Bundle Audit Committee Part 1 14 January 2019

0 AGENDA
1 Agenda Part 1 Audit Committee 14 January 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 8 October 2018
1.4 Part I AC Unconfirmed Minutes from 8 Oct 2018 GR.docx
1.5 Action Log
1.5 Audit Committee Action Log 14 January 2019.docx
1.6 Matters Arising not contained within the Action Log
2 PART 2 INTERNAL CONTROL AND RISK MANAGEMENT
2.1 Post Payment Verification Report
2.1 PPV Cwm Taf April - December 2018 AC 14 January 2019.docx
2.1.1 PPV Appendices Cwm Taf April - December 2018 AC 14 January 2019
2.1.1 PPV Appendices Cwm Taf April - December 2018 AC 14 January 2019.xlsx
2.2 Procurements & Scheme of Delegation Report
2.2 Scheme of Delegation Report AC 14 Jan 2019.doc
2.3 Losses & Special Payments Report
2.3 Losses & Special Payments Report AC 14 January 2019.docx
2.4 Standards of Behaviour Policy
2.4 Standards of Behaviour Framework Policy cover report 14 January 2019.docx
2.4.1 Appendix 1 Standards of Behavour Policy
2.4.1 Appendix 1 Standards of Behaviour Policy 14 Jan 2019.doc
2.4.1.1 Standards of Behaviour Policy - Overview (Appendix 1) AC 14 Jan 2019.doc
2.4.1.2 Standard of Behaviour Policy - Interests Form (Appendix 2) AC 14 Jan 2019.doc
2.4.1.3 Standard of Behaviour Policy - Gifts Form (Appendix 3) AC 14 Jan 2019.doc
2.4.1.4 Standards of Behavior Policy - Declaration Statement (Appendix 4) AC 14 Jan 2019.docx
2.4.1.5 Standards of Behavior Policy - Bribery Act (Appendix 5) AC 14 Jan 2019.doc
3 PART 3 CHARITABLE FUNDS
3.1 Charitable Funds Balances as at 30 November 2018
3.1 Charitable Funds AC 14 January 2019.doc
4 INTERNAL AUDIT
4.1 Internal Audit Progress Report
4.1 IA Progress Report AC 14 January 2019.pdf
4.2 Internal Audit Report - Retention of Staff
4.2 IA Retention of Staff AC 14 January 2019.pdf
4.3 Internal Audit Report - Directorate Review Facilities Management Arrangements
4.3 IA Facilities Management Arrangements Final Report AC 14 January 2019.pdf
4.4 Internal Audit Report - Raising Concerns
4.4 IA Raising Concerns Final Report 14 January 2019.pdf
4.5 Internal Audit Report - Wellbeing of Future Generations Act (Wales) 2015
4.5 IA WFGA Final Report AC 14 January 2019.pdf
4.6 Internal Audit Report - Continuing Healthcare
4.6 IA CHC Final Audit report AC 14 January 2019.pdf
5 PART 5 EXTERNAL AUDIT

5.1 Wales Audit Office Update Report

5.1 WAO Update Report AC 14 January 2019.pdf

5.2 Wales Audit Office Structured Assessment 2018

5.2 WAO Structured Assessment 2018 AC 14 January 2018.pdf

5.3 Wales Audit Office Primary Care Report

5.3 WAO Primary Care Report AC 14 January 2019.pdf

5.4 Wales Audit Office Annual Audit Report

5.4 WAO Annual Audit Report AC 14 January 2018.pdf

6 ITEMS FOR INFORMATION

6.1 Committee Forward Work Plan 2018/19

6.1 Forward work plan AC 14 January 2019.doc

7 PART 7 ANY OTHER URGENT BUSINESS

7.1 Items for Referral to other Committees

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

Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

CWM TAF UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING

14 January 2019

A meeting of the Audit Committee will be held on Monday 14 January 2019, at Ynysmeurig House, Navigation Park, Abercynon with Part 1 commencing at 9.30am.

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 8 October 2018	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	Post Payment Verification Report (Scott Lavender in attendance for this item)	Director of Primary, Community & Mental Health **Attachment**
2.2	Procurements and Scheme of Delegation Report	Director of Finance **Attachment**
2.3	Losses and Special Payments Report	Director of Finance **Attachment**
2.4	Standards of Behaviour Policy	Interim Board Secretary **Attachment**
PART 3. CHARITABLE FUNDS		
3.1	Charitable Fund Balances as at 30 November 2018	Director of Finance **Attachment**

PART 4. INTERNAL AUDIT

4.1	Internal Audit Progress Report	**Attachment**
4.2	Retention of Staff – **Limited Assurance**	**Attachment**
4.3	Directorate Reviews: Facilities - Management Arrangements – **Part Limited Assurance**	**Attachment**
4.4	Raising Concerns – **Limited Assurance**	**Attachment**
4.5	Wellbeing of Future Generations Act (Wales) 2015 – **Reasonable Assurance**	**Attachment**
4.6	Continuing Healthcare – **Reasonable Assurance**	**Attachment**

PART 5. EXTERNAL AUDIT

5.1	Wales Audit Office update Report	Wales Audit Office **Attachment**
5.2	Wales Audit Office – Structured Assessment 2018	Wales Audit Office **Attachment**
5.3	Wales Audit Office – Primary Care Report	Wales Audit Office **Attachment**
5.4	Wales Audit Office Annual Audit Report	Wales Audit Office **Attachment**

PART 6. ITEMS FOR INFORMATION

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

PART 7. ANY OTHER URGENT BUSINESS

7.1	Items for referral to other Committees	Oral/Chair
7.2	Close of **Part 1** of the meeting – Date and time of next meeting. • 09.00am Monday 11 February 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 8 OCTOBER 2018, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

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

IN ATTENDANCE

Marcus Longley	-	UHB Chair
Huw Evans	-	Head of Corporate Finance
David Jones	-	Local Counter Fraud Specialist
Sara Utley	-	Wales Audit Office
Steve Webster	-	Director of Finance (In part)
Mark Thomas	-	Assistant Director of Finance (In part)
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
Kelechi Nnoaham	-	Director of Public Health (In part)

AC/18/092 **WELCOME AND INTRODUCTIONS**

Chris Turner, Chair, **welcomed** everyone to the meeting, particularly Dilys Jouvenat, Independent Member who was attending her first Audit Committee meeting.

Gwenan Roberts extended a message received from Robert Williams to Chris Turner who paid tribute to the Chair (Chris Turner) for his excellent contribution to the Committee. Chris Turner added that he had also received a personal email and thanked everyone for the kind words and support at the end of his tenure as Chair of the Committee.

AC/18/093 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Robert Williams, Dave Thomas and Gareth Lucey.

AC/18/094 **DECLARATIONS OF INTERESTS**

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

AC/18/095 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 9 JULY 2018.**

The minutes of the meeting held on 9 July 2018, were **CONFIRMED** as a true and accurate record, subject to the following amendments:

- Page 8, Mrs J *Dowden* to be amended to Mrs J *Sadgrove*;
- Page 9, Charitable Funds, fourth sentence of the fifth paragraph to be changed to 'changing the levels of specified donations so that they were more *generic* as opposed to *specific*';
- Page 11, Internal Audit & Assurance Reports, final paragraph, Paul Dalton advised that a follow up review of Anaesthetics, Critical Care & Theatres (ACT) would be undertaken in 2018/2019 and not 2019/2020 and suggested that the minute did not need to be corrected as he had stated 2019/20 during the discussion in error.

AC/18/096 **AUDIT COMMITTEE ACTION LOG**

The Committee Action Log from the meeting held on 9 July 2018 was reviewed by Members and the following was **NOTED**:

17/130 – Gwenan Roberts advised that she had held a discussion with Jo Davies in relation to TOIL (time owing in lieu) and Members **NOTED** that work was being undertaken on reviewing TOIL processes and the development of a policy which was due for completion by December. Members **REQUESTED** that Jo Davies be invited to the January meeting to provide an update on progress made (**action log updated**).

18/026 – Huw Evans advised that Medical Variable Pay Financial Control Procedure had been drafted and would require Executive approval. Steve Webster advised that the procedure would be presented to the January Audit Committee for approval (**action log updated).**

18/081 – Gwenan Roberts advised that Board Secretaries had been working together in relation to the electronic process for declarations of interest and a discussion had been held to connecting the process to ESR accounts. Members **NOTED** that consideration was also being given to progressing the electronic submissions of gifts and hospitality forms through SharePoint.

18/078 – Huw Evans confirmed that this action had now been completed. Members **AGREED** that this could now be removed from the action log **(removed from the action log).**

18/077 – Maria Thomas requested an update in relation dental services and the significant variations experienced year on year. Steve Webster **AGREED** to send an update to Audit Committee members by email with an update on progress made **(action log updated).**

18/043 – Sara Utley advised that the Wales Audit Office would be undertaking a follow up on the response received from Public Health Wales in relation to the review undertaken. Members **NOTED** that the report was a Public Health Wales organisational closure report and not a Wales Audit Office closure report.

AC/18/097 **MATTERS ARISING**

AC/18/086 – Page 12 – Internal Audit Review Anaesthetics, Critical Care & Theatres – Paul Griffiths questioned whether a review would need to be undertaken of what inventories were available within directorates in relation to capital assets. Steve Webster advised that there was awareness of what was contained on the assets register in terms of accounts and that processes were robust where registers were being centrally managed. Members **NOTED** that processes may be less robust within individual Directorates which could be monitored through the Directorate Reviews undertaken by Internal Audit or a separate review could be commissioned.

Huw Evans confirmed that this was in relation to the capturing of assets under £5k and Steve Webster advised that he would write out to Directorates asking for an update as to whether their asset registers were up to date (**action log updated**).

A discussion was held as to whether there were any other common findings from Directorate Reviews which could be shared more widely. Paul Dalton confirmed that an analysis of common findings was being undertaken and advised that an update would be presented to the next meeting.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/18/098 **SCHEME OF DELEGATION REPORT**

Huw Evans presented the report, the purpose of which was to report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.6.18 to 31.8.18, to provide an update on the work undertaken to improve the Purchase to Pay processes and

to seek approval to changes in Financial Control Procedures and Scheme of Delegation.

Members **NOTED** that there had been no off contract engagements undertaken during the period reported with one single tender action reported which related to the joint funded project with MacMillan. Members **NOTED** there were no contracts requiring ministerial approval.

Members **NOTED** that the Health Board continued to meet its 95% target of paying non-NHS invoices within 30 days during 2018/19 and that the No Purchase Order No Pay policy was now in place.

Members **NOTED** that there had been a slight gap in the Scheme of Delegation in relation to the approval of medical agency staff, following the price caps introduced by Welsh Government. Members **NOTED** that the Scheme of Delegation had now been amended to reflect that any staff engaged above the price caps (whether on or off contract) would need to be explicitly approved by the Medical Director.

Members **NOTED** that a recent internal audit report recommended that a separate Financial Control Procedure (FCP) for Overseas Patients was put into place. Members **NOTED** that the Research & Development Policy presented to the Audit Committee in April had since had minor amendments made following presentation to other organisations **(added to the Forward Look).**

A discussion was held in relation to the FCP for Overseas Patients and it was noted that the Medical Records department were responsible for raising the initial request for invoicing following first contact with the patient and were not responsible for collecting the income. Members **NOTED** that the translation of documents from English to Welsh related to staff only, however, the Health Board offered an interpretation service to overseas patients. Steve Webster requested that an amendment be made to section 2.4 of the FCP to read 'Treatments provided at points of entry for *Unscheduled Care'*.

Members **RESOLVED** to:

- **NOTE** the transactions approved by exception within the Scheme of Delegation, for the period 1.6.18 to 31.8.18
- **NOTE** the update regarding Purchase to Pay issues
- **APPROVE** the change to the Scheme of Delegation
- **APPROVE** the new Financial Control Procedure (FCP) on Overseas Patients subject to one minor amendment
- **APPROVE** the change to the Research & Development (R&D) Finance Policy.

AC/18/099 **AUDIT RECOMMENDATIONS TRACKER**

Gwenan Roberts presented the report and Members were advised that the Board Assurance Framework was due to be presented to the Audit Committee. However, as a result of the number of unknowns in relation to the Bridgend Boundary Change, the document would now be presented to the January meeting (**added to the Forward Look**).

Members **NOTED** that in relation to the 63 Internal Audit Reports received, there were 15 recommendations which were now overdue, and that in relation to external audit, there were 12 recommendations outstanding out of the 23 reports received, 5 of which related to Follow Up Outpatients Not Booked.

Members **NOTED** that in relation to Occupational Health, appointments had been made to key posts which should enable some of the outstanding actions to be closed by the next meeting. Members **NOTED** in relation to access to occupational health services, waiting times had now improved. An update would be provided at the next meeting (**action log updated**).

Members **NOTED** that in relation to JAG Accreditation, a project based approach was now being taken which should enable completion of some of the ongoing actions. Maria Thomas advised that this matter had been discussed at Quality, Safety & Risk Committee on a number of occasions and advised that it would be helpful to have a closure update report to the next meeting (**action log updated**).. Paul Dalton advised that a number of actions had moved forward and the follow up review undertaken had moved from a limited assurance to a reasonable assurance rating.

Members **NOTED** that in relation to Information Management & Technology (IM&T), additional work had commenced in relation to the development of a revised Digital Strategy, which should be finalised by December 2018. Members **NOTED** that the Bridgend Boundary Change impact was being considered as part of the development of the Strategy and that some elements of the strategy were moving forward, with the Digitisation Business Case recently being approved by Executive Board.

Members also **NOTED** updates against the following areas:

- Private & Overseas Patients – An Invest to Save proposal for additional resource had now been approved which should enable completion of the two remaining outstanding actions;
- Fire Management – A statement of need had been developed and submitted which should move some of the outstanding actions forward;

- Anaesthetics, Critical Care & Theatres Management Arrangements – The Directorate team were continuing to work towards the completion of outstanding actions.

A discussion was held in relation to the process for identifying revised completion dates against some of the outstanding actions. Members **NOTED** that Directorates were being asked to identify alternative dates for completion, which were now being provided against some of the actions. Members **NOTED** that the UHB were in the process of requesting access to the Team Mate system operated by Internal Audit which would enable Directorates to input their updates directly into the tracker.

In relation to the 7 outstanding External Audit recommendations, the following updates were received:

- Follow Up Outpatients Not Booked (FUNB) – There were 3 outstanding actions. Discussions continued to take place at Finance, Performance & Workforce (FPW) Committee and Quality, Safety & Risk (QSR) Committee and a proposal had been agreed by the Executive Board for additional resource. Members **NOTED** Members of the FPW and QSR Committees remained concerned as to the lack of progress being made and advised that they would hope to see an improved position at the January meeting;
- Discharge Planning – Some progress had been made to complete the outstanding actions which should be closed by the January meeting.

Members **RESOLVED** to:

- **NOTE** the update and the summary of progress made.

AC/18/100 **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 June 2018 to 31 August 2018, as required in the Standing Financial Instructions.

Members **NOTED** the increase of £1.8m in medical negligence provision which was predominantly attributed to the changes in probability from 'Possible' to 'Probable' for a small number of cases.

Members **NOTED** that work had been undertaken between the Claims and Finance Teams in relation to the number of live cases, which had resulted in a number of the cases being removed as they had been closed. Members **NOTED** that this review would be undertaken on a regular basis.

Steve Webster advised that in relation to the increase in claims expenditure, he had asked Angela Hopkins to undertake a review of this matter (**action log updated**).

A discussion was held in relation to cash write offs, particularly in relation to one case which resulted in a loss of £1,400 cash from a patient suffering with dementia. Members **NOTED** that nursing staff had not followed correct procedures and had stored the cash in a locked cabinet as opposed to using a safe. Members **NOTED** that the patient had been fully reimbursed and a letter of apology had been written by the Chief Executive to the family. Jayne Sadgrove declared an interest in this matter as this related to a member of staff within her team. Members **REQUESTED** that a discussion was held with Angela Hopkins of the need to remind staff of the correct procedures to follow and what actions had been taken to learn lessons from this **(added to the action log).**

Members **RESOLVED** to:

- **NOTE** the losses and special payments made for the period 1 June 2018 to 31 August 2018.

AC/18/101 **PUBLIC HEALTH WALES CLOSURE REPORT – WALES AUDIT OFFICE REVIEW INTO PUBLIC HEALTH**

Kelechi Nnoaham was in attendance for this item.

Kelechi Nnoaham presented the report and advised that the Wales Audit Office (WAO) had undertaken a review of the arrangements for the delivery of Public Health on a local and national basis, working with Public Health Wales. Members **NOTED** that there were 15 specific actions that Public Health Wales agreed to take forward with key stakeholders and that resource had been put into place to address the actions.

Members were reminded that a previous discussion had been held in relation to fair distribution of resources as a fair degree of imbalance had been identified in relation to resource allocation to the Health Board. Members **NOTED** that in relation to the Bridgend Boundary Change, the Public Health Team at Abertawe Bro Morgannwg UHB were the most under-funded in Wales, closely followed by Cwm Taf UHB. Members **NOTED** that following discussions held, Cwm Taf UHB would receive an increase in their funding allocation from 1 April 2019, which would be used to ensure sufficient resource was put into place.

Members **WELCOMED** the report and the good progress that had been made. Paul Griffiths questioned what difference the additional funding would make to the population of Cwm Taf and Members **NOTED** that the additional funding received would be used to deliver and maintain current services for the new organisation's population. Members **NOTED** that over the next 2-3 years the Team would be working towards improving outcomes for residents within Merthyr Tydfil and Rhondda Cynon Taf.

Members **RESOLVED** to:

- **NOTE** the report and the update received.

Mark Thomas arrived at 10.24am. Steve Webster left at 10.24am.

PART 3. CHARITABLE FUNDS

AC/18/102 **CHARITABLE FUNDS**

Huw Evans presented the report which provided an update of the activity and balances on charitable funds for the period 1 June 2018 to 31 August 2018 and provided a progress update on other matters of interest.

Members **NOTED** that the balance at the end of August was £1.851m which was a reduction of £37k since the last report. Members **NOTED** that this was mainly as a result of the purchase of some pharmacy equipment associated with the Neonatal Scheme at Prince Charles Hospital (PCH).

Members **NOTED** that the number of funds had reduced by 4 since year-end following the closure of some funds with further funds being targeted for closure. Members **NOTED** that in relation to investments, the market value as at 31 August 2018 was £1,888m (a rise of £86k from the end of May), compared to £1.5m invested which equated to a surplus of £388k – 25.9%.

Members **NOTED** that the accounts and annual report for the year ending 31 March 2018 had been examined and approved by the Wales Audit Office and would be presented to the October Charitable Funds Committee for approval. Members **NOTED** that a proposal would also be presented in relation to the analysis undertaken into the Charitable Funds relating to Bridgend that would be transferring into Cwm Taf UHB. Members **NOTED** that these funds would be spent specifically on the Bridgend population and the new charitable funds would need to be registered with the Charity Commission. Following discussion, Members **REQUESTED** that a review of the Charitable Funds plan and priorities was undertaken at the October Charitable Funds Committee **(added to the action log).**

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/18/103 **INTERNAL AUDIT PROGRESS REPORT**

Paul Dalton, Head of Internal Audit & Assurance, presented the Internal Audit & Assurance progress report. Since the July meeting, Members **NOTED** that the following 5 reports had been finalised, with one report remaining in draft at present.

General Data Protection Regulation (GDPR)	**Reasonable**
Governance Arrangements of Board Committees	**Substantial**
Carbon Reduction Commitment	**Substantial**
Performance Management – Follow Up	**Reasonable**
Directorate Review – Facilities Compliance	**Reasonable**
Draft – Directorate Review – Facilities Management Arrangements	**Reasonable**

Members **NOTED** the report in draft related to the Directorate Review into Facilities Management Arrangements and that in light of the detailed management response received, further work was required to finalise the report. Members **NOTED** that in relation to performance monitoring, there had been a reduction in report turnaround times due to delays being experienced in the turnaround of management responses.

Members **NOTED** that there had been some changes made to the planned reviews scheduled to be undertaken during quarters 3 and 4. Members **NOTED** the suggestion to move the review into Consultant Job Planning to 2019/20, **NOTED** that an additional audit was being undertaken for the Emergency Ambulance Services Committee (EASC) in relation to Non-Emergency Patient Transport and that the Anaesthetics Critical Care and Theatres (ACT) Directorate Follow up Review would now be undertaken in 2018/19 as opposed to 2019/20.

Members **NOTED** that the Internal Audit team were starting to obtain a clearer understanding as to how many days were required to undertake Directorate Reviews, with 15 days required for Directorate Reviews into Compliance, with slightly more days required for Directorate Reviews into Management Arrangements.

A discussion was held in relation to the number of days required to undertake Directorate Reviews. Members **NOTED** that the number of days had increased as a result of the expanded scope of the reviews as requested by the UHB and that further reviews would need to be undertaken to determine whether any trends were being identified.

Members expressed concern as to the delays being experienced in management responses being submitted and requested that a discussion was held with the Executive Team and colleagues to ensure that they were made aware of the seriousness behind delayed responses. Gwenan Roberts and Mark Thomas **AGREED** to hold a discussion with the Executive Team **(added to the action log).**

Members **RESOLVED** to:

- **NOTE** the report.

AC/18/104 **INTERNAL AUDIT & ASSURANCE AUDIT REPORTS**

General Data Protection Regulations (GDPR) – Reasonable Assurance

Paul Dalton presented the report which reviewed the general awareness of GDPR within the UHB and how this was being communicated. Members **NOTED** that there were 3 medium and 5 low recommendations made. Members **NOTED** that work had progressed in relation to the recommendation made in relation to the Information Asset Register which now had 600 systems registered with further population being undertaken.

Members **RESOLVED** to:

- **NOTE** the report.

Performance Management Monitoring and Reporting Follow Up – Reasonable Assurance

Emma Samways presented the report which was a follow up report to the limited assurance report previously received by the Committee. Members **NOTED** that out of the 8 recommendations made, 2 had been fully implemented and 5 partially implemented which had resulted in a reasonable assurance rating being allocated.

Mark Thomas suggested that it would be helpful if a review could be undertake of Demand & Capacity planning within Surgery as part of their Directorate Review. Emma Samways confirmed that this was already in the scope of the review.

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

CRC Energy Efficiency Scheme – Substantial Assurance

Paul Dalton presented the report which had been given a substantial assurance rating. Members **NOTED** that this had been a mandatory review undertaken each year and would be the last review undertaken as the scheme had now been discontinued by Welsh Government. Members **WELCOMED** the report and extended their congratulations to the team for achieving a substantial assurance rating.

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

Governance Arrangements Primary & Community Care Committee – Substantial Assurance

Emma Samways presented the report which had been allocated a substantial assurance rating. Members **NOTED** that there were 4 low priority findings, 3 of which related to the Terms of Reference and 1 relating to the timeliness of distribution of papers. Members **WELCOMED** the report and extended their congratulations to the team for achieving substantial assurance.

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

Facilities Directorate Review Compliance – Reasonable Assurance

Emma Samways presented the report which was the first Directorate Review undertaken in 2018/19. Members **NOTED** that a reasonable assurance rating had been given with 4 medium priority findings identified. Members **NOTED** that there had been some difficulty experienced in obtaining management responses from some key areas of the service.

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

Facilities Directorate Review Management Arrangements – Reasonable Assurance - DRAFT

Emma Samways presented the report which was still in draft at present. Members **NOTED** that the report required further review and refinement as a result of the detailed management response received from the Directorate. Members **NOTED** that the review consisted of three elements, Governance Arrangements, Risk Management and Workforce Management & Service Delivery.

Members **NOTED** that a reasonable assurance rating had been given to Governance Arrangements and Risk Management, with a limited assurance rating given to Workforce Management & Service Delivery.

In relation to Workforce Management & Service Delivery, Members **NOTED** that there were 6 high priority and 4 medium priority findings identified. The review focussed on the Portering service across the Prince Charles (PCH) and Royal Glamorgan (RGH) hospital sites and the review identified differences in workforce management processes across both sites. Members **NOTED** that work had already commenced to resolve some of the issues identified and that a final version of the report would be presented to the January meeting.

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

PART 5. EXTERNAL AUDIT

AC/18/105 WALES AUDIT OFFICE UPDATE REPORT

Sara Utley presented the report and advised that reports in relation to Temporary Staffing, Primary Care and Structured Assessment 2018 would be presented to the Audit Committee at its January meeting. Chris Turner advised that he would welcome sight of the clinical coding report once the report had been finalised.

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

AC/18/106 COMMITTEE FORWARD WORK PLAN 2018-19

Members **RECEIVED** and **NOTED** the Forward Work Plan which would be amended to reflect the discussions held.

AC/18/107 ITEMS FOR REFERRAL TO OTHER COMMITTEES

There were no Committee referrals made.

AC/18/108 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 14:00hrs on Monday 14 January 2019.

…….

Dr Chris Turner, Chair

Date ……

AUDIT COMMITTEE ACTION LOG
FOLLOWING MEETING ON 8 OCTOBER 2018

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT January 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	Members **noted** at the last meeting that issues in relation to TOIL had been escalated to the Director of Workforce & OD and that a standard approach across the Health Board was being taken forward. Members **noted** that a revised scope for Directorate Reviews was being finalised with comments from the Executive and this would be used in the 2018/19 Internal Audit Plan. **In progress** – Follow up meeting held with Internal Audit to agree future scope of Directorate Reviews and revised scope being applied to current Directorate reviews likely to report in May 2018.

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT January 2019
						In Progress – 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. **Director of Workforce & OD invited to attend January meeting to provide an update.**
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	**In progress** FCP was not presented in May – oral update on progress **In progress** FCP drafted and in the process of being reviewed by the Assistant Director of Finance & Director of Workforce & OD **Deferred to February Meeting**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT January 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** **Ongoing** Executive Directors to be 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	**October meeting** **On Forward Look**
~~18/043~~	~~16/4/ 2018~~	~~WAO Review of Public Health Wales~~	~~Director of Public Health Wales to provide an oral update at the next meeting~~	~~July 2018~~	~~Director of Public Health~~	~~**Completed**~~
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	**In progress** Mr S Webster to 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	**On agenda**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT January 2019
18/081	09/07/ 2018	Standards of Behaviour Report	Board Secretary to undertake a benchmarking exercise against other Health Board's in relation to Gifts & Hospitality submissions	October 2018	Board Secretary	**In progress** Oral update to be provided
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	**In progress**
18/099	8/10/ 2018	JAG Accreditation	Closure report	January 2019	Deputy Chief Operating Officer	**In progress**
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 handling cash brought into hospital by patients and what actions had been taken to learn lessons from this. • Review the increasing claims	January 2019	Director of Finance	**In progress** Oral update

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT January 2019
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	**Completed – Discussion held at the October 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	**Completed**

Post Payment Verification Progress Report

For the period: 1st April 2018 to 31st December 2018

Cwm Taf University Health Board

Issued: 21st December 2018
Prepared by: Mr Scott Lavender (PPV Location Manager)

This document has been prepared for the internal use of Cwm Taf University Health Board.
For any queries or further information relating to this report, please contact Mr Scott Lavender. E-mail: scott.lavender@wales.nhs.uk

1. Introduction

This report has been prepared for the Audit Committee of Cwm Taf University Health Board. The aim of this report is to summarise the work undertaken by the Post Payment Verification (PPV) department in accordance to the Welsh Assembly Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS).

The purpose of a PPV visit to GMS contractors is to ensure that claims submitted by contractors in respect of GMS Enhanced Services are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and LHBs.

The purpose of a PPV visit to GOS contractors is to ensure that claims submitted by contractors in respect of GOS are correct and in accordance with the relevant NHS General Ophthalmic Services regulations and any specific LHB procedure.

The purpose of a PPV visit to GPS contractors is to ensure that claims submitted by contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific LHB, CPW or WG procedures.

The aim of the PPV process is to ensure propriety of payments of public monies by the LHBs. The probity checks conducted during a PPV visit will provide reasonable assurance to LHBs that public money has been spent appropriately by contractors making accurate claim submissions, contractors internal protocols are clinically sound and services are being claimed for in accordance to clinical specifications.

2. Post Payment Verification process

The PPV department carry out routine visits to all General Practitioner contractors on a three year cycle. During a GMS visit, the PPV department will analyse a sample of 20 claims or 10% of the total number of claims submitted during the year prior to the visit (whichever is the greater) for each enhanced service commissioned to the Practice.

The PPV department carry out routine visits to ophthalmic contractors based on the average number of GOS3 forms submitted during the year. The following table is used in determining the GOS visit schedule in a three year cycle:

Average monthly GOS3 submissions	Number of visits within a three year cycle
Up to 200	1
201 – 400	2
401 – 600	3

During a GOS visit, the PPV department will analyse a sample of 100 claims consisting of GOS1 (Sight tests), GOS3 (Vouchers), GOS4 (Repairs and replacement) and EHEW claims.

The purpose of a GPS PPV audit is to ensure that claims submitted by Pharmacy contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific specification set by WG, HB's and CPW.

Following a visit, an initial report is sent to the General Practitioner/ Ophthalmic contractor summarising the observations and findings of the visit and request further information from the contractor to queries that arise from the visit. The contractor is given 28 days to reply to the queries. If no response is received by the contractor, it will be assumed that they are satisfied with the report findings. If the contractor provides feedback, the PPV department will consider this information and assess if it clarifies the queries.

Taking the above into account, the report is finalised with recommended recoveries (If appropriate) and sent to the UHB Finance and Primary Care lead for approval.

If the report is approved, the PPV team will instruct the Payments department within NWSSP Primary Care Services to make the recovery against the contractor.

Where the PPV team identify a high number of claim errors for a particular service (10% for GMS, GOS & GPS), a recommendation will be made to the UHB that a more substantive review of the service needs to be carried out. If this is the case, the PPV team will carry out a revisit to the contractor within one year of the routine visit. During this visit all claims submitted by the contractor for the identified services only will be analysed for the period between the last visit and the routine visit date, usually three years.

In addition to carrying out visits, the PPV team continually monitor claims submitted by GMS, GOS and GPS contractors to assist in the identification of trends and outliers. This information is used to assist in the preparation of visit samples and also to alert the UHB and Local Counter Fraud Specialist if suspicious claiming patterns emerge.

The PPV team are also available to provide advice, support and guidance to contractors and UHBs when required.

3. Summary of findings and observations

General Medical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
12	7	5	12	0

During the period 1st April 2018 to 31st December 2018, the PPV team has visited 12 GMS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £4,944.42 from completed visits to GMS contractors in the UHB area due to errors identified in contractor's enhanced service claims. Recoveries are also to be made from on-going visits. These recoveries have not been included in the above total as they have not been authorised by the UHB. A summary of the GMS visits can be found in appendix one of this report.

The overall claim error rate for the locality was 6.06% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
10	9	1	10	0

During the period 1st April 2018 to 31st December 2018, the PPV team have visited 10 GOS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £2,749.75 from completed visits to GOS contractors in the UHB area due to errors identified in contractors' GOS claims. A summary of the GOS visits can be found in appendix three of this report.

The overall claim error rate for the locality was 4.82% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in appendix four of this report.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
20	17	3	20	0

During the period 1st April 2018 to 31st December 2018, the PPV team has visited 20 GPS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £252.00 from completed visits to GPS contractors in the UHB area due to errors identified in contractor's Medical Review Use claims. A summary of the GPS visits can be found in **Appendix 5** of this report.

The overall claim error rate for the Health Board was 0.71% from all claims sampled.

A summary of the PPV teams findings from visits by service can be found in **Appendix 5** of this report with a graphical representation of the error rates by service can be found in **Appendix 6**

4. Conclusions and recommendations

The PPV team have been working hard to develop and enhance relationships with contractors, Primary Care and Governing bodies to ensure we are delivering a service that is of the highest possible standard. As part of this I have scheduled a training event for Ophthalmic contractors in February 2019 where I will present to explain the PPV process and the requirements on the contractors when they are completing patient records.

New protocols have been written that accurately reflect our processes after a year of streamlining and changes. This has been quite a fruitful exercise as it has further enhanced networking and relationships for our department.

We are offering one on one training sessions with contractors where they make the request as we feel it would have a greater benefit long term and provide further assurance that we are taking the education and training aspect of our roles seriously.

The PPV team will continue to assist the UHB in providing training, advice or informally meeting with contractors or their staff to discuss PPV related issues.

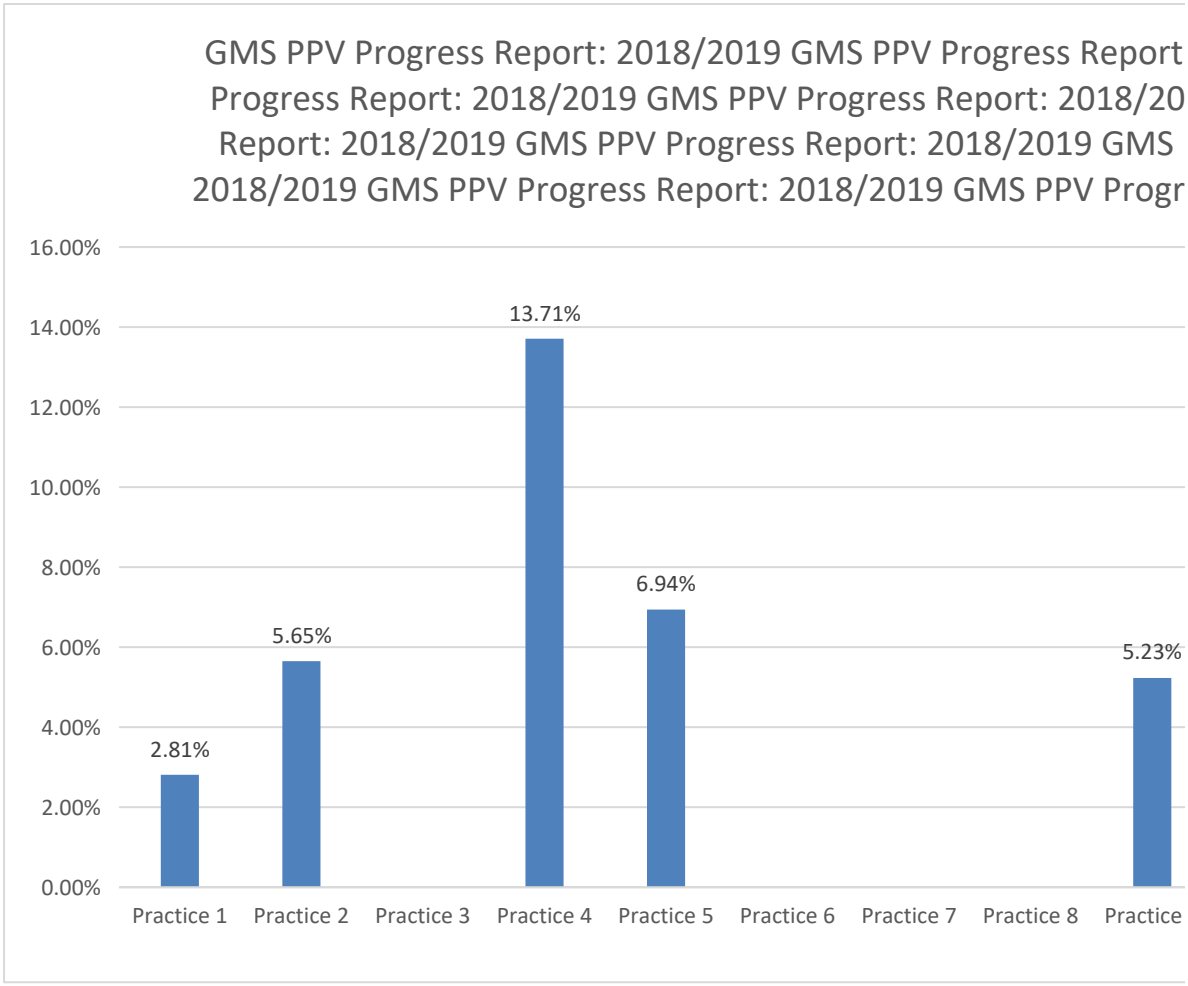
Cwm Taf University Health B
GMS PPV Progress Report: 20

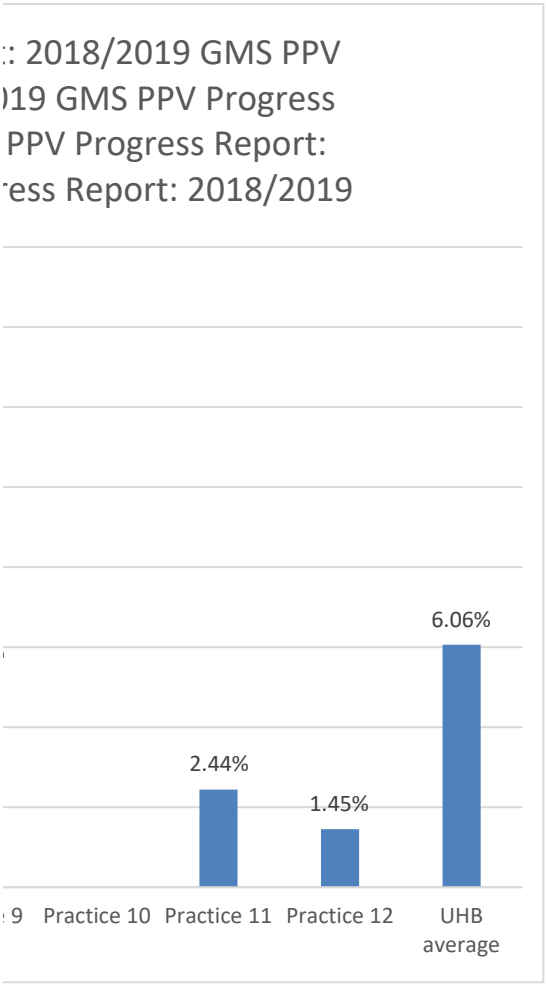
Completed GMS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery
Practice 1	Routine	178	5	3.93%	2.81%	£207.90
Practice 2	Routine	230	13	0.00%	5.65%	£943.77
Practice 3	Routine					
Practice 4	Routine	350	48	7.43%	13.71%	£1,807.76
Practice 5	Routine	173	12	1.73%	6.94%	£822.75
Practice 6	Routine					
Practice 7	Revisit					
Practice 8	Revisit					
Practice 9	Routine	172	9	13.37%	5.23%	£660.87
Practice 10	Routine					
Practice 11	Routine	205	5	3.41%	2.44%	£298.87
Practice 12	Routine	276	4	1.45%	1.45%	£202.50
UHB average		**1,584**	**96**		**6.06%**	**£4,944.42**

Board
)18/2019

Main error areas
1 x Anti-coagulation monitoring, 1 x DOAR and 3 x Near Patient Testing
1 x Administration of Gonadorelins, 2 x Anti-coagulation monitoring, 3 x Denosumab, 5 x DOAC and 2 x Minor surgery
File in progress, initial report sent to practice
1 x Anti-coagulation monitoring, 20 x Anti-coagulation monitoring DOM, 1 x Contraceptive services, 3 x DOAC/DOAR, 15 x Drug Misuse, 2 x Minor surgery, 3 x Near Patient Testing and 3 x Pertussis
11 x Minor surgery and 1 x DOAC
File in progress, visit undertaken
File in progress, initial report sent to practice
File in progress, visit undertaken
1 x Anti-coagulation monitoring, 1 x Contraceptive services and 7 x Minor surgery
File in progress, initial report sent to practice
2 x Minor surgery, 1 x Contraceptive services, 1 x Pertussis and 1 x Near Patient Testing
1 x Anti-coagulation monitoring, 2 x Care homes and 1 x DOAC/DOAR


GMS PPV Progress Report: 2018/2019 GMS PPV Progress Report
Progress Report: 2018/2019 GMS PPV Progress Report: 2018/20
Report: 2018/2019 GMS PPV Progress Report: 2018/2019 GMS
2018/2019 GMS PPV Progress Report: 2018/2019 GMS PPV Progr
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
2.81%
5.65%
13.71%
6.94%
5.23%
Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Practice 6
Practice 7
Practice 8
Practice

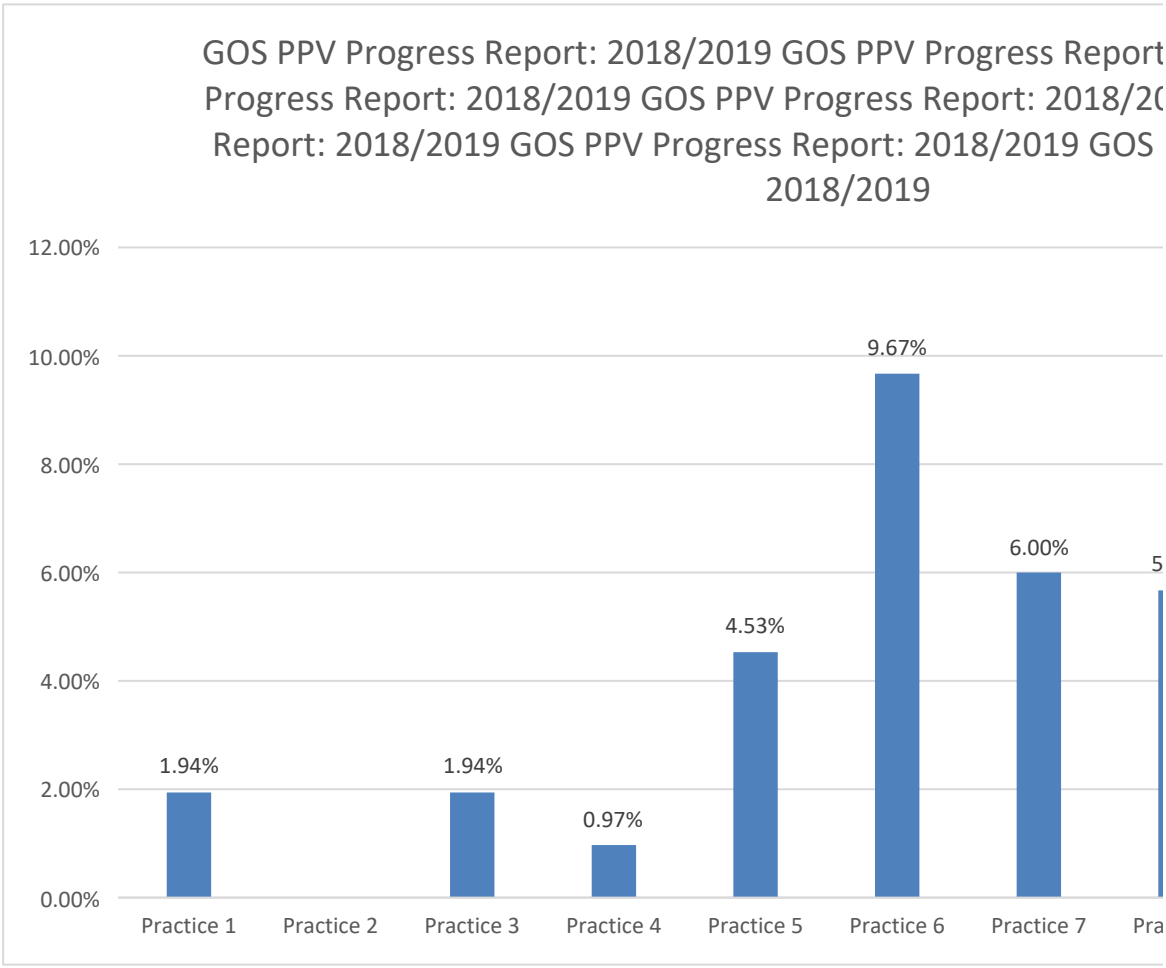

: 2018/2019 GMS PPV
)19 GMS PPV Progress
PPV Progress Report:
ess Report: 2018/2019
6.06%
2.44%
1.45%
9
Practice 10
Practice 11
Practice 12
UHB average

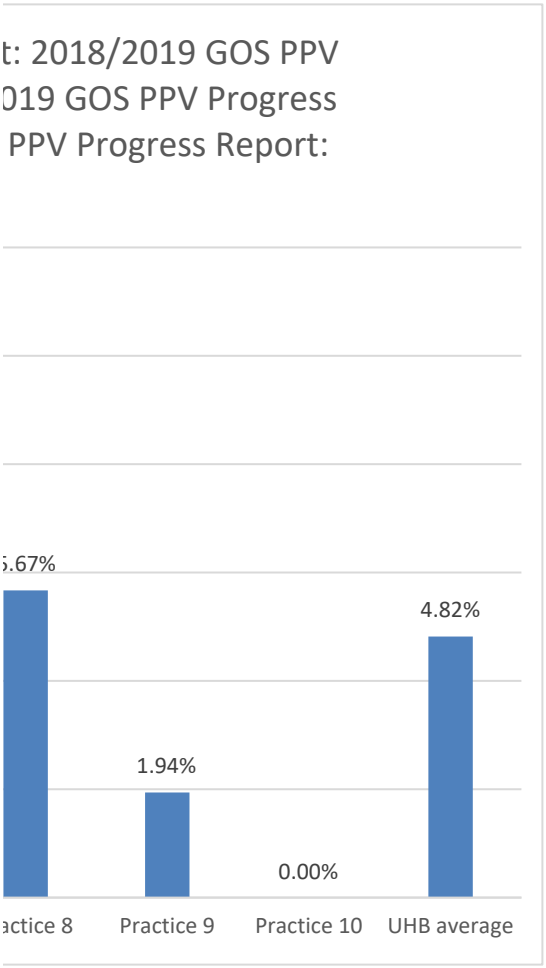
Cwm Taf University Health Board
GOS PPV Progress Report: 2018/2019

Completed GOS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery
Practice 1	Routine	103	3	4.00%	1.94%	£63.70
Practice 2	Revisit					
Practice 3	Routine	103	2	16.50%	1.94%	£80.80
Practice 4	Routine	103	1	8.74%	0.97%	£68.10
Practice 5	Revisit	300	12	1.33%	4.53%	£523.40
Practice 6	Revisit	300	29	32.66%	9.67%	£1,084.20
Practice 7	Routine	100	6	33.00%	6.00%	£198.10
Practice 8	Revisit	300	17	40.33%	5.67%	£631.95
Practice 9	Routine	103	3	26.21%	1.94%	£99.50
Practice 10	Routine	103	0	18.00%	0.00%	None
UHB average		**1,515**	**73**		**4.82%**	**£2,749.75**

Main error areas
1 x Tint on GOS 3 and 2 x GOS 4
File in progress, initial report sent to practice
2 x EHEW
1 x GOS 3
12 x EHEW
29 x EHEW
3 x GOS 4 and 3 x EHEW
8 x GOS 4 and 9 x EHEW
1 x GOS 3 and 2 x EHEW
All claims were verified


GOS PPV Progress Report: 2018/2019 GOS PPV Progress Report
Progress Report: 2018/2019 GOS PPV Progress Report: 2018/2(
Report: 2018/2019 GOS PPV Progress Report: 2018/2019 GOS
2018/2019
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
1.94%
1.94%
0.97%
4.53%
9.67%
6.00%
5
Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Practice 6
Practice 7
Pra

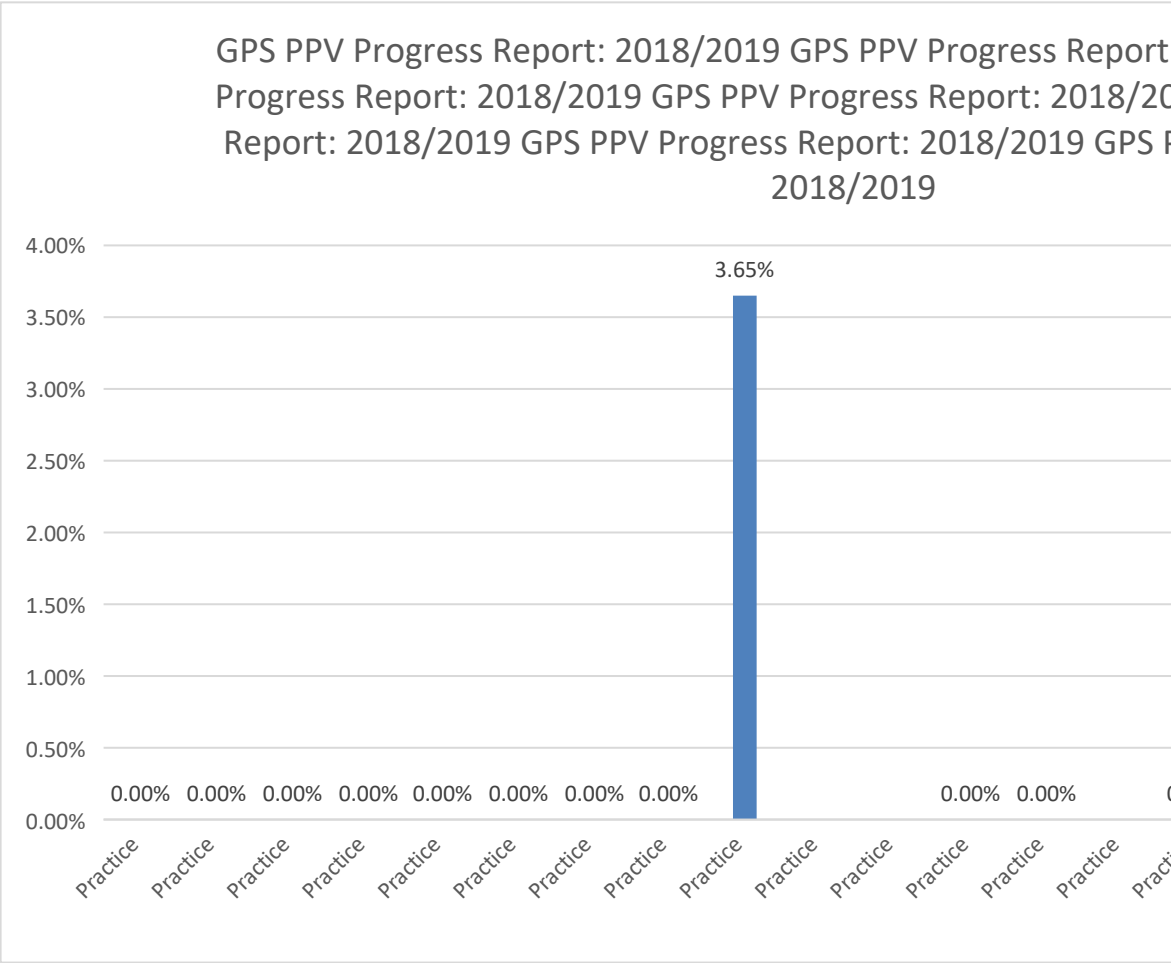

t: 2018/2019 GOS PPV
019 GOS PPV Progress
PPV Progress Report:
5.67%
1.94%
0.00%
4.82%
actice 8
Practice 9
Practice 10
UHB average

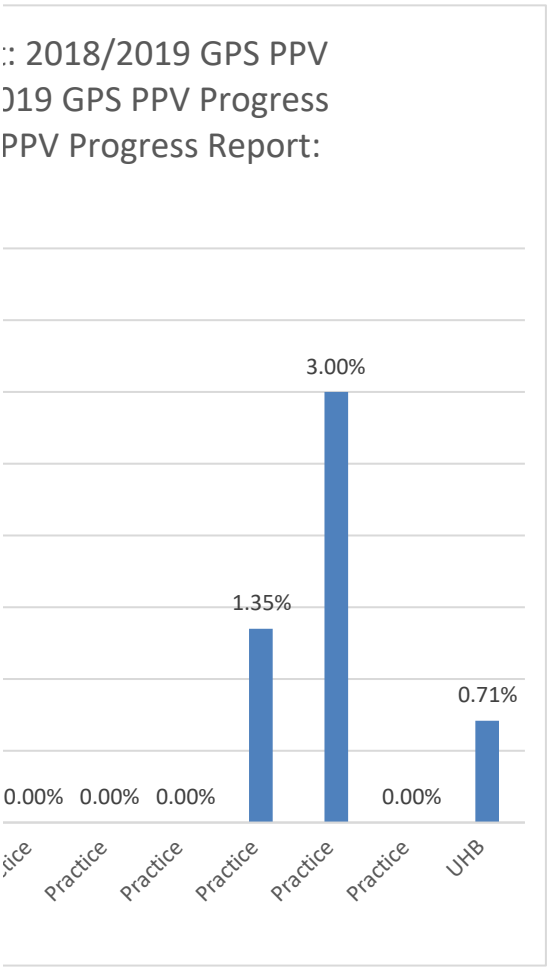
Cwm Taf University Health Board
GPS PPV Progress Report: 2018/2019

Completed GPS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery
Practice 1	Routine	2	0	5.00%	0.00%	£0.00
Practice 2	Routine	52	0	3.85%	0.00%	£0.00
Practice 3	Routine	100	0	2.00%	0.00%	£0.00
Practice 4	Routine	76	0	0.00%	0.00%	£0.00
Practice 5	Routine	90	0	8.91%	0.00%	£0.00
Practice 6	Routine	100	0	1.00%	0.00%	£0.00
Practice 7	Routine	20	0	25.00%	0.00%	£0.00
Practice 8	Routine	30	0	0.00%	0.00%	£0.00
Practice 9	Revisit	137	5	36.50%	3.65%	£140.00
Practice 10	Routine					
Practice 11	Routine					
Practice 12	Routine	100	0	21.00%	0.00%	£0.00
Practice 13	Routine	96	0	5.21%	0.00%	£0.00
Practice 14	Routine					
Practice 15	Routine	85	0	18.77%	0.00%	£0.00
Practice 16	Revisit	30	0	3.33%	0.00%	£0.00
Practice 17	Routine	97	0	0.00%	0.00%	£0.00
Practice 18	Routine	74	1	24.32%	1.35%	£28.00
Practice 19	Routine	100	3	6.00%	3.00%	£84.00
Practice 20	Routine	80	0	0.00%	0.00%	£0.00
UHB average		**1,269**	**9**		**0.71%**	**£252.00**

Main error areas
All claims were verified
All claims were verified
All claims were verified
All claims were verified
All claims were verified
All claims were verified
All claims were verified
All claims were verified
5 x MUR
File in progress, initial report sent to practice
File in progress, initial report sent to practice
All claims were verified
All claims were verified
File in progress, initial report sent to practice
All claims were verified
All claims were verified
All claims were verified
1 x MUR
3 x MUR
All claims were verified


GPS PPV Progress Report: 2018/2019 GPS PPV Progress Report
Progress Report: 2018/2019 GPS PPV Progress Report: 2018/2(
Report: 2018/2019 GPS PPV Progress Report: 2018/2019 GPS F
2018/2019
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
3.65%
0.00%
0.00%
0.00%
0.00%
0.00%
0.00%
0.00%
0.00%
0.00%
0.00%
Practice


:: 2018/2019 GPS PPV
)19 GPS PPV Progress
PPV Progress Report:
3.00%
1.35%
0.71%
0.00%
0.00%
0.00%
0.00%
Practice
Practice
Practice
Practice
Practice
UHB

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.2** **14 January 2019**

Audit Committee Report
SCHEME OF DELEGATION REPORT

Executive Lead: Director of Finance
Author: Head of Finance (Financial Accounts, Capital & Systems)
Contact Details for further information: Huw Evans on 01443 443810 or huw.evans2@wales.nhs.uk

Purpose of the Audit Committee Report
To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.9.18 to 30.11.18; To provide an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP).

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: a) **NOTE** the position on procurement matters for the period 1.9.18 to 30.11.18; b) **NOTE** the update regarding Purchase to Pay.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No specific impact						
Legal implications	No specific impact						
Population Health	No specific impact						
Quality, Safety & Patient Experience	No specific impact						
Resources	Assists in providing assurance that appropriate value for money is obtained where competitive tenders have not been sought, and ensures resources are deployed according to set control processes						
Risks and Assurance	Purchase to Pay processes are a key risk area for the UHB, which has contributed to a failure to meet the prompt payment target of 95% non-NHS invoices to be paid within 30 days in previous years.						
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						
Freedom of information status	Open						

SCHEME OF DELEGATION REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to:

- To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.9.18 to 30.11.18

- To provide an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP) and

2. BACKGROUND

The following areas within the Scheme of Delegation may be considered contentious and therefore the Audit Committee may wish to be given the opportunity to ask questions or request further information:

a) Engagement off contract of non-medical staff not paid via the payroll. The Director of Workforce and Organisational Development (W&OD) and the Head of Procurement would need to confirm agreement prior to any commitment.

b) Waiver of competitive tenders, as authorised by the Chief Executive.

c) Contracts requiring Ministerial approval (over £1m)

This report provides details of any such transactions within the period 1.9.18 to 30.11.18.

The report also provides an update on the Prompt Payment compliance for 2018-19

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Procurement Matters

a) Engagement off contract of non-medical staff not paid via the payroll

There were no engagements or contracts entered into during the period 1.9.18 to 30.11.18.

There have been some small payments made to 3 individuals that have been identified through the Creditors system (as opposed to payroll) during this period (total value £4k).

These are being looked at to assess the extent of any future commitment (if any) and the nature of the arrangement/contract in place.

2 of these have previously been considered re IR35. An assessment was undertaken on one of these, and it was found to be out of scope of IR35. The other was considered not to require an IR35 assessment. The new supplier will require further consideration in terms of IR35 and this is being pursued.

b) Waiver of competitive tenders, as authorised by the Chief Executive.

Standing Financial Instructions require 4 competitive tenders for supplies of goods and services over £25,000 up to OJEU thresholds (currently £118,133) and 5 competitive tenders above OJEU thresholds up to £1m. Purchases over £1m require Ministerial approval.

The Scheme of Delegation allows the Chief Executive to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules.

There were no such actions recorded for the period 1.9.18 to 30.11.18.

c) Contracts requiring Ministerial approval (over £1m)

There were no contracts requiring ministerial approval during this period.

3.2. Purchase to Pay (P2P)

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-18	7,528	16,162,134	7,960	16,933,681	94.6	95.4
May-18	12,425	21,324,160	12,968	22,061,869	95.8	96.7
Jun-18	14,280	19,051,050	14,869	20,097,298	96.0	94.8
Jul-18	8,379	17,008,664	8,677	17,790,226	96.6	95.6
Aug-18	13,099	25,707,783	13,614	26,714,775	96.2	96.2
Sept 18	11,437	19,137,306	11,915	20,409,027	96.0	93.8
Oct 18	11,655	21,054,810	11,987	21,772,821	97.2	96.7
Nov 18	12,409	21,713,494	12,849	22,628,035	96.6	96.0
YTD	91,212	161,159,403	94,839	168,407,732	96.2	95.7

The Health Board is meeting its 95% target of paying non-NHS invoices within 30 days during 2018/19, with an accumulated position for the year of 96.2% (95.7% in value terms). This compares to 95.3% (value 96.5%) in 2017/18.

The NHS invoice position shows that 76.3% of invoices were paid within 30 days for the year to date. (74.1% in 2017/18).

3.3 Scheme of Delegation/Financial Control Procedures

There are no proposed changes to the Scheme of Delegation or Financial Control Procedures for this meeting.

4. RECOMMENDATION

The Audit Committee is asked to:

a) **NOTE** the position on procurement matters for the period 1.9.18 to 30.11.18;

b) **NOTE** the update regarding Purchase to Pay

Freedom of information status	Open

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.3** **14 January 2019**

Audit Committee Report
LOSSES AND SPECIAL PAYMENTS 01.09.18 TO 30.11.18

Executive Lead: Director of Finance
Author: Financial Accountant
Contact Details for further information: Daxa Varsani on 01443 443808 or daxa.varsani@wales.nhs.uk or Huw Evans huw.evans2@wales.nhs.uk

Purpose of the Audit Committee Report
To advise the Audit Committee on the losses and special payments made by the UHB for the period 1 September 2018 to 30 November 2018, as required in Standing Financial Instructions.

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 2018-2021 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?
NWSSP – legal services and Risk Pool

Audit Committee Resolution To:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee are requested to: • **NOTE** the losses and special payments incurred for the period 1 September 2018 to 30 November 2018						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	No specific impact
Legal implications	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim
Population Health	No specific impact
Quality, Safety & Patient Experience	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee
Resources	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.
Risks and Assurance	Standing Financial Instructions require all losses to be reported to the Audit Committee. This report is therefore a key element of the governance process around losses and special payments.
Health and Care Standards	Standards for Health Services Reference Governance & Accountability Framework (1);
Workforce	No specific impact
Freedom of information status	Open

LOSSES AND SPECIAL PAYMENTS 01.09.18 to 30.11.18

1. SITUATION / PURPOSE OF REPORT

This report advises the Audit Committee on the losses and special payments made by the UHB for the three month period from 1 September 2018 to 30 November 2018, as required in Standing Financial Instructions.

2. BACKGROUND / INTRODUCTION

The report summarises the overall financial impact of losses in this financial year and provides detail on individual payments for write-off.

The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership. For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.

In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:

a) Amounts that have been charged to expenditure for which payments are yet to be made. These amounts are held within the balance sheet as future amounts owing (or owed by the WRP) at the appropriate Balance Sheet date

b) Amounts charged to expenditure during the current year (together with income from the WRP), and which therefore has a budgetary impact against the Health Board's Revenue Resource Limit, and

c) Cash payments made during the period for which write-off action is required, with details being provided within the appendices.

a) Provision and Creditors as at 30 November 2018

This is shown in table 1 below, together with equivalent figures at the end of the last three financial years, and the end of August 2018 which is the previous reporting date to the Audit Committee.

Table 1

	30.11.18	31.8.18	31.3.18	31.3.17	31.3.16
	£000	£000	£000	£000	£000
Medical Negligence claims/costs	90,926	91,667	78,961	68,215	50,246
Personal Injury claims/costs	411	407	1,618	784	884
Recoverable from Welsh Risk Pool	(99,598)	(100,372)	(87,408)	(75,527)	(54,849)
Net claim provision	**(8,261)**	**(8,298)**	**(6,829)**	**(6,528)**	**(3,719)**
Permanent Injury Benefit	3,265	3,262	3,258	3,413	3,249
Other	0	0	0	0	0
Net Provision	**(4,996)**	**(5,036)**	**(3,571)**	**(3,115)**	**(470)**
Number of live cases on losses system (LaSPaR)					
	30.11.18	**31.8.18**	**31.3.18**	**31.3.17**	**31.3.16**
Medical Negligence claims	303	301	397	502	445
Personal Injury claims	92	87	91	100	122

The Audit Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations, and is therefore an additional financial risk to those organisations. There is no expectation of the risk sharing agreement being invoked for 2018/19 but further analysis is ongoing by the WRP. We will continuously review this position in view of effectively manage any residual risk to the Health Board.

b) Expenditure incurred for the year to 30 November 2018

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit Committee (30.11.2018).

The net claim expenditure to date for the financial year 2018/19 is £1,318k (monthly expenditure of £164k), which is higher than the previous financial year (monthly expenditure £133K).

The annual budget for net claim expenditure for 2018-19 is £1.334m (year to date £889k). There is therefore a month 8 overspend on claims of £429k included within the Health Board's position. Effectively, the full year budget has been expended within the first 8 months

An initial notification has been received by the NHS Business Services Authority of one new case for Permanent Injury Benefit, which could have major financial implications for the Health Board. Based on the initial assessment, the provision would be approximately £4m. This is being challenged, particularly given the part-time status of the person involved prior to the incident taking place. Welsh Government have agreed to "underwrite" any provision over £1m thus limiting the exposure to the Health Board. The £1m potential charge is factored into the Health Board's financial plans for the year. No actual provision has yet been made for this claim pending confirmation of the amounts involved.

The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases (see appendix 4). The majority of the employment claims relate to a COT3 settlement agreement (via ACAS) for doctors in training in Prince Charles Hospital Accident and Emergency department regarding their inability to take breaks whilst on duty.

Table 2 **Expenditure incurred year to date**

Definition - Payments made during the year +/- changes in provisions

	Year to	Year to	Year ended	Year ended	Year ended
	30.11.18	**31.08.18**	**31.03.18**	**31.3.17**	**31.3.16**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	17,969	16,511	29,014	18,932	19,381
Personal Injury claims/costs	(651)	(771)	1,612	555	241
Recoverable from Welsh Risk Pool	(16,000)	(14,851)	(29,033)	(18,164)	(17,651)
Net claim expenditure	**1,318**	**889**	**1,593**	**1,323**	**1,971**
Permanent Injury Benefit	62	4	62	384	150
Other	80	25	174	310	(664)
Net I/E impact	**1,460**	**918**	**1,829**	**2,017**	**1,457**

Cash Write-Offs made for the period 1 September 2018 to the 30 November 2018

Table 3 shows the cash impact for financial year 2017-18 and up to 30 November 2018 of the current financial year. More detail is provided within the Appendices for the current reporting period.

An analysis of medical negligence payments and receipts over cases for the last quarter is shown in **Appendix 1.** A similar analysis is provided for personal injury claims in **Appendix 2** and Permanent Injury Benefit (PIB) in **Appendix 3.**

Other write-offs relate to ex-gratia payments approved by the Chief Executive or Deputy Chief Executive, Employment Claim Matters and debt write offs.

The ex-gratia payments include gratuities provided to staff on retirement with more than 20 years' service, in line with HR policy, and voluntary early release payments. These are shown in **Appendix 4.**

Table 3
Cash write-offs made during year to date 18/19

	1.09.18 - 30.11.18 £000	Previously reported £000	2018-19 £000
Medical Negligence (Appendix 1)			
Claims	1,440	2,589	4,029
Costs	619	981	1,600
Defence Fees	140	236	376
Personal Injury (Appendix 2)			
Claims	31	314	345
Costs	38	86	124
Defence Fees	47	40	87
Permanent Injury Benefit (Appendix 3)	55	0	55
Other (Appendix 4)			
Ex-Gratia	11	25	36
Debt Write Off	0	0	0
Employment Matter	44	0	44
Total	**2,425**	**4,271**	**6,696**
Recovered from Welsh Risk Pool	(1,924)	(1,886)	(3,810)
Net Cash Write-Off	**501**	**2,385**	**2,886**

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Standing Financial Instructions require all losses to be reported to the Audit Committee. This report is therefore a key element of the governance process around losses and special payments.

The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

4. RECOMMENDATION

The Audit Committee is requested to:

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

Freedom of information status	Open

Medical Negligence Payments 01/09/2018-30/11/2018							Appendix 1
Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
08RVEMN0013	-688	264			-424	107,042	106,618
12RYLMN0037		1,600			1,600	12,655	14,255
13RYLMN0029		10,593			10,593	16,163	26,757
13RYLMN0080				-496,449	-496,449	521,449	25,000
14RYLMN0006		6,480			6,480	20,688	27,168
14RYLMN0010		4,226			4,226	418,335	422,560
14RYLMN0090	40,000	100			40,100	187,024	227,124
14RYLMN0127		6,688			6,688	119,955	126,643
14RYLMN0145		-11,438			-11,438	47,094	35,656
14RYLMN0169	130,000	20,168	120,000		270,168	32,352	302,520
14RYLMN0198	35,000				35,000	255,867	290,867
14RYLMN0200		15,363			15,363	783,352	798,714
14RYLMN0208	65,000				65,000	287,616	352,616
14RYLMN0209	75,000	2,471			77,471	165,097	242,568
14RYLMN0214		5,810			5,810	240,466	246,276
15RYLMN0078	6,629				6,629	34,700	41,329
15RYLMN0079		990	30,000		30,990	86,610	117,600
15RYLMN0152				-166,110	-166,110	191,110	25,000
16RYLMN0042	4,000				4,000	64,179	68,179
16RYLMN0072				-11,700	-11,700	36,700	25,000
16RYLMN0074	17,500	2,450			19,950	104,381	124,331
16RYLMN0079	2,500		-506		1,994	19,500	21,494
16RYLMN0109				-19,040	-19,040	44,040	25,000
16RYLMN0170				-298,784	-298,784	323,784	25,000
17RYLMN0063		2,240			2,240	1,750	3,990
17RYLMN0185			627,284		627,284	10,764	638,048
18RYLMN0054	6,500				6,500	9,582	16,082
18RYLMN0059		2,158			2,158	4,063	6,220
07RRSMN0006				-485,327	-485,327	510,327	25,000
14RYLMN0178		100			100	81,880	81,980
15RYLMN0115		2,425			2,425	1,713	4,138
15RYLMN0136	24,000				24,000	1,200	25,200
15RYLMN0139				-4,000	-4,000	29,000	25,000
15RYLMN0166	-1,600			-92,174	-93,774	118,774	25,000
16RYLMN0099			500		500	2,450	2,950
16RYLMN0121			-637		-637	8,225	7,588
16RYLMN0139		200	4,200		4,400	1,315	5,715
17RYLMN0122	10,000	905			10,905	3,365	14,270
17RYLMN0142	1,600		20,000		21,600	5,635	27,235
18RYLMN0020	10,000				10,000	1,091	11,091
19RYLMN0006		550			550	4,315	4,865
05RVEMN0022		1,750			1,750	13,323	15,073
13RYLMN0131		5,183			5,183	838,027	843,210
14RYLMN0062		9,630			9,630	62,200	71,830
14RYLMN0135	50,000	1,742	160,000		211,742	3,215	214,957
15RYLMN0013				-9,751	-9,751	34,751	25,000
16RYLMN0090		6,550			6,550	883	7,433
16RYLMN0131		2,959			2,959	6,362	9,321
16RYLMN0165		350			350	2,100	2,450
17RYLMN0080	9,200				9,200	3,000	12,200

17RYLMN0150		800			800	5,000	5,800
17RYLMN0178		1,130			1,130	50	1,180
18RYLMN0118	1,600		17,500		19,100	2,101	21,201
18RYLMN0119		450			450	1,296	1,746
15RYLMN0070	3,200	400			3,600	36,897	40,497
15RYLMN0158	9,000				9,000	7,000	16,000
17RYLMN0071		125			125	425	550
17RYLMN0097	3,698		-3,698		0	16,698	16,698
17RYLMN0190		300			300	2,470	2,770
06RRSMN0037		1,400			1,400	7,019	8,419
10RYLMN0065	10,000				10,000	21,297	31,297
12RYLMN0031				-500	-500	25,500	25,000
12RYLMN0108				-1,100	-1,100	26,100	25,000
14RYLMN0012	10,000		65,000		75,000	14,200	89,200
15RYLMN0004		3,098			3,098		3,098
15RYLMN0062		1,600			1,600	480	2,080
15RYLMN0099		700			700	1,575	2,275
16RYLMN0138		8,185			8,185	31,594	39,779
16RYLMN0144		50			50		50
16RYLMN0145		3,184			3,184		3,184
16RYLMN0177				-4,032	-4,032	29,032	25,000
16RYLMN0178				-91,116	-91,116	116,116	25,000
16RYLMN0193		1,350	130,000		131,350	42,505	173,855
17RYLMN0113	1,600		3,700		5,300	1,367	6,667
17RYLMN0194			62,000		62,000		62,000
18RYLMN0053		1,080			1,080		1,080
19RYLMN0035			2,250		2,250		2,250
13RYLMN0160	26,000	1,931			27,931	159,787	187,718
15RYLMN0093	26,056				26,056	120,030	146,086
15RYLMN0106		1,400			1,400	6,080	7,480
16RYLMN0010		1,150			1,150	10,600	11,750
16RYLMN0115			15,000		15,000	60	15,060
17RYLMN0067			38,000		38,000	3,787	41,787
17RYLMN0120		985			985		985
18RYLMN0033		482			482		482
18RYLMN0106		1,500			1,500		1,500
19RYLMN0021		440			440		440
19RYLMN0029		110			110		110
19RYLMN0038		1,250			1,250		1,250
19RYLMN0039	3,100				3,100		3,100
19RYLMN0040			3,000		3,000		3,000
10RYLMN0078			5,000		5,000	50,314	55,314
13RYLMN0153				-72,025	-72,025	97,025	25,000
14RYLMN0046				-26,585	-26,585	51,585	25,000
15RYLMN0017				-18,812	-18,812	43,812	25,000
16RYLMN0052		100			100	600	700
16RYLMN0078	40,000	735			40,735	16,826	57,561
16RYLMN0205		500			500	1,625	2,125
17RYLMN0012		1,403			1,403		1,403
17RYLMN0061		400	80,000		80,400	20	80,420
17RYLMN0126			30,000		30,000	2,354	32,354
18RYLMN0057			31,000		31,000	684	31,684
18RYLMN0063		1,500			1,500		1,500
Total 01/09/2018 - 30/11/2018	**618,895**	**140,241**	**1,439,592**	**-1,797,503**	**401,225**	**6,833,377**	**7,234,602**

Personal Injury Payments 01/09/2018-30/11/2018							Appendix 2
Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
14RYLPI0055		14,108			14,108	380,589	394,697
15RYLPI0037		4,679	-6,500		-1,821	16,745	14,924
15RYLPI0038		3,813			3,813	15,969	19,782
15RYLPI0039				-19,273	-19,273	44,273	25,000
16RYLPI0010			18,750		18,750	1,810	20,560
16RYLPI0014		677			677		677
16RYLPI0020			3,334		3,334	255	3,589
16RYLPI0026	5,670		2,500		8,170		8,170
17RYLPI0003		563			563		563
17RYLPI0015				-28,841	-28,841	53,841	25,000
17RYLPI0016	7,933	200	1,500		9,633	1,350	10,983
17RYLPI0019		1,361			1,361		1,361
17RYLPI0021		2,258			2,258	200	2,458
17RYLPI0023		2,309			2,309	11,697	14,005
17RYLPI0024	6,500				6,500	5,916	12,416
17RYLPI0026		1,465			1,465	4,052	5,517
17RYLPI0027		1,237			1,237		1,237
17RYLPI0031		1,735			1,735	6,492	8,227
18RYLPI0001		1,197			1,197		1,197
18RYLPI0004	1,400				1,400	1,000	2,400
18RYLPI0009	5,069	100	2,000		7,169		7,169
18RYLPI0012		657			657	3,080	3,737
18RYLPI0013		3,860			3,860	720	4,580
18RYLPI0018	2,110				2,110	2,000	4,110
18RYLPI0020		100			100		100
18RYLPI0023	6,237	1,150	2,600		9,987		9,987
18RYLPI0029	1,300	620	2,000		3,920		3,920
18RYLPI0035		629			629	2,330	2,959
19RYLPI0002	1,256	50	1,750		3,056		3,056
19RYLPI0003		764			764	3,300	4,064
19RYLPI0005			2,444		2,444	2,080	4,524
19RYLPI0010	900	451	1,000		2,351		2,351
19RYLPI0014		1,900			1,900	50	1,950
19RYLPI0018		655			655		655
Total 01/09/2018 - 30/11/2018	**38,375**	**46,539**	**31,378**	**-48,114**	**68,178**		
TOTAL						**557,748**	**625,926**

Permanent Injury Benefit 01/09/2018 - 30/11/2018			Appendix 3
Laspar Number	**In period Payments £**	**Previous Write-Offs £**	**Cumulative £**
01RRSPI0020	3,293	176,181	179,474
02RVEPI0001	1,568	36,256	37,824
02RVEPI0003	2,479	127,694	130,173
02RVEPI0004	1,693	87,655	89,348
03RRSPI0020	11,488	635,433	646,921
03RVEPI0028	3,105	203,261	206,366
04RRSPI0009	3,371	167,359	170,730
04RRSPI0024	2,806	107,136	109,942
05RRSPI0020	1,335	53,829	55,164
05RRSPI0021	2,930	135,612	138,543
05RVEPI0033	4,547	206,760	211,307
05RVEPI0034	1,295	61,403	62,698
08RVEPI0009	3,080	131,029	134,110
10RYLPI0070	1,740	74,718	76,458
11RYLPI0065	4,987	150,106	155,092
12RYLPI0059	1,719	41,078	42,797
13RYLPI0020	913	20,788	21,701
13RYLPI0050	2,989	85,873	88,862
98RVEPI0005	98	5,193	5,290
Grand Total	**55,435**	**2,507,364**	**2,562,800**

Other Payments 01/09/2018 - 30/11/2018			Appendix 4
Case Reference	**Nature of Loss**	**Details**	**Amount £**
19RYLEG0088	Ex-Gratia	Loss/Replacement of Item (Clothing)	80
19RYLEG0089	Ex-Gratia	Loss/Replacement of Item (Clothing)	49
19RYLEG0101	Ex-Gratia	Loss/Replacement of Item (Desk Top Fan)	44
19RYLEG0077	Ex-Gratia	Retirement Gratuity	361
19RYLEG0078	Ex-Gratia	Retirement Gratuity	205
19RYLEG0079	Ex-Gratia	Retirement Gratuity	400
19RYLEG0080	Ex-Gratia	Retirement Gratuity	371
19RYLEG0081	Ex-Gratia	Retirement Gratuity	257
19RYLEG0082	Ex-Gratia	Retirement Gratuity	341
19RYLEG0083	Ex-Gratia	Retirement Gratuity	341
19RYLEG0084	Ex-Gratia	Retirement Gratuity	361
19RYLEG0085	Ex-Gratia	Retirement Gratuity	351
19RYLEG0086	Ex-Gratia	Retirement Gratuity	215
19RYLEG0087	Ex-Gratia	Retirement Gratuity	293
19RYLEG0090	Ex-Gratia	Retirement Gratuity	312
19RYLEG0091	Ex-Gratia	Retirement Gratuity	337
19RYLEG0092	Ex-Gratia	Retirement Gratuity	307
19RYLEG0093	Ex-Gratia	Retirement Gratuity	322
19RYLEG0094	Ex-Gratia	Retirement Gratuity	273
19RYLEG0095	Ex-Gratia	Retirement Gratuity	355
19RYLEG0096	Ex-Gratia	Retirement Gratuity	337
19RYLEG0097	Ex-Gratia	Retirement Gratuity	323
19RYLEG0098	Ex-Gratia	Retirement Gratuity	304
19RYLEG0099	Ex-Gratia	Retirement Gratuity	274
19RYLEG0100	Ex-Gratia	Retirement Gratuity	332
19RYLEG0102	Ex-Gratia	Retirement Gratuity	363
19RYLEG0103	Ex-Gratia	Retirement Gratuity	343
19RYLEG0104	Ex-Gratia	Retirement Gratuity	283
19RYLEG0105	Ex-Gratia	Retirement Gratuity	410
19RYLEG0106	Ex-Gratia	Retirement Gratuity	406
19RYLEG0107	Ex-Gratia	Retirement Gratuity	392
19RYLEG0108	Ex-Gratia	Retirement Gratuity	216
19RYLEG0109	Ex-Gratia	Retirement Gratuity	351
19RYLEG0110	Ex-Gratia	Retirement Gratuity	196
19RYLEG0111	Ex-Gratia	Retirement Gratuity	322
19RYLEG0112	Ex-Gratia	Retirement Gratuity	322
19RYLEM0001	Employment Matter	Employment Matter	7,085
19RYLEM0002	Employment Matter	Employment Matter	4,714
19RYLEM0003	Employment Matter	Employment Matter	4,714
19RYLEM0004	Employment Matter	Employment Matter	4,714
19RYLEM0005	Employment Matter	Employment Matter	7,884
19RYLEM0006	Employment Matter	Employment Matter	7,172
19RYLEM0007	Employment Matter	Employment Matter	5,022
19RYLEM0005	Employment Matter	Employment Matter	1,027
19RYLEM0006	Employment Matter	Employment Matter	927
19RYLEM0007	Employment Matter	Employment Matter	640
Total 01/09/2018 - 30/11/2018			**54,643**

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.4** **14 January 2019**

Audit Committee Report
STANDARDS OF BEHAVIOUR FRAMEWORK POLICY

Executive Lead: Board Secretary / Director of Corporate Services
Author: Interim Board Secretary / Director of Corporate Services
Contact Details for further information: Gwenan Roberts, 01443 744800 or email Gwenan.Roberts@wales.nhs.uk

Purpose of the Audit Committee Report
The purpose of this report is provide the Audit Committee with the reviewed and updated Standards of Behaviour Policy for approval.

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	• Standing Orders and SFI's • Raising Concerns (Whistleblowing) Policy • The NHS Wales All Wales Social Media Policy. • The Counter Fraud Bribery and Corruption policy • Velindre NHS Trust Standards of Behaviour policy References and further reading: • Standards of Business Conduct for NHS Staff (DGM(93)84) • Code of Conduct & Accountability (WHC(2006)90 • The NHS & Sponsorship & Pharmaceutical Industry – A Paper Guidance (WHC(2005)016

	• Bribery Act 2010 • NHS Protect – Bribery Act Guidance. • ABPI Code of Practice for the Pharmaceutical Industry

Engagement – Who has been involved in this work?
All Wales Board Secretaries

Audit Committee Resolution to:							
APPROVE	√	**ENDORSE**		**DISCUSS**		**NOTE**	
Recommendation	The Audit Committee is asked to: • **APPROVE** the updated policy and supporting appendices in relation to the Health Board's Standards of Behaviour Policy.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	The standards of behaviour framework policy been subject to a full equality impact assessment and no adverse impact has been identified.						
Legal implications	The standards of behaviour framework, together with standing orders and standing financial instructions, form the key elements of the governance and accountability framework for the Health Board.						
Population Health	No impact.						
Quality, Safety & Patient Experience	No impact.						
Resources	No impact.						
Risks and Assurance	Failure to declare relevant and material interests could place Health Board staff in a position where a conflict of interest occurs. This could lead to circumstances that could impact negatively on the reputation of the Health Board and its compliance with the accepted standards of corporate governance.						
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.						
Workforce	All employees and Independent Members will be required to uphold the requirements of the policy.						
Freedom of Information Status	Open						

STANDARDS OF BEHAVIOUR FRAMEWORK POLICY

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is provide the Audit Committee with the reviewed and updated Standards of Behaviour Policy for approval.

2. BACKGROUND / INTRODUCTION

CTUHB is committed to ensuring that its employees and Committee members practice the highest standards of conduct and behaviour. The Health Board's Standards of Behaviour Policy ensures that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality, Sponsorship and Honoraria. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

The existing Standards of Behaviour Framework Policy was last reviewed at the Audit Committee meeting in April 2016. The amendments made to the policy are highlighted for ease of reference in RED font.

Policy Review

The Interim Board Secretary has reviewed the Standards of Behaviour Framework policy in line with best practice identified through the Board Secretary network and it is presented at **Appendix 1** for approval.

Cwm Taf UHB's existing Standards of Behaviour Policy and supporting appendices have been updated using current accepted best practice.

Key areas of change include:

- Confirming that all managers band 8a and above must complete a declaration of interests form in March annually
- Confirming that the information will be published within the reports to the Audit Committee and on the website in the public domain
- Declarations of Interest from Senior Clinical Staff changed to March each year
- Adding the National Imaging Academy.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The Managing Director as "Accountable Officer" has overall responsibility for ensuring that CTUHB operates efficiently, economically and with probity. The Chief Executive will ensure that there are appropriate arrangements in place to support the delivery of the framework.

The Director of Corporate Services & Governance/Board Secretary has responsibility for ensuring that CTUHB is provided with competent advice and support regarding the application of the policy, and ensure that:

- A Register of Interests is established and maintained as formal record of interests declared by employees and Independent Members. The Register will include details of Directorships, pecuniary interests, a non-pecuniary interests in organisations that may have dealings with the NHS and membership of processional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.
- Arrangements are in place to prompt specific groups of Employees and Independent Members to complete a "Declaration of Interest Form" on initial employment with CTUHB and at periodic intervals thereafter. **Note: it is the individual employee's responsibility to make a declaration should their circumstances change.**
- A Register of Gifts, Hospitality and Sponsorship whether, accepted or declined, is maintained and information from the Register of Declarations of Interests, Gifts and Hospitality and Sponsorship will be published on the website in accordance with the requirements of the Freedom of Information Act to publish a Publication Scheme.
- Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship and the effectiveness of the arrangements in place are provided to the Audit Committee at agreed intervals.

Independent & Associate Members	Annually in January
Executive Directors	Annually in January
Clinical Directors, Directorate Managers and Heads of Nursing	Annually in March
Assistant Directors, Heads of Corporate Departments and all managers or staff at Band 8a and above	Annually in March
Senior Finance and Procurement Employees	Annually in March
Consultants and Senior Clinical Staff	Annually in March

3.1 Declarations of Interest at Meetings

It is a requirement that at the beginning of every Board, committee or decision making/formal meeting that members and those in attendance be invited to declare their interests in relation to any items on the agenda. Where a potential conflict is material or the member has a financial/pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. The potential conflict and the action will be recorded in the minutes of the meetings and Register of Interests will be updated if required.

3.2 Communicating with Staff

To ensure effective governance for CTUHB it is important the amended policy is communicated broadly to all staff across the UHB. The following activities will be undertaken to raise awareness:

- Article to be included in the internal newsletter
- Intranet news article raising awareness of the amended policy, and policy section to be updated with new policy
- The Information Governance module of the Corporate Induction day to be amended

There is also a requirement for staff to declare "relevant and material" interests held by their spouse or partner. This is because the pecuniary interest of one partner shall, if known to the other, be deemed to be also an interest of the other and as such must be disclosed.

In addition, Directors must ensure that:

- Staff are aware of the requirements contained within the Standards of Behaviour Framework Policy,
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship,
- Approve (or decline) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate **PRIOR** to the event,
- During periods of annual leave/prolonged absence they will ensure that they delegate the responsibilities outlined above to an Assistant Director.

It is recommended that where there is doubt, a declaration of interest should be made. An annual review of recorded interests is conducted and all Directors are required to confirm their entry in the Register. In the event that any staff have not submitted a completed form they will be contacted and failure to complete a form thereafter will be escalated to the relevant Directors.

4. RECOMMENDATION

The Audit Committee is asked to:

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

Freedom of Information Status	Open

Standards of Behaviour Policy (incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria)

INITIATED BY:	Board Secretary / Director of Corporate Services and Governance
APPROVED BY:	Audit Committee
DATE APPROVED:	14 January 2019
VERSION:	3
OPERATIONAL DATE:	January 2019
DATE FOR REVIEW:	April 2022
DISTRIBUTION:	Executive Directors Independent Board Members Associate Members Assistant Medical Directors Clinical Directors Directorate Managers Heads of Nursing Heads of Department All staff via the SharePoint
FREEDOM OF INFORMATION STATUS:	OPEN

CONTENTS

		Page No.
1.	Purpose	3
2.	Context and Background	3
3.	Aim	5
4.	Objective	5
5.	Scope	5
6.	Roles and Responsibilities	5
7.	Register of Interests	10
8.	Declarations of Interests at Meetings	11
9.	Gifts, Hospitality and sponsorship	12
10.	The Bribery Act 2010	19
11.	Research and Development	21
12.	Charitable Funds	21
13.	Secondary Employment and Private Practice	21
14.	Failure to Adhere to the Standards of Behaviour Framework	22
15.	Equality	23
16.	Resources	23
17.	Training	23
18.	Implementation	23
19.	Audit and Monitoring	24
20.	Retention and Archiving	24
21.	Distribution	24
22.	Review	24
23.	Further Information	25
24.	Legislative and NHS Requirements	25

Appendix 1	Standards of Behaviour Framework
Appendix 2	Form Declaration of Interests
Appendix 3	Form Declaration of Gifts, Hospitality and Sponsorship
Appendix 4	Declaration Statement re Honoraria
Appendix 5	The Bribery Act 2010

1. PURPOSE

The purpose of this Policy is to set out the Cwm Taf University Health Board (CTUHB) commitment to ensuring that its Employees and Independent Board Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Board Members are supported in delivering that requirement.

Any reference in this Policy to the Health Board should also be applied to any bodies that the UHB hosts such as the Welsh Health Specialised Services Committee (WHSSC), the Emergency Ambulance Services Committee (EASC) and the National Imaging Academy (NIA).

2. CONTEXT AND BACKGROUND

The Welsh Government's *Citizen-Centred Governance Principles* apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

Cwm Taf University Health Board is strongly committed to the Health Board being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Board expects all Independent Board Members and Employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.

The "Seven Principles of Public Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends

- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties

- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit

- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position

- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it

- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and

- **Leadership** – Individuals should promote and support these principles by leadership and example.

In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day to day functions. They must remain beyond suspicion at all times. They can achieve the "Seven Principles" above by:

- Ensuring that the interests of patients remain paramount
- Being impartial and honest in the conduct of their official business
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money
- Not abusing their official position for personal gain or to benefit family or friends
- Not seeking advantage or to further private business or other interests in the course of their official duties, and
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

This Policy re-states and builds on the provisions of Cwm Taf University Health Board Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations can be made.

The Policy is supported by a short guide on the Standards of Behaviour Framework (see **Appendix 1**) that provides a summary of expected conduct. This Framework is intended to compliment the various Professional Codes of Conduct relevant to Employees of the Health Board.

3. AIM

The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

Cwm Taf University Health Board is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported to deliver this requirement.

4. OBJECTIVE

The objective of this Policy is to clarify the relative responsibilities of individuals / committees in the discharge of this Policy and adherence to the Standards of Behaviour Framework.

5. SCOPE

This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board.

6. ROLES AND RESPONSIBILITIES

Chief Executive

The Chief Executive is the "Accountable Officer" with overall responsibility for ensuring that the Health Board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

Board Secretary / Director of Corporate Services and Governance

The Board Secretary/ Director of Corporate Services and Governance has delegated responsibility for ensuring that the Health Board is provided with competent advice and support regarding the contents and application of this Policy and the Standards of Behaviour Framework. They will ensure that:-

(i) A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Board Members. The Register will include details of Directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.

(ii) Arrangements are in place to prompt specific groups of Employees and Independent Board Members to complete a Declaration of Interest Form on initial employment with the Health Board and at periodic intervals thereafter as follows:

Independent & Associate Members	Annually in January
Executive Directors	Annually in January
Clinical Directors, Directorate Managers and Heads of Nursing	Annually in March
Assistant Directors, Heads of Corporate Departments and all managers or staff at Band 8a and above	Annually in March
Senior Finance and Procurement Employees	Annually in March
Consultants and Senior Clinical Staff	Annually in March

Note: It is the individual employee's responsibility to make a declaration should their circumstances change within these timescales.

(iii) A Register of Gifts, Hospitality and Sponsorship whether, accepted or declined, is maintained.

(iv) Appropriate information from the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship is published on the Health Board Website in accordance with the requirements of the Freedom of Information Act Publication Scheme and staff information will therefore be publicised on the website including as part of the report to the Audit Committee annually providing openness and transparency for the UHB.

(v) Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship and the effectiveness of the arrangements in place are provided to the Audit Committee at agreed intervals and will be available on the website.

(vi) The form that Employees should complete when making a Declaration of Interest or when advising if gifts, hospitality, sponsorship or honoraria have been accepted or declined are included as **Appendix 2** and **Appendix 3**.

Chair

The Chair should:

- Ensure that Independent Board Members are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.

- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.

- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Independent Board Members **PRIOR** to the event.

Executive and Clinical Directors

Executive and Clinical Directors must ensure that:

- Employees are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.

- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.

- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate **PRIOR** to the event.

Note: Clinical Directors are responsible for approval within clinical directorates and Executive Directors are responsible for approval within Corporate directorates.

- They review the contents of the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship on an annual basis to assist with the verification of the accuracy of the information contained within it.

- During periods of annual leave and prolonged absence they will ensure that they delegate the responsibilities to their Directorate Manager or Head of Nursing or an Assistant Director.

Line Managers / Departmental Managers

Line/Departmental Managers will:

- Ensure that this policy and the Standards of Behaviour Framework is brought to the attention of Employees for whom they are responsible, and that they are aware of its implications for their work.

- Ensure that Employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Behaviour Framework will be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate.

- Support their Employees in the application of the Policy and the Standards of Behaviour Framework, seeking advice from the Board Secretary / Director of Corporate Services and Governance if required.

Employees and Independent Board Members

All Employees, including those on Honorary Contracts will ensure that they:

- Understand this Policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification.

- Are not in a position where their private interests and NHS duties may conflict.

- Declare to the Health Board for recording in the Register of Interests any relevant interests
  At the commencement of employment
  Whenever a new interest arises, and
  If asked to do so at periodic intervals by the Health Board.

"Relevant interests" will include:-

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies

(b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less

(c) A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team

(d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary

(e) A position of authority in a charity or voluntary body in the field of health and social care

(f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests

(g) Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.

It is recommended that where there is doubt, a declaration of interest should be made

- Inform patients and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a patient. The fact that the patient has been informed must be recorded appropriately.

- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and committee meetings, during procurement processes.

- Declare to the Health Board for recording in the Register of Gifts, Hospitality and Sponsorship any offer of a gift, hospitality or sponsorship which requires recording.

- Obtain permission from their Director before accepting gift, hospitality or sponsorship which require recording.

- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Health Board.
-

Note: Employees should also refer to appropriate Professional Codes of Conduct and documents issued by the Welsh Government which will complement this Policy and the Standards of Behaviour Framework.

Procurement Department

The Procurement Department (provided by the NHS Wales Shared Services Partnership) scrutinise the Registers for Declarations of Interest and Gifts, Hospitality, Sponsorship and Honoraria to ensure that there is no opportunity for conflict of interest. A detailed protocol will specify the arrangements for undertaking this process and it will include:

- Details of the stages of the procurement process at which the Registers will be consulted
- The arrangements for checking of the Registers
- The arrangements for ensuring that all those involved in the procurement are given the opportunity to declare any relevant interest
- The arrangements for communicating this information to the Board Secretary / Director of Corporate Services and Governance for its inclusion in the Register of Interests, and
- The actions to be taken if there is a perceived conflict of interest at any point in the procurement process.

If an Employee is requested to participate in the procurement process they will be asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared. If they have not previously completed a Declarations of Interest Form they will be asked to do so before participating in the procurement process.

7. REGISTER OF INTERESTS

The Board Secretary / Director of Corporate Services and Governance will maintain Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship. Appropriate information from these Registers is available on the Health Board website.

The paper copy of the Register, together with the forms which are used to inform its contents will be retained by Corporate Services.

The Register is available for public inspection. Enquiries should be made to the Board Secretary / Director of Corporate Services and Governance Robert.Williams@Wales.nhs.uk or on 01443 744807.

8. DECLARATIONS OF INTEREST AT MEETINGS

It is a requirement that at the beginning of every University Health Board, Committee or decision making / formal Health Board meeting that members and those in attendance be invited to declare their interests in relation to any items on the agenda. Where a potential conflict is material or the member has a financial / pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall note vote upon it. The potential conflict and the action will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict the individual must declare their interest immediately. Under certain circumstances the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Board Secretary / Director of Corporate Services and Governance should always be sought prior to such a decision being made. From time to time, employees may need to declare interests at other Health Board or Partnership meetings. Such declarations will be recorded as if it were a Board or committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

9. GIFTS, HOSPITALITY AND SPONSORSHIP

Guidance regarding the types of gifts, hospitality and sponsorship which may or may not be accepted is detailed below:

9.1 Gifts

A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events / conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted.

The appropriate Director and the Board Secretary / Director of Corporate Services and Governance should be advised immediately.

9.2 Gifts from Patients / Service Users or their Relatives

Employees may accept, subject to it not contravening their professional Codes of Conduct, gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards. There is no requirement to declare such gifts.

Where a gift is offered by patients or their relatives that is likely to be over £25 in value it should be politely declined. In some cases the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of the Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Sponsorship and Honoraria Form declaring that the gift has been received must be completed.

Personal gifts of cash from patients or their relatives are not acceptable. It may only be accepted as a donation to an appropriate Charitable Fund and recorded as such.

9.3 Gifts from Suppliers/Commercial Organisations

No gifts, unless they are of low intrinsic value e.g. diaries, calendars, etc. are allowable from suppliers, contractors and other commercial organisations. All such offers of gifts should be politely declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined a Gifts, Hospitality, Sponsorship and Honoraria Form should be completed. This will allow the Health Board to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstances suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas. Whilst such practices should be discouraged and it is not acceptable for staff to personally accept these gifts, following discussion with the supplier / commercial organisation and the appropriate Director it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds.

9.4 Gifts from Dignitaries / Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it "culturally custom and practice" to exchange gifts. In such cases Employees should seek guidance from the Board Secretary / Director of Corporate Services and Governance and declare these gifts on a Gifts, Hospitality, Sponsorship and Honoraria Form. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the "gift culture" and may include decisions to "keep and display in public", "donate to an internal user group", "auction for charity" etc.

9.5 Hospitality

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours. Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality will not be misconstrued.

9.6 Acceptable Hospitality

Acceptable hospitality includes:

Offers of food and non-alcoholic drink, provided it is equivalent to that offered in similar circumstances by the NHS, can be accepted during working visits and does not need to be recorded in the Gifts, Hospitality and Sponsorship Register.

Other hospitality that may be accepted includes instances where:

- There is a genuine need to impart information, or represent the Organisation at Stakeholder Community Events e.g. Local Authority or Charitable organisations which have an association with the Health Board.
- An employee has been invited to receive an award or prize in connection with the work of the organisation or their role within it.
- An employee is invited to a Society or Institute Dinner or Function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Health Board.

These types of hospitality must be authorised prior to their acceptance by a Corporate or Clinical Director and a Gifts, Hospitality, Sponsorship and Honoraria Form must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of Employees to achieve the purpose of representing the Health Board should attend.

9.7 Unacceptable Hospitality

Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend / overnight break
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below)
- Use of a company flat or hotel suite
- Attendance at a function or event restricted to Employees which is not for the purposes of training or organisational development
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event
- Entertainment and / or tickets / hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories advice should be sought from their line manager in the first instance or if complex from the Board Secretary / Director of Corporate Services and Governance.

Employees should report any case where an offer of hospitality is pressed which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

9.8 Sponsorship

Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts and research and development.

No sponsorship should be accepted without the prior agreement of the appropriate Corporate / Clinical Director. A Gifts, Hospitality, Sponsorship and Honoraria Form should also be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and / or declined this should also be declared.

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.

More detail is provided below regarding the many forms that sponsorship may take.

9.8.1 Commercial Sponsorship for Attendance at Courses / Conferences

Employees may accept commercial sponsorship for attendance at relevant conferences and courses, but only where the employee seeks permission in advance from their Executive Director. The sponsorship should only be extended to the number of Employees who would have normally attended if funded by the Health Board. The Director must be satisfied that acceptance will not compromise purchasing decisions in any way.

9.8.2 Commercial Sponsorship to attend Demonstrations / Technical Evaluations

Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting.

Such sponsorship is not appropriate and the Health Board will meet the costs of such a visit so as to protect the integrity of subsequent purchasing decisions.

9.8.3 Commercial Sponsorship – "Linked Deals"

Pharmaceutical companies and other suppliers, for example, may offer to sponsor, wholly or partially, a post or equipment for the Health Board. The Health Board will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Health Board. Where such sponsorship is accepted, the Director of Finance & Procurement shall ensure appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement.

Under no circumstances should managers of the Health Board agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supplies from particular sources.

9.8.4 Sponsorship of Events in the context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations

The pharmaceutical industry and allied commercial sector representatives may organise meetings in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value. An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable.

9.8.5 Miscellaneous Payments/Honoraria

Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one off payment or honoraria is offered.

If this activity is to be undertaken during hours when the employee is contracted to work for the Health Board the payment should be made to the Health Board. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Sponsorship and Honoraria Form and it should be authorised by the appropriate Executive Director.

Honoraria received for work undertaken **during** Health Board hours

When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract **during** Health Board hours, any honoraria paid must be received back to the Health Board revenue budget to reimburse the Health Board for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is ***not*** managed by the employee who has provided their services during Health Board time.

To avoid personal tax implications, the Health Board employee is urged to request the Honoraria is paid directly to the Health Board. This is then seen as reimbursement to the Health Board to cover the loss of employee time, and not honoraria. This money will then be transferred into the Health Board revenue budget. The Health Board employee who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

If the employee receives the honoraria directly and then reimburses the Health Board, the **employee remains liable for the payment of both tax and National Insurance Contributions (NIC),** regardless of the final destination of the honoraria.

Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave) Individuals are **personally liable for the payment of both tax and NICs** on any honoraria payments received. Following their first honoraria declaration Individuals will be asked to sign a "Declaration Statement" (**Appendix 4**) confirming that they understand their responsibilities and this will be held on file by the Board Secretary / Director of Corporate Services and Governance.

If such an employee wishes to suggest a donation may be made to the Cwm Taf University Health Board Charitable Funds in lieu of an honoraria, this must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, staff should seek advice from the Board Secretary / Director of Corporate Services and Governance and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria has been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

9.9 Bequests left in Patient's or Service User Wills

On occasion's staff are left bequests in a service user's will which they become aware of before the service user is deceased or because they have been informed by the deceased service user's legal representative. In such circumstances the member of staff must immediately inform their manager. It should be borne in mind that staff cannot benefit from a bequest by virtue of their position as a Health Board employee, undertaking their duties. If a member of staff receives a bequest they should contact the Executive Director of Finance and the Board Secretary / Director of Corporate Services and Governance.

9.10 Gifts by Way of Inducement or Reward

The Prevention of Corruption Acts, 1906 and 1916, prohibit staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

a) Doing or refraining from doing anything in their official capacity; or
b) Showing favour or disfavour to any person in their official capacity.

It should be understood that a breach of the provisions of these Acts renders staff liable not only to dismissal but to prosecution

under the Acts, and it is expected that the Health Board would deal severely with any such breaches.

Staff should be aware that the Health Board is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Executive Director of Finance.

10. THE BRIBERY ACT 2010

The Bribery Act 2010 came into force on 1st July 2011.

It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers.

Broadly, the Act defines bribery as:

"Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith"

The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before.

The Bribery Act 2010 made it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". The maximum penalty for bribery is up to 10 years imprisonment, with an unlimited fine. In addition, the Act introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

Some simple examples follow:

- Bribery in order to secure or keep a contract.
- Bribery to secure an order.
- Bribery to gain any advantage over a competitor.
- Bribery of a local, national or foreign official to secure a contract.
- Bribery to turn a blind eye to a health safety issue or poor performance or substitution of materials or false labour charges.
- Bribery to falsify an inspection report or obtain a certificate.

The impact of other Health Board policies which should be considered by staff include:

- Raising Concerns.

Cwm Taf University Health Board is working towards a culture that encourages the raising of any concerns by staff to be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development) as these are the most effective mechanism for early warning of concerns, wrongdoing, malpractice or risks and line managers are accordingly best placed to act on, deal with and resolve such concerns at an early stage.

- The NHS Wales All Wales Social Media Policy.

NHS Wales organisations are making increased use of Social Networks to communicate with patients, service users, staff and other stakeholders to deliver key messages for good health care and other useful services. The policy governs the conduct of all staff (including contractors, agency and temporary staff) of NHS Wales with the aim of ensuring that they are aware of their personal responsibilities for appropriate use when using such social media facilities.

- The Counter Fraud Bribery and Corruption policy

This relates to all forms of fraud bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud. It provides a framework for responding to suspicions of fraud, advice and information on various aspects of fraud and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud bribery and corruption. The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in the UHB, irrespective of their position, about the risk of fraud bribery and corruption within the organisation and its unacceptability
- assist in promoting a climate of openness and a culture and or an environment where staff feel able to raise concerns sensibly and responsibly
- set out the UHB's responsibilities in terms of the deterrence, prevention, detection and investigation of fraud bribery and corruption
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
    - criminal prosecution
    - civil prosecution
    - Internal/external disciplinary action.

This is known as the triple track approach.

Appendix 5 provides additional clarification on how the Act may affect employees of the Cwm Taf University Health Board and further advice and clarification can be given by the Board Secretary / Director of Corporate Services and Governance if required.

11. RESEARCH AND DEVELOPMENT

All Research and Development sponsored by commercial companies, including those sponsored by the Pharmaceutical Industry must be approved by the appropriate mechanisms. It will be governed by specific policies and procedures. The Research and Development Department will be able to offer advice and support in this area.

12. CHARITABLE FUNDS

There may be occasions when commercial organisations offer to pay monies into Charitable Funds as a way funding attendances at courses or conferences. Monies may only be paid into Charitable Funds from commercial companies if it is a donation or sponsorship. It can only be used to fund expenditure which is in line with the terms of the funds use as set out within the Charitable Funds Policy.

Expenditure from Charitable Funds does not fall within the remit of this policy, however there may be a close association with the Standards of Behaviour Framework.

13. SECONDARY EMPLOYMENT & PRIVATE PRACTICE

Secondary Employment
Staff should inform their line manager of any secondary employment, and ensure that any secondary employment or private practice does not affect their Health Board employment. There should be no conflict with their normal contractual employment obligations to the Health Board, and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with the Health Board.

Private Practice
There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties.

The time spent in private practice does not count towards the 48 hours of the Working Time Directive Regulations, however, health and safety law indicates that no employee of the Health Board should work in a way detrimental to their health and performance.

Additional information and advice is available for staff in the Financial Control Procedure 'Private Patients'.

Failure to notify their line manager of secondary employment and/or private practice may invoke the Health Board's Disciplinary Policy.

14. FAILURE TO ADHERE TO STANDARDS OF BEHAVIOUR FRAMEWORK

If any Health Board employee fails to declare an interest as defined within this policy, the Standards of Behaviour Framework, or the guidance that will be published to support it and then:-

- participates in a decision making process where special favour is shown to unfairly award a contract; or
- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends,

disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary policy. Under some circumstances failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken if there is any suspicion that fraud, corruption and / or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within the Health Board in line with the Cwm Taf UHB Counter Fraud Bribery and Corruption policy.

Furthermore, if a member of staff breaches the Standards of Behaviour Framework this could in certain circumstances result in notification / reporting to the appropriate professional codes of conduct /registration / memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC) etc. This could incur registrations being revoked and employees no longer being able to be employed in their current position within the Health Board.

This is also extended to include the inappropriate acceptance of any gifts, hospitality or sponsorship. Failure to declare a relevant interest by an Independent Member of the Health Board will be reported by the Chairman and to the Minister for Health and Social Services, Welsh Government.

15. EQUALITY

This policy or procedure has been subject to a full equality assessment and no impact has been identified.

16. RESOURCES

The implementation and management of the arrangements associated with this Policy and the Standards of Behaviour Framework do not present any significant resource implications to the Health Board.

17. TRAINING

There are no training implications arising from this Policy and the Standards of Behaviour Framework. However, awareness of the importance of compliance will require reference in induction programmes, during Individual Performance Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when Employees are invited to make declarations.

18. IMPLEMENTATION

The Register of Declarations, Gifts, Hospitality, Sponsorship and Honoraria will be maintained by the Board Secretary / Director of Corporate Services and Governance who will also be responsible for issuing periodic invitations to declare interests.

Directors and managers need to be aware of their responsibilities for advising Employees accountable to them of their responsibilities in connection with the policy.

19. AUDIT AND MONITORING

The Board Secretary / Director of Corporate Services and Governance will review the operation of the policy and Standards of Behaviour Framework as necessary and at least once a year a report on the findings of the review will be submitted to the Audit Committee.

Directors will review the operation of the Policy within their Department as part of their processes for monitoring compliance with Standard 1 of the Standards for Health Services in Wales.

The Wales Audit Office and the Internal Audit Service may also review the arrangements from time to time and their findings are also reported to the Audit Committee.

Staff should note that following implementation of the Freedom of Information Act 2000 the information contained within the Health Board Register will be subject to disclosure to any member of the public on request. The information will also be routinely reported to the Audit Committee which will monitor the acceptance of gifts and hospitality by Health Board staff.

20. RETENTION AND ARCHIVING

In cases of complaints / claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Board Secretary / Director of Corporate Services and Governance will therefore ensure that copies of this policy are archived and stored in line with the Records Management Strategy and are made available for reference purposes should the situation arise.

21. DISTRIBUTION

The Policy and Standards of Behaviour Framework will be available via the Health Board intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

22. REVIEW

Review of this Policy and the Standards of Behaviour Framework must be undertaken no later than three years after the date of approval.

23. FURTHER INFORMATION

Further information can be obtained from Board Secretary / Corporate Director.

24. LEGISLATIVE AND NHS REQUIREMENTS

This policy aims to ensure that the Health Board complies with the requirements set out in: -

1. (DGM(93)84) Standards of Business Conduct for NHS Staff
2. WHC(2005)016 – The NHS and Sponsorship by the Pharmaceutical Industry
3. WHC(2006)090 - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
4. Director General, Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
5. Commercial Sponsorship - Ethical Standards for the NHS, Department of Health (November 2000)
6. Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011)
7. Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011)
8. General Medical Council – Conflicts of Interest (September 2008)
9. Health Board Standing Orders, Reservation and Delegation of Powers (March 2012)
10. Nursing and Midwifery Council, The code - Standards of conduct, performance and ethics of nurses and midwives (May 2008)

11. Royal College of Psychiatrists, Good Psychiatric Practice, Relationships with Pharmaceutical and Other Commercial Organisations (2008)
12. Association of the Pharmaceutical Industry (ABPI), Code of Practice for the Pharmaceutical Industry (November 2011)
13. The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010)
14. The Bribery Act 2010
15. NHS Protect – Bribery Act Guidance

Appendix 1

STANDARDS OF BEHAVIOUR FRAMEWORK

The Board has described its vision that underpin the way that services are provided and to support this, all employees must ensure that they carry out their roles with dedication and commitment to the Health Board and its core values.

All staff must have the highest standards of corporate and personal conduct and behave in an exemplary manner based on the following seven principles:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;

- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;

- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;

- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;

- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;

- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;

- **Leadership** – Individuals should promote and support these principles by leadership and example.

To uphold these principles you must:-

- Ensure that the interests of patients and the public remain paramount;
- Be impartial and honest in the conduct of your official business;
- Use NHS resources to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abuse your official position for personal gain or to benefit your family or friends;
- Not seek advantage or to further private business or other interests in the course of your official duties, and;
- Not seek or knowingly accept, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the UHB.

The Standards of Behaviour Framework Policy outlines the arrangements within the Health Board to ensure that staff comply with these requirements, including recording and declaring potential conflicts of interest and handling of gifts, hospitality and sponsorship (even if these are declined). Further guidance is available via the Standards of Behaviour Policy on the intranet site.

It is your responsibility to ensure that you are familiar with the requirements of the Policy and supporting guidance. The relevance of this information will vary depending on your role within the Health Board and your interests outside of your employment.

In summary:-

DO:

Make sure that you are not in a position where your private interests and NHS duties may conflict.

Declare any relevant interests. These include:-

- Directorships, including Non-Executive Directorships held in private companies or PLCs.;
- Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board.
- A position of authority in a charity or voluntary body in the field of health and social care;
- A personal or departmental interest in any part of the pharmaceutical or healthcare associated industries that could be perceived as an influence on decision making or on the provision of advice to members of the team;
- Sponsorship or funding from a known NHS supplier or associated company/subsidiary;
- Employment where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice;
- Anything else that could cause a potential for conflict.

Remember that the need to declare an interest also includes those of your close family and possibly friends.

Seek your manager's permission before taking any outside work, in accordance with employment terms and conditions.

Obtain your Directors permission before accepting any commercial sponsorship or hospitality;

Declare offers of gifts, hospitality or sponsorship using the appropriate form where required.

DO NOT:

- Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries;
- Accept any gifts over the value of £25 from patients or their relatives, these should be politely declined;
- Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations;
- Abuse your position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favouritism in your dealings with commercial organisations;
- Use NHS resources for your own private use.

If you need any further guidance please contact the Board Secretary / Director of Corporate Services and Governance on 01443 744800.

APPENDIX 2

CWM TAF UNIVERSITY HEALTH BOARD
STANDING ORDERS & STANDING FINANCIAL INSTRUCTIONS
DECLARATION OF INTERESTS IN THE HEALTH BOARD REGISTER

ONLINE FORM

http://cthb-intranet/Governance/TheBoard/Lists/Declaration%20of%20Interests/NewForm.aspx?RootFolder=%2FGovernance%2FTheBoard%2FLists%2FDeclaration%20of%20Interests

<table>
<tr><td>NAME:</td><td>DESIGNATION:</td></tr>
<tr><td>DATE OF APPOINTMENT FROM:</td><td>TO:</td></tr>
<tr><td rowspan="2">NATURE OF INTEREST:</td><td>DATE INTEREST ACQUIRED:</td></tr>
<tr><td>DURATION OF INTEREST:</td></tr>
<tr><td>INTEREST OF INDIVIDUAL SPOUSE OR PARTNER:</td><td>REMARKS:
(This section is to be used for any notes of clarification and also to indicate when interest ceases)</td></tr>
<tr><td colspan="2">I declare that the information given on this form is true and complete to the best of my knowledge. I understand that action may be taken against me if I make a false statement. I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.

Signature: …… Date: ……..</td></tr>
</table>

FOR OFFICE USE

ENTRY IN REGISTER OF INTERESTS	**DATE:**	**BY:**

N.B. The forms are no longer received in paper format – please use the link above on SharePoint. Any queries please contact Gwenan Roberts, Head of Corporate Services, Ynysmeurig House, Navigation Park, Abercynon. Information provided will be made available on line as specified within the Policy.

CWM TAF UNIVERSITY HEALTH BOARD
STANDING ORDERS & STANDING FINANCIAL INSTRUCTIONS
REGISTER OF GIFTS, HOSPITALITY, SPONSORSHIP AND HONORARIA

<table>
<tr><td>NAME OF RECIPIENT:</td><td>DIRECTORATE AND POST HELD:</td></tr>
<tr><td>DATE OF OFFER:</td><td>NATURE OF GIFT, HOSPITALITY, SPONSORSHIP OR HONORARIA:</td></tr>
<tr><td rowspan="2">NAME & ADDRESS OF OFFERER:</td><td>REMARKS:
(This section is to be used for any notes of clarification)</td></tr>
<tr><td>ACCEPTED / DECLINED:</td></tr>
<tr><td colspan="2">I declare that the information given on this form is true and complete to the best of my knowledge. I understand that action may be taken against me if I make a false statement. I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation</td></tr>
<tr><td colspan="2">Signature: …… Date: ……..</td></tr>
<tr><td colspan="2">AUTHORISATION / ACKNOWLEDGEMENT OF LINE MANAGER:

Signed: …… Designation: ……...

Date: …… Directorate: ……</td></tr>
</table>

FOR OFFICE USE

ENTRY IN REGISTER	**NO:**	**DATE:**	**BY:**

NOTE: This form must be completed when gifts (other than articles of low value such as diaries or calendars) or hospitality are accepted or declined. The completed and signed form must be returned to the Gwenan Roberts, Head of Corporate Services, Ynysmeurig House, Navigation Park, Abercynon, CF45 4SN

Information provided will be made available online – in line with the policy requirements

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

DECLARATION STATEMENT

TAX AND NATIONAL INSURANCE CONTRIBUTIONS IN RESPECT OF HONORARIA

I confirm that I am aware of the Personal Tax and National Insurance contributions responsibilities associated with receiving honoraria payments, as outlined in the Health Board's Standards of Behaviour Policy.

I understand that where honoraria is received for events undertaken in my own time (out of normal working hours or on authorised leave) I am **personally liable** for the payment of both Tax and National Insurance contributions on any honoraria payments received and it is my responsibility to personally declare this income to the inland revenue.

Where an honorarium is received for events undertaken in work time/and or whilst on study leave I will advise the sponsor that the payments should be paid direct to the Health Board. These funds will then be reimbursed to the appropriate Health Board revenue budget.

Print Name:	
Position:	
Signature:	
Date:	

Corporate Services

Received by:	
Position:	
Signature:	
Date added to Register	

Appendix 5

GOVERNANCE BULLETIN

The Bribery Act 2010

How Does It Affect You As An Employee Of Cwm Taf Health Board?

What is bribery?

Very generally, bribery is a form of corruption defined as giving someone a financial reward/payment or other advantage (a bribe) to encourage them to perform their functions or activities improperly (i.e. to favour one company or individual before others), or to reward them for already having done so.

What Is the Bribery Act?

The Bribery Act 2010 came into force on 1 July 2011. It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers.

What are the offences?

The Act contains two general offences covering the offering, promising or giving of a bribe (active bribery) and the requesting, agreeing to receive or accepting of a bribe (passive bribery). It also sets out two offences which specifically address commercial bribery. It also introduces a **corporate offence** which means that relevant commercial organisations will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery undertaken on their behalf.

Why is Bribery Act relevant to Health Boards?

The Bribery Act's definition of a relevant commercial organisation includes a body that is incorporated under the law of any part of the UK, which operates in any part of the UK or elsewhere. NHS organisations across the UK, including Welsh Health Boards and Trusts, will be subject to the provisions of the Act by virtue of the NHS and Community Care act 1990, which stipulates that all such organisations shall be a corporate body.

Similarly, for the purposes of the Act, a trade or profession is considered a business. This means that whether individually or in partnership, GPs, pharmacists, dental practitioners, opticians, finance professionals etc will also be subject to and personally liable under the Bribery Act.

Gifts and Hospitality

All staff must take great care over offering or accepting offers of gifts, hospitality and entertainment that are in any way linked (currently or prospectively) to the organisation's business. This is to avoid anyone being put in a position where there is potential or actual conflict of interest, or which might be construed in that light.

The guiding principle is that you must not accept gifts, hospitality or other benefits of any kind from a third party, which might be seen to compromise your personal and professional integrity. Corruptly soliciting or receiving any gift or favour is a criminal offence.

Further guidance is contained within the Gifts and Hospitality Policy which can be accessed via the Intranet site.

What should I do if I suspect that bribery is occurring?

Staff should report any suspicions or allegations of bribery immediately to one of the following:

- The Local Counter Fraud Specialists (LCFS)
- Local Counter Fraud Policy available here
- The Director of Finance & Procurement
- The NHS Fraud and Corruption Reporting Line – 0800 028 40 60
- On-line at **www.reportnhsfraud.nhs.uk**

Want to learn more?

The Ministry of Justice has produced guidance documents designed to help people and organisations understand just what the Bribery Act 2010 means to them. These can be found at **https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf**

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 3.1** **14 January 2019**

Audit Committee Report
CHARITABLE FUNDS

Executive Lead: Director of Finance
Author: Head of Finance
Contact Details for further information: Huw Evans on 01443 443810 or huw.evans2@wales.nhs.uk

Purpose of the Audit Committee Report
To advise the Audit Committee of the activity and balances on charitable funds for the period 1 September 2018 to 30 November 2018 and provides a progress update on other matters of interest.

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?
N/A

Audit Committee Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is requested to: • **NOTE** the contents of the report.						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	There are no specific equality and diversity issues
Legal implications	Charitable funds are required to be managed in accordance with charity legislation and requirements of the Charity Commissioner.
Population Health	No specific population health issues
Quality, Safety & Patient Experience	No specific quality, safety or patient experience issues
Resources	Investment of surplus funds assists in maximising income whilst safeguarding funds
Risks and Assurance	The report is a key element of the charitable funds governance and assurance process, and which enables Trustees' to discharge their responsibilities over the management of the charitable fund.
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. The work reported in this summary takes into account many of the related quality themes.
Workforce	No specific workforce implications
Freedom of Information Status	Open

CHARITABLE FUNDS

1. SITUATION / PURPOSE OF REPORT

To advise the Audit Committee of the activity and balances on charitable funds for the period 1 September 2018 to 30 November 2018 and provides a progress update on other matters of interest.

2. BACKGROUND / INTRODUCTION

The previous report to the Audit Committee highlighted balances and transactions up to 31 August 2018. This report updates the position as at 30 November 2018 and provides further analysis over their use by both fund type and location. It will also highlight those funds with low balances and slow moving funds with low levels of activity. An update is also provided on the investment performance, and impact of Bridgend Boundary Change.

BALANCES HELD BY THE CHARITABLE FUND

Balances held by the Charitable Fund as at 30 November 2018 are summarised in **Appendix A** analysed by fund type and location. Income received and expenditure incurred during the period 1 September to 30 November is also shown.

The balance at the end of November is £1.842m which is a reduction of £9k since the last report (31.8.18).

These balances exclude the unrealised gain on investment referred to below.

The number of funds has reduced by 4 since year-end following the closure of some funds.

LOW VALUE AND SLOW MOVING FUNDS

A listing of all funds below £1,000 as at 30 November 2018 is shown in **Appendix B.** Actions agreed with fundholders and other relevant observations are included within the comments section.

It should be noted that certain funds with low balances are very active and are being constantly used. This meets the objective of using funds for the purposes intended rather than allowing balances to accumulate. Also shown therefore within **Appendix B** are those funds with higher balances where there has been no expenditure activity during the previous six months, again with comments where appropriate.

INVESTMENT

The total units held remain at 783,307.83.

The market value at 30 November was £1.810m (a fall of £78k from the end of August), compared to £1.5m invested (i.e. a surplus of £310k – 20.7%).

Due to the volatility of the markets at this time, Trustees decided not to distribute any surpluses to individual funds at its annual meeting in October. Any surpluses will therefore be retained centrally as a buffer in the event of any future falls in investment values.

Forecast income for 2018-19 is currently £62k – an income yield of 3.4%.

A graphical presentation of the investment performance by week, along with a FTSE100 comparator, is shown in **Appendix C**.

BRIDGEND BOUNDARY CHANGE

Work continues on arrangements to transfer Bridgend funds between the two Charities. Confirmation of the name change will be required, along with the transfer order and supplemental deed, before formal arrangements can be made with the Charities Commissioner. Processes involved are on schedule.

The ABMU umbrella charity has a sub charity set up for Maesteg Hospital Fund which is scheduled to transfer. This will need to be set up as a separate sub charity within the Cwm Taf umbrella.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

This report is a key element of the charitable funds governance and assurance process, and which enables Trustees' to discharge their responsibilities over the management of the charitable fund.

4. RECOMMENDATION

The Audit Committee is requested to:

- **NOTE** the contents of the report.

Freedom of Information Status	Open

APPENDIX A

Summary of Funds and Transactions 01.04.18 - 30.11.18

No of Funds 31.03.17	No of Funds 31.03.18	No of Funds 30.11.18		Balance 31.03.18 £	Previous Period(s) Income £	Previous Period(s) Expend. £	Revised Balance £	Income Sept - Nov £	Expend Sept - Nov £	Balance 30.11.18 £
A			**By TYPE**							
10	10	10	General Purposes	444,335.88	3,978.89	(5,899.32)	442,415.45	11,315.29	(8,921.62)	444,809.12
65	62	58	Specific Purposes	1,159,581.84	31,873.51	(63,828.11)	1,127,627.24	27,454.99	(16,716.12)	1,138,366.11
5	5	5	Post Graduate Education	35,194.64	0.00	(126.99)	35,067.65	300.00	(2,059.08)	33,308.57
13	13	13	Research	248,587.40	2,262.95	(5,086.49)	245,763.86	2,334.00	(22,939.51)	225,158.35
93	**90**	**86**	**Total**	**1,887,699.76**	**38,115.35**	**(74,940.91)**	**1,850,874.20**	**41,404.28**	**(50,636.33)**	**1,841,642.15**
B			**By Location**							
33	32	31	RGH	264,692.22	3,261.60	(6,120.47)	261,833.35	4,775.00	(4,021.03)	262,587.32
17	15	15	PCH	409,986.32	9,804.03	(52,249.74)	367,540.61	18,313.95	(23,836.23)	362,018.33
9	11	11	RGH/PCH Combined	478,767.32	7,769.31	(4,591.47)	481,945.16	11,699.33	(2,220.00)	491,424.49
7	6	6	YCR	28,473.59	636.20	(1,732.96)	27,376.83	2,575.40	(1,598.90)	28,353.33
6	6	6	YCC	312,404.46	15,050.58	(6,773.93)	320,681.11	1,718.60	(11,162.01)	311,237.70
1	1	1	Dewi Sant	565.52	0.00	0.00	565.52	0.00	0.00	565.52
1	1	1	Y Bwthyn	62,799.90	300.00	(917.00)	62,182.90	365.00	(1,094.32)	61,453.58
4	3	1	YGT	5,269.46	100.00	(2,361.00)	3,008.46	545.00	0.00	3,553.46
5	5	5	Mental Health Unit	17,088.44	1,075.10	(160.82)	18,002.72	1,412.00	(2,550.00)	16,864.72
1	1	1	CAMHS	10,566.07	47.02	0.00	10,613.09	0.00	0.00	10,613.09
4	4	3	Community	10,419.37	0.00	0.00	10,419.37	0.00	0.00	10,419.37
3	4	4	LHB Wide	286,667.09	71.51	(33.52)	286,705.08	0.00	(4,153.84)	282,551.24
1	1	1	Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
92	**90**	**86**		**1,887,699.76**	**38,115.35**	**(74,940.91)**	**1,850,874.20**	**41,404.28**	**(50,636.33)**	**1,841,642.15**

Low Value and Slow Moving Funds

APPENDIX B

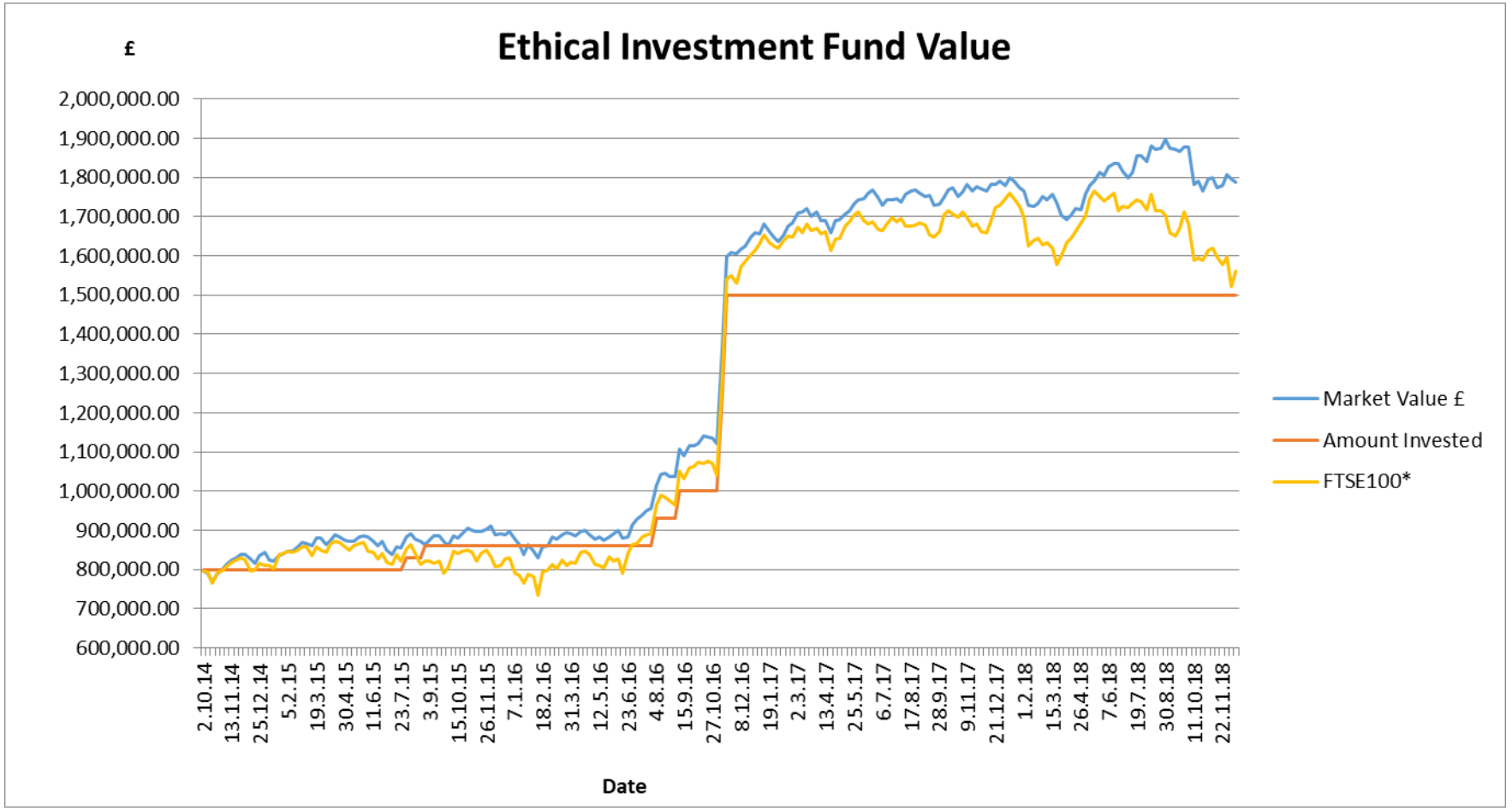
A **Low Value Funds** **Definition - fund balances below £1,000 as at 30.11.18**

Fund No	Fund Type	Location	Balance as at 30.11.18	Comments
9423	Post graduate Education	Mental Health Unit	514.81	Reminded fund holder - fund agreed to be spent and closed.
9459	RESEARCH	RGH	862.63	Fund Manger requested to keep fund open. Fund holder contacted 21.06.18
9465	RESEARCH	RGH	605.43	Fund to be used for course fees.
9483	Specific Purposes	RGH	870.80	Endoscopy - Fund to be used for training day. Reminder has been sent
9506	RESEARCH	RGH	207.74	Requested to keep fund open. Income expected for information packs.
9507	RESEARCH	RGH	339.93	Requested to keep fund open.
9516	Specific Purposes	RGH	56.36	Fund is used regularly.
9519	Specific Purposes	RGH	902.05	Requested to keep fund open.
9604	Specific Purposes	Dewi Sant	565.52	Dewi Sant Day Unit replaced by @home service. Fund will be closed. Reminded fund holder
9680	Specific Purposes	YCR	703.16	Fund has recently been accessed. Fund is used.
9824	Specific Purposes	RGH/PCH Combined	936.94	Expecting expenditure for furniture and some wall art for our patients' quiet room / bad news room.
9826	RESEARCH	PCH	368.28	Chest Unit Fund- planned for closure. Meeting to be arranged to discuss.
9850	Specific Purposes	LHB WIDE	302.33	Primary Care Fund. Requested to keep fund open.
9874	Specific Purposes	YCC	302.78	Fund holder has just been changed. E-Mail sent 13.12.18

APPENDIX B

B **Low Activity Funds** **Definition - balance over £1k but no expenditure against fund in last 6 months (other than management charges)**

Fund No	Fund Type	Location	Balance as at 30.11.18	Comments
			£	
9426	Specific Purposes	Mental Health Unit	3,922.00	Expenditure has been received in December
9450	General Purposes	RGH	41,802.12	Chief executive has been informed.
9453	Specific Purposes	RGH	1,291.85	Expenditure expected.
9455	Specific Purposes	RGH	52,621.88	Expenditure expected. Bladder scanner - will be a donated asset as price over 5k
9460	Specific Purposes	RGH	14,944.26	Fund is used for annual subscriptions
9463	Specific Purposes	PCH	9,625.44	PCH SCBU Fund on hold waiting for unit to be completed.
9469	Specific Purposes	RGH/PCH Combined	2,749.89	Fund will be used pending South Wales Plan. (Maternity).
9470	Specific Purposes	RGH	3,029.15	Fund Holder has retired. Possibility of merging fund. **Meeting to be arranged.**
9479	Specific Purposes	RGH	5,603.07	Fund will be closed - possibility of transferring to Giving To Pink Fund.
9481	Specific Purposes	RGH	4,906.72	New Fund Holder. Fund holder to be contacted.
9482	Specific Purposes	RGH	2,385.78	A&E Fund - will wait until changes to location have been implemented.
9486	Specific Purposes	RGH	3,061.96	Meeting was held and expenditure is expected. Reminder has been sent
9492	Specific Purposes	RGH	5,965.05	Fund holder has been contacted.
9494	RESEARCH	RGH	12,639.11	Meeting was held and expenditure is expected. Reminder has been sent
9497	Specific Purposes	RGH	5,920.73	Meeting was held and expenditure is expected. Reminder has been sent
9505	RESEARCH	RGH	4,344.07	Radiology - reminded fund holder the request for information.
9510	Specific Purposes	RGH	1,583.63	Fund Holder has been contacted
9625	General Purposes	Mental Health Unit	2,872.53	Expenditure has been received in December
9650	General Purposes	Community	2,351.74	Requested to keep fund open for future requests for aids for patient comforts.
9681	Specific Purposes	YCR	1,045.18	Fund holder has been contacted.
9730	General Purposes	Community	6,678.15	Requested to keep fund open for future requests for aids for patient comforts.
9731	Specific Purposes	Community	1,389.48	Requested to keep fund open for future requests for aids for patient comforts.
9751	General Purposes	YGT	3,553.46	Expenditure has been received in December
9801	Specific Purposes	PCH	30,480.23	Meeting was held and expenditure is expected. Reminder has been sent
9803	Specific Purposes	PCH	5,053.14	Expenditure for neurological rehab choir expected.
9809	RESEARCH	PCH	11,026.19	Meeting to be arranged to discuss**.**
9835	RESEARCH	PCH	66,627.05	Met with fund holder - spending plan to be agreed.
9827	Specific Purposes	PCH	2,434.94	Meeting was held and expenditure is expected. Reminder has been sent
9885	General Purposes	LHB WIDE	4,082.07	Chief executive has been informed.
9891	Specific Purposes	YCC	1,500.94	Fund holder has been contacted.


Ethical Investment Fund Value
£
2,000,000.00
1,900,000.00
1,800,000.00
1,700,000.00
1,600,000.00
1,500,000.00
1,400,000.00
1,300,000.00
1,200,000.00
1,100,000.00
1,000,000.00
900,000.00
800,000.00
700,000.00
600,000.00
2.10.14
13.11.14
25.12.14
5.2.15
19.3.15
30.4.15
11.6.15
23.7.15
3.9.15
15.10.15
26.11.15
7.1.16
18.2.16
31.3.16
12.5.16
23.6.16
4.8.16
15.9.16
27.10.16
8.12.16
19.1.17
2.3.17
13.4.17
25.5.17
6.7.17
17.8.17
28.9.17
9.11.17
21.12.17
1.2.18
15.3.18
26.4.18
7.6.18
19.7.18
30.8.18
11.10.18
22.11.18
Date
Market Value £
Amount Invested
FTSE100*

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

INTERNAL AUDIT PROGRESS REPORT

Audit Committee - January 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 2
4. Performance monitoring 2

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 3 January 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 October meeting of the committee six assignments have been finalised, and a further three reports have been issued in draft. The finalised reports are 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
Retention of staff	Limited
Directorate review – Facilities – management arrangements	Risk & governance - Reasonable Performance & plan - Reasonable Workforce - Limited
Raising concerns	Limited
Well-being of Future Generations Act (2015)	Reasonable
Continuing Healthcare	Reasonable
EASC – Non-Emergency Patient Transport Service – Follow up of baseline position	N/A

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.

4. Performance monitoring

4.1 In the table below we set out the current position of performance against the agreed measures for the 2018/19 programme of work.

Performance measure	Reviews	Notes
Report turnaround: Time from fieldwork completion to draft reporting (10 working days) Target:80%	18/19 (95%)	Review > 10 days: • CHC – 13 days
Report turnaround: Time taken for management response to draft report (15 working days) Target:80%	10/16 (63%)	Reviews > 15 days: • WHSSC – High cost drugs • Performance – follow up • Raising concerns • Retention of staff • CHC • WFG Act
Report turnaround: Time from management response to issue of final report (10 working days) Target:80%	15/16 (94%)	Review > 10 days: • CRC

4.2 In addition, after each audit review is finalised we issue a performance questionnaire. The questionnaire covers areas such as the professional conduct of the auditor, the opportunity to discuss findings, and overall satisfaction.

4.3 We report the number of performance questionnaires issued and the response rate to date for the 2018/19 work programme:

- Number of questionnaires issued: 16
- Number of responses received: 8 (50%)

Note: The response rate is affected by the timing of the issue of the questionnaire and the completion of this progress report.

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

Assignment	Days in plan	Status	Assurance	Timing	Notes
Retention of staff	15	Final	Limited	Q1	-
Directorate reviews: Facilities - Management arrangements	30	Final	-	Q1	Reported as 'draft' at the October 2018 committee
• 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	-
Medical equipment and devices	15	Draft	Limited	Q2	Draft report issued 4.12.18
Management of major capital	25	Draft	Limited	Q4	Draft report issued 20.11.18
IT systems	10	Draft	Reasonable	Q2	Draft report issued 11.12.18

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
Directorate reviews – Primary Care - Management arrangements	30	WIP	-	Q2	Fieldwork on going
Directorate reviews – Primary Care - Compliance	15	WIP	-	Q2	Fieldwork on going
Mandatory training	15	WIP	-	Q2	Fieldwork on going
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
Management of absence target	15	WIP	-	Q3	Fieldwork on going
Commissioning	15	WIP	-	Q1	Initial scoping meeting held June, second scoping in August. Fieldwork scheduled for November
Patient experience	15	WIP	-	Q3	Fieldwork on going
Service Change Plans	15	WIP	-	Q3	Fieldwork on going
Cyber security	15	Scoped	-	Q3	Awaiting ToR sign-off to start fieldwork

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
Water safety	15	Scoped	-	Q3	Planned to be preventative maintenance review – but refocused to water safety – ToR agreed – Fieldwork January
Directorate reviews – Radiology - Management arrangements	30	Scoped	-	Q4	Fieldwork planned for February start
Directorate reviews – Radiology - Compliance	15	Scoped	-	Q4	Fieldwork planned for February start
Welsh risk pool	2	Scoped	-	Q4	Mandatory review – Scheduled to start 04.02.19
Core financial systems	10	Scoping	-	Q4	ToR issued 18.12.18
Data quality review	15	Scoping	-	Q4	Scoping meeting 24.01.18. Planned start March
Health & Care standards	20	Scoping	-	Q4	Mandatory review
GP OOH	20	-	-	Q4	-

Appendix A

Assignment	Days in plan	Status	Assurance	Timing	Notes
WHSSC					
Risk management	10	WIP	-	Q3	Fieldwork on going
Governance arrangements	10	Scoped	-	Q4	ToR issued 18.12.18
EASC					
Governance and performance	15	Scoped	-	Q2	Fieldwork scheduled for 24.01.19
Additional work					
EASC - Non-Emergency Patient Transport Service – Follow up of baseline position review	N/A	Final	N/A	-	Additional review requested by EASC
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	-
WHSSC					
High cost drugs	15	Final	Reasonable	Q1	-
Review of network groups and advisory boards	10	Final	Reasonable	Q2	-

Retention of staff

Internal Audit Report

2018/19

Cwm Taf University Health Board

October 2018

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 7
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-1819-34
Report status:	Internal Audit Report
Fieldwork commencement:	12 June 2018
Fieldwork completion:	23 July 2018
Draft report issued:	8 August 2018
Management response received:	8 October 2018
Final report issued:	10 October 2018
Auditors:	Lucy Jugessur, Principal Internal Auditor Emma Samways, Deputy Head of Internal Audit
Executive sign off:	Jo Davies, Director of Workforce & Organisational Development
Distribution:	Hywel Daniel, Deputy Director of Workforce & Organisational Development Phillippa Doble, Head of Workforce Productivity Janet Gilbertson, Head of Organisational Development
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') we reviewed the procedures around the arrangements for the retention of staff.

The retention of staff is a key issue for the NHS. Whilst focus may be given to the workforce supply to create a recruitment pipeline, it is important that both new and existing staff are supported and encouraged to remain with the Health Board. Good staff retention levels will be the result of a combination of actions including for example supporting new starters, having development and career plans in place for staff and developing organisational cultures and values.

In the rolling 12 months to April 2018 the Health Board saw a net fall of 56.83 WTE in its workforce. Staff turnover for the same period was 9.03%, with nursing and midwifery being the staff group with the highest turnover rate, at 10.77%.

Within the Health Board's 2018/21 IMTP, concerns were raised relating to the recruitment and retention difficulties faced by the organisation, particularly in relation to adult, paediatric, mental health and practice nursing. The IMTP acknowledges that in recent years the Health Board's focus has been on the recruitment of staff, and it was recognised that there now needs to be an emphasis and greater effort on retention activity.

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 for the Health Board's management of processes in relation to the retention of staff. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives were managed appropriately.

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

- There are relevant strategies, policies and plans in place to outline the approach to staff retention.
- Data is collected and analysed in relation to staff turnover rates plus other relative data such as exit interviews, PADR compliance, sickness absence, and staff engagement and pulse surveys.
- Data is appropriately monitored and reported on to allow the effective monitoring of staff retention trends, and to inform decision making.
- Initiatives are in place that align to agreed strategies and plans, and outcomes are reviewed.

Similar to other health boards, the organisation has a number of recruitment and retention matters. In our planning discussions with the

Assistant Director of Workforce and Organisational Development, we agreed that the audit would focus on the retention of nursing staff.

3. Associated Risks

The potential risks considered in the review were as follows:

- Wards and departments unable to consistently operate in a safe manner due to insufficient staff.
- Additional costs incurred by the Health Board as a result of needing to employ agency staff or through additional recruitment campaigns.
- Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
- The failure to capitalise or reap the benefits of development investment in individuals.

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 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. 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 the retention of staff 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.

We identified a number of issues in relation to managing staff retention within the Health Board and have assessed the review as limited assurance.

The Health Board's 2018/21 IMTP identifies retention of nursing staff as an issue, and has recognised the need to develop a retention strategy to help address this. We note that a Nursing Retention Strategy and a Retention Action Plan are being drafted, but at the time of our audit fieldwork, more work is needed to align the two documents, and ensure that initiatives that are currently underway clearly link back to the Action Plan.

The Health Board has developed other strategies that are linked to nurse retention such as the Leadership Strategy and the Engagement Strategy. However, the links between all of these strategies is not explicit. Different strategies are being produced by the different areas with the Workforce and Organisational development directorate, without there being a consistent approach or sharing of knowledge to ensure crosscutting themes are identified.

We note that nurse retention data is collected from a number of sources including the Health and Wellbeing survey. However, following the collection of this data in summer 2017 it took a further nine months before it was reviewed and analysed. In contrast data in relation to sickness and staff turnover is presented at the monthly Nursing Workforce Group and retention is a standing agenda item.

At the time of our audit fieldwork no data in relation to exit questionnaires or interviews was being captured. Our sample testing of staff retention activity on three wards identified that no exit questionnaires had been completed for the staff that had left over the last year.

While a Task and Finish Group had been established by management to consider the exit interview process, the group only met twice in January 2018 and has not met since.

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	Relevant strategies, policies and plans		✓		
2	Data is collected and analysed		✓		
3	Data is appropriately monitored and reported		✓		
4	Initiatives are in place			✓	

** 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 weaknesses in the system control/design for the retention of staff.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for the retention of staff.

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 one: There are relevant strategies, policies and plans in place to outline the approach to staff retention.

We note the following area of good practice:

- Whilst acknowledging that the Nurse Retention Strategy is in the process of being developed, the document appears comprehensive, clearly stating the Health Board's objectives, values and behaviours, and outlining five inter-related strategic aims. The draft Retention Strategy Action Plan is user friendly, detailing the objectives, actions to achieve the objectives, responsibilities and timescales.

We identified the following findings:

- The Nurse Retention Strategy and Retention Strategy Action Plan are currently in draft format.
- The strategic objectives in the draft strategy and the actions in the draft action plan do not clearly align, and no reference is made to other interrelated strategies such as the Engagement Strategy or the Leadership Strategy.

Objective two: Data is collected and analysed in relation to staff turnover rates plus other relative data such as exit interviews, PADR compliance, sickness absence, and staff engagement and pulse surveys.

We note the following areas of good practice:

- The views and opinions of staff are gathered via the current NHS Staff Survey and at a Health Board level, via Health and Wellbeing surveys. A more localised 'Experience, Action, Results (EAR) survey has been developed for completion at a local level, allowing potential 'hotspots' to be targeted.
- Our testing of a sample of sickness records established that all sickness documentation including return to work forms and self-certification forms were completed on a timely basis.
- The PADR form has recently been revised and rewritten to make it more meaningful and more straightforward to complete and use. The objectives within them are also be linked to the IMTP.

We identified the following findings:

- The Health and Wellbeing Survey was issued to all staff by email or hard copy and was completed by over 500 nursing staff in summer 2017. However the results were only reviewed and analysed in April 2018.
- There is currently no document policy or procedure in place in relation to exit questionnaires and interviews.

  We visited three wards to review the process undertaken when staff leave the Health Board. No exit questionnaires had been completed for these three wards and no exit meetings had been held. In addition, data in relation to exit interviews is not collected or reviewed by the Nursing Workforce Group or any other group.
- Our testing of staff information on two of the three wards that we visited identified that PADRs were not being routinely conducted on an annual basis, and as such staff were not always able to set development objectives. In addition, progress was not always being monitored year on year.

Objective three: Data is appropriately monitored and reported on to allow the effective monitoring of staff retention trends, and to inform decision-making.

We note the following areas of good practice:

- On a monthly basis the Nursing Workforce Group receive a Staff Utilisation report which includes data such as sickness and turnover for each ward. In addition, retention was an agenda item and sickness was a standard agenda item for all the meetings.
- Nurse Establishment meetings take place on a monthly basis with the Senior Nurse and Ward Manager to allow a more detailed review on a ward by ward basis of the staffing and finance data. Where potential issues are identified, this will prompt a 'deep dive' review into that ward.

We identified the following finding:

- There is an Exit Meeting Task and Finish Group in place but the group has only met twice since convening in January 2018, there are no terms of reference for the group, and there are no agendas or minutes for the meetings that did take place.

Objective four: Initiatives are in place that align to agreed strategies and plans, and outcomes are reviewed.

We note the following area of good practice:

- A number of 'initiatives' are in place such as a review of the exit interview process, a revision of the PADR process, the introduction of the EAR pulse survey, and the development of rotational roles.

We identified the following findings:

- The initiatives that have and are being developed do not clearly align to the Retention Strategy Action Plan.

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	**3**	**3**	**0**	**6**

Finding 1 - Nurse Retention Strategy and action plan (Control design)	Risk
As part of the 2018/21 IMTP acknowledgment is given to the significant pressures on the nursing workforce and the requirement to review the nursing recruitment and retention strategy with a focus on retention. At the time of our audit fieldwork the Nurse Retention Strategy and Retention Strategy Action Plan 2018/19 were in draft format and had been since March 2018. The two documents do not appear to be clearly linked as the strategic objectives detailed in the strategy document and the actions recorded in the action plan do not align. For example, the strategy is structured around five strategic aims whereas the action plan is structured around nine objectives. We would expect the actions to align with the strategic aims. Furthermore, during our fieldwork we were also provided with copies of the Health Board's draft Engagement Strategy and draft Leadership Strategy. It is not clear if consideration has been given to aligning the content of these, and any other key workforce and organisation development strategies, with the Nurse Retention Strategy.	Wards and departments unable to consistently operate in a safe manner due to insufficient staff.

Recommendation	Priority level
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**
Management Response	**Responsible Officer/ Deadline**
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.	Phillippa Doble Head of Operational HR January 2019 Phillippa Doble Head of Operational HR January 2019

Finding 2– Exit interview process (Control design)	Risk
We visited three wards where there has been staff turnover in the past year, to review the processes in place when staff leave the Health Board. Whilst there is no documented policy or procedure in place, we understand that departing staff are asked to complete an exit questionnaire which is followed up with an exit interview to understand the reasons for the employee's departure. However, from our discussions with the Ward Managers and Senior Nurses on these wards, and a discussion with HR, it was apparent that no exit questionnaires had been received by HR, and no exit interviews had taken place for these three wards, despite the fact that questionnaires would have been sent We note that no data in relation to exit interviews is provided to the Nursing Workforce Group as part of the staff utilisation report.	Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
Recommendation	**Priority level**
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**

Management Response	Responsible Officer/ Deadline
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 will then be piloted within nursing during the rest of 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.	Phillippa Doble Head of Operational HR December 2018
All data captured from both exit and entry questionnaires will be presented to the Nursing Workforce Group monthly meeting.	December 2018
The importance of exit interviews is enforced at both the Snr 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.	February 2019

Finding 3 - Exit meeting Task and Finish Group (Control design)	Risk
We were advised by the Head of Workforce Productivity that a Task & Finish Group has been established to review the processes being followed when nursing staff leave the Health Board. The group includes Business Partners, Organisational Development colleagues and Compliance and Governance staff. However, there are no terms of reference for the group and there are no minutes or agendas available for those meetings that have taken place. The group was due to meet fortnightly and report into the Nursing Workforce Group which meets monthly, who in turn report into the Efficiency and Evaluation Board. However, the group has only met twice since it was created in January 2018. In addition, we saw no evidence of information being reported from the Task & Finish Group to the Nursing Workforce Group.	Continued reduction in the Health Board's nursing workforce as a consequence of retention issues not being monitored and relevant actions not being taken.
Recommendation	**Priority level**
A decision should be made regarding the need for a Task and Finish Group to review the exit process. Where there is deemed to be an ongoing need for the group, management should consider developing a terms of reference confirming the purpose, authority, attendees and the frequency of meetings for the Group. Agendas and minutes should be produced for each of the Task and Finish Group exit process meeting held and progress updates should be reported to the Nursing Workforce Group on a regular basis.	**High**

Management Response	Responsible Officer/ Deadline
A decision has been made to undertake this piece of work by using a graduate trainee, rather than a Task & Finish Group. The work has now been completed, and ongoing management will be undertaken via the Senior Nurse Forum and Nursing Workforce Group, as mentioned in the response to Finding 2 above.	Phillippa Doble Head of Operational HR Completed

Finding 4 - Timely use of survey data (Operating effectiveness)	Risk
During Summer 2017 a Health and Wellbeing Survey was undertaken by the Health Board. All staff were contacted by email or hard copies provided for those staff without email access. Over 1400 responses were received with 529 nursing staff responding. An initial review of responses was carried out by the Occupational Health and Wellbeing Manager in January 2018. However, the analysis and write up of the survey results in relation to nursing staff did not take place until April 2018. The completed surveys included a lot of changes requested by the nursing staff. Trends and themes were identified including: how staff rate their current physical and emotional health; what initiatives staff are interested in; which aspects of healthy behaviours impact on staff health and wellbeing; which communication channels do staff have access to in different areas; what themes and ideas for improvement have been expressed by the workforce; and are there any activities or initiatives that could be put in place. The length of delay in analysing the data captured in the survey appears to be 'time lost' where quick wins could have more quickly taken place to respond to the outcome of the survey. Aside from this survey, and the ongoing all Wales NHS staff survey which will provide directorate level responses, there have been no other attempts to gather staff views and opinions via 'pulse surveys' at a departmental level.	Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.

Recommendation	Priority level
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**
Management Response	**Responsible Officer/ Deadline**
In relation to the staff Health and Wellbeing survey which was conducted during the Summer of 2017, the results were collated in January 2018 and as the nurses were the largest responders (529 nurses responded representing 37% of the overall response rate) a more detailed analysis of their feedback was collated in February. The findings were presented at the Nurse Recruitment and Retention meeting on 8 March 2018. This was followed up with a detailed discussion with Lynda Williams, Director of Nursing on 24 April where it was agreed a workshop would be set up with the Director, the Assistant Director of Nursing and the Heads of Nursing. The workshop was held on the 11 July where analysis of the findings was presented and the group were able to conduct a qualitative analysis identifying key themes. From this work it was agreed that a Head of Nursing, Jane O'Kane, would join the organisations staff health and wellbeing group 'Feeling Fine, Working Well', and for the first time provide a voice for nursing staff on health and wellbeing	Karen Vaughan Occupational Health & Wellbeing Manager

issues. The idea is to establish a sub group dedicated to focusing on nurses and health care support workers as it is recognised this is a unique staffing group with specific working practices. Jane has already made links with Kerri Eilertsen-Feeney, Head of Midwifery, Gynaecology and Sexual Health, in relation to the Royal College of Midwifes (RCM) 'Caring 4 You' Charter to see if the principles of the charter can be adopted for the general nursing teams. The organisations sign up to the charter demonstrates its commitment to all midwifes and maternity support workers to improve health, safety and wellbeing at work. Kerri said: "Caring for staff is high on our agenda and we welcome this opportunity." It was felt the themes identified through the workshop such as communication, recognition and morale would be best addressed through a leadership programme which will be developed with the Organisational Development team. The nurse analysis of the survey will continue to be cascaded through the nursing networks via the senior nurse manager meetings with discussions on how the results can be utilised further to support staff health and wellbeing. During July and August 2018 a pedometer challenge was initiated and promoted to all staff groups via the staff intranet site and the staff champion network. This initiative was in support of the national physiotherapy campaign 'Love Activity, Hate Exercise'. The organisation supports and promotes various national and local health and wellbeing campaigns throughout the year. The All Wales staff survey has recently closed. High-level feedback will be received on 12 November 2018.	February 2019 November 2018

Regular pulse surveys will be conducted as part of the Engagement strategy.	January 2019

Finding 5 - PDR documentation (Operating effectiveness)	Risk
PDRs should be completed for all staff on an annual basis. Part of their purpose is to allow staff to record their development requirements for the forthcoming year and to reflect on the previous year, allowing both staff and their line managers to take action as necessary, which may ultimately prevent a member of staff from leaving. We selected a sample of 29 staff across three wards to ensure that a PDR had been undertaken on an annual basis. We requested to see copies of the PDR (as opposed to confirming completion via ESR), in order to evidence that development requirements and concerns had been captured. Our findings are as follows: <u>Ward A</u> • There was no evidence of tracking and monitoring of PDRs on an annual basis for any that we reviewed. • 4/10 PDRs had been undertaken over 12 months ago. • 9/10 PDRs referred to specific issues on the ward such as staff morale. <u>Ward B</u> • 8/9 PDRs - There was no previous PDRs on the employee's personal file. • There was no evidence of tracking and monitoring of PDRs on an annual basis for any of the PDRs that we reviewed.	Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.

• 1/9 PDR had been undertaken over 12 months ago. • 5/9 PDRs referred to specific issues on the ward such as staff morale. We did not identify any issues from our testing of sample of ten staff at the third ward. It is acknowledged detailed monitoring of PDR compliance on a directorate and ward basis is now closely monitored during the directorate Clinical Business Meetings.	
Recommendation	**Priority level**
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**
Management Response	**Responsible Officer/ Deadline**
PDRs are undertaken on an annual basis and recorded via ESR. In July 2018 PDR compliance was 73.95% against a target of 85% for the organisation with nursing and midwifery at 72.24%. Work continues through the CBMs to drive up compliance and PDR rates are reported monthly at every operational business meeting and quarterly for corporate areas. Compliance is also reported in the monthly Finance,	Janet Gilbertson Interim Assistant Director Organisational Development

Performance and Workforce Committee Report as part of the workforce metrics dashboard. 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.	January 2019

Finding 6 - Initiatives in place to retain nursing staff (Operating effectiveness)	Risk
Stemming from the Retention Strategy Action Plan we would have expected to have seen initiatives being developed as a means to implement the various actions identified. We have been informed by the Head of Workforce Productivity that some initiatives are in place. For example, Workforce are in the process of producing a 'Nursing Offer' for September 2018 that will confirm all grades within nursing, and the offer to 'new recruits' if they join, or already work within, the Health Board. Whilst these are mostly recruitment initiatives, there are also links to retention. In addition, the Health Board are hoping to introduce rotational roles whereby nurses can rotate between wards on a six monthly basis so they can experience work on different wards. However, currently there is no clear link between these initiatives and the action plan.	The failure to capitalise or reap the benefits of development investment in individuals.
Recommendation	**Priority level**
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**

Management Response	Responsible Officer/ Deadline
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.	Phillippa Doble Head of Operational HR January 2019 December 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.

Facilities Directorate review - Management arrangements

Internal Audit Report

Cwm Taf University Health Board 2018/19

October 2018

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 7
5. Assurance Summary 10
6. Summary of Audit Findings 11
7. Summary of Recommendations 15

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

Review reference:	CTU-1819-22
Report status:	Internal Audit Report
Fieldwork commencement:	2 July 2018
Fieldwork completion:	5 September 2018
Draft report issued:	14 September 2018
Management response received:	1 & 22 October 2018
Final report issued:	26 October 2018
Auditors:	Sian George, Liz Vincent, Emma Samways
Executive sign off:	John Palmer, Interim Chief Operating Officer
Distribution:	Russell Hoare Interim Assistant Director Steve Webster, Director of Finance Mark Thomas, Assistant Director Finance
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

The review of the Facilities 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').

The relevant lead for the assignment is the Interim Chief Operating Officer.

As part of the current year's Internal Audit programme, we will be reviewing the management arrangements for a number of directorates. We anticipate that all directorates will be audited over a three-year period.

In addition to this review of management arrangements a separate piece of audit work has been undertaken within the directorate to establish the level of compliance with the Scheme of Delegation and Financial Control Procedures.

As such we have produced two reports, one focussing on compliance with financial governance arrangements, and one focussing on management arrangements.

During the audit planning phase of this review, we met with members of the finance team, the Interim Assistant Director and a number of the business partners. As a result of those discussions, a risk in relation to the Porter service was identified and therefore formed part of the focus of testing during the review.

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 governance, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievements of system's objectives are managed appropriately.

The areas we sought to provide assurance on were:

Governance arrangements

- Appropriate governance structures are in place including key personnel and appropriate committees and groups.
- Directorate policies and procedures are owned and are up to date.
- Business partners' provide appropriate support for the directorate's key operational functions.
- There are appropriate mechanisms in place to ensure new legislative and regulatory information is received, 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.

Workforce management & service delivery

- 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 PDRs in good time.
- Staff complete mandatory training in line with specified 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 that its Integrated Medium Term Plan (IMTP) is developed in accordance with the Health Board's corporate planning framework.
- Budget holders and other relevant staff are appropriately engaged in the development of the directorate's IMTP.
- Budget holders within the directorate monitor budgets and agreed Cash Releasing Efficiency Scheme (CRES) targets and take action as appropriate.
- The directorate has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce. These are formally reviewed and reported on a regular basis.
- The directorate has appropriate action and recovery plans and mechanisms in place, where required, in relation to both financial and non-financial activities. For example, if performance targets begin to show an adverse variance.

Standards of conduct

- Declarations of interest (or nil returns) are submitted for all relevant staff and the directorate is aware of the declarations made.

Directorate specific objective

- We also considered how good practice is captured and communicated between the directorate and other directorates so that shared improvements to services can be made where appropriate.

3. Associated Risks

The potential risks considered in the review were as follows:

- The directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- 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 and capacity data failing to be properly used and monitored.
- The Porter service is delivered in an inefficient way resulting in savings targets not being achieved.

OPINIONS AND KEY FINDINGS

4. Assurance Opinions

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 and directorate specific), 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 has an up to date organisational chart that reflects the recent changes to the structure and has been included in the 2018-21 IMTP.

The directorate also has a facilities communications plan in place, which is a document that we have not seen in previous directorate reviews. The document identifies all meetings / groups within the directorate, what the purpose of each meeting is, what will be monitored at the meeting and the

frequency of each of them. Whilst some minor improvements have been recommended to enhance this document, consideration should be given to other directorates introducing a similar document.

The directorate has a good working relationship with its business partners and this was evidenced through the finance monitoring meetings, the support provided for a number of the Cash Releasing Efficiency Scheme (CRES) projects where there is a workforce implication, and the support offered in the IMTP development.

A robust process is in place for capturing and disseminating legislative and regulatory updates. However, further work needs to be undertaken to review the policies and procedures relevant to the directorate, and to ensure the versions are consistent within the directorate and more widely on SharePoint.

Risk management

Two different risk registers are in place within the directorate. One set of risks where there is a capital implication are recorded on a spreadsheet and are monitored at the Operational Group meeting and feed up the Quality, Safety and Risk Committee. A different set of risks are recorded on Datix and are reported at the directorate's Clinical Business Meetings.

Standards of conduct

We understand through discussions with the Directorate Manager that Declarations of Interest (DoI) requests are managed centrally by the Head of Corporate Services and the directorate are not made aware of the returns made. As such, declarations and personal interests may not be considered within the directorate. However, our testing confirmed that all relevant staff within the directorate had made a declaration or nil return.

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 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 directorate has used the Health Board's Local Planning Framework to develop its 2018-21 IMTP and all draft submissions were made to planning and performance in accordance with the Health Board's timetable. Evidence was seen of engagement with stakeholders from across other directorates and with the relevant business partners.

The monitoring of the IMTP, particularly the CRES target takes place through fortnightly update meetings. During these meetings an updated is provided on all projects that form part of the scheme. Some inconsistencies were noted in the data being presented at the meetings.

Monitoring of the overall financial position and non-financial performance measures takes place during the Corporate Business Meetings and the multi-disciplinary groups.

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 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.

Our workforce testing focussed on the Porter service at both Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH). Since 2016 and as part of the services redesign plan, changes within the directorate means that porter services and Housekeeping are managed by a Facilities site management team. Our workforce testing was split into six key areas; annual leave, flexi-time and Time of in Lieu (TOIL), sickness management, PDRs, mandatory training, staff rosters. It was apparent that different process are in place across both sites in order to manage the areas we tested.

We identified examples at both sites where the monitoring and management of annual leave, absence, PDRs and training was not in accordance with policies. More detail regarding these findings is in section 6 of this report, and full commentary regarding individual findings is in Appendix A.

Of particular concern is the approach to rostering within the porter service.

Current working practices appear to be based on historical arrangements and demand that does not reflect the current demand at both RGH and PCH. We acknowledge that work has commenced as part of CRES projects to introduce improvements in this area, however we identified a number of issues during our fieldwork.

5. Assurance Summary

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

Assurance Summary					
1	Governance arrangements			✓	
2	Risk Management		✓		
3	Workforce management & service delivery		✓		
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 four issues that are classified as weaknesses in the system control/design for management arrangements within facilities.

Operation of System/Controls

The findings from the review have highlighted eleven issues that are classified as weakness in the operation of the designed system/control for management arrangements within facilities.

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 organisational chart in place that was included in the IMTP.
- There is a clear line of communication from CBM to the Facilities Operations Group.
- The directorate has introduced a Team Operational Exception report for each service area which is presented by the Service Leads at the Operational Group meeting. The report includes Workforce KPI scores, Service Quality KPI's, establishment figures, and updates and actions from previous meetings.
- Governance issues such as compliance scorecards, health and safety, policies and documents for review were discussed in all multi-disciplinary groups.
- The Governance and Performance Manager maintains a register of legal compliance for the Environmental Management System and will cross reference this to the aspects and impacts register. New legislation that is relevant to the department is recorded and shared with the relevant staff.
- The directorate subscribes to the Environmental Legislations Update Service and Coroner Facilities Management and the Governance and the Performance manager routinely checks the HSE Website.
- The directorate has compliance scorecards in most service areas and evidence is provided annually to ensure compliance to all legislative and regulatory requirements is taking place. The scorecards are managed by the Governance and Performance Manager who also holds regular meetings with service managers to update the scorecards.
- Legislative requirements for each service within the directorate have been outlined in the IMTP. This is how the Service Leads are made aware of their responsibilities.
- The Governance and Performance Manager checks that relevant legislation has been referenced in new and updated policies.
- The directorate received positive feedback from their recent ISO 14001 audit report, which stated that the legal register process was of 'a very good standard'.

We identified the following findings:

- The directorate has a manual record of its policies and procedures. A set of policies and procedures also exists on SharePoint, however our comparison of the two registers identified discrepancies between the two.
- A Communications Plan is in place within the directorate, but could be enhanced to include more detailed Terms of Reference for the directorates groups.

Objective 2: Risk Management

We note the following areas of good practice:

- Risks are assessed in accordance with the Health Board's risk management policy and procedure and the directorate uses a compliance scorecard approach to review and manage service risks.

We identified the following findings:

- The directorate currently has two risk registers in place; one is a manual register which features service risks and the second register is what is recorded on Datix. A review of these documents established that they do not correlate.
- The risks recorded in Datix are not always reviewed in a timely manner and the audit trail within Datix is not being completed as evidence of review.

Objective 3 - Workforce & Service Delivery

We note the following areas of good practice:

Annual Leave

- All annual leave dates had been recorded correctly onto ESR for both sites and corresponded with the relevant documentation used.

PDR

- For the PDRs that we could review at PCH, all had been fully completed, objectives had been set and the document had been signed by both the employee and manager. The PDR dates given on ESR corresponded with the dates on the PDRS within personal files.

Mandatory training

- The RGH porters average compliance rate for mandatory training had a significant increase from 46% to 86%, between June and July 2018. The Porter Team Leader delivered intensive training sessions over a period of six weeks in a bid to increase the compliance rates.
- One of the facilities managers produces training compliance reports that are broken down by the key areas of the directorate and on a person by person basis. These are used to monitor when training is

due to expire in order to target training at relevant staff. An annual programme of training days has been developed for the two sites.

We identified the following findings:

Annual Leave

- At the current time there is no policy or procedure in place for requesting and managing annual leave at PCH. Attempts have been made to introduce the set of principles at RGH, however to date, this has not been agreed. There is no consistency across both sites.
- Testing was carried out across both sites which identified clerical errors when reviewing their annual leave documentation. There were examples where forms had not been completed fully, dates differed or signed inappropriately.
- Both sites allowed annual leave to be carried forward and also staff were able to purchase additional annual leave. Whilst the relevant forms had been completed in most instances; none had not been signed by the Directorate Manager which is a requirement of the Scheme of Delegation.

Flexi Leave and TOIL

- There is TOIL policy in place at RGH that is used by the Housekeeping staff. It is unclear from the policy if this includes Porter Services. Although it is acknowledged that the use of TOIL within Porter Services in low, a consistent approach should be applied across the departments / sites.

Sickness

- We identified numerous errors across both sites in relation to compliance with the All Wales Sickness Policy including missing documentation and failure to adhere to triggers.
- As part of our sickness testing at RGH we reviewed the staff signing in book. It was noted that on a number of occasions the signatures for individuals varied on different days.
- We also reviewed the signing in book at PCH during and that some staff had signed themselves out at the same time they signed in.

PDR's

- We found incomplete PDRs at RGH that had not been signed by the employee or manager.
- At the time of the audit fieldwork both areas were not compliant with the Health Board target for PDRs.

Mandatory Training

- PCH has an average compliance rate of 51% across the 11 core modules. Our testing identified some staff that did not have any 'in date' training.

Staff Rostering

- There are no consistent practices regarding porter rosters. Rosters are currently set around historical staffing levels resulting in the need for overtime to be routinely worked.
- Often staff do no correctly sign in or out of their shifts.
- Short notice swapping of shifts is common.
- Accuracy checks are not undertaken on pay returns at RGH and our testing of one week's data identified a number of errors.

Objective 4: Planning and Performance

We note the following areas of good practice:

- The IMTP was developed in line with the timetable set out in the current local planning framework and covered all the key areas / priorities that were required.
- The relevant staff attended the formal IMTP engagement session held in October 2017 and the directorate was proactive in seeking views of stakeholders and utilising the support of the business partners. Recognition was given to the directorate for this approach in their IMTP feedback.
- The directorate holds fortnightly IMTP meetings to monitor the Service Plan and CRES target plus regular meetings take place with Interim Assistant Director of Facilities and the Finance Business partner to monitor budget as a whole.
- The directorate has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery.
- The directorate also has workforce KPIs in place which form part of the Directorate Manager's report, which is discussed at the monthly CBM. The directorate is working towards the All Wales targets for PDR (85%), sickness (4.5%), and mandatory training (75%).

We identified the following finding:

- A number of small discrepancies were identified in the varying documents used to monitor CRES performance at the fortnightly IMTP meetings. Whilst it is acknowledged that there will be updates, this was not always clear, with different monitoring documents reporting different values, probabilities and stages.

Objective 5: Standards of Conduct

We note the following area of good practice:

- The Health Board has an annual process in place requesting relevant staff to complete a declaration of interest. Outcomes are reported to the Audit Committee.

We identified the following finding:

- Those declarations of interest that are made by Facilities 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. A recommendation regarding this has already been made to Corporate Services within the ACT directorate review.

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	2	1	1	**4**
Planning and performance	0	1	0	**1**
Workforce	6	4	0	**10**
Total number of recommendations	**8**	**6**	**1**	**15**

Risk management and governance

Finding 1- Risk recording and reporting (Operating effectiveness)	Risk
The directorate is currently working with two risk registers. One on Datix and the other on a spreadsheet. The spreadsheet version held within the directorate contains 48 risks that have been identified by the team, which require capital funding to mitigate the risk. At the time of the audit fieldwork these had not been included onto the Datix risk register but are reviewed, managed and reported at the Facilities Operations meeting, and the Quality, Safety and Risk Committee (QS&R). The directorate uses Datix to record other risks such as slips, trips and falls. The Datix register is currently showing 74 high and moderate risks and these are reported at the directorate's CBM on a quarterly basis as part of a wider report on Non-Patient Safety Incidents, Risk and Claims. These are different risks to those on the directorate's spreadsheet risk register. We reviewed the July 2018 report on Q1 data that had been produced for the CBM and note the following: • One high risk was in the 'awaiting final approval' stage. The risk 'handler' was the Director of Nursing and as such, the risk should not have been allocated to the Facilities directorate. • A table was included in the report, which identified 51 overdue actions relating to risks. Thirty nine of these outstanding actions belonged to one	Risks materialise as they have not been identified and / or addressed.

handler, and 38 of these should have been completed between November 2013 and February 2015. Risks that are identified on the directorate's spreadsheet risk register form part of the directorate's exception report, which is discussed at the QS&R committee. The exception report presented at the May 2018 committee reported five 'moderate' and one 'major' risk, whereas the spreadsheet risk register uses different terminology and records eight 'significant' risks and 22 'high'. As such, in addition to the difference in the numbers reported, we also note that risk terminology is not being consistently applied. For example, 'moderate' and 'significant'. While the risk register is not a formal agenda item in the Facilities Operational Group a facilities summary report is included which includes 'high' and 'significant' risks'. We compared these risks to the spreadsheet risk register and Datix, but we were unable to clearly reconcile these risks to the registers.	
Recommendation	**Priority level**
The directorate should amalgamate the risk registers into one to ensure that all risks are being captured and reviewed appropriately and that there is a consistent use of terminology. Proactive monitoring of risks should take place, especially high risks, to ensure action is being taken in a timely manner. All actions taken, including amending the review date should be recorded in Datix. Management should ensure that the Non-Patient Safety Incidents, Risk and Claims report that contains the risk register is presented at each CBM meeting	**High**

and if necessary at the Facilities Operational Group meetings in order for risks to be discussed in greater detail. The risk data contained in the report should be made more meaningful by including details of when the risk was first opened and when it was last reviewed. Where it is obvious that the data contained within the report is inaccurate, action should be taken to remedy this.	
Management Response	**Responsible Officer/ Deadline**
Prior to the audit the Facilities directorate was the subject of management and leadership change due to the retirement of the Facilities Governance Manager. A review of the governance, compliance, Datix risks and risk register arrangements had already been put in place and a plan of action agreed upon by the Facilities Operational Board where governance matters have been reviewed. In addition a new Governance and Compliance Manager was in the process of being appointed to take this work forward and has now taken up post. Facilities management will ensure that the recommendations are taken forward and put in place.	David Williams – Facilities Governance and Compliance Manager. 30/11/18

Finding 2 – Risk register monitoring (Operating effectiveness)	Risk
Risks within Datix are attributed to different members of the directorate (handlers) for monitoring and updating. Support is provided to assist this process by the central Patient Safety and Health and Safety teams. We reviewed the directorate's Datix risk register and identified the following: • There were 368 'open' risks of which 74 were scored between moderate to high risk. It is these risks that are pulled through onto the Non-Patient Safety Incidents, Risk and Claims report for CBM. • 50 (68%) of the moderate to high risks that are shown on the risk register have passed their review date. Eight (11%) of these have a review date between 2014 – 2016, and thirteen (18%) in 2017. • The directorate is currently reporting one high risk, which has a review date of December 2017 on the risk register. However, the Health Board's risk management policy states that high risks should be reviewed every 3 months. We reviewed a sample of ten moderate to high risks to establish if any mitigating actions had been identified, and to assess the audit trail within Datix for each. We found: • No actions had been identified for any of the risks reviewed in our sample. • There was no audit trail within Datix to show that the risks had been reviewed within the required timescale based on their scoring rate.	Risks materialise as they have not been identified and / or addressed.

• The audit trail identified that the open date had been altered for three of the risks reviewed; the original open date for all was 2014 but now shows 2017. A handler had been identified for all of the risks reviewed, however in some cases the risk had been on the register for so long, the handler had been changed up to three times.	
Recommendation	**Priority level**
The directorate should ensure that a thorough review of the risk register is undertaken and the records updated accordingly. It should be ensured that the correct handlers are attributed to risks i.e. current directorate employees and actions are input on Datix for each risk so that reminders are sent to handlers. Any changes or developments regarding a risk should be recorded in the note pad section of Datix so a clear audit trail can be found.	**High**
Management Response	**Responsible Officer/ Deadline**
It was discussed and agreed by the Facilities Operational Board that each risk should be reviewed and scored based on the following 4 assessment elements and scoring each element with a final score submitted onto the risk register: • Financial • Health and Safety • Business service delivery/continuity/contingency	David Williams – Facilities Governance and Compliance Manager. 30/11/18

• Statutory and Mandatory compliance Each risk would be reviewed using the Cwm Taf UHB RM22 risk matrix. Depending on the risk rating a review date is also assigned. The reviews are currently being carried out by the relevant service management team with support from the recently appointed Governance and Compliance Manager. The Datix incident reports, handler assignment, risk register and claims will be scrutinised and performance managed at the Facilities Operations and Governance Board meetings and KPIs reported to CBM for further scrutiny and to provide reassurance.	

Finding -3 –Policies and procedures (Operating effectiveness)	Risk
In addition to the Health Board's SharePoint record of policies and procedure the directorate also maintains a register. We tested a sample of five policies to see if the review date shown on the documents corresponded with the registers. We found that: • 2/5 the review date on the document corresponded with the date shown on SharePoint, but not the date on the directorate register. • 1/5 the review date shown on the document, the directorate register and the SharePoint record all differed. • 4/5 the document reference is different to that shown on the registers. We also note that FAC 03 - Housekeeping Standard Operating Procedure, is missing from the directorate register. The directorate register shows 10 polices that have passed their review date, whereas the SharePoint register shows 16. The Staff Residential Accommodation policy, does not appear to have been reviewed since 2011.	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 carry out a review of the SharePoint record and the register to ensure that they correspond and that the correct reference numbers and review dates are captured and match the actual document.	**Medium**

Once the correct number of expired policies has been identified the directorate should ensure that they are reviewed and updated accordingly with the appropriate approval for changes sought where necessary.	
Management Response	**Responsible Officer/ Deadline**
Facilities has in place a Policy and Procedures plan and the majority of the documents have been reviewed and approved by the relevant committees and are in date. The SharePoint policy and procedures web site has been under review for some time and still holds many UHB wide policies and procedures that are well out of date and indicating review is required. This does not mean in the case of Facilities that an up to date and approved policy or procedure does not exist. We can confirm that FAC 03 - Housekeeping Standard Operating Procedure, is a live and approved document approved in April 2016 and due for review in March 2019. It has now been inserted in the directorate register. The Staff Residential Accommodation policy is currently being reviewed and will shortly be submitted for approval. Recent work in this service area has been reported to CBM. The Policy and Procedure plan will then be monitored by the Facilities Governance and Compliance Manager and subject to performance management scrutiny at the Senior Managers Operational Board.	Claire Masters – Business Support Manager 30/11/18

Finding 4 – Communications plan (Control design)	Risk
The directorate has a facilities communications plan which identifies all directorate meetings and groups and provides a basic terms of reference (ToR) for each of the groups, outlining the purpose of each meeting, what will be monitored and the frequency of monitoring. There is an opportunity to further develop the plan by: • A pictorial diagram to show the flow of information/links between the groups. • The ToR to include who should be present at each meeting and the quorate level for each group. • The ToR to specify if minutes or action notes should be taken particularly for decision-making groups. The minutes/actions notes should be comprehensive enough to show what decisions have been made. Separate ToRs also exist for the key groups within the directorate. However, having detailed ToR for each group within the communication plan may negate the need to hold these as separate documents. The document is also unclear when referring to the names and numbers of groups. The core meetings shown on page two of the communications plan lists three groups: Operational Delivery; Facilities Integrated Plan/ CRES Board; and Clinical Business Meetings (CBM), whereas the narrative includes a fourth group, the Governance Board.	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 consider further refining its communications plan to incorporate: • A pictorial diagram to show the flow of information /links between the groups. • More detailed ToR for each group included. The document should then be formally agreed as it includes the terms of reference for each of the groups.	**Low**
Management Response	**Responsible Officer/ Deadline**
The communications plan has been updated to reflect the recommendations of the management audit and a copy of the plan has been provided.	Completed

Planning and performance

Finding 5 – IMTP monitoring (Operating effectiveness)	Risk
A fortnightly update of the CRES savings target is provided to the Assistant Director of Finance. In order to facilitate that process the directorate has a fortnightly IMTP meeting. The purpose of the meeting is to focus on the 15 projects that have been identified to assist in achieving the current year CRES target of £1,177k. The meetings follow the same format each time where an overview spreadsheet and narrative report is provided listing all projects. More detailed reports are then provided for each project with the project leads providing an update on each scheme. We reviewed papers for the directorates IMTP meetings in April, May and June 2018, and the related CRES information, and 'finance packs'. The information provided is comprehensive. However, we identified a number of errors that could make the monitoring of the CRES savings target and the projects difficult. We note: • Differing project reference numbers in the IMTP to other documentation. • Amendments to the full year plan target on the spreadsheet report, which had not been made to the narrative report, which forms part of the same agenda item. • Differences between the project stage and probability being reported in the IMTP, Finance packs and project update reports. For example, YCC Shuttle Bus scheme changes from a 75% probability and being at stage 3 in the	Directorate objectives are not achieved.

IMTP to 40% probability and stage 2 in the month one finance pack. The project update reports show a 50% probability. • Project update reports showing RAG ratings of green despite action dates having passed. For example the non-pay suppliers scheme is RAG rated green on the 25 June 2018 project update report, yet the target start date for certain actions was April 2018 and there is a comment 'to be commenced'.	
Recommendation	**Priority level**
Care should be taken to ensure that the CRES data reported in varying documents is consistent. Where stages, probabilities or values change, narrative should be included to explain the amendment. RAG ratings should be kept up to date in order for easy identification of projects that may need management attention.	**Medium**
Management Response	**Responsible Officer/ Deadline**
At the integrated plan and CRES board meeting on 17th September 2018, all managers were tasked to review their documents and amend to ensure consistency of reporting. To ensure this action is completed, a separate email has been sent to all managers asking for all action plans and highlight reports to be reviewed and submitted for discussion at the next integrated plan and IMTP/CRES board meeting scheduled for October 2018.	Claire Masters – Business Support Manager Completed

Workforce

Finding 6– Annual leave process (Design of control)	Risk
We looked at the annual leave process for porter services across both RGH and PCH and make the following observations: **RGH** The porter services team at RGH have developed a set of principles called 'Porter Services Governance and Management of Rotas and the allocation of overtime principles'. These principles cover aspects of annual leave and state that '*annual leave should be approved by either a Porter Team Leader or the Facilities Manager*'. However, we note that the Charge hands (Supervisors) authorise both the porters annual leave requests and each other's leave requests. Furthermore, the principles are not clear around the process for annual leave that is requested after the staff roster has been 'posted', 'short notice' annual leave. **PCH** There is no formal policy or procedure in place for requesting and managing annual leave. We understand that the Health Board has attempted to introduce guidance, but this has not been agreed with porter staff. In addition, short notice leave requests are authorised by a Charge hand but this can result in a Charge hand approving the leave of another Charge hand.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

Recommendation	Priority level
For the management of annual leave across porter services for all sites, clear and consistent guidance on all aspects of annual leave, particularly short notice annual leave requests, and the authorisation of leave, a common policy or set of principles should be developed.	**High**
Management Response	**Responsible Officer/ Deadline**
At the time of the audit Facilities were fully engaged in a Porter services redesign programme of work and along with business partners they have been developing department principles for managing annual leave, a new rota has also been developed and is being taken forward for all porter services. Currently with this porter redesign work there are a number of 'status quo' situations that have been invoked by Trade unions and staff resulting in disagreement and refusal from porter services staff and supervisors/dispatchers at to accept the new rota and service change. This is currently being taken forward in accordance with the Grievance policy. The new rota and the service redesign will ensure a more efficient process and that the Porter Services Supervisor will follow the operating guidelines laid down, which will be clear with last minute requests and an agreement that leave should be requested in advance with a minimum period of 2 weeks, so rotas moving forward can be done in a full week prior, staff will already be fully aware of the shift pattern.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

For the management of annual leave across porter services for all sites a clear and consistent guidance on all aspects of annual leave, particularly short notice annual leave requests, and the authorisation of leave, a common policy or set of principles will be developed.	

Finding 7 – Annual leave (Operating Effectiveness)	Risk
We tested a sample of annual leave taken by porter staff at both RGH and PCH between March and May 2018. Our findings are: **RGH** • While 9/10 request forms had been signed by the Charge hand, 8 of these did not confirm if the leave was approved or rejected. • 2/10 administration errors were identified on the paperwork submitted, such as the request form was not signed as authorised or wrong dates had been included. • 1/10 employee had not input a leave request for a bank holiday meaning that their leave balance is overstated. • 1/10 had bought additional leave. Whilst the relevant forms had been completed, it had not been authorised by the Directorate Manager as required under the scheme of delegation. We also note that three other members of staff outside of our sample carried over annual leave into 2018/19. The request documentation was available for two out of the three. We note that the forms have been authorised by the Facilities Manager not the Directorate Manager.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

PCH • 1/10 no leave request from was submitted therefore the leave was not authorised. However the leave has been correctly input on ESR and the running balance reduced. • For 3/9 of the leave requests that we reviewed we identified administration errors such as the leave was not recorded in the diary, the wrong amount of days had been recorded, or the request form had not been date stamped. • 3/10 bought additional leave or carried forward leave into 2018/19. Whilst the relevant forms had been completed they had not been authorised by the Directorate Manager as required under the scheme of delegation. • 3/10 staff took too much leave in 2017/18, although the additional amounts were then deducted from their 2018/19 opening balances. The department has a system in place whereby leave balances are checked prior to authorisation. In these three instances: ○ 1/3 the leave was authorised in error. ○ 1/3 no leave request had been made, therefore no check could be made and it was only identified when the Administration Officer checked the roster. ○ 1/3 the employee changed roles during year therefore no monitoring of the remaining balance took place.	

Recommendation	Priority level
Segregation of duties should be in place when authorising leave and no annual leave request forms should be authorised unless they are fully completed and submitted before the annual leave date. A reconciliation between ESR and the system used by the department (paper records or databases) should be carried out periodically to confirm that records remain accurate and the correct amount of bank holidays have be accounted for. This should prevent staff from taking too much leave at the end of the financial year. For those staff still using paper based annual leave records, consideration should be given to using ESR to manage annual leave. The directorate should ensure that they are following the Health Board's scheme of delegation when authorising carried forward leave and the purchase of leave. All forms should be authorised by the Directorate Manager or above.	**Medium**
Management Response	**Responsible Officer/ Deadline**
All recommendations are accepted and will be actioned. Immediate action will be taken to ensure regular monthly and daily audits take place to ensure compliance and accuracy. This will be undertaken by Porter Supervisor/dispatcher. Management approved principles to be put in place and clarified through training	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

and meetings with all staff for awareness, understanding and compliance. Staff are all trained to understand and use ESR System. This supports their awareness of annual leave entitlement, pay status etc. Facilities admin support team to ensure a regular monthly check against manual entry and ESR entry records are undertaken. To support audit a monthly checklist form has been developed to ensure accuracy and performance to assist monthly review.	

Finding 8 – Flexi / TOIL (Control design)	Risk
We looked at the flexi time, and Time off in Lieu (TOIL) process across both RGH and PCH and make the following observations: **RGH** The July 2015 TOIL policy for Housekeeping precedes the Portering Service becoming part of the Housekeeping department. As such, the policy does not appear to incorporate TOIL processes for porter staff. We reviewed two months (April and May 2018) rosters for porter staff and identified one instance where TOIL had been taken but the relevant form had not been completed. **PCH** There are no policies or forms in place at PCH and our review of two month's rosters for porter staff confirmed that no TOIL had been taken during the period.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Recommendation	**Priority level**
While we acknowledge that there is limited use of TOIL within the Portering Service, the Health Board should ensure that consistent and up to date polices are in place across the service area.	**Medium**

Management Response	Responsible Officer/ Deadline
Principles for TOIL that are in place for RGH Site will be adopted and managed across all HB Sites. Principles will be management approved and will be re-iterated to all porter services staff for information and compliance.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

Finding 9 – Absence management (Operating Effectiveness)	Risk
We reviewed the worked rosters between March and May 2018 at RGH and PCH and selected a sample of 10 absences identified in the rosters for staff at each site. We note the following: **RGH** • 5/10 the dates of absence recorded on the roster did not correspond with dates on supporting sickness documentation. • 1/10 no documentation to support the episode of sickness, (notification record, self-certification, Return to Work form), and the absence had not been recorded on ESR. • 7/9 episodes where there was documentation, there was no sickness notification form on file for the sickness episode. • 2/9 the sickness absence summary had not been completed for the episode of sickness. Completion of these forms allows easier monitoring an employee's sickness record and identification of sickness triggers. • 1/9 there was no self-certification document on file to cover the period of absence. • 3/4 where sickness triggers had been hit, there was no evidence that an interview had been carried out. • 2/2 where a long-term sickness interview should have been carried out, there was no evidence of the interview happening.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

In addition, during our fieldwork, we reviewed the staff signing in book. The signatures for a number of members of staff appear to vary significantly on different days. Furthermore, the signing in time in the book did not always run in chronological order. **PCH** • 2/10 no documentation to support the episode of sickness, (notification record, self-certification, Return to Work form) though both episodes had been recorded on ESR. • 8/8 no sickness notification forms on file for the sickness episode. • 1/8 no self-certification document on file to cover the period of absence. • 1/6 a reason for sickness was missing from the self-certification form though it was recorded on ESR. • It was also noted that for one of the cases where there was no documentation, the reason for absence recorded on ESR as 'unknown / unspecified'. When a return to work interview is completed or a sickness certificate received, ESR should be updated with the reason for absence as this will allow more accurate monitoring and provision of support if necessary. • Sickness absence summary sheets are not used at PCH. While undertaking our fieldwork work we reviewed the signing in book, and note that 12/20 staff had signed out at the same time as they signed in, as opposed to signing out at the end of their shift.	

Recommendation	Priority level
In line with the All Wales Sickness Absence Policy a record should be maintained when staff inform their line manager of sickness absence. Comprehensive and timely records of sickness, including the reason for absence should be maintained to allow the proper management of sickness within the directorate and accurate reporting. It should be ensured that self-certification and return to work forms are completed in a timely manner. All information contained on self-certification forms, RTW forms and ESR should correspond. Absence management triggers should be monitored and where periods of absence result in a trigger being breached, the appropriate action should be taken. Audit work undertaken in other areas of the Health Board has seen the use of sickness and absence summary sheets as a good practice tool for monitoring absence and identifying when triggers have been hit. Management should reiterate to staff the importance of signing in correctly. Staff must not sign out before the shift ends and only they should sign themselves in / out.	**High**
Management Response	**Responsible Officer/ Deadline**
Principles will be developed clearly indicating pathway for managing sickness absence. Principles approved by management and WF & OD business partners for all Porter Services across UHB Sites. Porter Supervisor/dispatcher will support monthly audit to ensure compliance and	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

accuracy, inclusive of proforma/check list to support and evidence audit. Advisories for failing to meet All Wales S&A Policy Guidelines will be actioned within Porter Services Management Team and ensure compliance through continual close monthly audit as detailed previously. All Porter services supervisors/dispatchers will receive/refresh sickness absence training. Sickness absence performance KPI's are being monitored monthly by the Facilities Operations Board and CBM monthly meetings. A deep dive report has also been provided for scrutiny at CBM by WF & OD business partners. All staff must sign in on arrival and sign out on leaving, end of shift. This will be audited daily by the Porter Supervisors, dispatchers. Porter services staff will be formally reminded through meetings of their obligation for compliance and disciplinary action will follow for any incidences of non-compliance.	

Finding 10 – PDRs (Operating Effectiveness)	Risk
As at 1 June 2018 the PDR compliance for directorate was 78%. The Health Board target is 85%. However, within Portering Services the compliance rate is 43% at RGH and 60% at PCH. During our fieldwork we identified that the PDR forms used within the porter service are dated 2015, and are not the corporate forms used more widely in the Health Board. We tested a sample of 10 staff from each of RGH and PCH and identified the following: **RGH** • 7/10 had an up to date PDR. However, no prior year PDRs were held on file so we were unable to confirm the tracking and monitoring of PDR targets. • 4/7 PDRs were not signed by the employee, and 6/7 PDRs were not signed by their line manager. • 1/7 ESR records was not updated to show a PDR had been completed during the year. • 1/7 ESR was showing a PDR was completed in the year, but only a handwritten, undated note could be provided to support this.	Staff performance is not effectively assessed and addressed.

PCH • 2/10 did not have a completed PDRs but were due to be updated in January 2018.	
Recommendation	**Priority level**
In line with Health Board targets, all staff should be subject to a PDR on an annual basis. An action plan should be developed to target those areas where compliance is low and to assist in overcoming any problems that may be preventing the completion of PDRs. Correct PDR documentation should be fully completed and forms signed by both the manager and employee. The ESR record should be updated with date the PDR took place. Copies of previous PDRs should be retained and used by management throughout the year to ensure staff are working towards agreed objectives and used in the following years PDR to reflect on achievements during the year.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Since the audit both acute HB Sites have achieved an improvement in completion of PDR's and action to improve the position will be continued. RGH porters has improved compliance from 43% to 80%. PCH from 60% to 61%. Progress has been made across all Facilities services with overall compliance reported at CBM 25/9/18 of 85% out of a total number of 940 staff.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

PDR training template to be used across all HB Sites to support Porter Supervisors, dispatchers, charge hands when completing. Key Skills Framework Outline will support this to ensure full awareness, understanding. Compliance will be tracked, monitored and performance managed monthly at the Facilities Operations Board and in the Facilities directorate report for CBM.	

Finding 11 – Mandatory training (Operating Effectiveness)	Risk
As at June 2018 the directorate had an average compliance rate of 63% across the 11 mandatory training modules. The Health Board target is 75%. RGH Porters had an average of 86% compliance and PCH Porters 51%. We tested a sample of five porter staff at each of RGH and PCH and identified the following: **RGH** No staff were up to date on all 11 core modules, and the lowest compliance rate for an individual was 27% (3/11 modules). **PCH** • None of the staff were 100% compliant with the 11 core modules. • The highest compliance rate from the sample was 6/11 of the core modules completed. • 1/5 staff had not undertaken any of the training modules.	Staff performance is not effectively assessed and addressed.
Recommendation	**Priority level**
The directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training and ESR should be updated accordingly to reflect the training undertaken.	**Medium**

Those areas and individuals with low compliance rates should be targeted to encourage completion.	
Management Response	**Responsible Officer/ Deadline**
Since the audit RGH has achieved an improvement in completion of training modules from 27% - 67%. Action to improve the position will be continued. At both RGH and PCH. Training remains on-going across all HB Sites, with significant improvement realised across the past 12 month period. Progress has been made across all Facilities services with overall compliance reported at CBM 25/9/18 of 73% out of a total number of 940 staff who each require 11 modules of core skills training. We will continue to support, through Porter Supervisor/dispatcher continual monthly review, operationally, we are challenged with releasing porter services staff however, are facing these challenges with support from the Facilities Business Support Manager and supervisory staff from other services who are trained in delivering core skills training. Once we get through the service redesign changes the plan is that Porter Services Supervisors will each be trained to deliver the core skills module within their service. Compliance will be tracked, monitored and performance managed monthly at the Facilities Operations Board and in the Facilities directorate report for CBM.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

Finding 12 – Guidance for porter services – rostering (Control design)	Risk
We looked at the rostering process for porter services across both RGH and PCH and make the following observations: **RGH** There is a set of principles in place called 'Porter Services Governance and Management of Rotas and the allocation of overtime principles'. These provide information about allocation of overtime, and the review of staffing levels, however they do not appear to have been formally approved. In addition, they refer to separate annual leave guidelines, but these could not be provided at the time of the audit. **PCH** The Porter service within PCH uses a 2006 internal overtime guidance document for roster arrangements, which does not appear to have been formally approved by the Health Board. The document does not provide information about the timeliness of annual leave requests, shift swapping, or amount of staff that may take leave at any one time.	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.

Recommendation	Priority level
A set of policies and procedures should be developed for use across all sites that allows for the consistent and efficient running of porter services.	**High**
Management Response	**Responsible Officer/ Deadline**
As per the porter redesign and current staff/supervisor/dispatchers Organisational Change process mentioned at previous Finding 6. Facilities supported by WF & OD business partners is currently in a period of status quo and grievance with staff and trade unions on a number of rota compliance and terms and condition issues. Grievance policy negotiations are ongoing with staff and staff side trade union colleagues. The new rota and the principles for rota management are key to ensuring compliance and to be agreed with staff and trade union colleagues and directed across the Porter Services teams at all sites. These Principles will support Porter Services re-design, reflecting appropriate manning levels, rota, service requirements and Supervisor/Dispatcher Organisational Change process.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 31/1/19

Finding 13 – Rostering documentation (Operating Effectiveness)	Risk
PCH The roster system runs over a four, ten or fifteen-week cycle dependant on the grade of staff. For example, Supervisors work on a four-week cycle, and Pool Porters work on a fifteen-week cycle. The day is split across three shifts: morning (6am - 2pm); afternoon (2pm -10pm); and night (10pm - 6am). Our fieldwork focussed on the rostering for Supervisors and the Pool Porters. Staff sign in and out on a timesheet and record their start / end times and hours worked to reflect the shift worked. However, we note that the actual shift times worked do not correspond with standard shift times. For example, the morning shift worked is 7am - 2pm, yet staff record 6am – 2pm on the timesheet. We acknowledge that over a working week staff work their contracted 37.5 hours, as time is made up on other shifts. It is unclear why worked shift times are not recorded in line with the standard shift cycle and why staff are incorrectly recording their hours as opposed to keeping an accurate record of actual hours worked. As such, there is a risk that, should shifts be swapped, enhancements and overtime may not be calculated correctly. **RGH** A diary is maintained by the supervisors/dispatchers for staff to record their availability to work overtime. This is referenced when filling unallocated shifts	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.

meaning there is less shift swapping and turning down of shifts. Overtime is offered across all porter roles and is not restricted to a core group. The finalised roster is reviewed by the Facilities Manager who signs to authorise it. A system is in place for staff who want to change their allocated shift. A shift swap form should be completed and authorised by the Supervisor in advance of the swap. For the 9 June roster that we reviewed we identified six shift swaps. Forms had been completed for 5/6 swaps although none of the forms had been fully completed. For the 1/6 instance where a form could not be traced we confirmed the swap to the signing in/out book. However, we note that the employee had signed in to work, but the signature significantly varied from their signature for other days within the book. **Signing in book** From our review of the roster, signing in book and pay return for week commencing 9 July 2018 we made a number of observations that include: staff signing in and out of their shift at the same time; staff not signing in at all; and staff arriving for their shift at a different start time to their allocated start time and then commencing work at that time, which may mean working longer or a double shift. This may have an impact on their overtime and enhancements and can mean that at times there are more staff on duty than are needed.	

Recommendation	Priority level
It should be ensured that all staff sign in and out for their shift in line with what they have actually worked and should not sign out until the end of their shift. Staff should only sign themselves in and should not sign in or out on behalf of others. Staff should ensure that they are aware of their shift start times and where they arrive early for work, they should be informed that cannot assume they can start work early and be paid for the additional time, unless there is deemed to be a specific service need.	**High**
Management Response	**Responsible Officer/ Deadline**
With support from WF & OD Facilities is working to migrate porter services staff onto e-rostering which will support compliance and with controls in place that are auditable. The swopping of shifts will be stopped with immediate effect. This will be highlighted in the management principles of rota and overtime management. All staff must sign in on arrival and sign out on leaving, end of shift. This will be audited daily by the Porter Supervisors, dispatchers. Porter services staff will be formally reminded through meetings of their obligation for compliance and disciplinary action will follow for any incidences of non-compliance.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

Finding 14– Rostering effectiveness (Operating Effectiveness)	Risk
Within the porter service, the overtime expenditure has been highlighted as a concern. As part of the directorate's CRES target a scheme has been identified to eliminate the need for overtime expenditure and to run the service more effectively and more in line with current service needs. **PCH** There are fifteen pooled porters covering the morning, afternoon and night shifts seven days a week. They are not allocated to specific roles / locations such as waste or mail room, instead they cover general porter duties across the site. Pool porters work on a 15-week cycle. Historically, a minimum of three pooled porters work a shift. Based on the current staffing levels there is spare capacity within the pool to cover up to seven shifts that may be affected by either annual leave, sickness or training. However, based on the historical need for three pooled porters per shift, there does not appear to be enough capacity to cover all of the required shifts, in line with the template roster, and annual or other leave. As such, overtime is offered each week. We reviewed shift arrangements for the week commencing 9 July 2018. During this week 35 additional shifts had to be allocated as overtime. Twenty-seven of these shifts were as a result of annual leave, of which seven were for short notice leave, where the leave was requested after the roster had been published.	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.

The roster generated aligns with the historical staffing levels. There may be an opportunity to use fewer people per shift when demand for porter services is known to be lower. Furthermore, overtime requirements are worked out by the Charge hands on the Friday for the following working week. It is unclear why the rosters are not prepared at an earlier stage to give staff more notification of the overtime shifts. **Use of security porters** Overtime appears to be mainly limited to the pooled porter services team. We understand that the porter security role was developed to allow greater flexibility to the porter service so that porter security could also cover the pooled porter duties. However, it appears that this resource is not being well used, as a result overtime is only offered within the pooled porter team which at times has meant staff working a number of shifts 'back to back', or on consecutive days and then needing to book short notice annual leave to recuperate. To ensure 'fairness' overtime is allocated to the porter who has worked the least amount of overtime, or been offered the least to date. However, the approach does not consider the porter's availability to work, and hours are allocated and changes dealt with as staff check the roster. There is a risk that this reactive approach can lead to shifts being swapped amongst staff, or staff refusing to do a particular shift at the last minute increasing the need for more overtime. We saw evidence of this for the roster that we reviewed. **Portering activity levels** As requests are made by departments / wards for a porter, a job is raised on the Portertrac system and then allocated to the next available porter. We reviewed	

data from the Portertrac system in order to determine activity levels. On the basis that rosters show a minimum of three porters working per shift, we analysed the number of jobs undertaken each hour for April 2018. The number of jobs the pool porters undertook per hour varied between one and a maximum of three. It is unclear if the current roster pattern is efficiently meeting the service needs. However, we acknowledge that as part of the directorate's CRES savings target, work has commenced on reviewing the current roster templates in order to better meet the current service needs. **RGH** There are a number of different porter roles such as general porters, night porters, porter security, and Charge hands (Supervisors). A roster system is in place that covers a morning, afternoon and night shifts and runs over a varying weekly cycle depending on the type of porter. Unlike PCH, there is not a pool of porters to cover general duties, porters are allocated specific functions. Rosters are compiled by the Charge hands, on a Friday, for the following week, although it is unclear why these cannot be prepared earlier in the week. There does not appear to be enough capacity to cover all of the required shifts as per the template roster and annual and other leave. As such, overtime is offered each week. We reviewed the roster for week commencing 9 July 2018 and note that 46 additional shifts were allocated as overtime. Annual leave contributed to 28 of these shifts, three of these were for short notice leave, and where the leave was requested after the roster had been published. The roster generated aligns with the historical staffing levels. There appears to be an opportunity to use fewer people per shift when demand for porter services	

is known to be lower. As mentioned above, a CRES scheme is already in place to deliver a new rota and service delivery redesign.	
Recommendation	**Priority level**
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**
Management Response	**Responsible Officer/ Deadline**
As per the porter redesign and current staff/supervisor/dispatchers organisational change process mentioned at Facilities Finding 6 response. Facilities supported by WF & OD business partners are currently in a period of status quo with staff and trade unions on a number of rota compliance and terms and condition issues. Grievance policy negotiations are ongoing with staff and staff side trade union colleagues.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 31/01/19

The portertrac system is used to monitor daily porter task activity. However the system is nearly 20 years old is challenging to navigate, is not an end user self-serve system, has to be manually interrogated to extract meaningful reports for effective reporting and does not provide accurate data as it is heavily reliant on accurate input from the porter services duty dispatcher. Facilities is currently developing a Facilities Management (FM) service investment in technology plan which would improve on 24/7 service delivery and address staff transactional management, replacing paper based systems of recording and auditing with software systems. This provides electronic log on duty and tracking of each member of the porter services duty teams shift, carrying out service tasks that can be tasked by end user departments using self-serve direct to each member of the porter team through to log off duty. This system will provide an auditable trace and provides service delivery performance information. We need to invest in FM management software solutions which will bring benefits to the Facilities services environment. The Porter Services re-design currently being taken forward will support the correct management of an efficient rota system across porter services at all sites which includes migration to e-rostering. The re-design scheme will also successfully support integration of the porter security requirement to the working rota. At RGH for example no additional staff have been recruited onto the porter establishment to enable the redesign scheme. The 11 porter security staff now in the pool have simply replaced vacancies over time in the porter pool using a new job description and following completion of the required SIA training. The problem has been that the existing old rotas across both acute HB Sites are	

supporting the new service redesign model which is designed and FY 2018/19 was budgeted for the new rota. The delays in implementing the redesign and new rota have resulting in additional cost and the continued use of the old rota that has already been identified as not cost effective and non-compliant. There have been instances early on in the scheme implementation whereby pool porter security staff have been side lined from tasks because of resistance to change from some members of the pool porter team. The management have intervened in such cases and there is more acceptance as the scheme progresses and pool porter security staff are now being tasked appropriate to their role. This will continue to be monitored. Rosters will be prepared further in advance in order for staff to know their core shifts and overtime shifts. Where there is a need to make use of overtime, efficient use will be made of all available staff. It is acknowledged that there is an immediate requirement for moving forward through negotiations with staff and staff side and support from WF & OD to implement the new rota to reduce cost and realise the final element of the savings associated with this Facilities CRES and service redesign scheme. Despite the push back and challenges with this scheme, the Facilities management team with support from WF & OD business partners are committed and doing everything they can within OCP process to progress the scheme to completion.	

Finding 15 – Porter rostering review (Operating Effectiveness)	Risk
PCH **Sign-off of overtime** Based on the current roster template and the current number of staff, overtime has to be allocated to staff in order to fill the agreed roster. We saw no evidence of review or sign-off of the weekly roster by either the team leader or Facilities Manager for the rosters that we reviewed. Therefore, the overtime does not appear to be formally authorised by a senior member of the team. **Pay return reconciliation** We note that the roster is continually updated as changes occur throughout the working week, due to swapping of shifts, sickness, or late annual leave requests. Changes are verbally agreed by the Charge hand and manual adjustments are made to the printed roster. The manually adjusted printed roster is used to complete the weekly pay return. While we did not identify any errors in the pay return the manually adjusted nature of the information means that there is a greater risk of inaccurate pay returns being submitted to finance. Furthermore, the directorate is unable to undertake accuracy checks back to timesheets due to the incorrect way that they are completed i.e. signing in / out at the shift pattern times and not actual times worked. **RGH** **Pay return reconciliation**	The Porters service is delivered in an inefficient way resulting in savings targets not being achieved.

We reviewed the pay return to the roster for week commencing 9 July 2018 and we identified 9 errors: 7 overpayments to staff; and 2 underpayments. The worked roster is checked by the Facilities Manager before it is forwarded to the General Office who will compile the pay return. There is no subsequent check of the pay return to ensure the roster data is correctly interpreted, transferred and calculated.	
Recommendation	**Priority level**
Where overtime is allocated on rosters, the Facilities Managers should approve these in advance of the rosters being published. Accuracy checks should be undertaken on pay returns prior to being submitted to payroll for processing.	**High**
Management Response	**Responsible Officer/ Deadline**
The Facilities managers monitor and check the rotas weekly however it is accepted that whilst they are checking they are not signing to confirm the checks. Action will be taken and instructions will be issued with regards to the management and control of the rota and overtime and allocation. This will also include accuracy checks on pay returns. E-rostering when implemented will also support Porter re-design to ensure compliance and improved rota management control.	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers. 30/11/18

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.

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Raising Concerns

Internal Audit Report

Cwm Taf University Health Board 2018/19

October 2018

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 7
6. Summary of Audit Findings 8
7. Summary of Recommendations 10

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

Review reference:	CTU-1819-06
Report status:	Internal Audit Report
Fieldwork commencement:	13 August 2018
Fieldwork completion:	13 September 2018
Draft report issued:	16 September 2018 & 9 October 2018
Management response received:	23 October 2018
Final report issued:	25 October 2018
Auditors:	Johanna Butt Emma Samways
Executive sign off:	Director of Corporate Services & Governance / Interim Board Secretary
Distribution:	Director of Workforce & OD, Head of Corporate Services
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 procedures around the arrangements for Raising Concerns (Whistleblowing) was carried out.

It is vital that staff in the NHS feel empowered to speak up for patients at the earliest opportunity, whenever service user safety may be compromised or potentially serious errors occur. Without this assurance, a safe service cannot be guaranteed.

The Health Board and senior management have a duty to provide an environment which facilitates open dialogue and communication so as to ensure that any concerns which staff may have are raised as soon as possible.

The relevant lead for the review is the Director of Corporate Services and Governance / Board Secretary.

2. Scope and Objectives

The overall objective of the audit was to review the raising concerns process within the Health Board. We assessed the adequacy of the systems and controls in place in relation to raising concerns, in order to provide assurance to the Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The main areas reviewed was to ensure that:

- There is a comprehensive policy in place which is in date and has been appropriately communicated to staff.
- Management responsibilities and arrangements are appropriately defined and adequate governance and reporting arrangements can be demonstrated.
- Designated contacts responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately.
- Concerns raised by staff are promptly investigated in full and where applicable additional action taken.
- There is an appropriate process in place to log both formal and informal concerns.
- Regular reviews of concerns raised by staff are carried out whereby concerns are examined and analysed to identify any recurring themes across the Health Board.
- The Health Board are kept informed of issues arising and these are reported to an appropriate forum or committee.

During testing of the above processes, consideration was given to best practice in this area, such as Public Concerns at Work (PCaW) guidance.

3. Associated Risks

The potential risks considered in this review were as follows:

- Poor practice in the Health Board may go unchallenged which may compromise the safety of service users and staff may not have confidence in the policy.
- Staff are unaware of the policy and therefore unclear how to report an issue.
- Management responsibilities and arrangements are poorly defined resulting in the failure to escalate key issues.
- Managers and senior officers with responsibility for dealing with issues have not received appropriate training, and issues are dealt with inconsistently with the policy.

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 **Raising Concerns** 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 recently updated its Policy for Raising Concerns, namely the 'Procedure for NHS Staff to Raise Concerns' (the policy / procedure) which is the 'All Wales Policy for NHS Staff to Raise Concerns'. However, we note that the named contacts and contact details require updating.

We identified that the Health Board has made access to the Policy as part of its key polices on its intranet site. As this is not a new policy and only an

update, it has not proactively communicated the Policy to its employees, and has not had a comprehensive awareness campaign to ensure all employees (with or without IT access) are familiar with their duties in respect of raising concerns. The raising concerns process is not included as part of the induction of new employees, and the Health Board has not provided any recent training to employees on raising concerns.

Line managers tasked with dealing with concerns (informal or formal) have not been provided with any additional documentation relating to the process to follow when a concern is brought to their attention. However, we acknowledge that the Health Board has a Business Partner model and concerns can be escalated to Business Partners as part of the regular meetings. The Workforce team logs concerns that are case managed by them, but there are weaknesses with the log. There was no evidence of a central log for all concerns raised via all other routes detailed in the policy.

The Health Board has recently procured and implemented Employee Relations Software from 'Selenity' which we understand has the functionality to case manage concerns raised, in line with the requirements of the Policy. At the time of our audit fieldwork this software was not being used to record concerns. We acknowledge that when this is used to record and manage concerns it may address some of the findings of this report.

Further work is required to demonstrate that the Health Board has a culture where staff are encouraged to raise concerns which could be achieved by adopting identified best practice in this area. The whistleblowing charity Public Concerns at Work (PCaW) now called 'Protect' provides best practice guidance on how this can be achieved which could assist the Health Board in embedding the process within the organisation.

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	Policy that is communicated to staff		✓		
2	Defined management responsibilities			✓	
3	Training		✓		
4	Investigation of Concerns			✓	
5	Concerns Log		✓		
6	Trend analysis	✓			
7	Reporting of concerns			✓	

** 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 six issues that are classified as weakness in the system control/design for raising concerns.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for raising concerns.

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: There is a comprehensive policy in place which is in date and has been appropriately communicated to staff

We note the following areas of good practice:

- The Health Board has an in date policy/procedure namely 'Procedure for NHS Staff to Raise Concerns' which was presented to the Quality, Safety and Risk Committee for approval in May 2018.
- The Health Board's Policy is the 'All Wales Policy for NHS Staff to Raise Concerns' which has been ratified by the Welsh Partnership Forum. As such, it is in line with relevant regulations relating to raising concerns.
- The policy / procedure includes a section on serious or continued concerns and provides contact information for the relevant regulatory external bodies.

We identified the following findings:

- The Health Board's policy/procedure details key contacts for staff to raise concerns. However, our review of the contact details identified that they have not been updated to accurately reflect current responsibility, and additional information may be required in some instances.
- The policy/procedure is linked on the Health Board's intranet site and as such is available to all staff with IT access. However, at the time of our fieldwork the Health Board was unable to demonstrate how the policy/procedure is communicated to staff who do not routinely have access to IT.

Objective 2: Management responsibilities and arrangements are appropriately defined and adequate governance and reporting arrangements can be demonstrated

We note the following area of good practice.

- The policy contains the high level process relating to the responsibilities of management at various levels within the Health Board and at various stages/levels of raising a concern including a flowchart detailing the levels of management to contact at different stages in the process.

We identified the following finding:

- The Health Board has adopted a Business Partner model and where concerns have been communicated to the Workforce Business Partners these should be consistently investigated. However,

supplementary procedure documents to guide individuals responsible for investigating and reporting any concerns raised which would ensure that the policy/procedure is consistently applied, have not been produced.

Objective 3: Designated contacts responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately

We identified the following finding:

- The Health Board were unable to provide evidence that training had been provided to line managers to ensure that staff concerns brought to their attention are appropriately investigated and reported, and that the policy / procedure is consistently applied.

  We were provided with a Raising Concerns presentation that pre-dated the 'All Wales policy for NHS Staff to Raise Concerns' which we understand was presented to the Heads of Nursing and the Local Negotiating Committee (LNC). However, there was no evidence available to support this.

Objective 4: Concerns raised by staff are promptly investigated in full and where applicable additional action taken

We identified the following finding:

- A concerns log is maintained by Workforce and includes all concerns being investigated by the Business Partners. Our review of the log confirmed that it lacked detail in respect of dates; included narrative that could be interpreted as providing a picture of the person raising the concern, and the log listing the person rather than the individual concern raised.

  The concerns log detailed 13 concerns. Our review of the narrative included on the log indicated that the log should have recorded over 24 concerns as it included one individual who had raised 12 concerns but has only been included once on the log.

Objective 5: There is an appropriate process in place to log both formal and informal concerns

We note the following area of good practice:

- The Workforce Business Partners record concerns raised on a Word document log and access to this log is restricted to staff within workforce via the shared drive.

We identified the following finding:

- The Health Board does not have a central log of concerns raised which includes both informal and formal concerns raised via all methods identified within the policy / procedure. We acknowledge that the Health Board has recently procured an Employee Relations tracking software which can be used to case manage concerns raised.

However, at the time of our review this was not being used to case manage concerns raised within the Health Board.

Objective 6: Regular reviews of concerns raised by staff are carried out whereby concerns are examined and analysed to identify any recurring themes across the Health Board

We identified the following finding:

- The Health Board has not undertaken a trend analysis on concerns raised. However, it is noted that the Health Board does not have a central log of all concerns raised, both formal and informal, via all routes which would be appropriate for meaningful trend analysis to be carried out.

Objective 7: The Health Board are kept informed of issues arising and these are reported to an appropriate forum or committee

We identified the following finding:

- The Board receive a bi-monthly (every two months) closed Board report on employee relations. This report includes an update on any new concerns raised since the last report which are being case managed by the Workforce Business Partners. However, in the absence of a central log of all concerns raised via all routes (i.e. Line / Senior Manager; Governance Staff; Professional Head; Raising Concerns Champion and Concerns Telephone Hotline), it is not possible to confirm that all concerns raised within the Health Board have been appropriately reported upwards.

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	**3**	**4**	**0**	**7**

Finding 1 - Raising concerns training (Control design)	Risk
Appendix 2 of the previous policy that was in place until May 2018, related to the 'Policy Training Impact Assessment'. This section detailed whether training is required on the policy. Our review of this section of the previous policy confirmed that it was assessed that training would be required for 'All employees', and detailed the relevant course as *'How to raise a concern - speaking out'*. The Learning and Development Team confirmed that they were not aware of any specific raising concerns training within the Health Board. The Workforce Team confirmed that it was the intention to offer the training, but this was not delivered due to lack of capacity to deliver it. We were informed that training was provided to the Heads of Nursing and the Local Negotiating Committee (LNC). However, there was no evidence available to confirm who attended or when the training was delivered. We read the Raising Concerns presentation that we understand was presented. This provided background information on raising concerns rather than the detail of dealing with a concern in line with the policy. We also note that the Raising Concerns presentation was created in April 2014 which pre-dates the 'All Wales policy for NHS Staff to Raise Concerns' which was ratified by the Welsh Partnership Forum in February 2015. The Health Board does not include Raising Concerns as part of the induction of new staff, and it is not included as part of Statutory and Mandatory training.	Staff are unaware of the policy and therefore unclear how to report an issue. Managers and senior officers with responsibility for dealing with concerns have not received appropriate training, and issues are dealt with inconsistently with the policy.

Recommendation	Priority level
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. The Public Concerns at Work (PCaW) Best Practice guidance recommends: ***Introduce whistleblowing resources:*** *Consider specific resources, training, forums or surveys for managers around receiving, handling and recording concerns.* ***Train and retrain:*** *Include whistleblowing awareness-raising and training as part of your induction for new starters and consider E-learning or other types of training for the wider staff group.*	**High**
Management Response	**Responsible Officer/ Deadline**
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	Claire Nicholas (Head of Workforce and Improvement Efficiency) December 2018

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. We will, however, create a comprehensive SharePoint (intranet) page which will provide supplementary information to the Policy including information on how it is appropriate to raise a concern, to be disseminated to staff via internal comms channels.	Gwenan Roberts (Interim Board Secretary) November 2018

Finding 2 - Communicating the policy (Control design)	Risk
Guidance on the Health Board's intranet appropriately recommends that policies are not printed as this could result in older versions of documents being used and correct procedures not being followed. As such, we would not expect hard copies of the policy/procedure to be made available for staff without IT access. Due to the number of acute sites, the Health Board may have a large number of staff who, due to the nature of their roles, such as domestic staff, nurses and porters, would not routinely have access to the intranet. The Health Board was unable to demonstrate how it promotes the policy/procedure to staff without IT access. Recognised methods of promoting awareness amongst staff without IT access include poster and social media campaigns, discussions at staff briefings or team meetings and raising awareness through the induction process.	Staff are unaware of the policy and therefore unclear how to report an issue.
Recommendation	**Priority level**
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. 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.*	**High**

Lead from the top: *use written and verbal messaging from senior staff members to promote the arrangements.*	
Management Response	**Responsible Officer/ Deadline**
Once the SharePoint page mentioned in the response to Finding 1 is developed we will 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.	Gwenan Roberts (Interim Board Secretary) November 2018
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.	Gwenan Roberts (Interim Board Secretary)November 2018
We will also consider producing materials (e.g. leaflets and posters) to raise awareness across the Health Board.	Gwenan Roberts (Interim Board Secretary) March 2019
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.	

Finding 3 - Log of concerns and trend analysis (Control design)	Risk
The Health Board policy/procedure does not set out a process to record all concerns raised through routes, such as: Line Managers; Governance staff; Professional Head; Raising Concerns Champion; or Telephone hotline. For example, a single repository for recording such information. A central log of concerns would allow the Health Board to monitor and identify any trends around the concerns being raised. For example, the 'type' of concerns being raised, the same concern being raised by multiple staff, or the spread of concerns across departments. The lack of clarity around recording of concerns and the absence of any supplementary guidance could result in inconsistent levels of recording. Concerns information may be stored on network drives that multiple staff have access to which may breach confidentially if the whistle-blower wants to remain anonymous. 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'. A central log should include where possible and applicable the fields included on these forms. The Policy also allows for concerns to be dealt with informally. In such instances, we would not expect forms WB1 and WB2 to be completed. However, the Health Board should identify an appropriate process for capturing and recording informal concerns on a central log as analysis of these could alert the Health Board to	Management responsibilities and arrangements are poorly defined resulting in the failure to escalate key issues. Managers and senior officers with responsibility for dealing with issues have not received appropriate training, and issues are dealt with inconsistently with the policy.

potential issues. For example, many informal concerns within a directorate / service area could indicate issues within that directorate / service areas. We acknowledge that the Health Board has recently procured and implemented Employee Relations Software which includes different case types, including Raising Concerns, which the Health Board are able to adapt to include fields that reflect the requirements of the policy. However, at the time of our review the software was not being used to record and investigate concerns.	
Recommendation	**Priority level**
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. The Public Concerns at Work (PCaW) Best Practice guidance recommends:	**High**

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.* ***Confidence is key:*** *Handle the concerns you do get effectively. Staff will remember it and share the experience with colleagues.*	
Management Response	**Responsible Officer/ Deadline**
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 Closed Board Committee.	Hywel Daniel (Deputy Director of Workforce and Organisational Development) November 2018 Hywel Daniel(Deputy Director of Workforce and Organisational Development) January 2019

Finding 4 - Raising Concerns policy - named contacts (Control design)	Risk
The Health Board has an in date policy/procedure namely 'Procedure for NHS Staff to Raise Concerns', which is the 'All Wales Policy for NHS Staff to Raise Concerns'. The policy was presented to the Quality, Safety and Risk Committee for approval in May 2018. We reviewed the Policy which confirmed that the key contacts are detailed in Stage 1 of the new policy under the following headings: 'Workforce and Organisational Development'; 'Governance'; 'Professional Head'; 'Raising Concerns Champion' and 'Telephone Hotline'. We note the following from our review of the key contacts: 1. Workforce and OD - this details that all members of the Workforce Team are able to provide assistance. At the various meetings that we held with key personnel from Workforce and Organisational Development and Corporate Governance it was highlighted that the Health Board operates a Business Partner Model as such it may be more appropriate to detail the contact details for the different Business Partners under this heading, being: Corporate / Unscheduled Care / Scheduled Care / Primary Care, Community and Public Health. 2. Professional Head - this provides contact details for Lynda Williams (Director of Nursing). The new policy was approved in May 2018 at which time the Health Board would have been aware that Director of Nursing was leaving the Health Board and as such is not an appropriate contact. As such, the Health Board should have identified an alternative professional head. We understand that the professional head would deal with any	Poor practice in the Health Board may go unchallenged which may compromise the safety of service users and staff may not have confidence in the policy. Staff are unaware of the policy and therefore unclear how to report an issue.

nursing concerns raised. The Health Board has not identified any other professional for example, for Medicine and Allied Health Professionals. We understand that consultants tend to raise concerns with the Chief Executive which could indicate that professional heads should be identified for the different professions. 3. Raising Concerns Champion - this details an Independent Member as the champion, but the contact details included are those of the Head of Corporate Governance. We note that the Independent Member has a Health Board e-mail address which has not been listed. 4. Telephone hotline - the Health Board has a 'Raising Concerns Hotline'. We called the hotline to confirm that it was in use. While the phone line was operational, there was no message stating that it was the 'Raising Concerns Hotline' or what information was required, or what action would be taken as a result of leaving a message. The only message was '*Name and a message. You may start your message now*'.	
Recommendation	**Priority level**
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	**Medium**

Concerns telephone hotline; the information required from the caller, and what will happen next. The Public Concerns at Work (PCaW) Best Practice guidance recommends: ***Overall responsibility:*** *Consider which named senior staff members should have overall responsibility for arrangements and why they are best placed. Think practically about their availability and the best ways of contacting them.* ***Ensure your policy is up to date:*** *Use any changes made as a chance to re-communicate the policy to staff.*	
Management Response	**Responsible Officer/ Deadline**
Policy has been amended to ensure the key contact details are updated.	Gwenan Roberts (Interim Board Secretary) October 2018
Additional professional heads have been considered but it was felt that the key relevant contact details are available. Within the SharePoint page we will identify links to external bodies / information for all staff groups.	Gwenan Roberts (Interim Board Secretary) November 2018
The telephone hotline will be further considered in terms of appropriate access for staff – we will discuss further with the telecoms manager to find the best solution for access for respondents and for managing the phone line.	Gwenan Roberts (Interim Board Secretary) & Claire Nicholas (Head of Workforce and Improvement Efficiency) November 2018

Finding 5 - Supplementary procedural guidance (Control design)	Risk
The Health Board has not produced supplementary guidance notes to ensure that those responsible for dealing with concerns have received clear instruction on how concerns should be investigated, and when and how to appropriately escalate any concerns raised. Line managers having to enquire how to record and investigate a concern (whether informal or formal) could result in an inconsistent approach from recording to investigating a concern as a result of different guidance being provided by different contact points. However, we acknowledge that the Health Board has a Workforce Business Partner Model who regularly meet with managers from the different directorates.	Management responsibilities and arrangements are poorly defined resulting in the failure to escalate key issues. Managers and senior officers with responsibility for dealing with issues have not received appropriate training, and issues are dealt with inconsistently with the policy.
Recommendation	**Priority level**
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.*	**Medium**

Introduce whistleblowing resources: *Consider specific resources, training, forums or surveys for managers around receiving, handling and recording concerns.* ***Engage with the key whistleblowing contacts*** *for their feedback on receiving concerns and the effectiveness of arrangements generally.*	
Management Response	**Responsible Officer/ Deadline**
The guidance for undertaking an investigation will be developed and will form part of the SharePoint page.	Gwenan Roberts (Interim Board Secretary) & Claire Nicholas (Head of Workforce and Improvement Efficiency) November 2018

Finding 6 - Investigation of concerns (Operational effectiveness)	Risk
The Workforce Team maintain a log of concerns that have been case managed by the Workforce Business Partners. The log contains 13 raised concerns. We note the following from our review of the 'headings' within the log: **Date of submission:** • Our review of the log confirms that it does not always record the specific date that the concern was raised or specific dates regarding when the investigation commenced and completed, as such it is not possible to confirm from the log that concerns were dealt with promptly. • A specific date of submission has only been included on 4/13 cases listed; 1/13 does not record a date; 2/13 detail the Month and Year only; 6/13 detail the Year or range of years, for example one line records '2014 – 2018' as the date of submission. **Category of concern raised:** • 1/13 did not detail the category of concern raised which is a requirement of the policy. It is also noted that the category of concerns included on the log does not list 'Value for Money' as a category which is listed as a category on the policy. **Ongoing/Complete:** This column is to record a brief summary of the current progress. We note: • Lines 6 and 7 of the log show that an individual has raised 12 separate concerns and several concerns respectively. As such, the total number of	Management responsibilities and arrangements are poorly defined resulting in the failure to escalate key issues. Managers and senior officers with responsibility for dealing with issues have not received appropriate training, and issues are dealt with inconsistently with the policy.

concerns that should be recorded should be greater than 24, and not the 13 concerns listed on the log. The Health Board should log every concern raised and investigate and report separately all concerns raised. In addition, the Health Board should avoid including statements detailing that the individual has raised numerous concerns, which could be interpreted as suggesting that the individual is a 'serial complainer'. This could influence the objectivity of the person investigating the concern. The Health Board must be seen to be objective and must demonstrate that it takes all concerns seriously and is an organisation that encourages openness when it comes to reporting concerns.	
Recommendation	**Priority level**
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. The Public Concerns at Work (PCaW) Best Practice guidance recommends:	**Medium**

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.* ***Confidence is key:*** *Handle the concerns you do get effectively. Staff will remember it and share the experience with colleagues.*	
Management Response	**Responsible Officer/ Deadline**
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.	Hywel Daniel (Deputy Director of Workforce and Organisational Development) November 2018

Finding 7 - Reporting of concerns (Control design)	Risk
The Board receive a bi-monthly (every two months) closed Board report on employee relations. This report includes an update on any new concerns raised since the last report. We reviewed the closed Board report for July 2018 which confirmed that it detailed that two new concerns had been received since the previous report. However, the report does not provide a summary on progress against previous concerns raised which would provide assurance to the Board that concerns are being investigated promptly and appropriately. We acknowledge that when the Health Board uses the new Employee Relations software for recording concerns this may be possible which may provide more meaningful information to the Board on progress against concerns. Whilst we were able to confirm that the Board receive an update of new concerns being investigated by the Workforce Business Partners, in the absence of a central log of all concerns raised via all routes (i.e. Line / Senior Manager; Governance Staff; Professional Head; Raising Concerns Champion and Concerns Telephone Hotline), it is not possible to confirm that all concerns raised within the Health Board have been appropriately reported upwards.	Poor practice in the Health Board may go unchallenged which may compromise the safety of service users and staff may not have confidence in the policy. Failure to appropriately escalate key concerns.
Recommendation	**Priority level**
The Health Board should ensure that there is an appropriate process in place for reporting all concerns raised.	**Medium**

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; Number of days spent investigating the concern; Percentage of concerns investigated and concluded; Percentage of concerns by directorate / department / service area. The Public Concerns at Work (PCaW) Best Practice guidance recommends: ***Specific audits:*** *Decide how often reports should be made to an Executive Committee or the Board and think about what information they can usefully receive and review.*	
Management Response 7	**Responsible Officer/ Deadline**
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.	Hywel Daniel (Deputy Director of Workforce and Organisational Development) January 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.

Well-being of Future Generations Act (Wales) 2015

Internal Audit Report

Cwm Taf University Health Board

2018/19

October 2018

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-1819-04
Report status:	Internal Audit Report
Fieldwork commencement:	4 July 2018
Fieldwork completion:	30 July 2018
Draft report issued:	8 August 2018
Management response received:	17 October 2018
Final report issued:	23 October 2018
Auditors:	Emma Samways Johanna Butt
Executive sign off:	Dr Kelechi Nnoaham, Director of Public Health
Distribution:	Dr Kelechi Nnoaham, Director of Public Health
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 Health Board's arrangements for ensuring the requirements of the Well-being of Future Generations Act (WFGA) (Wales) 2015 are being met, was carried out.

The Well-being of Future Generations (Wales) Act 2015 ('the Act') gives a legally-binding common purpose that is set out in seven well-being goals and applies to national government, local government, local health boards and other specified public bodies. It details the ways in which the public bodies must work, and work together to improve the well-being of Wales.

The Act provides for better decision-making by ensuring that those public bodies take account of the long-term, help to prevent problems occurring or getting worse, take an integrated and collaborative approach, and considers and involves people of all ages. The Act requires public bodies to carry out sustainable development, a principle that can be achieved through the five ways of working. The Health Board has a duty to set its own well-being objectives and to represent the Health Board as a statutory member of the Public Services Board, who also have a duty to set local well-being objectives for the Cwm Taf locality. These duties are separate but aligned.

Statutory guidance has been produced by Welsh Government for those public bodies specified within the Act, in order to assist them in taking the necessary action and communicating the contribution being made to the seven well-being goals.

The relevant lead for the review is the Director of Public Health.

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 processes in relation to the Well-being of Future Generations Act. The review sought to provide assurance to the Health Board's Audit Committee that risks material to achieving the system's objectives are managed appropriately.

The areas that the review has sought to provide assurance on are:

- A statement of the Health Board's well-being objectives has been produced and incorporates the key requirements outlined in Welsh Government Core guidance.
- The steps to be undertaken to meet the well-being objectives are clearly identified.
- The well-being objectives are reflected in the Health Board's Integrated Medium Term Plan (IMTP) and other key Health Board strategies such as the workforce strategy and are effectively monitored.

- The Health Board is appropriately represented and participates at the Public Services Board of which it is a statutory member and the links between the two are clearly aligned.

3. Associated Risks

The potential risks considered in the review were as follows:

- Non-compliance with statutory compliance required under the Act.
- Non-compliance with reporting requirements.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the implementation of the Well-being of Future Generations Act (Wales) 2015 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 for this review takes account of where we would reasonably expect the Health Board to be at this early stage in the process of implementation.

The Health Board has set and published its Well-being Objectives and Well-being Statement within its Integrated Medium Term Plan (IMTP). However, the Health Board's well-being objectives could be more prominent on the Health Board's intranet site.

The Health Board is appropriately represented and attends all meetings of the applicable Public Services Board (PSB), namely the 'Our Cwm Taf' PSB, demonstrating that the Health Board has contributed to the PSB's Well-being Plan and is an active member of the PSB.

However, whilst the Health Board has been fully engaged with the PSB, it must now focus on its individual role as a public body to ensure that the requirements of the Act are fully embedded within the Health Board and that decisions are made through the 'WFGA lens'.

Our review showed that there is a lack of ownership within the Health Board for driving the requirements of the WFGA within the Health Board. The Health Board must develop a cohesive plan to demonstrate how it intends to embed the requirements of the Act through all of its actions / activities.

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	Well-being Statement and Key Dates				✓
2	Steps to meet well-being objectives		✓		
3	IMTP - Well-being Objectives reflected			✓	
4	Public Services Board				✓

** 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 weakness in the system control/design for Well-being of Future Generations Act (Wales) 2015.

Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weakness in the operation of the designed system/control for Well-being of Future Generations Act (Wales) 2015.

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: A statement of the Health Board's well-being objectives has been produced and incorporates the key requirements outlined in Welsh Government core guidance.

We note the following areas of good practice:

- The Health Board held a full day workshop for Directorate Managers and Managers in January 2017. This enabled the Health Board to explore responsibilities under the WFGA and also to debate and shape the Health Board's well-being objectives.
- The PSB's 'Cwm Taf Well-being Assessment' was used to help inform the Health Board's well-being objectives and as such, this has ensured that view of external stakeholders within the Cwm Taf locality have been considered when setting the well-being objectives for the Health Board.
- The Health Board held a Board Development Session in February 2017 to provide the Board with details on the requirements of the Act and the work undertaken to establish its well-being goals.
- The Health Board's well-being objectives were presented to, and appropriately approved by the Board on 1 March 2017 and published as part the Health Board IMTP by the deadline of 1 April 2017
- The Health Board published its well-being objectives and well-being statement within its IMTP which is in line with the guidance issued which advises that sustainable development should not be treated as an add-on, instead, it should be included within the Corporate Plan/Strategy.
- The Health Board has mapped its well-being objectives to the WFGA well-being goals. These are detailed within the well-being statement on the IMTP.
- The Health Board responded to the 'WAO Call for evidence – August 2017'.

We identified the following findings:

- The Health Board is required to publish an Annual Report detailing progress towards meeting their well-being objectives. The Health Board was required to publish its first Annual Report as soon as practicable after 31st March 2018. At the time of our audit review

the Health Board had not published an Annual Report detailing progress.

- Our review of the Health Board's internet site found that the Health Board's well-being objectives were not prominent on its internet site. The Health Board does not have internet pages dedicated to its requirements under the WFGA. In order to find the Health Board's well-being objectives and well-being statement you would have to know that they are included within the IMTP.

Objective 2: The steps to be undertaken to meet the well-being objectives are clearly identified.

We identified the following findings

- We were provided with a list of key staff to speak to and meet with as part of the audit. From our discussions with key staff it was evident that none of the staff interviewed were responsible for embedding the WFGA within the Health Board and for driving forward the implementation of the Act and the Health Boards well-being objectives.

Objective 3: The well-being objectives are reflected in the Health Board's IMTP and other key Health Board strategies such as the workforce strategy and are effectively monitored.

We note the following areas of good practice:

- The Health Board held an IMTP workshop in November 2016 which highlighted the Health Board's responsibility under the WFGA and the impact on the departmental IMTPs.

We identified the following finding:

- We reviewed the Health Board's IMTP and a sample of five departmental IMTPs which confirmed that there did not appear to be a clear link between the well-being objectives within the Health Board's IMTP and the departmental IMTPs.

Objective 4: The Health Board is appropriately represented and participates at the Public Services Board of which it is a statutory member and the links between the two are clearly aligned.

We identified the following areas of good practice:

- The Health Board is a statutory member of the 'Our Cwm Taf' Public Services Board (PSB). We reviewed the available minutes for the PSB from its first meeting, held in May 2016, to the date of our audit review. Our review of minutes confirmed that the Health Board has been appropriately represented at the PSB meetings in line with statutory guidance.

- Review of the Health Board's well-being objectives confirms that the Health Board's objectives are aligned and will contribute to 'Objective 2: To help people live long and healthy lives and overcome any challenges' of the PSB's well-being objectives.

We did not identify any findings under this objective.

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**	**1**	**1**	**4**

Finding 1 - Annual Reporting (Operating effectiveness)	Risk
The Welsh Government has developed guidance on the Well-being of Future Generations (Wales) Act 2015, namely, Shared Purpose: Shared Future (SPSF). 'SPSF5: Key Dates' provides an outline of indicative key dates for the implementation of the Act for public bodies, public services boards, relevant community councils and others. The document states that: *'Public bodies are required to report annually on their progress towards meeting their well-being objectives. They must report in respect of each financial year. Financial year is defined as the period of 12 months ending with 31 March. The report must be published as soon as reasonably practicable following the end of the financial year to which the report relates.'* Based on the guidance, the first Annual Report on progress made against meeting the Health Board's well-being objectives relates to the financial year ended 31 March 2018. While at the time of our fieldwork the Health Board had not published its Annual Report, we subsequently reviewed the document and note that it does contain a specific section about the WFGA. The section outlines the purpose of the Act, the Health Board's objectives and the process for embedding the Act in existing Health Board processes. However, there is no explicit reporting on the progress that has been made in the year against its Well-being objectives.	Non-compliance with reporting requirements under the Act.

Recommendation	Priority level
Future Health Board annual reports should provide details on the review and outcome of the progress that has been made during the year towards meeting the agreed Well-being objectives. Whilst the objectives are incorporated into the IMTP process, there should be a clear distinction between setting out the objectives and reporting the progress made in achieving them.	**High**
Management Response	**Responsible Officer/ Deadline**
Notably, Welsh Government Guidance (Shared Purpose, Shared Future) recognised that "for greatest impact public bodies should ensure that their well-being objectives form part of their central planning arrangements, such as a corporate plan or similar organising tool". Accordingly, the Board of CTUHB had determined after detailed consideration of the Core Guidance that it already had an organisational planning processes which was successful, well-embedded and which clinical and non-clinical teams were very familiar with. It therefore agreed on the need to not establish a parallel review and reporting process for the WFG Act. The requirements of the Act would be met via the established mechanism of the UHB's Annual report and this remains the intention. We understand the core purpose of the annual reporting (in whatever format it is done) to be that of allowing public bodies to be transparent about the process and content of review of the well-being objectives and their continuing relevance to the seven national well-being goals. It is the belief of management that these	Kelechi Nnoaham – Director of Public Health June 2019

objectives have been achieved for the 2017/18 year through the UHB's annual review and reporting process. As a learning organisation however, we believe there is merit in continuing to review the process to ensure we continue to fulfil the central purpose of the review and annual reporting.	

Finding 2 - Health Board individual responsibility (Operating effectiveness)	Risk
From our discussions and meetings with key staff it was evident that there seemed to be a lack of ownership within the Health Board for driving forward the requirements of the WFGA in the Health Board as an individual body. Our review at other health boards identified the following good practice for driving forward and embedding the requirements of the WFGA in the Health Board as an individual body: • Establishing a WFGA Steering Group with members of the group at a suitably senior level in order to drive the requirements of the act within the organisation. • Identifying an independent member to act as 'WFGA Champion'. • Undertaking baseline assessment of the leadership team to gauge awareness of the WFGA. • Creating designated pages on its internet site detailing the work undertaken in respect of WFGA and highlighting the well-being objectives. The Health Board does not have any of the above in place. Furthermore, we identified that some officers, who were involved in the establishment of the well-being objectives for the Health Board, no longer have any responsibilities in this area.	Non-compliance with statutory compliance required under the Act. Non-compliance with reporting requirements under the Act.

Recommendation	Priority level
Management should develop a cohesive plan for driving forward the requirements of the WFGA within the Health Board. Key staff should be identified that will assist in embedding the WFGA within the Health Board.	**High**
Management Response	**Responsible Officer/ Deadline**
The second objective being scrutinised here is that the UHB has taken steps to meet the well-being objectives and that these are clearly identified. Consistent with our earlier response, we believe the UHB has done this through the mechanism of the IMTP. In the IMTP, both clinical and non-clinical Directorates of the organisation set out their plans to achieve the organisation's objectives, including the well-being objectives. The Directorate Managers are named leads on the IMTP plans and naturally have shared responsibility for ensuring the plans are delivered as intended. Having said this, we do recognise that the spirit of the Act is about moving on from a place where the 'sustainable development' (SD) principle is an add-on to one where it is effectively integrated as a means to deciding what our organisational objectives should be. We are not there. So we welcome the potentially helpful suggestions that might help us move faster and further on this path. We recognise that this is going to require organisational culture change at many levels. Every individual needs to be supported to embed SD principles in their work. Ownership at every level and across the organisation is what is needed. Of course the risk in this is that it is not owned by anyone but we believe	Kelechi Nnoaham – Director of Public Health June 2019

that embedding it in the established IMTP process mitigates this risk. In pursuance of this recommendation however, the UHB will explore the merit of: • Establishing a WFGA Steering Group • Identifying an independent member to act as 'WFGA Champion'. • Creating designated pages on its internet site detailing the work undertaken in respect of WFGA and highlighting the well-being objectives.	

Finding 3 - Link between Health Board and Departmental IMTP (Operating effectiveness)	Risk
We obtained a copy of the Health Board's IMTP and a sample of five departmental IMTP to establish whether there was a clear link between the Health Board's well-being objectives and the departmental IMTPs. The Health Board's well-being objectives, as detailed in the published 2017-20 and 2018-21 IMTP, are: We will work with communities to prevent ill health, protect good health and promote better health and well-being. 1. We will provide high quality care as locally as possible wherever it is safe and sustainable. 2. Our service delivery will be innovative, reflect the principles of prudent health care and promote better value for users. 3. We will work collaboratively with our public service partners and a broader range of partners to join up health and other services where this potentially represents better value for our residents and care users. 4. Through our commitment to corporate social responsibility and to improving health and social equity, we will work with our staff, partners and communities to build upon strong local relationships and solid foundations of the past. We reviewed a sample of five departmental IMTPs which confirmed that all included a section on the WFGA. However, there did not appear to be a clear link between the departmental IMTPs and the well-being objectives identified within	Non-compliance with statutory compliance required under the Act. Non-compliance with reporting requirements under the Act.

the Health Board's IMTP. The departmental IMTPs did not detail the well-being objectives of the Health Board and how the department will contribute to the Health Board meeting its well-being objectives.	
Recommendation	**Priority level**
The Health Board's departmental IMTPs should include the Health Board's well-being objectives and should clearly document how the department will contribute to the Health Board achieving its well-being objectives. This would also provide the Health Board with the information needed to demonstrate progress made against meeting its well-being objectives. This is a requirement for the Annual Report.	**Medium**
Management Response	**Responsible Officer/ Deadline**
We accept this recommendation. Although it was an explicit aim of the IMTP process during 17/18, the degree to which we were successful with it probably varied across directorates. We will look to strengthen this during the current IMTP planning round.	Kelechi Nnoaham – Director of Public Health March 2019

Finding 4 - Prominence of Health Board's wellbeing objectives (Control design)	Risk
The Health Board has published its well-being objectives and well-being statement within its Integrated Medium Term Plan (IMTP) for the period 2017-20. The Health Board IMTP must be published by 31 March each year and as such the Health Board had published its well-being objectives and its well-being statement by the deadline of 1 April 2017. However, our review of the Health Board's internet and intranet site confirmed that the Health Board's well-being objectives are not prominent on the intranet or intranet. Our review at other Welsh Health bodies showed that they had dedicated internet pages for the work undertaken in respect of the WFGA. These pages clearly detailed their well-being objectives and the requirements of the Act. We would consider it good practice to develop dedicated pages on the Health Board's internet site which clearly highlight the Health Board's well-being objectives.	Lack of awareness of the Health Board's well-being objectives by external stake-holders.
Recommendation	**Priority level**
The Health Board should consider developing dedicated pages on its internet site detailing its individual responsibilities under the WFGA and clearly highlighting its well-being objectives in order to raise awareness of these objectives.	**Low**

Management Response	Responsible Officer/ Deadline
We accept this recommendation.	Kelechi Nnoaham – Director of Public Health June 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.

Continuing Healthcare

Internal Audit Report

2018/19

Cwm Taf University Health Board

December 2018

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 7
6. Summary of Audit Findings 8
7. Summary of Recommendations 9

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

Review reference:	CTU-1819-07
Report status:	Internal Audit Report
Fieldwork commencement:	25 July 2018
Fieldwork completion:	8 October 2018
Draft report issued:	26 October 2018
Management response received:	10 December 2018
Final report issued:	11 December 2018
Auditors:	Sharon Edwards, Emma Samways
Executive sign off:	Angela Hopkins, Interim Executive Director of Nursing, Midwifery and Patient Care
Distribution:	Sian Lewis, Lead Nurse for CHC and NHS Funded Care
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 Health Board (the 'Health Board') a review of the procedures around the arrangements for Continuing Healthcare has been carried out.

Continuing Healthcare (CHC) is a package of care that is arranged and funded solely by the NHS for individuals who have been assessed as having a primary health need. Continuing healthcare can be received in any setting, including a patient's home or a care home.

Both the Health Board and local authorities have responsibilities to ensure that assessment of eligibility for and provision of continuing care takes place in a timely and consistent fashion and in compliance with the Continuing NHS Healthcare: National Framework for Implementation in Wales. Continuing Healthcare is free, unlike help from social services for which a financial charge may be made depending on an individual's income and savings. The NHS is the primary decision maker on questions of eligibility, but this is subject to review and should care needs change, the funding arrangements may also change.

The request to undertake an assessment of a patient to determine eligibility for CHC funding may be made by the patient themselves, a family member or a health care professional. An assessment is undertaken and a multi-disciplinary team meet to consider the patients eligibility for CHC. If deemed eligible, the completed assessment documentation will be reviewed by a directorate panel. The panel will establish if needs can be met from within existing services and funding arrangements, or if additional funding is required. All packages of care are referred to the CHC Unit panel, who will consider the recommendations made at the directorate panel and where appropriate agree to the proposals.

The relevant lead for the review was the Director of Nursing, Midwifery and Patient Care.

2. Scope and Objectives

The overall objective of the audit was to review the process within the Health Board for managing Continuing Healthcare. We sought to assess the adequacy of the systems and controls in place in relation to CHC, in order to provide assurance to the Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The areas that we sought to provide assurance on are:

- The Health Board has policies and procedures in relation to the Continuing Healthcare assessment process to identify the key stages in the process including dispute resolution.
- Where funding has been approved, agreed processes have been followed and within the agreed time lines. Relevant documentation, including consent forms are completed.

- Monitoring arrangements are in place to review agreed care packages in line with specified time frames.
- Effective arrangements are in place to communicate any changes in care packages to the relevant clinical and finance staff and action is taken to alter financial payments.
- Disputes raised are reviewed and investigated in line with the agreed process.
- Reports are provided to the Health Board identifying budget pressures and any other key performance issues.

3. Associated Risks

The potential risks considered in this review were as follows:

- Non-compliance with the provisions of the Welsh Government Continuing NHS Healthcare Framework.
- Incorrect or delayed decisions on the eligibility for Continuing Healthcare resulting in formal complaints.
- Inappropriate Continuing Healthcare packages are put in place.
- Financial loss due to inadequate management and / or forecasting of Continuing Healthcare costs.

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 Continuing Healthcare 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 CHC team within the Health Board manage the Continuing Healthcare application process and the administration requirements needed for the unit panel, which approves CHC funding. Our testing identified a number of issues in relation to paperwork not always being present on the patient files held by the central team.

In most cases paperwork is held by the referring directorate. We understand that the CHC team often spend time chasing forms that are required for panel meetings.

We note that many of the forms used contain duplicate information and elements of some forms are never completed. As the Welsh Government guidance for CHC has recently been reviewed, it would be timely for the forms and documents used by the team to also be reviewed.

The CHC team are looking to recruit an administrative assistant which will provide additional capacity to refine the current process by reviewing the paperwork, and enable closer working with referring directorates to ensure they are aware of their responsibility in accordance with Welsh Government guidance.

Our testing identified instances where care packages had not been appropriately approved. There were a number of cases where unit panel forms had been completed and although the funding had been agreed at panel the form was not authorised in line with the Scheme of Delegation.

Performance reporting to the Health Board and the Welsh Government is regularly undertaken, but our review highlighted the need for the narrative within these reports to be clearer and to ensure that the figures within the report are accurate and can be understood by the reader.

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	Funding approval			✓	
3	Monitoring arrangements			✓	
4	Communication of any changes.				✓
5	Review of disputes			✓	
6	Budget and performance reporting				✓

** 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 issue that is classified as a weakness in the system control/design of Continuing Healthcare.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control of Continuing Healthcare.

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: The Health Board has policies and procedures in relation to the Continuing Healthcare assessment process to identify the key stages in the process including dispute resolution.

We note the following area of good practice:

- The Health Board uses the Welsh Government (WG) 'Continuing NHS Health care: The National Framework for Implementation in Wales' as its policy guide. This is supplemented by a Health Board specific CHC Financial Control Procedure (FCP).

We identified the following findings:

- The WG framework and the FCP contain a number of forms and checklists. In addition there are a number of other forms for completion that are not contained within the framework or FCP. There is not always a clear link between these documents and there is no overarching guidance on which forms need to be completed at the various stages of the process. Our testing showed that some forms were never completed, and some aspects of some forms were never completed. Furthermore, many of the forms contained duplicate information.

Objective 2: Where funding has been approved, agreed process have been followed and within the agreed time lines. Relevant documentation, including consent forms are completed.

We identified the following findings:

- Our testing showed that in 12/14 cases the approval process, in line with the Scheme of Delegation, had not been followed when funding had been approved by the CHC Unit panel. Furthermore for one case that we tested, the Unit Panel form, was not authorised until 16 months after the individual initially became a patient, although services were provided, and invoices paid in the interim.
- Key information relating to the CHC process is not always held centrally making it difficult to establish if all of the necessary documentation has been completed.

Objective 3: Monitoring arrangements are in place to review agreed care packages in line with specified time frames.

We identified the following finding:

- Our testing identified that nursing reassessment forms for the current year or prior years were not evident on the personal files for half of the

patients that we reviewed. Furthermore, the date of the next nursing assessment is not recorded on patient's personal files meaning that there is a risk that care could continue at an inappropriate level.

Objective 4: Effective arrangements are in place to communicate any changes in care packages to the relevant clinical and finance staff and action is taken to alter financial payments.

We note the following area of good practice:

- Our testing showed that there are effective arrangements in place to communicate any changes in care packages to the relevant directorate and to the finance team who monitor expenditure.

We did not identify any findings under this objective.

Objective 5: Disputes raised are reviewed and investigated in line with the agreed process.

We identified the following finding:

- One dispute was deemed by the assessment staff involved to have not been resolved in a timely manner as it took over three months to reach a conclusion.

Objective 6: Reports are provided to the Health Board identifying pressures and any backlog in the assessment process.

We note the following area of good practice:

- Monitoring reports are produced on a quarterly and annual basis for the Executive Board.

We did not identify any findings under this objective.

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	**1**	**4**	**0**	**5**

Finding 1 - Funding authorisation (Operating effectiveness)	Risk
CHC Unit Panel forms are completed by the central CHC team for presentation at the Unit Panel meeting where a funding decision is made. Forms are presented following an initial nursing assessment, and should be presented annually thereafter to approve ongoing funding. In addition, requests for *ad hoc* funding may be requested during the year for things such as respite care or additional continual funding for equipment. Our testing of patient records identified that the financial data on the CHC panel forms is not recorded in a consistent way. For example, in some cases the annual cost of funding is recorded, in other cases the daily or weekly cost is recorded. This is not always made clear, and without the full annual cost being calculated and included on the form, there is a risk that the relevant parties are not fully aware of what they are approving and that the correct approval in line with Health Board's Scheme of Delegation (SoD) may not be sought. The Financial Control Procedure for Continuing Healthcare states that 'Implementation cannot take place until the required approvals have been obtained'. We tested a sample of CHC unit panel forms and identified that 12 /14 CHC forms had not been appropriately authorised in line with the SoD. • 8/14 exceeded an annual value of £60,000 but had been signed by the Director of Nursing, when they should have been authorised by the Chief Executive as required by the SoD. In one instance, the authorisation by the	Inappropriate Continuing Healthcare packages are put in place.

Director of Nursing did not take place until 16 months after the provision of services commenced and was a result of a query during the audit. • 4/14 had annual values between £30,000 and £60,000. While these had been correctly signed by the Director of Nursing, according to the SoD additional authorisation by the Director of Finance, who was also required to sign, had not taken place.	
Recommendation	**Priority level**
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**
Management Response	**Responsible Officer/ Deadline**
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;	Sian Lewis (Lead Nurse for CHC and NHS Funded Care) Feb 2019

• 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.	

Finding -2 - Policy and key documentation (Control design)	Risk
The all Wales guidance in relation to Continuing Healthcare '*Continuing NHS Healthcare: The National Framework for Implementation in Wales*' has been in place since 2014. We understand that the framework is currently under review following a recent update of the corresponding English framework. At a local level, while the Health Board has a Continuing Healthcare policy, we understand that it is not used as a reference point, with staff finding the framework a more practical guide. In addition, the Health Board has a Continuing Healthcare Financial Control Procedure (FCP) outlining the process to be followed prior to a case being put before the CHC Unit Panel for a funding decision. The FCP states that it should be read in conjunction with the Continuing Healthcare policy. However, given that the policy is not well used in practice reference to the framework document may be more appropriate. A number of forms are completed during the CHC process. In addition to the forms required by the framework and the FCP, additional forms such as the WG Decision Support Tool, the Nursing assessment form, and the Unit Panel form, which is used to outline funding requests must also be completed. From our testing of CHC documentation there appears to be a lack of clarity with regards to the forms that need to be completed, some contain a duplication of data, and some elements of some forms are either rarely completed, or not completed at all. For example, appendix 3 of the FCP is a patient checklist / *pro forma*. However, a different patient checklist was held on the files that we tested.	Non-compliance with the provisions of the Welsh Government Continuing NHS Healthcare Framework.

Recommendation	Priority level
Following the publication by Welsh Government of a revised CHC national framework, management should review Health Board procedure documents and forms used in the CHC process to ensure all aspects remain relevant and aligned to the national framework. Consideration should be given to having a single document within the Health Board that signposts users to the relevant guidance such as the framework, the FCP, and to the relevant forms that need completing. Management should also provide refresher training to relevant staff within directorates and extending training to local authority counterparts, to ensure that staff are fully aware of any revisions to the framework and fully understand their responsibilities for the aspects of the process that they are responsible for.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Welsh Government are in the process of finalising the revised CHC Framework for early 2019. Cwm Taf UHB plan to review all documentation in the line with the new CHC Framework to ensure consistence of application and prevent duplication. A joint training programme between health and social care will be an essential element of embedding the new framework.	Sian Lewis (Lead Nurse for CHC and NHS Funded Care) Within three months of implementation of the new framework (July 2019)

Finding 3 - Centralised documentation (Operating effectiveness)	Risk
We tested a sample of patient files to confirm that the correct CHC funding process had been followed. A patient file should be held by the central CHC team and contain key documents including the nursing assessments and unit panel forms. Referring directorates will also hold patient files that contain some of the same documentation, plus additional paperwork. For the 14 patients selected for testing, the central CHC team could not find three patient files. Information in relation to these patients therefore had to be requested directly from the relevant directorate. Our testing identified that for 3/14 files a consent form or best interest assessment was not held in the central records. We requested a copy of these from the directorate but these were not been received during the time of the audit fieldwork. We also note that patient files are mostly paper based, often containing forms, assessments and correspondence collated over a number of years. Given the volume of information held within the files, which may be held at more than one location, it can be difficult to identify key pieces of information. As such, there is a risk that key documents may be missing and should there be the need to consider an appeal or resolve a dispute, the Health Board may have difficulty locating the relevant information.	Non-compliance with the provisions of the Welsh Government Continuing NHS Healthcare Framework.

Recommendation	Priority level
A review of the current arrangements for storing patient CHC files should be undertaken. For all patients where funding is in place or an assessment ongoing, a file (preferably electronic) should be held by the CHC team. An electronic copy of the key documents required as part of the decision making process should be provided by directorates and held on file. If documents cannot be centrally saved to file in this way, a checklist should be in place on file indicating where the original copy of these key documents are being held, the date they were completed, and any key decisions.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Cwm Taf UHB to strengthen quality assurance at directorate level by developing a checklist for each application presented to Clinical Placement Panel. This will be included on the central file and will ensure applications contain necessary documents and then are available and accessible to the central team.	Sian Lewis (Lead Nurse for CHC and NHS Funded Care) March 2019

Finding 4 - Funding application (Control Design)	Risk
The Unit Panel form does not confirm if a nursing assessment has been carried out, if the Decision Support Tool has been used, or the dates that these key parts of the process were carried out. Presence of this information would support the integrity of the decision being made by the unit panel. We understand that the CHC Unit Panel receive each application for funding without being given a full breakdown of all other funding that is in place for that patient. Whilst this financial information is held by finance, we note that it is not made readily available to the panel. Therefore, each additional funding agreement is made without sight of the full package of CHC care that is currently being funded. Furthermore the template CHC Unit Panel form is not clearly aligned to the SoD. For example: • Section 7 of the form requires a signature from the directorate panel and refers to the SoD value of £5,000, however, this level of authorisation is not mentioned in the SoD. • Section 8 of the form requires a signature from the Assistant Director of Nursing and refers to the SoD value between £5,000 and £25,000. However, in the SoD the authorisation level is £30,000 and states the Chair of CHC panel can approve between these values. • The remainder of the form gives space for the Executive Director of Nursing, Director of Finance and Chief Executive to give financial	Inappropriate Continuing Healthcare packages are put in place.

authorisation. However the form is not clear as when these authorisations are required, whereas the SoD is clear when authorisation at this level is required.	
Recommendation	**Priority level**
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**
Management Response	**Responsible Officer/ Deadline**
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.	Sian Lewis (Lead Nurse for CHC and NHS Funded Care) Feb 2019

Finding 5 - Nursing reassessments and Panel decisions (Operating effectiveness)	Risk
An initial nursing assessment should be carried out when a patient is first referred for CHC funding. Following approval, reassessments should take place annually. We note that the date of the next 'nursing assessment needs' review is not recorded on the documentation as a matter of course. Our sample testing of the patient reassessments identified: • 7/14 of patients sampled there was no evidence of a nursing reassessment on the file held by the central CHC team for the current year, or for some of the prior years. During our fieldwork we saw evidence of one instance where a Community CHC Co-ordinator requesting over a period of months, that a District nurse complete a nursing assessment so that funding could be re-approved. • For 2/14 patients, there was no evidence on the file held by the central CHC team of a Unit Panel form for the current year or previous years. There is a risk that care and therefore funding continues at levels that may not be appropriate for that patient if reassessments are not taking place in line with the framework. Furthermore, any delay in reassessments taking place will mean a delay in the CHC Unit Panel approving ongoing funding. As such, there are likely to be periods where funding continues, but it is not approved.	Non-compliance with the provisions of the Welsh Government Continuing NHS Healthcare Framework.

Recommendation	Priority level
Management should ensure that copies of nursing assessments and appropriately approved CHC Unit Panel forms are retained on file (preferably electronically) for each year that a person is a CHC patient. Management should ensure that key documentation such as nursing assessments are completed in a timely manner to allow the Unit Panel to approve each year's funding request. Consideration should be given to including in the patient file the date the next nursing assessment is due.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The quality assurance process and checklist identified in Finding 3 will encompass the recommendation in Finding 5. The central CHC Team to provide training to the directorate teams to identify the importance of annual reviews and approvals.	Sian Lewis (Lead Nurse for CHC and NHS Funded Care) 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.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Cwm Taf University Health Board**

Date issued: January 2019

Document reference: 123A2017



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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at info.officer@audit.wales.

Contents

Summary report

About this document 4

Financial audit update 4

Performance audit update 5

NHS Related National Studies and Publications 8

Good Practice Exchange 10

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 2017-18	Our audit of the 2017-18 accounts is complete. The accounts were certified by the Auditor General for Wales on 6 June (with an unqualified audit opinion) and laid with the National Assembly for Wales on 14 June.	**Work complete.**
Charitable Funds Accounts 2017-18	Our independent examination of the 2017-18 charitable funds accounts is complete. The accounts were certified by the Auditor General for Wales on 8 November (with an unqualified opinion) and filed with the Charity Commission on 7 December.	**Work complete.**
Annual UHB Accounts 2018-19	We have now started planning for the audit of the 2018-19 Health Board accounts (incorporating WHSSC/EASC). There is little to report at this early stage, but we will keep the Committee informed as we progress this work and will produce our detailed Audit Plan for consideration in March 2019.	Work ongoing.

Performance audit update

Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

Topic (year of Outline Plan)	Focus of the work	Status	Executive lead	Considered by Audit Committee	Management response status
Primary Care Review	This work is being delivered in two phases. The first phase will build on existing data to provide an all-Wales data rich picture of primary care. Phase 2 will then focus on the work being undertaken by Health Boards to implement the strategic vision for primary care. This will draw on the commitments set out within the 2014 Plan for Primary Care Services for Wales and other relevant national delivery plans, together with key enablers of change such as the development of primary care clusters and mechanisms to increase capacity and capability within primary care services.	**Report Completed**	Alan Lawrie	January 2019	Completed
Structured Assessment	This work will assess the robustness of NHS bodies' arrangements for corporate governance and financial management, and the progress that is being made in addressing issues and concerns identified in previous years' structured assessments.	**Report Completed**	Allison Williams	January 2019	Completed

Work currently underway or planned

Exhibit 3: 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
Intermediate 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	Next Audit committee
Orthopaedic Services follow-up	This work will examine the progress made in orthopaedic 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.	**Fieldwork**	John Palmer	March 2019

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
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**
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.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Structured Assessment 2018 – **Cwm Taf University Health Board**

Audit year: 2018

Date issued: January 2019

Document reference: 966A2018-19



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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

The team who delivered the work comprised Sara Utley, Gareth Lucey, Urvisha Perez, Gareth Lewis, and Steve Stark under the direction of Dave Thomas.

Contents

About this report 4

Background 4

Main conclusions 5

Governance:

The Board continues to operate well, however, aspects of quality governance, risk management and oversight of ICT arrangements do require improvement 5

Strategic Planning:

The Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones 13

Wider arrangements that support the efficient, effective and economical use of resources:

Financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. However, there is a need for continued action to address several significant workforce challenges, including factors driving the relatively high use of locum and agency staff 16

Recommendations 26

Appendices

Appendix 1 – progress implementing previous recommendations 28

Appendix 2 – Health Board's response to this year's recommendations 32

About this report

1 This report sets out the findings from the Auditor General's 2018 structured assessment work at Cwm Taf University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 Our 2018 structured assessment work has included interviews with officers and Independent Members, observations at board, committee and management meetings and reviews of relevant documents, performance and financial data. We also conducted a survey of board members across all health boards and NHS trusts. Fifteen of the 22 (68%) board members invited to take part at the Health Board responded.

3 This year's structured assessment work follows similar themes to previous years' work, although we have broadened the scope to include commentary on arrangements relating to procurement, asset management and improving efficiency and productivity. The report groups our findings under three themes – the Health Board's governance arrangements, its approach to strategic planning and the wider arrangements that support the efficient, effective and economical use of resources. The report concludes with our recommendations.

4 Appendix 1 summarises the action that has been taken to address previous year's structured assessment recommendations. Appendix 2 sets out the Health Board's response to the recommendations arising from our 2018 work.

Background

5 Our 2017 Structured Assessment work found that the Health Board's governance arrangements and those for financial planning and management continued to operate effectively. We also identified opportunities to improve change management arrangements, progress reports against the strategic plan and ongoing issues with workforce management and implementation of the digital strategy.

6 During 2017-18, the Health Board remained on routine monitoring under the NHS Wales Escalation and Intervention Framework. It once again achieved a break-even financial position, reporting a £63,000 cumulative surplus for the years 2015-16 to 2017-18. The Health Board developed the Integrated Medium Term Plan (IMTP) for 2018-2021 within the timeframe required by the Welsh Government and it received approval from the Cabinet Secretary for Health and Social Services.

7 Over the past 12 months, there have been changes amongst the Executive team and most recently the Director of Nursing retired. The Health Board has put interim arrangements in place until a new Director of Nursing is appointed in 2019. Last year the Health Board experienced significant Independent Member turnaround similar to other Health Boards; five members left including the chair and the vice chair. The Health Board has managed this change well.

8 The most significant change to affect the Health Board this year is the Welsh Government's decision to expand the Health Board's boundaries to include the population of the Bridgend County Borough Council (BCBC) area. This means that healthcare services currently provided by Abertawe Bro Morgannwg University Health Board across the BCBC area will transfer to the Health Board from

1 April 2019. The Health Board will also need to forge new partnerships with BCBC particularly around the integration of health and social care.

9 For the purposes of this year's Structured Assessment, we did not review the Health Board's arrangements for the transfer of services and boundary changes. A Joint Transition Board has been established to manage the transfer of services between Abertawe Bro Morgannwg University Health Board and the Health Board. Membership of the Joint Transition Board includes the Chairs and Chief Executives of both the Health Board and Abertawe Bro Morgannwg University Health Board and a newly appointed programme director. Structures to support the Joint Transition Board have been established, including a Joint Transition Programme Group, which is underpinned by various workstreams. The Joint Transition Board reports to both health boards' executive teams through their respective Chief Executives and then subsequently to their respective Boards.

Main conclusion

10 This year's Structured Assessment work has demonstrated that **while the Health Board has good strategic planning and financial management arrangements, it continues to have significant workforce challenges and its quality governance arrangements require improvement**.

11 The findings which underpin these conclusions are considered in more detail in the following sections.

Governance

12 As in previous years, our Structured Assessment work examines the Health Board's governance arrangements. We comment on the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. We also looked at the information that the Board and its sub committees receive to help it oversee and challenge performance, and monitor the achievement of organisational objectives. We have drawn upon results from our survey of board members to help understand where things are working well, and where there is scope to strengthen arrangements.

13 We found that **the Board continues to operate well, however, aspects of quality governance, risk management and oversight of ICT arrangements do require improvement**.

Conducting business effectively

14 We looked at how the Board organises itself to support the effective conduct of business. We found that the Board is operating effectively, but the Quality, Safety and Risk Committee is not as effective as it could be, and there are gaps in the arrangements to oversee progress on ICT developments.

15 Sound governance arrangements are fundamental to help provide strategic direction, challenge the effectiveness of delivery and ensure that corrective actions resolve issues where they arise. The Board and committees have a good 'cycle of business' that ensures that key aspects of business are covered in the agenda. The administration of Board meetings is good, and it is clear when decisions are made and recorded. The Board and committees undertake annual self-assessments which provide opportunities to review their effectiveness. We continue to observe good levels of scrutiny and challenge with generally good responses from executive at board and committee meetings including Finance Performance and Workforce (FPW) and the Audit Committee, particular credit is given to the

work of the FPW committee into their deep dives into directorates and holding to account for performance as well as their review of the operation of directorates including scrutiny of the challenges they are facing. The Health Board operates an integrated governance committee (IGC), made up of the Chairs of all the Board's committees. The IGC maintains oversight of the work of the board sub committees. It ensures integration of the governance work to ensure that issues do not fall outside or between the work of the sub committees, minimises duplication and co-ordinating issues which need the attention of more than one of the Board's sub committees. The work of the Integrated Governance Committee is good and gives an opportunity for issues to be cross referred and discussed amongst committee chairs.

16 As part of this year's structured assessment, we asked board members about the conduct of board meetings. Our survey found that:

- 87% of board members responding felt that the agenda was a manageable length compared with 74% of board members across Wales;
- 87% of board members responding felt there was always or mostly sufficient time to consider all agenda items compared with 71% of board members across Wales; and
- 87% of board members responding felt that the agenda was always or mostly organised so that the important items appear first compared with 58% of board members across Wales.

17 Our survey sought board members' views about whether the information needed for effective oversight and scrutiny had been agreed and the level of confidence in the information they received. Most (93%) board members responding to our survey indicated that the Board had agreed the information it needed compared with 79% across Wales. Board members were generally confident in the quality and accuracy of the information received and that it was sufficient to inform decision making and to support effective scrutiny. Our observations of committee meetings show that Independent Members are confident in suggesting improvements to the presentation of information.

18 Last year we noted the challenges for the secretariat in producing committee papers one calendar week before meetings. The secretariat continues to work hard to ensure papers are available in the required timeframe. There have been examples where papers were not ready in time, but the committees have dealt with this appropriately.

19 Over the last year there has been significant turnover amongst the Health Board's Independent Member (IM) cadre with five IMs including the chair and vice chair of the Health Board coming to the end of their tenure. These were replaced by new members. The Health Board has managed this process well putting in place bespoke training and wrap around support for the new cohort of IMs who joined the Board. The findings from our board member survey show that IMs were satisfied with the training and support that they receive. In particular:

- all IMs responding were satisfied or very satisfied with the induction programme for new Board members compared with 65% of IMs across Wales;
- all IMs responding were satisfied or very satisfied with the training and support provided to them to discharge their responsibilities compared with 83% of IMs across Wales; and
- all IMs responding were satisfied or very satisfied with the programme of board development to support effective board working compared with 85% of IMs across Wales.

20 Board member walkabouts and ward visits have been in abeyance recently due to board level turnover, and the framework supporting these visits needs to be updated to reflect the recent IM

changes. All IMs responding to our survey were satisfied or very satisfied with the opportunities to meet staff and visit wards compared with 65% of IMs across Wales.

21 The Quality, Safety and Risk (QSR) Committee uses patient stories and this year has looked at three patient stories in relation to A&E and community pharmacy as well as clinical ethics. The Health Board provides support for patients to tell their story. However, papers presented to the QSR Committee are not yet succinct and meeting agendas are not prioritised. We are aware that the Health Board is also undertaking a review of the sub committees reporting into the QSR committee as this is an area that requires improvement. This year we also identified the following issues:

- during 2017-18, the QSR Committee approved 41 policies. Given the busy agenda it would be better to map policy renewals to assess whether some policies could be approved by an alternative committee or group, leaving valuable time for scrutiny.
- due to the IM tenure ending the committee had a vacancy for one IM on the committee for a significant part of the year.
- the information presented to the QSR Committee does not always highlight areas of concern at the front of reports and instead relies on the reader finding it within the report. There is little information on the remedial actions to address poor performance, and lessons learned could be better highlighted.

22 Last year the Health Board developed its Digital Health Strategy and it established the Digital Health Strategy Steering Group to oversee delivery of the strategy. The steering group's terms of reference state that it will align and work closely with the work of the Information Governance Group and provide regular assurance reports to the QSR Committee. Our review of the QSR Committee papers found no evidence that the Committee has received assurance reports from the steering group. Consequently, it is unclear how the Board receives assurance on progress with implementation of the Digital Health Strategy.

23 The Scheme of Delegation, Standing Orders and Standing Financial Instructions are up to date and reviewed regularly. However, the Health Board needs to update their Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to delegate responsibility for calculating nurse staffing levels to a senior registered nurse, usually the Executive Director of Nursing.

Managing risks to achieving strategic priorities

24 We looked at the Board's approach to assuring itself that risks to achieving priorities are well managed. We found that despite a board assurance framework and risk management strategy being in place there is a need to improve the operational identification, review and mitigation of risk.

25 The Health Board has an established Board Assurance Framework (BAF) clearly linked to the Integrated Medium Term Plan. The Board undertakes an annual review of the BAF, which is publicly available. The BAF outlines the principle risks threating the delivery of the Health Board's strategic objectives. It aligns the principle risks, key controls, risk appetite and sources of assurance against each strategic objective. The Health Board plans to further strengthen board awareness by providing training on risk and risk appetite for the Board before the next review of the BAF when the IMTP is refreshed.

26 Compilation of the BAF relies on robust risk management arrangements within the organisation to identify, review and update risks. The Health Board has an approved risk management strategy. The

risk management strategy notes that directorate managers will monitor and develop mitigating actions to control risks. The strategy also requires regular reviews of risk registers by integrated governance groups at directorate level to escalate risks where risks cannot be managed by the directorates to the executive team and then to Board. Executive directors then have a directorate risk profile and there is a process to escalate to the organisational wide risk register. Positively, each risk on the corporate risk register can be tracked back to the original risk assessment. The corporate risk register is received and reviewed by the executives, Board as well as the Quality, Safety and Risk committee regularly.

27 As part of this year's structured assessment, we asked board members about risk management. The findings from our survey show that board members are overall happy with the arrangements in place for identifying and managing risks:

- all board members responding to our survey understand the risks to achieving strategic objectives and how they are being managed;
- most board members (86%) felt they were involved in identifying risks to achieving strategic objectives compared to 91% across Wales;
- most board members (93%) felt that the information presented to the Board allows members to effectively scrutinise actions being taken to mitigate risks compared to 77% across Wales; and
- most board members (93%) responding were clear on how risks were both managed and escalated up to the Board or committees compared with 86% across Wales.

28 Although it is positive that board members are overall happy with risk management arrangements, recent work undertaken by the Internal Audit service in some directorates and our review of the estates risk register indicate potential to improve timeliness of risk reviews and associated actions to mitigate risks. Directorates are meant to review their risk registers at their routine clinical business meetings. However, this does not appear to have been happening consistently and therefore some risk registers are out of date. This could mean that the organisational risks currently on the BAF are not reflective of the current issues facing directorate teams.

29 Staff receive corporate training to assist them in completing risk registers, which includes identifying, managing and mitigating risks, and written guides are available on SharePoint.

Embedding a sound system of assurance

30 We also examined whether the Health Board has an effective system of internal control to support board assurance. We found that important aspects of the Health Board's quality governance arrangements require improvement and the Health Board needs to address information governance plans and capacity.

Performance management and monitoring

31 There are a range of activities in place to monitor performance within the Health Board, these include;

- Clinical business meetings – where a small core of executives meet on a monthly basis with clinical and managerial leads of each directorate to provide oversight and performance management of the entire operation;
- Corporate business meetings (CBM) – where a small core of executives meet on a bi-monthly basis with the managerial leads for each major corporate function to provide oversight and performance management; and
- Efficiency, Productivity and Value Board (EPV) – where the Chief Executive oversees the cluster of cross-cutting themes and associated activities to achieve medium to long-term improvement trajectories.

32 The Health Board produces a comprehensive Integrated Performance Dashboard linked to the NHS Wales Delivery Framework and Tier 1 targets. The dashboard contains relevant benchmarking, trends and forecasting, and supporting narrative provided for areas where performance needs to improve, eg performance against A&E targets. The indicators are grouped into the Health and Care Standards themes. Trend data shows performance over the preceding 12 months with a summary of performance and the action being taken to address areas of underperformance. The information is very detailed and enables scrutiny, and the Health Board continues to refine the presentation of this information.

33 Our survey sought board members' views on the information they receive to help them discharge their role. Overall, Board Members were positive about the information they received over several domains including operational delivery and service quality. We found that most board members (92%) felt that the board had agreed the information it needed for effective oversight and scrutiny compared to 79% across Wales. Overall, most board members (86%) felt that they had a good understanding about how well the organisation was performing in relation to service quality compared to 80% across Wales and (80%) felt that they had a good understanding of how the organisation performs in relation to patient experience compared to 64% across Wales.

Quality governance

34 Whilst the Health Board appears to have the necessary structures and processes in place to support quality governance, in practice we are concerned that the system is not effective in highlighting issues and concerns or demonstrating responses to improvements.

35 The Quality Strategy and the Quality Delivery Plan is designed, implemented and monitored by the Quality Steering Group (QSG), which reports to the Quality Safety and Risk Committee. The QSG collates information from several sub-groups, such as the concerns panels which consider complaints, redress, patient safety and incidents. The QSG is responsible for the preparation of the Quality Report received quarterly by the Quality, Safety and Risk Committee.

36 However, the QSG has not met as regularly as required, and reports of its activity have to the Quality Safety and Risk Committee have been infrequent and not compliant with the terms of reference.

37 Our review of the Quality Report found that the information presented does not enable readers to easily identify areas of concern. Summaries of the quality report do not effectively highlight where the

Committee's attention should be drawn and why. For example, there was a 9% increase in falls reported between May 2017 and June 2018, but the Quality Report does not identify what actions are being taken to address this issue. The information on patient experience and learning from concerns is also presented in the Quality Report but it is difficult to identify the directorates where concerns arise. This makes it difficult to triangulate information across a range of quality and safety measures. In general, the Quality Report could be more effective at highlighting where lessons have been learnt and changes have consequently been made.

38 The Health Board first produced a Quality Strategy covering the period 2015-2017. After considering the implications of the Bridgend boundary change a decision was made to hold off producing a full quality strategy until the transition of services has been delivered, and instead to produce an interim Quality Strategy covering one year.

39 The Health Board aims to revise the Quality Strategy following the transfer of services from Abertawe Bro Morgannwg University Health Board. We have noted that the interim Quality Strategy provides no assessment of the current state of quality within the Health Board nor makes it clear what progress they would want to see by when.

40 Arrangements for staff to raise concerns need strengthening. The Board survey respondents felt that, in the main, the organisation has a track record in actively encouraging staff to identify and report concerns and complaints and ensure that it listens and responds not only to good news stories but also to feedback on poor quality care. However, a recent Internal Audit review reported in October 2018 gave limited assurance in relation to arrangements for raising concerns (Whistleblowing). The review raised concerns around how the Health Board had communicated the raising concern policy to employees, it was not part of the induction for new employees and there had not been any recent training nor a comprehensive awareness campaign. The review also highlighted that policies and procedures were available on the intranet but the Health Board was unable to demonstrate how it communicated these to staff who do not routinely have access to IT. Additionally, more support was needed for line managers to support them in managing staff concerns and there was a requirement for a central log of concerns to enable analysis of this data to be undertaken. Positively results from the NHS staff survey do show that 93% of respondents (22% overall response rate which was below the average) said that the last time that they saw an error, near miss, or incident, that could have caused harm to staff, they reported it. A positive culture of incident reporting is to be recognised.

41 Issues with serious incident reporting within maternity have recently come to light. An independent review by the Royal College of Obstetricians and Gynaecologists was initially agreed to be commissioned by the Health Board. This has now been commissioned directly by the Cabinet Secretary for Health and Social Services and is due for completion by the end of spring 2019.In the interim, it is important that the Health Board demonstrates organisational learning and seeks assurance that issues uncovered in maternity services are not more widespread.

Clinical Audit

42 The Health Board has a clinical audit plan for 2018-19 in place. The plan identifies the clinical audit projects that that the Health Board must participate in nationally, as well as the local audits which have been identified through clinical priorities and patient and public experience initiatives. The plan also includes priorities from the quality strategy and the quality delivery plan.

43 The Health Board's strategy for clinical audit had previously been included within the Health Board's 2014-2017 Quality Strategy. However, a review by Internal Audit in January 2018 recommended that the Health Board produce a stand-alone plan for clinical audit, as coverage in the Quality Strategy was not sufficiently detailed. It is therefore an improvement that the Health Board presented a stand-alone document separate from the Quality Plan to the Audit Committee in July 2018.

44 Compliance with the Clinical audit plan is reviewed and monitored on a quarterly basis through the clinical audit and quality improvement operational group and the quality steering group. The Audit Committee and the Quality, Safety and Risk Committee both have responsibilities for clinical audit, which are;

- Audit Committee – that the Health Board has a visible clinical audit programme in place and the outcomes provide internal assurance to the board; and
- Quality Safety and Risk Committee – ensure arrangements are in place to undertake, review and act on clinical audit activity which responds to national and local priorities

45 The mechanism in place for monitoring performance of clinical audit for the Quality Safety and Risk Committee is through the Quality Report. However, there is a lack of detail; recently it was found that national audits were not being completed as required within maternity due to capacity issues. The clinical audit team have recently provided all directorates with an update of their progress against their audit plans.

Information governance and information security

46 Work has been ongoing to strengthen the Health Board's arrangements in relation to the General Data Protection Regulation (GDPR) requirements. There is an Information Governance Management Framework in place, which is supported by key policies. However, the Health Board needs to update its framework following the recent adoption of all-Wales policies on information governance and information security and reflect the change in Data Protection Officer. An Information Governance Group is in place and it reports to the QSR Committee. The Chair of the Information Governance Group, who is an IM, is stepping down when his tenure ends in December 2018, which will leave an IM&T champion gap at Board level. The Health Board is achieving its Freedom of Information request targets and the Health Board has recently recruited additional staff to the team, but impending boundary changes may require more resources in future. Compliance with information governance training has improved since last year and is currently 69.8%, but well below the 95% national target.

47 There is no cyber security action plan in place. In March 2018, the Health Board received the findings of an external cybersecurity assessment, which identified significant improvement actions needed to strengthen arrangements. The report highlighted the lack of cyber security personnel as the Health Board has only one Information Security Manager and no dedicated support staff, which limits the time available to provide suitable support and advice. The Information Security Manager has previously been unsuccessful when requesting additional cyber security staff and is currently waiting for a decision on a recent request to the Executive Management Board. The executive team are aware of the need for further staff in this area, and it has formed part of IMTP planning discussions, and further work is expected in the next planning cycle to enable additional resources to be allocated. The report also highlighted evidence of the existence of old and unsupported versions of software, and a significant number of instances indicating a failure or lack of up-to-date security patching of Microsoft Operating Systems. A clutch of third party-maintained imaging servers also showed poor patch

management. The Health Board needs to ensure that it addresses the issues identified in the report and develops an action plan, to minimise any associated risks (for example, a successful cyber-attack) as much as possible and progress is monitored through the Information Governance Group.

National Fraud Initiative

48 Last year, we reported that the Health Board did not review the recommended data matches from the National Fraud Initiative (NFI) biennial data-matching exercise in a timely way. In January 2017, the Health Board received 5,263 data-matches as part of the most recent biennial exercise. The data-matches highlight anomalies which when reviewed can help to identify fraud and error. Whilst we would not expect participants to review all data-matches, some of the matches are categorised as 'recommended matches'. These are matches considered to be of high risk and therefore recommended to be prioritised. The Health Board received 311 recommended matches. In our 2016-17 Annual Audit Report, we reported that as at 20 November 2017 the Health Board had only reviewed nine data matches and had failed to make effective use of NFI as part of its arrangements to prevent and detect fraud. As at 12 November 2018, the NFI web application records that the Health Board has now reviewed 216 data matches. Whilst we acknowledge that the Health Board has made progress, it still has a number of recommended matches that need reviewing. It is essential that these data-matches are reviewed as a matter of urgency. These matches include matches between payroll, creditor payments and Companies House data and matches between staff and supplier bank accounts.

Tracking recommendations

49 During 2018, the Health Board made changes to the audit tracker, which is presented at each meeting of the Audit Committee. Progress against recommendations is considered at every meeting with the pace of progress often challenged. At times, the Committee invites officers to prepare and present more detailed reports when action to address the recommendations is taking longer than anticipated and where audit reports have provided limited assurance. A cover report now accompanies the tracking log to give an overview to the committee of the position in respect of recommendations.

50 However, recommendations marked as complete are removed with little commentary to evidence removal of the recommendation. There is also an opportunity to utilise the tracker to co-ordinate actions in response to recommendations from other inspections and external reviews, such as Healthcare Inspectorate Wales, Ombudsman reports and Delivery Unit Reports. This approach would give the tracker wider applicability and could provide useful information to assist the work of the Quality, Safety and Risk Committee.

Ensuring organisational design supports effective governance

51 We looked at how the Health Board organises itself to deliver strategic objectives collectively while ensuring clear lines of accountability for delivery. We found that the Health Board has clear executive portfolios and lines of accountability, but clinical business meetings need more focus on quality and safety.

52 Arrangements for executive portfolios are clear, there is a clear organisational structure in place which sets out the roles and responsibilities. The Health Board has not made significant changes to its

overall operational structure since our last review. However, during 2018, there have been several changes amongst the Executive Management Team.

53 There are short to medium-term arrangements in place to manage changes to appointments amongst the executive team with the exception of the Board level role for the Director of Therapies and Health Sciences which is currently vacant. However, the Chief Operating Officer, who is also the Director of Therapies and Health Sciences, is currently seconded to Abertawe Bro Morgannwg University Health Board and he is available for advice should the assistant director of therapies and health sciences require support. Interim arrangements are in place with the Director of Primary and Community Mental Health moving into the Chief Operating Officer role, while a new Director of Primary Community and Mental Health was appointed. The Director of Nursing, Midwifery and Patient Care retired recently, and interim arrangements are in place until the appointment of a new director in 2019. The Director of Finance was appointed earlier this year having previously worked for the Health Board.

54 As mentioned previously in this report the Health Board has a mechanism of Clinical Business Meetings (CBMs), where a small core of executives meet on a monthly basis with clinical and managerial leads of each directorate to provide oversight and performance management. The Health Board sees these meetings as the mechanism to improve directorate performance against key performance indicators and improve service safety and service quality for patients and staff. In 2016, we recommended that the Health Board agree a consistent approach and terms of reference for Clinical Business Meetings as this had been highlighted in an Internal Audit Review. However, while there is a draft Terms of Reference for these meetings we have been unable to see a final version. From our review of minutes, we feel further work is needed to ensure quality and safety are discussed on a par with performance. Interviews within the executive management team have indicated that the ways the CBMs operate in the future are expected to change.

55 We have recently been made aware that the Health Board is reviewing the underpinning clinical governance structures and framework that underpin the directorate level arrangements. The new structure currently being developed aims to simplify the directorate and localities structures.

56 As the work progresses with the boundary change, the Health Board may need to reflect on executive portfolios and additional capacity requirements.

Strategic planning

57 Our work examined how the Board sets strategic objectives for the organisation. We assessed how well the Health Board plans how it will achieve its objectives, using funding, people and other resources that it has, or can make available. We wanted to know how the Health Board develops its strategic plans and how directorates are supported internally. Finally, we wanted to know if the Health Board is monitoring progress with these plans effectively.

58 We found that **the Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones**.

Setting the strategic direction

59 We looked at how the Board goes about setting its priorities in engagement with key stakeholders and setting them out in a clear IMTP. We found that the Health Board has a clear strategic vision and is developing its long-term clinical services strategy.

60 There is a clear strategic vision for the organisation and most board members (93%) responding to our survey reported that they were always or mostly involved in setting the vision and strategic priorities. The Health Board's central philosophy is Cwm Taf Cares. The 2018-2021 strategic priorities are grouped around five care themes and set out in the Health Board's IMTP. These care themes are:

- Wellbeing Self Care and Supported Care
- Integrated community care
- Care closer to home
- Acute care
- Tertiary services

61 Within these themes the Health Board has articulated three-year outcomes as well as priorities for 2018-19 – 2020-21. There are 16 priorities detailed over a wide range of areas and each of these has a 'plan on a page' for its achievement. The priorities are ambitious and build on successes from previous years, for example the Stay well @ Home service.

62 In addition to the care themes, there is an overarching enabler theme, which includes achieving financial balance, further developing leadership and delivery capacity and managing recruitment and retention amongst other areas.

63 The Health Board has a detailed engagement plan for consultation with key internal and external stakeholders on Health Board priorities. The strategic priorities set out in the IMTP were informed by effective engagement with key stakeholders both internally and externally. The IMTP engagement plan ensures that all the Health Board priorities are informed and influenced by those who have an interest in them. The groups range from Executive Board and the Board to Medical Leadership Forums and Strategic Partnership Boards and public fora.

64 This year the Health Board has been developing its long-term Clinical Services Strategy, but development was paused until the outcome of the consultation on boundary changes was known. The Health Board has indicated it has resumed its development and expects to publish before the end of 2018.

Developing strategic plans

65 We considered the Health Board's approach to developing the strategic plan. We found that the Health Board has a well-developed approach to its strategic planning underpinned by demand and capacity modelling and guidance.

66 The Health Board's approach to developing its IMTP remains consistent and builds upon the preceding plan. The Health Board has developed the IMTP within the required timeframe for the fifth consecutive year. In January 2018, the Board approved the draft IMTP, having reviewed and influenced the emerging draft through board development sessions and public board meetings.

67 Underpinning the IMTP is a series of plans that cover a range of cross-cutting themes, such as increasing workforce productivity and embedding the principles of prudent healthcare. The Health Board prepares annual guidance, which it launches at an organisation-wide planning workshop. The guidance sets out the local planning requirements and key milestones. As part of the IMTP planning process, the Performance and Information Department prepares skeleton demand and capacity plans for each directorate and locality with respective managers updating them. In March 2018, the Internal

Audit service reviewed the arrangements and highlighted concerns regarding lack of support for directorates, lack of clinical engagement and directorates not using demand and capacity plans to manage the business. The recent update report by Internal Audit has shown improvement, with improved clinical engagement and increased management oversight. The Health Board needs to be mindful of these areas when moving into the next IMTP planning round. Progress in developing the local IMTP plans is monitored by the Health Board's Integrated Planning Group and works well.

68 Last year, capacity within the Programme Management Office (PMO) was limited, which risked affecting the Health Board's ability to implement change. Additional support has been allocated to the PMO team to support work on the Bridgend transition. This is on a non-recurrent basis, and the Health Board is keeping this area under review with a view to growing its sustainable project management capacity to achieve its service transformation ambitions.

69 At the time of our audit work, the Health Board was preparing the next iteration of the IMTP, which will need to reflect the boundary changes and the wider integration of services following the transfer from Abertawe Bro Morgannwg University Health Board. The Health Board is developing processes to manage the transfer and integration of services and is currently engaged with them in developing their IMTP plans for next year. Information presented to Board highlights the Health Board approach to including Bridgend in the planning arrangements, and they are being engaged through the planning workshops and regular meetings with Cwm Taf.

70 The Health Board's IMTP contains several annexes, including details on financial strategies as well as workforce and organisational development. The IMTP provides a snapshot of the workforce with workforce assumptions set out, namely annual turnover and increase in salary costs. The IMTP does highlight workforce challenges such as reliance on agency and locum staff as well as areas within the Health Board where there are recruitment difficulties such as estates, maternity and primary care. Directorate IMTPs contain workforce plans and monitoring of these is through the clinical business meeting process.

71 Our board member survey found that, overall, board members who responded were happy that the clinical strategy, workforce plan and capital plan were effectively underpinning the delivery of the organisational objectives. The annexes to the IMTP also set out the Health Boards approach to prudent healthcare delivered through a cross-cutting theme managed by the EPV Board.

Monitoring delivery of the strategic plan

72 Finally, we looked at whether delivery of strategic plans is effectively monitored. We found that the Health Board has processes for monitoring delivery of the IMTP but without detailed milestones it is challenging to gain an accurate impression of progress.

73 Arrangements are in place to monitor and report on delivery of the IMTP. The Board receives a quarterly performance report against the five care themes within the IMTP and an annual summary of progress in the subsequent IMTP. However, the way the IMTP is set out makes it difficult to track milestones.

74 In 2017, we recommended that the Health Board refine the IMTP reporting process to include detailed information on milestones to enable Independent Members to understand progress against the expected trajectory. IMTP reporting has improved since our last Structured Assessment and the link to activities and the strategic themes of the Health Board are clearer, but without a clear picture of the

milestones in the IMTP it is difficult for an external audience to identify progress and see whether the IMTP priorities are on track.

75 Last year we reported on a new executive level board to provide oversight of the cross-cutting themes within the IMTP. The EPV Board first met in June 2017 partly in response to issues with the visibility of work on the cross-cutting themes. Board assurance is received through the Finance, Performance and Workforce Committee.

76 Board members reported they were happy with the information they received on the strategic change programme and IMTP performance reports. Our Board member survey found that;

- 86% of board members responding to our survey agreed that the information they received around strategic change programme delivery gave them a good understanding of the Health Board's performance compared with 83% across Wales; and
- all board members responding to the survey agreed that the information they received gave them a good understanding of the Health Board's performance in relation to IMTP delivery compared with 90% across Wales.

Wider arrangements that support the efficient, effective and economical use of resources

77 Efficient, effective and economical use of resources largely depends on the arrangements the organisation has for managing its workforce, its finances and other physical assets. In this section we comment on those arrangements, and on the action that the Health Board is taking to maximise efficiency and productivity. We examine if the Health Board is procuring goods and services well.

78 We found that, overall, **financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. However, there is a need for continued action to address several significant workforce challenges, including factors driving the relatively high use of locum and agency staff**.

Managing the workforce

79 The workforce is the Health Board's biggest asset, not least because pay represents such a significant proportion of expenditure. It is important that the workforce is well managed and productive because staff are critical for day-to-day service delivery and for delivering efficiency savings and quality improvements. Within Wales there are significant workforce challenges which are being faced by Health Boards. Within Cwm Taf UHB we found that Workforce issues continue to challenge the Health Board, but it is taking steps to tackle issues such as higher-than-average agency expenditure and turnover rates.

80 The following table shows how the Health Board is performing in relation to some key measures compared with the Wales average. Exhibit 1 shows that the Health Board's performance is the same or broadly comparable to the Wales average for sickness absence, vacancy rates and compliance with statutory and mandatory training. Turnover is higher than the Wales average, while compliance with the appraisal process is much better.

Exhibit 1: performance against key workforce measures July 2018[1]

Workforce measures	Health Board	Wales average
Sickness absence	5.6%	5.3%
Turnover	9.0%	6.9%
Vacancy	2.6%	2.6%
Appraisals	76%	67%
Statutory and mandatory training	74%	73%

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales, July 2018.

81 The Health Board's IMTP (2018-2021) highlights the biggest challenge to the Health Board's financial position is the overspend on medical, dental and nursing locums, and bank and agency expenditure. At July 2018, the Health Board's agency spend was 6% of their total pay bill, which is the second highest proportion in Wales. Agency spend is particularly high for medical and dental staff and accounts for 15% of the medical and dental pay bill while nursing and midwifery agency costs account for 6% of the pay bill. Since July 2017, there has been a small reduction (1.6%) in agency spend on medical and dental staff and an even smaller reduction (0.5%) on nursing and midwifery staff. Spend on agency allied health professionals has seen the biggest reduction since last year (8.7%). The Health Board recognises the need to reduce agency spend.

82 Workforce productivity is one of the Health Board's cross-cutting themes, which aims to reduce medical, dental and nursing and midwifery agency spend by approximately £5.1 million by next year (2018-19) through initiatives such as 'retire and return' for nurses and introducing e-rostering and e-job planning for the medical workforce. The cross-cutting programmes are overseen by the EPV Board, which is chaired by the chief executive.

83 There are several factors affecting recruitment and retention, such as an aging workforce, changes to pension and tax legislation and recruitment to training places, and these factors affect certain staff groups more than others. Exhibit 1 shows the Health Board has a higher-than-average turnover rate. As at July 2018, turnover amongst nursing and midwifery staff and allied health professionals was the highest in Wales at 10% and 9.6% respectively (the Wales average was 7.3% and 7.9% respectively). Compared to July 2017, the number of advertised vacancies for both staffing groups has seen little or no change. The Health Board's IMTP cites recruitment and retention as two of the key workforce challenges and poses a significant risk to delivering safe and effective services. The Health Board has cited difficulties recruiting medical staff in some specialities, such as consultants in acute medicine, accident and emergency, pathology, urology and general practitioners. In addition, nursing recruitment is a challenge, especially in the areas of acute medicine and maternity, both within Prince Charles

[1] Sickness: rolling 12-month average at July 2018; Turnover: 12-month period July 2017 to June 2018; Vacancy: one month at July 2018; Appraisal: preceding 12 months at July 2018; Statutory and mandatory training: at July 2018.

Hospital and Royal Glamorgan Hospital. There are other recruitment difficulties such as for imaging specialists, pharmacists and allied health professionals.

84 The Health Board is taking a number of actions to help fill vacancies, for example, recruiting nurses from abroad and running recruitment campaigns such as the national '#joincwmtaf.wales' campaign. The Health Board's IMTP states that the '#joincwmtaf.wales' campaign has resulted in an increase in its graduate and general nursing adverts. The Health Board also commissioned a PR company to develop a campaign that will initially focus on recruiting medical, and allied health professionals. This campaign aims to dovetail with the national 'TrainWorkLive' campaign. For certain staff groups, such as nursing, recruitment is relatively successful, but retention is poor. In response to this the Health Board is developing a nursing retention strategy.

85 Given the challenge, recruitment and retention are only part of the solution. The Health Board needs to modernise its workforce and use staff differently. The Health Board is implementing several workforce redesign programmes. The Health Board's key workforce modernisation priorities for 2018-2021 are:

- further development of advanced and extended clinical roles within secondary and primary care;
- trialling and introducing alternative practitioners, such as physician associates; and
- development of the healthcare support worker role within secondary and primary care.

86 In April 2018, the Health Board ran a workshop to showcase new roles and because of the workshop's success, it is establishing an executive level modernisation board. Whilst some service areas still recruit like for like, the Health Board reported that this practice is slowly changing, but more needs to be done. The Health Board is increasingly taking a bottom-up look at roles, to understand what types of roles services need.

87 The Health Board has one of the highest sickness absence rates when compared to other health boards and the Wales average. At July 2018, the rolling 12-month sickness absence rate was 5.6% and is the third highest when compared to other health boards (range 4.1% to 7.3%) and the Wales average (5.3%). Sickness absence rates are above average for all staff groups except for professional scientific and technical staff and allied health professionals. The Health Board's corporate risk register rates 'failure to achieve the management of absence target' as high. The Health Board reported a tailored approach to managing sickness absence. Sickness absence data is scrutinised at monthly CMB meetings, then followed up with work tailored to each directorate's needs. The Health Board has set a target of reducing sickness absence levels to 4.7% by the end of 2021. Given the issues with recruitment, retention and agency expenditure we would question whether this target is ambitious enough. The Health Board reported that they have a programme of staff wellbeing activities, and following reassessment in February 2018 have been awarded Platinum for the Corporate Health Standard.

88 The Health Board does not have a training and development plan and has not undertaken a training needs assessment. However, the IMTP states that the Health Board will be finalising and implementing three core organisational development frameworks supporting engagement, education and leadership. The frameworks and the associated workstreams are at various stages of development and implementation. At July 2018, the Health Board's annual appraisal compliance rate was better than the Wales average (76% and 67% respectively). Whilst not meeting the 85% national target, the Health Board's compliance rate has improved since last July (71%). The only staff group to meet the target is medical and dental. Appraisals form part of the annual revalidation process for

medical and dental staff and three-yearly revalidation requirements for registered nurses and midwifes. There has been a substantial improvement in statutory and mandatory training rates. In July 2018, the rate was 74% compared to 59% in July 2017. Allied Health Professionals are the only staff group meeting the 85% target. All statutory and mandatory training is accessed through the electronic staff record (ESR) which will also log when the training has been completed: compliance with the level one core skills training framework was 75% (November 2018) which the Health Board acknowledges requires improvement. The Health Board is currently reviewing its training provision as an initial demand and capacity analysis has indicated that that the Health Board is not delivering enough training to facilitate all staff maintaining their compliance with training requirements.

89 The Health Board has identified that current job planning compliance is lower than expected. To rectify the situation the Health Board has set a target of 90% compliance by December 2018 and for all job plans to be completed by the financial year-end. To monitor compliance rates, monthly reports are now submitted to Clinical Business Meetings (CBMs). The Finance, Performance and Workforce Committee also receives updates on job plan compliance through the workforce dashboard, but the Health Board recognises that presentation of this metric needs to be strengthened. Specifically, the dashboard was lacking trend data and Health-Board-wide compliance rates: these issues are being addressed.

90 The Finance, Performance and Workforce Committee receives a workforce dashboard each month, except for when the meeting is reserved for deep-dives and specific performance updates. The dashboard provides updates against the following six workforce areas: resourcing and recruitment, employee engagement, sickness absence, ESR and E-Systems roll out, personal development review and core mandatory training compliance and workforce utilisation. Workforce utilisation is demonstrated by showing figures for the supply of temporary registered nurses and healthcare support workers, medical agency expenditure and job planning compliance. The Board also receives the workforce dashboard at each meeting. The production and use of this dashboard are positive, however, the Health Board recognised that the dashboard was not adequately highlighting areas for the Board and committee to focus on. Since November 2018, the Health Board has made some improvements to performance reporting. For workforce, this has meant adding a coversheet to the workforce dashboard outlining the key points, highlights and lowlights related to workforce.

91 Our board member survey found that ten out of 15 members (67%) responding agreed that the information they receive gives them a good understanding about how the organisation performs in relation to workforce productivity compared with 40% of board members across Wales;

92 At the time of our audit work, the 2018 NHS Wales staff survey had just closed, and the results were not yet available. The Health Board learned that the response rate was only a 22% response compared with the Wales average (29%). The Health Board's response rate in 2016 was 38%. The Health Board is continuing to address the findings from the 2016 NHS Wales staff survey. The Health Board is also piloting pulse surveys across service areas with the aim of conducting all-staff surveys every six months. However, before rolling out this survey, the Health Board needs to understand the reasons for the low response rate to the national staff survey and take steps to try and secure better response rates in future staff surveys.

Managing the finances

93 We considered financial and budget management, financial controls, and operational support and processes. We found that the Health Board has a track record of achieving its statutory financial duties and has generally robust financial stewardship and management controls in place. However, there is a need to reduce the reliance on agency staff.

Achievement of financial objectives

94 Health Boards are subject to two statutory financial duties each year, under the NHS Finance Act (Wales) 2014. Firstly, they must spend within the Revenue Resource Limits (RRL) and the Capital Resource Limits (CRL) set by the Welsh Government, measured on a rolling three-year basis. Secondly, they must have their IMTP approved each year by the Cabinet Secretary for Health and Social Services.

95 The 2017-18 financial statements show that the Health Board underspent against its cumulative three-year RRL by £63,000 and against its cumulative CRL by £21,000, therefore meeting its statutory duty. Indications are that this duty will continue to be met in 2018-19. In its Monthly Monitoring Return issued to the Welsh Government for September 2018, the Health Board has year-to-date underspends of £77,000 against its RRL and £535,000 against its CRL and is forecasting to break even against both limits at the year-end.

96 The Health Board was able to return £3.0 million of brokerage to the Welsh Government in 2017-18 – effectively deferring this amount from their RRL from 2017-18 to 2018-19. The Health Board was able to achieve this position and still break even in the year by receiving additional funding from the Welsh Government (£1.8 million more than originally planned in its IMTP) and by over-achieving against its savings targets by £2.4 million. These amounts were offset slightly by additional cost pressures in areas, such as medical and nursing pay, drugs and other non-pay expenditure.

97 The Health Board has a good track record in respect of approval its three-year IMTP. The 2017-2020 IMTP was approved by the Cabinet Secretary for Health and Social Services in June 2017, while the 2018-2021 IMTP was approved in June 2018.

98 The Health Board's procurement arrangements are largely devolved to the NHS Wales Shared Services Partnership (NWSSP). There is an all-Wales Procurement Strategy, which the Health Board has signed up to. The NWSSP Procurement team have a local engagement strategy in place which was recently refreshed but needs to be agreed formally with the Health Board.

99 Management of procurement is through a service level partnership between the Shared Services Partnership and the Health Board, but we understand this is not proactively used to manage the 'contractual' relationship between the Health Board and the procurement provider.

100 As part of the Health Board's IMTP arrangements, there is a non-pay cross-cutting theme in place. The theme is led by the Director of Finance and the Head of Procurement, and performance is managed through the EPV Board, as well as the Non-Pay Strategy group. The non-pay cross-cutting theme achieves its targets. But, the executive-led Non-Pay Strategy group has not met since April 2018. We understand that the Health Board has good day-to-day relationships with the procurement service, and staff were complimentary on the support and guidance from the team. Additional procurement support is also being given to specific directorates, however, due to capacity limitations the procurement team are unable to offer this level of support across the Health Board. The Health Board could also adopt a more strategic approach in its procurement, to use it as a mechanism to help

deliver wellbeing of future generation objectives. This may, however, require a greater skill mix and resource in the procurement team and or an enhanced contribution and role by the Health Board's finance department.

Financial stewardship

101 The Health Board has a clear framework of roles and responsibilities, with appropriate control activities and processes in place. The Internal Audit service undertakes reviews of the 'financial governance and management' domain every year. In 2017-18, Internal Audit issued five reports in this domain, with only one of those reports on private and overseas patients leading to a 'limited assurance' opinion, which is a low proportion of activity within the Health Board. Its review of core financial systems gave an opinion of 'substantial assurance'.

102 Our own audit reporting during 2017-18 has not raised any material concerns over the Health Board's financial controls. The Audit Committee receives and reviews the outputs of Internal and External Audit on a regular basis, as well as the Health Board's Annual Governance Statement, which itself did not identify any significant concerns or failures of control.

103 The Health Board has a track record of meeting its statutory reporting requirements. Its draft and final financial statements were submitted to the Welsh Government in line with agreed deadlines. Similarly, the draft and final annual reports were produced in line with guidance from HM Treasury and in accordance with deadlines.

104 Regular finance reports are presented to the Finance, Performance and Workforce committee and the full Board. The structure and content of these reports are generally strong, with key findings and supporting detail clearly presented. The Director or Deputy Director of Finance also regularly attend Board or relevant Committee meetings. Management have engaged with IMs during the year to continuously improve the content and structure of these finance reports, to make them as clear and understandable as possible.

105 Our Board member survey found that 15 out of 15 (100%) members responding agreed that the information they receive gives them a good understanding about how the organisation performs financially compared with 97% of board members across Wales.

106 A Local Counter Fraud Service (LCFS) is in place to tackle fraud within the Health Board. Work in this area can be proactive (ie delivery of training, or review of internal policies/guidance) or reactive (review or investigation of specific allegations of fraud). The Health Board commissions this service from Cardiff and Vale University Health Board, with 1.5 full-time equivalent staff employed in its LCFS since the 2014-15 financial year.

107 However, the Health Board's counter-fraud landscape has developed in recent years. Its LCFS caseload has steadily increased, from 5 live investigations in 2014-15 to 20 in 2017-18. NHS Protect have provided a 'red' rating in the 'prevent and deter' domain in a recent review of the Health Board, due to internal policies not being reviewed by the LCFS. Furthermore, the impending boundary change (see paragraph 8) will increase the size of the Health Board significantly from April 2019. In response to the above challenges, the Health Board has reviewed its LCFS provision and counter-fraud service capacity will be increased from the 2019-20 financial year.

Financial management

108 The Health Board has a robust approach to financial management. Each directorate is allocated a Finance Business Partner (FBP), who meets at least monthly with directorate management to review progress against budget and identified savings plans. The Deputy Director of Finance oversees this process and meets with all FBPs each month to discuss issues arising at directorates.

109 This robust approach delivers consistent results for the Health Board. As noted above, the Health Board regularly meets its financial duty to break even over a three-year rolling period. In addition, performance against savings targets is strong, with 96% of savings achieved in 2016-17 and over 118% achieved in 2017-18. Furthermore, 60% of savings were classed as recurrent in both years.

110 The Health Board employs a Planning and Reporting team which acts as a 'business intelligence' function, providing costing and financial data to enhance decision-making by the Health Board. Detailed financial data is included in project appraisals for service change, allowing financial considerations to be fully considered by the Board alongside other factors when making decisions relating to service delivery.

111 The challenges in respect of relatively high use of agency staff highlighted earlier in this report will continue to present the Health Board with financial challenges.

Improving performance, efficiency and productivity

112 We looked at what the organisation is doing to improve performance, efficiency and productivity. We found that **the Health Board focuses on delivery of its key access targets and has examples of innovative ways of working to improve efficiency and productivity**.

Key waiting time targets

113 The Health Board is operating in a challenging environment, and while some performance metrics have improved the challenge is now to maintain this.

114 With regard to scheduled care, in March 2018, the Health Board delivered on its trajectory for referral to treatment times. This improvement has been supported by additional funding from the Welsh Government. Through its IMTP there has been a focus on the booking processes as well as a pathway transformation to deliver activities to improve pathway management for elective care. Work is also in progress to improve theatre utilisation and streamline processes for pre-assessment.

115 However, it is important that the Health Board maintains delivery of the referral to treatment time target throughout the coming year as this is technically a month-on-month target rather than an annual one. At the end of June 2018, 195 (1%) patients were waiting longer than 36 weeks to be seen compared to the Wales average of 3%.

116 In relation to unscheduled care, the Health Board is not achieving its four-hour emergency department target although performance is better than many other areas in Wales. Performance as at June 2018 was 90% compared with a Welsh average of 83%, and a national target of 95%. In the 2018-19 IMTP there are three specific objectives which involve looking at alternative interventions to provide alternative unscheduled care services for the elderly.

117 Follow-up outpatients remain a concern for the Health Board. The number of patients waiting for an outpatient follow-up (not booked) who are currently delayed past their agreed target date is 19,455,

and has been growing over the past four months. Work on clinical validation of follow-up lists is ongoing, and there has been a clear focus on outpatient follow-up appointments by the Quality Safety and Risk Committee.

118 Over the last 12 months there has been mixed performance in urgent suspected cancer performance but some improvement in relation to stroke performance measures, although the percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within four hours is low compared with other Health Boards in Wales.

Improving productivity and efficiency

119 Our work this year has considered the Health Board's arrangements for improving efficiency and productivity. We found that there is a good focus on prudent healthcare which is reflected in the IMTP and there have been some successes in this area, but further resources will be needed to fully embed the principles within directorates.

120 Compared to other health bodies in Wales, Cwm Taf Board members were more positive about the information they received in relation to service efficiency and care outcomes, although the responses to our board member survey indicates that scope exists to strengthen arrangements in both of these areas:

- nine out of 15 members (60%) responding agreed that the information they receive gives them a good understanding about how the organisation performs in relation to service efficiency compared with 52% of board members across Wales;
- seven out of 15 (50%) members responding agreed that the information they receive gives them a good understanding about how the organisation performs in relation to care outcomes compared with 47% of board members across Wales.

121 There is a clear focus on prudent healthcare and references to its importance throughout the IMTP. One of the Health Board's cross-cutting themes is 'Prevention and Improving Value from Healthcare', which is intended to embed prudent healthcare values. The executive lead for this theme is the Director of Public Health while the EPV Board monitors performance against the theme plan. The workplan for the group includes completion of opportunity analysis for interventions not normally undertaken, population heath management, science-based procurement and health outcomes measurement (ICHOM)[2]. The work of the prudent healthcare team is positive and shows a commitment from the Health Board in this area. Embedding prudent healthcare principles such that they are reflected in directorate IMTPs requires training and support; however, capacity within the prudent heathcare team is limited and prevents this.

122 Prudent healthcare principles are helping to reshape and modernise services. One example is Valley Steps, which is a new integrated service aimed at reducing demand and over-reliance on anti-depressant medication. At the same time, it reduces costs by reducing anti-depressant prescribing and supporting alternative interventions from traditional health services, eg mindfulness courses.

123 The Stay Well at Home (SW@H) service demonstrates where improvements to a service have not only helped in terms of prudent healthcare but also achieved financial savings and improved service user feedback. The SW@H service is a venture between the Health Board and local authorities to

[2] https://www.ichom.org/

improve engagement between health and social care within the A&E departments of the two main hospitals. The service aims to prevent health crisis, prevent avoidable hospital admission and prevent a lengthy hospital stay. A six-month evaluation of the project found that it had saved enough bed days to pay for its establishment and the NHS Wales Delivery Unit also found that delayed discharges because of problems between health and social care had reduced.

124 The Health Board has also taken steps to improve efficiency of outpatient services, for instance, by introducing text and remind services to reduce patient do not attends, which has had a positive effect.

Using informatics to support service delivery

125 We assessed the Health Board's arrangements to utilise technology to support service delivery. We found that the Health Board has an agreed digital health strategy, but challenges remain in securing the necessary resources to deliver it.

126 The Health Board has an agreed five-year digital strategic outline programme. This was first produced and agreed by the executive board in June 2017, and subsequently submitted to the Welsh Government. To implement the strategy, the Health Board requires capital funding totalling £17 million and £10.7 million revenue funding over the five-year period 2017-18 to 2021-22. Our 2017 Structured Assessment noted that the Health Board needed to break the strategy down into key deliverables and allocate financial resources accordingly. This work has been completed and each item on the digital health strategy is costed. The digital health strategy group prioritises capital funding based on the strategic needs of the Health Board.

127 The Internal Audit service reviewed the Digital Health Strategy and highlighted concerns that there is no ring-fenced funding for ICT. The lack of funding for implementing the informatics strategic outline programme may undermine the Health Board's ability to deliver strategic objectives. Capital monies allocated to ICT have been historically low and our previous work on ICT arrangements highlighted that ICT investment was less than other health boards.[3] In 2017-18 the initial allocation was £360,000 for rolling replacement only, despite a requirement for £1 million.

128 The Health Board has tried to progress some areas within the informatics strategic outline programme. For example, the Health Board applied for Welsh Government funding to support the digitisation of paper records project. Without the funding, the number of paper medical records will continue to increase exceeding the capacity of the Health Board's Williamstown medical records storage centre. The Health Board's bids have been unsuccessful to date.

129 In previous Structured Assessment reports, we commented on the movement of the ICT portfolio amongst executive directors. More recently, the Chief Operating Officer has taken on executive responsibility for ICT, which has created some welcome stability. Positively, the Health Board has been successful in recruiting a substantive Head of Information and Communications Technology (ICT) after previous interim arrangements.

[3] Wales Audit Office, Diagnostic Review of ICT Capacity and Resources, 2016.

Managing the estate and other physical assets

130 Finally, we considered how the estate and physical assets are managed. We found that the Health Board manages its assets well.

131 The Health Board has an overarching estates strategy and an asset management strategy in place. Work is ongoing to revise the estates strategy as it is due for renewal and needs to reflect the boundary changes coming into effect in April 2019. The Health Board also has a Capital and Estates Integrated Medium Term Business Plan, which outlines the service and key priorities for 2017-2020. Performance against this plan is monitored through the Clinical Business Meeting[4] arrangements.

132 The Health Board applies a risk management approach to help to prioritise the limited discretionary capital allocation across Estate, ICT infrastructure, medical equipment and other related assets. The Health Board flexes and responds to new priorities, for example, where urgent and unexpected health and safety risks occur, or unexpected equipment failure.

133 From a financial point of view the Health Board maintains a fixed asset register, which holds details of all assets owned by the Health Board including purchase date, value, revaluations, impairment, asset life and location. From an operational and maintenance point of view, the Estates department maintains an asset management system called TABS, which holds information regarding all buildings and the maintenance needs. This system also contains information on planned maintenance and replacement schedules. The information recorded is at a very detailed level, breaking down each building into its component parts (eg light switches, smoke detectors, plant rooms, piping, electrical sockets etc.). The Health Board is looking to replace this system as it is outdated and requires significant resource. The Estates directorate are exploring replacement now but want to wait until the transfer of services from Abertawe Bro Morgannwg University Health Board is complete to ensure the systems are compatible. The Health Board is also considering a four-facet survey[5] of the estate to gain a better understanding of the estate condition. Our review of the risk register within the Estates directorate has highlighted some issues with risks being out of date, and a need for a thorough review and update of the register.

[4] Clinical Business Meetings – where a small core of executive directors meet monthly with clinical and managerial leads of each directorate to provide oversight and performance management of the entire operation.

[5] A facet survey is an external condition review of the NHS estate and the number of facets relates to the scope of the survey.

Recommendations

Exhibit 2: 2018 recommendations

2018 recommendations
Implementing previous recommendations R1 We recommend that within 12 months, the Health Board fully implements the outstanding recommendations from our previous Structured Assessment (as detailed in Appendix 1).
Scheme of Delegations R2 The Health Board should update the Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.
Improve risk practice and assurance R3 To improve risk practice and provide assurance to the Board and Committees that risks to achieving strategic objectives are effectively managed, the Health Board should: a) undertake an organisational-wide review of the directorate risk registers to ensure they are up to date and reflect the current risks facing services, and; b) ensure timely ongoing review of all directorate risk registers.
Quality Governance R4 To improve quality governance arrangements the Health Board should: a) ensure the Quality Steering Group meets with the appropriate frequency; b) ensure that the quality report is more explicit at highlighting quality concerns and also articulates how the Health Board is learning lessons; c) consult with the public and service users when developing the new Quality Strategy; d) improve the quality and consistency of Quality, Safety and Risk Committee papers to ensure clarity and brevity, to enable areas of concern to be identified easily, to highlight action taken to address areas of concern and to demonstrate learning; e) audit the quality, safety and risk processes within directorates to gain assurance they operate effectively; f) review the relevance of organisation policies that the Quality, Safety and Risk Committee is asked to approve and reallocate responsibility to other committees; and g) provide bespoke induction for Independent Members newly appointed to the Quality, Safety and Risk Committee to ensure effective scrutiny and understanding of quality issues.

2018 recommendations
Audit tracker R5 The Audit Committee should ensure the tracker log records good information to enable Independent Members to review and take assurance that the recommendations are complete when removed from the tracker. R6 The Audit Committee tracker should be expanded to include the recommendations of other external agencies, eg Healthcare Inspectorate Wales and the Delivery Unit.
Information Communications and technology R7 The Health Board should take steps to strengthen the oversight arrangements in relation to ICT and Information Governance by: a) ensuring that minutes from the Digital Health Strategy Steering group and Information Governance group are scrutinised at the Quality, Safety and Risk Committee; and b) clarifying and articulating links between information governance and ICT to strengthen the oversight and scrutiny of the Trust's digital business. R8 The Health Board should develop a cyber security action plan to implement recommendations from the NHS Wales External Security Assessment and any other cyber security reviews as appropriate. It should also be used to ensure that cyber security arrangements are in place to meet the Health Board's needs.
National Fraud Initiative R9 We recommend that the Health Board put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed. We expect the Health Board to. a) commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; b) in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data matches; and c) ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.

Appendix 1

Progress implementing previous recommendations

Exhibit 3: actions in response to 2017 and outstanding previous recommendations

Recommendation	Action taken in response	Completed
R1 The Health Board's Quality Impact Assessment Tool, which must be completed for schemes over £100,000 currently asks directorates to consider the impact of their savings schemes on patient safety, clinical effectiveness, patient experience and staff experience. The Health Board should extend the template to also cover the impact of large savings schemes on other directorates and services, other health bodies and external partners and organisations.	Interdependencies, both internal and external, are now requested within the Key Service Change Tracker alongside the Quality Impact Assessment Score.	Yes.
R2 We found that the Health Board's IMTP peer review process does not fully identify potential cross-directorate working opportunities and supplication. The Health Board should review and strengthen the process to better facilitate joint savings schemes and identify similar or duplicate schemes.	For 2019 to 2022, each Directorate is required to list their priorities, including any service change. These priorities will be reviewed initially by planning business partners for cross directorate working opportunities and duplication and will then by a wider Assistant Director group. This intelligence will be shared with Directorates prior to them finalising their plans.	Partly- in progress recommendation.

Recommendation		Action taken in response	Completed
R3	We found that there can be complexities to cross-directorate working, especially if directorates do not directly benefit from savings schemes. The Health Board should develop a set of principles for directorates which encourages Health-Board-wide working.	Further work has been undertaken for 2019 to 2022 to better define how cross-cutting-theme savings opportunities impact on Directorates and where the benefits are realised.	Partly – in progress recommendation.
R4	We found the Health Board has limited project management and data analytics capacity and skills to support savings planning and delivery, especially for Health-Board-wide schemes. The Health Board should review and consider enhancing current project management and data analytics capacity and skills.	The UHB is currently reviewing the scope and capacity of the Programme Management Office with a view to growing its sustainable project management capacity. This will enable projects prioritised though the IMTP planning process to be more appropriately supported through project implementation and benefits realisation.	Partly – in progress recommendation.
R5	The Health Board should further refine the IMTP reporting process to include detailed information on milestones to enable Independent Members to understand the current performance in line with expected trajectory.	The UHB has, for 18/19, reviewed how best to monitor progress against the organisations objectives as set out in the IMTP. A revised process and quarterly report was instigated for quarter 1 and 2 2018/19. This revision has been positively received by the Board.	Partly – in progress recommendation.

Recommendation		Action taken in response	Completed
R6	The Health Board should ensure there is a detailed resourced action plan to enable delivery of the Digital Health Strategy.	The Digital Health Strategy is built on a set of annual priorities expressed over a five-year strategic staircase. Over the course of this year the strategy has prioritised the development of three business cases, with two that link into national procurements: digitisation of records is a foundational commitment to digitise 1.25m medical records, the final business case has been signed off and will shortly be shared with the Welsh Government to finalise funding routes; Emergency Department system procurement is due at Board in December 2018; and the Eprescribing and underpinning pharmacy system will come to Board before the end of the financial year 2018/19.	Partly

Recommendation	Action taken in response	Completed
R7 The Health Board needs to refine the quality of its papers presented to the Quality Safety and Risk Committee; • Making the papers more succinct and focussed; and • Consider the agenda management for example, bringing more complex issues to the beginning of the committee, and moving approval of policies to the latter end of the agenda	Work is continuing with this key Committee for Cwm Taf. During the year we the Chair has been appointed as the Vice Chair of the Board and has brought a different focus to the meeting and 2 new Independent Members joined in February 2018. Following discussion between the Chair and Vice Chair during the summer two additional Independent Members have been allocated to the Committee to assist with scrutiny bringing the total number to 5 from December 2018. Work is continuing to manage the agenda and the quality of the reports which although remains work in progress has assisted the Committee during the course of the year. The work planned from December 2018 onwards on the Clinical Governance Framework and the supporting structure to the Committee should also assist. This work also includes agreeing where policies are scrutinised and discussed before formal approval is requested at the QSR or any other Board Committee.	Partly

Appendix 2

Health Board's response to this year's recommendations

When the relevant committee has considered this report, we will insert a shortened version of the Health Board's response in the report before we publish it on the Wales Audit Office website.

Exhibit 4: management response to 2018 recommendations

Recommendation	Management response	Completion date	Responsible officer
R1 We recommend that within 12 months, the Health Board fully implements the outstanding recommendations from our previous Structured Assessment (as detailed in Appendix 1).			
R2 The Health Board should update the Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.			
R3 To improve risk practice and provide assurance to the Board and Committees that risks to achieving strategic objectives are effectively managed, the Health Board should: – a) undertake an organisational wide review of the directorate risk registers to ensure they are up to date and reflect the current risks facing services; and – b) ensure timely ongoing review of all directorate risk registers.			

Recommendation	Management response	Completion date	Responsible officer
R4 To improve quality governance arrangements the Health Board should: – a) ensure the Quality Steering Group meets with the appropriate frequency; – b) ensure that the quality report is more explicit at highlighting quality concerns and also articulates how the Health Board is learning lessons; – c) consult with the public and service users when developing the new Quality Strategy; – d) improve the quality and consistency of Quality, Safety and Risk Committee papers to ensure clarity and brevity, to enable areas of concern to be identified easily, to highlight action taken to address areas of concern and to demonstrate learning; – e) audit the quality, safety and risk processes within directorates to gain assurance they operate effectively; – f) review the relevance of organisation policies that the Quality, Safety and Risk Committee is asked to approve and reallocate responsibility to other committees; and – g) provide bespoke induction for Independent Members newly appointed to the Quality, Safety and Risk Committee to ensure effective scrutiny and understanding of quality issues.			

Recommendation	Management response	Completion date	Responsible officer
R5 The Audit Committee should ensure the tracker log records good information to enable Independent Members to review and take assurance that the recommendations are complete when removed from the tracker; R6 The Audit Committee tracker should be expanded to include the recommendations of other external agencies, eg Healthcare Inspectorate Wales and the Delivery Unit.			

Recommendation	Management response	Completion date	Responsible officer
R7 The Health Board should take steps to strengthen the oversight arrangements in relation to ICT and Information Governance by: – a) ensuring that minutes from the Digital Health Strategy Steering group and Information Governance group are scrutinised at the Quality, Safety and Risk Committee; and – b) clarifying and articulating links between information governance and ICT to strengthen the oversight and scrutiny of the Trust's digital business. R8 The Health Board should develop a cyber security action plan to implement recommendations from the NHS Wales External Security Assessment and any other cyber security reviews as appropriate. It should also be used to ensure that cyber security arrangements are in place to meet the Health Board's needs.			

Recommendation	Management response	Completion date	Responsible officer
R9 We recommend that the Health Board put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed. We expect the Health Board to. – a) commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; – b) in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data matches; and – c) ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.			

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Primary care services – **Cwm Taf University Health Board**

Audit year: 2017-18

Date issued: November 2018

Document reference: 924A2018-19



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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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

The person who delivered the work was Urvisha Perez.

Contents

The Health Board has a sound plan for primary care and is making reasonable progress towards implementing key elements of the national vision. Oversight arrangements are strong and performance against some indicators is above average. However, there is further scope to raise the profile of primary care, shift more resources towards primary care and to address workforce challenges.

Summary report

Background 4

Key findings 7

Recommendations 8

Detailed report

Strategic planning: the Health Board has a strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development, the Health Board is taking steps to support their ongoing development 10

Investment: the Health Board has some examples of resources shifting to primary care but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care 16

Workforce: workforce challenges are threatening the sustainability of some practices but the Health Board has begun workforce modelling and is in the early stages of testing solutions 22

Oversight and leadership: strong leadership and monitoring arrangements are in place and the Health Board is taking steps to improve primary care data, however, there is further scope to raise the profile of primary care 29

Performance and monitoring: the Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain 33

Appendices

Appendix 1: methods 43

Appendix 2: management response 44

Summary report

Background

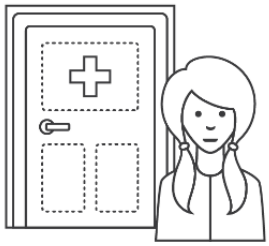
1 The national primary care plan[1] defines primary care as follows:

‘Primary care is about those services which provide the first point of care, day or night for more than 90% of people’s contact with the NHS in Wales. General practice is a core element of primary care: it is not the only element – primary care encompasses many more health services, including, pharmacy, dentistry, and optometry. It is also – importantly – about co-ordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.’

2 Exhibit 1 shows the important role that primary care plays in Wales.

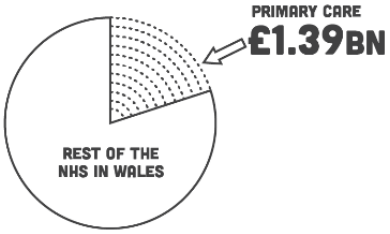
Exhibit 1: Why is primary care important in Wales?

First point of contact



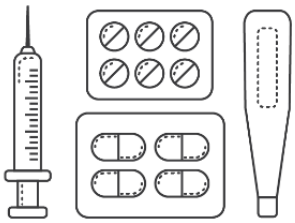
Primary care is the first port of call for the majority of people who use health services.

Spending on primary care



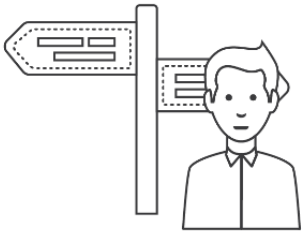
In 2016-17, the NHS in Wales spent £1.39 billion on primary care, which is around a fifth of the total NHS spending in Wales.

Prevention and early intervention



Primary care is also important because of its focus on promoting well-being, early intervention and preventing people’s conditions from getting worse.

Coordinating care



Primary care plays an important role in co-ordinating people’s care, acting as a gateway to many other services.

Source: Wales Audit Office. Note: primary care expenditure is not consistently categorised by health boards. As such, it is likely that the £1.39 billion figure from the NHS accounts does not represent the totality of primary care expenditure.

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

3 Wales has had plans for many years that stress the importance of primary care. The plans aim to rebalance the system of care by moving resources towards primary and community care. The national primary care plan aims for a 'social model' that promotes physical, mental and social wellbeing, rather than just an absence of ill health. The core principles in the plan are: planning care locally; improving access and quality; equitable access; a skilled local workforce; and strong leadership.

4 The national primary care plan and the NHS Wales planning framework place an expectation on health boards to set out plans for primary care as part of their integrated medium term plan. Each plan should explain how the health board will develop the capacity and capability of primary care services.

5 To support the implementation of the national plan, NHS Wales issued a workforce plan[2]. Health boards are expected to put in place actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles.

6 Primary care clusters are the main mechanism for planning services at a community level and they were first established in 2009[3]. Clusters are groups of neighbouring GP practices, other primary care services and partner organisations such as the ambulance service, councils and the third sector. There are 64 clusters (also known as neighbourhood care networks) in Wales. Their role is to plan and provide services for their local populations. The national primary care plan requires health boards to prioritise the rapid development of the clusters in their area. Officially there are eight clusters in Cwm Taf, but the clusters have agreed to join together to cover four localities, Rhondda, Cynon, Merthyr Tydfil and Taff Ely.

7 To support the national primary care plan and encourage innovation, the Welsh Government introduced the national primary care fund in 2015-16. And in 2016-17, the fund totalled £41 million. Cluster development was provided with £10 million and health boards were allocated £3.8 million for pathfinder and pacesetter projects, which aimed to test elements of the primary care plan. The projects funded in this way have produced some new ways of working that have been collated into the Transformational Model of Primary and Community Care[4].

8 Since the national primary care plan was published in 2014, there have been a number of developments. In October 2017, the National Assembly's Health, Social Care and Sport Committee published a report following an inquiry into clusters[5].

[2] NHS Wales, **Planned Primary Care Workforce for Wales: Approach and development actions to be taken in support of the plan for a primary care service in Wales up to 2018**, July 2015.

[3] Welsh Government, **Setting the Direction Primary & Community Services Strategic Delivery Programme**, 2009.

[4] http://www.primarycareone.wales.nhs.uk/pacesetters

[5] National Assembly for Wales, **Health, Social Care and Sport Committee. Inquiry into Primary Care: Clusters**, October 2017.

The report noted impressive examples of progress but said that a step-change is required if clusters are to have a significant impact. The Welsh Government has continued to support the cluster approach through its programme for government[6].

9 However, at the same time as health boards are introducing new ways of working in primary care, there have been difficulties with recruitment and retention of GPs and other professionals. While there have been recent successes in recruiting GP trainees[7], in many areas more GP partners are retiring and there are particular difficulties in recruitment in rural areas.

10 The Welsh Government is planning to respond to the Parliamentary Review of Health and Social Care in Wales[8] with a £100 million transformation fund. It will be used to improve population health, drive integration of health and care services, build primary care, provide care closer to home, and transform hospital services.

11 It is timely for the Auditor General to review primary care services in Wales. We have published two national reports on primary care this year. In April 2018, we published **A picture of primary care in Wales**. This provides a factual snapshot of primary care in Wales and contains background information that is not detailed in this report. And in July 2018, we published **GP out-of-hours services**.

12 This report summarises the findings of work in Cwm Taf University Health Board (the Health Board) carried out between March and May 2018. We considered whether the Health Board is well placed to deliver the national vision for primary care as set out in the national plan. Appendix 1 shows our methods. The work focused specifically on:

- **Strategic planning**: is the Health Board effectively driving implementation of the national primary care plan at a local level?
- **Investment**: is the Health Board managing its finances to support transformation in primary care?
- **Workforce**: is the Health Board well placed to deliver key aspects of the national primary care workforce plan?
- **Oversight**: does the Health Board have effective arrangements for oversight and leadership that support transformation in primary care?
- **Performance**: is the Health Board effectively monitoring its performance and progress in implementing its primary care plan?

[6] Welsh Government, **Prosperity for All: the national strategy**, September 2017.

[7] The Welsh Government reported that 91% of Wales' GP training places were filled in 2017. 16 October 2017. http://gov.wales/newsroom/health-and-social-services/2017/gprecruitnew/?lang=en

[8] The Parliamentary Review of Health and Social Care in Wales, **A Revolution from Within: Transforming Health and Care in Wales**, Final Report, January 2018.

Key findings

13 Our overall conclusion is: **The Health Board has a sound plan for primary care and is making reasonable progress towards implementing key elements of the national vision. Oversight arrangements are strong and performance against some indicators is above average. However, there is further scope to raise the profile of primary care, shift more resources towards primary care and to address workforce challenges**. Exhibit 2 sets out our key findings in more detail.

Exhibit 2: our main findings

Table detailing our main findings.

Our main findings
Strategic planning: the Health Board has a strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development, the Health Board is taking steps to support their ongoing development: • the Health Board has a strong primary care plan aligned to national priorities and it engages with a range of stakeholders in developing its plans. • most clusters remain at a relatively early stage of maturity but cluster development will be further supported through the Health Board's new strategic planning group. We found scope to strengthen cluster leadership, membership and to improve the evaluation of cluster projects.
Investment: the Health Board has some examples of resources shifting to primary care but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care: • the accounts suggest an overall real terms decrease in investment in primary care but the format of the accounts makes it difficult to say with any certainty. • the Health Board can point to some specific examples of shifting resources towards primary care, but it cannot demonstrate the extent of these shifts and large-scale change is being hampered by a range of barriers. • the Health Board has clear arrangements for monitoring cluster spending and cluster leads feel they have sufficient financial autonomy. • the Health Board is investing Welsh Government funding for health and wellbeing centres to support its primary care model, whilst supporting minor practice improvements.
Workforce: workforce challenges are threatening the sustainability of some practices but the Health Board has begun workforce modelling and is in the early stages of testing solutions: • gaps in data limit the Health Board's ability to map its primary care workforce but challenges include shortfalls in GPs and nurses and above-average patient lists. The Health Board has commissioned demand and capacity assessments in GP practices but take-up has been variable. • there are challenges to the sustainability of GP practices and the Health Board has recognised the need to strengthen the Primary Care Support Unit. • whilst the Health Board is in the early stages of implementing the national vision of multi-professional primary care teams, there are barriers to further implementing the model.

Our main findings
Oversight and leadership: strong leadership and monitoring arrangements are in place and the Health Board is taking steps to improve primary care data, however, there is further scope to raise the profile of primary care: • the Health Board has dedicated primary care representation at executive and Board level and there are clear leadership arrangements at directorate level. • primary care issues are prominent within the Health Board but some feel primary care still needs a greater profile. Primary care performance is monitored regularly and the Health Board is taking steps to improve its performance metrics. • GPs and practice managers provide cluster leadership, and they were generally positive about the support provided by the Health Board.
Performance and monitoring: the Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain: • some aspects of the Health Board's performance are better than the Wales average, although the national measures do not adequately represent primary care. • the Health Board has made reasonable progress in delivering its primary care and localities plan but several challenges remain.

Recommendations

14 As a result of this work, we have made a number of recommendations which are set out in Exhibit 3.

Exhibit 3: recommendations

Table outlining our recommendations to the Health Board.

Recommendations
Strategic planning
R1 The Health Board commissioned the Primary Care Foundation to carry out demand and capacity assessments in GP practices but the take-up from practices has been variable. To maximise value from the commissioned work, the Health Board should centrally analyse and collate the messages from the demand and capacity assessments and share the learning across all practices.

Recommendations
Investment in primary care R2 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a) calculate a baseline position for its current investment and resource use in primary and community care; and b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.
The primary care workforce R3 The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.
New ways of working R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments; and d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.
Primary care clusters R5 We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should: a) review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary; b) review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups; and c) develop an action plan for strengthening cluster leadership.

Detailed report

Strategic planning: the Health Board has a strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development, the Health Board is taking steps to support their ongoing development

The Health Board has a strong primary care plan, aligned to national priorities and it engages with a range of stakeholders in developing its plans

The Health Board's Primary Care and Localities Directorate Plan is well established and evolving and it clearly articulates the shift in focus needed to achieve transformation

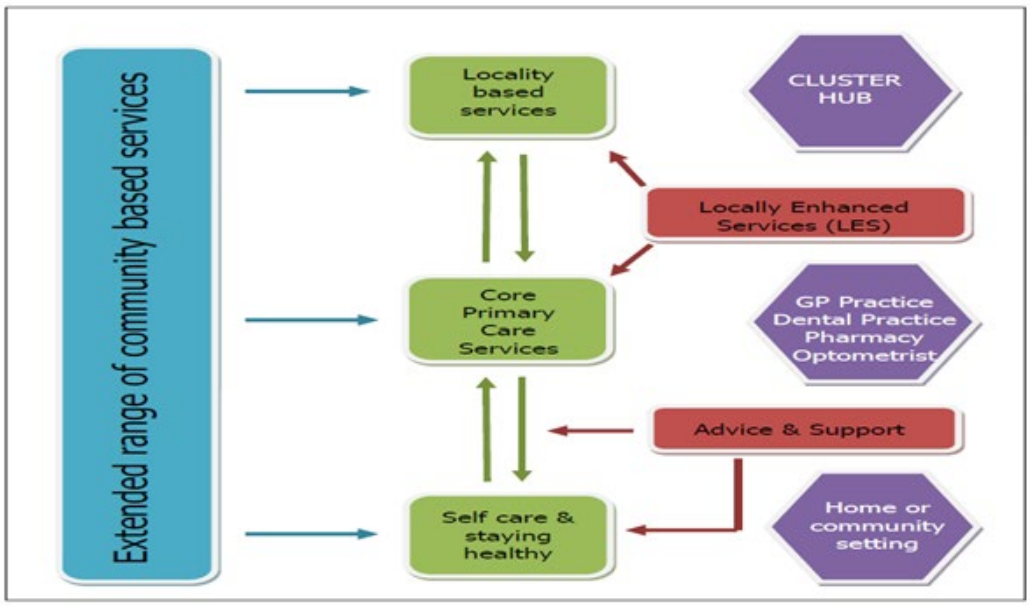
15 The Health Board has articulated its plans for primary care in its Primary Care and Localities Directorate Plan 2018-2021 (the plan), which is the directorate's three year integrated medium term plan (IMTP). The directorate's IMTP feeds into the Health Board's overarching IMTP. In 2015, the Health Board developed the Primary Care and Community Delivery Plan, which outlined its strategic intent. Each year, the directorate IMTP builds on this initial work.

16 The directorate's plan recognises the need for innovation and a radical approach to developing new models of care and workforce planning to meet current and future challenges. The plan sets out an ambition to move away from 'primary, secondary and social care towards integrated care, tailored to individual and community needs. The bullet points below show how the focus of the plan is evolving to achieve a fully integrated, whole system care model:

- 2015-16 – GP focus
- 2016-17 – Primary care focus
- 2017-18 – Community care focus
- 2018-19 – Integrated secondary care focus
- 2019-20 – Integrated patient centred model

17 Exhibit 4 sets out the Health Board's outline model for primary and community services. It shows a locality model which is integrated with other services. This means that patients can access a range of healthcare services close to their home. These services range from traditional primary care services and enhanced services to advice and support. The Health Board's local authority partners have replicated the locality model to make joint working easier.

Exhibit 4: outline model for Primary Care and Community Services



Source: Primary Care and Localities Directorate Plan 2018-2021.

18 We reviewed the Health Board's plan for primary care to assess whether it contained key elements that ensure alignment with the national primary care plan and transformational model. We found a number of areas which highlight particular strengths (Exhibit 5).

Exhibit 5: strengths of the Primary Care and Localities Plan

	Strengths
Strategic planning	Social prescribing and signposting: Cwm Taf recognises the value in social prescribing and signposting. This is evidenced by clusters piloting different social prescribing approaches such as Grow Rhondda and Arts based therapies sessions in Taff Ely. In terms of signposting, two clusters are piloting care navigator training.
	Out of hours and 111: Improving and remodelling the out of hours service and 111 is one of the Health Board's main vehicles for improving primary care services. This is evident by out of hours and 111 being a prominent theme in the directorate plan. Whilst there are a number of barriers to progressing this work, namely workforce, there is a clear direction for remodelling and transforming the service and implementing 111 in 2019.
Finance and resources	Modern technology: the plan lists priorities for ICT including an automated caseload scheduling system for district nursing, using ICT for triage, implementing the Vision 360 GP practice ICT system and the roll out of mobile devices for all community staff.

	Strengths
Workforce	Workforce Plan: the workforce plan for primary care is within the directorate plan. It outlines where multidisciplinary teams are already in place such as the Cynon Valley virtual ward; the enhanced primary care support unit; and how multidisciplinary working will be further developed. There is also reference to clinical triage systems, especially in terms of the out of hours service and non-clinical triage in the form of care navigators.
Oversight and leadership	Workstreams to take the plan forward: the plan outlines a model for taking the plan forward. The model is based on six themes: • Self-care and staying healthy • Advice and support • Early intervention • Rehabilitation within our community hospitals • Out-of-hours urgent care • Long-term conditions management
Performance and monitoring	The document outlines progress in delivering the 2017-18 plan. The key risk factors in delivering the IMTP are outlined at the start of the plan, with actions to mitigate the risks being discussed in later sections about service priorities.

Source: Wales Audit Office analysis of Primary Care and Localities Directorate Plan 2018-2021.

19 We found other areas of the Health Board's plan that need further development. The plan does not identify specific and costed actions to shift resources from hospitals to a community setting. The plan does include some details about enhanced services, rehabilitation of stroke patients in community hospitals and the new health parks but there is nothing explicit about moving resources. This could be because services are being transformed and remodelled, so it is not as clear cut as moving services from a hospital to a primary or community setting.

20 Neither does the plan show how the Health Board will measure the progress of shifting resources from a hospital to a community setting. Whilst the plan has a strong vision for transforming primary care, it does not include details on who within the organisation is responsible for taking forward the transformation programme, the leadership for the individual workstreams and governance arrangements.

21 We asked interviewees their thoughts on the directorate plan and there was consensus that it was a strong plan. Interviewees said the plan is well-written, ambitious, emphasises multidisciplinary team working, has links to service sustainability, service access and prudent healthcare, and includes cluster development and pilot initiatives, such as social prescribing.

22 However, some interviewees expressed concerns about the plan being too ambitious, too large and that the Health Board should concentrate on one or two big initiatives instead of many small ones. Some interviewees said the plan mainly

covers General Medical Services and that integration with other directorates could be stronger.

The Health Board engages with internal and external stakeholders in developing its plans and whilst it has not consulted the public on its entire plan, the Health Board has now introduced a dedicated communications officer for primary care

23 The Health Board regularly engages with stakeholders throughout the year. Within the Health Board, various groups such as the Performance into Action Cwm Taf (PACT) and Clinical Leadership forums give directorate managers and clinical directors an opportunity to discuss joint priorities and opportunities, reduce duplication and overcome barriers. Within the directorate, regular meetings such as monthly directorate meetings and clinical business meetings provide an opportunity to plan and monitor the directorate plan. Primary care managers meet fortnightly with business partners in finance and workforce and organisational development.

24 External to the Health Board, the Community Health Council (CHC) is involved in service planning meetings, project boards and steering groups. In addition, their executive team receives briefing reports. We spoke to the CHC and they confirmed they had been engaged in developing the directorate plan. The Health Board also engages with stakeholders by being part of (and leading on) several national peer support groups such as Directors of Primary, Community and Mental Health, and Heads of Primary Care and Assistant Medical Directors. These groups are forums to share and disseminate good practice.

25 The Health Board has a good working relationship with local authority and third sector partners. IMTP plans and progress are shared at both the Cwm Taf Regional Partnership Board and Public Service Board. Partners are represented at various strategic committees and there are a number of examples of joint working at cluster level. The Health Board also engages with the Local Medical Committee, Oral Health Advisory Group, pharmaceutical committees (via medicines management teams) and Eye Health Care Group when developing plans.

26 In terms of the public, whilst not engaging on the whole plan, the Health Board informs the public on service change through a variety of forums such as quarterly public forums held in each locality, and 50 plus forums. The public can feed back through patient participation groups, satisfaction surveys, social media, patient stories and complaints and compliments. The primary care team has appointed a dedicated communications officer, to promote primary care, for example, cluster initiatives and manage primary care social media accounts, and the team publishes a newsletter.

Most clusters remain at a relatively early stage of maturity but cluster development will be further supported through the Health Board's new strategic planning group. We found scope to strengthen cluster leadership, membership and to improve the evaluation of cluster projects

27 We looked at the way that the Health Board provides support to clusters in developing local needs assessments and cluster plans. Of the eight cluster leads responding to our survey:

- six respondents (75%) agreed that they had received helpful guidance from the Health Board when it was developing its cluster plan;
- four respondents (50%) agreed that they had received support from the Health Board to develop a needs analysis of their local population; and
- six respondents (75%) agreed that 'the Health Board listens to my cluster when it is developing Health Board-level priorities for primary care'.

28 Exhibit 6 shows the views of cluster leads on the level of maturity within their cluster. At the Health Board, five respondents said their cluster was 'stable and starting to deliver' and two said their cluster was 'mature'. Cwm Taf is one of two health boards where no leads rated their cluster as 'developmental'.

Exhibit 6: cluster leads' assessment of the level of their organisation's development

The table provides the number of clusters at each of three levels of maturity (see note)

	1 = Developmental	2 = Stable and starting to deliver	3 = Mature
Abertawe Bro Morgannwg	1	4	2
Aneurin Bevan	1	6	0
Betsi Cadwaladr	2	5	1
Cwm Taf	**0**	**5**	**2**
Cardiff and Vale	1	5	2
Hywel Dda	0	4	1
Powys	1	1	1
Wales	6	30	9

Note:

1 = Developmental: still at early stages of development with significant support required; not all cluster members fully engaged.

2 = Stable and starting to deliver: Starting to deliver some benefits but still early days, ongoing support required and full potential yet to be reached.

3 = Mature: all cluster members fully engaged; delivering across a number of areas in line with the cluster plan.

Source: Wales Audit Office survey of cluster leads, April 2018.

29 The Health Board supports clusters by employing cluster development managers, who have been in post since 2015. The four managers, one for each cluster, help clusters with developing cluster plans and initiatives, monitoring spending and administrative tasks.

30 Most cluster leads responding to our survey said their cluster had third-sector representation but not local-authority or lay representation. To support and advise clusters, the Health Board sends the following representatives to cluster meetings:

- Public health representative
- Dedicated finance officer to support the clusters in monitoring their spending plans
- Optometry Advisor
- General Dental Council representatives are co-opted in at various times
- Consultants are co-opted in at various times

31 To give cluster leads protected time for their role, the Health Board funds one session per week for both GP and practice manager leads. In addition, the Health Board funds backfill, so cluster leads can attend the bi-monthly cluster lead meetings. These meetings are an opportunity to share learning and good practice and discuss issues with the executive lead and Health Board managers.

32 All four clusters have a plan in place, they follow a similar format grouped under seven strategic themes. At the time of our review, the Health Board was establishing a new Primary Care Strategic Planning Group, to replace the cluster lead meeting. It was felt the cluster plans needed a more formal route into the Health Board. The new group also provides a forum for more strategic discussions and gives GPs a formal seat at the Health Board table. The meeting will be chaired by the Director of Primary, Community and Mental Health and attended by senior planning managers, the assistant medical director, finance and cluster leads amongst others.

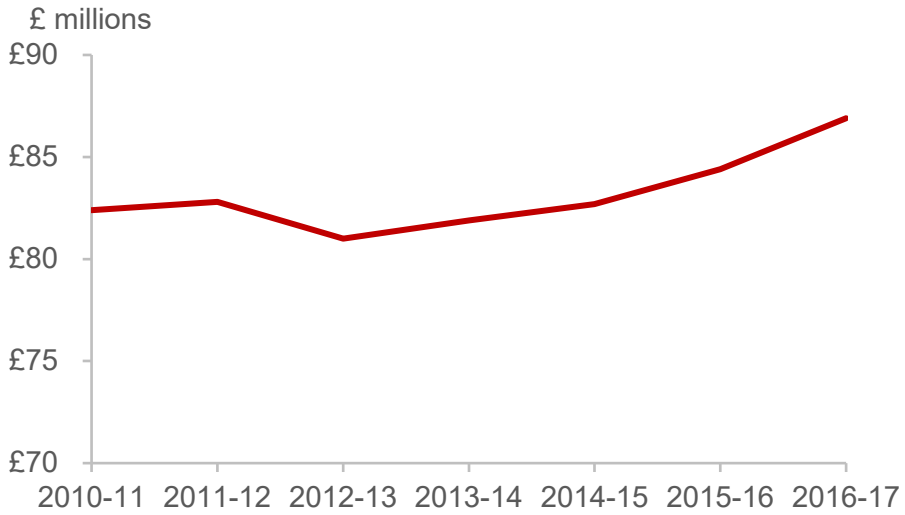
33 The majority of survey respondents, 88% (seven out of eight), agreed that the Health Board is empowering their cluster to drive innovation. Evaluation is an important part of testing innovation and 63% (five out of eight) respondents agreed that the Health Board is effectively evaluating examples of innovation in their cluster. Some cluster leads felt that evaluation was getting better, and that there was good outcome data for the Cynon Valley virtual ward. However, interviewees also said it should not be left to cluster leads to evaluate their own projects.

Investment: the Health Board has some examples of resources shifting to primary care but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care

The accounts suggest an overall real-terms decrease in investment in primary care but the format of the accounts makes it difficult to say with any certainty

34 Exhibit 7 is based on data from the Health Board's annual accounts and sets out the long-term expenditure on primary care. The total includes spending on General Medical Services (GMS), Pharmaceutical Services, General Dental Services (GDS), General Ophthalmic Services (GOS) and 'Other Primary Health Care' expenditure[9]. The exhibit shows that the Health Board spent £86.9 million on these primary care services in 2016-17.

Exhibit 7: the Health Board's spending on primary care services



Source: LHBs' Annual Accounts

Note: The vertical axis does not begin at zero. We have excluded expenditure on 'Prescribed drugs and appliances' due to the variable nature of this expenditure, partly as a result of drug price fluctuations. 'Other Primary Health Care' is a gather-all category in the accounts, used to record spending on numerous primary care items that do not fit into the other categories.

[9] Excludes spending on 'Prescribed drugs and appliances'.

35 In 2016-17, the Health Board had a mixed picture of underspends and overspends in different spending categories, when compared with the allocations provided by the Welsh Government. The Health Board's explanations of these variations are set out below:

- the General Medical Services overspend was due to the cost of locums to maintain the Health Board's four managed practices. The £45.4 million allocation was overspent by £900,000.
- Pharmaceutical Services spend and allocation have remained largely consistent in recent years. In 2016-17, the allocation increased from £18.1 million in 2015-16 to £18.6 million, and the Health Board spent £17.3 million.
- the General Dental Services underspend was largely because in 2015-16, 15 dental practices underperformed against their contracted units of dental activity (UDA), and the repayments for this underperformance were made in 2016-17. The £17.1 million allocation was underspent by £1.7 million.

36 After considering the effect of inflation, the Health Board's overall spending on primary care decreased in real terms by 3.8% between 2010-11 and 2016-17. Over the same period, expenditure on General Medical Services, General Dental Services and Pharmaceutical Services decreased in real terms but increased in General Ophthalmic Services and 'Other' primary care expenditure.

37 Across Wales, we found issues with the way that primary care expenditure is recorded in the accounts. Spending is not consistently categorised by health boards and the figures recorded in the accounts often do not represent the totality of primary care expenditure. However, the Health Board told us that the figures recorded in their accounts represent all primary care spend, including the £4.956 million they received in 2016-17 from the Welsh Government through the Primary Care Development Fund. The Health Board allocated the fund in the following ways:

- £1.071 million to support pacesetter projects, an enhanced primary care support unit and the Your Medicines, Your Health public information campaign;
- £1.017 million for clusters to develop initiatives based on their plans;
- £1.030 million to support service redesign (out of hours and older persons' mental health services);
- £494,000 to develop and implement community and localities services to help manage long-term conditions;
- £373,000 to fund primary care management and leadership;
- £360,000 on work to reverse health inequalities;
- £262,000 on training and development of future roles;
- £230,000 on other projects (such as a cancer diagnostic clinic, primary care estates and research and evaluation); and
- £119,000 on preparation for the 111 service.

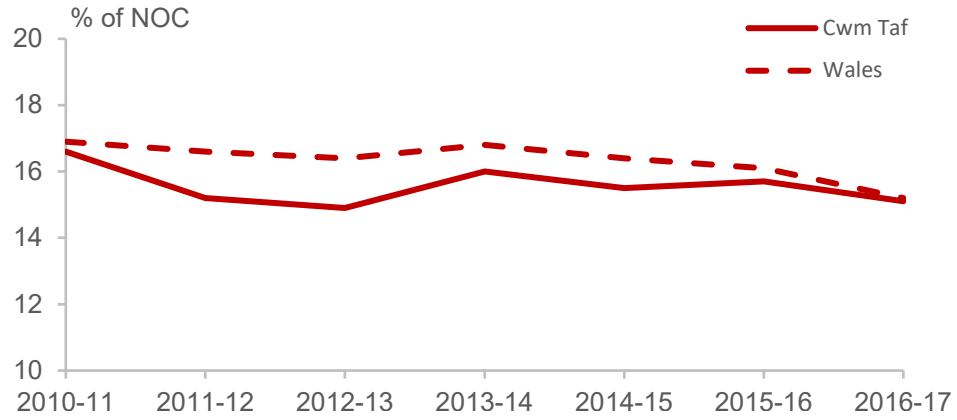
38 In March 2018, the pacesetter projects were mainstreamed meaning they are now funded through the directorate's core budget. This has allowed the Health Board to invest in new projects for 2018-2020. The focus of which will be on workforce and skills development within primary care through developing multi-professional advanced training practices in each cluster.

The Health Board can point to some specific examples of shifting resources towards primary care, but it cannot demonstrate the extent of these shifts and large-scale change is being hampered by a range of barriers

39 For many years, the NHS in Wales has planned to shift resources towards primary care, to reverse the 'relative under-development of primary care'[10]. However, issues with the format of NHS accounts (see paragraph 37) make it difficult to say whether health boards have secured such shifts.

40 Exhibit 8 shows the Health Board's expenditure on primary care as a percentage of its total expenditure. The figures exclude expenditure on prescribed drugs and appliances. The exhibit shows that despite national priorities for shifting resources towards primary care, across Wales as a whole, primary care spending has not kept pace with health boards' total spending. The trend for the Health Board is similar to that of Wales, although the percentage in the Health Board has been consistently below the all-Wales level.

Exhibit 8: the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17).



Source: LHBs' Annual Accounts.

Note: The vertical axis does not begin at zero.

[10] Welsh Government, **Improving Health in Wales: The Future of Primary Care**, July 2001.

41 We asked whether health boards are taking specific actions to achieve a shift in resources towards primary care. We found that none of the health boards has set targets for moving resources towards primary care, and none of the health boards has quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in 2014.

42 The general consensus amongst those we interviewed was that small pots of money have moved from primary to secondary care and some enhanced services are now delivered in a primary care setting, but they have not seen a large-scale shift. The bullet points below show some specific examples from the Health Board where services and resources have shifted towards primary and community care:

- minor oral surgery is now delivered from the Dental Teaching Unit in Porth and only complex cases are seen in hospital.
- some eye care services have moved from secondary to primary and community care, for example, post-operative cataract care, monitoring of patients with stable glaucoma or ocular hypertension, and there is a community-based wet age-related macular degeneration service.
- all opticians in Cwm Taf are accredited to provide a low-vision service, so patients with eye health issues can visit their optician instead of their GP or secondary care. The Health Board reported that take-up for this scheme was so successful that they had to invest an extra £200,000.
- the Health Board is introducing community and locality-based services to help people manage their long-term conditions closer to home. For example, lung conditions, musculoskeletal conditions, diabetes, cardiology, wound management, and warfarin and anticoagulation management. At present, some of these services are offered on a cluster basis.

43 We asked interviewees what barriers stood in the way of moving more services from secondary to primary care, barriers included:

- directorates within the Health Board working in silos;
- secondary care unwilling to release budgets into primary care services;
- secondary care being so overstretched that there is no money to release into primary care;
- lack of primary care funding and resources;
- cluster innovation constrained by annual funding regime where unspent monies cannot be rolled over into the following financial year; and
- the recognition that when moving services into primary care, it is not just picking and lifting services but doing things differently, transforming services.

The Health Board has clear arrangements for monitoring cluster spending, and cluster leads feel they have sufficient financial autonomy

44 Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. Our findings suggest the Health Board has a good approach to overseeing cluster spending. Each cluster has a dedicated cluster development manager, who supports the development of cluster initiatives and monitors cluster spending. Each month, these managers meet with finance to ensure spend against cluster plans is on track. Managers reported that these meetings have improved over the last 18 months. Cluster funds cannot be rolled over into the following year, so clusters now have slippage plans to prevent underspends. Finance partners reported that clusters spend most of their monies, and this year they forecast that all monies will be spent. In addition, cluster spend is monitored at cluster meetings and at regular and ad-hoc meetings between cluster leads, cluster development managers and the financial business partner for primary care.

45 At management level, cluster spending is monitored at fortnightly Localities and Primary Care Management Team meetings and by exception at monthly Clinical Business Meetings. At Board level, spend is overseen at the quarterly Primary and Community Care Committee. For national monitoring, the Health Board has to send regular updates to the Welsh Government alongside their other delivery agreements.

46 In our survey of cluster leads, we found all eight respondents agreed that the Health Board monitors its cluster expenditure effectively. And seven (88%) agreed that their cluster spends all the funding it receives and that the Health Board gives their cluster sufficient financial autonomy. Five out of seven respondents (63%) agreed that their cluster is able to spend its funding quickly once it has decided how to allocate it.

47 Cluster leads suggested that once an innovative project has proven successful, cluster budgets should not be used for ongoing funding for these projects. An example was given of a cluster funding three full-time pharmacists for four years, using approximately 70% of their budget. Cluster leads said they prepare business cases to submit to the Health Board but there are no guarantees that initiatives will be funded. Cluster leads also raised concerns about the length of time it takes to recruit, quoting an example of it taking nine months to recruit a cluster pharmacist.

The Health Board is investing Welsh Government funding for health and wellbeing centres to support its primary care model, whilst supporting minor practice improvements

48 A core part of the Health Board's primary care model is to support cluster working. In doing so they will be developing a health park in each of the four localities. Merthyr Tydfil already houses the Kier Hardie Health Park. In 2017, the Welsh

Government announced support for the development of health and wellbeing centres with a capital value of around £68 million. With this support the Health Board will be developing health parks in the remaining three areas:

- Rhondda: Tonypandy Health Centre, refurbishment and reconfiguration
- Taff Ely: Dewi Sant Phase 2 Development (Pontypridd), refurbishment
- Cynon Valley: Mountain Ash Primary Care Centre, new build

49 Some interviewees raised concerns about a number of practices still running out of small and ageing buildings. This leaves little room for expansion of premises and services. Whilst the Health Board is not able to use capital monies to fund primary care buildings, it supports minor improvements at GP practices through improvement grants for adaptations to meet Disability Discrimination Act (DDA) requirements.

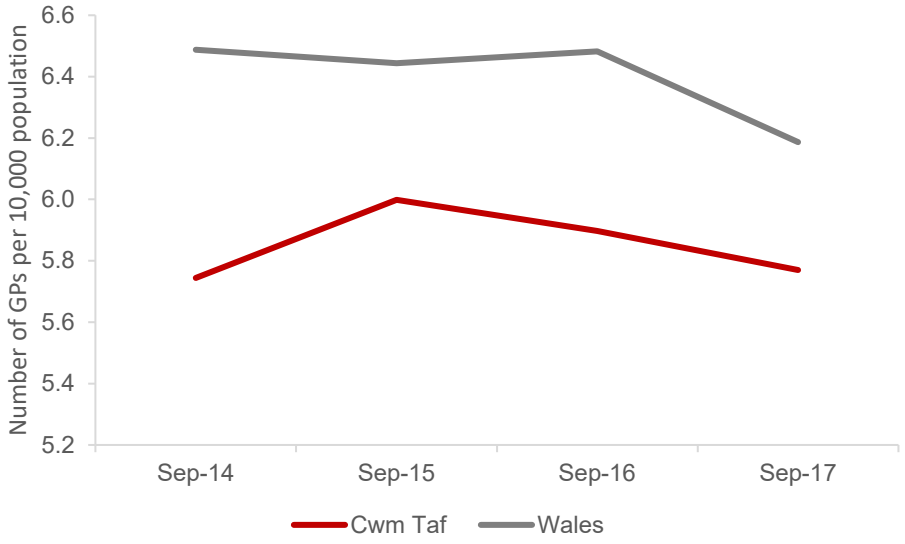
50 The NHS Wales Informatics Service leads on most ICT developments related to primary care, but the Health Board has ownership of ICT systems for GP practices and is responsible for the continued operating and maintenance costs and replacement IT systems where needed. The Health Board has identified priority areas for ICT which are outlined in the directorate plan. These include purchasing of Vision 360 to support sharing of clinical records and software such as My Health Online to improve access to primary care.

Workforce: Workforce challenges are threatening the sustainability of some practices but the Health Board has begun workforce modelling and is in the early stages of testing solutions

Gaps in data limit the Health Board's ability to map its primary care workforce but challenges include shortfalls in GPs and nurses and above-average patient lists. The Health Board has commissioned demand and capacity assessments in GP practices but take-up has been variable

51 The Health Board has a lower number of GPs per 10,000 population (5.8) than the Wales average (6.2) (Exhibit 9). The number of GP partnerships has reduced from 46 in September 2014 to 42 in September 2017, and the percentage of partnerships with just one partner (21%) is nearly double the Wales average (11%).

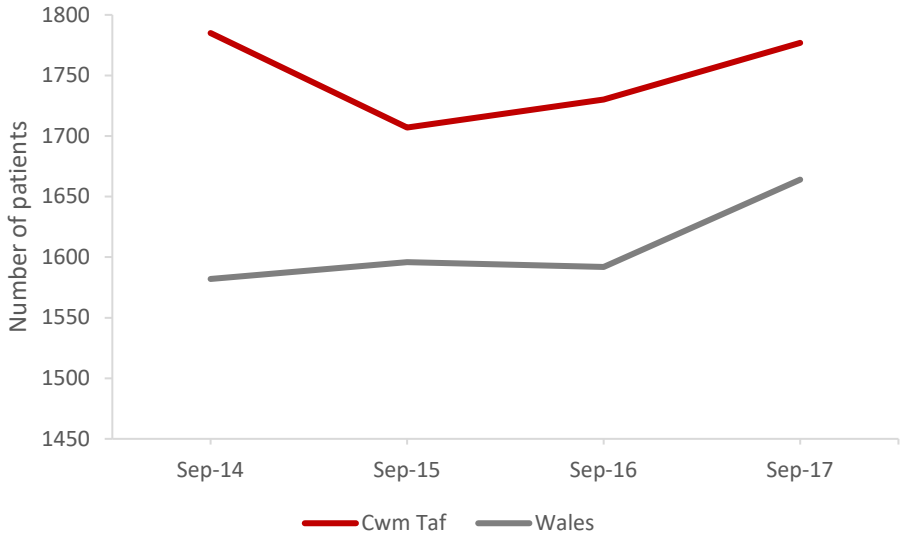
Exhibit 9: number of GPs per 10,000 population



Source: Welsh Government, September 2017.

52 As shown in Exhibit 10, since September 2015 the average patient list size per GP in the Health Board has increased. At September 2017, the Health Board's average list size per GP was 1,777 patients, which is 113 patients higher than the Wales average.

Exhibit 10: average list size per GP



Source: Welsh Government, September 2017.

53 Exhibit 11 shows that the proportion of GPs aged over 55 and the proportion of GPs that are female in the Health Board is slightly lower than the Wales average.

Exhibit 11: demographics of GPs by age and gender

	Cwm Taf University Health Board	Wales
• Aged over 55	21%	23%
• Female	53%	54%

Source: Welsh Government, 30 September 2017.

54 At the Health Board, the number of dentists offering NHS care fluctuates year on year. In 2017, the Health Board had 220 General Dental Services contractors. The number of optometrists offering NHS care increased from 66 in 2014 to 77 in 2017.

55 The national primary care plan requires health boards to map its workforce. The Health Board's primary care workforce plan is within the directorate's IMTP. The workforce plan includes some workforce data, namely the age profile of GPs, which shows the majority of GPs in Cwm Taf are in their mid to late 40s. It also highlights that the Taff Ely locality has the largest number of GPs in their 50s, which leaves the locality vulnerable should GPs decide to retire around the same

time. The workforce plan also highlights a similar issue with practice nurses, recognising the need to attract more primary care nurses.

56 The workforce plan also shows the profile of the GP workforce (as at October 2017). This shows the total number of whole-time equivalent (WTE) GPs by locality. The data is then further split to show how many GPs are partners, salaried, regular locums and on a retainer scheme. It also details the number of WTE non-medical staff, for example: advance nurses, practice nurses, healthcare assistants, pharmacists and administrative staff.

57 However, the Health Board does not hold information on the number or skill mix of staff working in community pharmacy, community dentistry or community optometry.

58 We assessed what health boards are doing to model the future capacity and skills they need in the primary care workforce. In 2017, the Health Board commissioned the Primary Care Foundation to carry out GP practice demand and capacity assessments. Assessments were offered to GP practices on a voluntary basis and the offer is continuing into 2018 because early participation was variable. Generally, there has been a good response from the Rhondda and Taff clusters, but less so in the Merthyr and Cynon clusters. Individual practice assessment reports will feed into practice development plans, which in turn inform wider cluster plans.

59 The directorate and Heath Board IMTP includes some workforce modelling for GPs and practice nurses. The Royal College of General Practitioners recommends one WTE GP per 1,500 patients. The Health Board used this ratio to analyse the workforce gap of GPs and practice nurses. Based on this assessment, there is a shortfall of 60.5 GPs and 18.5 practice nurses across Cwm Taf. To alleviate the risks of this shortfall, the Health Board modelled an alternative multidisciplinary approach that would support one GP per 2,000 patients and one practice nurse per 4,000 patients. Exhibit 12 shows that if this approach was taken forward it would reduce the shortfall to 19.46 GPs and 9.06 practice nurses.

Exhibit 12: GPs and practice nurse shortfall based on revised workforce model

Cluster	GP Shortfall (WTE)	Practice Nurse Shortfall (WTE)
Cynon	4.37	3.69
Merthyr Tydfil	2.25	1.43
Rhondda	8.12	1.59
Taf Ely	4.72	2.35
Total	**19.46**	**9.06**

Source: Health Board IMTP 2018-2021.

There are challenges to the sustainability of GP practices, and the Health Board has recognised the need to strengthen the Primary Care Support Unit

60 The Health Board reports that there is increasing pressure on general medical services, which is compounded by the workforce issues highlighted in the previous section. From our interviews and on reviewing the directorate IMTP it is clear that recruitment and retention of GPs and practices nurses are a significant challenge for the Health Board. We asked the Health Board what factors were making it difficult to recruit, they told us:

- newly qualified GPs do not want to be partners, preferring to work office hours and have a more flexible career;
- many GPs are deciding to be locums rather than salaried or partner GPs;
- Cwm Taf's geography might not be appealing to younger GPs;
- pension changes may push some GPs to take early retirement, leaving some areas vulnerable and younger GPs without mentors;
- the new roles to compliment GPs are also in short supply, plus recruiting to these new roles may leave gaps in other parts of the system as staff move to primary care; and
- difficulties in persuading nurses to choose to begin their career in primary care, rather than moving to primary care after a career in secondary care.

61 Many health boards have developed primary care support units (although the names of these vary across Wales). These units assist GP practices to overcome threats to their sustainability. Cwm Taf has had a Primary Care Support Unit (PCSU) since 2002 and enhanced[11] the unit as part of the pacesetter programme.

62 Between 2015-16 and 2017-18 the number of staff employed by the unit increased from 34.86 (WTE) to 50.21 (WTE) and subsequently the unit's budget rose from £1 million to £1.5 million.

63 In the past, the PCSU supported unstable independent GP practices, enabling issues to be dealt with early on. Consequently, very few practices got to the point where they needed to submit a formal application through the GP sustainability framework[12]. However, recently the unit's resources have concentrated on the Health Board's four managed practices[13]. But the unit is also experiencing the

[11] The Enhanced PCSU is a multidisciplinary team, comprising, locality clinical director lead for PCSU, two PCSU support managers, two practice development and improvement managers, 18 salaried GPs (equating to ten WTE), ten nurses, 1.30 healthcare support workers, 1.80 pharmacist, an occupational therapist, two practice nurse professional educators, and is awaiting approval for two physician associates.

[12] Welsh Government, **Revised GP Sustainability Assessment Framework: 2017/18**, 21 April 2017.

[13] GPs retiring or resigning from small or single-handed practices is the main reason for practices giving notice. The Health Board made the strategic decision to manage the four practices, one of which is a merger of three single-handed practices.

same workforce issues as independent contractors, such as having to rely on locum GPs, making it unable to offer the same level of support as before. However, the Health Board has reviewed arrangements, and from July 2018 the focus of the PCSU will be to help practices modernise and become more sustainable. To achieve this, the PCSU will support larger, stronger practices to transform smaller less stable or failing practices. The PCSU will also be further developed into a multidisciplinary team. In 2018-19, the Health Board's priority is to transfer the four Health Board managed practices back to independent status.

64 Expenditure on managed practices has increased over the last three years. The cost of running four managed practices in 2016-17 was £3.1 million, with £790,000 attributed to the PCSU.

Whilst the Health Board is in the early stages of implementing the national vision of multi-professional primary care teams, there are barriers to further implementing the model

65 The national plan says that in future, the role of GPs will be to provide overarching leadership of multi-professional teams. These teams would include pharmacists, therapists, optometrists, paramedics, advanced practice nurses and others. The national workforce plan says that health boards must find opportunities for these professionals to improve access by providing the first point of contact for patients.

66 The Health Board and cluster leads described several examples of alternative first points of contact. Some are well established and available across the Health Board, whilst others are at early stages, being piloted or only being run in certain clusters or practices. The following examples were given:

- patient signposting and education – such as the Choose Well campaign, training practice receptionists to become care navigators so they can better signpost patients, educating patients at public forums, and an education video is being developed.
- services offered at a cluster and/or practice level – such as MIND offering low-level counselling, direct access to physiotherapist and occupational therapists at GP practices, and clinical pharmacists supporting GPs with annual medication reviews.
- wellbeing and lifestyle support – such as General Practice Support Officers, Wellbeing Co-ordinators and Lifestyle Co-ordinators who can offer advice and signposting to appropriate services. Patients can self-refer or be referred by another professional such as a pharmacist.
- Minor Ailment Pharmacy Scheme – patients can be referred or can self-refer to pharmacies who can advise and prescribe for an agreed set of minor conditions.
- Welsh Eye Care Scheme (WECS) – where appropriate, patients with an eye problem are directed to an optometrist in the community, which has been accredited by WECS.

67 The Transformational Model highlights the importance of enhanced multi-disciplinary teams. In particular, the model stresses the need for these teams to provide a shared resource for all practices in a cluster. At Cwm Taf there are a number of examples of clusters sharing resources, for example, pharmacists, occupational therapists, initial response nurseS, counselling services provided by MIND and Care and Repair resources. Clusters are also a basis for sharing support and mentorship, with experienced GPs and practice managers mentoring those less experienced within their cluster and well-established and stable practices providing GP support to those less stable.

68 In the Cynon Valley, there is a virtual ward, which is a multidisciplinary, multi-agency team that is formed around four practices. The ward targets those in the community who are frail and have multiple and complex health and social care needs. The ward has been running for two years and those we interviewed reported that it works well and produced some good results. As such, the virtual ward model is being used as a basis to bid for Welsh Government transformational monies.

69 Between December 2016 and December 2017, the Health Board held four sustainability engagement workshops with GPs and practice managers. Each of the workshops had a different theme and aimed to explore issues facing primary care and solutions moving forward. At the workshops all clusters developed their own sustainability model. The common theme that runs through all of the models is multidisciplinary working, meaning clusters recognise the value of multidisciplinary working to secure the sustainability of primary care. The feedback from these workshops will feed into the Health Board's clinical services strategy.

70 We asked the Health Board what barriers stood in the way of implementing a multi-disciplinary workforce model for primary care. Barriers included some GPs taking a while to recognise that the funding for new roles needs to come from within their budgets. For example, if a practice has a GP vacancy and they recruit a physiotherapist, the funding set aside for a GP salary could be spent on the physiotherapist. However, some practices are funding their own physiotherapists and pharmacists. Indemnity for new roles might also be putting GPs off investing in new roles and a number of GPs are close to retirement so change at this time could be daunting. Other barriers included the GMS contract not supporting practices to work differently and the availability of a trained workforce.

71 In terms of making changes in primary care, interviewees felt that whilst GPs are contractors, in reality the Health Board does not have many levers over them to effect change. It is easier for the Health Board to change services around primary care, but they cannot force practices to change. However, a consistent message from interviewees was that the primary care team has a good relationship with GPs.

72 The Transformational Model also highlights the need for shared systems of triage for members of the primary care team. The Health Board reported that the majority of clinical triage systems are currently practice based and that they have undertaken a survey of systems in place to map their use. Whilst the Health Board recognises that clinical triage has its benefits they would not force a GP practice to implement it where access is good or where there are sustainability issues.

Oversight and leadership: Strong leadership and monitoring arrangements are in place and the Health Board is taking steps to improve primary care data, however, there is further scope to raise the profile of primary care

The Health Board has dedicated primary care representation at executive and Board level and there are clear leadership arrangements at directorate level

73 To transform primary care, health boards need clear and effective arrangements for oversight and senior leadership. Health board vice chairs have a specific responsibility for championing primary care issues. Cwm Taf's vice chair, who has been in post for approximately two months, chairs the Primary and Community Care Committee, which reports to the Board. She represents the Health Board nationally through groups such as the National Vice Chairs Group and through quarterly meetings with the Cabinet Secretary for Health and Social Services. Locally, she visits GP practices, primary care services such as the PCSU, attends locality meetings and attended the recent sustainability workshops.

74 The Director of Primary, Community and Mental Health is the Health Board's Executive Lead for Primary Care, there is also a deputy director. He is also the lead for the national Primary Care Directors Group. The former director is now the interim Chief Operating Officer so has a good background in the service area.

75 Operationally, the Primary Care Team is led by the Head of Primary Care, who reports to the Director of Primary, Community and Mental Health. Beneath the Head of Primary Care are service development managers and support staff for the various parts of primary care: General Medical Services; Dental and Optometry; Clusters; Primary Care Support Unit; Out of Hours; and cardiovascular disease health checks.

76 Clinically, there is an Assistant Medical Director for primary care and a clinical director for each of the four localities/clusters. The Assistant Medical Director also chairs the national Assistant Medical Directors' Group.

77 The Health Board has a business partner model and so the primary care team is supported by finance, planning and workforce and organisational development colleagues. The primary care team, apart from out of hours, is co-located with social services and public health at Kier Hardie Health Park. Those we interviewed felt the team was well resourced, but still developing. At the time of our review, the team held two vacancies and was recruiting a deputy to support the Head of Primary Care, so she can focus on strategy and transformation.

Primary care issues are prominent within the Health Board but some feel primary care still needs a greater profile. Primary care performance is monitored regularly and the Health Board is taking steps to improve its performance metrics

78 The Health Board has a Primary and Community Care Committee, the committee meets quarterly and provides assurances to the Board. Where appropriate, items are also identified for escalation or sharing with other sub-committees such as the Clinical Governance Committee, Finance and Performance Committee and Audit Committee as well as the Executive Board. The Board receives copies of committee minutes and there are regular agenda items such as the operational delivery report, which updates the Board on key operational issues and IMTP deliverables, both of which include primary care. In addition, the Board and Finance and Performance committee review the integrated performance dashboard which includes national measures related to primary care and a small number of local measures. Those we interviewed felt primary care has a prominence at Board level.

79 The Primary and Community Care Committee has a number of standing agenda items aimed at monitoring primary care progress. Each quarter the committee receives an update on the primary care IMTP deliverables. Detailed narrative is provided for actions that are not on target, so members are sighted of the issues causing slippage. The committee also receives updates on initiatives funded through the primary care development fund. The cover report updates on the current spend against each project and an explanation of any slippage, appended to the report is the quarterly monitoring report submitted to the Welsh Government. In addition, the committee has regular updates on cluster initiatives, with one cluster reporting at each meeting and progress against the eye care and oral health and anticoagulation services.

80 Operational monitoring takes place at the monthly primary care clinical business meetings. This group receives primary care update reports and finance and workforce reports. The directorate has service development managers for dentistry, optometry and GMS who are responsible for day-to-day contract management and monitoring of independent contractors. For optometry, there is no general contract so monitoring takes place through post payment verification visits, optometry services are also being monitored by Public Health Wales.

81 There was general consensus amongst those we interviewed that primary care is a priority for the Health Board, but it is not on an even keel with unscheduled and scheduled care. Whilst there is recognition that primary care should be a higher priority, interviewees said there are external pressures which keep the focus on secondary care. For example, reporting to the Welsh Government is focussed on secondary care which has national targets and a need to manage media coverage on issues such as long accident and emergency waiting times. In terms of funding, it was felt that primary care is not on a par with secondary care, whilst primary care

gets Welsh Government funding, it is short term and ring fenced. Interviewees felt a lack of investment in primary care leads to firefighting in secondary care.

82 Overall, those we interviewed felt that there is a wealth of data within primary care, but it is held within several unintegrated systems. In addition, there can be difficulties getting information from independent contractors. However, the Health Board is trying to improve primary care data and has a data analyst specifically for primary care. The directorate is also developing new primary care measures for the integrated performance dashboard and starting to discuss collating patient experience data for primary care.

GPs and practice managers provide cluster leadership, and they were generally positive about the support provided by the Health Board

83 Exhibit 13 sets out the professional backgrounds of the cluster leads across Wales. In the Health Board the cluster leads are GPs and practice managers. Each cluster has at least one GP lead and one practice manager lead. Compared to other health boards, Cwm Taf has the largest number of non-GP cluster leads. Since our fieldwork the Health Board has seen some movement of cluster leads, it now as 13 cluster leads in total, seven GP leads, and six practice manager leads.

Exhibit 13: professional background of the cluster leads

The table provides the numbers of cluster leads who are GPs and the number of cluster leads who are other professionals in each health board.

	Number of cluster leads: GPs	Number of cluster leads: other professionals	Total number of clusters
Abertawe Bro Morgannwg	11	0	11
Aneurin Bevan	9	3	12
Betsi Cadwaladr	12	2	14
Cwm Taf	**5**	**6**	**8**
Cardiff and Vale	9	0	9
Hywel Dda	6	1	7
Powys	2	1	3
Wales	54	13	64

Note: total number of cluster leads is 67 because Cwm Taf has more than one lead for each of its four clusters.

Source: Wales Audit Office, Health Board self-assessment returns.

84 Public Health Wales, through its Primary Care Hub, has developed a Confident Leaders Programme, which has been attended by 40 of the cluster leads. The cluster leads continue to share and learn from each other through a community of practice. Our survey of cluster leads found that 25% of respondents (two out of eight) had attended the Confident Primary Care Leaders course and both agreed that it helped them improve as cluster leads.

85 Cluster leads told us that the support provided to them by the Health Board has been effective, with 75% (six out of eight) of respondents agreeing that the Health Board provided them with effective support to undertake their cluster lead role. But 63% (five out of eight) of respondents felt they did not have enough time in their day to focus on cluster development.

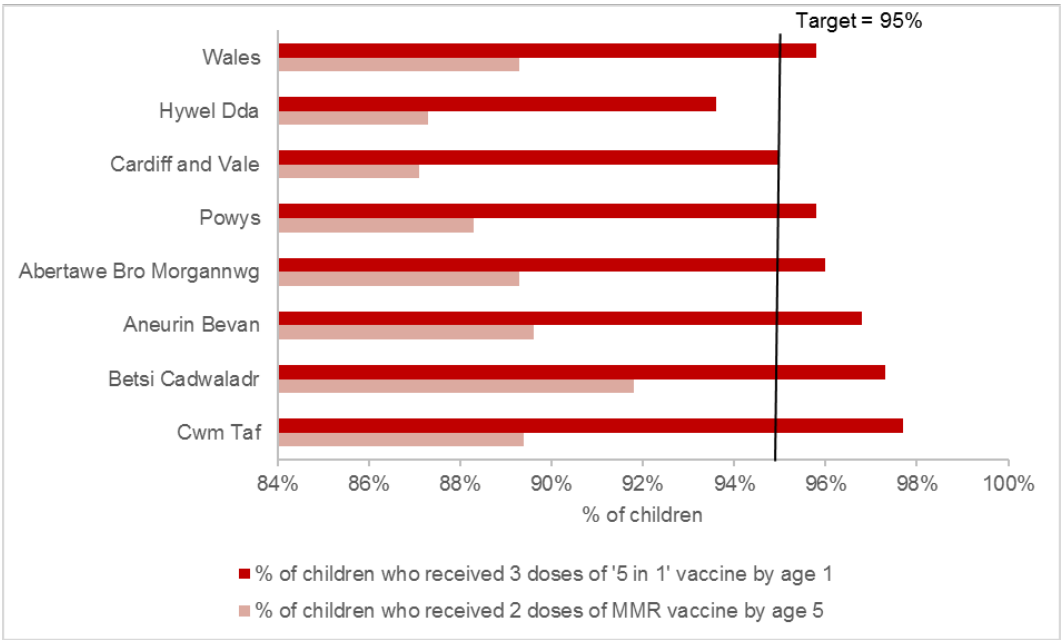
Performance and monitoring: The Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain

Some aspects of the Health Board's performance are better than the Wales average, although the national measures do not adequately represent primary care

87 In this section of the report we summarise the Health Board's performance against the Welsh Government's Outcome and Performance Measures, as described in the Health Board's Integrated Performance Dashboard. However, national measures do not cover the entirety of primary care. The National Primary Care Board is developing a set of national primary care measures.

88 Exhibit 14 shows the Health Board's childhood immunisation rates between January and May 2018. It is meeting the target for '5 in 1' vaccines and performs better than the other health boards and the Wales average. While it is below target for MMR vaccinations, none of the other health boards are meeting it either.

Exhibit 14: childhood immunisation rates for the quarter January to March 2018

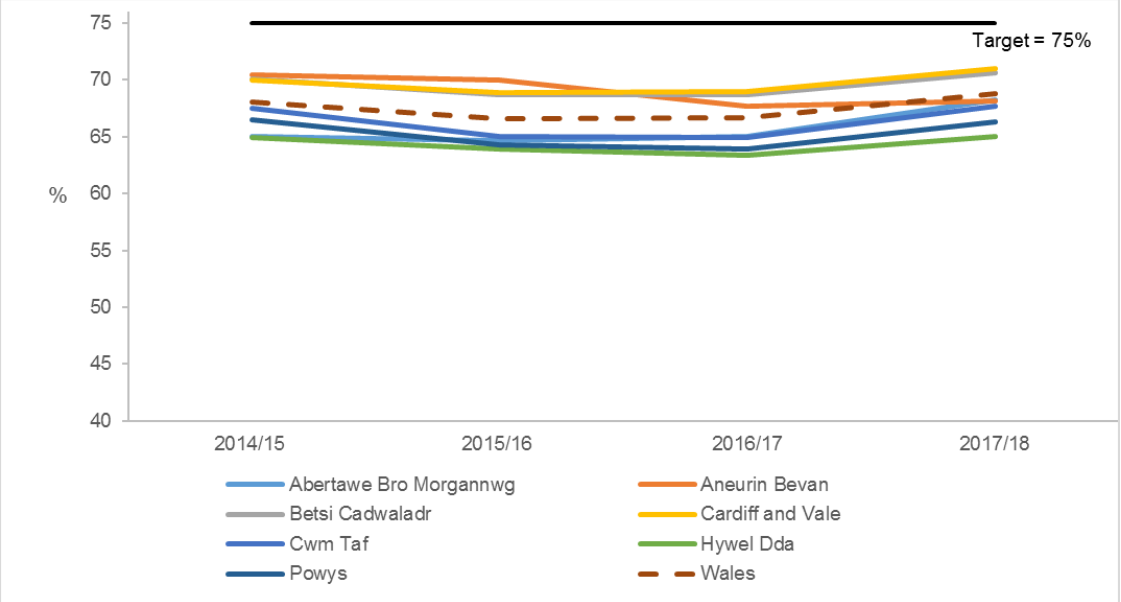


Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections. These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during the quarter 1 January to 31 March 2018.

Source: Public Health Wales.

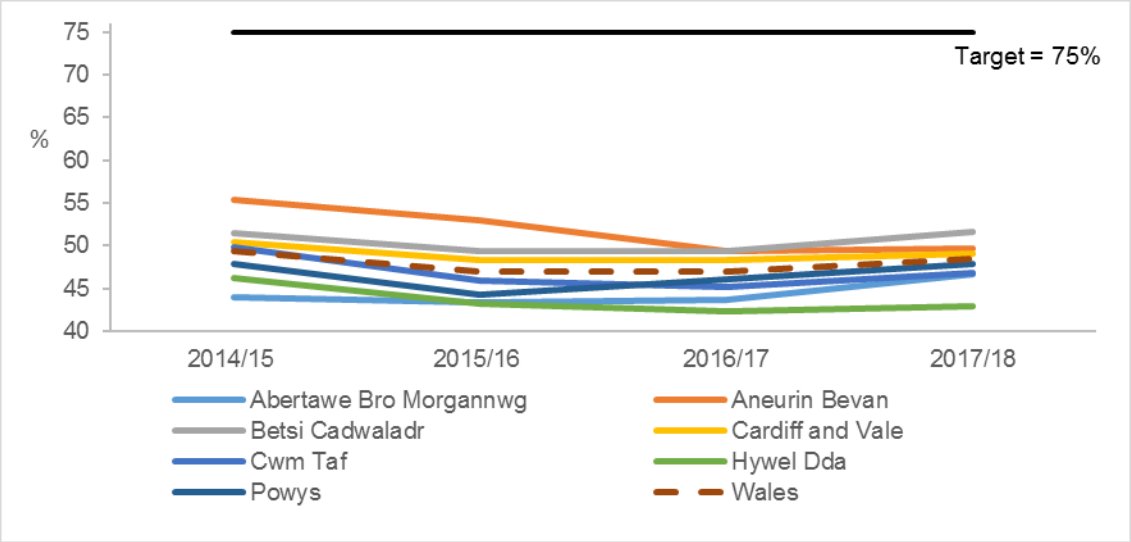
89 For adults, flu vaccinations are recommended for people aged 65 and over, as well as people with other risk factors such as asthma. The target for both groups is for 75% of those populations to receive the vaccination each year. Exhibits 15 and 16 show that the Health Board has not met the targets for flu vaccinations. The Health Board's flu vaccination uptake in patients aged 65 and over and younger than 65 at risk is below the Wales average. The Health Board's integrated performance dashboard also shows flu vaccination rates for pregnant women and health care workers. As at April 2018, none of the flu vaccination targets were being met.

Exhibit 15: trends in uptake of flu vaccination 2014-15 to 2017-18: uptake in patients aged 65 years and older



Source: Public Health Wales.

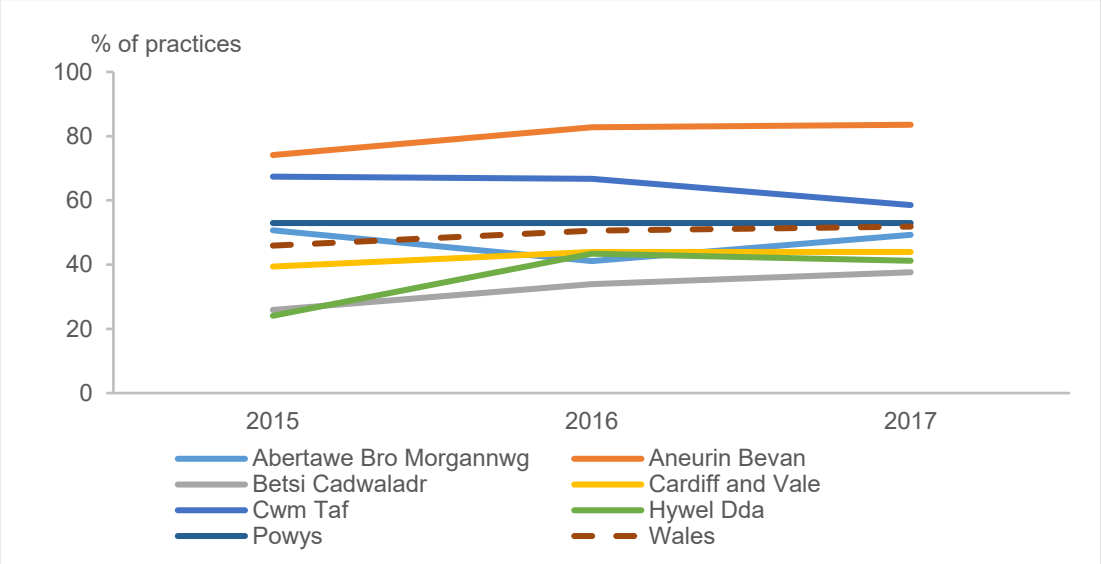
Exhibit 16: trends in uptake of flu vaccination 2014-15 to 2017-18: uptake in patients younger than 65 who are at risk



Source: Public Health Wales.

90 Exhibit 17 shows that in 2017, 59% of GP practices in Cwm Taf opened for 100% or more of their weekly core hours. This is better than the Wales average of 52% and is the second highest percentage after Aneurin Bevan.

Exhibit 17: percentage of practices open for 100% or more of weekly total core hours, by Health Board, 2017



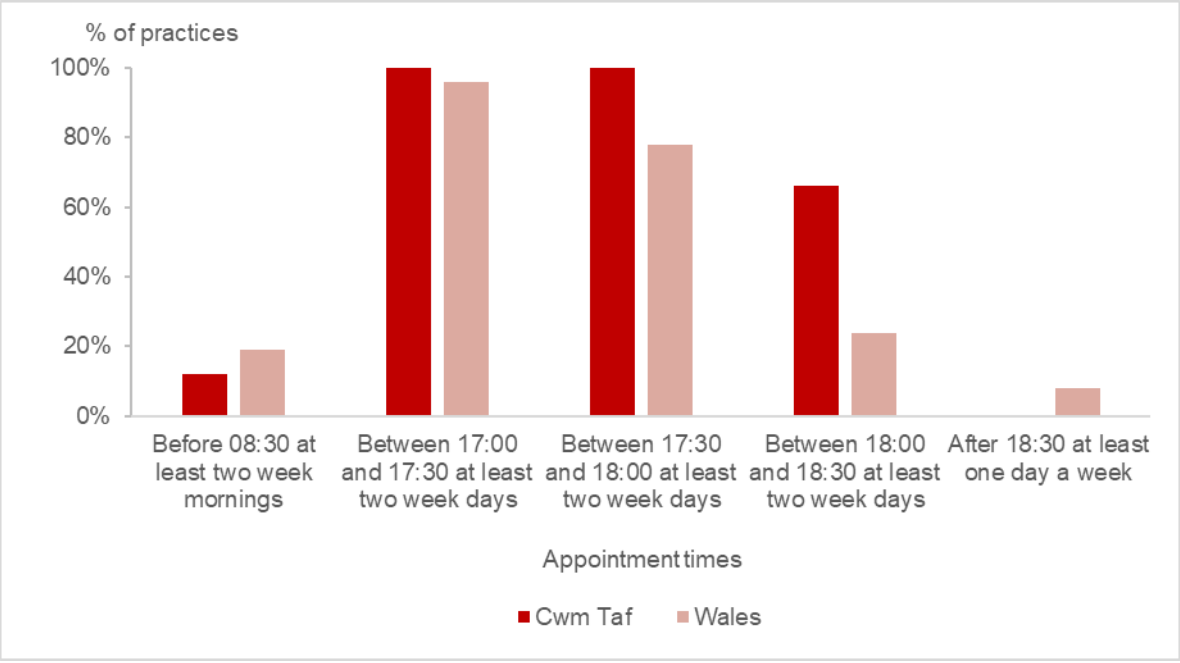
Note: total weekly core hours equals 52 hours and 30 minutes.

Source: Welsh Government.

91 Exhibit 18 shows various measures related to the provision of GP appointments at different times of the day. Except for appointment times before 8.30 am and after 6.30 pm, the Health Board performs better than the Wales average. Exhibit 19 shows how Cwm Taf compares to heath boards. Cwm Taf has the highest percentage of GPs offering appointments between 5 pm and 6.30 pm. But along with Powys has the lowest number of practices offering morning appointments, between 8 am and 8.30 am. Cwm Taf is one of five health boards where no appointments are offered after 6.30 pm.

92 Within the performance dashboard, the Health Board also has two local measures relating to GP practices. The first being, the number of GP referrals to secondary care, which stood at 9,779 at May 2018. The total is also broken down by cluster, with the target being a reduction in referrals. This measure was first reported to the Board in July 2018, so at the time of our review we are not able to comment on whether the Health Board is meeting this target. The second local measure is the percentage of patients registered as receiving palliative care with their GP practice, which was 1.41% of the cluster total in 2016-17. Again, while the dashboard shows the number of patients by cluster, a target for this measure is yet to be decided. The dashboard also includes a measure for the percentage of patients who did not attend a GP appointment, but the figure included in the Board papers for July 2018 was from February 2016.

Exhibit 18: extended appointment times at GP practices, 2017



Source: Welsh Government.

Exhibit 19: extended appointment times at GP practices, 2017

Percentage of practices offering appointments.

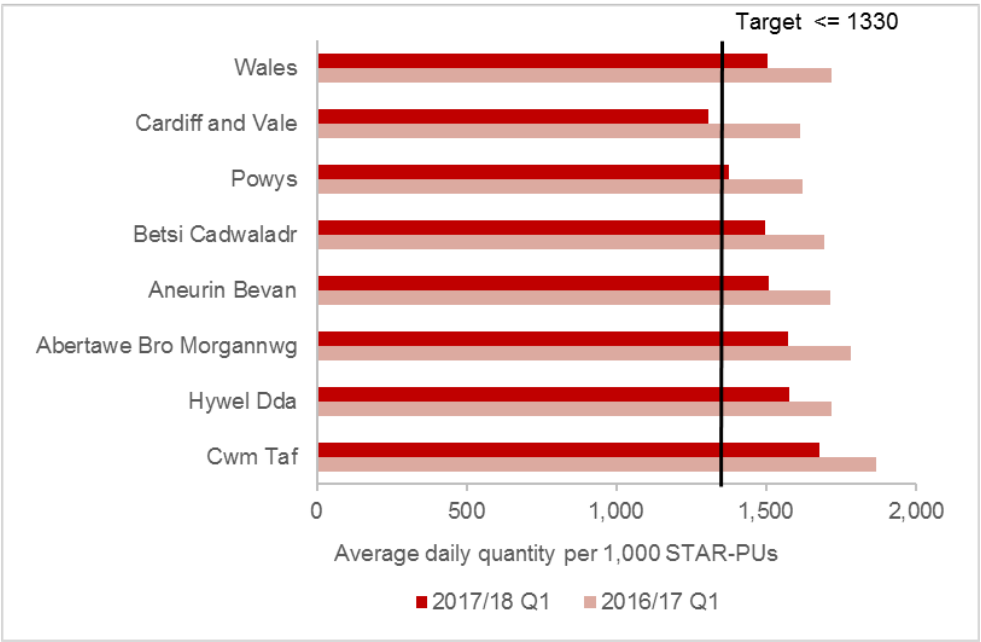
Health Board	Before 08:30 at least two week mornings	Between 17:00 and 17:30 at least two week days	Between 17:30 and 18:00 at least two week days	Between 18:00 and 18:30 at least two week days	After 18:30 at least one day a week
Abertawe Bro Morgannwg	14%	93%	77%	22%	0%
Aneurin Bevan	23%	97%	99%	25%	41%
Betsi Cadwaladr	15%	94%	56%	11%	0%
Cardiff and Vale	23%	95%	74%	12%	0%
Cwm Taf	**12%**	**100%**	**100%**	**66%**	**0%**
Hywel Dda	31%	98%	80%	37%	10%
Powys	12%	100%	76%	18%	0%
Wales	19%	96%	78%	24%	8%

Source: Welsh Government.

93 There is a target to reduce the use of painkillers like ibuprofen, known as non-steroidal anti-inflammatory drugs (NSAIDs), to reduce the risk of complications. Exhibit 20 shows the Health Board has reduced its prescribing in the previous 12 months (by 10.2%). However, its performance shows less of a decrease than the Wales average (12.3%) and it has higher prescribing rates compared to other health boards.

Exhibit 20: prescribing levels of NSAIDs in primary care, first quarter 2016-17 and 2017-18

Prescribing levels in average daily quantity per 1,000 STAR-PUs (specific therapeutic group age-sex prescribing units).

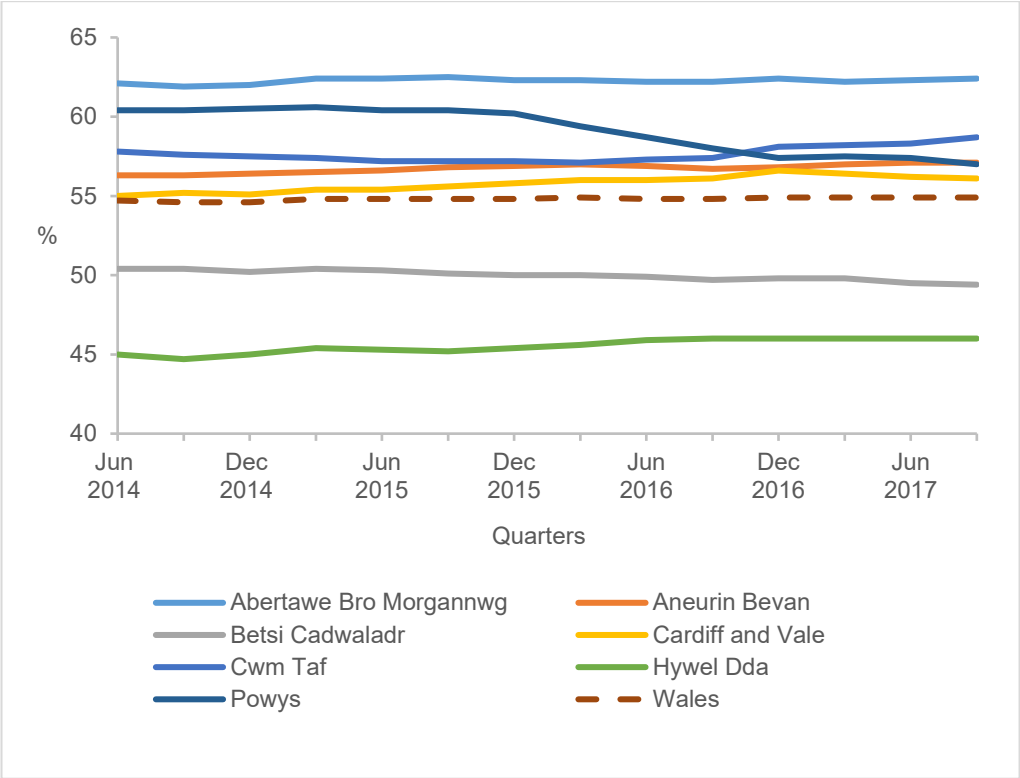


Target = <1,330

Source: Welsh Analytical Prescribing Support Unit

94 Exhibit 21 shows the percentage of the population regularly accessing NHS primary dental care in the previous 24 months as at 30 September. The target is for annual improvement, which the Health Board has achieved. At September 2017, Cwm Taf had the second highest percentage (59%) of patients treated at an NHS dental practice, in same month the Wales average was 55%.

Exhibit 21: percentage of residents treated at an NHS dental practice in the previous 24 months



Target = annual improvement.

Source: dental activity forms, Welsh Government.

The Health Board has made reasonable progress in delivering its primary care and localities plan but several challenges remain

95 The directorate reports monthly to its clinical business meeting and quarterly to the Primary and Community Care Committee on its IMTP deliverables. The report uses a traffic light system, so it is easy to see which actions are:

- Green = key milestones complete
- Amber = some milestones problematic
- Red = major problems

96 The Primary Care and Localities Directorate Plan 2018-2021 gives an overview of performance against 2017-18 deliverables. Exhibit 22 shows that as at March 2018, out of 103 actions, 80 had been completed, 22 were on amber and one was a red action. However, for the out-of-hours redesign and GP sustainability and workforce programme, the Health Board warns that whilst plans are in place to reduce and mitigate these issues, it is one of the highest risks for the directorate

and remains a high risk on its risk register. The Health Board's corporate risk register also includes the following high-rated primary care risks:

- Primary Care Workforce – Recruitment and sustainability
- Failure to continue to provide GP Out of Hours Services as currently configured
- Failure to invest in and develop Primary Care Services, across RCT and Merthyr Tydfil but particularly in the Rhondda Valleys

Exhibit 22: primary care and localities directorate progress against 2017-18 IMTP deliverables

Primary Care and Localities 2017-18 delivery programme	Number of actions	RAG status of actions at March 2018		
		Green	Amber	Red
Out of Hours Redesign	7	1	6	0
Enhanced Primary Care Support Unit (PSCU)	5	4	1	0
Cluster Hub Locality Cardiology Service	4	2	2	0
Cluster Hub Locality COPD service	5	4	1	0
Cluster Hub Locality Community Diabetes Service	7	5	2	0
Cluster Hub Locality MSK Service	4	2	2	0
Danish Cancer Diagnostic Model	6	6	0	0
Training and Development/Management and Leadership	6	6	0	0
Primary Care Cluster Initiatives	5	5	0	0
Inverse Care Law and Risk Stratification	7	7	0	0
Introduce New Primary Care Indicators	2	2	0	0
Continue to develop @Home Services	3	3	0	0
Development of Palliative Care Services	5	5	0	0
Development of 'Cluster Hubs' within each locality	3	2	1	0
Community Hospital Beds – Continue to improve flow across community hospital sites and review staffing and models	5	2	3	0
GP Sustainability and Workforce Programme	4	1	3	0
Community Eye Care Services	4	3	1	0
Lead Role for the organisation in managing with IT the testing of WCCIS.	2	1	0	1
Implement 111	4	4	0	0

Primary Care and Localities 2017-18 delivery programme	Number of actions	RAG status of actions at March 2018		
		Green	Amber	Red
Wound Cluster Service	7	7	0	0
Cost Containment of CHC	3	3	0	0
Oral Health	3	3	0	0
Primary Care Estates Development	2	2	0	0
Total	**103**	**80**	**22**	**1**

Source: Wales Audit Office analysis of Health Board's Primary Care and Localities Directorate Plan 2018-2021.

97 We asked the Health Board what the main barriers were to transforming primary care. Exhibit 23 shows that the directorate recognises that there needs to be a greater shift of resources towards primary care and that steps need to be taken to reduce locum use.

Exhibit 23: the directorate's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove the barriers
Prioritisation of Health Board finances against Welsh Government priorities	Recognition that a greater shift in resources towards Primary Care needs to be made.
Standing Financial Instructions for Health Board	Standing Financial Instructions were initially a barrier when clusters were introduced. But the Health Board produced guiding principles to help inform clusters around processes such as procuring services.
Workforce issues	Need to strengthen the independent contractor status and reduce the benefits being given to locum status.

Source: Wales Audit Office, Health Board self-assessment returns.

98 We sought views from cluster leads on the successes that have been achieved and the main challenges facing primary care in their health board area. Exhibit 24 shows the cluster leads feel their main successes are around improved collaboration, alternative services being available on a cluster and practice basis, and the increased use of technology.

Exhibit 24: successes described by cluster leads in our survey

Successes	Number of clusters
Cluster and practice-based services	8
Improved collaborative working	5
Increased use of technology	3
Intermediate care services	1
Cluster support	1
Health Board sustainability meetings	1
Rhondda recruitment website	1

Source: Wales Audit Office survey of cluster leads, April 2018.

99 Exhibit 25 shows that the main concerns expressed by cluster leads were increased patient expectation, where patients expect an instant service. Recruitment and retention of GPs, nurses and other health professionals are also a concern, along with increased demand and volume of work.

Exhibit 25: challenges described by cluster leads in our survey

Challenges	Number of clusters
Increased patient expectation	5
Recruitment and retention issues	5
Increased demand	3
Locum costs	2
Secondary care work falling to primary care and lack of funding to support it	2
Lack of mental health provision	1
Issues associated with a deprived population	1
Disparate IT systems	1

Source: Wales Audit Office survey of cluster leads, April 2018.

Appendix 1

Methods

Exhibit 26: methods

Method	Detail
Health Board self-assessment	The self-assessment was the main source of corporate-level data that we requested from the Health Board in February 2018. This tool also incorporated a document request.
Survey of cluster leads	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 63%. At the Health Board we sent out 12 surveys and received eight responses, giving a response rate of 67%.
Interviews	We interviewed a number of staff including the following with responsibility for primary care: • Vice Chair • Head of Primary Care • Assistant Medical Director • Clinical Directors • Finance lead • Workforce lead • Planning and Performance lead • Operational Managers • Community Health Council representative
Review of the Health Board's Integrated Medium Term Plan	We reviewed the Health Board's medium term plan to assess the extent to which primary care is considered.
Use of existing data	We used existing sources of data wherever possible such as data from the Welsh Government, Public Health Wales and the Health Board's annual accounts.

Appendix 2

Management response

Exhibit 27: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	The Health Board commissioned the Primary Care Foundation to carry out demand and capacity assessments in GP practices but the take-up from practices has been variable. To maximise value from the commissioned work, the Health Board should centrally analyse and collate the messages from the demand and capacity assessments and share the learning across all practices.	To maximise the value from the demand and capacity assessments.	Yes	Yes	Currently this is being undertaken and the outcomes will be shared at Cluster meetings, the Primary Care Strategic Planning Group and reported through to the Primary Care Committee. Numerous practices have implemented changes and this will be captured and shared as a key element of this work.	December 2018	Head of Primary Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2a	Calculate a baseline position for its current investment and resource use in primary and community care.	To establish the baseline from which to measure the resource shift out of secondary care.	Yes	Yes	This work has commenced and will be a crucial element in determining the baseline position for the primary and community element of the Cwm Taf Partnership Transformation Plan.	March 2019	DPCMH
R2b	Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	To understand progress made in moving resources from secondary to primary care.	Yes	Yes	The Cwm Taf Partnership Transformation Plan will require that a thorough assessment is made in regard to the impact of investment in primary, community and social care on the whole health and care system. This will require reporting to WG and also through the Regional Partnership Board as well as internal efficiency and productivity arrangements.	March 2020	DPCMH

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	To have a clear understanding of the whole primary care workforce, which will be the basis for current and future workforce planning.	No	Yes	The Health Board through the Oral Health and Eye Care planning arrangements will commence during 2019/20 more detailed work on the workforce issues in Dentistry and Optometry practices. In particular skill mix approaches and professional shortages. The CDS service will have been repatriated and a full workforce analysis and modernisation approach will be undertaken The Cwm Taf Transformation plan places great store on MDT working of which the role of pharmacy and pharmacists is crucial. Workforce planning in this area is key and will be worked through the Transformation Plan	March 2020 March 2020	AD (Primary Care, Localities and CYP) Chief Pharmacist/ DPCMH

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4a	Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	To support clusters to evaluate initiatives and understand whether it would be beneficial to carry on and expand or stop.	Yes	Yes	The Public Health Local Team have supported the clusters in evaluating a small number of schemes already but not all. In addition to this they have produced a template evaluation framework for clusters. The use of this template needs to be encouraged for all schemes. Detailed evaluation is an essential part of the new transformation plans to demonstrate the impact of the extended MDT team.	March 2020	Head of Primary Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters.	To provide a mechanism for clusters to learn from each other's initiatives.	Yes	Yes	A Primary Care Newsletter is in existence and is produced quarterly. This newsletter is intended for professionals and is shared across the clusters, between contractors and community.	Ongoing	Head of Primary Care
R4c	Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	To educate the public about alternative first points of contact available.	Yes	Yes	Work has already commenced with this as part of 'know your own team campaign'. A plan for 2018/19 has been produced. Engagement with clusters is essential. Opportunities to engage will be taken via media, press, existing forums and groups and events.	Ongoing	Head of Communications

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4d	Evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	To share learning with other health boards in Wales.	Yes	Yes	This process is already in place and evaluation/success measures are already detailed in the delivery agreement which is reported to the Welsh Government on six-monthly basis. Sharing of learning across Wales takes place via all Wales forum of Heads of Communication.	Ongoing	Head of Communications
R5a	Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	To strengthen and target cluster development support.	Yes	Yes	Significant support is already given to clusters however they will need to evolve both as part of the strategic direction set by the Welsh Government in A Healthier Wales and to fulfil the expectations and requirements of the transformed model. In addition, a new governance framework has been issued on a national basis and will be used locally as part of the delivery of the transformation plan to support clusters in their maturity.	March 2020	AD (Primary Care, Localities and CYP)

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5b	Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	To ensure clusters have the right representation.	Yes	Yes	This has been undertaken and steps are in place to strengthen the primary care cluster structure.	March 2019	Head of Primary Care/AMD (Primary Care)
R5c	Develop an action plan for strengthening cluster leadership.	To strengthen cluster leadership.	Yes	Yes	Various options will be offered to cluster leads in order to fit their skills and experience and to provide flexibility. This will be explored at cluster leads meeting.. An array of options are already available through their PCCI Hub	March 2020	Head of Primary Care

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Text phone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

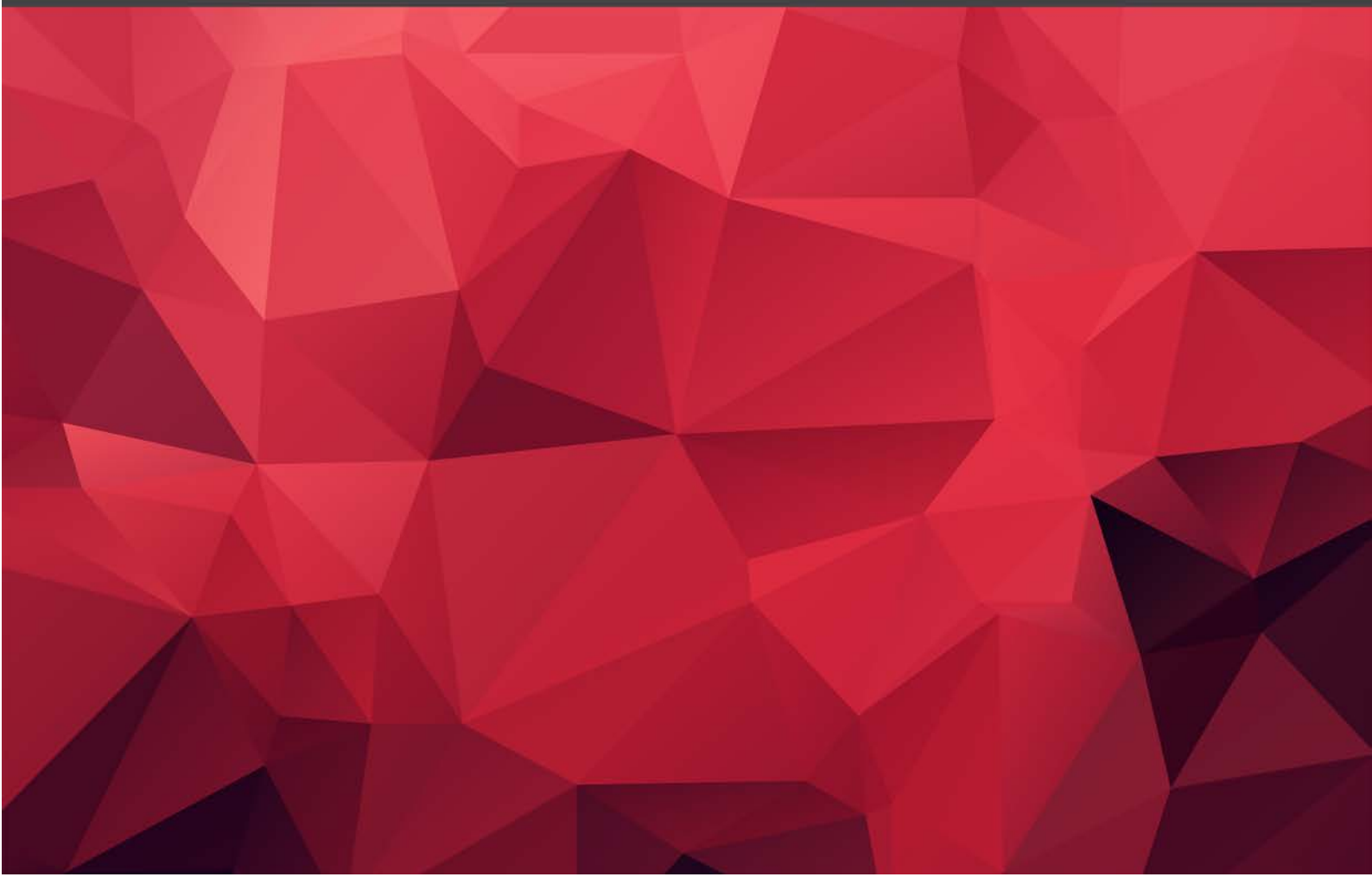
Archwilydd Cyffredinol Cymru
Auditor General for Wales

Annual Audit Report 2018 – **Cwm Taf University Health Board**

Audit year: 2017-18

Date issued: January 2019

Document reference: 999A2018-19



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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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

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

This report was prepared for the Auditor General by Dave Thomas, Derwyn Owen, Gareth Lucey and Sara Utley.

Contents

Summary report

About this report 4

Key messages 5

Detailed report

Audit of accounts 6

I have issued an unqualified opinion on the accuracy and proper preparation of the 2017-18 financial statements of the Health Board with no significant issues to bring to the attention of officers and the Audit Committee 6

I have issued an unqualified audit opinion on the regularity of the financial transactions within the financial statements of the Health Board 8

Arrangements for securing efficiency, effectiveness and economy in the use of resources 9

The Board continues to operate well however aspects of quality governance, risk management and oversight of ICT arrangements do require improvement 9

The Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones 11

Financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. However, there is a need for continued action address to several significant workforce challenges, including factors driving the relatively high use of locum and agency staff 12

My wider programme of work indicates that the Health Board is demonstrating effective planning, but improvements could be made in some areas 14

The Health Board has not made effective use of the National Fraud Initiative to detect fraud and overpayments 16

Appendices

Appendix 1 – reports issued since my last annual audit report 17

Appendix 2 – audit fee 18

Appendix 3 – significant audit risks 19

Summary report

About this report

1 This report summarises the findings from the audit work I have undertaken at Cwm Taf University Health Board (the Health Board) during 2018. I did that work to carry out my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

a) examine and certify the accounts submitted to me by the Health Board, and to lay them before the National Assembly;

b) satisfy myself that the expenditure and income to which the accounts relate have been applied to the purposes intended and in accordance with the authorities which govern it; and

c) satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2 I have reported my findings under the following headings:

- Key messages
- Audit of accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

3 I have issued several reports to the Health Board this year. This annual audit report is a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.

4 Appendix 2 presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my work at the Health Board, alongside the original fee that was set out in the 2018 Audit Plan.

5 Appendix 3 sets out the significant financial audit risks highlighted in my 2018 Audit Plan and how they were addressed through the audit.

6 The Chief Executive and the Director of Finance have agreed this report is factually accurate. We presented it to the Audit Committee on 14 January 2018. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange wider publication of this report. We will make the report available to the public on the Wales Audit Office website after the Board have considered it.

7 I would like to thank the Health Board's staff and members for their help and co-operation during the audit work my team has undertaken over the last 12 months.

Key messages

Audit of accounts

8 I have concluded that the Health Board's accounts were properly prepared and materially accurate, and my work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts. I have therefore issued an unqualified opinion on their preparation, with no significant issues to bring to the attention of officers and the Audit Committee.

9 The Health Board achieved financial balance for the three-year period ending 31 March 2018 and so I have issued an unqualified opinion on the regularity of the financial transactions within its 2017-18 accounts.

10 As the Health Board achieved financial balance and has an approved three-year plan in place and there were no other issues which warranted highlighting, no substantive report was placed on the Health Board's accounts.

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

11 My 2018 structured assessment work at the Health Board has found that:

- the Board continues to operate well however important aspects of quality governance, risk management and oversight of ICT arrangements require improvement;
- the Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones; and
- financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. However, there is a need for continued action address to several significant workforce challenges, including factors driving the relatively high use of locum and agency staff.

12 Reviews of discharge planning and primary care services have found some aspects of good practice as well as opportunities to strengthen arrangements for securing efficient, effective and economical use of resources

13 The Health Board is participating in the National Fraud Initiative but has made limited use of the data matches released in 2017.

14 These findings are considered further in the following sections.

Detailed report

Audit of accounts

15 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2017-18. These statements are how the organisation shows its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating appropriate stewardship of public money.

16 In examining the Health Board's financial statements, I must give an opinion on:

- whether they give a true and fair view of the financial position of the Health Board and of its income and expenditure for the period in question;
- whether they are prepared in accordance with statutory and other requirements, and meet the relevant requirements for accounting presentation and disclosure;
- whether that part of the remuneration report to be audited is properly prepared;
- whether the other information provided with the financial statements (usually the annual report) is consistent with them; and
- the regularity of the expenditure and income in the financial statements.

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

I have issued an unqualified opinion on the accuracy and proper preparation of the 2017-18 financial statements of the Health Board, with no significant issues to bring to the attention of officers and the Audit Committee

I have concluded that the Health Board's accounts were properly prepared and materially accurate, and my work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts

18 The draft financial statements were produced for audit by the agreed deadline of 27 April 2018 and were again of a good standard. The Health Board has quality assurance processes over the financial statements and there is a high level of scrutiny from the Audit Committee. We concluded that accounting policies and estimates were appropriate and financial statement disclosures were unbiased, fair and clear.

19 The deadlines for submission of the accounts and relevant parts of the Annual Report remain challenging and we would like to commend the Finance team and the wider Health Board for the timing and quality of their work. The constructive

working relationships with the Board Secretary, Director of Finance and the whole finance team have continued again this year, and we thank them again for that.

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

21 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 31 May 2018. Exhibit 1 summarises the key issues set out in that report.

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

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

Issue	Auditors' comments
Uncorrected misstatements	One such misstatement was identified, where £597,000 of income recovered by WHSSC/EASC from secondments to other NHS bodies was netted-off against expenditure, rather than recorded separately as miscellaneous income. This immaterial misstatement did not affect the overall financial position of WHSSC/EASC or the Health Board.
Corrected misstatements	A number of corrections were identified during the audit, as set out in Appendix 3 of the report. The only material corrections related to the classification of provisions and Welsh Risk Pool debtors arising from clinical negligence and personal injury legal claims, which again did not affect the overall financial position of the Health Board.
Other significant issues	No other significant issues were raised for the attention of management or the Audit Committee.

22 As part of my financial audit, I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2018 and the return was prepared in accordance with the Treasury's instructions.

23 My separate independent examination of the charitable funds financial statements is complete, and I certified these accounts on 8 November 2018. In this certification, I confirm that no matters have come to my attention giving me cause to believe that:

- accounting records are not kept as required;
- the accounts do not accord with those records;
- the accounts do not comply with applicable legislative requirements;

- the accounts have not been prepared in accordance with the Statement of Recommended Practice for accounting and reporting by charities.

I have issued an unqualified audit opinion on the regularity of the financial transactions within the financial statements of the Health Board

The Health Board achieved financial balance for the three-year period ending 31 March 2018 and so I have issued an unqualified opinion on the regularity of the financial transactions within its 2017-18 accounts

24 The Health Board's financial transactions must be in accordance with authorities that govern them. It must have the powers to receive the income and incur the expenditure that it has. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur. Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

25 The Health Board underspent against its Revenue Resource Limit by £23,000 in 2017-18. Added to further minor underspends in 2015-16 and 2016-17, it underspent against its cumulative three-year Revenue Resource Limit by a total of £63,000. The Health Board therefore complied with its statutory duty to break even over a rolling three-year period.

As the Health Board achieved its financial balance duty and has an approved three-year plan in place and there were no other issues which warranted highlighting, no substantive report was placed on the Health Board's accounts

26 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. As the Health Board met both of its financial duties: to achieve financial balance (as set out above) and to have an approved three-year plan in place; and there were no other issues warranting report, I did not issue a substantive report on the accounts.

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

27 I have a statutory requirement to satisfy myself that NHS bodies have proper arrangements in place to secure efficiency, effectiveness and economy in the use of their resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- assessing the effectiveness of the Health Board's governance and assurance arrangements;
- reviewing the Health Board's approach to strategic planning;
- examining the arrangements in place for managing the Health Board's finances, workforce, assets and procurement;
- specific use of resources work on discharge planning, primary care services and regional partnership working in respect of the Integrated Care Fund;
- reviewing the Health Board's arrangements for tracking progress against external audit recommendations; and
- assessing the application of data-matching as part of the National Fraud Initiative (NFI).

28 My conclusions based on this work are set out below.

The Board continues to operate well, however, important aspects of quality governance, risk management and oversight of ICT arrangements require improvement

29 My structured assessment work examined the Health Board's governance arrangements, the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. I also looked at the information that the Board and its committees receive to help them oversee and challenge performance and monitor the achievement of organisational objectives. I found the following.

30 **We found that the Board is operating effectively, but the Quality, Safety and Risk committee is not as effective as it could be and there are gaps in the arrangements to oversee progress on ICT developments.** Administration of the Board meetings is good, and it is clear when decisions have been made. There are positive levels of scrutiny and challenge evident at board and committee meetings. However, the Quality, Safety and Risk committee has a large agenda, and papers presented to this committee are not sufficiently succinct. There is scope to review the work of this committee with a view to prioritising its workload and refining the presentation of information to the committee to help support effective scrutiny.

Improvements to the oversight and scrutiny of progress on the implementation of the Digital Health Strategy is required. My staff have also noted that there is currently no cyber security action plan in place.

31 **The Health Board has a board assurance framework and risk management strategy in place, however, there is a need to improve the operational identification, review and mitigation of risk.** My work identified that although board members are overall happy with the arrangements in place for identifying and managing risk, there is the opportunity to ensure more frequent regular review of directorate risks registers as a sample we reviewed were not as current as they could have been.

32 **Important aspects of the Health Board's quality governance arrangements require improvement.** Whilst the Health Board appears to have the necessary structures and processes in place to support quality governance, in practice we are concerned that the system is not effective in highlighting issues and concerns or demonstrating responses to improvements. Aspects of the quality report presented to the Quality, Safety and Risk committee need to improve as we found that currently the information presented does not enable readers to easily identify areas of concern. The Quality Steering Group responsible for collating various sources of information from quality sub groups, as well as compiling the quality report has not been meeting as required due to pressures on clinical staff. A recent Internal Audit review recommended the Health Board strengthen arrangements to support staff in raising concerns. Additionally, issues with serious incident reporting within Maternity have been identified and it is important that the Health Board demonstrates organisational learning and seeks assurance that issues uncovered in maternity services are not more widespread.

33 **The Health Board has clear executive portfolios and lines of accountability, but clinical business meetings need more focus on quality and safety.** There are clear executive portfolios and a clear organisational structure in place which sets out the roles and responsibilities. Whilst there have not been significant changes to its overall operational structure since our last review there have been several changes to the Executive Management Team. Interim arrangements are in place with the Director of Primary and Community Mental Health moving into the Chief Operating Officer role, while a new Director of Primary Community and Mental Health was appointed. The Director of Nursing, Midwifery and Patient Care retired recently, and interim arrangements are in place until the appointment of a new director in 2019. The Director of Finance was appointed earlier this year having previously worked for the Health Board.

34 The Health Board holds Clinical Business Meetings (CBMs) which aim to continually improve performance against key indicators, and safety and service quality for patients and staff. The arrangements for these meetings have improved this year, however, they require further development to ensure that issues relating to the quality and safety of services receive sufficient attention. I am aware that work is underway to continue to refine the way CBMs operate.

35 **The Health Board has an embedded process for tracking Internal Audit and External Audit recommendations and reporting actions and progress to the committee.** However, we have highlighted that scrutiny of recommendations marked as complete which are subsequently removed from the tracker needs to improve as there is a risk the recommendations are closed without sufficient Independent Member scrutiny. Additionally, the Health Board could usefully explore the opportunity to utilise the tracker to coordinate actions in response to recommendations from other inspections and external reviews, such as Healthcare Inspectorate Wales, Ombudsman reports and Delivery Unit reports. My Structured Assessment review this year indicates a number of areas where the Health Board is making progress against my previous recommendations but there remains more to do before these actions are completed in full. I discuss this further in paragraph 48.

The Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones

36 My work examined how the Board engages partners and sets the strategic direction for the organisation. I also assessed how well the Health Board plans the delivery of its objectives and how it monitors progress in delivering the plans. My findings are set out below.

37 **The Health Board has a clear strategic vision and its developing its long-term clinical services strategy.** The Health Board has continued with its approach in previous years by developing a detailed engagement plan for consultation with key internal and external stakeholders on the Health Board priorities. The strategic priorities set out in the Integrated Medium-Term Plan (IMTP) were informed by effective engagement with key stakeholders both internally and externally. Board members were positive from our survey as to their level of engagement in setting the vision and strategic priorities.

38 **The Health Board has a well-developed approach to its strategic planning underpinned by demand and capacity modelling and guidance.** The Health Board's approach to developing its IMTP remains consistent and builds upon the preceding plan. This is the fifth consecutive year where the Health Board has received Welsh Government approval for its plan. An organisation wide planning workshop and detailed guidance and templates support each directorate to support completion of their directorate IMTPs. The Health Board has temporarily increased capacity to support transformation on a non-recurrent basis and is keeping this area under review. The next iteration of the IMTP will need to reflect the boundary changes and the wider integration of services following the transfer from Abertawe Bro Morgannwg University Health Board. The Health Board is developing processes to manage this transfer and integration of services and is engaged with them in developing their IMTP plans for next year.

39 **There are processes in place for monitoring delivery of the IMTP but without detailed milestones it is challenging to gain an accurate impression of progress.** As part of my structured assessment review I considered the monitoring arrangements in place for the IMTP. Positively IMTP reporting has improved this year with clearer links to the activities and strategic themes of the Health Board. However, without a clear picture of the milestones in the initial IMTP it is difficult for an external audience to identify progress and see whether the priorities are on track.

Financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. However, there is a need for continued action address to several significant workforce challenges, including factors driving the relatively high use of locum and agency staff

40 My structured assessment work examined the Health Board's arrangements for managing its workforce, its finances and other physical assets to support the efficient, effective and economical use of resources. I also considered the arrangements for procuring goods and services, and the action being taken to maximise efficiency and productivity. My findings are set out below.

41 **The Health Board has a track record of achieving its statutory financial duties and has generally robust financial stewardship and management controls in place.** The 2017-18 financial statements show that the Health Board met its statutory duty. Indications are that this duty will continue to be met in 2018-19. In respect of financial stewardship, the Health Board has a clear framework of roles and responsibilities with appropriate control activities and processes in place. The Health Board has a track record of meeting its statutory reporting requirements. Its draft and final financial statements were submitted to the Welsh Government in line with agreed deadlines. Similarly, the draft and final annual reports were produced in line with guidance from HM Treasury and in accordance with deadlines. Regular finance reports are presented to the Finance and Planning Committee and the full Board. My work also identified good operational procurement arrangements, but also potential to more proactively manage the 'contractual' relationship between the Health Board and the procurement provider. A Local Counter Fraud Service (LCFS) is in place to tackle fraud within the Health Board, however the caseload for the Health Boards local counter fraud service has steadily increased, coupled with impending boundary change has meant that the Health Board is reviewing its LCFS provision with the likelihood of increasing the counter-fraud service capacity from the 2019-20 financial year.

42 **Workforce issues continue to challenge the Health Board, but it is taking steps to tackle issues such as higher than average agency expenditure and turnover rates.** The Health Board's Integrated medium-term plan (IMTP) highlights

that the biggest challenge to the Health Board's financial position is the expenditure on medical, dental and nursing locums and bank and agency staff. The Health Board is aiming to reduce medical, dental and nursing and midwifery agency spend by approximately £5.1 million by next year (2018-19) through initiatives such as 'retire and return' for nurses and introducing e-rostering and e-job planning for the medical workforce. The Health Board is taking a number of actions to help fill vacancies, for example recruiting nurses from abroad and running recruitment campaigns such as the '#joincwmtaf.wales' campaign. This campaign aims to dovetail with the national 'TrainWorkLive' campaign. In addition, the Health Board is implementing redesign programmes to modernise its workforce and use its staff differently. At the time of reporting my Structured Assessment findings the Health Board did not have a training and development plan and had not undertaken a training needs assessment which needs to be an area of focus for the future.

43 **The Health Board is focussed on delivery of its key access targets and has examples of innovative ways of working to improve efficiency and productivity.** The organisation operates in a challenging environment and while some of its performance metrics have improved the challenge is now to maintain this. There is a positive focus on prudent healthcare which is reflected in the IMTP and there have been some successes in this area, but further resources will be needed to fully embed the principles within the directorates. The Stay Well at Home (SW@H) services has been recognised and received an award for its innovative approach, achieving both financial savings but also improving service user feedback.

44 **We found that the Health Board manages its assets well.** Supported by an estates strategy and asset management strategy, the Health Board has a risk management approach to prioritise the limited discretionary capital allocation across estates, ICT infrastructure, medical equipment and other related assets. A fixed asset register is in place, as well as an asset management system. Further work needs to be done to ensure that the Estates directorate risk register is up to date.

My wider programme of work indicates that the Health Board is demonstrating effective planning, but improvements could be made in some areas

The Health Board has plans in place to improve patient flow and discharge planning and there is regular scrutiny of performance; however, there is scope to improve the discharge policy and pathways

45 My work identified that the Health Board has plans in place to improve discharge planning underpinned by policies and improvement initiatives. The Integrated medium-term plan (IMTP) and the unscheduled care plan set out key initiatives for improving patient flow and the Health Board has developed a delayed transfers of care action plan in collaboration with local authority colleagues. However, there is scope of strengthen aspects of the discharge planning policy and the steps in the discharge pathway could be better articulated.

46 Dedicated resources are available to support discharge planning and ward staff are confident about what needs to be done to support timely discharge. There is a discharge liaison team available to support complex discharges and ward staff are confident about what needs to be done having been provided with training recently by the discharge liaison team.

47 A range of information related to discharge planning and patient flow is regularly presented to the Board and Board members feel well informed. Overall, performance related to discharge planning and patient flow is improving slowly but there is more to do to reduce delayed transfers of care, lengths of stay and waits in the Health Board's emergency departments.

The Health Board has a sound plan for primary care and is making reasonable progress towards implementing key elements of the national vision. Oversight arrangements are strong and performance against some indicators is above average. However, there is further scope to raise the profile of primary care, shift more resources towards primary care and to address workforce challenges.

48 I found that the Health Board has a strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development they are being supported to develop. The Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain. The Health Board can point to some specific examples of resources shifting to primary care, but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care. In addition, it is recognised that workforce challenges are threatening the sustainability of some general practices, but the Health Board has begun workforce modelling and is in the early stages of testing solutions. There are strong

leadership and monitoring arrangements in place and the Health Board is taking steps to improve primary care data, however there is further scope to raise the profile of primary care at the Board.

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

49 My work has found that the Health Board is making progress in addressing recommendations from my previous audit work. Of the 23 Wales Audit Office reports covered in the audit tracker we have made 174 recommendations, of which 162 have been reportedly implemented, although it is important to note that some require ongoing action. 12 recommendations are outstanding with five overdue their originally agreed completion date and related mainly to Follow Up Outpatients Not Booked and Discharge planning.

50 As part of our 2018 Structured Assessment, we have reviewed progress against implementation of the 2017 recommendations. Of the seven recommendations made, one has been implemented and the remainder are in progress, with some having a target date for completion during the current financial year.

My emerging findings on the Integrated Care Fund are showing some challenges

51 I have completed the fieldwork for my cross-sector Integrated Care Fund review. I intend to prepare a national summary report early in 2019, setting out my all-Wales findings. My audit team has already presented local findings to Regional Partnership Boards. The key messages for the Cwm Taf Regional Partnership Board (RPB) are:

- The Integrated Care Fund (the fund) has had a positive impact in bringing organisations together across the region, but the RPB will need to consider whether it has sufficient housing and financial representation and will have to take account of the changes that need to be made to the partnership arrangements following the Bridgend transfer.
- Due to the annual nature of the fund, the region recognises that it has not always used the fund strategically to develop services based on need, with scope to strengthen aspects of project management for the projects supported by the fund.
- Decisions surrounding the use of the fund are delegated to sub-groups of the regional partnership board. The RPB and its Transformation Leadership Group have a very positive and trusting relationship. This strengthens their ability to take confidence in decisions made through delegated responsibility. Also, RPB members consistently communicate discussions back to their own organisations.
- There is general agreement that the fund is supporting the right projects and having a positive impact on service users, but like other regional partnership

boards across Wales, few of the projects have been mainstreamed into core services. The Cwm Taf region is attempting to demonstrate outcomes more clearly, but this presents an ongoing challenge.

The Health Board has not made effective use of the National Fraud Initiative to detect fraud and overpayments

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

53 The Health Board received the outcomes from the 2016 data matching exercise in January 2017. The Trust received 311 recommended matches. In our 2016-17 Annual Audit Report we reported that as at 20 November 2017 the Health Board had only reviewed nine data-matches and had consequently failed to make effective use of NFI as part of its arrangements to prevent and detect fraud.

54 As at 12 November 2018, the NFI web application records that the Health Board has now reviewed 216 data matches. Whilst we acknowledge that the Health Board has made progress, there still appear to be some high-risk matches that need reviewing including: matches between payroll, creditor payments and Companies House data and matches between staff and supplier bank accounts.

55 In October 2018, participating bodies submitted data for the next data matching exercise. The outcomes of this exercise will be available early in 2019 and it is important that the Health Board implements a timely review of recommended matches that emerge from this exercise. Where data-matches have been reviewed, the Health Board also needs to ensure that NFI web application is updated to clearly record how these matches were reviewed and the outcomes.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2018.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	May 2018
Opinion on the Financial Statements	June 2018
Performance audit reports	
Review of Discharge Planning	February 2018
Primary Care Services	November 2018
Structured Assessment 2018	January 2019
Other reports	
2018 Audit Plan	March 2018

Exhibit 3: performance audit work still underway

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

Report	Estimated completion date
Clinical coding follow-up	March 2019
Locum Doctors Review	March 2019
Cross Cutting review on Integrated Care Fund	March 2019
Orthopaedic Services follow-up	October 2019

Appendix 2

Audit fee

The 2018 Audit Plan set out the proposed audit fee of £407,993 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Significant financial audit risks

Exhibit 4: significant audit risks

My 2018 Audit Plan set out the significant financial audit risks for 2018. The table below lists these risks and sets out how they were addressed as part of the audit.

Significant audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	Work completed and no issues arising.
There is a risk that the Health Board will fail to meet its first financial duty to break even against its aggregate revenue and capital resource limits over a three-year period. The Health Board continues to forecast a break-even position at 31 March 2018. Combined with the small surpluses achieved in 2015-16 and 2016-17, this indicates that the Health Board will meet this financial duty. If the Health Board fails this financial duty, I will place a substantive report on the financial statements highlighting the failure. The current financial pressures on the Health Board increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	My audit team will focus its testing on areas of the financial statements that could contain reporting bias. We will also review with management the Health Board's performance and the impact of all audit findings against the revenue and capital resource limits for the three-year period 2015-16 to 2017-18.	Work completed and no issues arising. My audit work on estimates and other subjective areas such as provisions did not identify any material adjustments to the Health Board's result for the year. My staff concluded that, taking trivial errors into account, the Health Board met its financial duties for resource limits over the three-year period 2015-16 to 2017-18.

Significant audit risk	Proposed audit response	Work done and outcome
The timetable for producing and certifying the annual accounts remains demanding. The Health Board will need to ensure appropriate arrangements to prepare the accounts and provide working papers for audit on a timely basis.	My audit team will continue to work closely with management to further improve supporting working papers and streamline the accounts preparation and audit processes.	Work completed and no issues arising. We have no significant matters to raise in terms of the quality or timeliness of working papers provided for audit.
There have been a number of changes at Board level during the year, covering both Independent Members and the Executive. The Health Board will need to update Remuneration Report and Related Party Transaction disclosures appropriately in response.	My audit team will liaise with management to ensure that these disclosures are accurate and will review these areas in detail during the audit.	Work completed. My audit team identified a number of required corrections to the Remuneration Report and Related Party disclosures. These corrections were all actioned by management.
The District Valuer has revalued the Health Board's land and buildings this year. In addition, the Health Board (along with other Health Boards in Wales) has reviewed the process of accounting for its revaluation reserve in the Balance Sheet, with assets now analysed by 'buildings' rather than larger 'sites'. The Health Board will need to reflect these developments accurately in the financial statements.	My audit team will: • test land and building revaluations in detail to ensure that information from the District Valuer is accurately reflected in the financial statements; and • review any adjustments to the revaluation reserve arising this year in detail.	Work completed and no issues arising.
The new HRG4+ tariff for specialised care services in England has increased the cost of these services in 2017-18. WHSSC are currently in dispute with English care providers as to whether the increased costs will have to be borne by themselves (and ultimately by Welsh Health Boards). If this situation remains unresolved, it could affect the ability of the Health Board to meet its revenue resource limit.	My audit team will liaise with management of WHSSC and the Health Board to determine how this issue could affect accounting entries in the financial statements.	Work completed and no issues arising. We were satisfied that accounting entries for this issue in the 2017-18 accounts by WHSSC/EASC and the Health Board were correct. As this dispute remained unresolved when the 2017-18 accounts were certified, we will need to review this issue again during planning for our 2018-19 audit.

Significant audit risk	Proposed audit response	Work done and outcome
There is a risk that the Health Board will not correctly account for ongoing legal claims between provisions and contingent liabilities. In particular, there are ongoing discussions regarding a Supreme Court judgement in August 2017 on Funded Nursing Care costs, which could result in a significant liability for the Health Board in 2017-18.	My audit team will review the most up-to date position and legal advice and discuss the accounting treatment and presentation of such issues in the financial statements.	Work completed and no issues arising.
In 2016-17 we commented to management on several areas during the course of our audit work including: • current/non-current classification of clinical negligence provisions and Welsh Risk Pool debtors; and • remuneration report disclosures. Ministerial approval of contracts of over £1 million.	We will follow up on the recommendations made in our Financial Accounts Memorandum and the adjustments arising from the audit of the financial statements in 2016-17 as part of our 2017-18 audit work.	Work completed. My audit team identified material corrections in classification required to provisions and related Welsh Risk Pool debtors. These corrections were processed by management and did not affect the overall financial position of the Health Board.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Text phone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

Agenda item 6.1

AUDIT COMMITTEE: FORWARD PLAN 2019/20

MEETING DATE – 14 JANUARY 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)**	Director of Finance
• Board Assurance Framework (moved to April following discussion at Board Development)	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	Chair
• Review of the Committee Forward Work Plan	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 – 11 FEBRUARY 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
• Medical Variable Pay Financial Control Procedure	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

Other items for 2019

- **Post Payment Verification Year End Report to include comparable data from across Wales (April 2019)**
- **Research & Development Policy for Approval (April 2019)**
- **Board Assurance Framework (Following discussion at a Board Development Session (planned Feb 2019)**

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