightly from 41% in February to 44% by September. We saw evidence that rates were being monitored at the Directorate Integrated Governance Business Meetings, and Heads of departments were being held to account for poor performance. In addition, we note that the head of department for speciality dental has requested staff participate in the necessary training, however based on the current compliance rates, these actions appear to be having little impact. We	Non-compliance is not identified and therefore not addressed.

note that in previous years, time was dedicated once a month to training provision, but this ceased at the start of 2018. <u>Radiology directorate – RGH Medical staff, PCH Radiology staff</u> The compliance level at the time of the audit fieldwork was 68% overall for the directorate, 24% for RGH Medical, and 72% for PCH Radiology. Throughout 2018 the directorate had seen its compliance rising slightly during the year to 71% by September, before dropping back to 68%. During our meetings with staff we confirmed that compliance reports were received within the directorate and reviewed during Clinical Business Meetings We understand that for Medical staff, there was previously some administration support to prompt staff whose compliance levels had fallen. At the time of the audit fieldwork, we were informed by the directorate that there is an expected responsibility on the individual to participate in the required training, without the need for continual prompts from directorate support officers. Reports received by the Head of Radiology are disseminated down to Heads of Department. Time is then allocated to staff to allow completion of training. Some concerns were raised regarding the lack of availability of classroom based courses. <u>Estates directorate – RGH acute maintenance staff</u> The compliance level at the time of the audit fieldwork was 86% overall for the directorate, and 80% for RGH acute maintenance. We note that the directorate has had consistently high compliance rates throughout the year. We reviewed the process applied within the directorate to establish if any best practice could	

be shared. The main difference in approach within the estates directorate is that they have an administration support who maintain a training database and assist in monitoring and arranging training, including mandatory training. This may contribute to the high compliance rates. Though care should be taken to ensure there is not a duplication of effort in maintaining the database for mandatory training records as ESR is the primary recording platform. Furthermore, support is provided to groups of staff who have limited IT access or skills in order to guide them through the E-learning training modules. <u>Directorate action plans</u> We did not identify any action plans in place, specific to poor performing directorates or departments, to help them address their low compliance rates and to address barriers they believe they are facing to improve compliance.	
Recommendation 4	**Priority level**
Management should consider developing action plans for the poorest performing directorates and departments in order to improve compliance rates. The action plans should be the responsibility of directorates / departments to implement but should be developed in conjunction with the Learning and Development department, who can help draw on the practices being used in the better performing directorates / departments such as the administration support utilised in the Estates department.	**Medium**

Management Response	Responsible Officer/ Deadline
The UHB holds directorate management teams to account for their mandatory training compliance through regular Clinical/Corporate Business meetings. Each directorate is supported by a WOD Senior Business Partner who also attends the CBM. Directorate Managers of poorly performing areas will be asked to develop action plans to demonstrate an improved performance trajectory, supported by WOD Senior Business Partners and the Learning and Development Department Directorate management teams will continue to be held accountable for the implementation of plans at routine CBMs.	Directorate Managers and Hywel Daniel, Deputy Director of Workforce & OD, April 2019

Finding 5: Staff training competencies (Operating effectiveness)	Risk
Employees with relevant or similar CSTF training qualifications as a result of additional skills or training obtained from other sources can be marked competent in relevant modules and excluded from the need to undertake additional training. Within ESR line managers can mark a member of staff as competent if they believe their professional qualifications exceed the CSTF level of training. Through our meetings with Learning and Development staff, and staff within the three directorates that we tested, we identified the following: • Managers have been made aware of the functionality to mark staff as competent during briefing sessions and some information is available on the Learning and Development intranet pages. However, it is unclear if this is commonly known, which may mean some managers are not applying this discretion, therefore impacting on the organisation's compliance rates. • The information on the Health Board's intranet does not state that there is a responsibility on the manager to be satisfied and to obtain evidence where necessary that the employee is fully competent prior to marking them as competent on ESR. • No reports are currently run from ESR of the number of staff with CSTF modules marked as 'competent' by a line manager. This in effect makes it impossible for anyone to monitor the system and make sure it is being used appropriately, and to challenge managers if necessary.	Patient and staff safety is compromised.

Key staff with an appropriate level of access within the Learning and Development department can view the approver on ESR where a manager awards a competency, though this is not carried out on a routine basis.	
Recommendation	**Priority level**
Management should ensure that a process of monitoring is in place for those modules manually marked as competent on an individual's account. Clear guidance should be developed outlining to managers the process to follow on ESR when applying competencies and the evidence that should be available to support any competencies granted if appropriate.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Guidance to Managers The UHBs new Core Mandatory Training Policy to be developed for CTMUHB shall include the responsibilities of managers with regard to mandatory training. In particular it shall make clear that managers must assure themselves of an individual's competence before manually awarding an ESR competency to exclude the individual from undertaking the associated training. It will also make clear the need to retain evidence of the individual's competence to support their decision in case this should this be required. This process will be audited periodically to ensure monitoring of modules marked as competent have been completed in accordance with the Policy. The L&D Mandatory Training guides, useful documents and awareness	See timescales in Finding 1 around Policy Development L&D Department, Ongoing Basis Mark Gibbs, L&D Manager, March 2019

presentation will be updated and enhanced to reflect this requirement.	

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.

Absence Management

Final Internal Audit Report

2018/19

Cwm Taf University Health Board

February 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

1. Introduction and Background 4
2. Scope and Objectives 4
3. Associated Risks 5

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 9

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-32
Report status:	Final Internal Audit Report
Fieldwork commencement:	21 November 2018
Fieldwork completion:	21 January 2019
Draft report issued:	25 January 2019
Management response received:	4 February 2019
Final report issued:	5 February 2019
Auditors:	Emma Samways, Sharon Edwards, Sian George
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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.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, 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 Cwm Taf 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 line with the 2018/2019 Internal Audit Plan for Cwm Taf University Heath Board (the 'Health Board') a review of the processes around the arrangement for managing absence within the Health Board was carried out.

Sickness absence represents a significant cost to the Health Board both directly in relation to the payment of sick pay, but also indirectly in relation to the potential need to pay overtime or agency rates to back fill shifts or roles. Sickness absence can also have an adverse effect on the morale of staff and ultimately on the ability of the Health Board to deliver quality services in a safe way. Absence needs to be managed in a consistent way in all areas of the Health Board, with effective monitoring taking place at all levels if the Welsh Government sickness target of 4.5% is to be achieved.

A report to the Finance, Performance and Workforce Committee in January 2019 indicated that the Health Board's sickness level in November 2018 was at 5.53%. A report of sickness levels over the last three years indicates that absence levels are decreasing, with the average for the last rolling year (August 17 to July 18) being 5.47%, a decrease from 5.58% in previous years.

The relevant lead for the review is the Director of Workforce and Organisational Development.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Boards processes for managing sickness absence. The review sought to provide assurance to the Health Board's Audit Committee that risks material the system's objectives are managed appropriately.

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

- Key documents are in place outlining the Health Boards strategic approach and policy for managing absence.
- Training and guidance is available to all employees who have responsibility for managing and monitoring absence.
- Appropriate mechanism are in place and are used to record and monitor absence in line with the All Wales Sickness Absence Policy and to ensure that all relevant parties are adhering to the All Wales policy and the obligations within it.
- Reporting and monitoring of sickness absence is undertaken appropriately at varying levels within the Health Board.

It should be noted that testing undertaken during the course of the audit was against the All Wales Sickness Absence Policy as the sickness episodes

sampled all took place prior to the introduction of the All Wales Managing Attendance Policy.

3. Associated Risks

The potential risks considered in the review were as follows:

- Financial implications of inappropriately paying sick pay and the backfilling of shifts or roles at potentially premium rates.
- Patient and staff care reduced if desired staffing levels cannot be achieved.
- Inconsistent treatment of staff if the All Wales Sickness Absence Policy is not complied with.
- Inappropriate or no action taken if misleading information is reported.
- Absence periods lengthened if support is not provided to aid recovery and return to work.

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 Absence Management 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 level of assurance provided in this review takes into account the good practice that we could see taking place at a corporate level. Following the introduction of the All Wales Managing Attendance at Work Policy in October 2018, the Health Board acted promptly to make staff aware of its existence. Training programmes have been updated to reflect the revisions in managing absence that were brought in, and to date over 200 managers

have taken part in the revised training. At the current time, spaces on training courses are being filled by those managers putting themselves forward to attend. Going forward some consideration should be given to ensuring that managers in areas where absence rates are high are encouraged to attend the training sessions. Work on updating the absence management toolkit is also underway. This provides managers with guidance on the application of the policy, template letters for absence interviews and other key documents.

Our testing of sickness and long term sickness in a number of wards and departments where absence is high, has highlighted there are inaccuracies and inconsistencies in the way in which absence is being recorded, and therefore managed. Refresher training of key staff in these areas may help address these issues.

The monitoring of absence can be seen taking place at various levels within the Health Board including at the Finance, Performance and Workforce Committee, and during monthly directorate Clinical Business Meetings. At a ward and departmental level, hot spot reviews and deep dives were seen to be taking place in some directorates, though staff resource issues mean this is not happening consistently across directorates. This may result in some directorates facing less scrutiny than others do and may be a missed opportunity for sharing of best practice.

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	Key documents			✓	
2	Training and guidance				✓
3	Recording of absence			✓	
4	Reporting and monitoring			✓	

** 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 two issues that are classified as a weakness in the system control/design for absence management.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as a weakness in the operation of the designed system/control for absence management.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Key documents are in place outlining the Health Board's strategic approach and policy for managing absence.

We note the following areas of good practice:

- The revised All Wales policy in relation to absence management has been communicated to staff via a number of sources and training programmes have been updated to reflect the revised policy.
- The 2018/21 IMTP acknowledges that reducing sickness absence is a key priority and references the programme of wellbeing activity that will be undertaken in order to try and address some of the issues.

We identified the following finding:

- Whilst the IMTP states that reducing sickness is a priority for the Health Board, and reference is made to a programme of wellbeing activity, there does not appear to be a strategy or action plan in place that outlines the measures the Health Board is going to put in place in an attempt to reduce absence levels to the targets that have been set.

Objective 2: Training and guidance is available to all employees who have responsibility for managing and monitoring absence

We note the following areas of good practice:

- A revised training programme has been developed to train managers on the updated All Wales policy. Training is targeted in two levels, refresher training for those that had already received training on the old policy, and full training for those that have not received any training. Since the introduction of the revised policy in November 2018, over 200 managers have received training.
- A designated email in-box and help-desk are available to assist managers with queries relating to staff sickness and the processes to be followed.

We identified the following finding:

- The current version of the managing absence toolkit on the intranet relates to the previous All Wales Absence Management policy. Work is underway to update the toolkit to reflect the revised All Wales Managing Attendance at Work policy.

Objective 3: Appropriate mechanisms are in place and are used to record and monitor absence in line with the All Wales Sickness Absence Policy and to ensure that all relevant parties are adhering to the All Wales policy and the obligations within it.

We identified the following areas of good practice:

- The Ward Manager for Royal Glamorgan Hospital Acute Medicine Unit (RGH AMU) Ward 6 has already completed the overview training for the new Managing Absence policy. The Senior Nurse and the Ward Manager meet every four weeks to discuss the sickness on the ward and look at any long term sickness. Reports are run from ESR which are also looked at with the Senior Nurse.
- We note that during our audit fieldwork the 'unknown' absence category in ESR has been removed. Therefore, the reason for any sickness absence should be recorded going forward.

We identified the following finding:

- Our testing identified instances were documentation was not being completed for episodes of sickness, and discrepancies between key documents.
- Return to Work (RTW) interviews are not always taking place in a timely manner.
- Not all of the relevant paperwork was on file for all of the episodes of sickness that we tested, including self-certificates, RTW forms, and sickness trigger interviews.
- We saw instances where 'unauthorised days' absence occurred as dates on the self-certificate and medical certificate but did not cover the whole period of sickness.

Objective 4: Reporting and monitoring of sickness absence is undertaken appropriately at varying levels within the Health Board.

We identified the following areas of good practice:

- Sickness levels and targets are being discussed at a range of forums and levels within the Health Board.
- Sickness absence target is included on the Health Board's risk register, thus highlighting the importance the Health Board places in reducing sickness. This is reported to Quality, Safety and Risk Committee.

- Deep dives and 'hot spot' audits are carried out by business partners where sickness has been identified as 'high'.

We identified the following finding:

- At present, there is no consistent approach to undertaking 'hot spot' audits and deep dives as HR business partners adopt different processes. Furthermore, good practice is not shared with other business partners across the Health Board.

7. Summary of Recommendations

The audit findings and 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**	**3**	**1**	**4**

Finding 1 - Absence target plan (Control design)	Risk
The Health Board's 2018/21 IMTP contains a Workforce and Organisational Development section, which provides some information on the sickness absence issues that it faces. The IMTP states that reducing the sickness level is a key priority and there will be locally set targets that will continue to reduce over the life of the IMTP, and a programme of wellbeing activity. We have seen data on the targets that the Health Board is striving to achieve within the various staff groups and have seen evidence of activity that is taking place to help manage and reduce sickness absence. This includes the appointment of a member of staff to undertake deep dives, and audits into 'hot spot' problem areas with a view to helping identify local problems for resolving. There has also been a health and wellbeing conference where a number of health and wellbeing aims were outlined for future implementation. However, we have not been able to identify an overall plan that clearly outlines the targets the Health Board is striving to achieve, the actions they are planning to put in place to achieve these targets and any associated time frames.	Patient and staff care reduced if desired staffing levels cannot be achieved.
Recommendation	**Priority level**
A plan should be developed that clearly outlines the sickness absence targets that the Health Board is striving to achieve and the actions that it is going to take in an attempt to achieve those targets.	**Medium**

Management Response	Responsible Officer/ Deadline
A plan will be developed to outline the Health Board's approach to achievement of its sickness absence target, with links made to other relevant programmes of work, e.g. health and wellbeing, retention and engagement. The action plan will be monitored and reviewed via the sickness work stream, the focus of which will be refreshed as part of this plan.	Joanne Jamieson, Sickness Work-stream Lead End of March 2019

Finding 2 - Absence recording and monitoring (Operating effectiveness)	Risk
We analysed sickness data to identify wards and departments with high levels of sickness and long-term sickness to appropriately target our testing. We also reviewed a number of cases where the reason for sickness had been recorded on ESR as 'unknown'. **General Sickness** <u>RGH AMU Ward 6</u> • 2/10 dates differed on the self-certification forms to other documentation such as ESR. • 4/10 Return to Work (RTW) forms were not completed in a timely manner. In the worst instance the RTW meeting did not take place until 55 days after the employee returned from absence. • For 4/10, sickness interviews we were informed had been undertaken but there was no evidence on file to confirm this. • 4/10 trigger interviews were carried out, but there was no evidence in files to confirm this. <u>RGH/YCR Pharmacy</u> • 3/10 the information was not completed on the self-certification form such as the sickness end date and the date the employee returned to work.	Inconsistent treatment of staff if the All Wales Sickness Policy is not complied with.

• 1/10 a RTW form was not completed, however a self-certification form was available. • 3/9 RTW forms were missing information such as the date the return to work was completed, the reason for the absence and a manager's signature. • 1/10 had days of sickness which were not authorised by a self-certification or a medical certificate. • 3/10 sickness triggers were hit, however an interview was not carried out. <u>RCT Community District Nursing</u> • 2/10 a self-certification form was not completed. • 3/8 information was not completed on the self-certification form, such as the date the sickness ended and the date of their return to work. • 2/10 the dates on the RTW form differed to the dates on the self-certification form. • 1/10 the RTW form was not signed by the manager. **Long term sickness** <u>RGH AMU Ward 6</u> • 1/5 no documentation was provided to support the sickness episode where the staff member had been absent for 82 days. As a result, we could not confirm that the individual's long term absence was being properly managed. • 2/4 medical certificates were not available for the periods of absence.	

PCH CDU • 2/5 no self-certification form was completed for the sickness episode. • 2/5 had days of sickness, which were, not authorised by a self-certification or a medical certificate. • 1/5 episodes was a planned sickness but a planned absence discussion form was not completed for the episode (the line manager was not aware that a planned absence form should be completed.) • 1/5 a sickness trigger was hit but an interview was not carried out. **Sickness reasons recorded as 'unknown'** We tested three staff members where sickness was recorded in ESR as 'unknown'. A response was received in two cases and it was confirmed that manager did know the reason for absence, but this had not been correctly input on ESR. While the category of 'unknown' remains on ESR there remains the risk that absence will be categorised as the absence not properly managed.	
Recommendation	**Priority level**
Ward and department managers should be reminded of the importance in ensuring the correct absence management documentation is accurately completed, in a timely manner and evidence retained on the employee's personal file.	**Medium**

Self-certification forms and medical certification forms should be in place to cover the whole period of absence. Monitoring of absence triggers (prompts) should take place and action taken as necessary, with records maintained. It should be ensured that the managers of those wards and departments who have high absence levels participate in training at the earliest opportunity.	
Management Response	**Responsible Officer/ Deadline**
Managers will be reminded of their responsibilities in terms of recording absence management documentation via internal communications. This documentation will be audited periodically via sickness audits performed by the Human Resources Team. This information is also reinforced in Absence Management Training which is provided across the Health Board, and will be targeted towards hot spot areas. Managers will be reminded of the absence triggers, and audits will be performed periodically to ensure that action has taken place where appropriate, and records maintained.	Jo Jamieson, Sickness Work-steam Lead, March 2019 (audits on an ongoing basis) Jo Jamieson, Sickness Work-stream Lead, May 2019 Jo Jamieson, Sickness Work-stream Lead, March 2019 (audits on an ongoing basis)

Finding 3 - Monitoring (Operating effectiveness)	Risk
We have seen evidence of sickness absence rates being monitored at various levels within the Health Board including at the Finance, Performance and Workforce Committee, and during Clinical Business Meetings within directorates. Within the workforce team, absence data is used to monitor trends within departments and directorates and to inform the need for 'hot spot' audits or deep dives by the business partners. We saw evidence of the audit reports that are produced following these reviews and of feedback being given to ward managers and Senior Nurses at a local level. However, there did not appear to be a consistent approach between the business partners to undertaking the audits and the deep dives. We understand that this was due to the staffing resources needed to be able to complete them. We reviewed the minutes of the November 2018 Sickness Absence Work stream meeting and note that the 'hot spot' audit update reports were only provided by two of the four business partners. Whilst the 'hot spot' audits and deep dives should provide a focus to ward and departmental staff on the specific areas they need to improve on, the outcomes of them should be shared with other business partners in order to identify any Health Board wide trends or issues that may need addressing and to allow the sharing of any good practice identified.	Inappropriate or no action taken if misleading information is reported.

Recommendation	Priority level
A level of consistency in undertaking 'hot spot' audits and deep dives should be in place to ensure that all managers and areas of the Health Board are receiving the same level of scrutiny (where applicable) and support in reducing their absence rates. Where good practice has been identified as a result of these reviews, this should be shared amongst the business partners as part of the Sickness Absence Work stream meetings.	**Medium**
Management Response	**Responsible Officer/ Deadline**
As part of the Absence Management Plan referred to in Finding 1, a programme of sickness audits will be developed, linked to hot spot areas. Any good practice identified as part of this work will be shared among the business partners as part of the Sickness Absence Work-stream Meetings.	Jo Jamieson, Sickness Work-stream Lead, March 2019 Jo Jamieson, Sickness Work-stream Lead, Ongoing

Finding 4 - Absence toolkit for managers (Control design)	Risk
The Health Board has an absence management toolkit that is available on the intranet site and provides guidance for managers on application of the policy, as well as providing template forms and letters that managers can use. At the time of the audit fieldwork the toolkit was in the process of being updated to reflect the revised Managing Attendance at Work policy. We were informed by the Head of Workforce Productivity that the revised toolkit should be available to staff by the end of January 2019.	Inconsistent treatment of staff if the All Wales Managing Attendance at Work policy is not complied with.
Recommendation	**Priority level**
The managing absence toolkit review should be completed as soon as possible and made available on the internet. All managers should be made aware that it has been revised.	**Low**
Management Response	**Responsible Officer/ Deadline**
This work will be completed by the end of February 2019 and will be communicated to all managers and business partners via internal communications.	Jo Jamieson, Sickness Work-stream Lead, March 2019

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.

Private and Overseas Patients
Follow up

Internal Audit Report
2018/19

Cwm Taf University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

1. Introduction 4
2. Scope and Objectives 4
3. Associated Risks 4
4. Opinion 4
5. Summary of audit findings 6

Appendix A Original Action Plan and follow up position
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-45
Report status:	Final Report
Fieldwork commencement:	26 November 2018
Fieldwork completion:	9 January 2019
Draft report issued:	14 January 2019
Management response received:	31 January 2019
Final report issued:	4 February 2019
Auditors:	Paul Dalton – Head of Internal Audit Emma Samways – Deputy Head of Internal Audit Lucy Jugessur – Principal Auditor

Executive sign off:	Steve Webster – Director of Finance
Distribution:	Julie Keegan, Assistant Director Commissioning Andrew Jones, Head of Finance – Financial Planning and Reporting
Committee:	Audit Committee

Please note:

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1. Introduction

The follow-up review of Private and Overseas Patients was completed in addition to the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board').

The original, 'limited assurance' report was finalised in May 2018 and identified six issues. As such, the report was finalised after the 2018/19 Internal Audit plan had been agreed.

The relevant lead for the assignment is the Director of Finance.

2. Scope and objectives

The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the Private and Overseas Patients review that was undertaken as part of our 2017/18 work programme.

The scope of this follow up review does not aim to provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

The main areas that this review sought to provide assurance on were:

- Appropriate progress has been made with the implementation of the agreed management responses within the agreed timescales.
- Adequate evidence is available to support the level of progress that has been made.
- The actions implemented have effectively addressed the issues highlighted during the original audit.

3. Associated risks

The potential risks considered in this review were as follows:

- Review of key documents including policies, financial control procedures and committee minutes.
- Non-compliance with legislation or corporate and operational policies.
- Under-recovery of costs due to incorrect tariffs/billing.

4. Opinion

This review considers all recommendations made (high, medium or low priority). This follow-up review **does not** aim to provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

Reasonable assurance	 Yellow	**Follow up** - Some high and medium level recommendations implemented and progress on the medium and low level recommendations.

The Health Board has made some progress towards implementing the agreed recommendations from the original review. An Overseas Financial Control Procedure has been developed and approved by the Audit Committee, and an Overseas Patients policy and Standard Operating Procedure have been developed, although these are still awaiting final approval prior to distribution.

Management are in the process of recruiting an additional staff member to provide additional support in the Medical Records team. In addition, reminders have been sent to relevant staff regarding the correct process to follow for private patients and reconciliations of records are now being undertaken. However, there are still a number of findings to be implemented.

We consider that the original three high priority findings are partially implemented, with further work to be undertaken on the private patients' documentation, and awareness of overseas patients to be given to staff when the new staff member is appointed. There is demonstrable evidence of on-going progress of the actions in respect of the three medium priority findings, with full implementation one of the medium priority findings whilst the other two remain medium priority.

Whilst the high priority recommendations made in the original audit review have not been fully implemented, the work that has been undertaken to date demonstrates a good level of progression towards full implementation. As such, we have reassessed the level of assurance given to manage the risks associated with Private and Overseas Patients as **Reasonable Assurance.**

5. Summary of audit findings

In summary, progress against the six agreed recommendations to be implemented is as follows:

Priority rating	No. of recommendations to be implemented	Fully implemented	Partially implemented	Not implemented
High	3	-	3	-
Medium	3	1	1	1
Low	-	-		-
Total	**6**	**1**	**4**	**1**

The action plan within Appendix A provides full details of the findings, priority ratings and management responses from the original review, along with details of the current position, as verified by our follow-up work. Revised recommendations and priority ratings are included where necessary.

The Health Board provided evidence to confirm that one of the six agreed recommendations has been fully implemented. This relates to staff being advised of the process to follow in relation to private patients and a reconciliation being undertaken from the Myrddin system to the monitoring spreadsheet for private patients.

In addition, the Health Board has made progress implementing a further four of the recommendations. Due to the progress made against three of the high priority recommendations we now consider two to be medium priority recommendations and one to be a low priority recommendation. One of the medium recommendations has been fully implemented. The other two medium findings have remained at the original priority rating.

Original Finding 1 – Policies and procedures (Design Effectiveness)	Original Risk
Unlike other health boards the Health Board does not have an overarching corporate policy outlining the management oversight of private and overseas patients. In addition, there are no Standard Operating Procedures (SOPs) for dealing with such patients on a day-to-day basis, or financial guidance for the administration of overseas patients. <u>Private patients</u> The Health Board has a Financial Control Procedure relating to private patients. In addition, a 'Consultant's Guide to Private Practice' was drafted in 2017 to provide guidance to staff undertaking private patient work on UHB premises. However, it is unclear whether this guide has been approved and disseminated to all relevant staff groups. <u>Overseas patients</u> In 2009 the Welsh Government issued guidance to health boards: 'Implementing the Overseas Visitors Hospital Charging Regulations'. The guidance is clear that there are legal obligations for health boards to undertake specific functions. It is also clear that the guidance does not cover all aspects of the regulations, implying that health boards should have their own tailored documentation in place. However, unlike other health boards, we did not see any evidence of this guidance being available to staff through the Health Board's intranet or internet.	Potential loss of income if patients are not identified as being from overseas or privately treated.

Original Recommendation 1	Original Priority level
a) The Health Board should introduce formal policies that outline the organisational approach to the management and monitoring of private and overseas patients. b) Where necessary, policies should be supplemented by Standard Operating Procedures to provide day-to-day guidance on the application of the policies. c) A Financial Control Procedure should be developed in relation to overseas patients.	**High**
Original Management Response 1	**Original Responsible Officer/ Deadline**
a) Agreed. This will be actioned with support from the Commissioning and Finance teams. b) Agreed. c) Agreed.	a) Directorate Manager & Head of Medical Records (30 Sept 2018). b) Directorate Manager & Head of Medical Records (30 Sept 2018). c) Head of Financial Control (31 July 2018).

Current Position	
a) An Overseas Patients policy has been produced and circulated for comment, however, it has not been formally signed off by the Executive Board as we understand that the policy and the Standing Operating Procedure need to be consistent before being signed off by the Executive Board. There is no Private Patients Policy and as per the original audit, staff are utilising the Consultants Guide to Private Patients which has recently been re-circulated. We have been informed that the Consultants Guide will form the basis of the new policy, which should be drafted imminently. b) The Standard Operating Procedure for Overseas Patients has been drafted, but needs to be approved by the Executive Board. The Private Patients SOP has yet to be produced. c) A Financial Control Procedure for Overseas Patients has been produced and was approved at the Audit Committee on the 8 October 2018. We consider this action to be **partially implemented**. However, as a consequence of the progress that has been made to date, the priority of this recommendation has been re-assessed as a medium priority.	
Updated Recommendation 1	**Updated Priority Level**
a) Management should ensure that the **Overseas** Patients policy and Standard Operating Procedure is approved by the Executive Board. b) Management should ensure that the **Private** Patients Policy and Standard Operating Procedure is produced and approved by the Executive Board.	**Medium**

Updated Management Response 1	Updated Responsible Officer / Deadline
The Policies and Standard Operating Procedures for both Private patients and Overseas patients will be completed and approved by the Executive Board by 31 March 2019.	Finance Manager, Contracting and Commissioning/ 31 March 2019.

Original Finding 2- Roles and responsibilities (Design Effectiveness)	Original Risk
There is no formal structure outlining staff roles and responsibilities for the oversight and management of private and overseas patients. As such, the Health Board does not have a single executive lead with this responsibility. Our work in other health boards has identified a varied picture of responsibility including the Director of Finance, the Medical Director and the Chief Operating Officer. Additionally within the Health Board, there is no formal corporate management oversight or review relating to those processes that are currently in place. There is no evidence of reports relating to activity and issues pertaining to private and overseas patients being presented to any board group or committee. Currently, the operational management of private and overseas patients sits with one member of staff within the Medical Records Department as an additional activity to their substantive role. However, the nature and delivery of overseas patient management may require more time resource in order to be undertaken in full and to minimise the associated risks to the organisation.	Loss of income or reputational damage to the Health Board where ownership for overseeing service provision is not clear.
Original Recommendation 2	**Original Priority level**
a) Management should assign a single executive lead with the overarching responsibility for the oversight and management of private and overseas patients. b) The roles and responsibilities of key staff involved in private and overseas patients should be defined.	**High**

c) Consideration should be given as to whether the current resource, provided for the day-to-day operational management of private and overseas patients, is sufficient to facilitate proactive management in these areas.	
Original Management Response 2	**Original Responsible Officer/ Deadline**
a) Private and overseas patients span a number of Executive Director portfolios. These include the Chief Operating Officer, Director of Finance and Director of Planning. Going forward the overarching responsibility will rest with Director of Finance. b) Roles and responsibilities of key staff will be included within the Standard Operating Procedures referred to in Recommendation 1. c) The Directorate Manager with responsibility for the Medical Records Department will review the current resources for managing private and overseas patients to determine if this is sufficient.	a) Completed. b) As above. c) Directorate Manager responsible for Medical Records (31 July 2018).
Current position	
a) We confirmed that the Director of Finance has the overarching responsibility for private and overseas patients. b) The roles and responsibilities of key staff have been included within the Standard Operating Procedures for overseas patients however, this has not yet been approved and finalised. There is a Private Outpatients Appointments Protocol and a Private Outpatients Checklist which we were not made aware of during the original audit review. These detail the roles of staff within the process and this is provided to	

new staff. However, the Private Outpatients Appointments Protocol was last reviewed in August 2012 and therefore in need of review.

c) Management has undertaken of current resources and identified that a resource is required. A staff resource will be put into place for 12 months who will be responsible for managing private and overseas patients. The recruitment process is currently underway.

We consider this action to be **partially implemented**. However, as a consequence of the progress that has been made to date, the priority of this recommendation has been re-assessed as a low priority.

Updated Recommendation 2	**Updated Priority Level**
b) The Standard Operating Procedures for overseas patients, where roles and responsibilities are defined should be approved and finalised. Management should review the Private Outpatients Appointments Protocol to ensure that it is up to date and reflects the roles and responsibilities of the relevant staff.	**Low**
Updated Management Response 2	**Updated Responsible Officer / Deadline**
b) The SOP for overseas patients is already included within the overseas policy above and so will go through the same approval process. The private outpatients appointment protocol will be reviewed and is unlikely to need significant amendment. c) Interviews for the new post are scheduled for the 25th February 2019.	b) Deputy Medical Records manager /31 March 2019.

Original Finding 3 – Training and awareness (Design Effectiveness)	Original Risk
We understand that overseas patient training was provided in the past few years for the medical records staff based in A&E departments and to maternity staff, as these were deemed to be two of the key points of entry into the NHS system. However, we were not provided with evidence to confirm when this training was provided, who was trained, or the content of the training. We note that no other awareness exercises or training courses have been provided to staff in respect of overseas patients and their rights, the rules governing how they should be approached and managed, and the process to determine their eligibility. In addition, the Health Board's induction process does not include any information regarding this patient group, and has not been tailored to provide an awareness to those staff most likely to encounter overseas patients. We have seen evidence that other Welsh health boards have internal and external sources of information that provide guidance to staff and the public accordingly. It appears that due to the lack of clear guidance and training in relation to private and overseas patients the Health Board is reactively managing information in relation to these patient groups. For example, we were unable to determine if the Medical Records department is being made aware of all such activity, and as such activity may to go undocumented and therefore unchecked and income not being recovered in the required manner.	Non-compliance with legislation or corporate and operational policies.

Original Recommendation 3	Original Priority level
a) Following the development of procedures for overseas patients, the Health Board should ensure that all relevant staff are made aware of the need to identify those patients that are potentially from overseas. b) Management should ensure that those staff who are more likely to encounter overseas patients should have appropriate training and awareness incorporated into their induction process.	**High**
Original Management Response 3	**Original Responsible Officer/ Deadline**
a) Agreed but this will be dependent upon additional resources being available as per recommendation 2c above. b) Agreed but this will be dependent upon additional resources being available as per recommendation 2c above.	a) Directorate Manager & Head of Medical Records (30 Sept 2018) b) Directorate Manager & Head of Medical Records (30 Sept 2018)
Current Position	
a) We understand that the Deputy Head of Medical Records has made staff aware of the need to identify those patients that are potentially from overseas through discussions with relevant staff. As such, we were unable to confirm who and how many staff have been made aware. It will be the responsibility of the new staff resource to ensure that relevant staff are aware of the need to identify those patients that are potentially from overseas going forward.	

b) While we note that the Deputy Head of Medical Records has discussed with staff from clinical wards and A&E of the need to be aware of overseas patients, it will be the responsibility of the new staff resource to ensure that relevant staff are provided with appropriate training and that the induction process incorporates an element of awareness training.

We consider this action to be **partially implemented**. However, as a consequence of the progress that has been made to date, the priority of this recommendation has been re-assessed as a medium priority.

Updated Recommendation 3	**Updated Priority Level**
Management should ensure that the new resource is aware of their responsibility for informing staff about the process to follow for overseas staff.	**Medium**
Updated Management Response 3	**Updated Responsible Officer / Deadline**
The new overseas patients officer will work with relevant staff across all sites to ensure that processes are understood and followed.	Medical Records manager – on appointment of new resource

Original Finding 4 – Identification and management of private patients (Operational Effectiveness)	Original Risk
We obtained a Myrddin (the patient information system) report of private patients treated between April and December 2017. During this period 40 patients were recorded as having been treated, some of which received more than one procedure. We selected a sample of 21 patients from Myrddin and compared the information to the private and overseas patient monitoring spreadsheet held by the Deputy Medical Records Manager, who monitors these patient activities. Our testing identified the following: • 2/21 patients were not reported to the Deputy Medical Records Manager and so not recorded on the monitoring spreadsheet. As such, the costs incurred had not been identified and the patient had not been invoiced. • 4/21 while the patient had been appropriately invoiced, the patient's details had not been input onto the monitoring spreadsheet. We understand that these were a clerical errors, which were corrected at the time of the audit fieldwork. • 3/21 patients were incorrectly classified as private patients on Myrddin. Again, these were corrected at the time of the audit fieldwork. We also tested a sample of 11 patients from the monitoring spreadsheet to the report generated from Myrddin. Our testing identified: • 3/11 patients that were recorded on the monitoring spreadsheet, but were not included on the report obtained from Myrddin as they had not been correctly classified as private patients. Again, this error was rectified at the time of the audit fieldwork.	Potential loss of income if patients are not identified as being from overseas or privately treated.

We understand that there is no regular reconciliation between the monitoring spreadsheet and the private patient report from the Myrddin system.	
Original Recommendation 4	**Original Priority level**
a) Staff involved in dealing with private patients should be reminded that the Deputy Health Records Manager should be notified in a timely manner of such patients being treated privately in a ward or any other clinical setting, so as to facilitate the billing process. b) Staff involved in inputting patient data on the Myrddin system should be reminded of the importance of accurate data input and the correct classification of a patient as private. c) The Deputy Health Records Manager should receive a regular report from the Myrddin system in order to reconcile information held on the patient monitoring spreadsheet. Any discrepancies should be investigated and action taken as necessary.	**Medium**
Original Management Response 4	**Original Responsible Officer/ Deadline**
a) Agreed - A reminder of this requirement together with a copy of the Private Patients FP will be sent to all relevant staff. b) Agreed - A reminder will be sent to all relevant staff. c) Agreed - This reconciliation will be completed on a monthly basis from the end of June 2018.	a) Head of Financial Control (30 June 2018) b) Head of Medical Records ((30 June 2018) c) Deputy Health Records (30 June 2018)

Current position	

a) We have confirmed that the Head of Finance (Financial Accounts, Capital & Systems) has reminded staff of the requirement to comply with the Consultants Guide to Private Patients, and to inform the Deputy Health Records Manager of any private patients.

b) The Head of Finance (Financial Accounts, Capital & Systems) has sent out a reminder of the requirement for the accurate input of data to the Myrddin systems.

c) A reconciliation has been undertaken twice between the report from Myrddin and the patient monitoring spreadsheet for private patients since the Audit. No discrepancies were identified during this process. *Ad hoc* reconciliations will continue to be undertaken in the future.

We consider this action to be **fully implemented.**

Original Finding 5 – Treatment of overseas patients (Operating effectiveness)	Original Risk
We obtained a report of overseas patients treated between April and December 2017 from the Myrddin patient information system. During this period 14 overseas patients were recorded as having been treated, some of which received more than one procedure. We selected a sample of eight patients from Myrddin and compared the information to the private and overseas patient monitoring spreadsheet held by the Deputy Medical Records Manager, who monitors these patient activities. Our testing identified the following: • 3/8 patients on Myrddin were not on the monitoring spreadsheet, therefore eligibility checks had not been undertaken. • 1/8 patients was miscoded on Myrddin and was not an overseas patient. As with the private patients, we understand that there is no regular reconciliation between the monitoring spreadsheet and the overseas patient report from the Myrddin system.	Potential loss of income if patients are not identified as being from overseas or privately treated.
Original Recommendation 5	**Original Priority level**
a) Staff involved in dealing with potential overseas patients should be reminded that the Deputy Health Records Manager is notified of such patients, so as to determine eligibility and facilitate the billing process. b) The Deputy Health Records Manager should receive a regular report from the Myrddin system in order to reconcile information held on the patient monitoring spreadsheet for overseas patients. Any discrepancies should be investigated and action taken as necessary.	**Medium**

Original Management Response 5	Original Responsible Officer/ Deadline
a) Agreed - A reminder of this requirement together with a copy of the new Overseas Patients FCP will be sent to all relevant staff. b) Agreed - This reconciliation will be completed on a monthly basis from the end of June 2018.	a) Head of Financial Control (31 July 2018) b) Deputy Health Records Manager (30 June 2018)
Current position	
a) A reminder of the requirement for overseas patients has yet to be sent out and will be undertaken when the new role has been appointed to. b) It has been agreed going forward that a monthly list of patients which could be charged according to their postcode will be sent to the Deputy Head of Medical Records. The Deputy Head of Medical Records can check these against the amount that has actually been billed by checking their status through the PAS system We consider this action **not implemented** and the priority of this recommendation remains as a medium priority.	
Updated Recommendation 5	**Updated Priority Level**
a) A reminder of the requirement for overseas patients' needs to be produced and sent out when the new staff member is appointed. b) A monthly list of patients which could be charged according to their postcode needs to be produced and sent to the Deputy Head of Medical Records to check.	**Medium**

Updated Management Response 5	Updated Responsible Officer / Deadline
a) A reminder of this requirement together with a copy of the new Overseas Patients FCP will be sent to all relevant staff. b) Completed – monthly reports now sent.	Medical Records Manager – End February 2019 Started December 2018

Original Finding 6 – Public awareness (Operating Effectiveness)	Original Risk
In accordance with the Welsh Government: 'Implementing the Overseas Visitors Hospital Charging Regulations', we note that other Welsh health boards have sources of information that readily provides guidance to overseas patients. However, there is no clear evidence that overseas patients receiving care from the Health Board are made aware of their rights and responsibilities, and any services for which they may be charged if it is deemed that they are ineligible for free health care under a reciprocal agreement. Similarly, there is no information contained on the Health Board's website that informs private patients that they will be charged by the Health Board for any accommodation or facilities costs associated with their treatment.	Non-compliance with legislation or corporate and operational policies.
Original Recommendation 6	**Original Priority level**
a) Management should produce documentation for members of the public that provides information on their rights and responsibilities as an **overseas patient** and the expectations that will be placed upon them in order to determine eligibility for free health care provision. b) Information relating to potential charges that an **overseas patient** may incur should be made publically available. c) Information relating to potential charges that a **private patient** may incur should be made publically available.	**Medium**

Original Management Response 6	Original Responsible Officer/ Deadline
a) Agreed. This will be actioned with support from the Commissioning and Communication teams. b) Agreed. c) Private Patients are provided with details of the charges made by the Health Board for their 'hotel services costs' prior to their admission. It is important to note that the Health Board does not charge for any clinical staff costs etc., as these are charged directly by the clinician concerned. *Audit comment: While we note the management response to recommendation 'c', at the time of the audit fieldwork we were not aware of the details of charges provided to private patients prior to their admission. We consider this process appropriate to address the recommendation.*	a) Directorate Manager & Head of Medical Records (31 July) b) Head of Financial Planning (31 July 2018) c) N/A
Current position	
a) There are Department of Health posters that provide information on the rights and responsibilities as an overseas patient and these can be sent to the patients. It has been agreed that the new staff resource will further develop this when they are in post. b) The Head of Finance - Financial Planning and Reporting has reviewed other health boards and NHS England websites to ascertain if they have the tariffs recorded, and if they refer to appropriate charges. A draft paragraph on the principle of prices has been produced and will be added onto the Cwm Taf website. c) The Consultants and the medical team arrange the fees with the patients and the patients are aware of the costs prior to admission.	

While private patient fees are addressed, further work is required in relation to overseas patients. As such we consider this action to be **partially implemented**. The priority of this recommendation remains as medium priority.	
Updated Recommendation 6	**Updated Priority Level**
a) Management should ensure that the new resource is made aware that documentation should be produced for members of the public that provides information on their rights and responsibilities as an overseas patient. b) Information relating to potential charges that an overseas patient may incur should be added onto the Cwm Taf website.	**Medium**
Updated Management Response 6	**Updated Responsible Officer / Deadline**
a) Agreed b) Finance are working with the website development team to include this information.	Medical Records manager - On appointment of new member of staff Head of Financial Planning – end of March 2019

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.

Follow up - All recommendations implemented and operating as expected.

 **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.

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

 **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.

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **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.

Follow up - No action taken to implement recommendations.

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

Audit Committee Update – **Cwm Taf University Health Board**

Date issued: February 2019

Document reference: 123A2017



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Contents

Summary report

About this document 4

Financial audit update 4

Performance audit update 5

NHS Related National Studies and Publications 7

Good Practice Exchange 8

Summary report

About this document

1 This document provides the Audit Committee of the Cwm Taf 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 UHB Accounts 2018-19	Planning work is underway for the audit of the 2018-19 Health Board accounts (incorporating WHSSC/EASC). We have held initial planning meetings with key staff to identify key areas of focus for 2018-19, and our work is progressing on schedule. We will keep the Committee informed as we progress this work and will produce our detailed Audit Plan for the Committee's consideration in March 2019.	Work ongoing.

Performance audit update

Work currently underway or planned

Exhibit 2: Work currently underway or planned

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Work in progress				
Review of Temporary Staffing Local Work 2017	Work in relation to temporary staffing usage within the Health Board.	**Draft report being completed**	Joanna Davies	Next Audit committee
Integrated Care Fund (ICF) review	This crosscutting review will involve all public sector bodies. The review will focus on whether the ICF is being effectively managed to deliver integrated and sustainable services to achieve better outcomes for services users. The work will focus at arrangements at both a national and regional level. Fieldwork is anticipated to take place between February and June 2018 to take account of the bid process for the 2018-19 ICF monies.	**Reporting**	TBC	March 2019
Orthopaedic	This work will examine the progress made in orthopaedic	**Briefing Stage**	John Palmer	October 2019

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Services follow-up	services since our 2015 all Wales review. The will assess whether recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.			
Clinical coding follow-up	We will review the progress made in responding to the recommendations set out in the 2014 review of clinical coding arrangements. This review will assess the extent to which there have been improvements in raising the profile of clinical coding, the timeliness and quality of clinical coding data, and the quality of the medical records, which are the predominant source of the coding process.	**Draft Report**	Ruth Treharne	March 2019

NHS Related National Studies and Publications

The Audit Committee may also be interested in the following studies/planned outputs. Where the work is completed and reported, these are highlighted in red, and include a link to the report.

Exhibit 3: Other Auditor General Studies

Recent publications / planned publications	
Topic	**Update**
Expenditure on Agency staff by NHS Wales	Expenditure on agency staff by NHS Wales has increased markedly in recent years. About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited. NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them.
Primary Care out of hours services July 2018	The report shows that despite patients being generally positive about Out of Hours services, those services are under real strain in terms of ability to fill shifts and maintain morale amongst staff. There are also challenges associated with meeting national standards on timeliness, poor quality management information, and integrating the planning of Out of Hours services with other parts of the urgent care system.
Speak my language: Overcoming language and communication barriers in public services April 2018	This report looks at how public bodies, particularly local government and NHS bodies providing front-line services, provide interpretation and translation services for BSL and other languages to enable people facing these communication barriers to access services. We have concluded that organisations varied in the degree to which they understood the needs of their communities and ensured their services were accessible to people needing interpretation and translation services. A summary report is also available.
Well-being of Future Generations – reflecting on Year One May 2018	The report provides an assessment of how public bodies in Wales, including the Health Board, have responded to the Well-being of Future Generations Act. The report found that public bodies are able to give examples of how they have used the Act to make the changes needed for them to effectively apply the sustainable development principle. Public bodies now need to set out how they will continue developing their approach to the Act so that they can deliver on the ambition and maximise the opportunities it affords.
Management of follow up outpatients	This work has considered whether health boards have fully implemented previous audit recommendations for improving the management of follow-up outpatient appointments, particularly in light of the growing numbers of patients who experience delays in receiving their follow-up treatment. Since the publication of the local health board progress update reports, we are bring together the key all-Wales messages, along with findings from supplementary work at a national level, together into a short summary report.

Recent publications / planned publications	
Topic	**Update**
Radiology services in Wales	This report summarises the key messages from our local work on radiology services in Wales Waiting time targets for radiology examinations are currently being met and our work has shown that radiology services are generally well managed. However, rising demand, difficulties with recruitment and retention of staff, outdated and insufficient scanning equipment, along with IT weaknesses are putting services under pressure and point to the need for clear and targeted action to ensure that radiology services are able to cope with future demand.

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 confirmed events, shared learning seminars and webinars can be found on the forthcoming pages on the Wales Audit Office's website.

Event/Product	Details
Young people influencing decisions about what matters to them	In partnership with Inspection Wales and the Children's Commissioner for Wales, the Good Practice Exchange is hosting an event which will highlight the key challenges facing young people of Wales today. March 12th 2019, 09:30 - 15:30 Glamorgan Country Cricket Ground, Sophia Gardens, Cardiff March 28th 2019, 09:30 - 15:30 Glasdir Rural Development Centre, Llanrwst, Conwy Valley

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.

Y Pwyllgor Cyfrifon Cyhoeddus / Public Accounts Committee

PAC(5)-31-18 P1

MANAGEMENT OF FOLLOW UP OUTPATIENTS ACROSS WALES

OCTOBER 2018

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



CONTENTS

This report has been prepared for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006

The Wales Audit Office study team comprised Anne Beegan, Andrew Doughton, Emily Howell, Katrina Febry, Matthew Brushett, Delyth Lewis and Sara Utley under the direction of David Thomas.

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SUMMARY 3

DETAILED FINDINGS 5

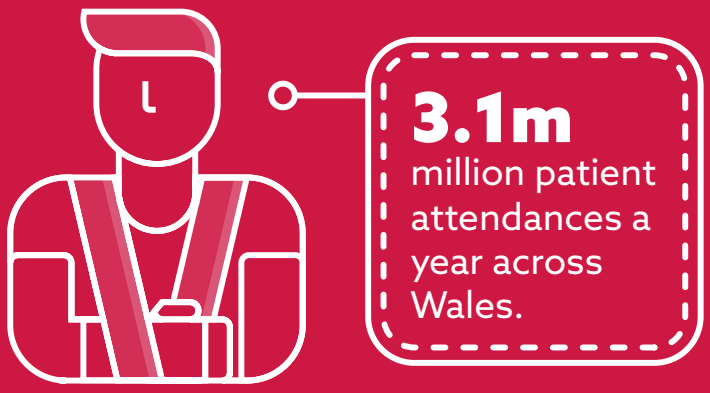
RECOMMENDATIONS 15

SUMMARY

Outpatient services play a crucial role in the majority of NHS care pathways...

Outpatient departments see more patients each year than any other hospital department, with approximately 3.1 million patient attendances a year across Wales.

The performance of outpatient services has a major impact on the public's perception of the overall quality, responsiveness and efficiency of health services.



Follow-up outpatient appointments make up a large proportion of outpatient activity but there have been concerns about the management of these appointments in recent years...

- A follow-up appointment is one that follows an initial attendance to outpatients.
- Over two-thirds of all outpatient appointments are follow-up appointments.
- In 2014, the Royal National Institute for the Blind Cymru (RNIB) issued a report called **Real patients coming to real harm.** This report highlighted the risks of ophthalmology patients losing their sight because of a delayed follow-up.
- The concerns raised by the RNIB were the stimulus for improving the management of ophthalmology follow-ups, led by the Chief Medical Officer, and the subsequent need for health boards to report their follow-up positions on a monthly basis to the Welsh Government.

The Auditor General examined health boards' arrangements for managing follow-up outpatient appointments in 2015-16. This work found...

- Large numbers of patients were on waiting lists for follow-up appointments, and many patients were experiencing delays in receiving appointments.
- The potential risks of delays in follow-up appointments were not being effectively assessed.
- Health boards' arrangements for reviewing outpatient follow-up performance were generally underdeveloped.
- While all health boards were working to improve the accuracy of their follow-up waiting lists, the majority were not meeting Welsh Government reporting requirements.
- Actions to improve outpatient services were mostly delivering short-term solutions.



Findings from the Auditor General's 2015-16 work were reported locally and nationally...

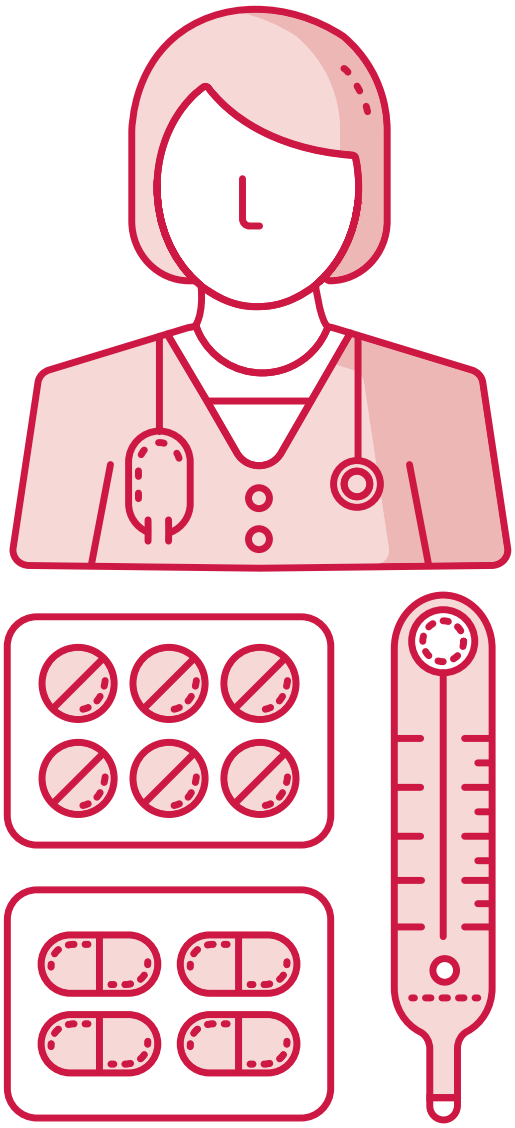
All health boards received a report with recommendations for securing improvements.

We shared a summary of the findings from local audit work at health boards, and key areas for action, with the national Planned Care Programme Board in May 2016.

In 2017-18, the Auditor General did further work to assess the local and national level progress in response to the challenges and issues he identified in his 2015 work. This found that...

- Health boards have made some progress but the pace and impact of improvements are limited, and delays in follow-up appointments vary significantly across Wales.
- National improvement arrangements are starting to focus on follow-up outpatients, but so far they have led to few tangible improvements.
- Since 2015, the number of patients on outpatient follow-up waiting lists and those whose appointment has been delayed has increased substantially.





The worsening situation since our original work in 2015-16 is of significant concern and action is needed in a number of areas ....

- Health boards need to get better at assessing and managing the clinical risks to patients from delays in follow-up appointments.
- The unexplained variation in delayed follow-up appointments across health boards needs to be addressed as a matter of urgency.
- There needs to be greater focus on the management of outpatient follow-up appointments within national and local performance management arrangements.
- National working group arrangements need to be more effective at driving change and improvements locally.
- Work to modernise and improve the outpatient system needs to pick up pace, supported by strong and engaged clinical leadership.
- There needs to be a clearer strategy for supporting new outpatient service models using technology, underpinned with costed and resourced plans.

DETAILED FINDINGS

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 Follow-up outpatient services are a core part of a continued treatment approach for a large and growing proportion of the population. Patients will have a broad variety of needs including (but not limited to) a review after surgery, management or maintenance of chronic conditions, or monitoring for signs of deterioration, prior to intervention.

3 Health boards manage follow-up appointments that form part of the referral to treatment pathway and these are subject to the Welsh Government target of 26 weeks. However, follow-up appointments for many patients falls outside the referral to treatment pathway. These follow-up appointments are managed within clinical guidelines where available and clinically set target follow-up outpatient dates. These dates will be different dependent on the specialty, condition and clinician's opinion. Delays are measured based on the extent of the delay beyond the clinically set target date, as a percentage. Data is collected on patients experiencing 100% delays ie patients waiting as, a minimum, twice as long as they should be.

4 There are known clinical risks associated with delays in follow-up appointments, and patients can come to irreversible harm while on the waiting list. The RNIB report highlighted the risks of ophthalmology patients losing their sight because of delayed follow-up, but there are also a number of other high-risk specialties were patients could equally come to harm because of delays in receiving follow-up care.

5 Good management of follow-up outpatient services is needed to ensure efficient, effective and economical use of resources by:

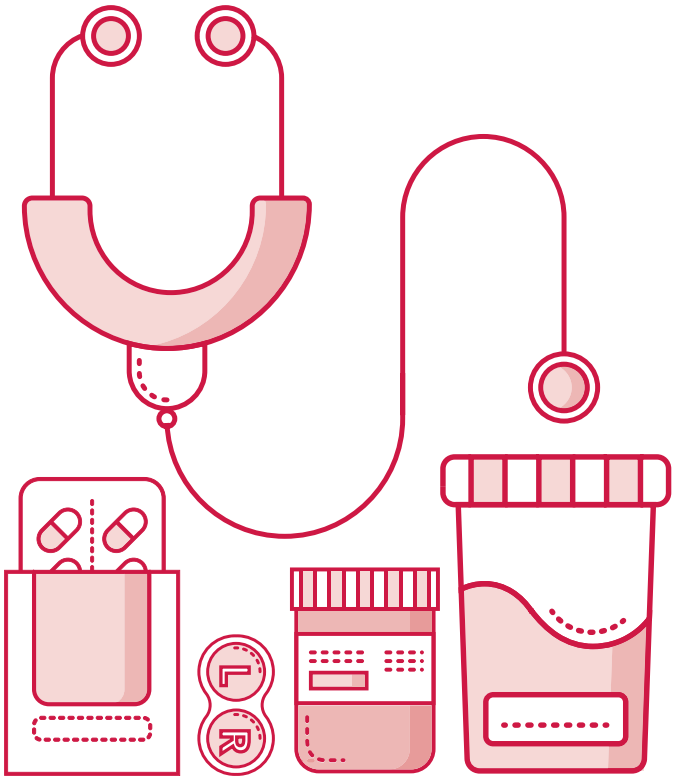
- ensuring only those with a clinical need to see an acute specialist are booked for a follow-up appointment;
- adopting see-on-symptom[1] and virtual clinic[2] approaches;
- exploiting opportunities to use technology[3] for example by allowing patients to self-manage their condition, avoid unnecessary travel, and to record and track outcomes;
- transforming the service model and pathway, by developing community and primary care based services, which reduces reliance on traditional hospital-based care models.

FOOTNOTES

1 A 'see on symptom' approach results in patients being discharged when clinically safe to do so, and then relies on the patient to self-refer if there are any issues with their condition.

2 There is no single definition for the scope and function of a virtual clinic. However, these may be clinics that result in a clinical decision being made without the need for the patient to attend. These may include reviewing case notes, reviewing diagnostic test results or making telephone or video contact with the patient.

3 Includes the use of email and/or text to upload test results or blood pressure readings to minimise the need to attend an outpatient appointment.



Wales Audit Office work on follow-up outpatients

6 As a result of growing national concerns relating to the management of follow-up outpatients, the Auditor General has undertaken initial and follow-up reviews at each health board in Wales over recent years to help define the extent of the challenges being faced and the progress that has been made in addressing them.

7 This report summarises:

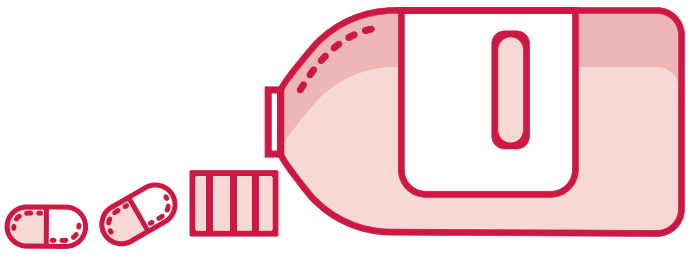
- progress made by health boards since the Auditor General's initial 2015-16 review, which focussed on data reporting and validation, arrangements to determine patient risks, and the extent of operational improvement and longer-term service modernisation;
- national arrangements to improve the management and performance of follow-up outpatients; and
- changes in the waiting list, including the volume of patients waiting on the follow-up outpatient waiting list, and those experiencing a delay.

Health Boards have made some progress in response to recommendations made in 2015-16, but the pace and impact of those improvements are limited, and the extent to which patients experience delays in follow-up appointments varies significantly across Wales

8 In 2015-16, auditors found:

- waiting lists for follow-up appointments were large, and delays remained a significant concern across Wales;
- most health boards were not consistently meeting Welsh Government reporting requirements;
- all health boards were working to improve the accuracy of follow-up waiting lists;
- health boards were not effectively assessing clinical risks associated with delays;
- reporting and scrutiny of follow-up outpatient performance within health boards was insufficient; and
- health boards were taking several short-term actions to improve outpatient services, but longer-term plans to develop new service models were less developed.

9 In each health board, auditors made a number of recommendations aimed at improving the management of follow-up outpatient appointments. Our 2017-18 follow-on reviews at health boards demonstrated that some progress had been achieved in response to our original recommendations, but, in key areas, progress had been slow.



10 Some health boards have a better understanding of clinical risk associated with harm because of a delay but more work is required. We found:

- health boards have taken different approaches to determining the clinical risk of harm associated with a delay.
- Cardiff and Vale University Health Board has developed a more systematic approach for identifying specialties and conditions presenting the greatest risk of harm and similar work is ongoing in Cwm Taf University Health Board. Other health boards have been slower to respond.
- systems to identify the incidence of harm associated with delays are not yet effective.

CASE STUDY

Cardiff and Vale University Health Board has developed a clinical risk assessment to identify the specialties or clinical conditions that are of higher clinical risk associated with follow-up delays. Their analysis identifies the specialty, specific clinical condition and the potential harm that may be caused because of a delay. The assessment is being used to inform how resources are directed to the areas with the greatest risk of harm.

11 All health boards are working to improve the overall operational effectiveness of outpatient services. We found:

- health boards were introducing text reminder services to minimise the number of patients who 'do not attend';
- an improving picture in relation to utilisation of clinic time through the revision of clinic templates to ensure an appropriate balance of available new and follow-up appointment slots;
- better analysis of demand and capacity for outpatient treatment; and
- improving use of clinical 'validation' of follow-up waiting lists to ensure only those patients with a clinical need are receiving a follow-up appointment.

12 These initiatives have yet to make a significant impact on the growth in demand. Auditors found that:

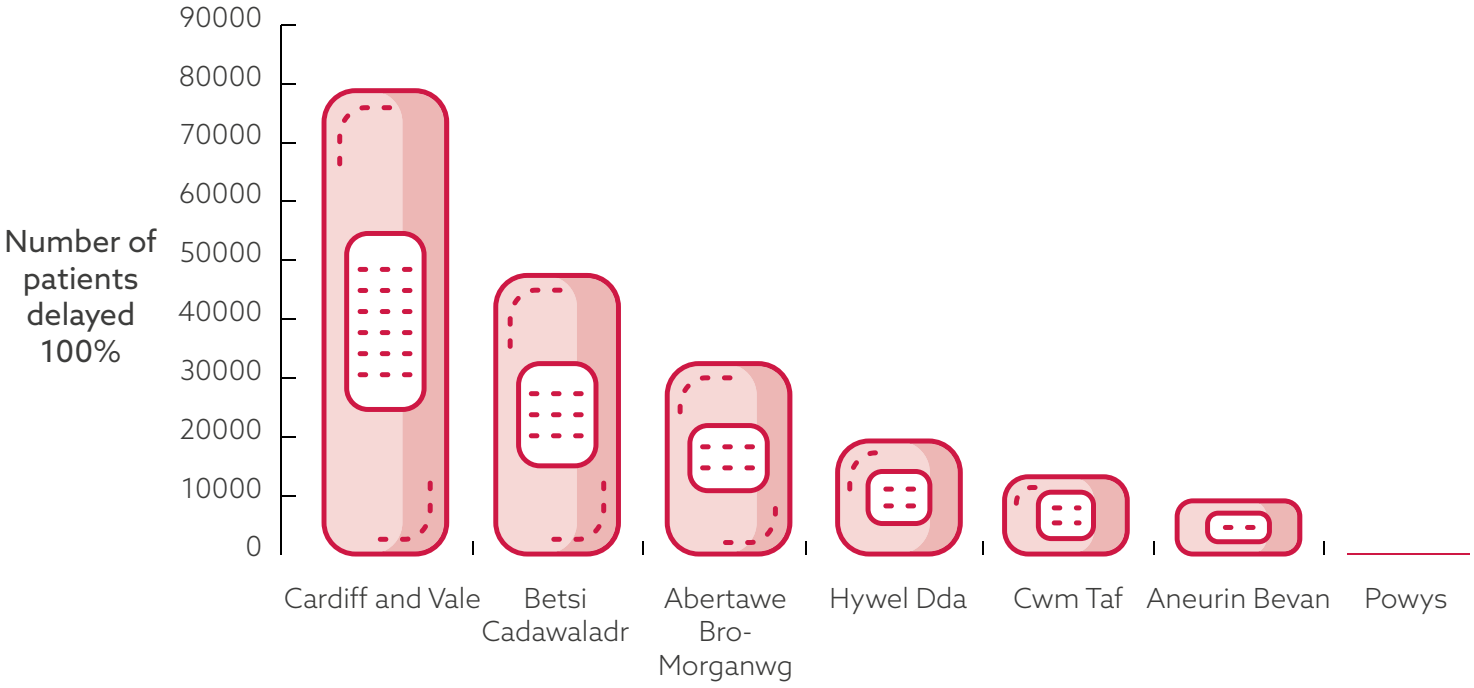
- some aspects of the operational improvement of outpatients need further development, such as reduction of clinically inappropriate referrals, development of efficient clinical pathways, and the system-wide introduction of 'see on symptom' pathways;
- none of the recommendations that the auditors made in 2015-16 in relation to outpatient modernisation were completed and progress remains slow and challenging; and
- there was an awareness that more needed to be done to address variations in clinical practice such as the consistent application of the cataract pathway across Wales.

13 Health boards are making some improvements to the quality and reliability of follow-up outpatient data and information. We found:

- Betsi Cadwaladr and Aneurin Bevan University Health Boards have resolved the issues relating to the under-reporting of patients on the follow-up outpatient waiting list with a booked appointment, although this remained an issue for Hywel Dda University Health Board until 2018; and
- there are now improving levels and quality of information used internally by health boards to actively manage operational improvement activity and performance

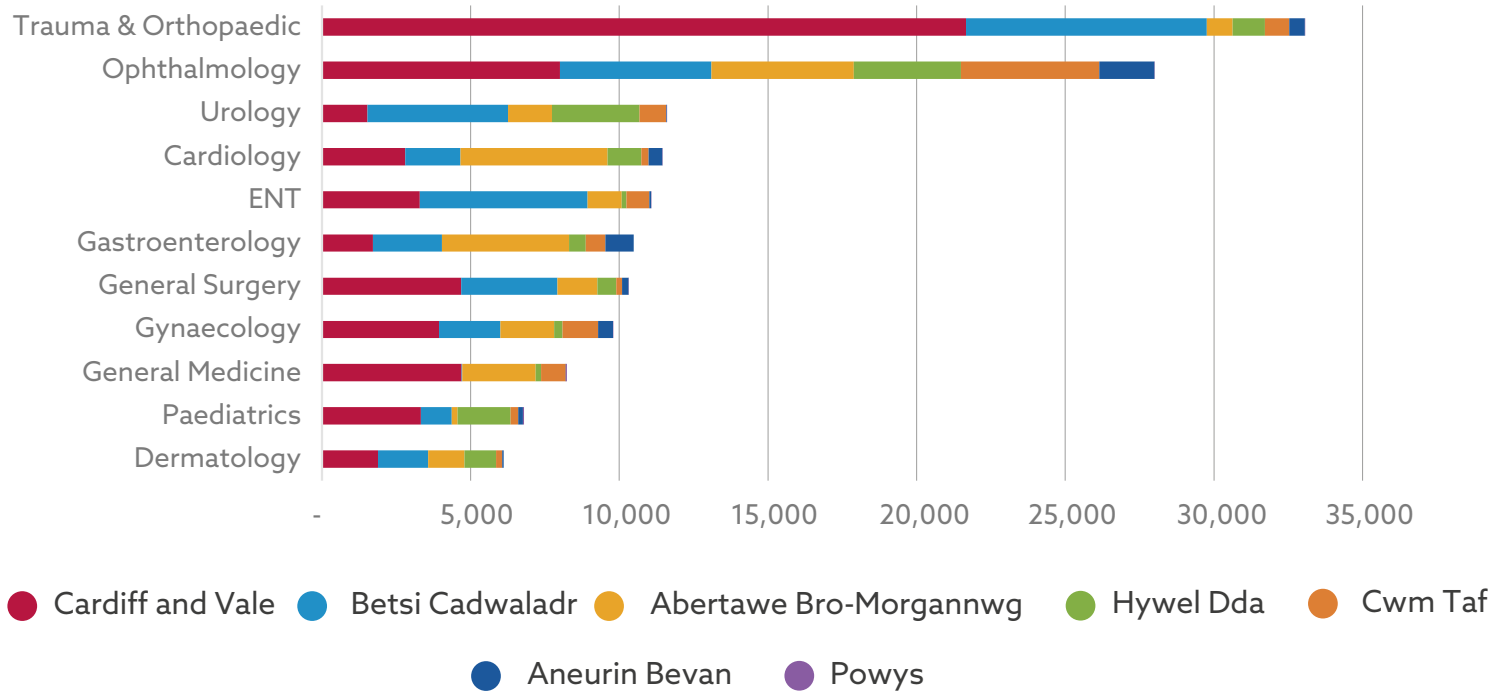
14 There is variation across health boards and specialties in the number of patients delayed more than twice as long as they should be (**Exhibits 1 and 2**). Whilst some of this variation reflects the overall volume of activity in larger health boards, this alone does not explain the variation observed within and between health boards. The data indicates a clear need for targeted remedial action alongside planning future-proof sustainable services.

Exhibit 1: number of follow-up outpatients delayed more than twice as long as they should be, by health board, as at April 2018



Source: Health Board submissions to the Welsh Government

Exhibit 2: number of follow-up outpatients delayed more than twice as long as they should be, by specialty and health board, as at April 2018



Source: Health Board submissions to the Welsh Government

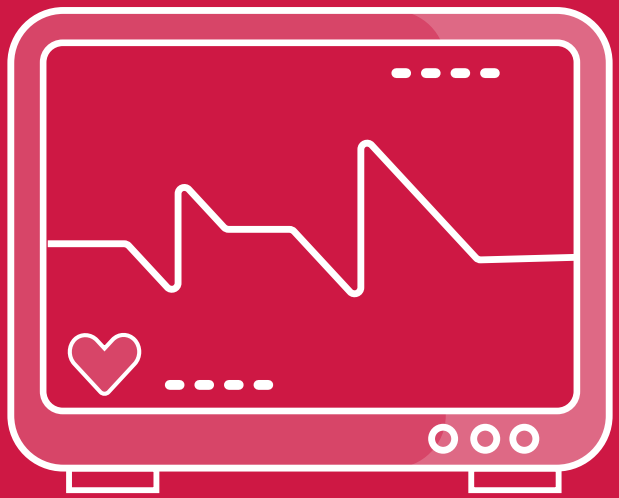
National improvement arrangements are starting to focus on follow-up outpatients, but so far these have failed to translate into tangible improvements

15 There is improving recognition of the extent of the problem, and a growing ambition to resolve it at a national level:

- since 2016, there has been a notable increase in the focus on follow-up outpatients by the Planned Care Programme Board, through creation of the Outpatient Steering Group.
- the Cabinet Secretary for Health and Social Services has set out a requirement to take action to tackle follow-up outpatient improvement challenges across four specialties. These are orthopaedics, ophthalmology, ENT and urology. Supporting groups have been established under the Planned Care Programme Board to reflect these four specialties.
- there has been ongoing work since 2016 to develop a good practice compendium, a good practice guide and national learning events, but the extent of adoption of these at a clinical level in health boards appears highly variable.
- there is a developing high-level vision for outpatients, but there is also lack of clarity about agreement and adoption by health boards as well as plans to deliver it.
- there is a commitment to utilise value-based healthcare principles and patient-reported outcome measures to improve efficiency, but actions in these areas are not yet being taken forward with sufficient scale and pace.

16 Performance arrangements to date have predominantly focussed on the 26-week referral to treatment time target:

- the focus on improving referral to treatment time performance, particularly at the year-end, drives an increase in new appointments but also has the effect of increasing demand for follow-up work, as the majority of new patients will require a follow-up appointment. Additional funding made available to improve waiting time performance does not include funding for subsequent additional follow-up outpatient demand. This exacerbates a gap between demand and resourced capacity for follow-up outpatient waiting lists.
- follow-up outpatients have not been a key performance target within national and local performance management arrangements. Although more recently, quality and safety aspects of follow-ups are starting to be discussed at national Quality and Delivery meetings with health boards.
- a new performance management target for ophthalmology, which integrates the referral to treatment pathway with follow-up outpatient care, is in the process of being introduced. This may help enable a better focus on patient outcome and preventable harm.



17 The availability of data is improving, but it is not yet fully reliable and informatics are not yet sufficiently enabling outpatient pathway improvement:

- opportunities available through improved use of informatics are not yet being taken to enable 'quick to introduce' solutions to improve outpatient management.
- the separate primary and secondary care clinical systems appear to be reinforcing silo working. This is not yet enabling integrated management of pathways across primary and secondary care, which are particularly important for the management of patients with chronic conditions.
- there is a lack of informatics involvement or sufficient resource in some of the planned care group structures.
- from a low baseline in 2014, follow-up outpatient data quality is improving. However, information is not always recorded in the same way (such as 'see on symptom' and virtual clinics), and assessment of patients' clinical risk while on the waiting list is hampered by a lack of clinical condition coding. The outpatient steering group is currently working on standardising a definition for a virtual clinic.

18 Although there is clinical willingness to change, more needs to be done to set the clinical direction across Wales:

- there is a lack of clinical leadership at the national Outpatient Steering Group. The group is focussing on operational improvements such as reducing 'did not attend' rates but there are opportunities to focus more on required changes in clinical practice and pathways.
- obstacles get in the way of rapid progress to improve outpatient efficiency, with a resistance to change clinical practice amongst some clinicians and a lack of systematic adoption of nationally agreed lean clinical pathways, for example, knee and cataract pathways.
- there is opportunity to engage medical directors more, as a conduit to lead clinical change and adoption of nationally agreed pathways within health boards.

19 The national Planned Care Programme arrangements are not conducive to drive timely change or performance improvement:

- there is varied understanding by key stakeholders on the role and function of the national planned care specialty groups. Some view them as providing a diagnostic overview, while others view the groups as responsible for delivering change across Wales.
- given the extent of the challenge for nationally-led service improvement and modernisation, the groups do not have the necessary capacity and authority to drive changes between meetings. The groups also do not meet frequently enough, and although have large memberships, significant numbers of apologies are given.
- until recently, there has been a lack of holding health boards to account for delivery of service improvements and change identified through the Planned Care Programme Board and its supporting specialty groups. Delivery against Planned Care Programme priorities, however, is now featuring more prominently in the regular Joint Executive Team meetings with health boards.
- the lack of capacity at a national level does not necessarily mean additional revenue funding is required, but the existing capacity across the national infrastructure could be better co-ordinated.
- the Outpatient Steering Group has recently strengthened its membership and focus but still lacks clinical leadership and needs to demonstrate it is positively influencing service performance improvements and transformation within health boards.

20 The issues identified above appear to be tempering the extent of ambition to 'what is potentially achievable' rather than 'what needs to be done'.

Since 2015, the number of patients on outpatient follow-up waiting lists, and the number of patients whose appointment has been delayed have substantially increased

21 Analysis of the health boards' data submissions to the Welsh Government paints a worrying picture with an upward trend in patients waiting, growth in delayed follow-up appointments, and in particular a growth in those waiting twice as long as they should have.

22 There has been a growth overall in the numbers of patients waiting for a follow-up outpatient appointment between April 2015 and April 2018. This growth is reflected across many high volume specialties (**Exhibit 3**).

12% GROWTH

Average number of patients on the follow-up waiting list has increased from 941,000 to 1,059,000 from April 2015 to April 2018



Exhibit 3: number of patients waiting for a follow-up outpatient appointment in April 2015 and April 2018, by specialty

Specialty	Patients waiting for a follow-up outpatient appointment **April 2015**	Patients waiting for a follow-up outpatient appointment **April 2018**
 ORTHOPAEDICS	131,105	150,283
 OPHTHAMOLOGY	97,784	116,758
 GENERAL SURGERY	63,564	69,706
 CARDIOLOGY	54,578	65,064
 ENT	53,194	66,299
 UROLOGY	44,731	51,592
 PAEDIATRICS	34,047	46,131
 GYNAECOLOGY	40,481	42,636
 DERMATOLOGY	38,104	38,996
 GASTROENTEROLOGY	27,678	34,208

Source: Health Board submissions to the Welsh Government.

23 The number of patients waiting for a follow-up appointment that is delayed has grown substantially between 2015 and 2018 (**Exhibit 4**):

- in April 2015, there were 240,108 patients waiting for a delayed follow-up outpatient appointment. This has increased to 376,229 by April 2018.
- in April 2015, there were 128,000 patients waiting twice as long as they should be. By April 2018, this has increased to just under 200,000 patients.

55% GROWTH
Patients waiting twice as long as they should be (100% delayed)

24 In comparison to the referral to treatment waiting list, there are substantially more patients experiencing delayed follow-up outpatients:

- overall, the number of patients on the referral to treatment waiting list has increased by 0.7% to 431,872, and the number of patients on the follow-up outpatient waiting list has increased by 12% to 1,059,610 between April 2015 and April 2018; and
- in April 2018, 88% of patients were waiting within 26 weeks on the referral to treatment waiting list, whereas only 65% of follow-up outpatients are within their target appointment date.

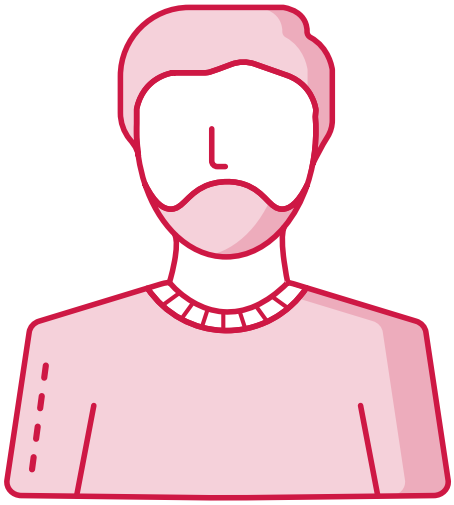
Exhibit 4: number of patients delayed twice as long as they should be between April 2015 and April 2018, by specialty

Specialty	Number of patients delayed twice as long as they should be			
	April 2015	April 2016	April 2017	April 2018
Orthopaedics	17,294	19,723	23,881	33,063
Ophthalmology	16,412	17,143	21,438	28,009
Urology	11,056	11,019	9,938	11,593
Cardiology	7,529	6,954	9,231	11,464
ENT	7,939	8,491	8,322	11,089
Gastroenterology	5,819	7,229	9,171	10,488
General surgery	9,273	7,552	8,688	10,331
Gynaecology	6,057	6,528	7,744	9,794
Paediatrics	2,939	4,991	5,805	6,710
Dermatology	3,973	3,877	4,047	6,112

Source: Health Board submissions to the Welsh Government.

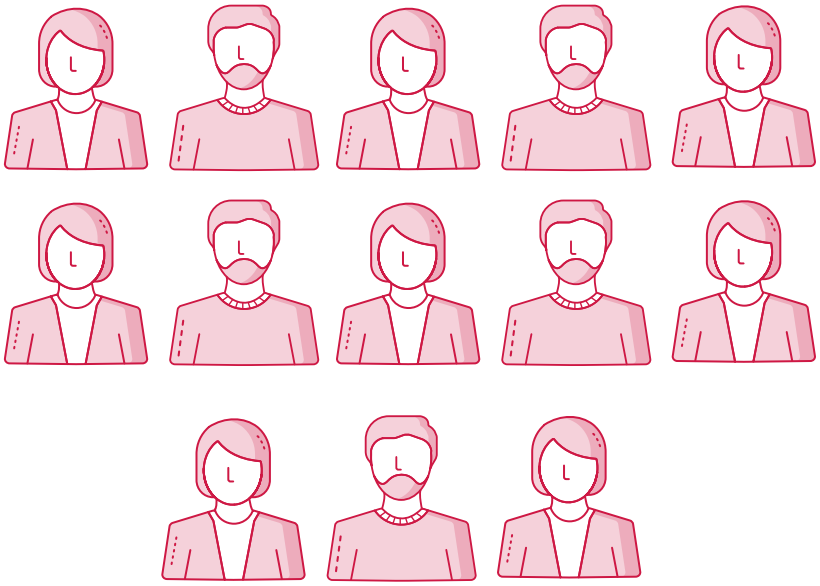
At April 2018, there were over 13 times as many people waiting twice as long as they should be on the follow-up list compared to the number of patients waiting on the referral to treatment list over 36 weeks.

REFERRAL TO TREATMENT >36 WEEKS



(14,797)

FOLLOW-UP OUTPATIENTS 100% DELAYED



(199,968)

RECOMMENDATIONS

25 In preparing and discussing this report with stakeholders, numerous references were made to some good examples of work emerging that will have a positive impact on the management of follow-up appointments. This is encouraging, although it will be important to ensure that any such emerging good practice is shared, spread and scaled up to leverage the change which is required.

26 The continuing growth in follow-up outpatient waiting lists and patients waiting beyond their target date for a follow-up review points to the need for further concerted action to curb and reverse this trend. In addition to the recommendations that we have already made to health boards through our local audit reports, we make the following recommendations to Welsh Government.

R1 **Set a clear ambition –** set a clear target and timeframe to reduce the number of patients delayed twice as long as they should be waiting (ie 100% delays).

R2 **Strengthen the national delivery structure** – adapt the Planned Care Programme Board and its underpinning structure to ensure it is delivering improvements that materially improve follow-up outpatient performance and drive the development of transformed service models and pathways that are efficient and meet expected growth in demand. In doing so, the Welsh Government should ensure:

- membership of the Planned Care Programme Board and its supporting groups is appropriate.
- the lines of accountability for delivery of improvement actions at national and health board level are clear and work as required.
- there is sufficient capacity to lead change between meetings of the various groups, which should include consideration of the frequency of meetings, the use of task and finish groups between meetings, and the capacity of members to lead improvements between meetings.
- ensure informatics is integral to the solution. NWIS needs to be a key stakeholder in procuring, developing and project managing solutions to improve outpatient services and new models of care. The service should be a key member of the Planned Care Programme Board. Where technological solutions are required, procurement rather than development may achieve better scalability and pace of delivery.

R3 **Develop a clear plan to support national level service developments** – set out a clear plan of action needed at a national level to accelerate the scale and pace of outpatient transformation through the Planned Care Programme Board structure, which is costed and resourced, and makes maximum use of available technologies.

R4 **Plan sustainable services** – ensure there are clear plans to improve follow-up performance and modernise outpatient services within health board Integrated Medium Term Plans (IMTP) and annual plans.

R5 **Align the priorities of the national resource**s – to maximise the impact of the national resources available to support improvement, such as the Delivery Unit, ensure that their programmes of work are aligned to support the transformation of outpatient services and reductions in follow-up delays. The national resources will include but not be limited to NWIS, the Delivery Unit, and the 1,000 lives team.

R6 **Strengthen and focus performance accountability** – build on the developing focus at Quality and Delivery meetings with health boards, by strengthening the focus on holding health boards to account for delivering improvements to reduce follow-up outpatient waiting lists in the short, medium and long term.

R7 **Strengthen clinical accountability** – raise awareness amongst health board Medical Directors of their professional roles and responsibilities in driving through the required clinical changes and adherence to national follow-up outpatient guidance.

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Welsh Government

Adrian Crompton
Auditor General for Wales
Wales Audit Office
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20 November 2018

Dear Adrian

Auditor General for Wales Report – Follow Up Outpatients

I am writing in response to the report on Follow up Outpatients Appointments. I acknowledge the recommendations and areas highlighted for action and will work in partnership with the NHS to address them. While the report acknowledges that the Planned Care programme is working to support the reduction of follow-up delays, I do recognise that further work to transform outpatients and improve waiting times for outpatients is required. We will work with the Outpatients Steering Group (OPSG) to ensure that the OPSG challenges and drives delivery against the recommendations in your report and those already made to health boards through local audit reports.

I also acknowledge that despite significant past additional investment in this area a greater focus on service redesign is needed to deliver a sustainable service model for the future. This redesign requirement is strengthened through “A Healthier Wales” to care for patients in the most appropriate setting. There are many opportunities for different pathways and innovative multi disciplinary services, in appropriate settings outside the traditional secondary care model.

Following a presentation from the WAO on their report, the national OPSG group has developed a national outpatient performance dashboard. This dashboard will be used to monitor and challenge the progress health boards are making in achieving improvements. The dashboard will support the formal performance management process within Welsh Government which monitors progress against agreed targets, such as to reduce the numbers of patients delayed more than twice as long as their stated target review date.

The introduction of the new eye care measure highlights the impact that national work led by clinicians can have on the service. In this instance it is driving the management and redesign of eye care services.

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I can confirm that we accept all the recommendations in the report, and I will now respond to each one in turn.

Recommendation 1 **Set a clear ambition** – set a clear target and timeframe to reduce the number of patients delayed twice as long as they should be waiting (i.e. 100% delays).
Recommendation – accepted I have asked the OPSG to make recommendations to Welsh Government for a national target and timeframe for the reduction of the number of patients delayed twice as long as they should. Welsh Government will consider their advice before deciding on the actual target.
Recommendation 2 **Strengthen the national delivery structure** – adapt the Planned Care Programme Board and its underpinning structure to ensure it is delivering improvements that materially improve follow-up outpatient performance and drive the development of transformed service models and pathways that are efficient and meet expected growth in demand. In doing so, the Welsh Government should ensure: • Membership of the Planned Care Programme Board and its supporting groups is appropriate; • The lines of accountability for delivery of improvement actions at national and health board level are clear and work as required; • There is sufficient capacity to lead change between meetings of the various groups, which should include consideration of the frequency of meetings, the use of task and finish groups between meetings, and the capacity of members to lead improvements between meetings; • Ensure informatics is integral to the solution. NWIS needs to be a key stakeholder in procuring, developing and project managing solutions to improve outpatient services and new models of care. The service should be a key member of the Planned Care Programme Board. Where technological solutions are required, procurement rather than development may achieve better scalability and pace of delivery.
Recommendation - accepted Membership and accountability of the programme is regularly reviewed. The next review of the programme role and function will form part of the "A Healthier Wales" recommendation looking at the role of programme boards and networks. The review (due in early 2019) will also consider other aspects of this recommendation around resources and the role of digital support which is another key area of focus in the A Healthier Wales.
Recommendation 3 **Develop a clear plan to support national level service developments** – set out a clear plan of action needed at a national level to accelerate the scale and pace of outpatient transformation through the Planned Care Programme Board structure, which is costed and resourced, and makes maximum use of available technologies.
Recommendation - accepted This will form part of the review of the role of national programmes and the linkage with the national transformation programme and fund, as covered in the response to recommendation two. The OPSG are also in the process of developing an action plan that will accelerate a number of key actions to support the transformation required.

Recommendation 4 **Plan sustainable services** – ensure there are clear plans to improve follow-up performance and modernise outpatient services within health board Integrated Medium Term Plans (IMTP) and annual plans and we will revisit the detail of each organisations plans and commitments.
Recommendation – accepted The need to improve follow-up performance and modernise outpatient services has been identified as a priority within the planning framework. I expect this to be fully addressed within health board Integrated Medium Term Plans (IMTP) and annual plans.
Recommendation 5 **Align the priorities of the national resources** – to maximise the impact of the national resources available to support improvement, such as the Delivery Unit, ensure that their programmes of work are aligned to support the transformation of outpatient services and reductions in follow-up delays. The national resources will include but not be limited to NHS Wales Informatics Services, the Delivery Unit, and the 1,000 lives team.
Recommendation – accepted As part of the A Healthier Wales plan, work is in train to create a National Executive Function which will strengthen the national approach in key areas, including the transformation of the outpatient service. Whilst this is underway, my officials are aligning priorities across the support functions to ensure better alignment of the work of the Delivery Unit, NWIS and 1,000 Lives.
Recommendation 6 **Strengthen and focus performance accountability** – build on the developing focus at Quality and Delivery meetings with health boards, by strengthening the focus on holding health boards to account for delivering improvements to reduce follow-up outpatient waiting lists in the short, medium and long-term.
Recommendation – accepted The outpatient dashboard described in our response to recommendation one will be formally used as part of the Welsh Government's accountability arrangements with health boards to ensure they achieve the required improvements and the appropriate redesign of services. The national OPSG will be used to add additional challenge but and to support the sharing of good practice and national adoption where possible of evidence service redesign.
Recommendation 7 **Strengthen clinical accountability** – raise awareness amongst health board Medical Directors of their professional roles and responsibilities in driving through the required clinical changes and adherence to national follow-up outpatient guidance.
Recommendation – accepted Through the Chief Medical Officers national group, NHS medical directors will be tasked with ensuring that local clinical leadership is fully engaged in the national OPSG as well as local outpatient improvement arrangements. This will accelerate and support the required drive in system changes. The clinical leads within the national planned care groups and the national planned care clinical lead will play an important role in providing visible clinical leadership.

Yours sincerely



Dr Andrew Goodall

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PAC(5)-31-18 P3

November 2018

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Radiology Services in Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998 and 2006.

The Wales Audit Office study team comprised Anne Beegan, Elaine Matthews, Fflur Jones, Katrina Febry, Phillip Jones, Rachel Harries, Tracey Davies and Urvisha Perez under the direction of David Thomas

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Contents

	Summary report	5
	Background	5
	Key findings	7
	Key challenges and recommendations	11
1	Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results	15
2	Workforce challenges are threatening the sustainability of the service and limiting health boards' ability to train and appraise staff	23
3	Ageing and underutilised equipment is making it harder for health boards to meet demand, and health boards do not have the staffing resources to extend opening hours	29
4	Wales-wide radiology IT system challenges and weaknesses in local IT infrastructure inhibit radiology services' efficiency	35
5	Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services	39
	Appendices	
	Methodology	48
	Five-year waiting times trends	51

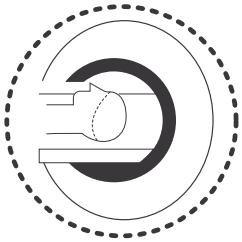
Summary report

Background

1 Radiology is a key diagnostic and interventional service used to help diagnose, monitor and treat disease and injuries.

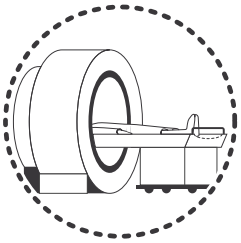
2 Hospital-based clinicians and general practitioners refer patients to radiology departments to undergo radiological examinations or to have images taken. Radiographers use sophisticated radiology equipment to produce differing types of images, depending on the issue being investigated. Exhibit 1 provides a summary of the key radiology techniques commonly used across the NHS.

Exhibit 1: key radiology imaging techniques



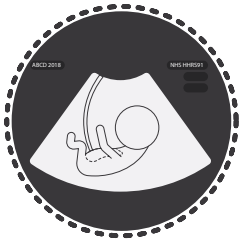
Computerised tomography (CT):

Uses X-rays and a computer to create detailed images of structures inside the body, including internal organs, blood vessels and bones. Patients lie on a bed that passes into a doughnut shaped scanner



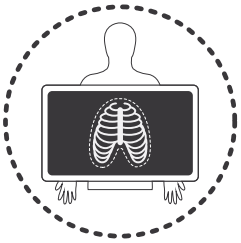
Magnetic resonance imaging (MRI):

Uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Can be used to examine almost any part of the body, including bones and joints, the heart and blood vessels, and internal organs, such as the liver. An MRI scanner is a large tube in which patients lie during the scan.



Ultrasound (US):

Uses high-frequency sound waves to create an image of a part of the inside of the body. Ultrasound probes gives off high-frequency sound waves. The sound waves bounce off different parts of the body, creating an "echo" that is picked up by the probe and turned into a moving image. This image is displayed on a monitor while the scan is carried out.



X-ray:

Uses radiation to pass through the body, the energy from X-rays is absorbed at different rates by parts of the body. X-rays are mainly used to look at bones and joints, but can also be used to detect problems affecting soft tissue, such as heart problems and tumours.

Source: NHS Choices

3 Following an examination, a clinical radiologist[1] will view the resulting image or images, and produce a report, which provides an interpretation. Radiologists play a key role in the clinical management of a patient's condition, advising on, and selecting the best imaging technique to enable diagnosis and minimise radiation exposure. Interventional radiologists have a more direct role in treating patients, using minimally invasive procedures, aided by radiology imaging, to diagnose and treat various diseases.

4 Many clinical decisions about the management of a patient cannot be made without a radiologist's input into the diagnosis. Where rapid diagnostic testing is in place, this enables clinical decisions to be made quickly.

5 **The Future Delivery of Diagnostic Imaging Services in Wales** (2009)[2] report set out that demand for some types of radiology examinations was increasing by between 10% and 15% per year.

6 In 2010, the National Imaging Programme Board was created at the request of NHS Chief Executives, as the primary source of advice, knowledge and expertise for the planning of diagnostic radiology services in Wales. The National Imaging Programme Board, through NHS Chief Executives was given delegated authority for developing and implementing a programme of strategic work for radiology, and for adopting all-Wales standards and protocols for radiology services across Wales. Since then, although progress has been made at a national level, a number of significant challenges are yet to be fully addressed.

7 It is widely accepted that there are ongoing difficulties in recruiting general and specialist radiology staff. There are also concerns about the capability of radiology information systems to support the delivery of services. In addition, radiology equipment is expensive to purchase and maintain. Waiting time performance in the past five years suggests that the current capacity of radiology services is not sustainable.

8 The Wales Audit Office report on **NHS Waiting Times for Elective Care in Wales** (January 2015)[3] showed that waiting time targets for diagnostic tests were not being met. Similarly, the Wales Audit Office report **A Review of Orthopaedic Services** (June 2015)[4], showed that the long waiting times for radiology examinations was contributing to long waits for overall orthopaedic treatment.

1 In this report, reference made to radiologists, includes consultant radiologists, middle-grade doctors, specialist registrars and junior doctors. Where there is any variation from this, the report content will specify what the variation is, for example, 'consultant radiologists'.

2 Welsh Assembly Government, The Future of Diagnostic Imaging Services in Wales, 2009

3 Wales Audit Office, NHS Waiting Times for Elective Care in Wales, January 2015

4 Wales Audit Office, Orthopaedic Services, June 2015

9 Given the challenges, the Auditor General commenced a review of radiology services at all health boards in Wales in late 2016. The work examined each health board's arrangements to meet demand for radiology examinations and made recommendations for service improvements. We excluded therapeutic radiology from the review. Appendix 1 provides the audit approach and methodology used for this work.

10 During 2016-17, the Wales Audit Office conducted a value-for-money examination of the NHS Wales Informatics Service[5]. The review considered the implementation of key NHS information systems, including the implementation of RADIS[6] across Wales. The report highlighted that frontline staff are dissatisfied with the functionality of RADIS.

11 This report summarises the key messages from the Auditor General's local work on radiology services, and refers to the findings set out in the Auditor General's separate report on the NHS Wales Informatics Service where relevant.

Key findings

12 Waiting time targets for radiology examinations are currently being met and our work has shown that radiology services are generally well managed. However, rising demand, difficulties with recruitment and retention of staff, outdated and insufficient scanning equipment, along with IT weaknesses are putting services under pressure and point to the need for clear and targeted action to ensure that radiology services are able to cope with future demand.

13 Our key findings are set out further in the paragraphs below.

Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results

14 Demand for radiology examinations is increasing each year, in particular for the most complex scanning techniques. The reasons for the increase in demand are numerous.

15 Where a GP or consultant decides that a patient is in need of a radiology examination, those referred as outpatients are added to a waiting list. Our review found that waiting lists are prioritised according to need, and all health boards review the appropriateness of the referral priority.

5 Wales Audit Office, Informatics systems in NHS Wales, January 2018

6 RADIS – Wales Radiology Information System.

16 Hospital inpatients with emergency health needs may need prompt access to radiology examinations. In normal working hours, hospitals set aside a small number of appointments to accommodate urgent inpatient cases. However, we found that out of hours access to radiology examinations for patients with urgent needs is variable. Whilst CT and X-ray examinations are available out of hours in most hospitals, MRI and US examinations are not.

17 There has been improvement in waiting time performance over the last five years, with a reduction in the number of patients waiting more than eight weeks for a radiology examination, supported by additional funding from the Welsh Government. Health boards have secured improvements in waiting times by outsourcing examinations to private sector mobile units and making use of unused capacity in other health boards.

18 Following a radiology examination, a report of the image is produced. Generally, reporting turnaround targets are met, however, some patients wait a long time for their results, and not all examinations are reported.

19 Whilst radiologists report most examinations, specially trained radiographers are able to report on less complex images. However, staff shortages were limiting health boards' ability to make greater use of radiographer reporting. As a result, health boards have relied on outsourcing reporting to help ensure timely turnaround of radiology reports.

Recruitment, retention and an ageing workforce are threatening the sustainability of the service and limiting health boards' ability to train staff

20 We found that all but one health board was struggling to recruit and retain radiologists and radiographers. Health boards have been increasingly reliant on using locum staff to bridge the gap caused by unfilled vacancies. At the same time, the radiology workforce is aging and at the time of our review, more than one third of radiologists and radiographers were aged 50 or over, and therefore, vacancy levels could increase without appropriate action.

21 To help address the reporting capacity shortfall, a National Academy has been set up to provide a training facility for trainee radiologists. The first cohort of trainees are due to commence training in September 2018.

22 We found that staffing shortages were limiting health boards' ability to train their staff, and all health boards were struggling to keep staff compliant with statutory and mandatory training modules.

Ageing and underutilised equipment are making it harder for health boards to meet demand and health boards do not have the staffing resources to extend opening hours

23 Comprehensive arrangements are required to ensure the maintenance and replacement of radiology equipment. Older imaging equipment is more expensive to maintain and has a greater risk of failure. At the time of our review, all health boards had equipment nearing the end of their lifespan. A capital replacement programme for radiology equipment requires significant funding, and as such, capital funding is provided on an all-Wales basis but not necessarily to the level needed to replace all out of date equipment. Since our review, the Welsh Government provided funding for additional radiology imaging equipment in 2016-2017 and 2017-18, and is working with health bodies to identify and prioritise further additional imaging investment over the period 2018-19 to 2020-21.

24 We found there was scope to increase the utilisation of scanning equipment in all health boards. However, additional radiology staffing would be required to achieve this. A further complication is that increasing operating hours would also lead to higher maintenance costs, and reduce equipment lifespans.

Wales-wide radiology IT system challenges and weaknesses in local IT infrastructures inhibit radiology services' efficiency

25 Our review found that the core radiology system, RADIS, was not fulfilling health boards' needs. Inadequacies in the system were causing difficulties for some health boards in planning and delivering radiology services and leading to inefficiencies. We also found that inadequacies in local IT infrastructures were also compounding inefficiencies.

26 At the time of our review, the absence of an e-referral system and weaknesses in Picture Archiving and Communications Systems (PACS) and voice recognition systems were creating inefficiencies in the planning and delivery of radiology services. However, since our review there has been phased implementation of electronic referrals as part of the wider rollout of the Welsh Clinical Portal.

Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services

27 We found that strategic and operational planning of radiology services need strengthening in most health boards. Only three health boards undertook demand and capacity modelling. At the time of our review, only one health board had a specific, detailed financial plan for radiology.

28 Performance data and audit results help health boards to monitor and evaluate the performance of radiology services. However, we found that most health boards had opportunities to widen the range of radiology performance measures reported to their Boards and Committees. In addition, currently there is no standard radiology activity measurement. Health boards do not record radiology activity consistently across Wales. This makes it difficult to provide true comparisons of activity and performance between health boards.

29 Our review found that the operational management and accountability arrangements for radiology services were clear and appropriate. We found that nearly all health boards are taking positive steps to reduce inappropriate referrals, but signposting to local referral guidance could be improved. However, since our review, access to national referral guidance has improved.

30 Our review also found that not all health boards had an executive lead for radiology that was a member of the Board. The absence of an executive lead for radiology attending board meetings at some health boards may mean the opportunity to highlight and monitor emerging issues is missed.

31 Given the nature of some of the issues facing radiology services, action taken alone by health boards will not be enough to ensure the future sustainability of radiology services. National strategic planning is required to address the challenges facing radiology services. Since we reviewed radiology services across Wales, the Welsh Government established an Imaging Taskforce to develop and deliver a high-level **Imaging Statement of Intent**[7]. The aim of the Imaging Statement of Intent (the Statement of Intent) is to address the challenges facing diagnostic radiology services in Wales. In developing the Statement of Intent, the Imaging Taskforce took account of the findings from our local work. The Statement of Intent was published in March 2018. It contains a number of actions for NHS Wales to address.

7 Welsh Government, Imaging Statement of Intent, March 2018.

Key challenges and recommendations

32 The findings from our work identify a number of key challenges that face health boards, and require action both locally and nationally by NHS Wales, or locally by some or all health boards. These are set out in Exhibit 2.

Exhibit 2: key challenges that need to be addressed nationally and locally

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Workforce		
• Ensure that the level of trainee radiologists and radiographers is sufficient to address recruitment challenges and increasing demand.	✓	
• Ensure that opportunities to maximise the contributions that support staff and other professions can make to radiology services are identified and secured.		✓
• Ensure that health boards have radiology workforce plans, which identify the capacity and skill mix required to sustainably meet current and future radiology demand in a timely and safe way.		✓
Equipment		
• Ensure that there is a national coordinated approach to address equipment needs, with sufficient funding for the replacement of equipment and purchase of new technology to meet increasing demand and technology advances.	✓	
• Ensure that health boards have equipment replacement programmes, which set out priorities, requirements and associated costs.		✓

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Demand		
• Ensure that regional levels of current and future demand are known, to enable planning for additional capacity to be coordinated across regions.	✓	
• Ensure that health boards know the current and future demand for each referring specialties that takes account of changes, such as to patient pathways.		✓
• Ensure that health boards have action plans that detail how waiting times and reporting targets will be achieved in the short-term, and sustained in the future.		✓
• Ensure that health boards can demonstrate a value-based approach to radiology services by making better use of benchmarking information across Wales and the UK.		✓
ICT		
• Ensure that information systems are efficient and enable reliable management and performance information to be produced, and facilitate the appropriate sharing of patient information and images within and between health boards.	✓	
Management of services		
• Ensure that management accountability and strategic oversight is appropriate to drive service improvements.		✓
• Ensure that referral guidance provides sufficient information and is accessible to referring clinicians.		✓

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Quality		
• Ensure that common procedure codes are in place and used to ensure that workload is measured consistently with and between health boards.	✓	✓
• Ensure that common performance indicators are in place to drive the consistency of benchmarking and improvement of services.	✓	✓
• Ensure that appropriate and robust performance quality measures are in place, which includes the review of patient experiences and service quality reviews.		✓
• Ensure that appropriate monitoring arrangements are in place at board and committee level.		✓

Source: Wales Audit Office

33 Our local audit reports set out specific recommendations for health boards. All health boards have prepared management responses setting out the actions they are taking to address audit recommendations. Our local reports and the associated management responses are available on the Wales Audit Office website (www.audit.wales).

34 The challenges that require a national response align closely to the actions set out in the Statement of Intent. Consequently, we do not see value in repeating those actions in the form of recommendations here.

35 The Imaging Taskforce, in consultation with the public and stakeholders, is developing a national imaging implementation plan for NHS Wales to address the actions set out in the Statement of Intent. We therefore base our recommendations around ensuring that national implementation adequately addresses the challenges identified through our work and the Statement of Intent.

Recommendations

The national challenges facing radiology services across Wales are reflected in the Imaging Statement of Intent and appropriate action has been identified. However, delivery against these actions is reliant on a timely national imaging implementation plan being developed and acted upon.

R1 The Welsh Government, through the Imaging Taskforce, should ensure that the national imaging implementation plan addresses each of the actions set out in the Imaging Statement of Intent, and the key challenges highlighted in this report.

R2 The national implementation plan should include clear implementation dates to deliver action in the short to medium term, with clearly identified accountabilities for delivery.

R3 The Welsh Government should properly cost the implementation plan and ensure that the necessary resources are in place to support delivery.

R4 The Welsh Government should ensure the necessary arrangements are put in place to monitor delivery of the national implementation plan.

Part 1

Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results



Demand for radiology imaging is increasing annually, and in particular for the most complex scans

1.1 The growing role of radiology in clinical care has led to increasing demand for radiological examinations. A number of factors drives the increase in demand. This includes demographic changes, new clinical guidelines, lower thresholds for referral, and advances in technology and understanding about how the features of disease present themselves on diagnostic images.

1.2 In Wales, the total number of diagnostic radiology examinations undertaken per year increased by 9% between 2013-14 and 2016-17[8] (Exhibit 3). In addition, scans are becoming more complex. The biggest percentage rise in volume for radiological examinations has been for CT and MRI imaging due to an increase in their role in the early diagnosis of many diseases. Between 2013-14 and 2016-17, the number of CT scans undertaken per year increased by 33% and the number of MRI scans increased by 28% (Exhibit 3). MRI and CT examinations are complex and can include multiple images, and therefore, per patient examination, are more labour-intensive for radiologists interpreting images than other examinations, such as X-rays.

Exhibit 3: increase in demand for CT, MRI, US and X-ray imaging between 2013-14 and 2016-17

	2013-14	2014-15	2015-16	2016-17	Percentage increase 2013-14 to 2016-17
CT	235,861	256,935	284,672	313,947	33%
MRI	97,929	109,506	119,066	126,335	29%
Plain film X-ray	1,291,395	1,279,348	1,299,609	1,281,067	-1%
Total ultrasound	409,363	419,378	444,540	468,361	14%
All others	120,532	143,956	144,203	153,941	28%
Total examinations	2,155,080	2,209,123	2,292,090	2,343,651	9%

Source: NHS Benchmarking Network

8 These figures are based on data provided by five health boards who participated in the NHS Benchmarking Network review of radiology services. Hywel Dda University Health Board and Powys Teaching Health Board did not participate.

1.3 The increase in demand for radiology examinations is not unique to Wales. In England between 2013 and 2016 the number of CT examinations increased by 33% and MRI examinations by 31%, equating to a mean annual growth of just over 10%[9].

Patients on waiting lists are prioritised according to clinical urgency, and emergency access for radiology examinations in normal working hours is good, but emergency access out of hours is variable

1.4 While most radiology departments offer some form of open access to patients referred to the department as outpatients, the extent of access varies and typically is limited to X-rays only. Where open access is not available, patients are placed on a waiting list. The referral should specify the degree of urgency. This ensures that the patients with the most critical needs are seen first. The referrer assigns the urgency.

1.5 All health boards operate three priority levels for outpatients: urgent, urgent suspected cancer and routine. Urgent referrals are prioritised and seen as soon as they can be accommodated.

1.6 In all health boards, radiologists or appropriately trained advanced practice radiographers review the priority of the referral using the clinical information provided by referrers. The priority of the referral may be amended following review. This system ensures waiting lists are based on clinical priority.

1.7 However, only two health boards operate a centralised waiting list within the health board. Five health boards have separate radiology waiting lists in different parts of the organisation. By maintaining more than one waiting list, health boards are failing to manage demand on an organisation-wide basis, with the result that some patients may wait longer than they would have if they had been on a single waiting list.

1.8 Inpatients with emergency health needs may need prompt access to a radiology examination both within and outside of normal working hours. During normal working hours, all health boards told us they set aside a small number of appointments to accommodate emergency inpatient referrals, based on historic demand. However, the unpredictable nature of emergency demand means that sometimes, too much or too little time is allowed in the appointment timetable.

9 NHS England, Diagnostic Imaging Dataset (accessed 24 August 2017).

1.9 Out of hours provision is based on staff working on call rotas. At the time of our review, access to out of hours examinations for inpatients with urgent healthcare needs was variable across health boards. CT scans and X-rays were available out of hours at the majority of hospital sites, and at least one hospital site at each health board provided cover. However, out of hours MRI scans and US scans were not available in three health boards.

The percentage of patients waiting more than eight weeks for an examination has fallen in the last five years, waiting time performance has been helped by securing additional scanning capacity from the private sector

1.10 All NHS bodies in Wales are required to comply with the Welsh Government diagnostic waiting times target which states that no patients should wait more than eight weeks to receive their diagnostic test[10].

1.11 Since 2009, waiting times for radiology examinations have also formed part of the referral to treatment target[11], where the referral for radiology has been made as part of the patient pathway. Health boards in Wales are required to ensure that 95% of all patients waiting for elective treatment receive their treatment within 26 weeks from the point at which the referral was received. For many of these patients, diagnostic tests help decide which treatment is the best option.

1.12 In March 2018, there were no patients waiting more than eight weeks for a diagnostic radiology examination at three health boards. However, there were patients waiting more than eight weeks for a radiology examination at Aneurin Bevan, Betsi Cadwaladr and Cardiff and Vale University Health Boards, and Powys Teaching Health Board[12]. Exhibit 4 provides the number of patients that had been waiting more than eight weeks at the time of our review, and in March 2013 and March 2018.

10 The diagnostic waiting time target applies to all radiology examinations including MRI, CT, and non-obstetric US, fluoroscopy, barium enema, and nuclear medicine. The Welsh Government target does not include X-rays.

11 Welsh Health Circular (2007) 014 – Access 2009 – Referral to Treatment Time Measurement, Welsh Health Circular (2007) 051 – 2009 Access – Delivering a 26 Week Patient Pathway – Integrated Delivery and Implementation Plan and Welsh Health Circular (2007) 075 – 2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways.

12 Abertawe Bro Morgannwg, Betsi Cadwaladr, Hywel Dda University Health Boards and Powys Teaching Health Board. Powys Teaching Health Board provides plain X-ray and US examinations only, other imaging and interventional procedures are commissioned from a range of providers in neighbouring health boards in Wales and NHS trusts in England.

Exhibit 4: all-Wales waiting times for CT, MRI and non-obstetric US scans[1]

		Total number of patients waiting for an examination					
		Up to 8 weeks	Over 8 weeks and up to 14 weeks	Over 14 weeks and up to 24 weeks	Over 24 weeks	Total waiting	Percentage of patients waiting more than 8 weeks
CT scan	March 2013	6,777	159	61	5	7,002	3%
	August 2016[2]	7,301	63	51	11	7,426	2%
	March 2018	8,054	9	1	1	8,065	0%
MRI scan	March 2013	11,087	2,520	2,241	278	16,126	31%
	August 2016[2]	11,662	913	66	163	12,804	9%
	March 2018	10,662	121	59	62	10,904	2%
Non-obstetric US scan	March 2013	19,454	3,110	867	7	23,438	17%
	August 2016[2]	18,944	1,999	626	133	21,702	13%
	March 2018	20,097	13	0	0	20,110	0%

Notes:

1 Waiting time targets do not apply to X-rays as most health boards provide open access for X-ray examinations.

2 Waiting time data reported in our local reports.

Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

1.13 Exhibit 4 shows that waiting time performance has improved over the last five years, although there have been fluctuations in performance (Appendix 2). Generally, the month 12 performance has shown an improvement compared to the full year's performance in general. The improvement is a result of a concerted effort by health boards to meet waiting time targets, often funded with additional Welsh Government monies. Whilst the waiting time target applies all year around, performance monitoring tends to focus on the year-end performance as opposed to performance during the year.

1.14 Health boards have achieved reductions in waiting times for radiology examinations over the last five years by securing additional scanning capacity by outsourcing imaging to private sector mobile CT and MRI units, and utilising unused capacity in other health boards. In 2014, the Welsh Government provided £840,000 to radiology services across Wales to reduce the backlog of patients waiting more than eight weeks for an MRI examination[13]. Since then, health boards have funded initiatives to keep waiting times within the eight-week target by outsourcing examinations and increasing radiology opening hours.

Whilst average reporting turnaround targets were largely being met, some patients waited more than six months for results, and health boards were unable to make full use of their reporting capacity

1.15 A report outlining the interpretation of the image must be produced following a radiology examination. This report is then used to make further decisions about the ongoing care of the patient.

1.16 All examinations must be reported and provided to the referring clinician within a timeframe appropriate to the patient's clinical condition. The Welsh Reporting Standards for Radiology Services 2011 were produced in order to clarify previous guidance and regulations[14]. The Standards range from same-day to ten working days.

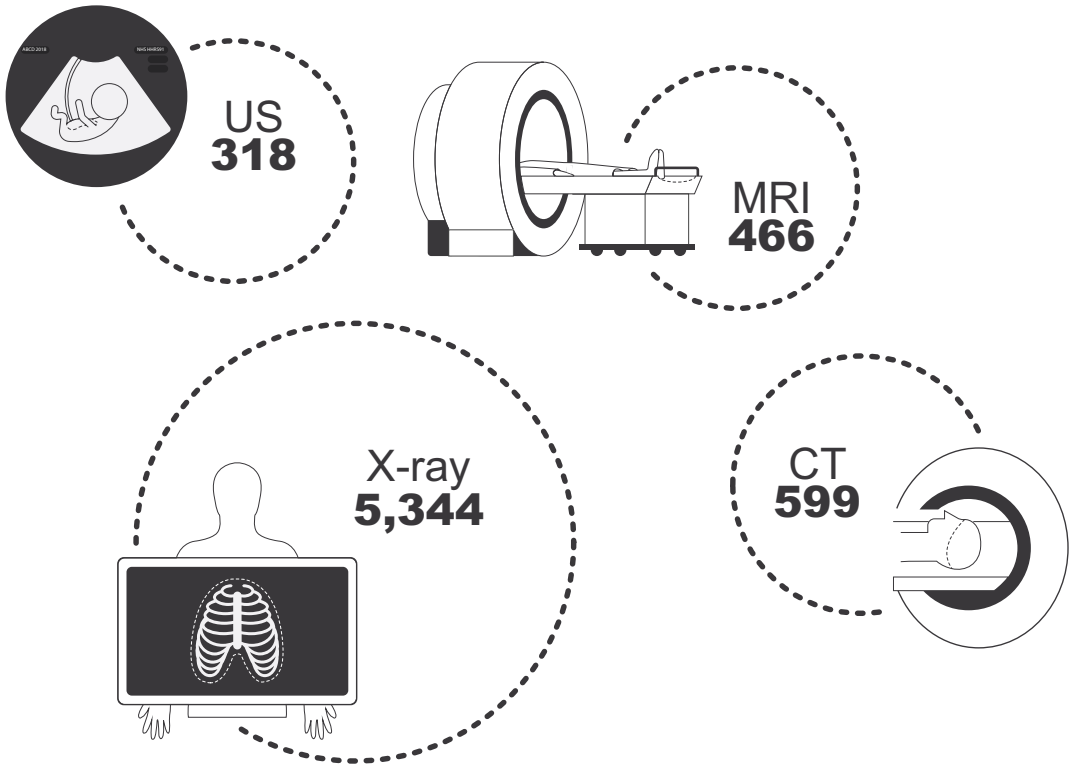
13 In January 2014, 41% (7,179) of patients waiting for an MRI had been waiting more than eight weeks, 1,463 patients had waited more than 24 weeks.

14 Produced by the Medical Imaging Sub-committee (a sub-group of the Welsh Scientific Advisory Committee). The Reporting Standards for Radiology Services 2011 set out that radiology should aim to provide reporting turnaround times appropriate to the type of referral as follows: urgent – immediately/same working day; inpatient – within one working day; accident and emergency – within one working day; GP – within three working days; and outpatient – within ten working days.

1.17 We asked health boards to provide the average and longest reporting times and the number of unreported examinations for CT, MRI, US and X-ray imaging by hospital. The type of referral (for example urgent, inpatient, GP) is not routinely available. The average reporting time between 1 April 2015 and 31 March 2016 for each type of scan was 10 days or less at all but one of the hospitals participating in the review[15]. However, local audit work found that some patients wait a long time for their scan to be reported. At the time of the audit, the longest report turnaround time was over six months. Exhibit 5 shows the number of unreported examinations at the end of March 2016. Whilst these represent less than 1% of the total examinations undertaken, they nonetheless show that a notable number of examinations have delayed reporting or are not reported at all, with associated quality of care risks to patients from delayed diagnosis and treatment.

Exhibit 5: number of examinations not reported as at 31 March 2016 across Wales[1]

Total for hospitals participating in the review



Note:

1 Unreported examinations include those examinations that remain unreported more than 10 days since the examination date. The figures exclude Cardiff and Vale University Health Board and Powys Teaching Health Board.

Source: Wales Audit Office, Hospital Site Survey

15 One hospital told us that the average reporting time for X-rays was 16 days.

1.18 Whilst radiologists report most images, specially trained radiographers provide additional reporting capacity. Extended practice radiographers (EPRs) receive training to interpret and report some types of images, typically less complex scans, such as X-rays, and sonographers report US scans.

1.19 Whilst all health boards, with the exception of Powys Teaching Health Board, have invested in EPRs, at the time of our review shortages in the radiology workforce across Wales was making it difficult for health boards to utilise EPR reporting skills. Our review found that resourcing constraints in the radiologist workforce meant that opportunities to train and support EPRs were limited. Similarly, radiographer shortages has resulted in health boards being unable to release EPRs from undertaking examinations, to enable them to report images, resulting in reduced reporting capacity within health boards.

1.20 Radiologist staffing shortages and the resulting reduction in EPR reporting capacity led to the introduction in November 2014 of a national contract to provide additional, outsourced reporting capacity from the private sector. Radiology Reporting Online Limited was awarded a contract to provide reporting capacity across Wales. The contract was initially for a two-year period, with an option to extend the contract for an additional year. The contract value was £1.5 million (excluding VAT) for the initial two-year period. However, increasing demand, particularly for CT and MRI reporting, resulted in the service being used significantly more than predicted with the actual spend across the initial two-year contract being £3.5 million excluding VAT. The contract was subsequently extended until November 2019, at a cost of £11 million over the three-year extension. At the time of our review, outsourced reporting capacity bridged the gap created by staff shortages, but is not a sustainable solution for the long-term.

Part 2

Workforce challenges are threatening the sustainability of the service and limiting health boards' ability to train and appraise staff



All but one health board is struggling to recruit and retain radiology staff, resulting in a reliance on locums

2.1 Radiologist, radiographer and sonographer vacancy levels compound the ability to meet increasing demand for radiology examinations. On 31 March 2016, there were 112 full time equivalent (FTE) vacancies within radiology departments across four health boards in Wales (Exhibit 6).

Exhibit 6: number of radiology staff vacancies in Wales as at 31 March 2016[1]

	Radiologists	Radiographers/ sonographers	Other radiology staff[3]
Number of FTE vacancies	22	58	32
FTE vacancies as a percentage of the FTE establishment[2]	15%	9%	6%

Notes:

1 The figures are based on four health boards. Cardiff and Vale, Cwm Taf University Health Boards and Powys Teaching Health Board did not provide their vacancy levels.

2 The FTE staffing establishment is the level of staff that the Health Board has determined it needs to provide services and for which funding has been made available.

3 Other radiology staff includes staff such as nurses, scientific and technical staff, healthcare support workers and administrative staff.

Source: Wales Audit Office, Hospital Site Survey

2.2 Whilst vacancy levels were reasonably consistent across the health boards providing data, there were particularly high radiologist vacancy levels at Hywel Dda University Health Board with 42% of FTE establishment posts vacant. The relatively high vacancy rate for radiologists shown in Exhibit 6 creates particular challenges. Many radiologists specialise in a particular area, meaning that the loss of a single radiologist can have a big impact on a radiology department. For instance, at the time of our review there were two interventional radiologist posts in Cwm Taf University Health Board, however, only one was filled. The vacancy put the interventional radiology service under considerable pressure and resulted in restricted out of hours interventional radiology cover. Across Wales, there is a shortfall of consultant radiologists in interventional, breast, paediatric and nuclear radiology specialties. The level of radiologist vacancies is not unique to Wales. Across the UK, the number of unfilled consultant radiologist posts in 2016 was 9%, compared with 13% in Wales[16].

2.3 Whilst vacancy levels were high at the time of the audit, the age profile of staff working in radiology services creates further challenges in terms of retirement and succession planning. As at June 2018, 38% of consultant radiologists and 34% of radiographers and sonographers in Wales were aged 50 or over (Exhibit 7).

Exhibit 7: number and percentage of consultant radiologists and radiographers in Wales by age group as at June 2018

	Age					
	Under 39	**40–44**	**45–49**	**50–54**	**55–59**	**60+**
Consultant radiologists[1]	27	36	41	23	15	26
	(16%)	(21%)	(24%)	(14%)	(9%)	(15%)
Radiographers[2]	535	98	84	147	133	86
	(49%)	(9%)	(8%)	(14%)	(12%)	(8%)

Notes:

1 NHS workforce definition: staff with consultant grade code or job role working in radiology – note this includes both diagnostic and therapeutic radiologists.

2 NHS workforce definition: Staff bands 5–9 with a diagnostic radiography occupation code (S*F).

Source: NHS Wales Workforce, Education and Development Services, NHS workforce census data for June 2018

16 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2016 Report, 2017.

2.4 For the period 2016-2021, consultant workforce attrition due to retirement is likely to be higher in Wales than in any other part of the UK. Around 30% of consultants in Wales are expected to retire, compared to 22% for the UK as a whole (based on an assumed retirement age of 60)[16].

2.5 At the time of our review, all health boards, other than Cardiff & Vale University Health Board, told us that they found recruiting both radiologists and radiographers challenging. More than one health board told us that some adverts for radiology posts had received no suitably qualified applicants.

2.6 Our review found that health boards across Wales were making use of locum staff to bridge staffing gaps, although this was not successful in covering all the vacant posts with 35 FTE locums recruited compared to 112 FTE vacancies[17].

2.7 NHS Wales has experienced particular challenges in securing sufficient trainee radiologists and then retaining those staff in Wales. In 2015, compared to other parts of the UK, Wales had the lowest proportion of trainees to consultant radiologists; 25% in Wales compared to 38% across the UK[16], and NHS Wales has previously lost two out of every five trainees to England or countries outside of the UK[18].

2.8 In response to the challenges facing the radiology workforce, the National Imaging Programme Board developed a business case for a National Imaging Academy for Wales (the Academy) to be based in Bridgend. The Academy is a collaboration between health boards to provide a bespoke training facility for at least 20 trainee radiologists a year, with trainees splitting their time between the Academy and clinical placements in hospitals across South Wales. The Welsh Government has funded initial set up costs, and the health boards will meet the annual running costs. Initially, the Academy will train radiologists; however, later will also train enhanced practice radiographers, sonographers and other imaging professionals to report images.

16 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2016 Report, 2017.

17 The FTE of locums is based on the average FTE of locum use between 1 Oct 2015 and 31 March 2016, and FTE vacancy levels at 31 March 2016. Includes all staff groups, and is based on five health boards, Wales Audit Office, Hospital Site Survey.

18 NHS Wales, NHS Wales Health Collaborative Diagnostic Services Modernisation Programme, December 2015.

2.9 The Academy combines training and provides a reporting facility across Wales. The Academy is intended to address the recruitment challenges experienced across Wales, and may help to reduce the reliance on outsourced reporting in future years. However, whilst the Academy opened in 2018, it will take a number of years before the first trainees have completed their training. The first cohort of trainees have been recruited, and the full cohort of 22 trainers have been appointed to the Academy.

2.10 Whilst in the long-term the Academy should increase the number of trained radiologists in Wales, our local work found that radiology services were also planning to amend their staffing models to increase their reporting capacity. Health boards were planning to train more radiographers and other appropriate staff groups, such as cardiologists, to report examinations. Using a different staff mix to report examinations will help to reduce health boards' reliance on radiologists. In addition, we found that health boards were reviewing the skill mix of their staff to explore opportunities to make more use of non-professional grades, such as assistant practitioners, to help provide additional capacity for imaging (whilst working under supervision) to help bridge radiographer staffing shortages.

Operational pressures and staffing constraints are limiting health boards' ability to train staff

2.11 Annual staff appraisals and continuing professional development (CPD) reviews are an important part of ensuring that the quality of radiology services is maintained and that staff training needs are properly addressed. We asked health boards to provide us with the percentage of staff that had received an appraisal and a CPD review. Across Wales, at least 75% of radiologists, radiographers and other radiology staff had received an appraisal or a CPD in 2015-2016.

2.12 However, not all staff are compliant with statutory and training modules[19]. In 2015-2016, there was variation in the percentage compliance rates between staff groups and modules across health boards. One health board told us that only 48% of radiographers were compliant with Moving and Handling Training, and another health board told us that only 33% of radiographers were up to date with Information Compliance Training. Some health boards told us that they had been unable to maintain compliance with mandatory training and were struggling to achieve higher rates of annual appraisals and CPD reviews due to staffing constraints. Non-compliance with statutory and mandatory training could present a risk to staff members, patients and ultimately health boards.

19 The statutory and mandatory training modules are set out in the UK Core Skills and Training Framework. They are: Equality, Diversity and Human Rights; Health, Safety and Welfare; Fire Safety; Infection Prevention and Control; Moving and Handling; Safeguarding Adults; Safeguarding Children; Resuscitation; and Information Governance.

Part 3

Ageing and underutilised equipment is making it harder for health boards to meet demand, and health boards do not have the staffing resources to extend opening hours



3.1 Health boards must ensure their radiology equipment capacity and specifications meet increasing demand and advances in both clinical practice and technical sophistication.

All health boards have equipment nearing the end of their lifespan

3.2 Comprehensive arrangements are required for the maintenance and replacement of radiology imaging equipment. Older imaging equipment has a higher risk of failure and maintenance costs increase. Image quality also declines with age. Radiology equipment more than ten years old is typically considered to no longer be state of the art and technical advances render the equipment obsolete[20]. In addition, the lifespan of radiology imaging equipment shortens with increased use.

3.3 In November 2015, NHS Wales estimated that 87% of imaging department scanners would require replacement by 2017[21]. We asked health boards to provide us with the age of their CT, MRI and US scanners as at September 2016 (Exhibit 8).

Exhibit 8: age of CT, MRI and US imaging equipment across Wales as at September 2016[1]

		CT	MRI	US
Median scanner age (years):		5	7	4
Number of scanners:	aged up to 6 years	17	9	105
	aged between 6 and 10 years	6	7	9
	aged over 10 years	1	2	1
	total	**24**	**18**	**115**

Note:

1 Based on equipment in five health boards for CT and MRI scanners, and six for US scanners. Aneurin Bevan University Health Board did not provide data. Powys Teaching Health Board has US scanners, but no CT or MRI scanners.

Source: Wales Audit Office, Radiology Equipment Age Survey; and European Society of Radiology

20 The European Society of Radiology advocates that equipment aged: up to five years old reflects the current state of technology, and can be upgraded; between six and ten years old is fit to use if properly maintained, but require replacement strategies to be in place; and 11 or more years old requires replacement.

21 Diagnostic Service Programme NHS Wales, All Wales Gantry (MRI, CT, Gamma Camera and Ultrasound) Usage/Capacity, November 2015.

3.4 In September 2016, 17% of US scanners in Wales were six or more years old. However, 29% of CT scanners and 50% of MRI scanners were six or more years old. Our review identified two 13 year-old MRI scanners, and one 11 year-old CT scanner. Staff at all health boards identified ageing radiology equipment in need of replacement. One health board told us about an ageing CT scanner which regularly broke down (approximately every eight weeks). As the only CT scanner in that hospital, the regular disruption was affecting the care of critically ill patients and resulting in the cancellation of outpatient appointments. Since our local work, the CT scanner has been replaced.

3.5 It is essential that health boards have equipment replacement plans to identify how and when imaging equipment will be replaced. Our review found that whilst six health boards has a radiology equipment plan, all health boards were struggling to identify finances to replace and purchase additional radiology equipment.

3.6 MRI and CT scanners cost upwards of £800,000. Historically, health boards have relied on capital funding from the Welsh Government to buy replacement and additional radiology imaging equipment. In 2014, the Welsh Government provided funding for £8.5 million between five health boards to purchase new and replacement CT, MRI and mammography equipment.

3.7 At the end of 2016, the Welsh Government announced £16 million of funding to provide additional and replace out of date radiology imaging equipment. The funding was allocated across all health boards and Velindre NHS Trust for CT, MRI, mammography, US and X-ray equipment.

3.8 Since our review, the Welsh Government has provided a further £9 million for imaging equipment in health bodies, and to support the development of the Imaging Academy. The Welsh Government is working with NHS organisations to identify and prioritise further additional imaging investment over the period 2018-19 to 2020-21.

3.9 When replacing aging equipment, it is essential that health boards adequately plan for the installation of the new equipment. CT and MRI scanners are large, and the cost of installation can be as much as the cost of the scanner. Where a new scanner is required to replace existing equipment, the downtime can be considerable. In addition, where the new scanner is in addition to existing scanners, an extra room may be required to house the scanner, and this can cause considerable disruption and be costly. In 2016, two of the CT scanners financed by the Welsh Government in 2014 remained in storage because the health boards who were receiving them had struggled to identify finances to modify their buildings to install the equipment. Since our review, the two CT scanners have been put to use.

3.10 The Statement of Intent recognises that a national coordinated approach is needed to plan, identify and address imaging equipment needs. The Statement of Intent sets out that planning is required on a regional level with additional scanners providing extra capacity for regions, rather than a single health board. In 2016, the Welsh Government announced an additional £6 million for a Diagnostic Hub at the Royal Glamorgan Hospital (Cwm Taf University Health Board) which included funding for a replacement CT scanner and an additional MRI and CT scanner, to serve the needs of the South Wales area. The Diagnostic Hub opened in February 2018, and Cwm Taf University Health Board have reported that it provides additional capacity of approximately 7,200 MRI scans and 6,600 CT scans a year. A Regional Planning and Delivery Group established in October 2017, is overseeing the Diagnostic Hub and rollout of wider regional solutions across the South Central and East Wales region.

Whilst there are opportunities to increase imaging capacity with existing equipment by increasing the operating hours, this would have a significant impact on resourcing

3.11 One way for health boards to shorten waiting times for radiological examinations, particularly diagnostic radiography scans is to maximise the opening hours, and thus increase the number of available appointments. The longer the operating hours, the more patients can be seen; however, there are additional costs associated with this.

3.12 In 2014, NHS Wales undertook a review of the operating hours of CT, MRI and US scanners in Wales (Exhibit 9).

Exhibit 9: percentage usage of CT, MRI and US scanners in 2014, averaged across Wales, 2014

Type of scanner	Average number of operating hours per scanner per day		Percentage usage of equipment[1]
	Monday to Friday	Saturday to Sunday	
CT	8.7	0.7	52%
MRI	10.6	2.1	67%
US	7.7	0.0	46%

Note:

1 Based on the planned operating hours as a percentage of potential operating hours (seven days a week and 12 hours a day).

Source: NHS Wales, All-Wales Gantry Usage/Capacity Report, November 2015. Data based on the operating hours in 2014

3.13 In 2014, if all CT, MRI and US scanners across Wales had operated 12 hours a day and seven days a week, we estimate that it may have been possible to undertake at least an extra 1,340 CT examinations, 1,110 MRI examinations and 4,630 US examinations a week[22].

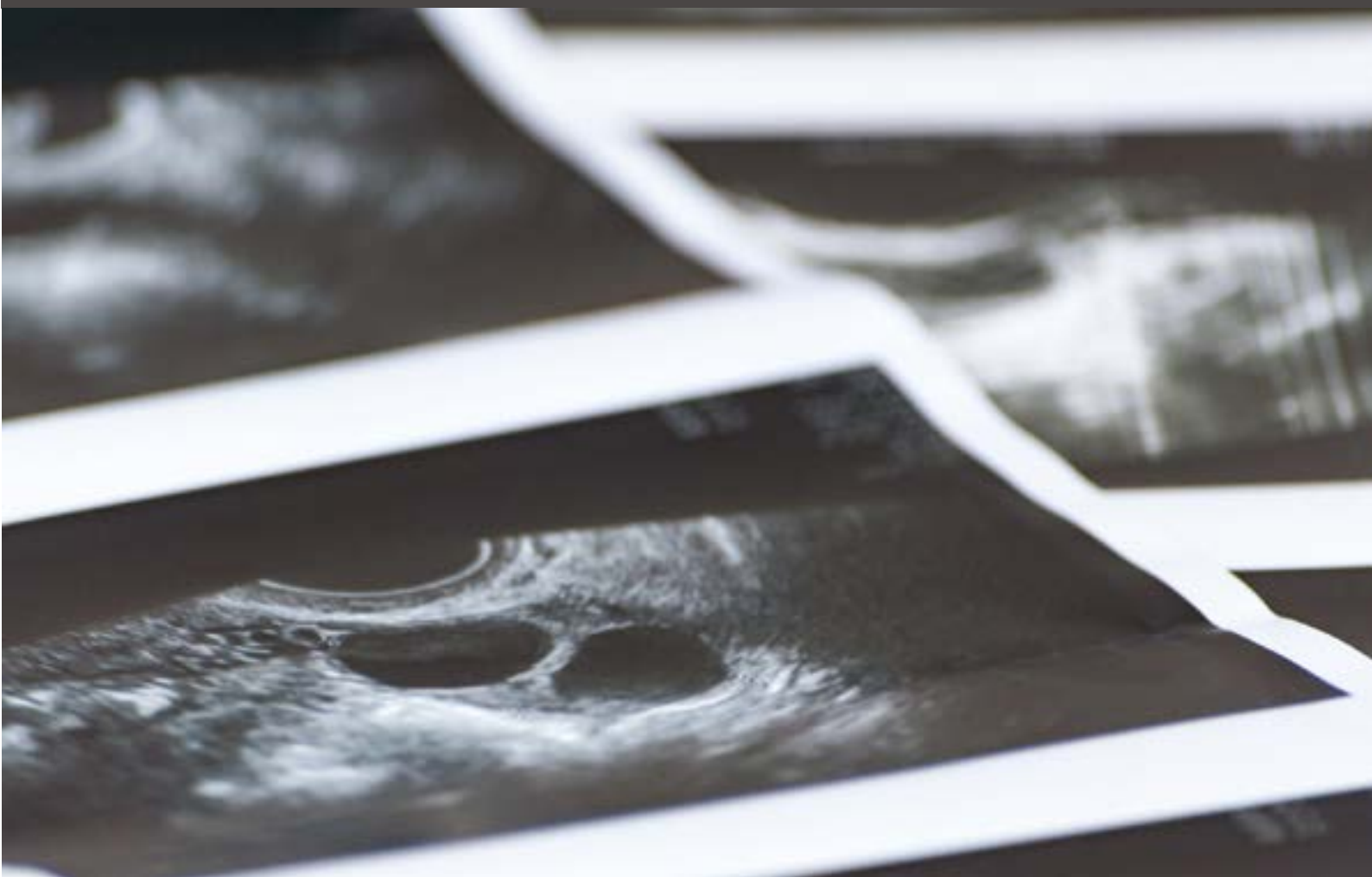
3.14 Since then, health boards have increased the number of operating hours of CT and MRI examinations on weekdays and weekends. Health boards have achieved the increase in operating hours largely by staff undertaking shift work. However, at the time of our review, only one health board was providing CT and MRI examinations for at least 12 hours a day over seven days a week at each hospital site. The standard operating hours across the other health boards varied. Out of 17 hospital sites surveyed, on weekdays, only seven provided CT examinations for 12 or more hours a day, and 10 provided MRI examinations for 12 or more hours a day. On weekends, only two hospital sites provided CT examinations for 12 hours a day and the same number provided MRI examinations for 12 hours a day (the same two hospitals). None of the hospitals provided US services 12 hours a day on weekdays or weekends, and only one hospital provided US examinations as standard on weekends.

22 The time an examination takes depends on the nature of the examination required. CT examinations can take between 10 and 45 minutes, MRI examinations between 15 and 90 minutes, and US examinations between 15 and 30 minutes. Therefore, our estimation is based on a CT examination length of 45 minutes, 90 minutes for MRIs and 30 minutes for a US examination.

3.15 However, extending operating hours is not a simple option for increasing capacity. Extending operating hours would require additional staff, meaning additional cost, and at a time when health boards are already finding it challenging to fill existing vacancies (paragraph 2.2). In addition, higher rates of equipment use results in shortened equipment lifespans, and potentially higher maintenance costs (paragraph 3.2).

Part 4

Wales-wide radiology IT system challenges and weaknesses in local IT infrastructure inhibit radiology services' efficiency



The core radiology management system is not serving health boards' needs, and this is further impeded by weaknesses in local IT infrastructures

4.1 Having effective ICT systems plays a central role in delivering efficient radiology services. In Wales, the Radiology Information System (RADIS) is a national system developed and run by NHS Wales Informatics Service. All health boards use RADIS. RADIS supports the scheduling of radiology investigations, provides a clinical record of scans received by patients and allows health boards to generate reports and statistics on performance. Other systems link to RADIS to provide additional functionality; these different systems must integrate with each other to ensure that information easily transfers and updates between systems.

4.2 Our review found that across Wales, health boards had mixed views on RADIS. Despite RADIS 2 being rolled out in 2005, at the time of our review three health boards were running separate instances[23] of RADIS, and a further two health boards were using a mixture of RADIS and alternative core radiology systems. Having numerous instances of RADIS or alternative systems, is a consequence of NHS reorganisation during the latter half of the 2000s. Hospitals that were part of separate organisations are now part of the same health board, but the separate infrastructure remains in place in some areas. Work is ongoing to provide a single instance of RADIS in all health boards.

4.3 Having separate instances of RADIS is time consuming for clinicians and makes it difficult to plan and deliver services across the whole health board. For example, if a patient has a scan in one hospital, another hospital in the same health board will not have a record of it. Having multiple instances of RADIS also makes it difficult to retrieve management information, as this has to be done separately for each instance and then consolidated into one report manually.

23 An 'instance' refers to a separate database that is specific to a particular location. It is used in order to differentiate from 'versions', which refer to updates and upgrades. For example, two hospitals could have the same version of RADIS, ie they are both equally up to date, but they would still have separate instances because staff in one hospital would not be able to access the records held in the other. Separate instances mean that clinicians cannot access patient information across administrative or geographical boundaries.

4.4 Whilst, some health boards told us they felt that RADIS is adequate in terms of patient scheduling, clinical reporting and management reporting, other health boards expressed doubts in the reliability of the reports produced, and said that they were unable to create bespoke reports in-house. In addition, health boards expressed concerns that RADIS does not integrate with other systems in use by health boards, meaning that changes to information in RADIS had to be updated manually in other systems.

The current absence of a fully functional e-referral system and weaknesses in picture archiving systems and voice recognition systems are creating inefficiencies in the service

4.5 In addition to the core radiology system, other systems are required for each stage of the patient journey, including electronic referrals, archiving of images and providing a record of the report.

4.6 Electronic requesting systems can enable clinicians referring patients for diagnostic imaging to request and receive updates and the outcomes of radiology requests quickly. At the time of our review, the functionality of request software was generally limited to providing a template for a request, which then has to be emailed to the radiology service. The absence of an e-referral system across Wales means that the vast majority of referrals are paper based. Paper based referrals can be problematic, creating more administration because all referral forms have to be scanned and there is the risk that sections are not fully completed or legible.

4.7 Once the examination has been undertaken, radiologists create a report to record their interpretation of the image. When reporting on images, radiologists can choose to use voice-activated dictation systems to record their report. Across Wales, health boards were generally dissatisfied with voice-activation dictation systems. Whilst some health boards used the dictation software built into RADIS, others were using alternative systems. Staff in some health boards indicated that IT network weaknesses meant that dictation systems were prone to freezing and timing out. The consequence of dictation software timing out is that all reports dictated in a session are lost and need to be repeated, leading to frustration and inefficient working.

4.8 All images must be archived. Picture Archiving and Communications Systems (PACS) acquire and archive radiology images, and enables the safe distribution of the image to other health professionals[24]. The report of the image (stored on RADIS) and the scan image (stored on PACS) together comprise the clinical record of the image. Whilst we found that health boards were generally satisfied with their PACS, there was variation in accessibility to PACS images. All health boards told us that radiologists and other hospital staff working within the health board could access images. However, not all radiologists can access PACS images remotely out of hours, and access for GPs and other NHS staff working in other locations was limited.

4.9 Work is ongoing to roll out the full functionality of the Welsh Clinical Portal across Wales. The Welsh Clinical Portal is a digital workspace, which allows the sharing of medical information between professionals securely. When fully functional, the system will provide an electronic platform for sharing information across Wales, including test results and allow electronic patient referrals. The system is being rolled out in a phased approach, with health boards implementing the different elements of the system in a timeframe that is manageable for the individual organisation. The Welsh Government has formed a Welsh Technical Standards Board to support the creation and maintenance of a catalogue of standards and requirements to enable integration and interoperability across all health and care systems in a consistent and secure manner.

4.10 The Statement of Intent has set out a vision for high quality radiology informatics systems to be developed with a secure IT infrastructure that operates across Wales. The vision is for systems that allow electronic referrals, review, processing and reporting through standardised software and that are interoperable, to allow the safe transfer of care between hospitals and allow imaging sharing across Wales.

24 A third party, Fujifilm, provides PACS. Fujifilm supplies hardware and software to health boards for the provision of PACS services, including voice recognition and full disaster recovery solutions. Each health board provides the necessary infrastructure to run those services, including networks and server space.

Part 5

Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services



Most health boards need to strengthen strategic and operational planning

5.1 Health boards should clearly set out their strategy for meeting current and future demand for radiology services. Service changes and developments in the wider organisation should inform radiology operational plans. Almost all clinical specialties rely heavily on radiology to help diagnose, treat or monitor disease or injury. When health boards are planning service changes that may lead to an increase to the number of patients referred for radiology imaging, they must ensure that they adequately consider the impact on radiology departments.

5.2 At the time of our review, only three health boards undertook demand and capacity modelling. Across Wales, our review found that there was variation in the degree to which radiology teams were involved in decisions about service changes that affected radiology services.

5.3 Each radiology service should have an agreed documented annual operational delivery plan. The operational plan(s) should clearly identify service demand, the workforce and equipment capacity required to meet this demand as well as the finances available and required to deliver the service safely, efficiently and effectively. Our review found that whilst one health board had a five-year strategic plan, four health boards did not. Four health boards did not have operational plans, and two health boards had neither a strategic nor an operational plan. Not all health boards had clearly set out their workforce needs. Only one health board had a specific, detailed financial plan for radiology, with other health boards financial planning being informed by the previous year's expenditure. Our local work found financial expenditure in four health boards exceeded the budgeted expenditure, which may be a symptom of the absence of adequate financial planning.

Nearly all health boards are taking positive steps to reduce inappropriate referrals, however, signposting to local referral guidance could be improved

5.4 GPs and consultants refer patients to radiology. Ensuring that patients are referred for the most appropriate diagnostic investigation depends on clear guidance and standards. Each inappropriate investigative image performed is, in effect, an example of valuable NHS resources being wasted. Encouragingly, all health boards told us that they return inappropriate referrals to consultants with an explanation for the refusal. In addition, six health boards regularly undertake audits to highlight patterns of inappropriate referrals.

5.5 All health boards use the Royal College of Radiologists' iRefer[25] guidance although at the time of our review, some consultants told us they found it difficult to access iRefer guidance. Since our review, iRefer has been made available via the NHS Wales e-library, providing access to all Welsh NHS professionals.

5.6 Most health boards had also developed supplementary local guidance. Although in the sample of consultants we interviewed many said that they were unaware of local guidance highlighting a need for better signposting and awareness raising in respect of these documents.

All health boards review the clinical performance of their radiology service, although there are opportunities to increase the range of reviews undertaken

5.7 Radiology services must ensure that clinical performance always meets the appropriate standards for patient treatment and care. They need to comply with the **National Diagnostic Imaging Framework**[26] and monitor clinical performance to ensure compliance. Radiology services must ensure that their practices are safe and comply with the Ionising Radiation Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017.

5.8 At the time of our review, all health boards had good arrangements in place to learn from incidents, errors and complaints, and the reporting of incidents is encouraged. All health boards had a regular programme of audits to assess service quality, however, there were opportunities for all health boards to increase the range of audits they undertook (Exhibit 10).

25 iRefer is a radiological investigation guidelines tool from The Royal College of Radiologists.

26 Welsh Government, National Diagnostic Imaging Framework, 2009

Exhibit 10: number of health boards undertaking regular audits of quality and clinical performance

	Number of health boards undertaking regular audits[1]
Appropriateness of referrals	6
Appropriateness or urgent and/or out of hours referrals	5
Quality of written requests	5
Demand levels by time of day/day of week	4
Demand levels by GPs/hospitals	6
Accuracy of reporting	7
Reporting turnaround times	6
Lost and late reports	3

Note:

1. Health boards were asked to indicate whether they undertake the audits listed in the review.

Source: Wales Audit Office, Health Board Survey

5.9 Whilst five health boards regularly undertook patient experience surveys, the other two health boards did not and should review arrangements to learn from patient experiences.

5.10 The Imaging Services Accreditation Scheme (ISAS) is a patient-focused accreditation scheme that helps imaging services to manage the quality of their services and make continuous improvements. In Wales, the National Imaging Programme Board is overseeing the introduction of ISAS. However, progress at individual health bodies has been limited by a lack of staff resources to enable coordination of the work associated with the accreditation process. Since our review, Betsi Cadwaladr University Health Board commenced a two-year pilot exercise to attain ISAS accreditation. The exercise will be used to identify how best to roll out ISAS across Wales.

In most health boards we identified opportunities to widen the range of operational performance measures reported

5.11 Effective monitoring and scrutiny of radiology service performance is important in assessing if the service is delivering its organisational goals and objectives, and identifying the need for remedial action. Health boards should use performance data and audit results to monitor and evaluate the performance of their radiology departments. Performance monitoring and review should take place at all levels within the organisation, from operational level to board level.

5.12 Our review found that whilst all health boards regularly review performance information about their radiology services, there was variation in the range of performance information reported. All health boards regularly viewed radiology waiting times data and incidents data. Most health boards regularly reviewed a range of workforce performance measures on appraisal and compliance with training rates, sickness levels, and planned versus actual staffing levels. However, not all health boards reported key information such as capacity versus demand and reporting turnaround times. All heath boards had scope to further develop the range of performance measures to support business reports by reviewing existing measures and identifying gaps.

5.13 Five[27] health boards in Wales are members of the radiology NHS Benchmarking Network (NHSBN). The NHSBN undertakes an annual radiology survey of approximately 85 radiology departments across the UK. The survey collects data and allows participants to compare a range of measures relating to staffing and activity levels. Despite the range of information available, the use of benchmarking comparative data in business reports was limited across health boards.

5.14 One of the challenges for health boards when comparing their performance with other health boards is the absence of a standardised radiology activity measurement. When measuring radiology activity, care is needed to ensure that comparisons are like for like. A single image may count as one unit of activity. However, where a patient receives complex or multiple images this may count as one or more units of activities depending on a health board's view.

27 Hywel Dda University Health Board told us it does not participate in the network because it does not have the administrative capacity to complete data collection returns. Powys Teaching Health Board does not participate because comparative data for the health board is limited due to the differences in the radiology service.

5.15 In the absence of standard activity count, the medical classification system, the Systematised Nomenclature of Medicine Clinical Terms (SNOMEDCT), has enabled some activity measurement. SNOMEDCT in an international classification system that allows clinical data to be recorded in a consistent way, as it uses a standardised set of clinical terminology and codes. NHS England is adopting SNOMEDCT as the universal classification and terminology for all health organisations and for all aspects of health. In Wales, SNOMEDCT has only been adopted in radiology and a small number of other specialties. SNOMEDCT automatically applies multiplication for some activities depending on the coding applied. However, comparisons of activity between radiology departments has to be treated with caution as any count of activity is reliant on organisations recording activity using SNOMEDCT consistently. At the time of the audit that was not the case in Wales, meaning that even with SNOMEDCT in place, there were still difficulties in obtaining meaningful comparisons of activity.

5.16 The Statement of Intent indicated that improving radiology informatics systems must incorporate common international procedure codes to improve benchmarking of radiology services. In addition, the Statement of Intent has set out that a common set of performance indicators will be developed to broaden the range of information collated to drive the improvement of quality and consistency of radiology services.

In most health boards, operational management and accountability arrangements are clear

5.17 Effective leadership and clear lines of accountability are vital components of any healthcare service. Radiology is a complex service, which comprises radiologists, radiographers and nursing staff working together to produce and interpret images. For a health board to deliver effective radiology services, it needs leadership, and an operational and professional management structure with clear lines of accountability.

5.18 Radiology team structures and lines of accountability differ in each health board. Generally, our review found that the operational management and accountability arrangements were clear.

Health boards could do more to proactively make their boards aware of the issues effecting radiology services

5.19 Our review found that there was variation across health boards in the degree to which radiology services are represented at board level. Not all health boards had an executive lead for radiology that was a member of the Board. However, our local work found that service managers were invited to provide updates on radiology issues and risks at board committees (and board meetings where appropriate). Whilst this ensures that risks and challenges are highlighted to Boards and Committees when required, the absence of an executive lead for radiology attending board meetings at some health boards may mean the opportunity to highlight and monitor emerging issues is missed.

5.20 The Welsh Government has published a Statement of Intent in response to challenges being faced by radiology services.

5.21 The Welsh Government's Future Delivery of Diagnostic Imaging Services in Wales and the National Diagnostic Imaging Framework provided a set of measures to be taken forward at local, regional and national level to improve radiology services. The National Imaging Programme Board was established in 2010 to take action at an all-Wales level, and comprises clinical and management representatives from organisations involved in the delivery of imaging services in NHS Wales.

5.22 The National Imaging Programme Board was given delegated authority for developing and implementing a programme of strategic work for radiology through to 2016, and for adopting all-Wales standards and protocols for imaging services in NHS Wales. Although the National Imaging Programme Board has made progress, most notably the progress made in setting up the Academy, there remain significant challenges that require strategic input from the Welsh Government.

5.23 In March 2018, the Cabinet Secretary for Health and Social Services published a high-level Imaging Statement of Intent for radiology services. The Imaging Taskforce is developing a national implementation plan to address the actions set out in the Statement of Intent, and the Taskforce is due to report back to the Cabinet Secretary in summer 2018.

5.24 The Statement of Intent addresses many of the challenges identified through our local audit work and summarised in this report, including:

a Workforce (paragraphs 2.8 to 2.10)

b Equipment (paragraph 3.9)

c Information systems (paragraph 4.10)

d Consistent activity recording (paragraph 5.16)

e Performance indicators (paragraph 5.16)

Appendices

Appendix 1 – Methodology

Appendix 2 – Five-year waiting times trends



Appendix 1 – Methodology

We undertook our review of radiology services at all major hospital sites that provide a range of radiology imaging, including CT and MRI examinations. In Powys Teaching Health Board, we undertook the review at the six hospitals providing X-ray and US examinations[28]. Exhibit 11 provides the hospital sites included in the review.

Exhibit 11: hospital sites that were included in our review

Health Board	Hospital sites included in the review
Abertawe Bro Morgannwg University Health Board	• Morriston Hospital • Neath Port Talbot Hospital • Princess of Wales Hospital • Singleton Hospital
Aneurin Bevan University Health Board	• Nevill Hall Hospital • Royal Gwent Hospital
Betsi Cadwaladr University Health Board	• Glan Clwyd Hospital • Wrexham Maelor Hospital • Ysbyty Gwynedd
Cardiff and Vale University Health Board	• University Hospital Llandough • University Hospital of Wales
Cwm Taf University Health Board	• Prince Charles Hospital • Royal Glamorgan Hospital
Hywel Dda University Health Board	• Bronglais General Hospital • Glangwili General Hospital • Prince Philip Hospital • Withybush General Hospital

28 Powys Teaching Health Board commissions other imaging and interventional procedures, such as MRI and CT scans as well as X-ray and US reporting from a range of providers in neighbouring health boards in Wales and NHS trusts in England. Commissioning arrangements are through service level agreements which cover a range of services including professional support for the radiographers, radiation protection and IT services to archive and share images with health professionals.

Health Board	Hospital sites included in the review
Powys Teaching Health Board	• Brecon War Memorial Hospital • Llandrindod Wells County War Memorial Hospital • Machynlleth Community Hospital • Montgomery County Infirmary • Victoria Memorial Hospital • Ystradgynlais Community Hospital

Our methodology is provided in Exhibit 12.

Exhibit 12: audit approach

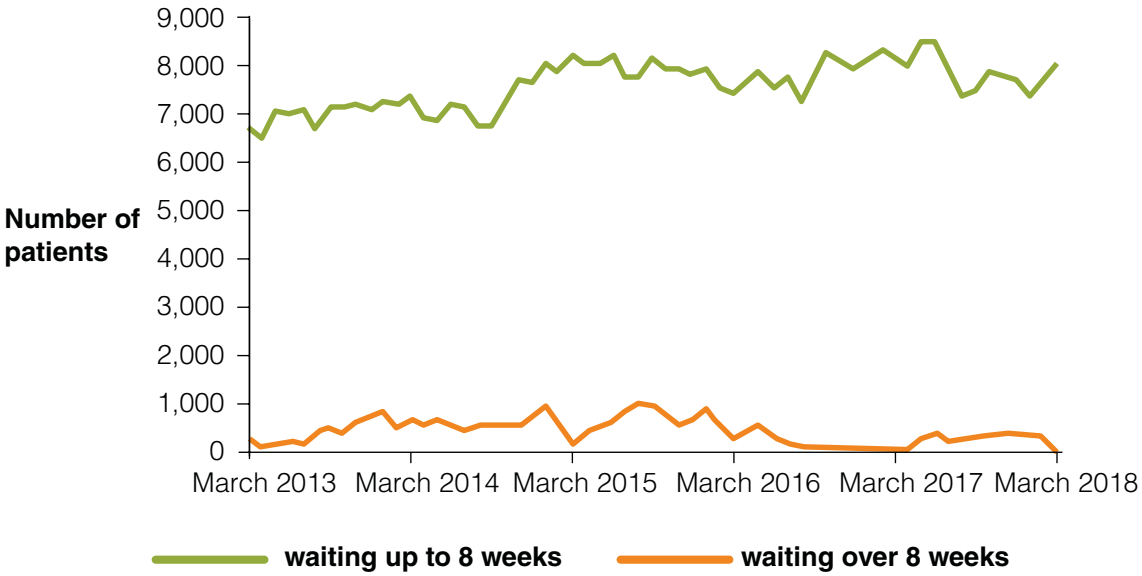
Method	Detail
Information and data collection	We used health board and hospital-site level data collection forms to capture data and information on radiology services. We also utilised data and information from a number of other sources, including: • NHS Benchmarking Network radiology 2015 and 2016 data collection (data collection period 2 May to 8 July 2016); • The All Wales Equipment Capacity Report, NHS Wales Health Collaborative (December 2015); • Stats Wales: Radiology Diagnostic Waiting Times; and • National Reporting and Learning System (NRLS) data: Patient safety incidents.

Method	Detail
Document request	We requested and reviewed documents from each health board, including: • terms of reference and membership of health boards' main radiology groups, together with a sample of minutes from the previous meetings; • examples of condition pathway documents (for stroke, cancer or heart disease) illustrating radiology service provision requirements; • relevant radiology papers to board and committees along with operational papers including safety reports; • examples of each health boards' main radiology service performance reports or performance scorecards from the past six months; • the most recent financial reports showing progress towards the savings/cost improvement plan; • health boards' radiology equipment replacement plans; • health boards' radiology risk registers; • guidance provided to hospital referrers and GPs on expectations when referring patients to the service; and • examples of any work carried out by health boards over the past two years to measure radiology patient experience.
Interviews	We interviewed staff at each health board including: • the Radiology Directorate Manager; • the Radiology Clinical Director; and • a sample of consultants selected by health boards from Surgery, Medicine, Accident and Emergency and Anaesthetics specialties.
Focus groups	We carried out focus groups at each health board of: • Radiographer Senior Leads at each main hospital site; and • GP Locality Leads.

Appendix 2 – Five-year waiting times trends

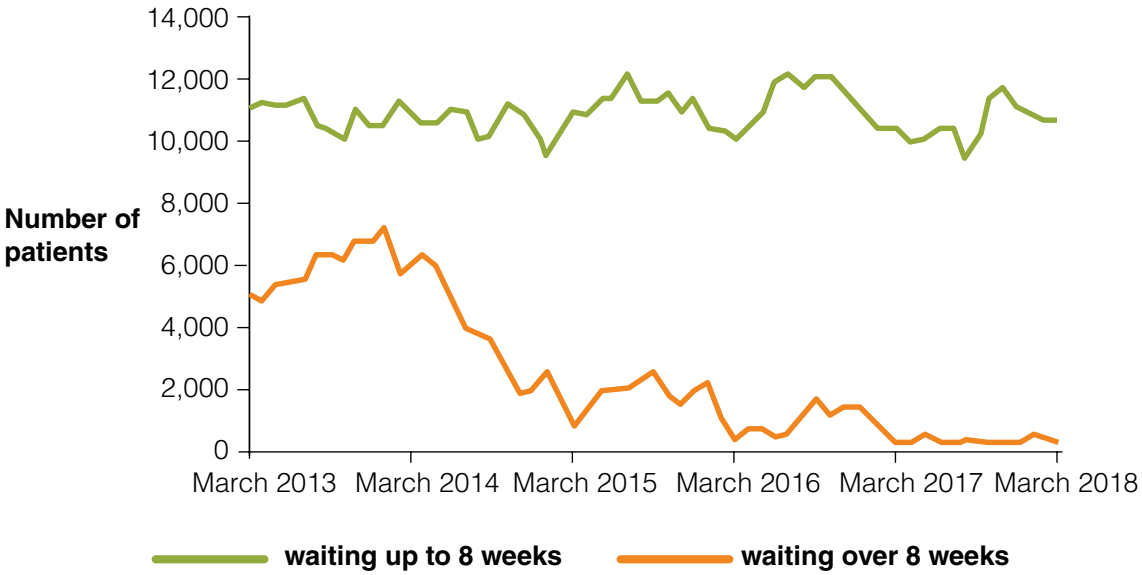
Exhibits 13, 14 and 15 provide the numbers of patients waiting up to eight weeks and more than eight weeks for CT, MRI and US examinations between March 2013 and March 2018.

Exhibit 13: all-Wales CT waiting times trend March 2013 to March 2018



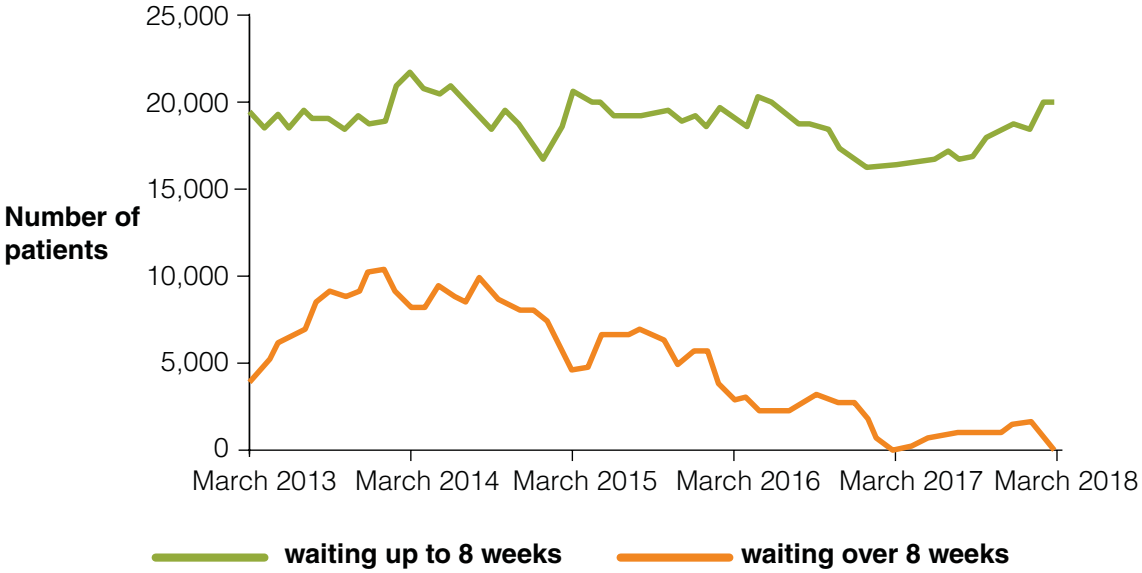
Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

Exhibit 14: all-Wales MRI waiting times trend March 2013 to March 2018



Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

Exhibit 15: all-Wales non-obstetric US waiting times trend March 2013 to March 2018



Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

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Llywodraeth Cymru
Welsh Government

5 Dec 2018

Mr. Adrian Crompton
Auditor General for Wales
24 Cathedral Road
Cardiff
CF11 9LJ

Dear Mr. Crompton,

Response to the Auditor General for Wales Report on: Radiology Services in Wales

Thank you for your report on Radiology Services in Wales, we are grateful for your assessment of these services in Wales. We are working closely with NHS Wales to address the challenges that your report highlights and the recommendations contained within. We have previously shared a draft of our response with your colleagues, attached to this letter is a final copy of the Welsh Government response.

If you have any questions please do not hesitate to contact me.

Yours sincerely



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Annex 1

Response to the Auditor General for Wales Report on: Radiology Services in Wales

Provided by: Dr Rob Orford

Date: 19 November 2018

The Welsh Government welcomes the findings of the report and offer the following response to the four recommendations contained within it.

Recommendation 1 – *The Welsh Government, through the Imaging Taskforce, should ensure that the national imaging implementation plan addresses each of the actions set out in the Imaging Statement of Intent, and the key challenges highlighted in this report*.
Accept – As described in the published Imaging Statement of Intent for Imaging (2018), Welsh Government is working closely with NHS Wales to deliver on the recommendations within the Statement (1).
The Statement addresses many of the challenges identified by the local audit of Radiology Services within Health Boards in 2016 and summarised in this overarching report including: Workforce, Equipment, Information systems, Consistent activity recording and Performance indicators.
The Imaging Taskforce is working to produce a National Imaging Implementation Plan that will provide more granularity as to how each of the challenges described in the Statement of Intent will be addressed. The plan will be shared with the Welsh Audit Office ahead of publication to ensure that the activities contained are consistent with the challenges and recommendations described within this report.

Recommendation 2 – *The national implementation plan should include clear implementation dates to deliver action in the short to medium term, with clearly identified accountabilities for delivery.*
Accept – Welsh Government is working closely with the Strategic Programme Unit within the NHS Health Collaborative to develop the Imaging Implementation Plan. The plan will be developed in accordance with the Managing Successful Programmes (MSP) methodology and will clearly describe deliverables, milestones, objectives, outputs and outcomes for each of the areas as well as identifying those accountable for delivery.

Recommendation 3 – *The Welsh Government should properly cost the implementation plan and ensure that the necessary resources are in place to support delivery.*
Accept – The resources required to support the Imaging Implementation Plan and how these will be acquired, used and shared effectively will be considered and defined by the Strategic Programme Unit in a Resource Management Strategy (MSP). Prior to approval, national imaging programme costings will be scrutinised by Welsh Government to ensure that resource allocation is proportionate to the level of activity required to achieve the desired outcome.

Recommendation 4 – *The Welsh Government should ensure the necessary arrangements are put in place to monitor delivery of the national implementation plan.*
Accept – In keeping with recommendations from the Organisation for Economic Co-operation and Development review of Healthcare Quality in the UK (2016); Parliamentary Review of Health and Social Care (2016) and actions arising from Healthier Wales (2018) Welsh Government have worked closely with the NHS Health Collaborative to develop a new collaborative and nationally directed approach to strategic programmes; such as imaging (2-4). This approach supports a clearer working arrangement between NHS Wales and Welsh Government and includes regular monitoring of progress against programme activities.

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There is an interactive version of this document, please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

January 2019

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Expenditure on agency staff by NHS Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

	Introduction	5
1	Expenditure on agency staff by NHS Wales has increased markedly in recent years	8
	Definition of agency expenditure	9
	Expenditure on agency staffing	10
	Distribution of agency expenditure	13
	Agency expenditure as a percentage of total pay expenditure	14
	Real-term growth in total pay expenditure and staff numbers	16
	Factors that have contributed to increased agency expenditure	18
2	About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited	19
	Reasons for using agency staff in 2018-19	20
	Availability of information about agency staff used	21
3	NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them	22
	National workforce developments	23
	National Initiative – Controlling the cost of nursing agency staff	24
	National Initiative – Controlling the cost of medical and dental agency staff	26

4 We identified two key challenges to improving the management of agency staffing expenditure 28

Developing all-Wales information to better understand and manage agency expenditure and usage 29

Leadership of future initiatives to manage agency and other temporary staffing expenditure 30

Introduction

The NHS in Wales employs almost 80,000 full-time equivalent staff, excluding General Practitioners and those employed directly by General Practices, spending £3.62 billion on pay in 2017-18.

But NHS Wales also needs to use additional staff to supplement the full-time workforce so that they can continue to deliver services when:

- key posts are vacant;
- staff are on sick leave, on holiday or absent for some other reason; or
- demand for services increases because of, for example, winter pressures.

The seven Local Health Boards and three NHS Trusts (collectively referred to as health bodies in this report) secure the services of temporary staff from:

- substantive staff paid overtime to work additional shifts;
- internal staff banks, which typically include staff who have substantive contracts at the health body or at a neighbouring health body, as well as other suitably qualified staff who prefer to be able to choose where and when they work;
- private-sector agencies, who charge a fee for supplying staff; and
- people who enter into a direct contract with the health bodies on ad hoc terms of engagement. Some of these people may also have substantive contracts within the NHS.

Staff working on a temporary basis generally cost more for a shift than a person of the same grade who has a substantive contract. Staff supplied by agencies tend to be the most costly source of temporary staff. NHS bodies in Wales collectively spent over £160 million on agency staff in 2016-17, more than four times the equivalent figure for 2012-13. There have also been large increases in agency expenditure in other UK countries.

The scale and rapid growth of expenditure on agency staffing have created considerable media and public interest, not least because of the financial pressures faced by NHS bodies. NHS Wales has responded through a range of national and local initiatives aimed at reducing demand and controlling costs.

This report sets out key facts about the use of agency staff by NHS bodies in Wales, including:

- expenditure;
- analyses by health bodies of underlying reasons;
- national initiatives to control this type of spending; and
- challenges that lie ahead.

The report, together with the data tool we have developed, aims to:

- offer insight, enabling readers to conduct their own analyses; and
- promote improvement by sharing information about initiatives to curb spending on agency staff and highlighting issues for the NHS to consider when developing future initiatives aimed at managing agency expenditure.

It does not attempt to evaluate the use of agency staff or the effectiveness of the actions taken to control costs. This report and information gathered when preparing it will also be used to inform the planning of the Auditor General's forward programme of national and local audit work.

Agency expenditure in **2017-18**



£135.7m

Proportion of agency expenditure by staff group in **2017-18**

Medical and dental



44%

Nurses and registered midwives



38%

Other



18%

Agency expenditure as a proportion of total NHS pay in **2017-18**





About **82%** of agency expenditure in **2018-19** is providing cover for vacant positions

Part 1 – Expenditure on agency staff by NHS Wales has increased markedly in recent years

Agency expenditure in 2017-18 was £135.7 million, a rise of 171% over seven years. (See Definition of agency expenditure on page 9). After a period of stability, it grew significantly after 2013-14, peaking at £164.4 million in 2016-17. (See Expenditure on agency staffing on page 10)

On average, health bodies in Wales have spent nearly half their total agency expenditure on medical and dental staff since 2014-15 and a further third on nurses and midwives. (See Distribution of agency expenditure on page 13)

Agency expenditure as a proportion of total pay increased from 1.6% of total pay in 2013-14 to 4.7% in 2016-17, before falling to 3.7% in 2017-18. (See Agency expenditure as a percentage of total pay expenditure on page 14)

Real term growth in total pay expenditure has outpaced the growth in staff numbers in recent years, reflecting the sharp increase in agency expenditure. (See Real-term growth in total pay expenditure and staff numbers on page 16)

Factors that have contributed to the rise in agency expenditure include:

- escalating hourly rates of pay charged by agencies and individuals engaged directly by health bodies;
- increase in demand for services;
- skill shortages;
- difficulties recruiting and retaining staff;
- meeting the requirements of the Nurse Staffing Levels Act (Wales) 2016; and
- individuals choosing to work through agencies.

But there is no national analysis of just how much each of these factors has contributed to the increase in agency spending. (See Factors that have contributed to increased agency expenditure on page 18)

Definition of agency expenditure

The definition of 'agency expenditure' in this report is set out below. It is the definition provided in Welsh Health Circular WHC 2018/017, '2018-19 LHB & Trust Monthly Financial Monitoring Return Guidance' that is used by Local Health Boards (LHBs) and NHS Trusts (Trusts) to report on agency and locums (paid at a premium) expenditure in their monthly financial monitoring returns to Welsh Government.

Agency expenditure includes:

- staff not employed by the LHB or Trust and therefore not in receipt of payments through its payroll. This would include staff employed through Agencies, Self Employed Individuals etc.
- staff employed by another NHS organisation who are undertaking sessional work within the LHB or Trust, and again are not in receipt of payments through the LHB's or Trust's payroll for whom the work is being undertaken, which are paid at a premium.

Expenditure excludes:

- staff that are employed by the LHB or Trust, who undertake additional work on a temporary basis for another department within the same LHB or Trust or at another hospital site within the same LHB or Trust.
- any staff employed on a temporary basis or fixed term contract but who are in receipt of payment through a LHB's or Trust's payroll, on terms and conditions defined by that LHB or Trust.

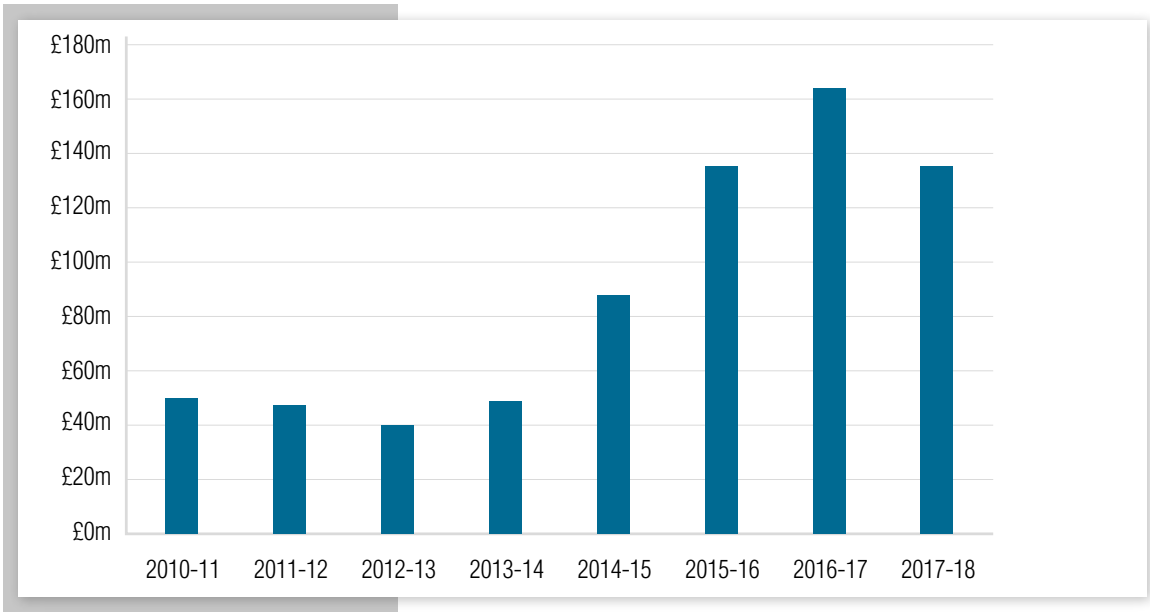
  Locums 'paid at a premium' are those paid above the rate of the substantive post holder.

The above definition, and all data in this report, exclude doctors and dentists who are General Practitioners, because they are independent NHS contractors. The analysis also excludes staff who are employed directly by General Practices.

Expenditure on agency staffing

Expenditure on agency staff was relatively stable until 2013-14, after which there was a sharp increase, with expenditure peaking at £164.4 million in 2016-17.

Exhibit 1: total NHS expenditure in Wales on agency staff between 2010-11 and 2017-18



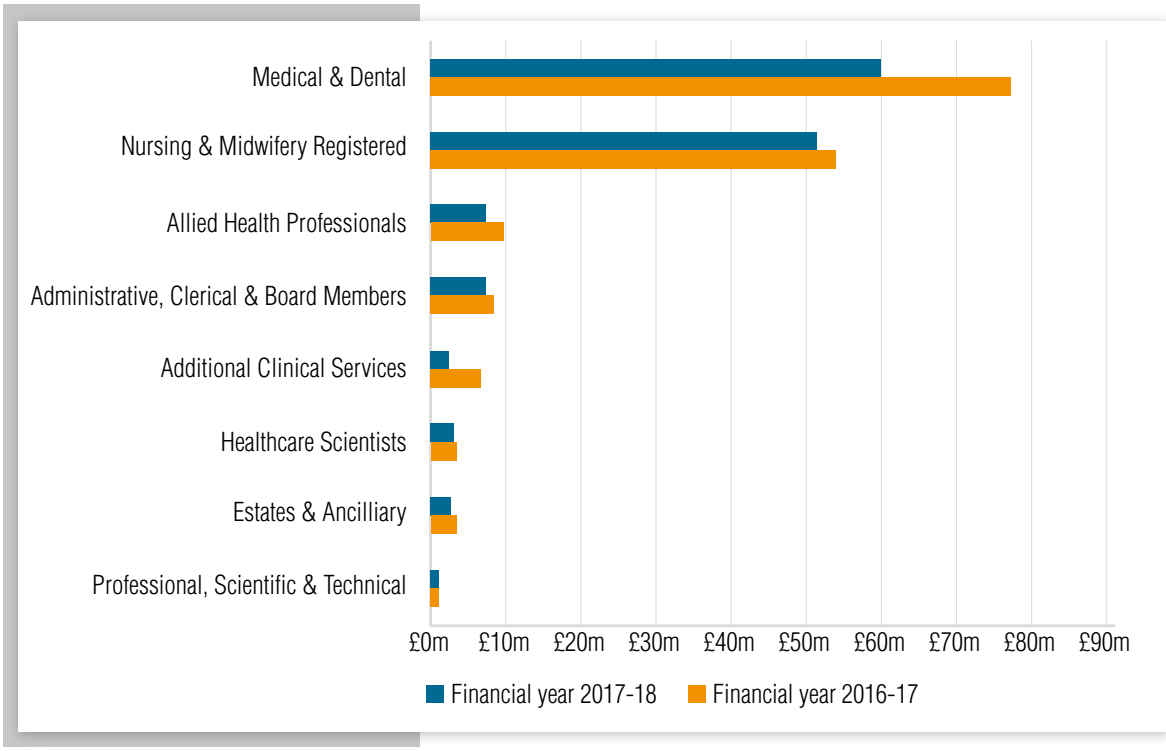
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership



This link opens a data tool that will allow analysis of expenditure on agency staff at each health body over the period 2010-11 to 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

There was a fall in total agency expenditure in 2017-18 of £28.7 million. Expenditure fell in all staff categories except one.

Exhibit 2: NHS expenditure in Wales on agency staff by staff group for 2016-17 and 2017-18



Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

The largest reduction in expenditure was for Medical and Dental agency staff, where expenditure fell by over £17 million. There was a further reduction of £2.4 million in expenditure on Nursing and Midwifery agency staff. However, the scale of reduction varied widely between health bodies.



This link opens a data tool that will allow analysis of the changes in expenditure on the different agency staff groups at each health body between 2016-17 and 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

A reduction in agency expenditure may be offset by increases in other elements of the NHS pay bill, but a breakdown of variable pay elements is not provided in the financial monitoring returns submitted by health bodies to Welsh Government.

The reported falls in agency expenditure may, in part, be because changes to the method of paying agency staff and locums result in expenditure falling outside the definition of agency expenditure in the monthly financial returns to Welsh Government.

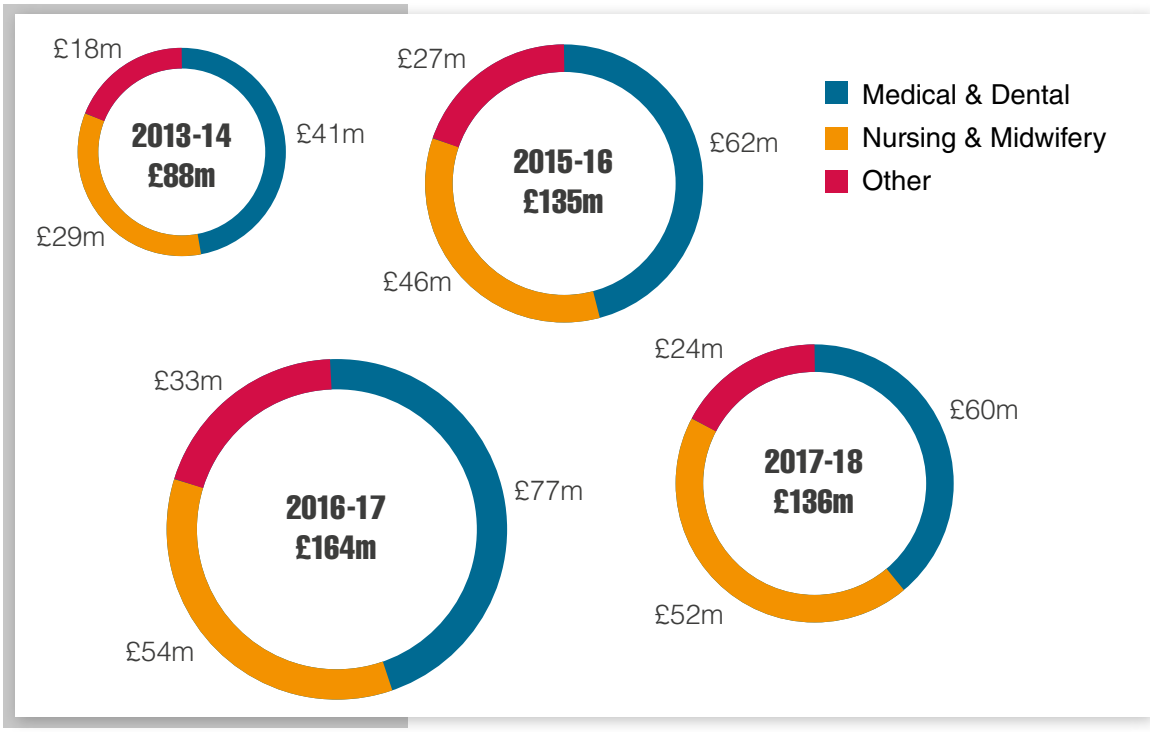
A national working group (the Medical Workforce Efficiency Group) is leading a project to improve the consistency of coding locum variable pay.

Distribution of agency expenditure

Health bodies use agencies to provide all types of staff, but expenditure on doctors and nurses represents about 80% of total agency expenditure.

Although total agency expenditure increased significantly between 2014-15 and 2016-17, Exhibit 3 shows that the proportion spent on each staff group has remained broadly constant.

Exhibit 3: the distribution of agency expenditure by staff group between 2014-15 and 2017-18



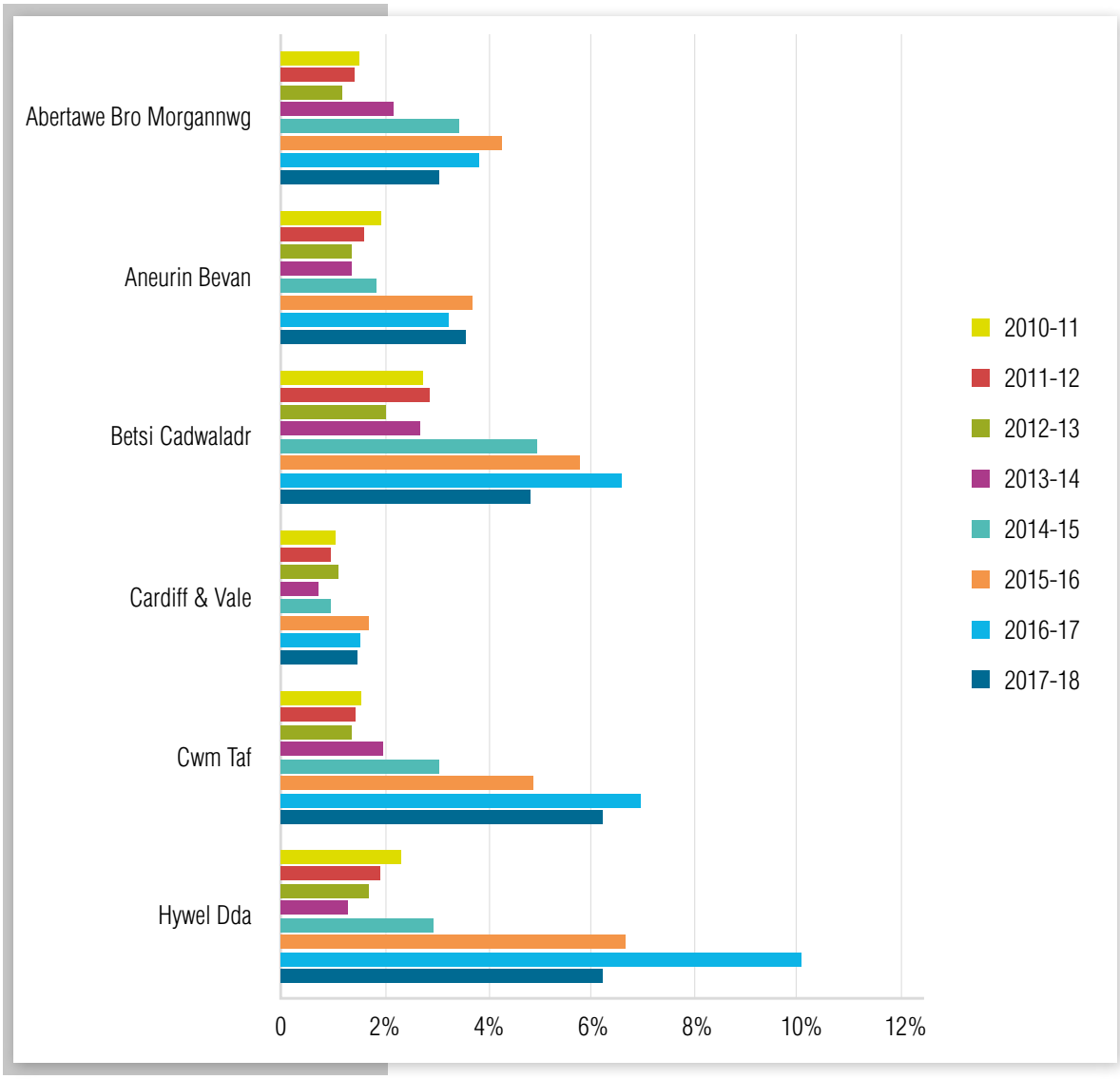
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

Agency expenditure as a percentage of total pay expenditure

In 2010-11, expenditure on agency staff represented only 1.7% of total pay across the 10 health bodies in Wales. By 2016-17, the proportion had increased to 4.7%, before falling to 3.7% in 2017-18.

In most health bodies in Wales, there was a significant growth in expenditure on agency pay as a proportion of total pay between 2014-15 and 2016-17, followed by a small decrease in 2017-18.

Exhibit 4: total expenditure on agency staff as a proportion of total pay in the six largest health bodies in Wales between 2010-11 and 2017-18



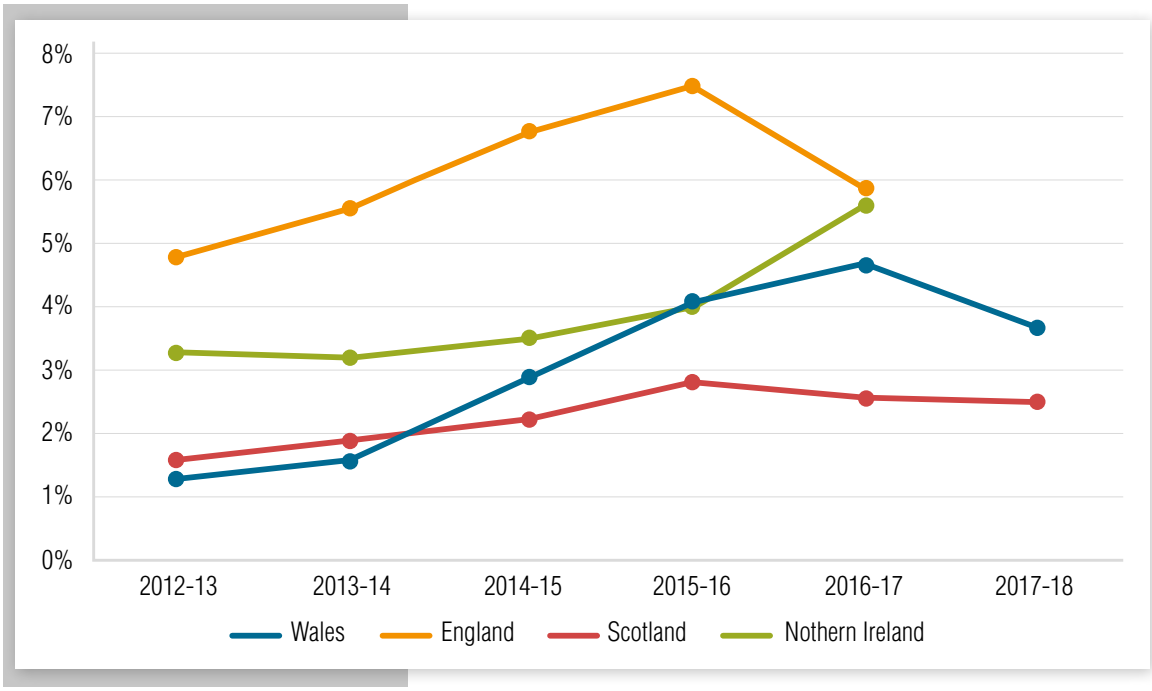
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership



This link opens a data tool that will allow analysis of total agency expenditure as a percentage of total pay expenditure at each health body between 2010-11 and 2017-18.
https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

Significant increases in NHS expenditure on agency staff have not been confined to Wales, with high levels also being seen in England and Scotland. The scale of expenditure across the United Kingdom is different, but the trend in agency expenditure as a proportion of total pay expenditure is similar.

Exhibit 5: total agency expenditure as a proportion of total NHS pay in Wales, England, Scotland and Northern Ireland between 2012-13 and 2017-18



Note: The data for 2017-18 are not yet available for England and Northern Ireland.

Sources: Data received and collated by NHS Wales Shared Services Partnership, the National Audit Office, Audit Scotland and the Northern Ireland Audit Office from financial returns and accounts

Real-term growth in total pay expenditure and staff numbers

On 30 September 2017 the NHS in Wales employed almost 80,000 full-time equivalent staff, excluding General Practitioners and those employed directly by General Practices.

The composition of the workforce is shown in Exhibit 6.

Exhibit 6: number of full-time equivalent staff directly employed by health bodies in Wales by staff group on 30 September 2017

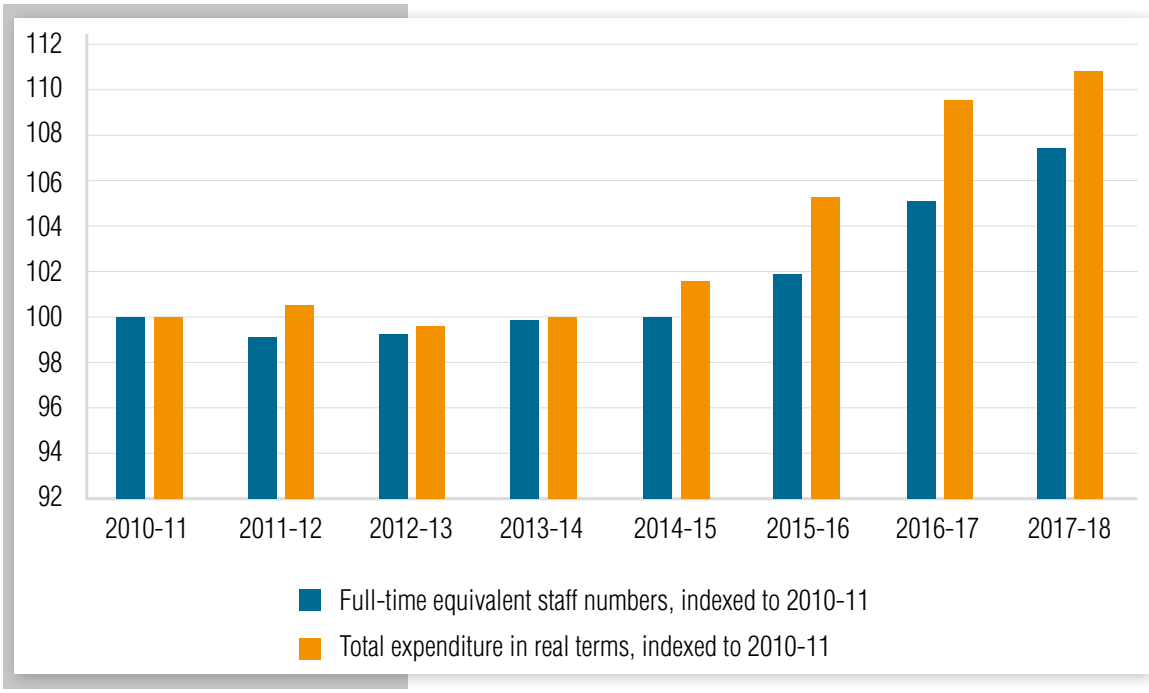
Staff group	Number of full-time equivalent staff at 30 September 2017	Proportion of workforce
Medical and dental staff	6,321	8.1%
Nursing, midwifery and health visiting staff	29,524	37.9%
Administration and estates staff	17,384	22.3%
Scientific, therapeutic and technical staff	12,799	16.4%
Health care assistants and other support staff	9,704	12.5%
Ambulance staff	2,084	2.7%
Other non-medical staff	101	0.1%
Total	**77,917**	**100%**

Source: NHS staff by staff group and year, StatsWales

The NHS workforce increased by 7.5% between September 2010 and September 2017. Medical and dental full-time equivalent staff numbers increased by 12.1% during this period and nursing, midwifery and health visiting staff increased by 4.7%.

Total pay expenditure increased from £2.92 billion in 2010-11 to £3.62 billion in 2017-18, an increase of almost 24% in cash terms. Exhibit 7 shows real-term growth in total pay expenditure since 2010-11 and compares it with the increase in full-time equivalent staff numbers. The graph shows that, from 2014-15, both staff numbers and total pay began to increase, with total pay in real terms accelerating more quickly than full-time equivalent staff numbers.

Exhibit 7: real-terms comparison of full-time equivalent staff numbers against total NHS pay expenditure in Wales between 2010-11 and 2017-18



Source: Wales Audit Office calculations, drawing on data provided by Workforce, Education & Development Services, NHS Wales Shared Services Partnership

The growth in total pay expenditure relative to staff numbers shown in Exhibit 7 cannot be explained by pay inflation among staff on substantive contracts, given that NHS staff have faced pay caps in recent years. Although not the only possible explanation, the growth in total pay is consistent with a significant increase in expenditure on temporary staff, whether via agencies or from other sources.

Factors that have contributed to increased agency expenditure

The increase in expenditure on agency staffing is due to a range of factors that include:

- escalating hourly pay rates;
- increases in demand for services and changes to the way in which health services are delivered;
- skill shortages;
- difficulties recruiting and retaining staff;
- levels of sickness absence;
- the need to comply with the requirements of the Nurse Staffing Levels Act (2016); and
- actions taken in England to drive down agency expenditure making it more attractive to agencies to focus more directly on the market in Wales.

We were told that increasing numbers of doctors and nurses choose to work for agencies or on a self-employed basis rather than being employed directly by the NHS.

Anecdotal evidence suggests that the lack of public sector pay growth has been a key factor for people registering with agencies for additional shifts or simply leaving substantive posts to work for an agency.

Findings published in the National Institute of Economic and Social Research report 'Use of Agency Workers in the Public Sector', produced in 2017, suggest that other factors attracting individuals to agency work include:

- valuing highly the preference for flexible working and improved work-life balance, with the opportunity to pick and choose shifts to suit their needs;
- dissatisfaction with working conditions and workloads within the NHS;
- being paid more quickly, as agencies generally make weekly payments; and
- younger generations attaching less importance to job security and pensions, and their desire to experience career breaks.

Part 2 – About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited

Financial projections by health bodies indicate that £90 million (77% of total forecast agency expenditure) will be spent to cover vacant posts in 2018-19.

For the first six months of 2018-19 about 82% of total agency expenditure was covering vacancies, with most of the remainder covering additional activity and sickness absence. (See Reasons for using agency staff in 2018-19 on page 20).

Each health body holds data on how many agency staff they use, and why. But there is still no all-Wales analysis of how many doctors, nurses and other staff are being hired through agencies, their specialties and their grades. The NHS is developing arrangements at an all-Wales level to better understand nursing and medical agency usage, which are the two largest areas of spend. (See Availability of information about agency staff used on page 21)

Reasons for using agency staff in 2018-19

The NHS in Wales has only recently begun to analyse at a national level the reason for each instance of hiring agency staff.

The financial position of individual organisations and the overall financial health of NHS Wales is monitored using monthly financial returns submitted by each health body to Welsh Government. Since April 2018 these financial returns require health bodies to provide an analysis of the reasons for incurring agency expenditure.

Most of those we spoke to in preparing this report were confident that the need to cover vacant posts accounted for most expenditure on agency staff. The financial returns by health bodies bear out this confidence.

- 77% of forecast agency expenditure for 2018-19, reported by health bodies at the end of April 2018, was to cover vacant posts; and
- 82% of the £66.8 million spent on agency staff during the first six months of 2018-19 was covering vacancies. Six per cent of the reported agency expenditure reflected the need to cover for sickness absence, while 8% was needed for additional activity.

Vacancies are reported at a national level based on ‘advertised’ posts. NHS Wales acknowledges that this reported data about the number and nature of vacancies is only a proxy for the true number of vacancies and does not give the true vacancy position.

Most organisations do not have a defined substantive staff complement to give a baseline to measure vacancies. Reporting vacancy rates based on ‘advertised’ posts can lead to:

- ‘double counting’ of vacancies because posts may be advertised more than once before they are filled; and
- vacant positions not being reported if the position is not being recruited to.

We found that, despite the reported link between agency expenditure and vacancies, there is no correlation between month-to-month changes in the number of advertised vacancies and corresponding fluctuations in agency spend.

Availability of information about agency staff used

Health bodies hold data on how many agency staff they use, who the individuals are and what they are used for. But this data is not collected in a common NHS-wide system, nor is it shared with other health bodies.

By not sharing information there is a risk that individuals may work excessive hours across different health boards, potentially putting patient safety at risk. Also, it is harder for NHS Wales to prevent fraudulent practices, such as people working for agencies whilst on sickness absence from their NHS employer.

Data produced at a national level on agency usage is limited but is developing. To better understand the use of agency doctors and nurses, which are the two largest areas of agency spend:

- spending data on agency nurses that is collected by a sub-group of the Temporary Nurse Staffing Capacity Steering Group is being converted to whole-time equivalent staff for each agency supplier since April 2017. This gives a better understanding of the volume of agency staff engaged as well as the cost. However, the data is collected independently of the financial monitoring returns submitted by health bodies to Welsh Government and is not consistent with the agency spend reported by Welsh Government.
- health bodies are submitting data about their use of agency and locum doctors to Welsh Government following the introduction of Welsh Health Circular 2017-042 ‘Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales’ in October 2017 (see National Initiative – Controlling the cost of medical and dental agency staff on page 26 for detail on the Circular). However, the data reflects ‘bookings’ made in the month rather than expenditure incurred. The bookings may be worked and paid for over a period covering more than one month or may not be worked in full if it is a ‘call off’ booking.

Part 3 – NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them

In seeking to reduce agency expenditure, NHS Wales bodies generally deploy a two-pronged combination of:

- reducing the need to hire agency staff; and
- where they are hired, paying less than before to do so.

NHS managers generally hire agency staff only as a last resort. Initiatives at individual health bodies to reduce the demand for agency staff focus mainly on: recruiting and retaining more staff; reducing sickness absence; and improving rota management and job planning.

NHS Wales has put in motion a number of national workforce initiatives aimed at increasing the attraction of the health service as an employer and therefore reducing the demand for agency staff. (See National workforce developments on page 23)

The demand for agency staff has fuelled competition between health bodies and driven up rates of agency pay, particularly in areas of skill shortages. Health bodies are working together via all-Wales working groups to control the cost of using nursing and medical agency staff. In this report we profile two national initiatives:

- the introduction in 2017 of capped rates of pay for nursing agencies with a focus on eradicating 'off-contract' agency usage, led by the Temporary Nurse Staffing Capacity Steering Group. (See National Initiative – Controlling the cost of nursing agency staff on page 24)
- the introduction of arrangements in November 2017 to drive down both the volume of medical and dental agency and locum use and its cost, which took account of detailed work undertaken by the Medical Workforce Efficiency Group. (See National Initiative – Controlling the cost of medical and dental agency staff on page 26)



This link opens a data tool that will allow analysis of expenditure on Medical & Dental and Nursing & Midwifery agency staff at the six largest health bodies between 2012-13 and 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

National workforce developments

National workforce developments and initiatives aimed at increasing the attractiveness of NHS Wales as an employer, and therefore reducing the demand for agency staff, include:

- the recent creation of the special health authority Health Education and Improvement Wales whose key functions include: education and training, workforce development and modernisation, leadership development, strategic workforce planning, workforce intelligence, careers and widening access.
- the campaign to attract high calibre health professionals by promoting Wales as an excellent place for doctors and dentist to train. The campaign[1] promotes initiatives such as:
  - the Less Than Full-Time Training policy;
  - the Wales Clinical Academic Track (WCAT) scheme; and
  - the new education contract for junior doctors which ring-fences time for learning opportunities during the working week to support career development, a UK first.
- The Train Work Live national campaign launched in 2016 to promote Wales as an attractive place to work for GPs and other doctors.
- The recent pay agreements for the NHS Wales workforce. The pay deals agreed for doctors, nurses and other NHS staff include a range of pay and non-pay measures aimed at providing better terms and conditions for NHS Wales staff and thereby improving recruitment and retention within the workforce.

1 https://www.walesdeanery.org/future-doctors-and-dentists-–-come-and-train-wales/future-doctors-and-dentists-–-come-and-train

National Initiative – Controlling the cost of nursing agency staff

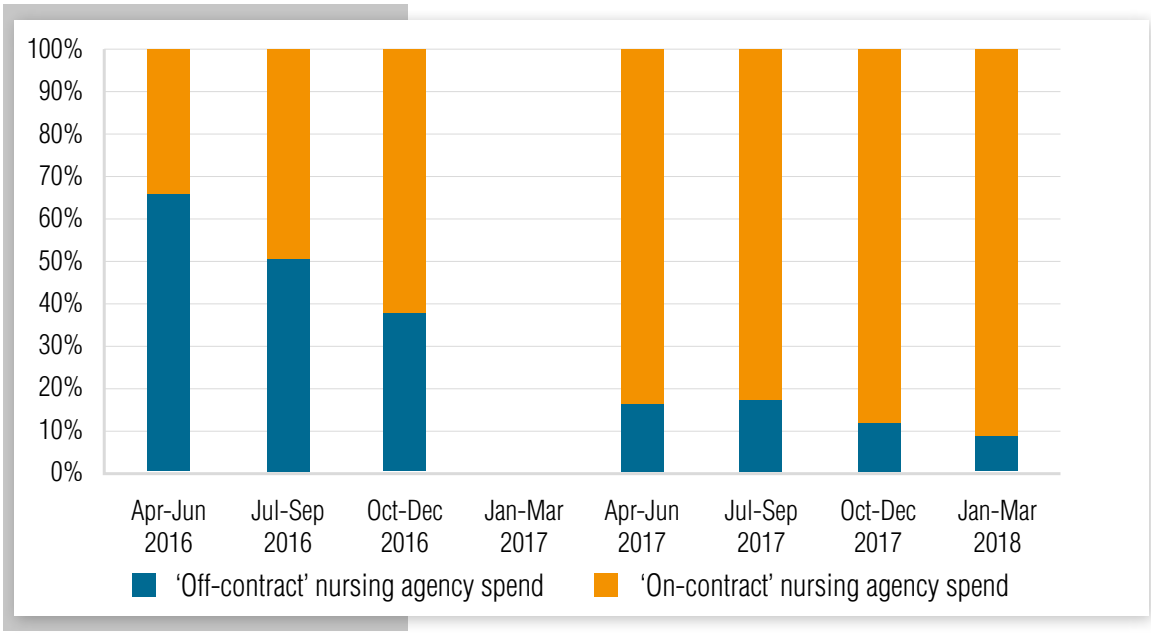
Framework agreements for supplying agency nurses have been in place since 2006. Such agreements avoid the need for each health body to conduct procurement exercises before hiring agency staff. The current All Wales Agency Framework Contract came into effect on 1 April 2017 and introduced capped hourly rates of pay to nursing agencies. The contract has a duration of 24 months with the option to extend for up to a further two years.

Suppliers of agency nurses through a framework contract are referred to as 'on-contract' agencies. Agencies that are not part of a framework contract, referred to as 'off-contract' agencies, generally have a higher hourly charge to health bodies than 'on-contract' agencies.

The Temporary Nurse Staffing Capacity Steering Group was set up in 2015 to explore how health bodies in Wales can work together to address the growing concern over high cost and escalating nursing agency spend. The group aims to eradicate the use of 'off-contract' agencies to meet the demand within NHS Wales for temporary nurses.

Exhibit 8 shows there has been a reduction in the proportion of nursing agency expenditure. 'Off-contract' agency spend across Wales fell from 65% at the beginning of the 2016-17 financial year to an average of 14% for the 2017-18 financial year.

Exhibit 8: proportion of nursing agency expenditure spent with 'off-contract' and 'on-contract' agencies



Note: Data for the period January 2017 to March 2017 is not available.

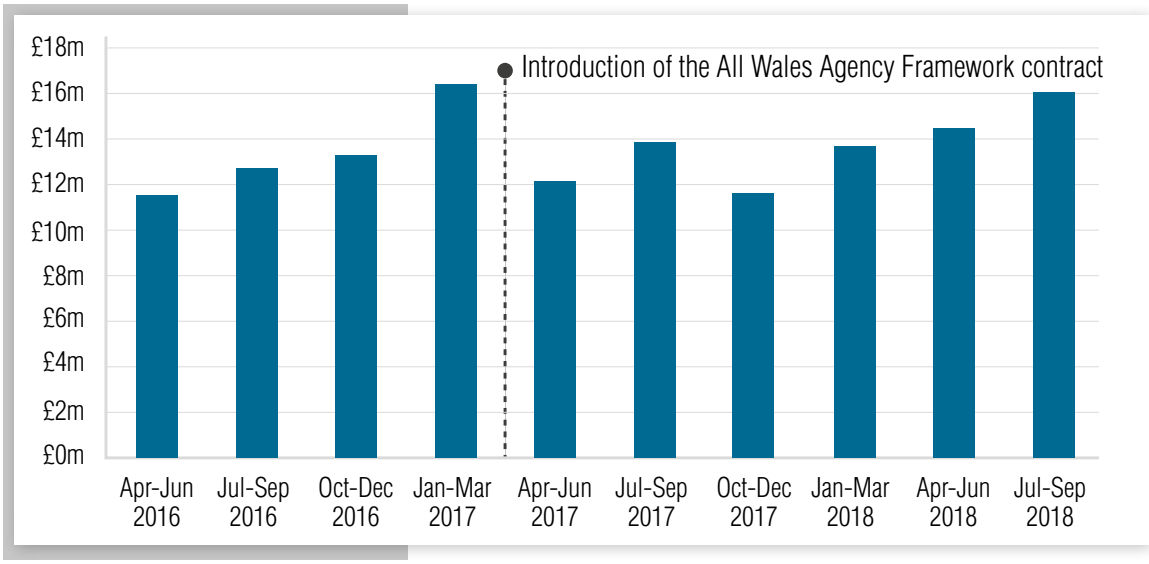
Source: NHS Wales Shared Services Partnership

We were told that two main factors have been instrumental in achieving this significant and consistent decrease in the use of 'off-contract' nursing agencies:

- the commitment from health bodies to use agencies on the framework contract as much as possible and not to breach the contract's capped rates; and
- setting capped rates that are deemed to be good but not excessive so that the framework contract can supply the agency nurses needed.

Despite the success in reducing the proportion of 'off-contract' agency expenditure, Exhibit 9 shows that agency expenditure on nurses and midwives in the first two quarters of 2018-19 is greater than it was in the corresponding periods in 2016-17 and 2017-18. Data is not available to fully explain the reasons for expenditure increasing.

Exhibit 9: expenditure on Nursing and Midwifery Registered agency staff from April 2016 to September 2018



Source: Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

National Initiative – Controlling the cost of medical and dental agency staff

Welsh Government issued Welsh Health Circular 2017-042, 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' (the Circular) in October 2017.

The Circular sets out the arrangements for:

> **'a programme of coherent and coordinated system-wide action across the NHS in Wales aiming to drive down agency and locum deployment and expenditure whilst maintaining the delivery of a safe and sustainable service across Wales'.**

The programme aims to:

> **'encourage return of people to the NHS labour market so improving regular workforce supply and quality and consistency of care to patients; increasing the equity and transparency of reward systems and reduction of internal wage competition; and reduce the overall spend whilst we focus on the underlying causes'.**

The Circular was developed by Welsh Government in partnership with the NHS in Wales, taking account of detailed work undertaken by the Medical Workforce Efficiency Group. This group was established in 2017 with aims and objectives that, if achieved, should reduce both reliance on and cost of agency doctors across NHS Wales. The membership of this group is drawn from Welsh health bodies and NHS Wales Shared Services Partnership.

The Circular sets out a national control framework of limits and targets for agency and locum deployment and expenditure, clearly defining the respective roles and responsibilities of Welsh Government and health bodies, and setting out a performance management regime at local and national levels.

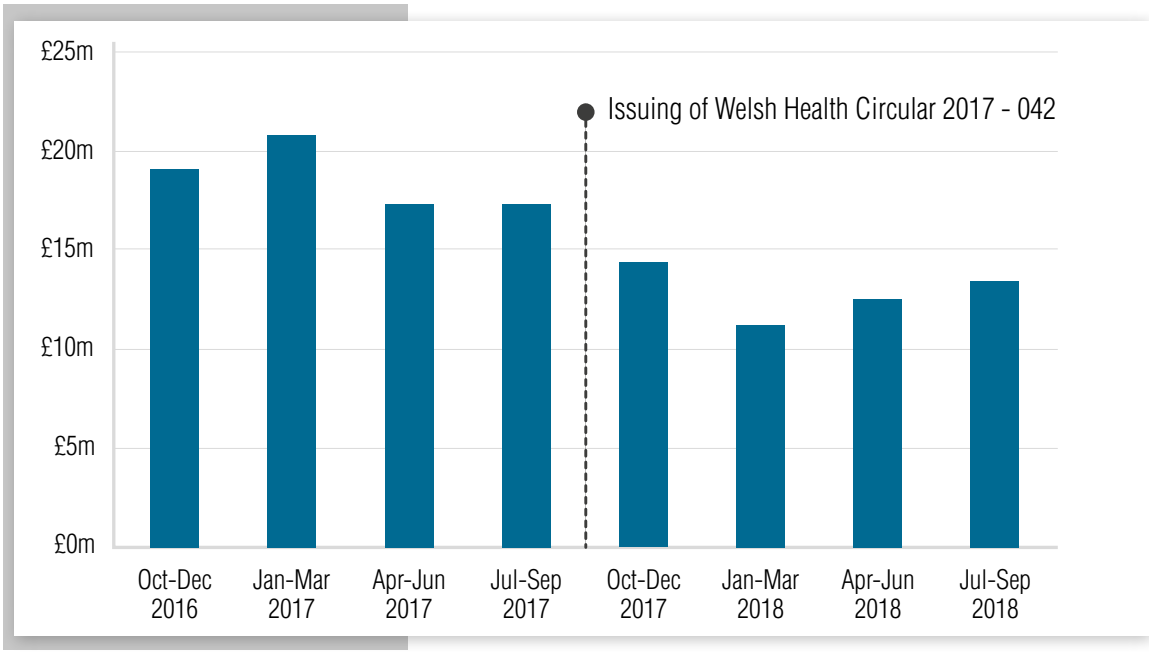
A key feature of the control framework is the introduction of price caps for all medical and dental agency workers. The framework includes provision for health bodies to override the price caps under prescribed circumstances, which is not the case for nursing agency staff.

The Circular has improved controls over the authorisation of expenditure. The price caps can only be breached following internal escalation processes that require authorisation at Executive level following a robust risk assessment of the impact on patient safety.

The Circular refers to the establishment of a Workforce Delivery Unit to provide central capacity for scrutiny, identifying and sharing effective practices and targeted interventions to tackle specific issues or priorities. The Workforce Delivery Unit would also analyse the monthly data returns submitted by health bodies on medical and dental agency usage set out in the Circular 2017. The Workforce Delivery Unit had not been established at the end of our fieldwork.

Exhibit 10 shows that since the introduction of the Circular in November 2017, expenditure on medical and dental agency workers has reduced. However, the lack of data available means that NHS Wales is unable to ascribe the entire fall in expenditure to the impact of the Circular. Other factors may have contributed to this reduction, such as the hiring of fewer staff and the use of alternative temporary staffing solutions.

Exhibit 10: expenditure on Medical and Dental agency staff from October 2016 to September 2018



Sources: Workforce, Education & Development Services, NHS Wales Shared Services Partnership, and Welsh Government

Part 4 – We identified two key challenges to improving the management of agency staffing expenditure

This report does not attempt to evaluate the effectiveness of the actions taken to control the use of agency staff. However, we have identified two factors that we consider key to underpinning the management of agency expenditure in the wider context of temporary staffing across NHS Wales.

1 To gain a deeper understanding of the root causes of agency spend NHS Wales needs consistent and comparable data at an all-Wales level on:

- the volume, nature and cost of agency staff used; and
- the impact of changes in agency expenditure on other temporary staffing costs, such as overtime and internal staff banks. (See Developing all-Wales information to better understand and manage agency expenditure and usage on page 29)

2 The working groups established by NHS Wales to reduce nursing and medical agency costs are delivering much of what they set out to achieve. But the next steps in managing agency expenditure are expected to require the consistent implementation of difficult decisions across Wales. To achieve this, future projects to manage agency and other temporary staffing expenditure will therefore need strong leadership and the capacity to drive change in a timely fashion. (See Leadership of future initiatives to manage agency and other temporary staffing expenditure on page 30)

Developing all-Wales information to better understand and manage agency expenditure and usage

Information on agency cost and usage at a national level is limited. Data is held by individual organisations but is not easily accessible in a consistent form.

We consider that action to further develop two data-related themes is necessary to manage agency expenditure more effectively at a national level.

1

The ability to access and share consistent and comparable data held by individual NHS organisations at an all-Wales level.

This will allow information to be produced that is detailed enough to understand and explain:

- the volume of agency staff used;
- the frequency and regularity with which they are used;
- the roles they fill;
- the reason for needing them; and
- the cost.

Such information has the potential to inform and significantly enhance workforce planning across NHS Wales.

2

The ability to assess agency spend and usage data in the context of other temporary staffing costs.

A fall in agency spend or usage may lead to increases in other areas of temporary staffing such as overtime and internal bank working.

NHS Wales needs to be capable of evaluating reductions in agency expenditure and fully understanding consequential changes in agency expenditure on other forms of temporary staffing.

Leadership of future initiatives to manage agency and other temporary staffing expenditure

The Temporary Nurse Staffing Capacity Steering Group and Medical Workforce Efficiency Group have made positive contributions to reducing agency expenditure and are delivering much of what they set out to achieve. The groups rely heavily on the commitment of members and on partnership working. But, at times progress with developing and implementing change is hampered by:

- difficulties in reaching consensus before making decisions; and
- the lack of staff capacity to carry out work outside meetings of the groups.

In our view, a step change is needed to drive forward projects focusing on managing temporary staffing expenditure with greater pace and consistency.

Future national projects that are set up to manage expenditure on agency and other temporary staffing, such as developing the capacity and usage of staff banks, will need:

- leadership of sufficient seniority and membership of sufficient authority to make difficult decisions and drive change in a consistent way across the whole of NHS Wales;
- the financial, staffing and technological support needed to support and deliver the work; and
- a structure that is closely linked with wider workforce planning considerations.

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Agenda item 6.1

AUDIT COMMITTEE FORWARD WORK PLAN 2019/20

Meeting Date – 1 APRIL 2019	**Lead**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP)	Director of Finance
• Audit Recommendations Tracker Report	Board Secretary
• Losses and Special Payments Report	Director of Finance
• Local Counter Fraud Specialist update report **(CLOSED ITEM)**	'Acting' Director of Finance
• Post Payment Verification Reports to include comparable data from across Wales	Internal Audit & Assurance / Primary Care Lead
• Research & Development Policy for Approval	Director of Finance
• Financial Control Procedure – Medical Variable Pay	Director of Finance
• Standing Orders and SFI's	Board Secretary
CHARITABLE FUNDS	
• Charitable Fund Balances for last quarter	Director of Finance
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Annual Audit Plan 2019/20	Head of Internal Audit

EXTERNAL AUDIT	
• WAO Progress report and any related external audit reviews	Wales Audit Office lead
• WAO Draft Structured Assessment Report 2018 and Management Response (Executive Lead in attendance as appropriate)	Wales Audit Office lead
• Wales Audit Office Annual Audit Report 2018/19	Wales Audit Office lead

• Wales Audit Office – Annual Audit Plan 2019-20	Wales Audit Office lead
ITEMS FOR INFORMATION	
• Only items for information raised in advance with the Chair will be discussed	Chair
• Any other urgent Business	Chair
OTHER ITEMS	
• Referrals to other Committees of the Board • Review of the Committee Forward Work Plan	Chair Chair
PART II MEETING – HOSTED BODIES	
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• WHSSC Audit Recommendations Tracker Report	Committee Secretary
• WHSSC 'Draft' Annual Governance Statement 2018/19	Committee Secretary
• WHSSC CRAF Update	Committee Secretary
• EASC 'Draft' Annual Governance Statement 2018/19	Board Secretary
• EASC Risk Register Update	Board Secretary
AUDIT & ASSURANCE	
• Receipt of Hosted Body Internal/External Audit Reports / Management Responses ○ EASC Unscheduled Care Programme	Audit & Assurance / WAO

MEETING DATE – 13 MAY 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• 'Draft' Annual Accounts & Financial Statements 2018/19	Director of Finance
• 'Draft' Accountability Report 2018/19	Board Secretary
• Finalised Medical Variable Pay Financial Control Procedure	Directors of Finance/Workforce & OD
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Reports outstanding from 2018/19 Internal Audit Plan (any Limited or No assurance audit reports require the lead Executive Director to be present – and at the discretion of the Committee Chair for any Reasonable Assurance Rated Report)	Head of Internal Audit (Executive Leads as appropriate)

MEETING DATE – 30 MAY 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Final Annual Accounts & Financial Statements 2018/19	Director of Finance

MEETING DATE – 15 JULY 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP)	Director of Finance
• Audit Recommendations Tracker Report	Board Secretary
• Losses and Special Payments Report	Director of Finance
• Clinical Audit & Effectiveness Plan 2019/20 (and summary of progress against 2018/19 plan)	Medical Director
• Local Counter Fraud Specialist update report **(CLOSED ITEM)**	'Acting' Director of Finance
• Board Assurance Framework (BAF) – following discussion at Board Development/Integrated Governance Committee	Board Secretary
CHARITABLE FUNDS	
• Charitable Fund Balances for last quarter	Director of Finance
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Reports (any Limited or No assurance audit reports require the lead Executive Director to be present – and at the discretion of the Committee Chair for any Reasonable Assurance Rated Report)	Head of Internal Audit (Executive Leads as appropriate)

EXTERNAL AUDIT	
• WAO Progress report and any related external audit reviews	Wales Audit Office lead
• WAO Audit Reports (as per Annual Audit Plan 2018/19)	Wales Audit Office lead
ITEMS FOR INFORMATION	
• Only items for information raised in advance with the Chair will be discussed	Chair

• Any other urgent Business	Chair
OTHER ITEMS	
• Referrals to other Committees of the Board • Review of the Committee Forward Work Plan	Chair Chair
PART II MEETING – HOSTED BODIES	
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Audit Recommendations Tracker Report	Board Secretary
• WHSSC CRAF Update	Committee Secretary
• EASC Risk Register Update	Board Secretary
AUDIT & ASSURANCE	
• Receipt of Hosted Body Internal/External Audit Reports / Management Responses	Audit & Assurance / WAO

MEETING DATE – 28 OCTOBER 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Audit Recommendations Tracker Report	Board Secretary
• Losses and Special Payments – Review of Plans and Priorities	Director of Finance
CHARITABLE FUNDS	
• Charitable Fund Balances for last quarter	Director of Finance
INTERNAL AUDIT & ASSURANCE	

• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Reports (any Limited or No assurance audit reports require the lead Executive Director to be present – and at the discretion of the Committee Chair for any Reasonable Assurance Rated Report)	Head of Internal Audit (Executive Leads as appropriate)

EXTERNAL AUDIT	
• WAO Progress report and any related external audit reviews	Wales Audit Office lead
• WAO Audit Reports (as per Annual Audit Plan 2018/19)	Wales Audit Office lead
ITEMS FOR INFORMATION	
• Only items for information raised in advance with the Chair will be discussed	Chair
• Any other urgent Business	Chair
OTHER ITEMS	
• Referrals to other Committees of the Board • Review of the Committee Forward Work Plan	Chair Chair
PART II MEETING – HOSTED BODIES	
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Audit Recommendations Tracker Report	Board Secretary
• WHSSC CRAF Update	Committee Secretary
• EASC Risk Register Update	Board Secretary
AUDIT & ASSURANCE	
• Receipt of Hosted Body Internal/External Audit Reports / Management Responses	Audit & Assurance / WAO

Meeting Date and Time	
Monday 1 April 2019	9.00am Rhondda & Cynon Rooms YMH
Monday 13 May 2019	9.00am Rhondda & Cynon Rooms YMH
Thursday 30 May 2019 – Annual Accounts Sign Off TO BE CONFIRMED 9.00am Rhondda & Cynon Rooms YMH	

Monday 15 July 2019	9.00am Rhondda & Cynon Rooms YMH
Monday 28 October 2019	9.00am Rhondda & Cynon Rooms YMH