Integrated Locality Groups (ILGs) review

Final Internal Audit Report

September 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Audit and Assurance Services

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Contents

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

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

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1. Introduction and Background

Our Integrated Locality Groups (ILGs) review was part of our 2020/21 programme of work but was delayed due to the pandemic. As such, this review forms part of our 2021/22 work for Cwm Taf Morgannwg University Health Board (the 'Health Board' or 'Organisation'). The review seeks to provide the Health Board with assurance that effective processes have been put in place to manage the risk associated with the set-up of the ILGs.

As a direct result of the April 2019 boundary change, which saw the incorporation of services on the Bridgend area combining with those in the former Cwm Taf Health Board area, there was a need for the service delivery structure to be amended and enhanced. Throughout 2019 a consultation took place to help shape and define what the operating model for the new organisation would look like, ensuring that any new structure had patients and communities at its heart.

In April 2020 the new operating model came into existence. This saw an Integrated Locality structure based around the three geographical areas of Merthyr Cynon, Rhondda Taf Ely and Bridgend. Each ILG comprises of a number of Clinical Service Groups (CSGs) and is responsible for delivering services in their local area. Each is managed by a senior team comprising of a Group Director, Operational Director and Nurse Director. Sitting alongside the geographical ILGs is the Primary Care service that operates in a similar way to an ILG. A governance framework has been established that allows levels of autonomy at an ILG level and ensures accountability up to the Board of the organisation.

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

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the set-up of the three ILGs and the Primary Care service. The review sought to provide assurance to the Health Board's Audit and Risk Committee that risk material to the system's objectives are managed appropriately. The areas that the review sought to provide assurance on are:

Within each ILG and Primary Care:

- An appropriate governance structure has been put in place and is operating effectively, with clear reporting lines that support the key functions of the ILG.
- Suitable arrangements are in place with support functions and their respective specialist business partners to provide appropriate support to the ILG.
- The ILG has a risk management process that ensures risks identified in Clinical Service Groups (CSGs) and other areas of the ILG are appropriately captured, monitored and reported.
- An appropriately agreed set of performance measures are in place for the ILG that consider Health Board wide targets and incorporate quality, outcome and resource targets.

- Performance targets are scrutinised and monitored and there are appropriate mechanisms in place to give assurances on the identified measures and targets, with escalation as necessary.
- There is clear accountability for managing quality governance within the ILGs.
- Earned autonomy - A process has been established and is being followed to allow ILGs to earn increased autonomy, and for this to be periodically reviewed.

At a Health Board level:

- The Health Board has a clear governance framework in place to ensure that ILGs operate to meet wider Health Board expectations. Oversight arrangements are in place that ILGs are operating within their remit and that where necessary consistency is applied.

3. Associated Risks

The risks considered in the review were as follows:

- ILGs are not properly governed which could result in services that are not delivered safely and efficiently.
- Risks materialise as they have not been identified, monitored or addressed.
- Quality issues arise within the ILG due to lack of scrutiny and accountability.
- Population and community needs are not met by the ILG.

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 the ILGs review 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 attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Overall, our review of the processes that have been implemented within the ILGs to oversee governance, risk management, performance and quality monitoring are of a reasonable standard.

The terms of references for the ILG Board meetings does not require any representation from the Health Board's Executive team. Management may wish to consider introducing this requirement as it would bring an independent view to the meeting and enable the ILG Board to be challenged on its business. At the current time, monitoring and reporting upwards take place during monthly performance meetings between the Interim Chief Operating Officer and ILG senior management teams.

The new operating model guidance refers to a process of earned autonomy where *'higher performing and mature functions have more freedom and are subject to less central control'*, it is not clear how this process is operating or is intended to operate.

Some enhancements to controls are required within some of the ILGs and these are detailed in the summaries below for each ILG:

Primary Care

The service area is still in the early stages of implementing its meeting structure to support its governance arrangements, and as such some groups within the structure are yet to take place. With regards to those meetings that have taken place, we found that the meetings were quorate, attendance appropriate, and meeting documentation was to a good standard. The management and oversight of quality, risk and performance was good. The area is undertaking a cleansing exercise of the risk register, but ongoing management of risks continues. Looking forward the service area plans to develop new quality and performance measures.

Rhondda Taf Ely ILG

The governance processes within the ILG are operating effectively. The ILG Board meets regularly and there are monthly Service Group Performance Review meetings with each of the CSGs, where a consistent approach is used to monitor performance and quality information. Regular meetings have taken place in line with terms of reference for Local Partnership Forum, Health, Safety & Fire and Quality, Safety Risk & Experience groups. Updates from these meetings are provided to the ILG Board and all meetings were quorate with appropriate attendance.

A team manages quality and safety issues who have issued a 'flowchart' for the management of risks withing the ILG. The cleansing exercise of the risks that have been assigned to the ILG is still ongoing. The format of risk information reported varied between CSGs, with some providing narrative information, others providing an extract from the Datix risk management system, some reporting risks scoring above 12, whereas others were reported risks scoring above 15. Management may want to consider standardising the risk updates provided by CSGs in order to have a consistent approach.

Merthyr Cynon ILG

Many of the ILG's meetings were not in accordance with the frequency set out in their terms of reference and where some meetings were paused due to the Covid-19 pandemic, they do not appear to have been reinstated as promptly as other ILGs. We note that membership of the ILG Board did not include representation from the CSGs, despite the terms of reference stating that ‘directorate managers’ form part of the group’s membership.

Performance measures, such as workforce metrics, financial targets, quality and patient safety data, should be monitored at the monthly Service Group Performance Review meetings held with each CSG. However, at the time of our fieldwork we understand that no meetings had taken place this financial year. Although aspects of this monitoring was seen to take place at the Quality, Safety & Patient Experience Committee, where each CSG provides an update report.

The Quality & Governance Team within the ILG oversees risk management and even though a risk cleansing exercise is still ongoing, risks are being actively managed with updates from the CSGs being provided to the ILG's Quality, Safety & Patient Experience Committee. With regards to the updates, we note that, as per the

Rhondda Taf Ely ILG, the format varied between CSGs and management may wish to consider standardising these updates.

Bridgend ILG

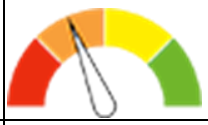
While senior ILG staff attend a number of key meetings on a regular basis, the ILG Board has not met since July 2020. The terms of reference for the ILG Board remain in draft and membership does not include representation from the CSGs unlike the other ILGs.

We note that good arrangements are in place for risk and quality monitoring. Updates on the ILG risk register are presented at the weekly senior leadership team meetings. Also, CSG level risk updates are presented to the Quality Safety & Experience meeting and the Health, Safety & Fire meeting. Work remains ongoing to cleanse the ILG risk register.

Performance monitoring takes place at the monthly Service Group Performance Review meetings with each of the CSGs where a set slide deck is used to ensure consistency.

5. Assurance Summary

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

Assurance Summary					
1	Governance structure and reporting lines			✓	
2	Business partner support				✓
3	Risk management processes				✓
4	Performance measures are in place				✓
5	Performance targets are scrutinised and monitored			✓	
6	Accountability for managing quality governance				✓
7	Earned autonomy process	✓			
8	Oversight arrangements at a Health Board level				✓

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

Design of Systems/Controls

The findings from our review have highlighted one issue that is classified as a weakness in the system control/design of the ILG arrangements.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for the ILG arrangements.

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: An appropriate governance structure has been put in place and is operating effectively, with clear reporting lines that the support the key functions of the ILG.

We note the following areas of good practice:

- Each ILG has an appropriate structure in place that sets out governance arrangements.
- There are Terms of References in place for all key meetings of each ILG.
- For the sample of ILG meetings that we reviewed all were quorate.

We identified the following findings:

- For some ILG group meetings the frequency of meetings was not in accordance with the terms of reference. (Finding 3 – Medium)
- Not all key staff were included on the membership list within the terms of reference for one of the ILG groups and in another instance, whilst staff were listed as being members of a group, they did not appear to attend the meeting. (Finding 4 – Medium)
- A number of terms of reference were overdue their annual review or remained in draft. (Finding 5 – Low)

Objective 2: Suitable arrangements are in place with support functions and their respective specialist business partners to provide appropriate support to the ILG.

We note the following areas of good practice:

- There are designated Business Partners in place in each ILG for Finance, Workforce, Planning and Therapies (where applicable). They attend key ILG meetings which include:
    - ILG Board meeting;
    - performance meetings with the Chief Operating Officer;
    - Clinical Service Group performance meetings; and
    - Senior Leadership Team meetings.
- At each ILG there are individual meetings between the Business Partners and the Director of Operations.

We did not identify any findings under this objective.

Objective 3: The ILG has a risk management process that ensures that risks identified in Clinical Service Groups and other areas of the ILG are appropriately captured, monitored and reported.

We note the following areas of good practice:

- Responsibility for risk management is assigned to the ILG's Quality, Safety & Risk groups.
- Hire scoring risks on ILG risk registers are reviewed by the Quality, Safety & Risk Group.
- At each ILG Quality, Safety & Risk Group meeting update reports are provided by the ILG Clinical Services Groups/Specialties on their specific risks.
- Risks relating to each CSG are reviewed at the monthly Service Group Performance review meetings.
- The Rhondda Taf Ely ILG has produced a flowchart that details the process to be followed for managing identified risks.
- Within the Bridgend ILG a Task and Finish Group has been set up to review all risks scored 9 and above.

We did not identify any findings under this objective.

Objective 4: An appropriately agreed set of performance measures are in place for the ILG that consider Health Board wide targets and incorporate quality, outcome and resource targets.

We note the following area of good practice:

- The current performance measures reported by each ILG are those that have been determined by the Health Board and Welsh Government.

We did not identify any findings under this objective.

Objective 5: Performance targets are scrutinised and monitored and there are appropriate mechanisms in place to give assurances on the identified measures and targets, with escalation as necessary.

We note the following areas of good practice:

- The performance measures for the ILG are reviewed and discussed at the monthly performance meeting with the Interim Chief Operating Officer. The slide packs that are presented at these meetings include the following performance measures:
    - Patient Activity;
    - Quality;
    - Finance; and
    - Workforce.

  These measures are also reported more locally at the Service Group Performance Review meetings within CSGs.
- Action logs are maintained and reviewed at each CSG performance meeting.

We identified the following finding:

- No Clinical Services Group performance meetings have taken place to date this financial year within the Merthyr Cynon ILG. (Finding 2 – Medium)

Objective 6: There is clear accountability for managing quality governance within the ILGs.

We note the following areas of good practice:

- The ILGs have a governance structure in place for overseeing and managing quality that covers incidents, concerns, risk and health & safety. Specific responsibility for quality is assigned to the Quality, Safety Risk & Experience groups that are in place within each of the ILGs.
- Updates regarding quality are provided as part of the Clinical Service Group update report at the ILG's Quality, Safety, Risk & Experience Group meetings.
- Quality features within the slide pack for both the Performance Meetings with the Interim Chief Operating Officer as well as the Clinical Service Group performance meetings.
- Updates on ILG quality governance is reported to the Health Board's Quality & Safety Committee.

We did not identify any findings under this objective.

Objective 7: Earned Autonomy - A process has been established and is being followed to allow ILGs to earn increased autonomy, and for this to be periodically approved.

We identified the following finding under this objective:

- We were unable to evidence any process in place for increasing the level of earned autonomy for the ILGs. (Finding 1 – Medium)

Objective 8: The Health Board has clear governance framework in place to ensure that ILGs operate to meet wider Health Board expectations. Oversight arrangements are in place to ensure that ILGs are operating within their remit and that where necessary consistency is applied.

We note the following areas of good practice:

- A monthly performance review meeting takes place between each ILG and the Health Board's Interim Chief Operating Officer. Attendees at the meeting include key senior management of the ILG and there is an open invitation for other Executive Directors of the Health Board to attend if they so wish.

  There is standard slide pack for each meeting with information populated by the Health Board's performance department and then issued to the ILG to add narrative ahead of the meeting. Information reported in the slide pack includes:

  - Quality & Safety;
  - Concerns;
  - Workforce;
  - Finance;

- Performance; and
- IMTP priorities.

After each meeting a record of actions agreed / identified is produced.

We did not identify any findings under this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	High	Medium	Low	Total
Number of recommendations	0	4	1	5

Appendix A: Management Action Plan

Finding 1 - Earned Autonomy (Control design)	Risk
The Health Board's April 2020 Operating Model makes reference to 'earned autonomy', stating that '*higher performing and mature functions will have more freedom and are subject to less central control'*. During our fieldwork, we have not been able to determine if any guidance has been issued to ILGs about the process of 'earned autonomy'. It is unclear if there is any form of framework in place to allow this process to happen.	Integrated Locality Groups could be operating outside their agreed level of autonomy.
Recommendation	**Priority level**
Management should ensure that the term 'earned autonomy' is clarified for the ILGs. A framework that sets out the purpose and value of earned autonomy and the process for increasing the level of autonomy should be created, approved, communicated and implemented in line with the Operating Model.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Executive Team and ILGs recognise this as a key issue. A piece of work has already commenced, being led by the CEO's Chief of Staff to review the operating model that was implemented intra-Covid. This review was always planned as part of the implementation of the new model and following the re-introduction of normalised ways of working post-Covid, that review has now started. This will specifically include consideration of the roles & responsibilities of the ILGs and individual roles within those, along with a review of the framework for earned autonomy and delegation of decision rights to ILGs	UHB Chief of Staff Q4 2021/22

Finding 2 - Performance Monitoring - Merthyr Cynon ILG (Operating effectiveness)	Risk
Each ILG has a number of Clinical Service Groups (CSGs). As part of the ILGs governance arrangements, each month there should be a Service Group Performance Review meeting between each CSG and ILG management. These meetings are used to monitor the performance of the CSG in areas including service delivery, workforce metrics, risk, financial data and patient safety and quality information. During our fieldwork we were informed that within the Merthyr Cynon ILG no Service Group Performance Review meetings have taken place so far this financial year. We have been advised that the meetings are due to resume in July 2021	Performance issues concerning the Clinical Service Groups are not being identified and monitored.
Recommendation	**Priority level**
<u>Merthyr Cynon ILG</u> Management should ensure that the Service Group Performance Review meetings for each CSG take place on a regular basis. Appropriate records should be retained for each meeting so that actions identified are recorded, monitored and escalated as required.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Clinical Service Group performance reviews re-started following the draft findings of the Internal Audit in 2021/22. With the third Covid surge, significant pressure has been placed on leadership capacity which places these at risk. The Chief Operating Officer will specifically include review of CSG Performance Reviews as part of the ILG level performance reviews.	Chief Operating Officer

Finding 3 - Meeting Frequency (Operating effectiveness)	Risk
Each ILG and Primary Care should have a governance structure in place with a series of key groups and committees that report into the ILG or Primary Care Board. Groups include Health, Safety and Fire, Quality and Safety, Service Group Performance Review and Local Partnership Forums. We reviewed a sample of key ILG and Primary Care meetings to ensure that meetings were taking place in line with the frequency set out in their terms of reference. We found that: <u>Primary Care</u> • Health & Safety – draft ToR states quarterly meetings. No meetings have been held to date, though we were advised they will start in July 2021. <u>Merthyr Cynon ILG</u> • Quality, Safety & Experience - frequency should be bi-monthly, but no meetings were held between October 2020 and February 2021. • Local Partnership Forum - frequency should be quarterly. A meeting was held September 2020, but the next meeting was not scheduled to be held until March 2021. • Health & Safety - frequency should be quarterly but no meetings have been held since November 2020, though were advised that will be resuming July 2021. <u>Bridgend ILG</u> • ILG Board - frequency should be a minimum of quarterly yet no meeting has taken place since July 2020. We acknowledge that whilst no ILG Board meeting has taken place, there have been fortnightly 'Bronze' meetings with updates discussed from all areas of the ILG, though it would appear that not everyone who should attend an ILG Board is present in the Bronze meetings, for example CSG Managers do not attend. We recognise that due to the Covid-19 pandemic some of the above meetings may have stood down, but with the easing of pressures as the year has progressed, we would have expected meetings to have resumed from April onwards.	ILG's are not properly governed which could result in services that are not delivered safely or effectively.

Recommendation	Priority level
Primary Care, Merthyr Cynon and Bridgend ILGs Management should ensure that all meetings are scheduled and take place in accordance with the terms of reference for that committee or group. If the previously agreed meeting frequency is no longer suitable, then the terms of reference should be amended accordingly and reapproved.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Governance meeting occurrence and regularity has been reviewed with the ILGs as a result of the issue of the draft Internal Audit. A number of key actions have taken place: • **Primary Care** and **Merthyr Cynon ILG** have confirmed that the meetings have re-commenced since the initial audit was carried out. Management capacity within MC ILG remains a risk and specific reporting of meeting occurrence and attendance will be sought through the ILG PR process. • **Bridgend ILG** – the ILG found that meeting as a 'Board' was duplicating other meetings. Following discussion with the COO and other ILG colleagues there will be a second look at the terms of reference to make the meeting more useful in terms of providing a forum for approval of policies and assurance. This will also review whether the role of the Board could be aligned with the ILG Performance Review.	Chief Operating Officer. Monthly from October 2021
The Chief Operating Officer has also requested that the role of the ILG Board is included within the specification of the Chief of Staff review into the ILG Operating Model with recommendations on its future role to be made as part of that specific piece of work.	Chief of Staff. Q4 2021/22

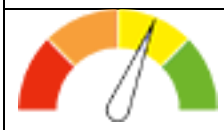
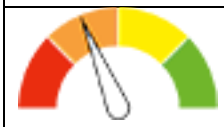
Finding 4 – Meeting Membership (Operating effectiveness)	Risk
Our review of the terms of reference and minutes for key meetings for each ILG identified the following points in relation to meeting membership and quoracy: <u>Merthyr Cynon ILG</u> • ILG Board - the membership section of the terms of reference states Clinical Directors and Directorate Managers (now CSG Managers) should attend the meeting. However, we note a lack of representation from Clinical Services Group Managers. • Local Partnership Forum - the meeting notes did not include the job titles of the people that attended so it was not possible to determine if the meeting was quorate. <u>Bridgend ILG</u> • ILG Board - the terms of reference remain in a draft format and membership does not include representation from the CSG managers. Whilst each ILG can apply discretion as to who should attend meetings, we note that the other ILGs include CSG Managers as part of the Board membership as this appears to be the main forum where all parties can meet. <u>All ILGs and Primary Care</u> We note that there is no Health Board Executive membership at the ILG or Primary Care Board meetings to provide independent challenge. Whilst separate performance meetings with the Chief Operating Officer take place on a monthly basis, these do not include wider representation from the ILG, such as the CSG managers.	ILGs are not properly governed which could result in services that are not delivered safely and efficiently.
Recommendation	**Priority level**
<u>Merthyr Cynon and Bridgend ILGs</u> Management should ensure that the terms of reference for the key groups are reviewed to ensure that membership requirements are appropriate and reflect the current governance structure. Management should also ensure that where notes/minutes of meetings are maintained they reflect the names and job titles of all attendees where appropriate.	**Medium**

<u>All ILGs and Primary Care</u> Consideration should be given to expanding the membership of the ILG and Primary Care Board meetings to include a Health Board Executive in order for independent challenge to be provided.	
Management Response	**Responsible Officer/ Deadline**
For Merthyr Cynon and Bridgend ILGs, the terms of reference will be updated and the names and titles of attendees recorded correctly. For all ILGs and Primary Care Board Meetings – an Executive will be asked to attend each ILG / PC meeting. Since the Internal Audit review has taken place, the role of the ILG Performance Reviews has also expanded and specifically includes a broader range of executives to ensure a shared understanding and robust challenge between executive and ILG leadership.	ILG Group Directors Q3 2021/22 ILG Group Directors Q3 2021/22 Chief Operating Officer, completed

Finding 5 - Terms of Reference Review Dates (Operating effectiveness)	Risk
We reviewed a sample of terms of references for ILG meetings. We found: <u>Primary Care</u> • Health & Safety Group – the terms of reference are in draft. <u>Merthyr Cynon ILG</u> • ILG Board Meeting - review due March 2021 • Quality, Safety & Experience - review due June 2021 • Local Partnership Forum - review due June 2021 • Health & Safety - review due June 2021 • Service Planning Group - review due June 2021 <u>Bridgend ILG</u> • ILG Board - terms of reference are in draft. • Quality, Safety & Experience - review due June 2021 • Health, Safety & Fire - review due June 2021 • Local Partnership Forum – the terms of reference are generic and need to be updated to reflect the ILG requirements. We acknowledge that many of the terms of reference have passed their review date in recent months and management should use the review process to consider the other findings raised in our report.	ILGs are not properly governed which could result in services that are not delivered safely and efficiently.
Recommendation	**Priority level**
<u>Primary Care, Merthyr Cynon and Bridgend ILGs</u> Management should ensure that all terms of references are reviewed, updated where applicable and then appropriately formally finalised.	**Low**
Management Response	**Responsible Officer/ Deadline**
Primary Care, Merthyr Cynon and Bridgend ILGs – all terms of references will be reviewed and then formally finalised.	ILG Group Director Q3, 2021/22December 2021

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 in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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.