A meeting of the Aneurin Bevan University Health Board Audit Committee will be held on Thursday 17th January 2019, commencing at 1:30pm in Conference Room 1 & 2, Conference Centre, Health Board Headquarters, St Cadoc's Hospital, Caerleon

AGENDA

1	**Private Discussions – 1:30pm**			
	1.1	**Committee members to have private discussions with Counter Fraud**	Verbal	**Committee Members and Counter Fraud**
2	**Preliminary Matters - 2:00pm**			
	2.1	**Apologies for Absence**	Verbal	**Chair**
	2.2	**Declarations of Interest**	Verbal	**Chair**
	2.3	**Draft Minutes of the Meeting held on** • **11th October 2018**	Attachment	**Chair**
	2.4	**Action Sheet** **For consideration**	Attachment	**Chair**
3	**Counter Fraud**			
	3.1	**Counter Fraud Progress Report**	Attachment	**Head of Counter Fraud**
4	**Clinical Audit**			
	4.1	**Clinical Audit Update**	Attachment	**Assistant Director Quality and Patient Safety/Assistant Medical Director**
5	**External Audit**			
	5.1	**WAO Progress Update**	Attachment	**Wales Audit Office**
	5.2	**GP Out of Hours/Primary Care Services**	Attachment	**Director of Primary Care, Community and Mental Health**
	5.3	**Estates Review Report**	Attachment	**Head of Estates (Maintenance and Operations)**
6	**NWSSP Audit & Assurance - Internal Audit & Specialist Service Unit**			
	6.1	**Internal Audit Progress Report**	Attachment	**Head of Internal Audit**

	6.2	**IT Service Management Limited Assurance Internal Audit – Follow Up Report Update**	Attachment	**Director of Planning, Digital and IT**
	6.3	**Interim Head of Internal Audit Opinion Update**	Verbal	**Head of Internal Audit**
	6.4	**Patient Discharge Process Internal Audit Final Report and Management Response Limited Assurance Report**	Attachment	**Director of Operations**
7	**Governance and Assurance**			
	7.1	**Update on Governance, Financial Control Procedures and Technical Accounting Issues**	Attachment	**Assistant Director (Corporate Finance)/ Board Secretary**
	7.2	**Losses and Special Payments Report**	Attachment	**Assistant Director (Corporate Finance)**
	7.3	**Risk Management Review and Assurance Framework Development Report**	Attachment	**Board Secretary**
	7.4	**Audit Recommendation Tracker Report**	Attachment	**Board Secretary**
	7.5	**Draft Committee Work Programme for 2019**	Attachment	**Director of Finance/ Board Secretary**
8	**Date of Next Meeting**			
	Wednesday 3rd April 2019 at 1:30pm in the Executive Meeting Room, St Cadoc's Hospital, Caerleon			**Chair**
	Supplementary Papers Reasonable Assurance Internal Audit Reports submitted this period: • Divisional Review – Facilities • Budgetary Control			

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Aneurin Bevan University Health Board

Minutes of the Audit Committee held on Thursday 11th October 2018, in the Executive Meeting Room, Headquarters, St Cadoc's

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Present:

Catherine Brown	-	Chair, Independent Member (Finance)
Shelley Bosson	-	Independent Member (Community)
Katija Dew	-	Independent Member (Third Sector)

In Attendance:

Ann Lloyd	-	Chair, Aneurin Bevan University Health
Kay Barrow	-	Acting Head of Corporate Governance (Secretariat)
Richard Bevan	-	Board Secretary
Glyn Jones	-	Director of Finance
Andrew Naylor	-	Assistant Director of Finance, Corporate Finance
James Quance	-	Head of Internal Audit, NWSSP
Stephen Chaney	-	Deputy Head of Internal Audit, NWSSP
Terry Lewis	-	Wales Audit Office
Dave Wilson	-	Wales Audit Office

In Attendance for Specific Items:

Dr Mererid Bowley	-	Consultant in Public Health
Richard Pryce	-	Directorate Manager (Primary Care & Community)

Apologies:

Martyn Edwards	-	Head of Counter Fraud
Simon Cookson	-	Director of Audit & Assurance, NWSSP
Judith Paget	-	Chief Executive
Dr Paul Buss	-	Medical Director
Bronagh Scott	-	Director of Nursing
Geraint Evans	-	Director of Workforce and OD
Dr Sarah Aitken	-	Director of Public Health
Claire Birchall	-	Interim Director of Operations
Peter Carr	-	Deputy Director of Therapies and Health Science
Nicola Prygodzicz	-	Director of Planning and Performance

Audit 1110/01 Welcome and Introductions

The Chair welcomed members to the meeting and thanked all members for their attendance.

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The Chair commented that this was Andrew Naylor's last meeting and thanked him for the significant contribution he had made to the Committee. The Committee wished Andrew Naylor well with his future endeavours.

Audit 1110/02 Apologies for Absence

Apologies for absence were noted.

Audit 1110/03 Declarations of Interest

There were no declarations of interest to note.

Audit 1110/04 Minutes of Previous Meeting

The minutes of the meetings held on 20th July 2018 were agreed as a true and accurate record of the meeting.

Matters Arising:
Audit 2007/10 Estates Assurance (Fire Safety) – Limited Assurance
Following the update received at the last meeting, the Chair questioned whether the Health and Safety Department staffing levels were now at full capacity, as had been anticipated by the Head of Health and Safety. The Board Secretary agreed to check the status in relation to the staffing resource and for an update to be appended to the minutes. **Action: Board Secretary**

Audit 1110/05 Action Log

The actions were noted and it was acknowledged that all actions were either on the agenda or scheduled for a future meeting. However, the following points were noted:

- **Audit 2007/01 Agenda and Papers**
  The Chair raised a concern that despite the efforts and assurances of all involved, Committee papers had been issued on Friday afternoon for a meeting on the following Thursday, leaving 3 clear working days, 5 days including the weekend, for committee members to read them before the meeting. The secretariat reported that this was due to the late receipt of reports by them and said that they would continue to work with the executive to improve the timeliness of management responses so that

papers could be sent out in a timely fashion in future. **ACTION: Secretariat**

- **Audit 2007/10 Estates Assurance (Fire Safety)**
  The Committee raised concerns in relation to the update provided about fire safety training compliance as this was a high risk area. It was agreed that further improvement was required and asked that an assurance report be brought back to a future meeting of the Committee. **Action: Secretariat**

- **Audit 2007/11 Staff Performance Management and Appraisals**
  The Chair of the Board asked that an assurance report on the quality of the appraisal process be brought back to a future Board meeting. **Action: Secretariat**

- **Audit 2007/12 WAST Internal Audit Report**
  It was noted that the Interim Director of Operations was drafting a response on behalf of the Health Board for the Chief Executive to sign off. The final response will be shared with Committee members. **Action: Board Secretary**

- **Audit 2007/16 Review of Corporate Governance Processes**
  James Quance informed the Committee that he had spoken to the Chief Executive in relation to the Audit Committee's request to undertake a review of Corporate Governance processes. He explained that he would await the outcome of the WAO Structured Assessment to ensure that the audit focussed on the right areas.

Audit 1110/06 **Wales Audit Office (WAO) Progress Update**

The Committee received and noted the WAO progress report which provided an update on current and planned WAO financial and performance audit work.

The Health Board Chair raised concerns in relation to the Integrated Care Fund (ICF) review and the governance arrangements for the Greater Gwent Regional Partnership Board (RPB). She explained that the RPB was not a decision-making body but nonetheless was approving ICF expenditure. Dave Wilson advised that governance and accountability was an area included as part of the audit

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terms of reference and would feature as part of the findings in the final reporting.

The Committee noted that the Health Board's Structured Assessment was almost complete. Following internal quality assurance and challenge on the findings, they would be reporting their findings and evidence based feedback to the Executive Team in early November 2018 and to the Board at its Briefing Session in December 2018.

The Committee noted the information provided in relation to the Good Practice Exchange and the publication of national value for money reports with relevance to the NHS in Wales.

Audit 1110/07 **Update on the Public Health Wales Report**

The Chair welcomed Dr Mererid Bowley, Consultant in Public Health.

Dr Bowley provided an update in relation to the progress that has been made by Public Health Wales (PHW), Local Health Board Executive Directors of Public Health (DsPH) and Welsh Government (WG) in respect of the actions arising from the WAO review of the governance and accountability arrangements between PHW and Local Public Health Teams (LPHT).

The Committee noted the substantial progress that had been made on the collaborative delivery of the actions. It was highlighted that the review had been a useful process for shared thinking and reaching congruence on how the whole system could work to achieve maximum health gains for the public. It had also assisted in improving accountability for the local public health resource however, there was a need for sustainable structures and processes to be in place, and a joint commitment to maintain these new ways of working.

Concerns were raised in relation to the response to the staff survey feedback asking for better communication between national and local teams. The Committee asked that their view be fed back to the Public Health Joint Leadership Team that something should be done to address the issue raised by staff, and ensure that information is regularly shared so that local staff feel that they know what is happening at national level. **ACTION: Consultant in Public Health**

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It was highlighted that PHW and Health Boards have worked in partnership to clarify and optimise accountability and reporting arrangements in relation to the management of LPHTs.

The Committee were informed that in collaboration with DsPH, PHW continues to work to improve the existing mechanism for effective communication, engagement and knowledge sharing across the public health system.

Following discussion, it was suggested that the Public Service Boards needed to be kept informed and involved due to their statutory responsibilities in relation to the well-being of their local population. **Action: Consultant in Public Health**

The Committee noted the report and thanked Dr Bowley for attending.

Ann Lloyd left the meeting.

Audit 1110/08 GP Out of Hours/Primary Care Services

The Committee received the WAO national GP out-of-hours services report which was the second in the suite of work on primary care services in Wales and describes each Health Board's progress in delivering the national primary care plan.

Dave Wilson advised that the majority of the field work was concluded at least 12 months ago, but that Welsh Government recognises the OOH service is still fragile.

The Committee noted the Public Accounts Committee has received the report and a decision was awaited as to whether an evidence meeting will be called.

The Chair welcomed Richard Pryce, Directorate Manager for Primary Care and Community who explained that he had taken responsibility for this area a few weeks previously.

The Committee was reminded that the local audit had taken place in 2017 and had been presented to the Audit Committee in July 2017.

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The Committee were informed that a newly appointed Clinical Director for OOHs was making positive steps in terms of management and leadership, and in addressing staff morale. A Communication Strategy had also been developed to address the concerns raised in the report and progress was also reported in relation to engagement with the GP workforce to address the issues related to rota shift gaps. The Clinical Director had also successfully recruited into the OOHs service and this had resulted in a much improved shift fill rate however, there were still pressures around weekends but there are plans in place to mitigate those risks. It was noted that the OOHs service had close links with the 111 team and, in particular, around the implementation and roll-out of 111 which was anticipated to 'go live' in quarter 4. Richard Pryce informed the Committee that the GP OOHs would be undergoing a Peer Review by Welsh Government on 8th November 2018.

The Chair raised concerns about the level of progress since July 2017 and explained that the Committee could not feel assured on the basis of the updated management response that appropriate progress was being made.

It was agreed that a status report would be provided for the next meeting updating on progress with implementing the recommendations and that either Sian Millar, Divisional Director or Dr Sarah Aitken, Executive Director Lead for Primary Care would asked to attend the next Committee meeting. **Action: Directorate Manager (Primary Care and Community)/Secretariat**

Dave Wilson left the meeting

Audit 1110/09 Internal Audit Progress Report

James Quance provided an overview of the Internal Audit Progress Report highlighting the completion of reporting to the Audit Committee in respect of the 2017/18 Internal Audit Plan and progress against the 2018/19 Internal Audit Plan to date.

The Committee noted that the following audits had been completed since the last report which had received Reasonable Assurance:

- Annual Quality Statement;
- Unscheduled Care Wards Follow-up

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- Royal Gwent Hospital Wards
- Nevill Hall Hospital Wards
- Management of Balance Sheet Assets
- Digitisation of Medical Records

In relation to the Management of Balance Sheet Assets, concerns were raised regarding the fixed assets limited assurance element.

Concerns were raised in relation to the high priority audit recommendation that the Health Board progress the introduction of tagging or identity marking of all relevant assets in order to facilitate the identification and traceability of assets against the asset register. Medical equipment above the £5k threshold were captured by EBME however, this was not the case for lower value asset items. It was highlighted that the Health Board was exploring the option of linking in with the EBME asset tagging process/system for medical equipment however, the task of identifying and tagging all items below £5k across the Health Board would be significantly onerous and time consuming. It was noted that a business case was in development. It was agreed that this recommendation should be added to the audit tracker. **Action: Board Secretary**

The Committee also raised concerns around internal control mechanisms relating to drugs and, in particular, petty cash. It was highlighted that the majority of the petty cash issues related to small amounts within the Mental Health and Learning Disabilities Division. It was acknowledged that further work was required with the Mental Health and Learning Disabilities General Manager to ensure the appropriate scrutiny of claims, while not having a negative impact on clients and their care.

The Committee acknowledged the significant progress made in relation to the Unscheduled Care Wards Follow-up audit and the NHH and RGH Ward reviews which had increased the level of assurance to that of reasonable. This was as a result of the effective management of the actions across all high priority areas and a framework to enable compliance to be monitored more effectively going forward. It was agreed that the thanks of the Committee would be passed to the Unscheduled Care Divisional Nurse and Director of Nursing for their hard work in ensuring that the actions to address the recommendations had been undertaken. Richard Bevan

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agreed to draft on behalf of the Chair. **Action: Board Secretary**

Concerns were raised about the partial agreement in relation to 'aged debts'. It was highlighted any disagreements or partial disagreements with recommendations need to specify whether management are accepting the residual risk or have put in place alternative measures to mitigate it, in which case they should be specified. The Committee noted the additional audit activity undertaken with the Board Secretary in the development of the Board Assurance Framework, and follow up work with the Assistant Directors of Workforce as part of the Staff Performance Management and Appraisals (PADR) audit.

James Quance explained that the KPI for management responses was currently showing as red, with only three of the eight reports receiving satisfactory management responses within the timescales agreed. Internal Audit will continue to work with Executive Leads and the Board Secretary to ensure that management responses are both timely and appropriately address the recommendations.

Audit 1110/10 **IT Service Management Limited Assurance Internal Audit – Follow Up Report**

This item was removed from the agenda for the second time in order to allow the Director of Planning and Performance to attend. It was noted that all Executive Directors had the Committee meetings in their diaries however, on this occasion the Director of Planning and Performance had sent her apologies as she had other priority meeting commitments and had asked the Assistant Director of Informatics to attend. Unfortunately, the meeting clashed with an NHS Wales Informatics Services meeting and he was unable to attend. The Chair did not think that it was appropriate for Matthew Mahoney, Head of ICT to attend in their stead as the Committee had specifically requested Director level engagement with this important Limited Assurance report, given the problems they had identified with the management responses to the report. This item was therefore deferred to the next meeting. **Action: Secretariat**

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Audit 1110/11 **Update on Governance, Financial Control Procedures and Technical Accounting Issues**

The Committee received and noted the report

The Committee noted that the number of outstanding debts that were deemed irrecoverable, were in line with the Health Board's debt recovery process as set out in the Accounts Receivable Financial Control Procedure and had been subject to the detailed debt collection procedures. The Finance Department was commended for its robust implementation of the Accounts Receivable Financial Control Procedure. The Committee approved the write off of 110 invoices with a total value of £67k.

The Committee received the Post Payment Verification (PPV) update for the period April to September 2018 and noted that the Primary Care Division's Senior Management Team receive PPV reports on a regular basis in order to review the performance of primary care practices. It has previously been agreed that the Committee will receive a PPV Annual Report for consideration and discussion at strategic level and only be updated in the interim on a by exception basis. **Action: Assistant Director of Finance (Corporate)**

The Committee received the report and approved the reporting framework for future meetings. **Action: Assistant Director of Finance (Corporate)**

Audit 1110/12 **Update on Board Assurance Framework and Sources of Assurance Mapping**

The Committee received the update which provided an overview of the work being undertaken on the development of a Board Assurance Framework aligned to the Integrated Medium Term Plan and, also the work on the development of a new Risk Management System for the Health Board.

It was highlighted that the assessment of risk was being undertaken in tandem with a review of the risk management landscape aligned to the Well-being of Future Generation Act.

Richard Bevan advised that the sources of assurance mapping would be completed by the end of October with

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further engagement with the Board at its November meeting. However, the Committee raised concerns in relation to the delivery timeframe for the work. Richard Bevan assured the Committee in relation to the level of progress that has been made to date and agreed that an update on the risk management landscape work would be provided at the next Committee meeting. **Action: Board Secretary**

Given that inadequacies in risk management and assurance mapping had been commented on at year end by Internal Audit, and a need for pressing action identified, The Committee raised concerns in relation to how this may affect the end of year Audit Opinion if significant progress was not rapidly made. It was highlighted that the overall opinion was formed by summarising audit outcomes across a number of key assurance domains in relation to the arrangements to secure governance, risk management and internal control. Terry Lewis highlighted that the Head of Internal Audit Opinion would also be included in the WAO audit of accounts letter. While the direction of travel outlined by the Board Secretary was unimpeachable, the pace of implementation was of significant concern and there was real anxiety about whether the promised completion date of the end of the year would be achieved. Richard Bevan agreed to raise his concerns with the Chief Executive outside of the meeting. **Action: Board Secretary**

The following comments were made in relation to the framework:

- Appendix B – Risk Appetite: Level 5 – the impact of service user should not be at the end.
- Table 1 – Key Business Drivers – Patient Safety - in the context of prudent healthcare and co-production, the expression of the patient safety priority needs to be considered in light of patient choice and quality of life considerations.

The Committee agreed to send any further comments/feedback on the framework to Richard Bevan. **Action: Committee Members and Officers**

Audit 1110/13 Losses and Special Payments Report

The Committee received and noted the report.

Audit 1110/14 **Wales Audit Office (WAO) and Internal Audit High Level Tracker**

The Committee received the tracker and it was highlighted that the Chief Executive had made contact with each of the leads for each of the recommendations and had requested a resolution with one month. It was agreed that a proposal was required from the Executive Team for each red area in relation to the materiality of the risk and its disposal for consideration and discussion at the next Committee meeting. **Action: Board Secretary**

Richard Bevan informed the Committee that an audit tracker tool/system 'Team Mate' was being implemented across Wales which would make the tracking and Audit Committee interaction much easier.

It was noted that the Executive Team would discuss the Tracker in November/early December 2018 and would provide a brief for the Committee Chair following the Executive Team review. **Action: Board Secretary**

Audit 1110/15 **Date of Next Meeting**

The Committee noted that the schedule of Board and Committee meetings was being finalised. It was agreed that, as a number of items had been deferred to the next meeting, it was agreed that the first meeting of the Committee would be scheduled in January 2019. **Action: Secretariat**

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Audit Committee
17th January 2019
Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Audit Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Audit Committee these actions will be taken off the rolling action sheet.)

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 2007/01	**Audit 2007/01 Agenda and Papers** The issuing of the agenda and papers to be at least 7 days prior to the meeting	**Secretariat**	Ongoing	Noted the secretariat will always seek to issue papers 7 days in advance to meet organisational standards.
Audit 2007/10	**Estates Assurance (Fire Safety)** The Board Secretary agreed to check the status in relation to the staffing resource and for an update to be appended to the minutes.	**Board Secretary**	Completed	The Head of Health and Safety has confirmed that the Corporate Health and Safety Department re-structure was implemented on 1st October 2018 following a staff consultation process.
	An assurance report be brought back to a future meeting of the Committee.	**Secretariat**	July 2019	An assurance report has been added to the Committee work programme for the July meeting.
Audit 2007/11	**Staff Performance Management and Appraisals** The Chair of the Board asked that an assurance report on the quality of the appraisal process be brought back to a future Board meeting	**Deputy Director of Workforce & OD**	April 2019	An assurance report on the quality of the appraisal process to be presented at the April 2019 Audit Committee meeting.
Audit 2007/12	**WAST Internal Audit Report** The Interim Director of Operations was drafting a response on behalf of the Health Board for the Chief	**Board Secretary**	Completed	A response was prepared and submitted. This will be circulated to the Audit Committee for information

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Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	Executive to sign off. The final response will be shared with Committee members.			
Audit 1110/07	**Update on the Public Health Wales Report** The Committee asked that their views be fed back to the Public Health Joint Leadership Team that something should be done to address the issue raised by staff, and ensure that information is regularly shared so that local staff feel that they know what is happening at national level.	**Consultant in Public Health**	Completed	The views of the Committee have been shared with the Public Health Joint Leadership Team.
	The Public Service Boards need to be kept informed and involved due to their statutory responsibilities in relation to the well-being of their local population.	**Consultant in Public Health**	Completed	The Director of Public Health will ensure that Public Service Boards are kept informed and involved in relation to population well-being.
Audit 1110/08	**GP Out of Hours/Primary Care Services** A status report would be provided for the next meeting updating on progress with implementing the recommendations and that either Sian Millar, Divisional Director or Executive Director Lead for Primary Care would asked to attend the next Committee meeting.	**Directorate Manager (Primary Care/Community)**	January 2019	The Director of Primary Care, Community and Mental Health confirmed to be attending the January Committee to give assurance on key issues.

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Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1110/09	**Internal Audit Progress Report** Tagging all items below £5k across the Health Board would be significantly onerous and time consuming. It was noted that a business case was in development. It was agreed that this recommendation should be added to the audit tracker.	**Board Secretary**	January 2019	The high level recommendation relating to fixed asset tagging has been added to the tracker.
	It was agreed that the thanks of the Committee would be passed to the Unscheduled Care Divisional Nurse and Director of Nursing for their hard work in ensuring that the actions to address the recommendations had been undertaken. Richard Bevan agreed to draft on behalf of the Chair.	**Board Secretary**	Completed	The thanks of the Audit Committee were sent to the Director of Nursing who agreed to communicate these to the Divisional Nurses.
Audit 1110/10	**IT Service Management Limited Assurance Internal Audit – Follow up Report** The Committee had specifically requested Director level engagement with this important Limited Assurance report, given the problems they had identified with the management responses to the report. This item was therefore deferred to the next meeting.	**Secretariat**	January 2019	Director of Planning, Digital and IT confirmed to be attending the January Committee to provide an update on the report.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1110/11	**Update on Governance, Financial Control Procedures and Technical Accounting Issues** It had previously been agreed that the Committee will receive a PPV Annual Report for consideration and discussion at strategic level and only be updated in the interim on a by exception basis.	**Assistant Director of Finance (Corporate)**	Completed	Noted on the Committee forward work programme.
	The Committee received the report and approved the reporting framework for future meetings.	**Assistant Director of Finance (Corporate)**	Completed	Action noted for future reporting.
Audit 1110/12	**Update on Board Assurance Framework and Sources of Assurance Mapping** An update on progress to be presented at the next meeting.	**Board Secretary**	January 2019	Update on the Committee agenda for the January meeting.
	The Board Secretary to raise the concerns of the Committee around the pace of the risk management and assurance mapping work with the Chief Executive.	**Board Secretary**	Completed	The Board Secretary has discussed this with the Chief Executive and brought the concerns of the Committee to her attention.
	Comments/feedback on the framework to be sent to Richard Bevan.	**Committee Members and Officers**	Completed	Comments received have been considered and incorporated into the Framework as appropriate.
Audit 1110/14	**WAO and Internal Audit High Level Tracker** It was agreed that a proposal was required from the Executive Team for	**Board Secretary**	January 2019	Update on the Committee agenda for the January meeting.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	each red area in relation to the materiality of the risk and its disposal for consideration and discussion at the next Committee meeting.			
Audit 1110/15	**Date of Next Meeting** Schedule of Meetings for 2019 to be finalised with a meeting in January 2019.	**Secretariat**	Completed	Completed

	Audit Committee 17th January 2019 Agenda Item: 3.1

Aneurin Bevan University Health Board

Counter Fraud Update Report

Executive Summary

An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It highlights the Counter Fraud work conducted by the Local Counter Fraud Specialist (LCFS) in accordance with the National Assembly for Wales Directions to NHS Bodies on Counter Fraud Measures (WHC (2005) 095) under the provisions of the National Health Service Act 1977. This work is also undertaken in compliance with the anti-fraud bribery and corruption measures under the Minister for Health and Social Service Directions and the service agreement between NHS Protect under S.83 of the Government of Wales Act 2006. This document summarises the work carried out by the LCFS to date during the financial year 2018/19 and incorporates outcomes and learning under standards for fraud, bribery and corruption.

The Audit Committee is requested to receive this report for their information and to discuss and provide views. The LCFS has kept up to date on professional development, legislation and working practices through attendance at various training sessions and will continue to maintain those core professional skills.

The Audit Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	√
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance and Performance

Report Author: Martyn Edwards, Head of Counter Fraud

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report:

Supplementary Papers Attached:
Appendix 1 - Index of LCFS Investigations as at 4th January 2019

Background and Context

In 1998 the NHS Counter Fraud Service (NHS CFS) was created as part of the Department of Health. The NHS CFS evolved into NHS Counter Fraud and Security Management

Service (NHS CFSMS) and subsequently NHS Protect – an executive agency of the NHS Business Services Authority.

In July 2001, the National Assembly for Wales directed that all Health Bodies in Wales must nominate at least one person as a Local Counter Fraud Specialist (LCFS) to tackle Fraud within the NHS.

Each NHS Health Body was issued with an NHS Anti-Fraud Manual. The Director of Finance (DoF) and the LCFS have access to the manual. In September 2001, the Assembly published their Fraud Strategy entitled, "Countering Fraud in the NHS in Wales". The strategy aims are:

- To reduce fraud to an absolute minimum
- To hold it permanently at that level
- To free up resources for improved patient care

The aforementioned strategy outlines the collaboration between the Counter Fraud Service and the Welsh Government and refers to NHS Counter Fraud Service Wales – CFS (Wales).

The NHS CFS Wales Team is funded by the Welsh Government to carry out investigations into complex, high value fraud, cross boundary cases and allegations that involve corruption by a public official.

On 1st November 2017, NHS Protect ceased to exist and under amendment from the Secretary of State for Health (UK Government) this date saw the implementation in England of an independent special health authority entitled the NHS Counter Fraud Authority (NHSCFA).

As a result, the arrangements which Welsh Ministers entered into with the NHSBSA/NHS Protect, pursuant to section 83 of the Government of Wales Act 2006 which deals with the discharge of certain counter fraud functions in relation to the health service in Wales were reviewed and remain effective with the NHSCFA.

The NHSCFA strategy and business process are as follows:

Mission: To lead the fight against crime affecting the NHS and the wider health group, protecting vital resources intended for patient care.

Vision: For an NHS which can protect its valuable resources from crime.

Purpose: To lead the NHS in protecting its resources by using intelligence to investigate serious and complex economic crime, reduce the impact of crime and drive improvements.

Strategic Goals

- develop and use its intelligence function to improve understanding of crime risks across the NHS and the wider health group and provide high quality analysis of those risks

- develop and deliver evidence-based strategic, tactical and operational crime reduction solutions for the NHS and enable the prioritisation and removal of both existing and potential crime risks

- develop its people and services, identifying and developing new technology and systems that support continuous organisational improvement and reductions to operating cost

- provide anti-crime standards, benchmarking data and robust assessment mechanisms that will be used to measure and drive improvement in work done to identify and tackle crime across the NHS

- where serious, complex, or high-value fraud or corruption is identified and money lost to the NHS, to investigate fully those allegations, seek to recover losses and pursue all possible and appropriate sanctions against offenders

In order to achieve these aims, the Counter Fraud Service introduced a national framework of Standards for NHS bodies (Wales) and has collaborated with the Welsh Government to establish this structure within the principality.

The LHBs in Wales are committed to the elimination of fraud bribery or corruption by investigating any suspicions that arise.

Issues

The following demonstrates work undertaken in the key strategic areas of Counter Fraud work:

- **Strategic Governance**

  Since April 2011, the LCFS has acted in a consultation role to the Workforce and OD Policy Group and has received notification of all policies, terms of reference guidance notes that are subject of review by the group.

  This ensures that the policies are robust and 'Fraud Proofed' at concept stage. To date for 2018/19, the LCFS has actively reviewed a total of thirteen (13) policies as fit for purpose. A full inventory of the specific polices in question will feature in the Counter Fraud annual report.

  The most relevant polices reviewed and updated during this period are the LCFS protocol with Workforce & OD and the Counter fraud and Internal Audit joint working protocol.

- **Inform and Involve**

  The fraud awareness programme undertaken by the LCFS is reaching its target audience and all mediums are being promoted in order to encourage fraud referrals.

Fraud awareness presentations have been delivered to 603 staff members at 21 Corporate Induction sessions between 9th April and 10th December 2018.

Fraud awareness presentations have also been delivered to a combination of a further eleven staff groups and events consisting of 825 individuals. The LCFS has presented at the ABUHB Annual Fayre and the ABUHB Career Event. Following these events, the LCFS has been approached with requests for bespoke inputs to diverse staff groups.

Furthermore, LCFS attendance is a standing input at the Clinical Futures Core Skills for Managers and Supervisors events which is currently scheduled to run until 2020.

On a rollover basis, Counter Fraud displays have been sited in prominent locations in every ABUHB Hospital which have included scheduled drop-in clinics staffed by the LCFS.

As a consequence of this continuous rolling programme of promotional work, a high number of referrals to the Counter Fraud Services have been received, as reflected in Appendix 1, predominantly by means of referral forms downloaded from the Counter Fraud web-pages incorporated within the ABUHB intranet and via the 0800 NHS National Fraud & Corruption Reporting Line which is linked to Crimestoppers.

The Audit Committee, at its meeting in April, requested that a question be incorporated on the referral form which asks how the author became aware to send the referral form to the Counter Fraud Team in ABUHB, Appendix 2 refers. The LCFS is not only striving to further drive the most popular cited means of awareness, but additionally promote the lesser used ones.

Investigations by counter fraud referred to in Appendix 1, have promoted fraud awareness due to the considerable media coverage given to court cases relating to LCFS prosecutions.

ABUHB Counter Fraud received some very positive outcomes in all Wales statistics provided to the Counter Fraud Steering Group in May 2018:

- On LCFS fraud awareness presentations, ABUHB was top having delivered to the highest percentage of staff per capita for all Wales with a headcount of 3,463.
- On fraud awareness eLearning uptake, ABUHB was second in Wales with 2,130 compared to the leader with 2,150.
- On financial recoveries ABUHB ran a close second with £58,609.00 compared to £63,070.00.
- Most importantly, because of the scale of its fraud awareness programme, ABUHB had the highest number of fraud referrals per capita of staff in Wales with 39 referrals.

This has been achieved with less Counter Fraud WTE staff than some other NHS organisations.

These outcomes were disseminated to the Director of Finance and Planning, and are available for Audit Committee review should they be required.

- **Prevent and Deter**

During 2018, nationally within the NHS, there has been a marked resurgence on an old theme of banking mandate fraud and ABUHB has been subject to attack from this type of high risk/high value fraud.

This fraud occurs when fraudsters implement changes to the banking mandate details of legitimate external suppliers/service providers, on Oracle via NHS Procurement Services (Accounts Payable) to that of the fraudsters own bank accounts. Outgoing payments are then hijacked into the fraudsters' bank accounts.

In July 2018, the LCFS established that fraudsters had successfully implemented a banking mandate change within procurement in ABUHB. Remedial measures were implemented and the fraud was intercepted prior to any payments being transacted from ABUHB. There has also been examples of banking mandate fraud in NHS England with significant levels of loss i.e. £900k and £157k.

Due to the threat level, ABUHB reviewed and risk assessed preventative measures which had been implemented a number of years previously to discover that due to a reconfiguration of duties measures may have become diminished and weakened.

The following directives have been reinforced to mitigate this area of fraud:

- No banking mandate changes will be implemented on the receipt of an email or letter alone.

- The requesting supplier/service provider should be telephoned (not on the telephone number on the letter but on the business number NHS have held for them historically on file).

- A contact who is known to the NHS from the company (who NHS have done business with previously) should be spoken with to and confirm the authenticity of the banking mandate request.

- To mitigate the insider threat, the NWSSP staff member who implements banking mandate changes should not be authorised to process payments on Oracle etc. This means that it would require two members of staff to collude or conspire together to transfer payments to a fraudulent bank account.

- **Hold to Account**

A list of current investigations is attached in Appendix 1 which incorporates three impending prosecutions listed as cases (5) (24) and (26) with criminal sanctions listed as cases (1) (4) and (13). Financial recoveries are evident in this Appendix as are disciplinary proceedings.

Recommendation
The Audit Committee is requested to receive this report for their information and to discuss and provide views. The LCFS's have kept up to date on professional development, legislation and working practices through attendance at various training sessions and will continue to maintain those core professional skills.

Appendix 1

INDEX OF LCFS INVESTIGATIONS AS AT 4th January 2019

Case	FIRST Ref	Health Body	Area	Subject	Status
1.	WARO/15/00062	ABUHB	GP Practice Staff	Fraudulent prescribing.	Two defendants pleaded guilty at Newport Crown Court on 17/04/2018. They received a 12 hour Community Order to undertake 140 hours if unpaid work. They were ordered to pay £4,600.55 compensation and LCFS investigation costs. Both dismissed from employment Case closed 09/08/2018.
2.	WARO/15/00112	ABUHB	Community Pharmacist	Falsely claiming dispensing fees.	NFA on criminal aspect. Case referred to GPhC for professional sanction. Fitness to practise hearing held by GPhC on 26/10/2018. Outcome decision was registrant's fitness to practice was not impaired.
3.	WARO/16/00007	ABUHB	NHS Staff	Create false clinical history for family member to support fraudulent motor insurance personal injury claim.	Defendant convicted of fraud at Cardiff Crown Court on 29/01/16. Sentenced to 9-months imprisonment suspended for 2-years and 230 hours community order within 12-months. Dismissed from employment for gross misconduct following disciplinary hearing on 16/08/16. NMC action 12-months suspension from nursing register. Defendant appeared in Court again on 08/01/18 on fresh charges. She was found guilty by jury and sentenced to 12-months imprisonment. Further NMC referral made by LCFS.
4.	WARO/16/00043	ABUHB	NHS Staff	Timesheet fraud.	Employee dismissed from employment with ABUHB for gross misconduct following

3.1

INDEX OF LCFS INVESTIGATIONS AS AT 4th January 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					disciplinary hearing on 10/05/17. Defendant was found guilty on 13/08/2018 at Cardiff Crown Court and sentenced to 12-months imprisonment suspended for 12 months, placed on an 8pm-6am curfew for 20 weeks and forced to wear an electronic tagging device. Defendant paid £10,402.92 before her hearing and was ordered to pay a further £2,560.42 LCFS investigation costs within 15 days of hearing. NMC action ongoing.
5.	WARO/17/00053	ABUHB	NHS Staff	Falsify WLI claims.	Impending prosecution. Case progressing through criminal justice system.
6.	WARO/17/00103	ABUHB	NHS Staff	Senior Manager falsify CV and salary claims.	Investigation ongoing.
7.	WARO/17/00125	ABUHB	NHS Staff	Computer misuse.	NFA on criminal aspect. Subject issued with a formal written warning as disciplinary sanction on 29/10/2018.
8.	WARO/17/00141	ABUHB	NHS Staff	Falsification of timesheets.	NFA on criminal aspect. Disciplinary action ongoing.
9.	WARO/17/00159	ABUHB	NHS Staff	Fail to complete contracted hours.	NFA on criminal aspect. No disciplinary issue identified. Case closed 25/06/2018.
10	WARO/17/00163	ABUHB	NHS Staff	Computer Misuse.	NFA on criminal aspect. Written warning disciplinary sanction. Case closed 25/06/2018.
11	WARO/17/00164	ABUHB	NHS Staff	Computer Misuse.	NFA on criminal aspect. Written warning disciplinary sanction. Case closed 25/06/2018.
12	WARO/18/00013	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Insufficient evidence to incept criminal prosecution. Recovery of £12,600 made

INDEX OF LCFS INVESTIGATIONS AS AT 4th January 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					from civil recovery. Case closed 27/09/2018.
13	WARO/18/00028	ABUHB	NHS Staff	Falsification of Timesheets.	Subject was issued with a police caution as a criminal sanction on 16/08/2018 and a recovery of £532.35 was made. Case closed 20/08/2018. Defendant has been excluded from working future bank shifts with ABUHB.
14	WARO/18/00029	ABUHB	NHS Staff	Working whilst on sick leave.	Investigation ongoing.
15	WARO/18/00038	ABUHB	Student Nurse	Falsification of timesheets and professional portfolio.	Investigation ongoing.
16	WARO/18/00040	ABUHB	GP Practice Staff	Fraudulent prescribing.	Investigation ongoing.
17	WARO/18/00048	ABUHB	Community Pharmacist	Falsely claiming pharmacy fees.	Investigation ongoing.
18	WARO/18/00064	ABUHB	NHS Staff	Fraud by abuse of position – alleged subject is not charging family members for food from canteen.	Investigation ongoing.
19	WARO/18/00067	ABUHB	NHS Staff	Falsification of timesheet.	Investigation ongoing.
20	WARO/18/00069	ABUHB	NHS Patient	Compensation claim as a consequence of hospital procedure.	Investigation ongoing.
21	WARO/18/00073	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	Investigation ongoing.
22	WARO/18/00084	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	Investigation ongoing.
23	WARO/18/00102	ABUHB	NHS Staff	Fraudulently claiming mileage expenses	NFA criminal aspect. No disciplinary issue identified. Case closed 28/12/2018.

3.1

INDEX OF LCFS INVESTIGATIONS AS AT 4th January 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
24	WARO/18/00106	ABUHB	NHS Staff	Working elsewhere whilst on sick leave and falsification of NMC revalidation paperwork	Impending prosecution, case progressing through criminal justice system.
25	WARO/18/00119	ABUHB	NHS Staff	Failing to disclose previous convictions	NFA on criminal aspect. No disciplinary issue identified. Case closed 27/09/2018.
26	WARO/18/00122	ABUHB	NHS Staff	Working elsewhere whilst on sick leave	Recovery of £3,996.43 from civil recovery. Impending prosecution, case progressing through criminal justice system. Disciplinary and professional action has also been implemented by ABUHB and GMC.
27	WARO/18/00130	ABUHB	NHS Staff	Working elsewhere whilst on sick leave	Investigation ongoing
28	WARO/18/00133	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Recovery of £7,100.98 from civil recovery. NFA on criminal aspect. No disciplinary issue identified.
29	WARO/18/00136	ABUHB	NHS Staff	Timesheet	Investigation ongoing
30	WARO/18/00154	ABUHB	GP Practice Staff	Fraudulent prescribing.	Investigation ongoing
31	WARO/18/00161	ABUHB	NHS Staff	Computer misuse.	Investigation ongoing
32	WARO/18/00162	ABUHB	NHS Patient	Compensation claim as a consequence of hospital procedure	Investigation ongoing
33	WARO/18/00169	ABUHB	Member of public	Falsification of medical history using ABUHB letter headed paper to misappropriate charity funds.	Investigation ongoing

INDEX OF LCFS INVESTIGATIONS AS AT 4th January 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
				Investigation ongoing	
34	WARO/18/00173	ABUHB	NHS Staff	Falsification of expense claims	Investigation ongoing

Appendix 2

NHS Fraud, Bribery and Corruption Referral Form

All referrals will be treated in strictest confidence and investigated by professionally trained staff

Anonymous referrals are accepted but may delay any investigation. Staff who make a referral to Counter Fraud are protected under the Procedure for NHS Staff to Raise Concerns Policy which stipulates that they will not suffer detrimental treatment or be threatened or retaliated against in any way for reporting concerns.

1. **Date of Referral**

2. **Anonymous referral Yes/No (Delete as appropriate)**
   Yes (If 'Yes' go to section 5) or No (If 'No' complete sections 3 and 4)

3. **Your Full Name**

4. **Your Contact Details (email/telephone number)**

5. **Suspicion**

6. **Please provide details including the name, address and date of birth (if known) of the person to whom the suspicion relates.**

7. **Please attach any available additional information that could assist the investigation.**

8. **How did you become aware to send the referral form to the Counter Fraud Team in ABUHB.**

Submit the completed form (in a sealed envelope marked 'Restricted – Management' and 'Confidential') for the attention of Martyn Edwards, Head of Counter Fraud, Aneurin Bevan University Health Board, 2nd Floor, Block C, Mamhilad House, Mamhilad Park Estate, Pontypool, NP4 0YP.

Alternatively you can telephone or email martyn.edwards3@wales.nhs.uk tel: 01495-765470 jeff.howells@wales.nhs.uk tel: 01495-765471 joanne.bodenham@wales.nhs.uk tel: 01495-765401. Or ring the fraud & Corruption Reporting Line on 0800 028 40 60. Or report On-Line at www.reportnhsfraud.nhs.uk

	Audit Committee 17 January 2019 Agenda Item:4.1

Audit Committee

Position Statement on Internal Audit of Clinical Audit 2016-17

Executive Summary

The purpose of this report is to:

- Provide the Audit Committee with an overview of the progress that has been made in the last year against the recommendations of the 2016/17 report on Clinical Audit, issued in May 2017.
- Note that there has been a re-audit in 2018-19. The audit is currently going through the Health Board's clearance processes and will be reported to the next Audit Committee.

Clinical Audit has been used in the NHS as an improvement methodology for a number of years. ABUHB has continued to use clinical audit but has also embraced other improvement methodologies, so that clinical audit is now one of a number of improvement methodologies used.

The Health Board's clinical audit programme is primarily based on participation in National Clinical Audit (NCA) and a small programme of health board wide clinical audits on clinical issues/risks across the health board, such as Informed Consent. Healthcare Quality Improvement Partnership (HQIP) and Welsh Government determine the programme of NCAs, using their National overview of which clinical services have the greatest clinical risks – that is the clinical specialties where it is thought that services need to develop as the evidence base is changing and there is broad variation in outcomes achieved. The programme of health board wide clinical audits on key risks in the health board is agreed by the Quality and Patient Safety (QPS) Operational Group, which receives reports from the Divisions on their clinical risks, the Quality Report for Quality and Patient Safety Committee (QPSC), and an overview of issues from the Putting Things Right Team.

The background and context section of this report provides an overview of the progress that has been made against the recommendations of the 2016/17 Internal Audit Report and the further work needed to complete these recommendations.

The Audit Committee is asked to note this paper for information.

The Audit Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	

<table>
<tr><td colspan="3">Note the Report for Information Only</td><td>x</td></tr>
<tr><td colspan="4">Executive Sponsor: Paul Buss/Stephen Edwards/Peter Carr</td></tr>
<tr><td colspan="4">Report Author: Kate Hooton</td></tr>
<tr><td colspan="4">Report Received consideration and supported by :</td></tr>
<tr><td>Executive Team</td><td>X</td><td>Committee of the Board [Committee Name]</td><td></td></tr>
<tr><td colspan="4">Date of the Report: 8.1.19.</td></tr>
<tr><td colspan="4">Supplementary Papers Attached: Appendix I – 2016-17 Internal Audit of Clinical Audit recommendations</td></tr>
</table>

4.1

Purpose of the Report

The 2016-17 Internal Audit of Clinical audit received limited assurance. The purpose of this report is to:

- Provide the Audit Committee with an overview of the progress that has been made in the last year against the recommendations of the 2016/17 report on Clinical Audit, issued in May 17.
- Note that there has been a re-audit in 2018-19. The audit is currently going through the Health Board's clearance processes and will be reported to the next Audit Committee.

Background and Context

Clinical Audit in ABUHB
Medical and then Clinical Audit were the first quality improvement mechanism for clinical services introduced into the NHS in the 1980s. The predecessor organisations to ABUHB set up systems and processes to agree and monitor audit programmes in each clinical directorate, with support from a central audit team. This continued through the Clinical Effectiveness Initiative and Clinical Governance era. Participation in the Safer Patients Initiative II (SPI II) programme and the Saving 1000 Lives initiative, meant that the UHB broadened its use of improvement methodologies. ABUHB now has ABCi as a focus to drive improvement of services using a range of methodologies. Other Health Boards in Wales do not have such a strong and established department to support improvement using methodologies other than clinical audit.

Changes to National Clinical Audit (NCA) in the UK
In Wales there is a mandatory programme of about 40 National Clinical Audits – the National Clinical Audit and Outcome Review Programme (NCAORP). In the last two years, National Clinical Audits have been changing, which has increased the resource required to support them, at the same time as the Health Board has experienced an increased number of clinical staff vacancies. In previous years, NCAs have been a one off data collection exercise over a short period of time, undertaken every 2 years. An Audit report is produced by the co-ordinating organisation, often a year after the data was collected. This was unsatisfactory as the data in the report was out of date by the time it was published. In recent years, more audits have been moving to collecting real time data on all relevant patients with the clinical condition covered by the audit. This produces data closer to real time, but is much more labour intensive. It has proved very

difficult to support the data collection required for audits that have moved to continuous data entry (eg Chronic Obstructive Pulmonary Disease). Other more established continuous data entry audits, where the data collection and entry had been running well, have been shown to have little resilience as the absence of a member of staff against the background of the staffing issues/vacancies across the Health Board has led to a reduction in data entry/case ascertainment (eg Heart Failure). The Medical Director's Support Team have supported a small number of NCAs by taking on some data entry in order to reduce the burden on clinical staff. However, this is not part of their original remit and so their capacity to do this is very limited. They are also non-clinical staff and so are unable to do this for some NCAs which require clinical knowledge.

Progress against the 2016/17 report Recommendations
However, progress has been made against the recommendations in the 2016/17 report.

Recommendation 1: Clinical Audit Approach

Recommendation:
An assurance mapping exercise should be completed across the Health Board to identify service areas / assurance providers that are currently providing assurance on clinical risks in order to:

- identify gaps and overlaps in clinical audit coverage;
- minimise duplication in clinical audit work;
- promote collaboration and opportunities for reliance on the work of other assurance providers; and
- provide effective assurance over the organisations major clinical risks.

The Health Board should consider whether the Medical Director's Support Team should co-ordinate or manage and undertake a range of local clinical audit work, in conjunction with the national clinical audit work already required. This should ensure that major clinical risks are identified and mitigated to an acceptable level.

If this approach is agreed then it should be formalised via a strategic document, specific to the Health Board which outlines the following elements relating to both local and national clinical audit:

- the governance structure;
- a programme methodology for identifying clinical audits to undertake;
- reporting/monitoring of audits;
- process for following up audit results;
- clear communication pathway direct to Board; and
- the procedure to follow for adverse results.

This document should be reviewed and approved by the Board or a nominated sub-committee.

An annual clinical audit plan should be produced which incorporates a range of local health board wide and national clinical audits to be completed. This should be based on available resources within the Medical Director's Support Team, high clinical risk areas identified, via the risk management process and discussions with key stakeholders throughout the Health Board e.g. Executives, Assistant Medical Directors etc.

Progress against the plan should be reported to and reviewed periodically by the Quality and Patient Safety Committee.

Guidance (published 2016) on how to develop a Clinical Audit Policy, Strategy and Programme is available on the Healthcare Quality Improvement Partnership website, for reference, if required.

Action Taken:

- Programme of local Health Board audits agreed through Quality and Patient Safety (QPS) Operational Group and audits completed on Consent, Record Keeping, Observational Review of Records, and Urgent Care Audit. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) to start shortly and audit of National Safety Standards for Invasive Procedures (NatSSIPs) in Feb 19. Processes for agreeing and monitoring action plans resulting from audit require greater clarity and this is being built into the process for agreeing the 2018-19 programme of audits at QPS Operational Group.
- The Clinical Audit Strategy and Policy have been drafted and taken to QPS Operational Group for agreement. In addition, the Strategy and Policy have been sent out for Consultation through mechanism for Clinical Policies. These have therefore now been adopted until the time when it is clear how they will need to be revised, taking into account any new recommendations in the 2018-19 report.
- The Assurance Mapping exercise across the Health Board to identify service areas/assurance providers that are currently providing assurance on clinical risks has not been completed, due to its complexity across all levels of the Health Board. However, the Executive Director for Therapies and Health Sciences, Deputy Director of Nursing and Assistant Director – QPS have been working on assurance relating to Quality and Patient safety and have review the Assurance Framework for Quality and Patient Safety and are developing a process to provide improved assurance about clinical quality, linked to Health and Care Standards and including NCAs where relevant, through a tighter system and process of reporting within the Quality and Patient Safety Committee structure. This was discussed at the last QPS Operational Group. A paper proposing the changes to the reporting and the Assurance Framework will be taken to the Executive Team.

Recommendation 2: National Clinical Audits

Recommendation:
In conjunction with recommendation 1, management should:

- Ensure that the necessary resources, governance and organisational structures are in place to support engagement with national audits and registers that are included within the NHS Wales National Clinical Audit and Outcomes Review Plan;
- Continue to implement effective monitoring controls (i.e. new spreadsheet) for the completion of national clinical audit work. This record should be reviewed on a regular basis to identify potential issues with completion of work so timely and effective action can be taken to address it; and
- Ensure that progress against the plan is reported to and reviewed periodically by the Quality and Patient Safety Committee.

Action Taken:

- Every member of the Medical Director's Support Team (MDST) has responsibility for liaising with a number of NCA Clinical leads for the NCAs in the NCAORP. Relationships are developing with the Clinical Leads for the Audits, along with understanding of the requirements.
- A spreadsheet has been developed to maintain an overview of the NCAs on the NCAOR programme, but its emphasis has been on compliance with the return of Part A and Part B forms to Welsh Government, which was understood to be the requirement from the 2016-17 Internal Audit, rather than participation /case ascertainment for data entry into the audits. Participation/case ascertainment will now also be collated and reported from 2019-20.
- An Annual report is in preparation for Clinical Audit in 2018, building on the annual report for 2017, and will be taken to the QPS Operational Group and then QPSC.
- The Ophthalmology NCA has not progressed as expected as a decision has not been made about which electronic record system to introduce in Ophthalmology. As the data entry to the NCA comes directly from the electronic record system, participation in the NCA has not started.

Recommendation 3: Follow up of Clinical Audit Results

Recommendation:
An effective mechanism for the identification and follow-up of actions arising from clinical audit work, undertaken locally (should the Health Board agree to implement the approach outlined in recommendation 1) and nationally, should be implemented as soon as possible, in order to provide assurance that effective action is being undertaken to mitigate clinical risk.

Action Taken:

- It was stated in the management response that it would take 2 years for the processes with NCAs to embed and this is still ongoing. Headline dataslides, giving the main results for ABUHB for a NCA, are agreed with the NCA clinical lead after the audit report is published, and these are included in a report on the National Clinical Audit results taken regularly to the QPS Operational Group, which has representation from all the Divisions. The results of the audits are therefore being disseminated more widely. However, they are not being sent to the Divisions directly. The Divisions are therefore still not routinely picking up the results of NCAs and discussing these with their Directorates. The NCA headline data slides will be sent out routinely directly to the Divisions.
- The results of one NCA are included in the QPS Report to the Quality and Patient Safety Committee at every meeting.

Recommendation 4: Clinical Audit Activity

Recommendation:
Should the Health Board agree to implement the approach outlined in recommendation 1, then an effective mechanism for collating and reporting on local directorate level clinical audit activity should be implemented as soon as possible.

Action Taken:

- The Clinical Audit Strategy identifies 3 levels of clinical audit activity, 2 of which (NCA and HB local audits) are supported by the MDST. Directorate audits are the responsibility of the Directorates/Divisions, which has been the case since the corporate support for Divisional Audit ceased. This has been clarified in the Clinical Audit Policy. However, the Directorates may require resource if there is now a requirement to co-ordinate and monitor their clinical audit activity.

Recommendation 5: Training

Recommendation:
Management should:

- Identify a potential programme of training courses / opportunities provided either internally or externally that staff can attend in order to develop knowledge and competency in order to improve clinical audit work and provide 'added value' to the Health Board; and

- Develop a mechanism for monitoring training and development of staff within the Medical Directors Support Team going forward, to ensure that appropriate training has been received and identify where further training is required.

There are a number of E-learning courses relating to clinical audit available on the Healthcare Quality Improvement Partnership website. Alternatively, potential learning opportunities could be arranged through sharing information and observing the work of Internal Audit or through liaising with service areas within the clinical environment, when undertaking audit research.

Action Taken:

- The new staff within the MDST received training on clinical audit and this has been backed up by practical experience undertaking audits. They have regular 1-1 with their manager at which any further training needs are highlighted and addressed.
- No requests for clinical audit training have been received from clinical staff in the Health Board. The MDST intranet pages provide comprehensive information on undertaking an audit. The principle training for Quality Improvement in the Health Board is the IQT training, co-ordinated through ABCi. However, an e-learning package will be identified so that this is also available for clinical staff.

Reflecting on the progress made against the 2016-17 report recommendations, it was a significant programme of work and meeting the timescales for the actions has proved challenging. There were also some issues of interpretation. Further work is now required to map and update action against the stretch recommendations in the 2018/19 report, building on what has been achieved so far.

Assessment and Conclusion

The Audit Committee is asked to note the progress that has been made in this area. However, it is also recognised that further work is required. The progress in this area is

4.1

being monitored by the Executive Team and reports will also be made to the Quality and Patient Safety Committee for assurance. The progress will continue to be tracked via the audit recommendations tracker and progress reported to the Audit Committee.

Recommendation
The Audit Committee is asked to note this paper for information.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The Internal Audit of Clinical Audit received limited assurance. There are therefore clinical risks associated with this area of work as the clinical risks in the organisation need to be highlighted and mitigated through clinical audit or through another process like ABCi or the value based work.
Financial Assessment, including Value for Money	The paper proposes that there should be a piece of work to assess the level of the clinical audit programme needed and the resources required to support this. It may require additional resources to do this, either corporately or within the Divisions.
Quality, Safety and Patient Experience Assessment	If the clinical audit programme, with other quality improvement programmes in the Health Board, does not address all the clinical risks, then this could impact on the quality, safety and patient experience of our services.
Equality and Diversity Impact Assessment (including child impact assessment)	Advice will be obtained from the Workforce and OD Directorate.
Health and Care Standards	Clinical Audit comes with standard 3.1 Safe and Clinically Effective Care.
Link to Integrated Medium Term Plan/Corporate Objectives	The IMTP Quality Appendix includes full participation in the NCAORP of National Clinical Audits.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – *can you evidence that the long term needs of the population and organisation have been considered in this work?* Clinical audit is about improving the service now which should improve the health and wellbeing of the population longer term, and support the long term needs of the population.
	Integration – *can you evidence that this work supports the objectives and goals of either internal or external partners?*

	Clinical audits are usually related to Health Board services only.
	Involvement – *can you evidence involvement of people with an interest in the service change/development and this reflects the diversity of our population?* Local Clinical Audits can be designed with service users, but usually are designed by clinicians. The NCAs do have service user representation.
	Collaboration – *can you evidence working with internal or external partners to produce and deliver this piece of work?* The Clinical Audit work is focussed on ABUHB and has not involved others.
	Prevention – *can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?* Clinical audit will identify areas where standards are not being met, and therefore should ensure they are addressed and this should prevent issues in the future.
Glossary of New Terms	**HQIP** *healthcare quality improvement partnership sets the programme of audits for England, but Wales pays to be a part of this programme, and has representation at key decision making bodies so that the programme responds to the differences in the Welsh NHS.* **NatSSIPs** *National Safety Standards for Invasive Procedures were issued as a Patient Safety Notice in Wales and were designed to address the continued occurrence of never events in theatres.*
Public Interest	This paper has been written for the public domain

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Aneurin Bevan University Health Board**

Date issued: January 2019

Reference: 648A2018-19

This document has been prepared for the internal use of Anerin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

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

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Progress update

About this document

This document provides the Audit Committee 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.

Outline of audit work and Annual Audit Report

Exhibit 1: outline of audit work

Area of work	Current status
Audit Plan 2018	February 2018 Audit Committee
Annual Audit Report 2018	March 2019 Public Board
Audit Plan 2019	April 2019 Audit Committee

Financial audit update

Exhibit 2: financial audit update

Work area	Progress	Emerging conclusions
2018-19 Financial Statements & Charitable Funds 2017-18		
Do the Heath Board's accounts present a true and fair view of the financial position at 31 March 2019 and of its income and expenditure for the financial year?	Our interim work on the Financial Statements is well advanced with our final audit scheduled for April/May 2019. We have completed our audit of the Board's 2017-18 Charitable Funds and issued an unqualified audit report in November 2019.	No significant issues to report.

Performance audit update

Exhibit 3: work completed

Area of work	Considered by Audit Committee
NHS Structured Assessment 2017	February 2018 (Audit Committee) and March 2018 (Board)
Annual Audit report 2017	February 2018 (Audit Committee) and March 2018 (Board)
Diagnostic Overview of Workforce Planning	November 2018
Review of GP Out-of-Hours Services	September 2017
Estates	January 2019

Exhibit 4: work currently underway or planned

Focus of the work	Scope	Status	Executive Lead
Work in progress			
Review of primary care	In addition to work on out-of-hours services, we are taking forward a wider programme of work on primary care. The first phase of the work comprised a landscape analysis of data to present a "Picture of Primary Care in Wales". See below for details and the link to the report. The second phase of the work examined the extent to which the Health Board has implemented the Welsh Government's three year plan for primary care. We issued the draft report to the Health Board on 13th September 2018; we received comments on 10th October 2018 and the management response on 29th November 2018. The revised final draft, incorporating the management response was sent to the Health Board on 7th December 2018. We are awaiting confirmation from the Health Board that our changes to the report appropriately address comments made. The final phase of the work will comprise a national report pulling together all the key messages from our work, together with recommendations for action at the all-Wales level. We expect to publish this by May 2019.	Phase 1 - complete Phase 2 – final draft report issued Phase 3 underway	Sarah Aitken

Focus of the work	Scope	Status	Executive Lead
Integrated Care Fund (ICF) review	The work is considering the extent to which the Integrated Care Fund is being used effectively to deliver sustainable services. The work focuses on the Welsh Government arrangements as well as the local arrangements that are in place through the seven Regional Partnership Boards. We have completed fieldwork across Wales and have presenting local findings to each of the Regional Partnership Boards during October and November. We will be publishing a single national report in early 2019.	Fieldwork complete	Nick Wood
NHS Structured Assessment 2018	Our annual structured assessment work assesses the robustness of NHS bodies' arrangements for corporate and financial governance. It also examines the progress being made in addressing issues and concerns identified in previous years' structured assessments. We issued the draft report on 19th December 2018 for comments	Fieldwork complete	Judith Paget
Clinical coding: follow-up review	This work is considering whether the Health Boards has fully implemented previous audit recommendations for improving their clinical coding arrangements. It follows on from our initial work on clinical coding which we completed in 2013. Fieldwork took place between July and November 2018 we expect to issue the draft report in March 2019.	Fieldwork underway	Nicola Prygodzicz
Orthopaedics - follow-up review	This work is considering the extent to which health boards have fully implemented the recommendations and areas for improvement identified in our 2015 work. Detailed fieldwork is due to take place in early 2019.	Development	To be confirmed
Local work	The precise focus of this work is yet to be agreed but will be reflected in the regular updates that are produced for the Audit Committee as appropriate.	Not yet started	To be confirmed

5.1

Good Practice Exchange and products

Since the last Audit Committee, we have held the following Good Practice Exchange events. Materials are available via the links below.

Exhibit 5: Good Practice Exchange and products

Event	Details
Working in partnership: Holding up the mirror September 2018	This seminar, jointly delivered with Academi Wales, focused on 'holding up the mirror' so that the design and delivery of a service is focused on the individual, irrespective of who is actually delivering the service.
Building Resilient Communities October 2018	In partnership with the Wales Co-operative Centre, we looked at the rise in the number of communities that have taken ownership of their particular community's needs. Many of the components that make a successful community group can be utilised, shared with others and adapted to suit other communities.
Why using data effectively enables better decision making: Webinar October 2018	The Well-being of the Future Generations Act wants us to think and act differently, and this means using different data and thinking about the data we use differently to help drive our decision making. We discussed the role data can and should play in changing the way we work and becoming the Wales We Want by 2050, and the leadership, tools and skills we will need to utilise that data effectively.

During the period up to March 2019, we plan to hold the following Good Practice Exchange seminars.

Exhibit 6: Good Practice Exchange seminars

Event	Details
Supporting people in their communities: Reducing unnecessary hospital admissions 5 and 14 Feb 2019	Following on from 'I'm a patient get me out of here' in March 2018, this seminar is seeking to highlight innovative approaches where public services are delivering services that help prevent unnecessary hospital admissions.
Young people influencing decisions about what matters to them 12 and 28 Mar 2019	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.

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.

NHS-related national studies and publications

We have published the following national value-for-money reports recently, with relevance to the NHS in Wales.

Exhibit 7: national value-for-money reports

Recent publications and those still in progress	
Topic	**Update**
A picture of primary care in Wales April 2018	This report is a snapshot of the current state of primary care in Wales and brings together numerous sources of data on primary care. It does not attempt to provide a detailed analysis of the strengths and weaknesses of primary care. We have used this report to inform audit work in each health board during 2018 (see above), which will look at the amount of progress health boards are making in implementing the national primary care plan. This report is also available in a new online version
Primary Care Out-of-Hours Services July 2018	This work has reviewed the governance and sustainability of out-of-hours services. Since the publication of the local reports, the team have brought the key all-Wales messages, along with findings from supplementary work at a national level, together into a national summary report.
National Fraud Initiative in Wales 2016-18 October 2018	This report summarises the findings of the biennial National Fraud Initiative in Wales for the period 1 April 2016 to 31 March 2018 and concludes that the latest National Fraud Initiative has made a significant contribution to tackling fraud against Welsh public bodies.
Management of follow up outpatient appointments across Wales October 2018	The Auditor General examined health boards' arrangements for managing follow-up outpatient appointments and concluded that: Outpatient services play a crucial role in the majority of NHS care pathways. Follow-up outpatient appointments make up a large proportion of outpatient activity but there have been concerns about the management of these appointments in recent years.

Recent publications and those still in progress	
Topic	**Update**
Radiology Services in Wales November 2018	This report summarises the key messages from our local work on radiology services in Wales and concludes that: 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.

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5.2

Review of GP out-of-hours services – **Aneurin Bevan University Health Board**

Audit year: 2016

Date issued: March 2017

Document reference: 361A2017

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.

This work was delivered by Urvisha Perez.

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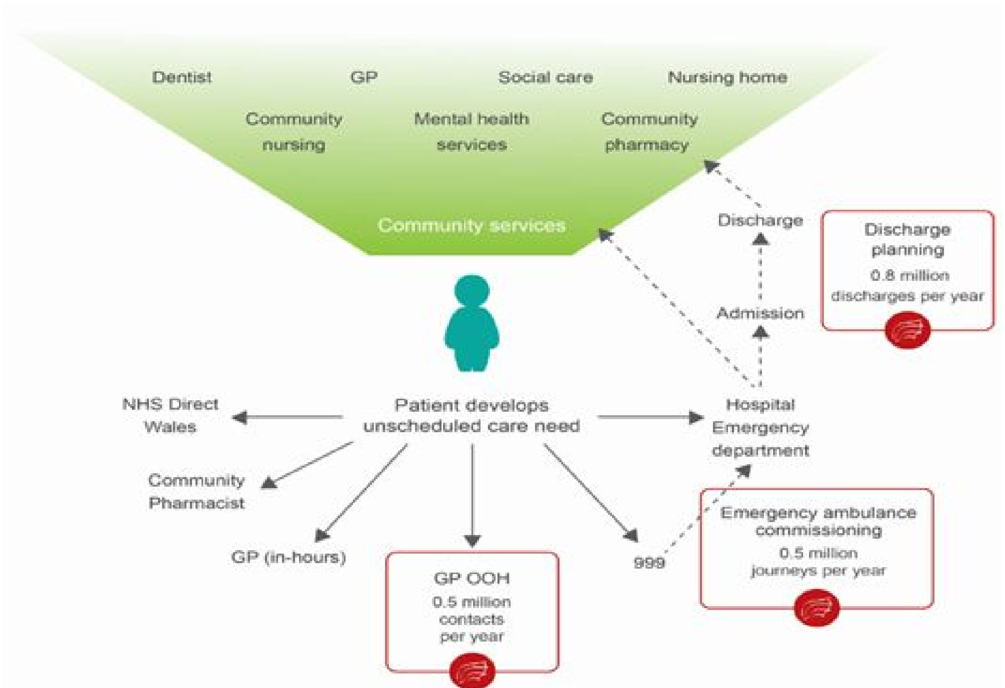
Summary report

Background

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

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



Source: Wales Audit Office

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

[1] The out-of-hours period runs from 6.30 pm until 8 am on weekdays, as well as weekends and public holidays.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 At the Health Board, the GP out-of-hours service is based within the Primary Care Division. The service is run in-house and is based at Vantage Point House, along with the contact centres for the Welsh Ambulance Services NHS Trust (WAST) and NHS Direct Wales. The GP out-of-hours service runs three primary care centres, based at:

- St Woolos Hospital, Newport
- Ysbyty Ystrad Fawr, Ystrad Mynach
- Nevill Hall Hospital, Abergavenny

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

Key findings

14 Our overall conclusion is: **The Health Board is in the early stages of a long-term plan to improve the sustainability and leadership of GP out-of-hours services. Scope remains to improve performance against several targets and consistency of GP practice messages about the out-of-hours service.** In the paragraphs below we have set out the main reasons for coming to this conclusion.

Governance arrangements

15 The Health Board is robustly monitoring GP out-of-hours services and is in the early stages of a plan to modernise the service and strengthen its leadership. We reached this conclusion because:

- the Health Board is in the early stages of a long-term plan to modernise the out-of-hours service but more work is needed to involve operational staff in service development;
- the Health Board recently strengthened clinical and operational management arrangements but our survey results suggest staff have not yet felt the benefits; and
- there are comprehensive performance monitoring and scrutiny arrangements in place, and staff are confident that lessons are learnt from incidents and complaints.

Financial and clinical sustainability

16 The Health Board has reduced spending on out-of-hours in real terms and the planned remodelling of the service will take time to address the current overreliance on GPs. We reached this conclusion because:

- the Health Board is trying to increase the skill mix of out-of-hours staff but still relies heavily on GPs, has difficulty filling shifts and needs to improve morale and support training and development; and
- the Health Board plans to address weaknesses in its GP pay model and whilst its out-of-hours spending per contact is relatively high, total spending has fallen in real terms.

Performance and patient experience

17 There is scope to improve performance on call taking, call backs and urgent appointments, and further scope to improve signposting to out-of-hours from GP practices. We reached this conclusion because:

- there is good in-hours access to GPs and generally good public information about the out-of-hours service but there is scope to improve signposting on practice websites and answerphones;
- the Health Board's call taking performance is worse than the all-Wales average and is not meeting targets;
- the Health Board is not meeting call back targets, manages comparatively few patients through hear-and-treat, and needs to improve telephone triage training;
- compared to the rest of Wales, the Health Board is not providing timely appointments for 'very urgent' and 'urgent' patients; and

- Aneurin Bevan's out-of-hours service makes comparatively few referrals to other services.

Recommendations

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

Exhibit 2: Recommendations

Recommendations	
R1	**Staff engagement:** Whilst the Health Board had an engagement plan, we found that only 16% of staff responding to our survey felt they were given enough of an opportunity to contribute to the development of the GP out-of-hours plan. In future service developments, the Health Board should: a. develop a consultation and communication plan including a variety of methods for operational staff to participate in discussions and decisions; and b. give regular updates to staff as plans develop and opportunities for further participation.
R2	**Clinical leadership and operational management:** We found that staff responding to our survey felt the service was not effectively managed by clinical leaders and management staff. We recognise that at the time of our review there had been some staff changes and team restructures. The Health Board's GP out-of-hours leaders should seek to repeat a staff survey to understand whether staff perceive any improvement in the management of the service since the restructure.
R3	**Staff support:** We found weaknesses in staff support arrangements, for example less than 50% of staff responding to our survey saying they get sufficient learning and training opportunities, and only 10% feeling morale is good. The Health Board should: a. as part of annual appraisals, make sure all staff have a personal development plan where training needs can be identified and progressed; and b. carry out work to understand the reasons for low morale amongst staff, perhaps by giving staff the opportunity to sit on or lead working groups to resolve the issues causing low morale.
R4	**Extended GP practice hours:** Aneurin Bevan is the only Health Board in Wales that has increased spend on extended GP practice hours between 2009-10 and 2015-16. However, the practice of extending hours has not been evaluated. The Health Board should undertake an evaluation of the benefits of extending GP practice hours.

Recommendations	
R5	**Public information:** We found that generally information about the out-of-hours service is readily available, but messages on GP practice websites and answerphones need to describe the GP out-of-hours service more consistently. The Health Board should: a. include GP out-of-hours opening times on the Health Board webpage; and b. develop standardised wording for GP practices answerphone messages and practice websites.
R6	**Telephone triage:** We were told that some GPs lack confidence with telephone triage, and that training, which is provided by an external contractor, is not as extensive as it could be. The Health Board should: a. revise the current training on telephone triage and offer GPs refresher courses; and b. include telephone triage training as part of GPs inductions.

Detailed report

The Health Board is robustly monitoring GP out-of-hours services and is in the early stages of a plan to modernise the service and strengthen its leadership

The Health Board is in the early stages of a long-term plan to modernise the out-of-hours service but more work is needed to involve operational staff in service development

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

20 We assessed the Health Board's plans, looking for a documented plan for GP out-of-hours services that identified and addressed the key risks related to the service. We also reviewed the Health Board's wider plans for unscheduled care, to assess whether GP out-of-hours features prominently and coherently.

21 The Health Board has developed a business case which sets out proposals to revise the current GP out-of-hours service model over the next three to five years. The Health Board decided it needed such a business case because it identified a number of demand, capacity and workforce issues which meant the GP out-of-hours service was not running as efficiently as it could. The GP out-of-hours service receives approximately 2,000 calls per week, but does not meet national performance targets. The Health Board recognised that to overcome these issues and deliver a resilient service, the out-of-hours service had to be delivered in a different way. The costed business case was approved by the Health Board's Executive Team in October 2015 and it sets out a revised service model for GP out-of-hours services. Implementing the revised service model is one of the workstreams within the Health Board's three-year Integrated Medium Term Plan (IMTP) for 2016-19.

22 Specifically, the business case highlights the following key issues that impact on the efficiency of the GP out-of-hours service:

- insufficient clinical cover to meet current demand;
- skill mix levels, nursing capacity and their role;
- increasing demand and public expectations;
- prescription requests and dispensing demands out-of-hours;
- the availability and responsiveness of other services needed for onward referral;
- the sustainability of non-clinical support services and ICT; and
- the impact and alignment of 111 implementation.

23 In order to address these issues the business case sets out high-level priorities:

- short term – recruit additional nurses, increase pay rates for year one and alter demand flow;
- medium term – increase recruitment of a mixed skilled workforce, decrease non-urgent demand flow and faster onward flow; and
- long term – have a revised workforce that is more consistent with demand.

24 At the time of our review, the Health Board was a year into implementing the revised service model, and as such, a number of initiatives were in the early stages of development and trial. Some of the initiatives highlighted through both our interviews and review of service redesign progress reports (to the Urgent and Primary Care Leadership Group) include:

- reviewing the operating hours of the three primary care centres;
- increasing GPs' rates of pay to better fall in line with neighbouring health boards and locum GPs;
- introducing advanced paramedics to the GP out-of-hours service to conduct appropriate home visits;
- implementing a community pharmacy service to stream out-of-hours requests for repeat prescriptions;
- working to extend the role of community pharmacies in supporting minor illnesses; and
- recruiting a frequent callers co-ordinator (in conjunction with WAST).

25 We interviewed a selection of strategic leaders and operational staff, who were positive about the initiatives and the need for change. The revised service model and progress to date suggests the Health Board is committed to an improved and sustainable GP out-of-hours service.

26 The Health Board also has an integrated winter pressure plan which outlines how primary and community care, and WAST will work together to prevent unnecessary acute admissions. Specifically, by sending advanced paramedic and primary care practitioners to see patients in their homes, before being transferred to an acute hospital if needed.

27 The Health Board reports that GP out-of-hours service staff, the local medical committee (LMC) and the community health council (CHC) were engaged when developing the new service model. Furthermore, the Health Board is having ongoing discussions with the CHC about matters such as implementing the national 111 service. Encouragingly, the CHC representative reported that the Health Board involves them at an early stage when developing proposals and that communication was a strong point.

28 We reviewed presentation slides dated between October 2015 and April 2016, which show there were several engagement sessions with stakeholders through such mechanisms as the GP cluster leads, business forum, urgent care forum and the Health Board's Quality and Patient Safety Committee. The slides covered an outline of the new service model, discussions about widening engagement and progress updates against the revised service model.

29 Our survey of GP out-of-hours staff[7] asked whether the Health Board had consulted staff in relation to the planning of the service. In the survey, only 16% of the Health Board's respondents agreed or strongly agreed with the statement 'I was given ample opportunity to give my opinions to inform the development of the plan for GP out-of-hours services'. The equivalent figure in Wales as a whole was 24%. These findings suggest that whilst engagement was apparently wide ranging, it might not have succeeded in recruiting enough involvement from operational staff.

30 Health boards are required to implement the national GP out-of-hours standards by March 2018. In late 2015, the Delivery Unit (DU) asked health boards to self-assess their readiness to implement each of the standards. Appendix 3 shows that the Health Board compared favourably against other health boards in Wales. The Health Board's own assessment suggests that out of the 34 criteria set out within the nine standards, 31 were already in place (green) and the remaining three were underway (amber). We saw no evidence of an action plan to meet the national standards. However, in July 2016 the Health Board's executive team received a progress report.

31 Our previous work on unscheduled care across Wales found that health bodies were planning services without a comprehensive understanding of demand. This was contributing to problems in meeting demand, such as delays in patients receiving their care. The Health Board had undertaken some demand and capacity modelling for the GP out-of-hours service, which has led to service changes and pilot initiatives. For example, for high demand weekend shifts, the Health Board now incentivises GPs to sign up for shifts four weeks in advance. The Health Board also ran a six week pilot which saw the primary care centre at Nevill Hall Hospital closed overnight (12 am to 8 am), Monday to Thursday, as analysis showed that this centre was quiet during these shifts. This allowed the service to make better use of available resources. Since the pilot, the Health Board has been looking to make this a permanent service change and will be seeking Board approval in May 2017.

32 The Director of Primary Care reported that a further piece of work looking at demand on the GP out-of-hours service by sector (eg care home sector) is planned to take place. The information from this exercise will be used to target training and education on a sector-by-sector basis.

33 Planning work is ongoing at an all-Wales level to put in place a new care co-ordination service called 111. This service will be a single point of access for unscheduled care services including GP out-of-hours and will provide integrated call taking, clinical assessment, information provision, signposting and referral. The introduction of 111 is therefore both an opportunity and a complicating factor in the planning of GP out-of-hours services.

[7] We carried out an online survey of all staff that work in the GP out-of-hours service. We received 32 responses from across the Health Board. The Health Board indicated that it had a total workforce of 332 staff.

34 The Health Board reported that a programme board and work plans have been developed for implementing 111. Through the interviews it is apparent that whilst there is some apprehension based on the issues experienced in England, there is a strong appetite for rolling out the 111 service, so much so that the Health Board has agreed to aim to implement the 111 programme in autumn 2017. In preparation, the Head of Service for GP out-of-hours is the Health Board's lead for 111 implementation, and a programme manager and director of service has been appointed.

The Health Board recently strengthened clinical and operational management arrangements but our survey results suggest staff have not yet felt the benefits

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

36 In common with all health boards, we found that the Health Board has a specific executive member directly responsible for GP out-of-hours. However, to maintain corporate and clinical oversight the responsibility is shared between the Chief Operating Officer and Medical Director. The next tier of management lies with the Divisional Director of Primary Care and Networks.

37 The self-assessments against implementation of the national standards submitted to the DU showed health boards across Wales had taken a variety of approaches to providing clinical leadership within GP out-of-hours services. At the Health Board the Assistant Medical Director for Primary Care has strategic and professional oversight for all services within the division, including GP out-of-hours. At the time of this review the out-of-hours service had recently appointed a clinical lead, who sits within the GP out-of-hours operational management team. The clinical lead is mainly responsible for managing GPs, for example, inductions, performance management, and training. She is also responsible for clinical governance and reviewing clinical pathways and ensuring non-clinical staff understand them.

38 In response to our staff survey, 28% of the Health Board's respondents agreed or strongly agreed that GP out-of-hours is 'effectively managed by the service's clinical leaders' (the figure across Wales was 48%). 44% of Aneurin Bevan staff disagreed or strongly disagreed (compared with 26% across Wales). Similarly, 72% of respondents felt that the service's management staff did not effectively manage the GP out-of-hours service. Up until recently the clinical lead post had been vacant and this may go some way to explaining the findings of the staff survey. Also, at the time of our work, the out-of-hours operational management team had recently been restructured and had recruited an operational manager to drive forward the GP out-of-hours service redesign.

39 The results of the staff survey are in contrast to feedback received from the Local Medical Committee (LMC) representative, who was generally impressed with the

way the service is run, despite the difficulties facing the service. In particular the LMC cited the following strengths:

- next day communication with in-hours GPs (about their patients);
- communication during the shift (using the ASOC[8] system),;
- working at the emergency department;
- access to emergency drugs; and
- the Health Board not abusing GPs' time so they are not over loaded.

40 The Chief Operating Officer was of the opinion that operationally the team manages the service well.

There are comprehensive performance monitoring and scrutiny arrangements in place, and staff are confident that lessons are learnt from incidents and complaints

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

42 The Health Board collates comprehensive data on the operational performance of the GP out-of-hours service through a weekly and monthly performance dashboard. The types of measures collated are set out in Exhibit 3.

Exhibit 3: Examples of performance measures at Aneurin Bevan University Health Board

Performance measures
• Total cases per month by GP cluster, broken down by weekday, weekend and cancelled calls. • Time taken to call an ambulance for life threatening conditions. • Case type, for example: advice given, home visit, primary care centre visit. • Time taken to return calls and triage. • Length of time between initial call and consultation. • Demand for secondary emergency care, for example: referrals to 999, emergency departments and direct admission to hospital. • Demand for GP out-of-hours from secondary emergency care, for example: referrals from WAST and emergency departments. • Percentage of cases prioritised as urgent and routine. • Unfilled shift hours. • Supply of clinical details relating to patients seen out-of-hours to in-hours GPs by 9 am.

Source: Aneurin Bevan University Health Board performance dashboards

[8] ASOC is the communications system used by call handlers.

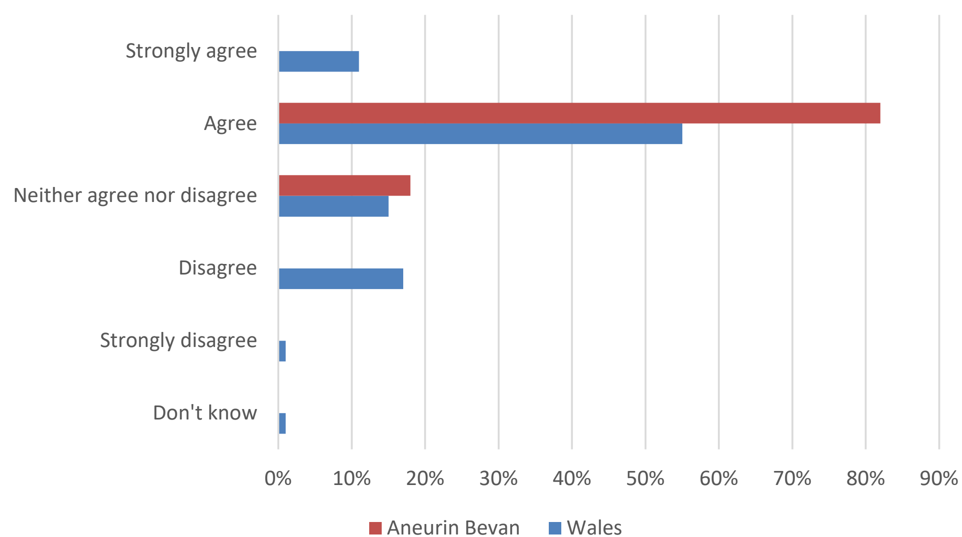
43 On a weekly basis, the executive team receives a performance summary and the performance dashboard. The Director of Primary and Community Care and the Assistant Medical Director of Primary Care meet with the out-of-hours operational management team each week to discuss service risks, pressures and performance. On a monthly basis, GP out-of-hours performance is also reviewed as part of the Urgent Primary Care Leadership Group, and clinical governance meetings.

44 To safeguard patient safety it is important to test the quality of service delivered by clinicians. The clinical lead manages GP performance through a performance framework. Each quarter, GPs that regularly work out-of-hours shifts are sent a personal performance report via email. The clinical lead said that introducing a performance framework ensures performance discussions are consistent and backed by data. The service also undertakes a random spot check of patient notes (1% audit) to make sure records are correctly updated, collect significant incidents data, and nurses also undertake quality reviews.

45 To better understand patient experience the Health Board told us they occasionally conduct face-to-face patient surveys, targeting different primary care centres each time.

46 If governance of GP out-of-hours is to be effective, the Board and committees should routinely consider high-profile information on performance. At the Health Board, whilst the Board, and Quality and Safety Committee only consider the out-of-hours service on an annual basis, the service is considered monthly at their Primary Care Committee. Exhibit 4 shows that in response to our Structured Assessment survey, Board members in the Health Board are confident that there is regular scrutiny of the out-of-hours service, however only 18% said they were satisfied with the performance and quality of the service.

Exhibit 4: Percentage of Board Members who agreed with the following statement 'The Board and its committees regularly scrutinise the performance and quality of GP out-of-hours services'.



Source: Wales Audit Office survey of Board Members.

47 Where health boards identify errors or incidents in relation to GP out-of-hours services, they should report the incidents to the National Reporting and Learning System (NRLS). Exhibit 5 highlights considerable variation between health boards in the number of incidents reported to the NRLS within GP out-of-hours services. Aneurin Bevan has the largest number of reported incidents compared to the other health boards and shows a year-on-year increase. However, this does not necessarily mean the Health Board has more incidents, but instead it could mean that staff at the Health Board are better at reporting incidents to the NRLS.

Exhibit 5: Number of incidents reported to the NRLS between 2013 and 2015

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

Source: NRLS, NHS Commissioning Board Special Health Authority.

48 In our survey of GP out-of-hours staff, 71% of the Health Board's respondents agreed or strongly agreed with the statement 'information obtained through complaints, incidents and error reporting is used to make care safer'. 14% neither agreed nor disagreed, 7% said they disagreed, and 7% said they did not know. These are better results than the rest of Wales. This suggests that the Health Board has instilled a learning culture.

49 The operational management team raised that the service sees approximately 2,000 patients per week, but receives relatively few complaints. The CHC and LMC representatives said they had not received any patient complaints or concerns about the service.

50 Another key aspect of reviewing GP out-of-hours services is through health boards' monitoring and management of risks. The Health Board reported that key risks are discussed at weekly operational meetings and reported at the divisional and Board's Quality and Patient Safety committee.

The Health Board has reduced spending on out-of-hours in real terms and the planned remodelling of the service will take time to address the current overreliance on GPs

The Health Board is trying to increase the skill mix of out-of-hours staff but still relies heavily on GPs, has difficulty filling shifts and needs to improve morale and support training and development

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

52 We requested from health boards, documentation setting out their workforce plan for GP out-of-hours services. We were looking for clear plans for the future, setting out required skills and resources, based on a good understanding of demand. At the Health Board, the overarching issue that prompted the need to redesign the GP out-of-hours service was that demand exceeds the available capacity for many shifts. Whilst we did not find a specific workforce plan for the out-of-hours service, the redesign business case sets out proposals to increase the skill mix within the service. These proposals range from making sure there is a mix of triage nurses and GPs in the call centres during peak times, introducing advanced paramedic practitioners, to investigating commissioning non-emergency ambulances to bring housebound (non-palliative) patients to primary care centres during peak times. Since our fieldwork, the Health Board has reported that a detailed workforce plan is now in place for GPs and nursing, the plan identifies the change in skill mix needed each year until 2018-19.

53 Another workforce proposal is to invest in educating community nurses, and as such the Heath Board has started to draft a 'nursing staff education, development and workforce planning strategy'. At the time of this review the strategy was in the early stages of development, however we reviewed a very early draft. The strategy is aimed at all primary and community care nurses, so not just nurses working within the out-of-hours service. It aims to develop nurses' skills so they can work across primary and community care services, which in turn will give the services some flexibility. Given the nursing recruitment challenges faced by the GP out-of-hours service, and other primary and community care services, this is a realistic approach.

54 When deciding their ideal mix of salaried and sessional staff, health bodies have to weigh up the pros and cons. For example, whilst salaried staff can provide more stability, sessional staff may provide greater flexibility. At the Health Board, there are 115 sessional GPs and 2.2 (whole time equivalent) salaried GPs. Between

2013 and 2015 the service gained an additional 40 sessional GPs (from approximately 79 to 115), however, the Health Board also reported that while there might be more GPs they are signing up for fewer shifts. The Health Board is looking to recruit more salaried out-of-hours GPs, and is planning on running a joint recruitment campaign with the in-hours service.

55 Traditionally, GPs provide the direct patient care in GP out-of-hours but staffing models are gradually changing. The national Primary Care Plan[9] states that 'No GP should routinely be undertaking any activity which could, just as appropriately be undertaken by an advanced practice nurse, a clinical pharmacist or an advanced practitioner paramedic'. As such, health bodies are gradually trying to move towards GP out-of-hours teams that supplement GPs with specialist nurses, paramedics and pharmacists.

56 The Health Board still has a largely GP-reliant out-of-hours service, however, has recently taken steps to increase the mix of skills within the team. For example, the Health Board is training nurses to confirm deaths, (traditionally done by GPs) and will be introducing advanced paramedic practitioners to the service. The Health Board has also established an overnight nursing team[10] (from 8 pm to 8 am), which saves approximately 50% of GPs' home visiting time. In addition, as part of a six month pilot, paediatric[11] nurses worked in the busiest primary care centres on weekends. The Health Board's executive team is reviewing the outcome of the pilot and considering a way forward.

57 Staffing and capacity within GP out-of-hours services should be flexible enough to be able to respond to seasonal spikes in activity, such as the pressures experienced in April and December each year because of respiratory viruses. The Health Board reported that during predictable peaks in demand, such as Christmas and Easter, they include additional shifts in the GP out-of-hours rota for all staff and flex staffing levels up and down depending on demand levels.

58 Even when health boards have a robust workforce plan, there can still be problems in ensuring appropriate staffing of GP out-of-hours services. For example, there may be difficulties in recruiting staff to posts, and difficulties in filling shifts. However, despite measures in place to cope with extra demand, staff we interviewed expressed concerns about recruiting both GPs and nurses for out-of-hours shifts because of staffing shortages within these professions. GP out-of-hours progress reports also highlight ongoing issues with recruiting nurses and salaried GPs. Having flexible capacity to meet peaks in demand is a requirement of the GP out-of-hours standard. The DU's review found no evidence to show the Health Board was meeting these criteria and also found a Board paper which indicated that the Gwent GP out-of-hours service generally struggles to meet

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

[10] The overnight nursing team is funded through the Primary Care Fund.

[11] Children represent approximately half of weekend out-of-hours demand at the Health Board.

adequate staffing levels. However, as already stated the Health Board is in the process of introducing service changes to better manage demand within the current staffing capacity.

59 Exhibit 6 shows the staffing position in the Health Board compared with the rest of Wales. The data suggests that in 2015-16, the Health Board had the highest unfilled GP shift rate, however, the Health Board reported that the figure for 2016-17 was 15%, which is a 5% improvement on the previous year. Very few staff responding to our survey believe current staffing levels are enough to meet demand (9%).

60 The LMC representative that we interviewed explained some of the reasons GPs might be reluctant to work out-of-hours shifts. These included stresses of in-hours practice, and retired GPs wanting to work a few shifts being put off by annual revalidation and appraisal and the rising cost of medical indemnity cover.

Exhibit 6: Measures comparing staffing resources across Wales

Aspects of staffing	Health Board	Across Wales
Size of list of GP pool to draw upon per 1,000 population	0.20	Ranging from 0.17 in Betsi Cadwaladr to 0.25 in Abertawe Bro Morgannwg.
GP shifts unfilled rate (2015-16)	20%	7% (average) Ranging from 0.5% in Powys to 20% in Aneurin Bevan
Percentage of staff		
• agreeing or strongly agreeing that their workload was manageable; and	69%	66%
• agreeing or strongly agreeing that the current staffing levels in the GP out-of-hours service are sufficient to meet demand	9%	21%

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

61 The staff that work in GP out-of-hours services are essential to the success of patient care. Health boards, therefore, need to support these staff to engender positive morale and to ultimately ensure they are happy to continue to work within the service. Exhibit 7 suggests the Health Board's staff wellbeing and support arrangements are worse than the average position across Wales. Only 10% of Health Board staff responding to our survey agreed that morale in the out-of-hours service was good, this is compared to 31% across Wales. Less than half (47%) agreed that they get sufficient training, learning and development to carry out their role. This is despite our review finding a range of induction handbooks and training

documents including induction materials for GP registrars, induction booklets for staff operating the online support system (ASOC) and a triage nurse handbook. In addition, only 56% of staff agreed they would be working in the out-of-hours service in a year's time, this is compared to 73% across Wales. However, the Health Board reported that in 2015-16, 72% of out-of-hours staff had received an annual appraisal.

Exhibit 7: Staff support arrangements and measures of staff wellbeing

Percentage of staff…	Health Board	Across Wales
agreeing or strongly agreeing that they received a comprehensive induction when they started work for the out-of-hours services	57%	64%
agreeing or strongly agreeing that they get sufficient training, learning and development within the out-of-hours service to carry out their role	47%	57%
agreeing or strongly agreeing that morale in the out-of-hours service is good	10%	31%
agreeing or strongly agreeing that they will still be working in the out-of-hours service in a year's time	56%	73%
who received a personal appraisal development review	72%	Insufficient data to calculate all-Wales position

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

The Health Board plans to address weaknesses in its GP pay model and whilst its out-of-hours spending per contact is relatively high, total spending has fallen in real terms

62 Exhibit 8 compares the amount of funding that the Welsh Government notionally allocates to GP out-of-hours services with the actual expenditure on GP out-of-hours services in each health board. Hywel Dda is the only geographical area in Wales that has had an increase in its notional GP out-of-hours funding from the Welsh Government since 2004-05[12]. In 2015-16, Aneurin Bevan subsidised its GP out-of-hours services to the sum of £1.342 million. Aneurin Bevan pays the second highest subsidy when compared to other Welsh health boards.

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

5.2

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

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

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

63 Exhibit 9 shows that whilst the total GP out-of-hours expenditure by health boards in Wales increased in cash terms by 6% between 2009-10 and 2015-16, when we took inflation into account, there was a real-terms reduction of 3%. Over the same period in the Health Board, expenditure increased by 1% in cash terms, but fell by 8% in real terms. Aneurin Bevan is one of four health boards where real-terms expenditure fell.

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

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

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

64 If the Health Board's GP out-of-hours service is going to succeed in meeting demand and providing quality care to patients, it needs an appropriate budget and a robust approach to budget-setting. We found the Health Board executives agreed to fund the revised service model, which was approved in 2015. Any unspent budget for example through unfilled GP shifts is reinvested in other staffing or schemes to support the service such as advanced practitioners.

65 Generally, staff we interviewed as part of this review felt the out-of-hours service was sufficiently funded but this is mainly because shifts are not filled so the service does not fully spend its budget. As explained above, the service is now starting to invest the underspent budget on increasing the service skill mix through their revised service model. The out-of-hours service does not have savings targets.

66 Exhibit 10 shows how the Health Board's expenditure on GP out-of-hours services compares with other bodies across Wales when considering its catchment population. The Health Board expenditure per 1,000 population and expenditure as a percentage of total GMS is in line with the all Wales average. However, their cost per contact is over £15 higher than the average, and the third highest compared to other health boards in Wales.

Exhibit 10: GP out-of-hours expenditure across Wales

Health Board	Out-of-hours expenditure per 1000 population (£)	Cost per contact (£)	Out-of-hours expenditure as % of total GMS expenditure (2015-16)
Abertawe Bro Morgannwg	9.33	36.07	6.7%
Aneurin Bevan	**10.45**	**68.88**	**7.0%**
Betsi Cadwaladr	10.40	50.36	6.2%
Cardiff and Vale	7.77	34.63	5.5%
Cwm Taf	10.33	50.65	6.8%
Hywel Dda	15.68	93.32	9.8%
Powys	19.17	71.63	7.4%
WALES	**10.84**	**52.74**	**6.9%**

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

67 A key aspect of the financial sustainability, as well as the clinical sustainability, of GP out-of-hours services is the approach the Health Board takes to paying GPs. Whilst staffing models are gradually changing, GPs remain essential in leading GP out-of-hours services. Health boards need to strike a balance between paying enough to attract GPs to work in the service whilst also ensuring value for money.

68 Exhibit 11 shows how the Health Board's approach to GP sessional pay compares with other bodies across Wales. Since the Health Board completed our questionnaire they have stopped increasing pay rates at the last minute when shifts are difficult to fill. Instead, the service now incentivises GPs for booking four weeks in advance for high demand shifts on weekends.

69 The general sentiment amongst staff interviewed was that the approach to deciding pay rates for GPs was not sustainable. Staff felt that pay rates across health boards should be standardised because GPs can work across boundaries where there might be better rates of pay. Another issue raised was that the out-of-hours service is having to compete with the in-hours service for locum GPs, who are in short supply and offered better pay to work in-hours. This issue was highlighted in the GP out-of-hours service redesign business case. And as such, in December 2015, the Health Board increased GP pay rates to better align with neighbouring health boards and locums. Whilst there is an initial investment, the redesign plan aims to reduce overreliance on GPs, so in time, pay costs will decline. Staff we interviewed reported that the Health Board is working towards creating a sustainable pay structure. The Health Board's pay rates are comparable to the neighbouring health boards of Cardiff and Vale, and Cwm Taf.

Exhibit 11: Approach to sessional pay across Wales

	This Health Board	All health boards	
		Yes	No
Increased rate of pay for filling shifts at late notice.	Yes	3	4
Increased rate of pay for filling shifts well in advance (thereby incentivising early sign up to shifts.	No	0	7
Increased rate of pay for committing to more than one shift (incentivised bundling model).	No	3	4
Increased rate of pay for completing shifts as intended (thereby incentivising staff to work the shifts they agreed to fill).	No	0	7
Standardised rates of pay agreed with neighbouring health boards.	No	2	5
Standardised rates of pay agreed with all health boards in Wales.	No	0	7
Sessional rates in the out-of-hours service are identical to in-hours locum rates for GPs.	No	1	6

Source: Health Board Questionnaire.

70 Between 2009-10 and 2015-16, all health boards other than Powys were at one point paying some of their GP surgeries to extend their normal opening hours. Aneurin Bevan is going against the trend when it comes to expenditure on extending opening hours. Unlike other health boards, Aneurin Bevan has increased spend on extended hours, this is in direct contrast to all other health boards where expenditure has either stopped or dramatically fallen. In 2009-10, the Health Board was spending £127,000 per year and by 2015-16 this had risen to £557,000. Despite increased spend, the benefits of extending practice hours have not been evaluated. The next section of this report explores further the data on extended opening hours.

There is scope to improve performance on call taking, call backs and urgent appointments, and further scope to improve signposting to out-of-hours services from GP practices

There is good in-hours access to GPs and generally good public information about the out-of-hours service but there is scope to improve signposting on practice websites and answerphones

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

72 Health boards have tried a range of actions to inform the public about GP out-of-hours services. The Health Board told us that they were using a variety of approaches to educate the public on when to use the GP out-of-hours services, these included:

- plans to work with public health and the Welsh Government on developing Wales-wide public messages;
- sign-posting the public to the NHS Choose Well Campaign and leaflets;
- the Health Board has developed an on-line self-assessment application (app) to help direct patients to the appropriate health care service;
- working with the Heath Board's communication team on campaigns targeting frequent service users;
- recruiting a 'Frequent Callers Coordinator' to case manage patients who regularly call the out-of-hours service; and
- Public Health short films (Dr Olivia).

73 The staff we interviewed thought the public understood when to access the out-of-hours service. However, reasons such as lack of time to attend in-hours GP service because of work pressures and public expectations mean the service is seen as an extension of the in-hours GP service. In addition, the alternative out-of-hours services, such as pharmacies, are not developed enough to reduce the demand on the GP out-of-hours services. This is something that the Health Board is working to improve.

74 We reviewed health board websites to assess the extent of information on GP out-of-hours services for the public. Exhibit 12 shows how the results for the Health Board compared with the rest of Wales. Overall, we found comprehensive information about the GP out-of-hours service on the Health Board's website. The only crucial piece of information missing was GP out-of-hours opening times.

Compared to other health boards, Aneurin Bevan provides one of the most complete sets of information about its service.

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

	This Health Board	All health boards	
		Yes	No
Is there any information on the landing page about GP out-of-hours services?	Yes	4	3
Is there any information on the landing page about the Choose Well campaign?	Yes	7	-
Does the website have a page on GP out-of-hours services?	Yes	7	-
Does the GP out-of-hours page provide a description of the GP out-of-hours service?	Yes	3	4
Does the GP out-of-hours page provide examples to illustrate conditions/circumstances where it is appropriate to access GP out-of-hours services?	Yes	1	6
Does the GP out-of-hours page provide the opening hours of the GP out-of-hours service?	No	2	5
Does the GP out-of-hours page provide the locations of the GP out-of-hours primary-care centres?	Yes	2	5

Source: Wales Audit Office review of health board websites.

75 We reviewed a sample of GP practice websites and carried out ‘mystery shopping’ calls to GP practice phone lines, outside normal working hours, to assess how well they signpost patients to GP out-of-hours services. Exhibit 13 shows how GP practices in the Health Board compared with those across Wales. In the Health Board, the GP practices we reviewed had better information about the GP out-of-hours service on their answerphone messages than on their websites.

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

	This health board (10 practices)		Wales (70 practices)	
Practice websites	**Yes**	**No**	**Yes**	**No**
Does the practice have a website?	9	1	59	11
Does the landing page signpost patients to GP out-of-hours services?	5	4	31	29
Does the website give patients the telephone number for the GP out-of-hours service?	9	0	57	3
Does the website state that GP out-of-hours services are for 'urgent' cases only?	7	2	34	26
Does the website state that GP out-of-hours services are not for 'emergency' cases?	4	5	22	38
Does the website signpost patients to NHS Direct Wales (and other services)?	7	2	44	16
Practice phone lines	**Yes**	**No**	**Yes**	**No**
Was the call answered?	10	0	69	1
Was the call automatically diverted to the GP out-of-hours service?	1	9	16	53
Did the answerphone message give the phone number of the out-of-hours service?	9	1	49	18
Did the message say that out-of-hours services are not for 'emergency' cases, or explain what to do in an 'emergency'?	10	0	32	36
Did the message state that GP out-of-hours services are for 'urgent' cases only?	7	3	35	33
Did the message signpost patients to NHS Direct Wales (and other services)?	10	0	47	20

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

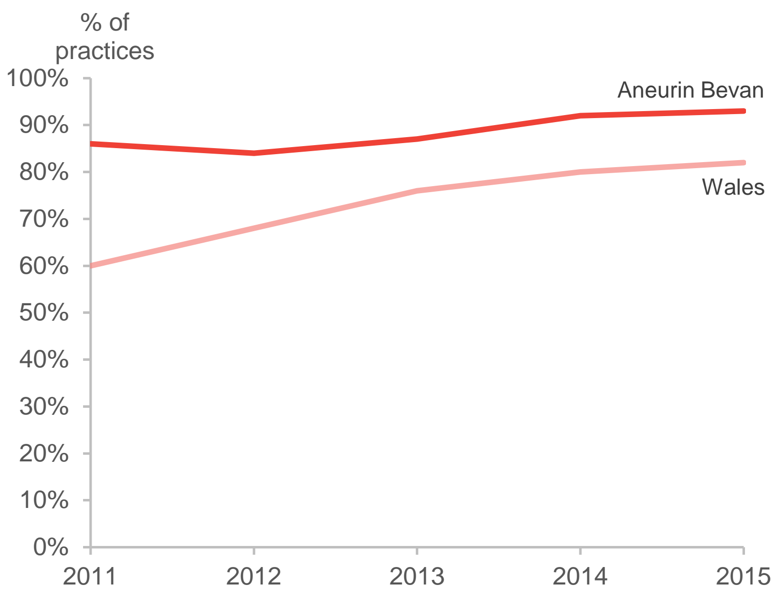
76 Our mystery shopping showed that the Health Board has a single number for its GP out-of-hours service, however the answerphone message at one of the GP practices gave a different phone number[13]. And whilst five of the answerphone messages were similar and gave a clear description of the out-of-hours service, for the rest we found some variation. In terms of GP practice websites our mystery shopping exercise found that in general there was little information on the websites

[13] The phone number given was 0845 6001231 instead of 01633 744285.

about the out-of-hours service. Most sites signposted patients to NHS Direct Wales and one site signposted patients to NHS 111, which is not yet available in Wales.

77 Our scoping suggested that problems in accessing in-hours primary care may be driving additional demand for GP out-of-hours services. Exhibit 14 shows an increase across Wales in the percentage of GP practices that are open for the entirety of their core hours[14]. The definition of 'open' in this instance is that the practice's doors are physically open and a patient can have face-to-face contact with a receptionist. The exhibit shows that over 90% of Aneurin Bevan GP practices are open for their entire core hours: this is better than the Wales average of 82%.

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



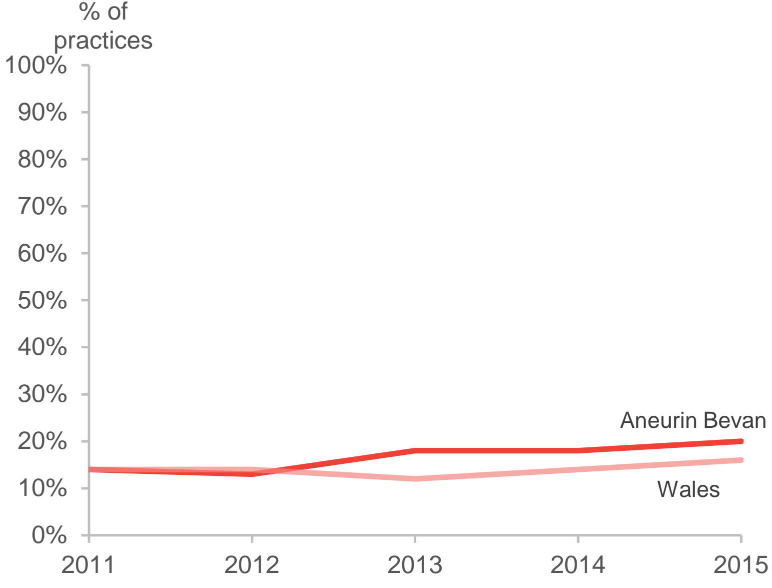
Source: Wales Audit Office analysis of data from My Local Health Service, NHS Wales.

78 There has been an increase across Wales in the percentage of practices that offer appointments between 5 pm and 6.30 pm, on at least two days per week. Aneurin Bevan is one of four health board areas where all GP practices offer such appointments.

[14] Under the General Medical Services (GMS) contract (the UK-wide contract between general practices and primary care organisations for delivering primary care services to local communities), GP practice core hours are Monday to Friday, between 8 am and 6.30 pm (except on Good Friday, Christmas Day and Bank Holidays).

79 Exhibit 15 shows less progress across Wales in ensuring practices offer appointments before 8.30 am on at least two days a week. Compared with other health boards, at 20%, Aneurin Bevan has the second highest number of GP practices offering early appointments. The average across Wales is 16%.

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



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

80 The Health Board recognises that one of the keys to reducing demand on the GP out-of-hours service is to improve access to in-hours GP services. They identified there was variation in levels of access across different practices, for example some GP practices closed for half a day each week, or closed their doors over the lunch period. In an effort to standardise access, in 2012, the Gwent GP Access Group[15] developed a benchmarking and accreditation scheme called 'A is for Access', which is based on the following five standards:

- morning opening time of 8 am or earlier, and first doctor routine appointment time of 8.30 am or earlier;
- doors remain open during the lunchtime period;
- last doctor routine appointment 5.50 pm or later;

[15] The GP Access Group includes representatives from the Health Board, Community Health Council and Local Medical Committee.

- routine telephone access to 'live person' from 8 am to 6.30 pm; and
- 'sort in one call' or 'My Health Online' (patients can book an appointment in one telephone call or via the internet).

81 Only practices that meet all five standards are offered extended practice hours. Practices are awarded an accreditation poster to display in their public space. The scheme demonstrates the Health Board's commitment to improving in-hours access, and providing a consistent service for all patients.

The Health Board's call taking performance is worse than the all-Wales average and is not meeting targets

82 Most GP out-of-hours services use an automated system to answer calls, so that patients hear a pre-recorded message. If the message is too long or complicated, or if it takes too long for the message to begin, patients may decide to terminate the call. In the Health Board, 29% of calls to GP out-of-hours were terminated[16] in this way, which is higher than the all-Wales average (Exhibit 16).

83 After the answerphone/automated message, patients will typically speak to a call taker. If there are delays at this stage, patients may choose to abandon the call. In the Health Board, 22% of calls were abandoned[17] at this stage, which is higher than the all-Wales average. The data also shows that between April and September 2016, the Health Board's GP out-of-hours service answered 56% of calls within 60 seconds of the end of the answerphone message. The national standards for GP out-of-hours services state that health boards should be achieving 95%. The Health Board has recently developed an action plan outlining barriers to achieving the national performance targets and steps to address them. The action plan includes all GP out-of-hours national performance targets that are not being met.

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

[17] Definition of abandoned calls: Calls where the caller hung up before the call was answered by a call handler after the pre-recorded message (or after the initial 30 seconds, if there is no pre-recorded message). The data cover April 2016 to September 2016.

Exhibit 16: Call handling performance

	Health Board %	Wales %
Percentage of calls terminated	28.8	14.6
Percentage of calls abandoned in 60 seconds or less	12.7	7.0
Percentage of calls abandoned after 60 seconds	9.1	5.3
Percentage of calls answered within 60 seconds (after the pre-recorded message)	55.5	74.3
Percentage of calls answered after 60 seconds (after the pre-recorded message)	44.5	25.7

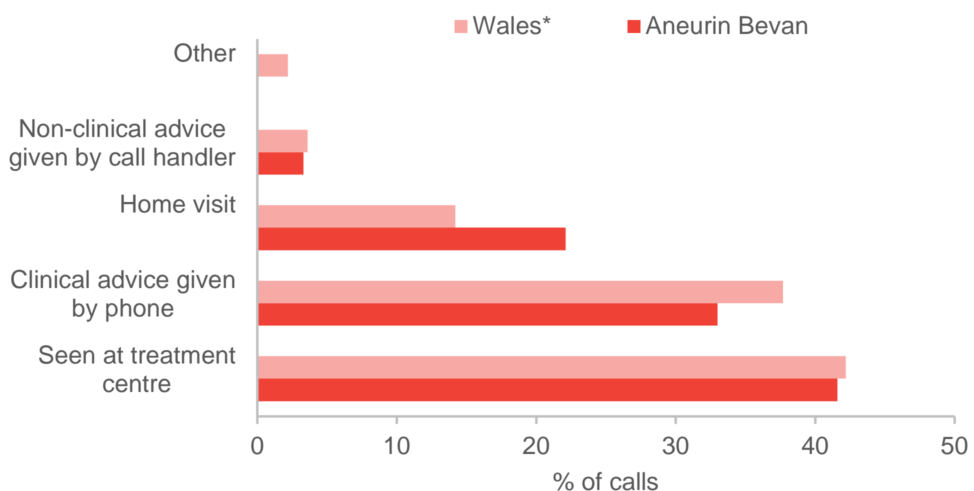
Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to the Welsh Government by the health boards, between April 2016 and September 2016.

The Health Board is not meeting call back targets, manages comparatively few patients through hear-and-treat, and needs to improve telephone triage training

84 Once the GP out-of-hours service has taken a call from a patient, the call taker may choose to manage the patient in one of several ways. Exhibit 17 shows how the Health Board handled calls[18] between April 2016 and September 2016. It shows that the Health Board's patients were more likely to receive a home visit and were less likely to have all of their needs met by phone than in Wales as a whole.

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

Exhibit 17: The way in which the GP out-of-hours service manages calls



Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to the Welsh Government by the health boards, between April 2016 and September 2016.

85 Telephone triage is the process that GP out-of-hours services use to assess the immediate needs of patients. If GP out-of-hours services are to provide effective hear-and-treat services, they need to ensure the staff carrying out telephone consultations have the requisite skills. The Health Board reported that nursing staff receive training on the telephone clinical triage support system, and through on the job training and mentoring. Telephone triage training for GPs is mainly through work shadowing, and training is also provided by an external training provider.

86 The Health Board and LMC representative told us that GPs do not feel as confident about telephone triage as seeing patients face-to-face. As a consequence, GPs are sometimes overcautious, meaning they spend an extended amount of time with patients on the phone, as well as sending them to a primary care centre or arranging a home visit. The Health Board feels the training provided by the external company is not as extensive as it could be, and recognises training on telephone triage needs to be improved. The LMC representative we spoke to had not received any training on telephone triage, but admitted that this was also because GPs are busy during practice hours so have little time for training.

87 After a patient has described their symptoms to the call taker, the GP out-of-hours service may decide that the patient needs a call back from a clinician. The national standards state that 98% of ‘urgent’ calls should receive a call back within 20 minutes. Between April and September 2016, 87% of urgent calls in the Health Board received a call back within 20 minutes (compared with 78% across Wales as a whole). The national standards also state that 98% of ‘routine’ calls should receive a call back within 60 minutes. Between April and September 2016, 74% of

routine calls to the Health Board received a call back within 60 minutes (compared with 82% across wales as a whole).

88 In our survey of GP out-of-hours staff in the Health Board, 14% of respondents said they were comfortable with the proportion of calls dealt with entirely on the telephone (sometimes referred to as 'hear and treat'). 54% were not comfortable. Across Wales, 54% were comfortable whilst 25% were not.

89 For hear-and-treat to be most effective, it helps if the clinician has access to a summary of the patient's medical history through a computer system called the GP Record. In the Health Board, 17% of the patients that contacted GP out-of-hours had their GP Record accessed by the service. This is higher than the Wales average which is 5.6%.

Compared to the rest of Wales, the Health Board is not providing timely appointments for 'very urgent' and 'urgent' patients

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

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

Exhibit 18: Percentage of patients seen within the relevant time targets

	Health Board %	Wales[1] %
Home visits		
Percentage of 'very urgents' seen within one hour	65.5	59.9
Percentage of 'urgents' seen within two hours	61.6	69.2
Percentage of 'less urgents' seen within six hours	91.3	92.7
Treatment centre		
Percentage of 'very urgents' seen within one hour	77.9	85.7
Percentage of 'urgents' seen within two hours	63.3	80.9
Percentage of 'less urgents' seen within six hours	93.7	97.2

Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to the Welsh Government by the health boards, between April 2016 and September 2016.
[1] The figures for Wales exclude Abertawe Bro Morgannwg University Health Board and Cwm Taf University Health Board.

92 In the Health Board between April 2016 and September 2016, 1.1% of patients that had an appointment booked at the GP out-of-hours treatment centre did not attend their appointment. This equates to an approximate cost of £12,400 between April 2016 and September 2016[19].

Aneurin Bevan's out-of-hours service makes comparatively few referrals to other services

93 Our scoping work suggested that GP out-of-hours services may be experiencing demand from patients that were suitable for other services. Out-of-hours services are for urgent cases but not emergencies, therefore the life-threatening emergency cases seen in GP out-of-hours services represent misplaced demand. Across Wales, 3.5% (6,756 cases) of all calls to GP out-of-hours services between April 2016 and September 2016 were life-threatening emergency cases. In the Health Board, the corresponding figure was 3.2% (1,328 cases).

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

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

patient's own GP. In the Health Board, the corresponding figure was 11.8% (4,867 cases).

95 Across Wales, 40.8% of patients that contacted GP out-of-hours between April 2016 and September 2016 required a referral to a different service. In the Health Board, the corresponding figure was 28.9%. Exhibit 19 shows the pattern of referrals made by the service.

Exhibit 19: Pattern of referrals made by GP out-of-hours services

	Health Board %	Wales %
Category: Hear-and-treat patients		
Received a telephone assessment only and the call was closed	60.8	54.7
Referred to emergency ambulance service	4.4	5.7
Referred to hospital emergency department or minor injury unit	9.8	10.6
Referred to hospital admission or assessment on a hospital ward	6	2.9
Referred to their own GP	17.7	14.4
Referred to district nursing	0.5	2.6
Referred to dentist	0.3	0.3
Other	0.5	8.9
Category: Patients seen at treatment centres		
Did not attend the appointment or left before the appointment took place	1.1	1.0
Treated and discharged	77.1	61.1
Referred to emergency ambulance service	0.1	0.1
Referred to hospital emergency department or minor injury unit	0.6	1.8
Referred to hospital admission or assessment on a hospital ward	11.7	9.1
Referred to their own GP	9	23.4
Other	0.5	3.6
Category: Patients seen at home		
Treated and discharged	72.9	60.4
Referred to emergency ambulance service	0.6	0.6
Referred to hospital emergency department or minor injury unit	0.4	2.1
Referred to hospital admission or assessment on a hospital ward	9	7.9
Referred to their own GP	11.2	17.0
Other	0.2	6.2

Source: Wales Audit Office analysis of monthly GP out-of-hours data submitted to the Welsh Government by the health boards, between April 2016 and September 2016.

96 Where GP out-of-hours refers emergency cases to the ambulance service, the national standards state that the service should transfer all such calls within three minutes. The Health Board's data for this measure was inconsistent, therefore we are unable to report performance against this measure.

97 A potential barrier to effective referrals is the availability of other services outside normal working hours. In our survey of GP out-of-hours staff we asked for views on the availability of services for a range of conditions. In the Health Board, the services that staff felt were least available related to:

- mental health crisis;
- frail patients with diarrhoea and vomiting who need hydration; and
- patients suffering with swollen leg/deep vein thrombosis

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

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

100 Fieldwork undertaken as part of our review of emergency ambulance commissioning found that whilst the primary care centre at Nevill Hall Hospital is co-located with accident and emergency, it is the first place to be closed when there are capacity issues, and also the relationship between GP out-of-hours staff and emergency department staff can be strained at times. However, as stated earlier, the Health Board has found Nevill Hall Hospital to be one of the quieter primary care centres and therefore, following a pilot, is looking to permanently close the centre overnight, Monday to Thursday.

Appendix 1

Audit methodology

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

Exhibit 20: Audit methodology

Method	Detail
Health board questionnaire	The questionnaire was the main source of corporate-level data that we requested from the Health Board.
Document request	We reviewed documents from the Health Board which covered: • Service modernisation plan • Wider unscheduled care plans • Workforce plans • Performance reports • Minutes of operational meetings • Minutes of Board and committee meetings • Structure charts
Interviews	We interviewed a number of staff including: • Chief Operating Officer • Divisional Director of Primary Care and Networks • Clinical Lead for GP out-of-hours service • Operational Lead for GP out-of-hours service • GP out-of-hours management team • Local Medical Committee representative • Local CHC representative
Surveys of GP out-of-hours staff	We carried out an online survey of all staff that work in the out-of-hours service. We had 32 responses at the Health Board.
Survey of patients	We carried out a postal survey of 1,990 randomly selected patients in Wales that had contacted the out-of-hours service on any of the following dates: 12, 13, 16, 17, 18 July 2016. We received responses from 330 patients, giving a response rate of 16.6%.
Survey of Board members	As part of our structured assessment work, we surveyed NHS Board members. We included a small number of questions relating to out-of-hours services. At Aneurin Bevan, we had responses from 11 members.
Review of health board websites	We reviewed the health board's website to assess the effectiveness of information provided on how and when to access out-of-hours services.

Method	Detail
Mystery shopping: GP practice phone lines and websites	We made telephone calls, after practice closing times, to a sample of 10 practices in each Health Board. We assessed the answerphone message for effectiveness in information provision to patients. We also assessed GP-practice websites to assess the signposting to the out-of-hours service.
Use of existing data	We used existing sources of data such as incident data from the National Reporting and Learning System, data from the Delivery Unit's 2015 work on out-of-hours, data from the My Local Health Service website and data submitted by health boards to the Welsh Government.

Appendix 2

All-Wales patient survey results

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

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

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

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

Source: Wales Audit Office survey of patients.

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

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

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

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

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

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

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

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

Source: Wales Audit Office survey of patients.

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

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

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

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

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

Face-to-face appointments (180 respondents)

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

Home visits (73 respondents)

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

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

78% of respondents to our survey said that after accessing GP out-of-hours they needed to access another service to have their needs met. This may suggest patients are not accessing the right service for their needs, or it may reflect that patients are contacting GP out-of-hours with complex problems that are not easy to solve in the out-of-hours environment.

Appendix 3

Health boards' self-assessment against the national standards

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

Key: Achieved; Work Underway; Limited Development; No response

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

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

Appendix 4

Management response

Exhibit 26: Aneurin Bevan Health Board's management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer

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Management response

Report title: Review of GP out-of-hours services – Aneurin Bevan University Health Board

Completion date:

Document reference: 361A2017

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Update at March September 2018
R1a	Develop a consultation and communication plan including a variety of methods for operational staff to participate in discussions and decisions.	Staff are engaged and have greater opportunities for participation.	Yes	Yes	Develop a consultation and communication plan including a variety of methods for operational staff to participate in discussions and decisions.	December 2018	Richard Pryce	Range of Communication & Engagement Processes in place with mechanisms for different levels of delivery.

					This will be split into 2 sections: 1. Discussions on operational issues and team working on shift – opportunity for ideas and development and joint leadership across teams. 2. Give regular updates and gain feedback to and from staff as plans develop for service redesign and 111 developments and opportunities for further participation.			**SharePoint has been updated** – all documents shared with staff on performance, policies, updates on headlines of service developments. New DM Investigating the use of ‘Flight Deck’ working to mirror the approach used in acute hubs to manage demand and capacity. Aim to implement a new OOH sitrep and communication method by the end of Q3 18/19. DM has engaged with 111 Project Team – regular staff ‘drop in sessions / ask us anything sessions’ planned to start in Q3 18/19 to mitigate any anxiety around 111 implementation.

					3. Focus groups/workshops were organised in early 2018 with representation from a range of nonclinical teams to better integrate working arrangements across nonclinical staff and processes.			ABUHB Comms Team are working in partnership with OOH team to deliver messages to staff and patients around the model of 111 / OOH that will be developed as paart of CF. Initial comms out will start in Q3 18/19 to prepare staff and patients for change. 111 Team have a regular communication session booked on the PCC Divisinal Day starting from September through to April – will extend beyond April if ongoing comms post 111 is needed.

					Action: We will take forward the recommendation to develop a communication plan for staff to participate in a variety of ways.			Monthly open meetings For Nursing and Non Clinical Staff. Arranged across the centres and alternative times and dates Clinical Reference Group (CRG) set up November 2017. Meetings monthly to advise Senior Divisional and OOHs Senior Management Team. Comprising – GPs, Nurses, Non clinical representation and LMC. Advising on key work arears for operational and strategic developments. TOR in place and priority action plan agreed.

								DM has set up a regular forum for overnight staff to attend since September 2018. Attendance has been fair to date – this is likely to stay in place in future. From September 2018 DM has requested that all management staff review their current working patterns to enable each manager to work one twilight shift per week (DM Included in this). This will provide more management visibility and presence going forward.

								111 Workforce Planning Group continually discussing updates with Oohs staff on 111 developments. DM has engaged with 111 Project Team – regular staff 'drop in sessions / ask us anything sessions' planned to start in Q3 18/19 to mitigate any anxiety around 111 implementation. 111 Communication Plan in place through 111 Workstream in readiness for relevant go live trigger dates for staff and public consultation. ABUHB Comms Team are working in partnership with

								OOH team to deliver messages to staff and patients around the model of 111 / OOH that will be developed as part of CF. Initial comms out will start in Q3 18/19 to prepare staff and patients for change
R1b	Give regular updates to staff as plans develop and opportunities for further participation.	Staff are well informed and understand service development plans.	Yes	Yes	As Above	Ongoing	Richard Pryce/ Senior OOHs Team	As above in R1a
R2	The Health Board's GP out-of-hours leaders should seek to repeat a staff survey to understand whether staff perceive any improvement in the management of the service since the restructure.	To understand whether staff feel the management of the service has improved since the restructure.	Yes	Yes	The Health Board's GP out-of-hours leaders should seek to repeat a survey staff to understand whether staff perceive any improvement in the management of the	Initially done in April 18 – Will repeat in Q3 18/19.	Richard Pryce / OOHs Senior Team/HR support	GP Survey drafted in April 2018 and issued to all GP's in the service. A retrospective contact will be made with all GP's who have not worked in the service in the last 12 months and

					service since the restructure. We have made a number of changes since the review. We have a senior manager in post leading the service and ensuring the redesign and structured governance arrangements into the Divisional and organisational processes are in place amongst a range of other elements and there is now a Clinical Director in post.				analyse the themes of the qualitative analysis

R3a	As part of annual appraisals, make sure all staff have a personal development plan where training needs can be identified and progressed.	Staff are encouraged to reach their full potential.	Yes	Yes	The Health Board should: a. Increase appraisal rates; b. Undertake more robust monitoring of appraisal completion rates, perhaps as part of operational managers meetings. c. As part of annual appraisals, make sure all staff have a personal development plan where training needs can be identified and progressed. d. Carry out work to understand the reasons for low morale amongst staff.	Ongoing	Richard Pryce	Appraisal Rates remain steady and sickness low. We have seen an improvement in our staff PADR rates in OOHs from 72% in the report currently standing at 75% (June 18) and will increase in July 18 to around 85%. Both KPI's are monitored monthly by the DM and weekly management assurance meetings are held to deliver sustainability to achieve 85% PADR compliance and sickness <5%

					The elements of training and development need to be discussed in these PADR processes. A large number of nonclinical staff work small numbers of hours across our service as they have other jobs. GPs are appraised at a Deanery level – we only have 3 salaried GPs who have a job plan agreed with the Clinical Director. **Action: This will be an item on the Senior management team Operational meeting for monitoring of PADRS, sickness and mandatory**			CD / DM are planning to develop a performance plan to ensure that all staff are aware of the service performance data and individual performance but in a non-threatening fashion. It is envisaged tis will be developed during Q4 18/19 as part of improving staff / management communication. Each report reviewed by manager and staff identified have been given support. Nurses revalidation also on track and linking with the PADR process where possible.

					training performance.			Regular Nursing Team Meetings are undertaken, interspersed with individual team meetings which is allowing each group to work more cohesively
R3b	Carry out work to understand the reasons for low morale amongst staff, perhaps by giving staff the opportunity to sit on or lead working groups to resolve the issues causing low morale.	To understand and tackle reasons for low staff morale.	Yes	Yes	As above	Ongoing	Senior Team	From September 2018 DM has requested that all management staff review their current working patterns to enable each manager to work one twilight shift per week (DM Included in this). This will provide more management visibility and presence going forward.

								DM has set up a regular forum for overnight staff to attend since September. Attendance has been fair to date – this is likely to stay in place in future. – Initial impression from staff is that providing access to the head of service has created a sense of inclusion. DM has contacted ETD to deliver resilience and wellbeing education to OOH staff. Plan to deliver this routinely going forward starting in Q3 18/19. DM has suggested that this is treated as 'mandatory training' for this staff group to

								maximise participation.
R4	The Health Board should undertake an evaluation of the benefits of extending GP practice hours.	To understand the benefits of investing in extending GP practice hours.	No	Yes	The Health Board offers extended hours to patients via their registered practices provided the practices meet a set of basic criteria in relation to standard contracted hours. The extended hours are offered via a Directed Enhanced Service in line with Welsh Government policy, as an enhancement to access to regular GP services for patients who find it difficult to attend in normal hours and it is not designed as a supplement or substitute for	Some surgeries commenced. Uptake will be monitored.	Dr Liam Taylor	The utilisation of appointments for GP appointments provided outside contracted hours as part of the Extended Hours Enhanced Service continues to be monitored by the GP Access group. It is worth reiterating that this service is not designed to reduce the requirement to access urgent care via the GP Out of Hours Service but to enhance access to routine care. A National review of enhanced services

					emergency out of hours services. This is not designed to reduce OOH demand but to make routine appointments more convenient for working people. They are usually booked well in advance. The uptake of appointments is monitored via the GP Access Group. The Health Board will be reviewing the ongoing value of the investment in extended hours in the coming year to determine whether the current investment should be increased, maintained or re-focussed. This will be in the context of a wider service improvement programme in			is now being undertaken by Welsh Government and the future provision of the extended hours enhanced service will be considered in the context of this review

					relation to access to GP services. **Action: This will be kept under review and updates included following relevant evaluation as necessary.**			
R5a	Include GP out-of-hours opening times on the Health Board webpage.	To improve public information about the service.	Yes	Yes	We agree the website needs updating and consistently updated as the service develops and we will agree this with the HB Communications Team. The Primary Care and Community Division is also updating a web page for the Division and the OOHs service will ensure it has up to date information within this also.	Q3 18/19	Richard Pryce / Nick Jones /Communications Team	DM will task the IT lead to modernise the existing site and re design to ensure it is up to date and fit for purpose. Q3 18/19

R5b	Develop standardised wording for GP practices answerphone messages and practice websites.	To ensure the public get consistent information about the service.	Yes	Yes	**Completed Action**	March 17	Sam Crane	ACTIONED
R6a	Revise the current training on telephone triage and offer GPs refresher courses.	Improved training and GPs regularly update their skills to maintain their confidence and service quality.	Yes	Yes	We have in place GP Registrar and GP induction packs which have been improved and triage is part of this. Induction for registrars and GPs starting on shift with OOHs have supervised triage support. The M&K External course was very well attended by a range of professionals including nurses, paramedics and pharmacists and 1 GP attended. We have also run a national triage	Ongoing Review of uptake and outcomes September 17	Dr Alice Groves/ Richard Pryce	GP registrar pack is updated every 6 months GP induction pack is sent to the doctors requesting induction Nurse triage and induction pack in place with a robust training programme via the band 7 triage lead for all new starters In progress is a NP induction pack which includes self-assessment of skills to highlight training needs. Have continued with the health board nursing

					course on a weekend led by the previous CD funded across Wales by ABUHB. We have a range of CPD sessions throughout the year where triage takes priority. **Action: We continue to work on processes for improving triage and reduce risk aversion by support and guidelines currently being revised by the CD and Senior Nurse and AMD for rolling out across all OOHs practitioners.**				education and WEDS funding for course and staff have undertaken courses paid by the service due to delays in WEDS and University places. Utilising other universities not just Welsh universities such as Gloucester for non-medical independent prescribing. Education and practical support for the 5 year plan for nurses to move from triage to NP in place.

R6b	Include telephone triage training as part of GPs inductions.	GPs are confident in performing telephone triage when joining the service.	Yes	Yes	As Above Will change as part of 111 introduction in September/October 17	Q3 18/19	Dr Alice Groves	As part of registrar and GP induction triage training is undertaken , advise GP's to book 2-3 triage shifts and with the help of Medical lead consolidate their learning . There is no compulsory elements of the VTR training to undertake set number of hours of triage in their training Medical lead role should exclude them from training of new staff to concentrate on running and supporting the shift of a weekend

12 July 2018

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Primary Care Out-of-Hours Services

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared and published this report in accordance with the Government of Wales Act 1998.

The team that delivered the work was Anne Beegan, Nigel Blewitt, Matthew Brushett, Fflur Jones, Philip Jones, Delyth Lewis, Stephen Lisle and Urvisha Perez, under the direction of Dave Thomas.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg.

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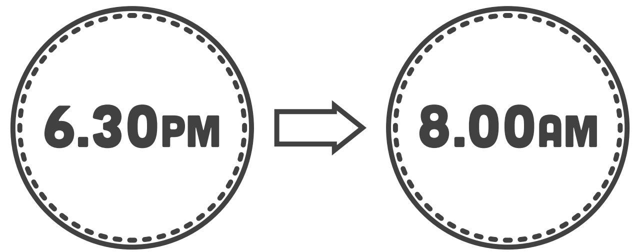
Background

1 Exhibit 1 describes what primary care out-of-hours services are and how they work.

Exhibit 1 – Primary care out-of-hours services in Wales

Primary care out-of-hours services are sometimes referred to as GP out-of-hours or urgent primary care services. These services provide healthcare for patients with urgent but not emergency medical problems outside normal surgery hours. General practitioners have traditionally led the delivery of out-of-hours services but other clinicians are increasingly involved in these services, including nurses, paramedics and pharmacists.

The out-of-hours period

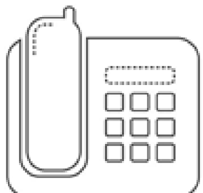


Plus weekends and public holidays

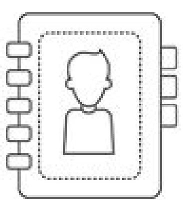
Who is responsible for providing out-of-hours services?

Since 2004, health boards have been responsible for ensuring their resident population can access these services. Some health boards choose to provide these services directly, by employing staff. Other health boards choose to commission other organisations (ie private companies or not-for-profit cooperatives) to provide these services (see Appendix 1).

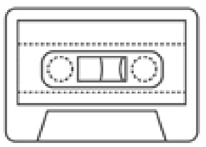
How do out-of-hours services work?



0.6 million
people contact out-of-hours every year.

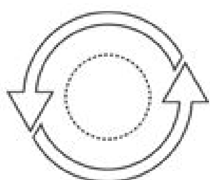


People call their GP surgery's number,
or
the out-of-hours service's direct number,
or
in some areas people can now call 111.

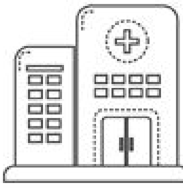


Recorded message
A welcome message signposts patients to alternative services. Hold the line to speak to the out-of-hours service.

Call taking
The call is answered by a trained call handler. They ask what the problem is.



Call back
A doctor, nurse or paramedic often calls the patient back.



Advice or Appointment
Some patients are advised to self-care, some are visited at home and most have an appointment at a primary care centre.

2 The timeline below highlights the important events and changes that have affected out-of-hours services in Wales since 2004.

Exhibit 2 – Timeline of key developments in out-of-hours services

Year	Development
2004	A new General Medical Services contract allowed GPs to opt out of the provision of out-of-hours services. Responsibility for commissioning out-of-hours services fell to health boards.
2012	A ministerial review by Dr Chris Jones, found that out-of-hours services across Wales were unsustainable. The report highlighted a lack of investment, opportunities for economies of scale, a lack of comparable data and a shortage of medical staff.
2013	A report from the Wales Audit Office on unscheduled care highlighted issues with recruitment and retention of GPs as well as scope to improve integration and information sharing between out-of-hours services and other unscheduled care services.
2014	The NHS in Wales produced a set of national standards for out-of-hours services, with a target date to reach these by March 2018.
2015	A review of out-of-hours services at Betsi Cadwaladr University Health Board found a number of problems including inadequate staffing levels, long waiting times and a lack of clinical leadership. There was also potential to improve staff training, monitoring and clinical governance.
2015	The NHS Wales Delivery Unit carried out a baseline review of out-of-hours services in Wales. The report found issues in relation to call handling systems and challenges with recruitment, retention and financial probity.
2016	In October 2016, the NHS in Wales began a pathfinder project to implement the 111 service. In late 2016, the Wales Audit Office carried out fieldwork on out-of-hours services at all health boards.
2017	Further work from the Delivery Unit found that achievement of the national standards would require a considerable amount of development work. During 2017 the Wales Audit Office published reports in all health boards regarding out-of-hours services.
2018	Health boards were expected to have implemented the national standards for out-of-hours services by March 2018.
2018	In May 2018 the Board of Community Health Councils in Wales published a report highlighting the fragility of out-of-hours services in Wales.

Source: Wales Audit Office

3 This report considers whether patients in Wales have access to resilient and well-run out-of-hours services. It summarises the findings from our 2017 audit reports on out-of-hours services at each health board. We have also examined the current arrangements for the national leadership and planning of out-of-hours, and the progress that has been made in delivering the 111 telephone service (see Exhibit 3). Appendix 2 describes our methods.

4 This report is part of a suite of Wales Audit Office work on primary care. In April 2018, we published A Picture of Primary Care in Wales. During autumn 2018, we will publish reports describing each health board's progress in delivering the national primary care plan.

Exhibit 3 – What is 111?

The 111 service is a new way for people to get health information, advice and urgent care, 24 hours a day. People should still call 999 for emergencies.

The service brings together the phone-based aspects of NHS Direct Wales and out-of-hours.

The Welsh Government and National 111 Programme intend to roll out the 111 service across Wales subject to a successful pathfinder scheme in Swansea, Neath Port Talbot, Bridgend and Carmarthenshire. People in these pathfinder areas can dial 111 free of charge.

The pathfinder is part of wider work on developing a Transformational Model of Primary Care in Wales. Click this link for more details on the model: www.primarycareone.wales.nhs.uk/pacesetters

The service is for people who are unsure of which service to use, or who just want advice or information. Importantly, the service is also for people who want to access out-of-hours services. 111 will eventually replace the out-of-hours phone number.

People calling 111 get through to a bank of trained call taking staff employed by the Welsh Ambulance Services NHS Trust. If necessary, people then have an assessment over the phone, with a doctor, nurse or pharmacist. These clinicians may solve the person's problem through advice or information, they may make a referral to another service or they may make an appointment or arrange a home visit from the out-of-hours service.

Provision of home visits and face-to-face appointments remains the responsibility of each health board, not the 111 service.

Evaluation of the ongoing pathfinder has shown some positive results, as shown later in this report.

Navigate to the Welsh Ambulance Services NHS Trust website for further details on 111.

Source: Wales Audit Office, Welsh Ambulance Services NHS Trust

5.2

Key findings and recommendations

5 Overall, we concluded that primary care out-of-hours services are appreciated by patients but are not meeting national standards[1] and are under strain due to morale and staffing issues. Poor information hampers effective management of services, and planning of out-of-hours is not properly integrated with other key services. The introduction of a new 111 service presents opportunities for important improvements but cannot solve all of the issues facing out-of-hours services. The findings that have led us to draw these conclusions are summarised below.

Our survey suggests patients have generally positive views about out-of-hours services but there is a need to improve signposting and to achieve the national standards on timeliness

6 Our patient survey revealed generally positive views about out-of-hours services. Whilst our survey provides only a small snapshot of the views of 330 patients, half of all respondents rated out-of-hours as 'Excellent' and 89% rated it as excellent, very good or good.

7 Our mystery shopping exercise showed there is scope to improve signposting to help the public understand when and how to use out-of-hours services. We found scope for more consistent and clearer messages on health board websites and GP practice phone lines.

Recommendation 1

In parallel with the national roll out of the 111 telephone service, the Welsh Government should lead work to standardise the way that NHS websites, GP phone lines and other NHS information sources refer and signpost to out-of-hours services. The work should also aim to provide a clear, nationally-agreed definition of the scope of out-of-hours services and the circumstances in which the public should access them.

8 The available data on out-of-hours services suggests some service users face delays in call handling, home visits and face-to-face appointments. The Welsh Government expected health boards to meet the national standards for out-of-hours services by March 2018. However, the most up-to-date data (up to October 2017) suggests health boards are some way off from meeting many of the standards.

1 Wales Quality and Monitoring Standards for the Delivery of Out-of-Hours Services, May 2014.

Recommendation 2

The Welsh Government is carrying out work to update the national standards for out-of-hours, to make sure the standards fit with the new ways of working between 111 and out-of-hours. The Welsh Government should introduce an annual report to describe the health boards' progress in implementing the new national standards.

Notional funding from the Welsh Government has fallen in real terms and services are strained due to morale and staffing issues that threaten the resilience of services

9 Our staff survey highlighted poor morale in out-of-hours services. Factors contributing to this include perceptions of under-staffing, antisocial hours and a lack of career development. These factors may be deterring staff from working in out-of-hours services.

10 There is a range of staffing problems in out-of-hours services. Health boards are struggling to fill shifts and they rely on a small number of staff to fill unpopular shifts. All health boards are trying to reduce their reliance on GPs by expanding the range of professionals working in out-of-hours teams. But progress is piecemeal and at the time of our fieldwork, no health board had a specific workforce plan for out-of-hours.

11 Health boards' spending on out-of-hours services varies widely, and across Wales as a whole, Welsh Government's notional funding for out-of-hours has fallen 21% in real terms since 2004-05. Services are taking unsustainable approaches to paying GPs, such as increasing pay rates for last minute shifts, and by increasing rates to compete with neighbouring health boards. There is concern that out-of-hours services may be affected by the need to demonstrate increased compliance with rules relating to the tax and employment status of GPs. These issues have the potential to increase service costs and further deter staff from working in out-of-hours. Work is ongoing within NHS Wales to assess the impact of these issues.

Recommendation 3

To make out-of-hours services more attractive places to work, the Welsh Government should work with the health boards to carry out a national project to engage with out-of-hours staff, to identify and address the factors that are causing poor morale and deterring staff from working in these services.

Recommendation 4

The Welsh Government should work with the health boards, ambulance service and the 111 Programme to develop a national workforce plan for out-of-hours services. This should build on the engagement work in Recommendation 3. The plan should set out the mix of skills and competencies that multi-disciplinary out-of-hours teams need in future and the national-level actions required to deliver that mix of skills.

Poor information on service quality and performance is hampering the effective governance, planning and management of services at a national and local level

12 The frequency of reporting out-of-hours information to boards and committees varies considerably across Wales. Some interviewees told us that out-of-hours only receives enough attention at senior levels in health boards when the service begins to suffer operational problems.

13 Problems with gathering data on the performance and quality are causing difficulties with performance management. There are longstanding problems with the monthly data that health boards submit to the Welsh Government. There are large gaps in the data and there are issues with comparability between health boards. Some of these problems may be solved by a new national computer system (see paragraph 19) but the system will not be in place until October 2020.

14 There is scope to improve intelligence on the quality of out-of-hours services. The monthly data that health boards submit to the Welsh Government focus on national standards related to timeliness but do not cover the quality-related aspects of the standards. We also found that some health boards are not carrying out sufficient clinical audit to monitor the quality of care provided by clinicians. There is also scope to improve the way that services report and learn from patient safety incidents.

Recommendation 5

The Welsh Government should work with health boards to introduce a regular national assessment of quality in out-of-hours services, to consider clinical audit, learning from incidents and patient experience. The assessment should also lead to a set of national and local improvement actions for the NHS in Wales.

Planning of out-of-hours services is not properly integrated with other key services. The new 111 service will address some integration issues but will not solve all of the problems facing out-of-hours services

15 We found weaknesses in the planning of out-of-hours services at a national level. Whilst two national plans mention the strategic direction for out-of-hours, neither provides a comprehensive picture of the future for these services. For example, the national plan for 111 sets out the future model for 24-hour call taking, information and advice but there is no such model for face-to-face services like appointments and home visits. Health boards are not meeting the national timeliness standards for face-to-face appointments and home visits. And without a clear strategic plan or model for delivering these face-to-face services in new, innovative ways, it is likely that health boards will continue to struggle to meet the standards in future.

Recommendation 6

The Welsh Government should work with health boards, ambulance service and relevant all-Wales groups to test and spread innovative practice in the provision of out-of-hours face-to-face appointments and home visits. This work should result in a clear model of face-to-face services for the NHS to implement locally or regionally.

16 We also found weaknesses in the planning of out-of-hours services by health boards. Most health boards have action plans for out-of-hours services but these are operational rather than strategic. We also found that some health boards' unscheduled care plans barely mention out-of-hours, highlighting the need for more integrated planning.

17 There is scope to review and strengthen leadership arrangements at both a local and national level. Given that out-of-hours forms part of a wider system of urgent care, health boards have struggled to decide where to position out-of-hours within their existing management structures. Some health boards have chosen to split the executive responsibility for out-of-hours between two or more staff, which potentially muddies lines of accountability. Where appropriate, our local audit reports have made recommendations about strengthening leadership arrangements for out-of-hours services.

18 At a national level, there is a professional lead for primary care. The remit of this role is to take forward the national primary care plan but as the plan makes only one mention of out-of-hours services, out-of-hours has not been a major focus for the professional lead. Out-of-hours services have also not been a major focus of the national boards for unscheduled care and primary care. The All Wales Out-of-Hours Forum is a national, clinician-led group that guides developments in out-of-hours services but its remit is loose. There is also scope to better align the forum's work with that of the national boards and the Directors of Primary, Community Care and Mental Health.

Recommendation 7

Welsh Government should review the national leadership arrangements for out-of-hours services. The review should consider whether there is a need for more specific leadership of out-of-hours at a national level. The review should also consider the role of the All Wales Out-of-Hours Forum and whether its work is sufficiently joined up with that of the other national NHS groups.

19 The introduction of the 111 service provides a key opportunity to improve integration of out-of-hours with other services. The 111 service will provide 24-hour call taking, information and advice. Importantly, it will provide integrated call taking and triage for out-of-hours plus NHS Direct Wales. A 111 pathfinder scheme is showing encouraging results, and whilst implementation of 111 is taking longer than planned, the NHS in Wales now has a plan and business case that plots a full national roll out. Betsi Cadwaladr University Health Board will be the final health board to implement 111 and its roll out will begin in Quarter 4 of 2020-21. However, the plan does not set out the overall cost of implementing 111 across Wales. In particular, the plan does not set out the cost of implementing an integrated computer system to replace existing systems in 111 and out-of-hours services. At the time of drafting, the national 111 Programme was drafting a business case for the integrated computer system.

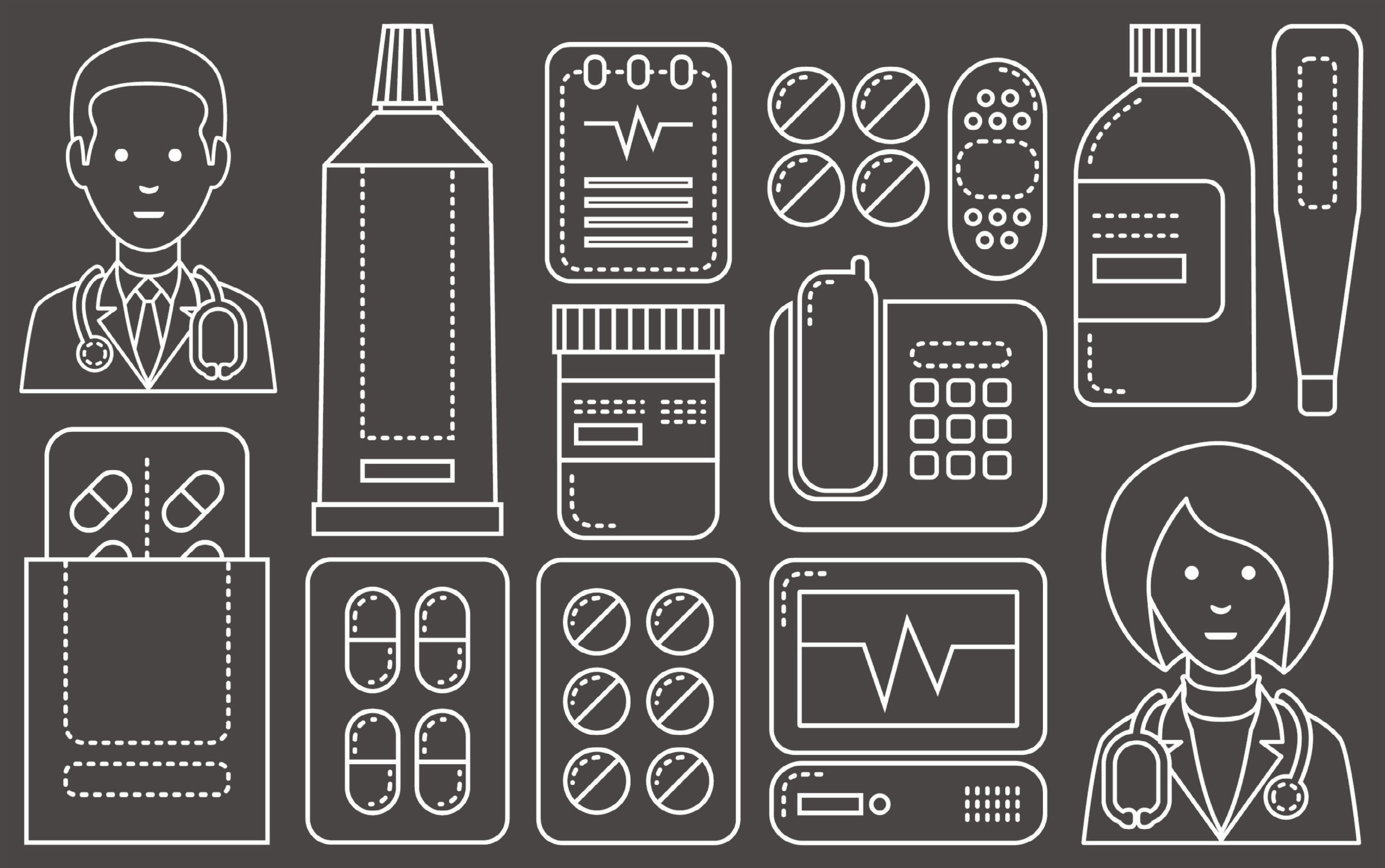
Recommendation 8

Welsh Government and the 111 Programme should clarify the timescales for finalising and assessing the business case for the integrated computer system to replace existing systems in 111 and out-of-hours services, to ensure decisions on affordability are taken as soon as possible.

20 While the 111 service has many potential benefits, it is not a solution to all of the problems facing out-of-hours services. A successful 111 service should ease some of the current call taking pressures. But as out-of-hours services will remain responsible for providing appointments at primary care centres and home visits, services are still likely to face challenges in filling shifts and ensuring adequate staffing levels.

Detailed report

5.2



Our survey suggests patients have generally positive views about out-of-hours services but there is a need to improve signposting and to achieve the national standards on timeliness

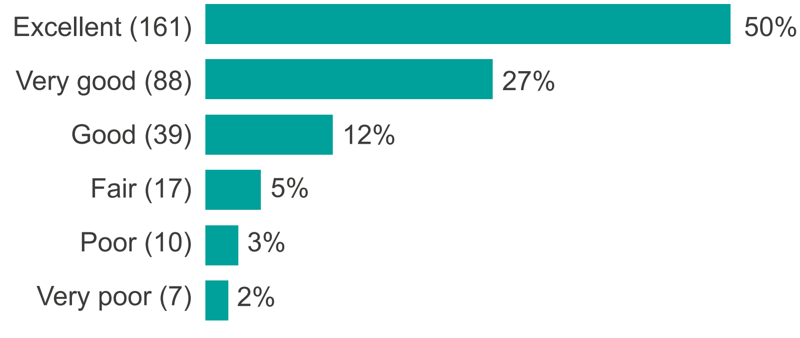
Our patient survey suggests people have generally positive views about out-of-hours services

1.1 We surveyed nearly 2,000 out-of-hours patients to ask their views on the care they received. We received 330 responses so we recognise that our survey provides only a small snapshot of opinions. Exhibit 4 suggests that overall, patients had positive experiences of out-of-hours.

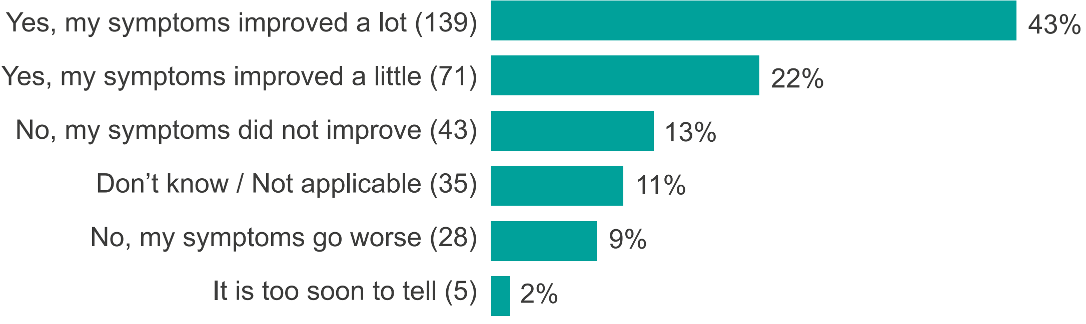
Exhibit 4 – Results of our patient survey

Overall satisfaction

How would you rate the service you received from the out-of-hours service?



Did your symptoms improve as a result of the advice/treatment you received from the out-of-hours service?



Call taking

- 89% thought the call taker always listened carefully to them.
- 92% thought the call taker always treated them with respect.

Patients offered an appointment

- 82% said the appointment location was convenient or very convenient.
- 89% said the healthcare professional always listened carefully.
- 93% said they were always treated with respect.

Patients visited at home

- 90% said the healthcare professional always listened carefully.
- 93% said they were always treated with respect.

A sample of positive views expressed by patients:

‘ While there was some delay in the doctor arriving, necessitating a second phone call to the out of hours service, when the doctor did arrive his care and thoroughness was excellent, we could not have asked for more from him.’

‘ Whatever statistics say this service is essential in a rural county like Powys.’

‘ The young doctor who attended me was truly sympathetic and helpful.’

‘ I was dealt with quickly and professionally and due to starting a course of antibiotics straight away my symptoms were under control in a few days. I feel this service is excellent and I was so impressed with this service as it was the first time I had call to use it.’

‘ My daughter is an epileptic and has suffered lots of problems during the night time. I have visited the out of hours many times and have always appreciated the fact that they are there. I will always be grateful. Thank you.’

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

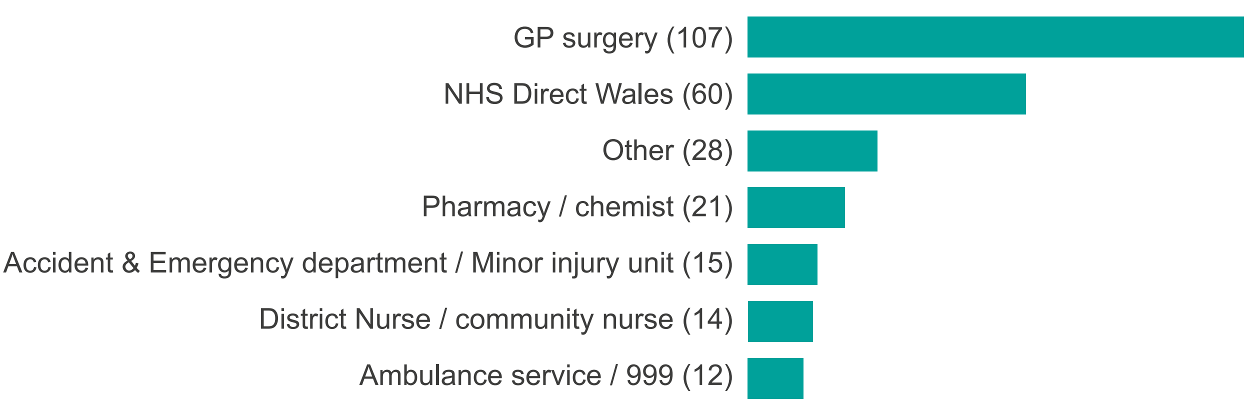
There is scope to improve signposting to help the public understand when and how to use out-of-hours services

1.2 We carried out a 'mystery shopping' exercise of GP practice phone lines and websites to better understand patients' experiences of contacting out-of-hours. We found scope to improve signposting to out-of-hours services through health board websites. Four out of seven health board websites had clear information about out-of-hours on their landing pages. And whilst all health boards had a specific webpage dedicated to out-of-hours, only three of these pages provided a description of the service and only two gave the opening times. Only Aneurin Bevan University Health Board's webpage provided examples to illustrate circumstances where it is appropriate to access the service.

1.3 There is also scope to improve signposting to out-of-hours services through GP practice telephone lines. We called 70 practices during the out-of-hours period and found that more than a quarter of the answerphone messages we heard did not give the telephone number of out-of-hours services. Only around half of the answerphone messages stated that out-of-hours services are for 'urgent' cases only.

1.4 The results of our patient survey also suggest there is a need to do more to help patients find their way to the most appropriate service for their needs. Exhibit 5 shows that many patients accessed other health services before contacting out-of-hours. Whilst this may be unavoidable in some cases, better public understanding of services may ensure people find the right help more quickly.

Exhibit 5 – Many patients contact other health services before finding their way to out-of-hours



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

While incomplete, data suggests health boards are not meeting the national standards for timeliness in out-of-hours services

1.5 Later in this report we highlight weaknesses in out-of-hours performance data (see paragraphs 1.28 to 1.30). The data that does exist suggests problems with the timeliness of aspects of out-of-hours services[2]. The Welsh Government expected health boards to achieve the national standards by March 2018 but the analysis below suggests health boards are some way off from meeting many of the standards.

1.6 The national standards require services to answer 95% of calls within 60 seconds of the end of any introductory message. During the year ending October 2017, health boards achieved only 75% against this standard. Four health boards did not meet the standard in any month.

2 The rest of this section uses data submitted to the Welsh Government from health boards for the year ending October 2017. However, there are some considerable gaps in the data. Abertawe Bro Morgannwg and Hywel Dda (for Carmarthenshire only) did not submit data during this period due to migration to 111 and associated technical issues. Aneurin Bevan and Betsi Cadwaladr had telephony problems that affected their data during the period.

1.7 The standards also state that 98% of 'urgent' calls should be logged and returned within 20 minutes. The performance across Wales during the year to October 2017, was 70%. No health board met this standard during any month.

1.8 There was also poor performance in returning 'routine' calls. The standard states that 98% of routine calls should be logged and returned within 60 minutes. Performance across Wales was 74% during the year ended October 2017. Again, no health board met this standard during any month.

1.9 Exhibit 6 shows services are also struggling to achieve the standards for timeliness of providing face-to-face appointments and home visits, particularly for very urgent and urgent cases. There is also large variation in performance levels between health boards. As these data show average performance across a year, they do not show daily variations in performance. During our interviews, we were told that daily performance can vary significantly, with particular difficulties in maintaining performance levels at weekends.

Exhibit 6 – Many patients are not receiving timely face-to-face appointments and home visits from out-of-hours services

Expected standard	**Performance in Wales** (year ended October 2017)	
	Face-to-face appointments	**Home visits**
90% of very urgent cases should have an appointment within 1 hour of clinical assessment	77% [Range: 64% in Cardiff and Vale to 100% in Powys]	63% [Range: 34% in Cwm Taf to 78% in Powys]
90% of urgent cases should have an appointment within 2 hours of clinical assessment	80% [Range: 61% in Cwm Taf to 100% in Powys]	66% [Range: 47% in Cwm Taf to 86% in Powys]
90% of less urgent cases should have an appointment within 6 hours of clinical assessment	98% [Range: 96% in Aneurin Bevan to 100% in Powys]	89% [Range: 71% in Cardiff and Vale to 99% in Powys]

Source: Wales Audit Office analysis of monthly data submitted by health boards to Welsh Government

1.10 As shown in Exhibit 7, our patient survey suggests a mixed picture of opinions on the timeliness of certain aspects of out-of-hours services.

Exhibit 7 – Results from our patient survey on the timeliness of out-of-hours services

Patients who were called back by the service

- 70% were told how long it would be before they were called back.
- 83% thought it took as long as expected or less time than expected for their call back.

Patients offered an appointment

- 85% thought it took as long as expected or less time than expected for their face-to-face appointment.

Patients visited at home

- 62% were told how long it would be before they were visited.
- 74% thought it took as long as expected or less time than expected for their visit.

A sample of views on timeliness expressed by patients:

‘ Doctor did not call, waited all day, no visit. Cancelled call at midnight and contacted my own doctor the following day.’

‘ I was extremely unwell with breathing issues and felt I should have been seen sooner.’

‘ I waited a total of 9 hours before being seen. I was admitted to hospital following the appointment for emergency treatment. Obviously this is unacceptable.’

‘ The waiting times for a home visit which did take most of the day, but otherwise a very good service.’

‘ I was told I would have to wait 8 hours for a call back so I went to A&E and was up there for 8 hours.’

Source: Wales Audit Office survey of patients

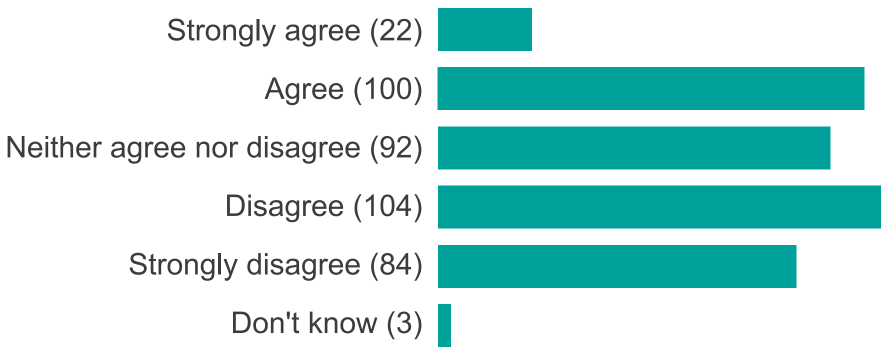
Notional funding from the Welsh Government has fallen in real terms and services are strained due to morale and staffing issues that threaten the resilience of services

Our staff survey suggests issues with morale in out-of-hours services

1.11 As part of our audit work we undertook a survey of staff working in out-of-hours services across Wales. Exhibit 8 shows that just 30% of the staff that responded to our survey agreed or strongly agreed that morale in the service was good. Exhibit 8 also shows some of the factors that are affecting morale of existing staff and are potentially deterring other staff from working in out-of-hours services.

Exhibit 8 – A range of factors are impacting on staff morale

In our survey, we asked staff about the extent to which they agreed with the statement: Morale within the out-of-hours service is good?



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

5.2

A selection of negative views about morale from our staff survey:

‘ Antisocial hours also have an impact.’

‘ The service is chronically understaffed, and this causes significant stress for those who remain. Consequently morale is low.’

‘ There is a lot of pressure on call handlers to decide whether the case is urgent or routine.’

‘ Morale is so low and career development - the goal posts keep changing - I am disillusioned as to whether I will ever get to where I want to be.’

‘ No facilities to take a rest break overnight.’

‘ I feel that out-of-hours is the "forgotten" relation within the health board.’

‘ There is a severe lack of communication between management and staff.’

‘ The volume of calls that we get and the pressure on the service is massive.’

A selection of positive views about morale from our staff survey:

‘ We have a great team.’

‘ Friendly atmosphere. Work as a team. Always availability to discuss any issues that arise during a shift, whether needing a second opinion before decision making.’

‘ The direct staff I have worked with for many years are what keeps the (service) going, keeping our spirits up and helping others. I have worked here for many years and consider them friends along with valued colleagues.’

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

Health boards have tried to modernise out-of-hours teams but services still rely heavily on GPs and a range of factors are dissuading many GPs from working in out-of-hours

1.12 The ministerial review of out-of-hours services carried out by Dr Chris Jones in 2012 stated that there was a 'manpower crisis' and said services were struggling to ensure adequate staffing. Our audit findings indicate that there are still significant staffing challenges within out-of-hours services in many parts of Wales. Even when services have a large pool of GPs to draw upon, only a small number of GPs tend to be willing to work overnight and weekend shifts. We also found that out-of-hours managers and administrators were having to spend a disproportionate amount of their time focusing solely on filling shifts instead of their numerous other tasks and roles.

1.13 During our fieldwork, we heard about a range of factors that may be dissuading GPs from working in out-of-hours services. Some of these factors included:

- increasing pressure during in-hours services (many of the GPs that work in out-of-hours also work in GP surgeries during the daytime);
- fear of litigation and patient complaints;
- perceptions of increasing workload pressure and low staffing in out-of-hours services;
- poor facilities and working conditions, such as access to food and refreshments, in some out-of-hours services; and
- issues related to the tax and employment status of GPs working in out-of-hours services (see paragraph 1.22 for further details).

1.14 Difficulties attracting GPs mean that services are trying to reduce their reliance on doctors by expanding the range of professionals in their teams. All health boards are exploring alternative staffing models by looking to employ additional triage nurses, advanced nurse practitioners, advanced paramedic practitioners and/or pharmacists. However, progress is piecemeal across Wales, partly because none of the health boards had a workforce plan for out-of-hours at the time of our fieldwork. A general challenge facing many services is in ensuring that the non-GP members of clinical teams receive adequate supervision and support to perform their clinical roles in out-of-hours.

1.15 In November 2017, the NHS in Wales produced its Strategic Development Plan for 111, which aims to roll out a standardised model of 111 across the country. That plan cites out-of-hours fragility as its highest risk. The Directors of Primary, Community Care and Mental Health now have an action plan for stabilising the out-of-hours workforce. Actions include reviewing capacity and demand, developing new approaches to home visits and approaches that allow GPs to carry out telephone triage from home, developing multi-disciplinary team working, and consideration of harmonising pay rates.

Notional funding for out-of-hours has fallen in real terms, services are taking unsustainable approaches to GP pay and the NHS needs to assess the impact of taxation issues relating to GP employment status

1.16 The ministerial review of out-of-hours services in 2012 highlighted a lack of investment in these services. We found that notional funding from the Welsh Government for out-of-hours has remained largely static at around £28.7 million between 2004-05 and 2016-17[3]. When inflation is taken into consideration, this equates to a 21% decrease in real terms[4].

1.17 The paragraph above considers the level of funding that health boards received from the Welsh Government. In this paragraph, we consider the health boards' actual expenditure on out-of-hours services. Between 2009-10 and 2016-17, health boards' spending on out-of-hours increased slightly from £31.7 million to £35.2 million. When inflation is taken into account, this represents a small decrease of 0.4% in real terms. Exhibit 9 shows that spending on out-of-hours varies widely by health board. In 2016-17, the cost of out-of-hours services per 1,000 population ranged from approximately £8,000 in Cardiff and Vale to £19,000 in Powys. We did not analyse the reasons for this variation and we recognise that fair comparison of the costs between health boards is complicated for reasons including:

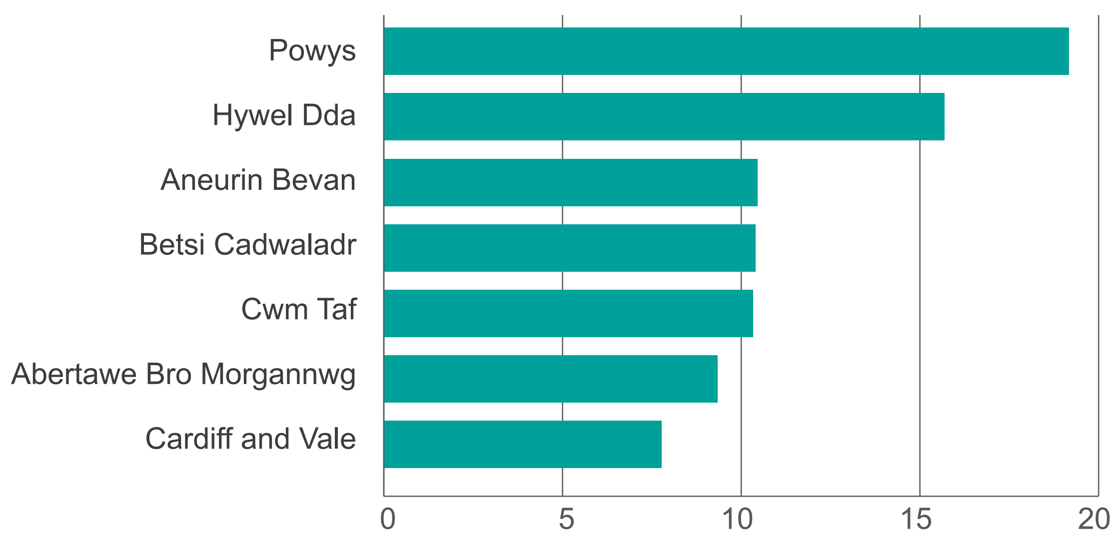
- **Geography**: Large, rural health boards may need more primary care centres and staff to cover larger geographical areas.
- **Population**: Areas with large, dense populations may be able to benefit from economies of scale.

3 This data was sourced from the Welsh Government. In 2004-05, when out-of-hours services became the responsibility of health boards to provide, the Welsh Government repatriated approximately £28.7 million in funding into the health boards' budgets. This sum has remained largely static ever since. The Welsh Government states that health boards receive a block allocation of funding from the Welsh Government and it is for each health board to determine how to spend that funding, based on local needs.

4 Calculated using HM Treasury GDP deflators at market prices, and money GDP December 2017 (Quarterly National Accounts).

- **Different models of provision**: The out-of-hours service in Powys is quite different to other services in Wales. The service in Powys is provided by a privately run not-for-profit doctors' cooperative called Shropdoc. The scope of the service provided by Shropdoc is broader than a traditional out-of-hours service[5]. This different model of provision and the different scope of the service makes it difficult to compare costs in Powys with costs in other health boards.
- **Shift fill rates**: Some services are unable to spend their full budget because they are unable to fill all staff shifts, which reduces pay costs.

Exhibit 9 – Spending on out-of-hours services varied widely across Wales in 2016-17



Source: Health boards' local financial returns; Mid-Year Population Estimates, Office for National Statistics.

5 Under the out-of-hours contract in Powys, Shropdoc provides 'margins cover' where GP surgeries can divert telephone calls to Shropdoc 30 minutes before closing and 30 minutes after opening. Other aspects of the contract include provision of a surgery service to Newtown Practice on Saturdays, provision of extended support to Dyfi Valley Practice throughout the week, provision of the drugs used during the out-of-hours period and provision of a violent patients telephone line.

1.18 We found that health boards set budgets for out-of-hours services that are largely historic and not based on actual need. Most health boards simply roll over the budget from previous years, with minor adjustments for changes planned during the forthcoming year.

1.19 One of the most significant financial challenges facing out-of-hours services is GP pay rates. To fill shifts, health boards must set pay rates that are high enough to attract GPs, while also ensuring good value for money. When services are struggling to fill a shift at late notice, many health boards increase their rate of pay. This approach can discourage staff from signing up to shifts in advance, which causes ongoing uncertainty about the service's ability to fill shifts, and potentially increases costs.

1.20 Three health boards use a 'shift bundling' approach. This is where staff are paid better rates by committing to work a bundle of shifts. Often the bundle must include some overnight and weekend shifts, so this approach can help to fill unpopular shifts.

1.21 As different health boards pay different rates for out-of-hours shifts, this creates a market where some staff can vary their place of work depending on how much they are paid. This means health boards are competing for the same pool of staff. There is extra competition for GPs from in-hours primary care services, and online GP consultation services run by private companies, that often pay higher rates than out-of-hours services.

1.22 There is concern that out-of-hours services may be affected by the need to demonstrate increased compliance with rules related to the tax and employment status of GPs. Her Majesty's Revenue and Customs (HMRC) has challenged a number of health bodies across the UK in recent years in relation to non-compliance with tax rules. The main issue relates to whether GPs working in out-of-hours should be classed as 'employees'. The NHS in Wales is concerned that this may result in unforeseen costs for health boards and further deter some GPs from working in out-of-hours. Work is ongoing within NHS Wales to assess the impact of these issues.

Poor information on service quality and performance is hampering the effective governance, planning and management of services at a national and local level

There is scope to increase the attention paid to out-of-hours at board and committee level in health boards

1.23 The frequency of reporting out-of-hours information to boards and committees varies considerably across Wales. Three health boards report performance and quality information annually to their board, whilst four report at least every quarter. There is similar variation for quality and safety committees.

1.24 Our survey of NHS board members showed that respondents were generally comfortable with the frequency with which they received information on out-of-hours services. 58% agreed that their board and committees regularly scrutinise out-of-hours performance. However, only 40% of respondents were satisfied with the quality of information they received.

1.25 During our fieldwork, some interviewees told us that out-of-hours only receives enough attention at senior levels in health boards when the service begins to suffer operational problems. Welsh Government is now trying to raise the profile of these services by including specific consideration of out-of-hours during regular performance meetings with health boards.

Health boards have good data to predict peaks in demand but staffing issues mean services still struggle to adapt

1.26 Despite the unscheduled nature of demand on out-of-hours services, peaks in demand are largely predictable. These services experience particular pressures during public holidays and during periods of cold weather.

1.27 Most health boards use past activity data to predict future peaks in demand. They then use these predictions to adjust their staffing rotas. Despite this ability to plan additional staffing requirements, out-of-hours services often struggle to attract staff to fill the additional shifts in the rota. In our staff survey, 66% of respondents felt their service was not flexible enough to meet peaks and troughs in demand.

Problems with gathering data on the performance and quality of services are causing difficulties with performance management

1.28 Robust performance data is essential to the effective management of out-of-hours services. Health boards are required to submit monthly data to the Welsh Government focusing largely on the performance levels set out in the national standards. However, there are significant gaps in the datasets provided by some health boards and there are problems with comparability of data between health boards.

1.29 The comparability problems stem from health boards having different versions of the Adastra software system in their out-of-hours services. Some data definitions are inconsistent between services, so benchmarking is difficult. Some of the gaps in the data are due to problems with telephone and computer systems that have prevented the recording of certain data items. There are further gaps in the data in the health boards involved in the 111 pathfinder (see paragraphs 1.48 to 1.54).

1.30 Welsh Government and the health boards have now agreed to standardise the way that patients' outcomes are recorded in Adastra. It remains to be seen whether this standardisation work will address current inconsistencies in the recording of timing points related to call handling, appointments and home visits. The Strategic Development Plan for the new 111 service aims to replace the Adastra system with a new IT system in October 2020.

There is scope to improve data on the quality of out-of-hours services

1.31 Some out-of-hours services are not doing enough to collect and review information about the quality of care provided by clinicians. At the time of our fieldwork, out-of-hours clinical leaders in two health boards[6] did not have enough time to carry out clinical audit to monitor the quality of care provided by all clinicians.

1.32 The out-of-hours data that health boards submit to the Welsh Government every month focuses almost exclusively on timeliness and does not cover the broader aspects of the national standards, including quality. At a national level, therefore, there are gaps in knowledge around the quality and safety of out-of-hours services.

1.33 Where health boards identify errors or incidents in relation to out-of-hours services, they should report the incidents to the National Reporting and Learning System. In 2015, two health boards did not report any such incidents stemming from out-of-hours services, however one health board reported 136 incidents. This suggests inconsistency between health boards in their approaches to reporting patient safety incidents. The All Wales Out-of-Hours Forum has recently taken on additional responsibilities for sharing learning across health boards following incidents.

1.34 In our staff survey, 53% of respondents agreed that information obtained through complaints, incidents and error reporting was used to make care safer. Twenty-one percent neither agreed nor disagreed, 14% disagreed and 12% said they did not know.

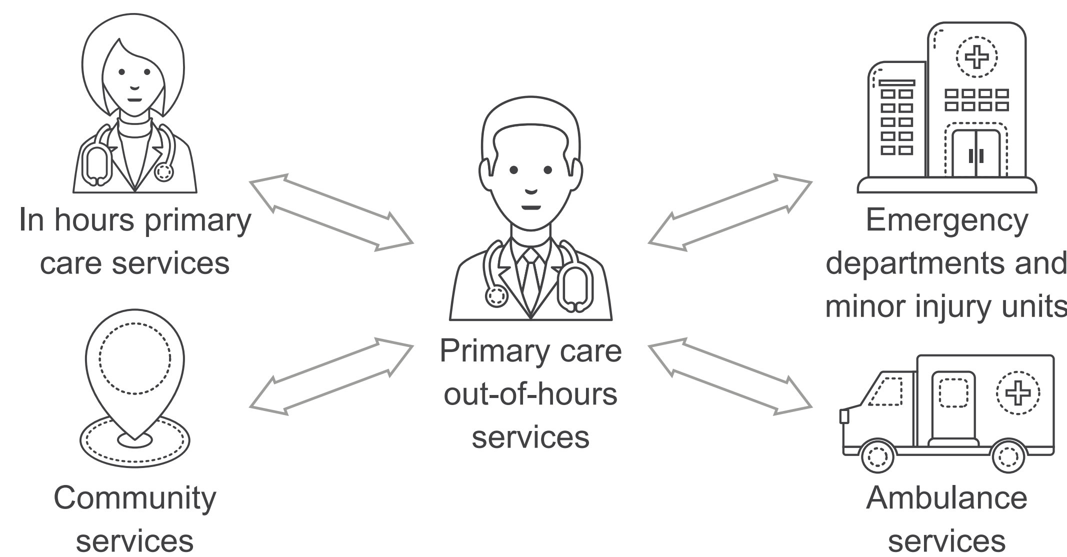
6 Cardiff and Vale University Health Board and Hywel Dda University Health Board.

Planning of out-of-hours services is not properly integrated with other key services. The new 111 service will address some integration issues but will not solve all of the problems facing out-of-hours services

There is no national out-of-hours strategy and these services are often not considered enough during wider planning of health and care

1.35 This section of the report considers whether the NHS in Wales is planning out-of-hours services as a fully integrated part of the system of health and social care. Exhibit 10 shows that out-of-hours services are a key component of the wider system. It also shows that if the NHS plans out-of-hours services in isolation from other services, this can cause problems.

Exhibit 10 – Out-of-hours services are a key part of the wider health and care system



When out-of-hours services are under pressure, or close temporarily due to staff shortages, significant additional demand can spill into ambulance services, hospitals, community services and in-hours primary care services.

These services are dependent on one another. Changes to one service can have negative impacts on others. So if out-of-hours services are planned in isolation of other services, this can cause problems. Integrated planning and leadership of all of these services is really important.

Source: Wales Audit Office

1.36 Despite the importance of out-of-hours services, Wales does not have a single, comprehensive strategy for out-of-hours. Two national plans mention the strategic direction for out-of-hours but neither provides a comprehensive picture of the future for these services. For example, whilst there is a national primary care plan, it makes only one mention of out-of-hours services. And whilst the national plan for 111 sets out a model for out-of-hours call taking and triage, it does not cover appointments at out-of-hours primary care centres and home visits. It is these face-to-face aspects of out-of-hours services that health boards are struggling most to provide.

1.37 NHS Wales has a set of national standards for out-of-hours services but the standards set out expected performance levels rather than providing a model or strategic direction. The standards are summarised at Appendix 3. The Welsh Government is now revising the standards to cover out-of-hours and 111. This presents an important opportunity for the Welsh Government to clarify the future model for out-of-hours services.

1.38 Wales has national boards for planning unscheduled care and for primary care. However, out-of-hours has not been a major focus of either board. Out-of-hours issues have been more of a focus at the meetings of the health boards' Directors of Primary, Community Care and Mental Health. During the past year or so, there has been an increase in focus on out-of-hours at meetings of health board chief executives.

1.39 Wales does have a national group that guides developments in out-of-hours services. The All Wales Out-of-Hours Forum began as a group to explore the educational needs of out-of-hours doctors but has now taken on an informal role of providing advice to health boards and Welsh Government. The group is well-attended by clinicians and senior out-of-hours managers, is a good forum for open discussion and provides a mechanism for peer support for clinical directors and operational managers. However, its remit is loose and its work needs to be better integrated with that of the national boards and the Directors of Primary, Community Care and Mental Health.

1.40 At a local level, most health boards have action plans to improve out-of-hours services. However, these tend to be operational, rather than strategic plans. In our survey, only 28% of staff said their health board had a good plan for the future of out-of-hours. We also found that some health boards' wider unscheduled care plans barely mention out-of-hours services.

7 Our plan for a primary care service for Wales up to March 2018

Out-of-hours does not always get the attention it needs, partly due to weaknesses in leadership arrangements

1.41 Given the significance of out-of-hours services, it is important that health boards and Welsh Government have strong leadership arrangements for these services. We found weaknesses in these arrangements, partly because health boards and Welsh Government have struggled to decide the best place for these services within their management structures.

1.42 Out-of-hours services are difficult to place within existing structures because they sits across traditional service boundaries. Out-of-hours is partly a primary care service because GPs have traditionally led its delivery. But out-of-hours is also an urgent care service due to its role in meeting the urgent needs of patients. Out-of-hours is also closely related to emergency and unscheduled care due to its links with accident and emergency departments and ambulance services.

1.43 Most health boards have positioned out-of-hours within their unscheduled care management division or directorate. Other health boards have placed out-of-hours within the primary care division. Health boards have also taken mixed approaches to deciding their executive leadership arrangements for out-of-hours. All health boards have named executives with responsibility for these services but five have split this responsibility between two or more executives. These arrangements potentially muddy the lines of accountability.

1.44 Our staff survey revealed mixed views on the clarity of lines of accountability for out-of-hours services. 47% of respondents agreed that lines of accountability were clear, 31% disagreed, and 21% were neutral or did not know.

1.45 We conclude that there is scope to strengthen leadership of out-of-hours within health boards. The lack of clarity in these arrangements contributes to out-of-hours being somewhat isolated from other service areas. These weaknesses mean that the issues faced by out-of-hours services do not always have a high enough profile within health boards.

1.46 We also found issues with leadership arrangements for out-of-hours at a national level that might be reducing the profile of these services. Within Welsh Government's Health and Social Services Group, responsibility for out-of-hours sits with the Urgent Care team. However, the team is relatively small at just three posts.

1.47 Whilst there is a national professional lead for primary care, the role does not focus specifically on out-of-hours. The lead's role is to take forward the national primary care plan but as the plan makes only one mention of out-of-hours services, this has not been a major focus area for the professional lead. Interviewees told us, however, that the Welsh Government's new primary care lead is being more proactive in ensuring their role covers out-of-hours as well as in-hours primary care.

The 111 pathfinder is showing promise and is an opportunity to better integrate out-of-hours with other services but roll-out is taking longer than planned and 111 cannot solve all problems facing out-of-hours

1.48 In December 2011, the Welsh Government took the decision in principle to introduce a three-digit phone number for urgent, non-emergency care.[8] The 111 service aims to provide call taking, health information and advice. Importantly, the service aims to provide integrated call taking and triage for out-of-hours plus NHS Direct Wales.

1.49 Implementation of 111 is taking longer than planned. After the initial decision to launch 111, there were delays in developing costed options for implementation, partly because the Welsh Government deliberately waited to learn from an evaluation of the 111 scheme in England. We consider this a pragmatic decision to enable Wales to learn from the large-scale changes in England, which included start-up issues such as delays in responses and abandoned calls within the 111 service. In a statement to the Senedd on 23 April 2013, the Minister for Health and Social Services said that the planning of 111 would be accelerated. As reported in our September 2013 unscheduled care report[9], Welsh Government planned to complete its phased implementation in 2015.

1.50 Progress in the 111 project accelerated after the appointment of a new programme director in 2015. In late 2016, NHS Wales launched a 111 pathfinder scheme at Abertawe Bro Morgannwg University Health Board. Evaluation of the first six months of the pathfinder has shown encouraging results. As shown in Exhibit 11, the evaluation suggests the 111 service is providing high patient satisfaction and timely call taking. Nevertheless, the Welsh Ambulance Services NHS Trust told us that the 111 service has also suffered some operational challenges, particularly when out-of-hours services have struggled to fill shifts.

8 Department of Health and Social Services, Chief Executives' Meeting, CEO(30)09

9 Auditor General for Wales, Unscheduled care: An update on progress, September 2013.

Exhibit 11 – The 111 pathfinder is showing encouraging results

92% of patients said they would recommend the service.

94% of patients said the health advice and information was helpful.

75% of staff said patients were receiving the right care in the right place all or most of the time.

94% of calls were answered within 60 seconds.

The average triage time for the most urgent calls was 3 minutes.

The pathfinder did not create additional demand for emergency departments or out-of-hours services. However, the health board also notes that demand for out-of-hours services has not reduced since 111 began.

During the pathfinder phase, there was a reduction in ambulance conveyances and a reduction in emergency department attendances. Whilst the evaluation of the pathfinder suggests that 111 might have contributed to these reductions, it also recognises that other factors could have contributed to this change.

Source: Abertawe Bro Morgannwg University Health Board and NHS Wales Review of the 111 Pathfinder, in association with Janette Turner, University of Sheffield, September 2017.

1.51 In November 2017, the NHS in Wales produced its Strategic Development Plan for 111, which aims to roll out a standardised model of 111 across the country. The plan sets out a range of potential benefits including simpler access to services with seamless transfer of information between clinicians. Service benefits include standardisation and integration of services across Wales, with improved efficiency and better outcomes.

1.52 The Strategic Development Plan provides a timeline for the roll out of 111 at all health boards. The final health board to implement 111 will be Betsi Cadwaladr where roll out is due to begin in Quarter 4 of 2020-21, approximately 9 years after the initial decision to launch a 111 service.

1.53 The Strategic Development Plan states that the cost to the Welsh Government of rolling out 111 to five health boards from 2017-18 to 2019-20 will be £18.7 million. Health boards will also contribute up to £400,000 each per year. However, the plan does not set out the full cost of implementing 111 across all health boards in Wales. In particular, the plan does not set out the cost of implementing a new integrated computer system to replace existing systems in 111 and out-of-hours services. At the time of drafting this report, the national 111 Programme was developing a business case for the replacement IT system.

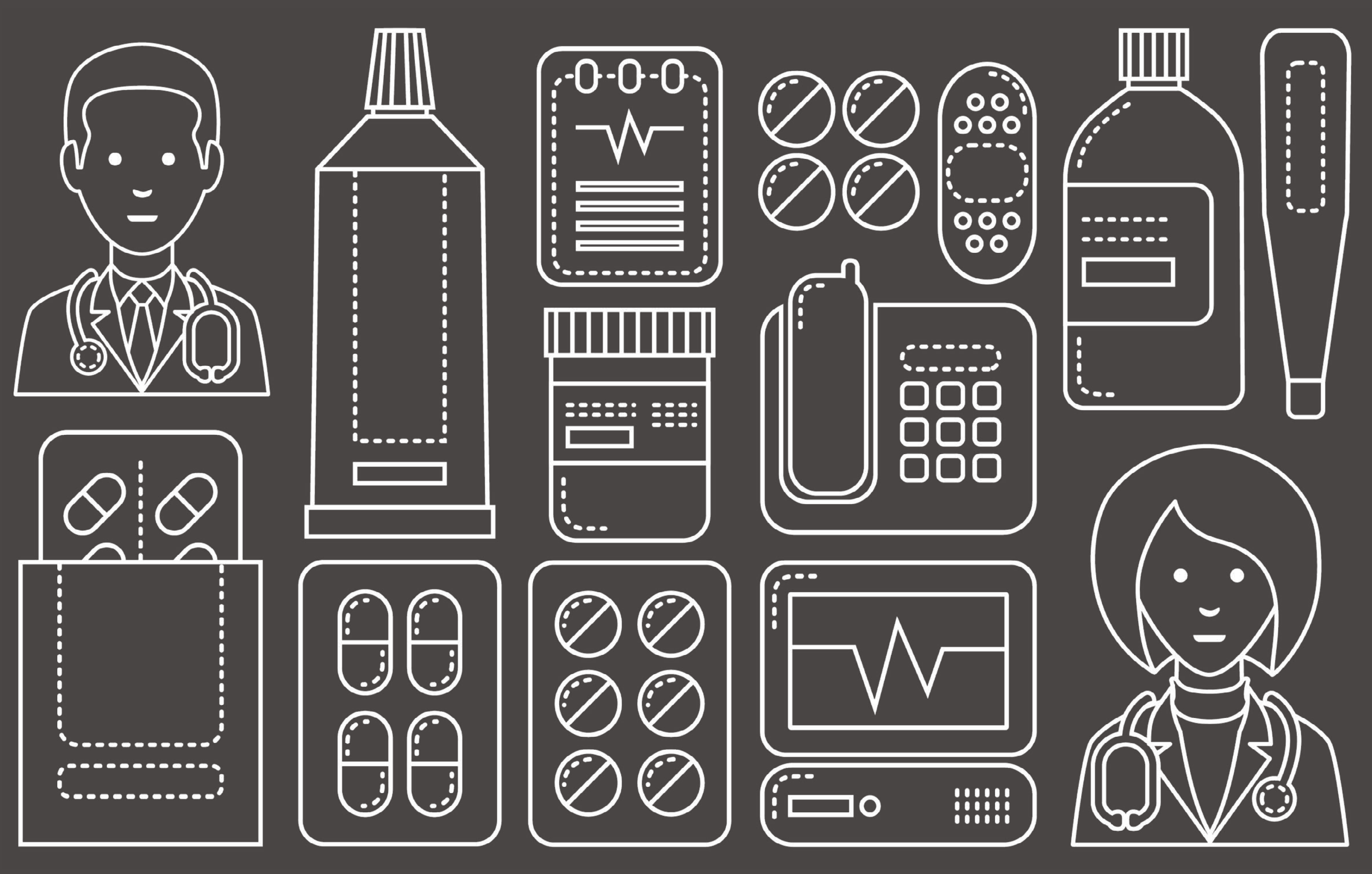
1.54 The Strategic Development Plan sets out a wide range of benefits that it hopes 111 will deliver. These benefits include improved clinical outcomes, maximising a scarce workforce and help for patients in choosing the right service for their needs. While the roll out of 111 represents a significant change for the NHS in Wales, it will not solve all of the problems currently facing out-of-hours services. A successful 111 service should ease some of the current call taking pressures. But as out-of-hours services will remain responsible for providing appointments at primary care centres and home visits, services are still likely to face challenges in filling shifts and ensuring adequate staffing levels.

Appendices

Appendix 1 – Locations and call handling arrangements for out-of-hours services

Appendix 2 – Our methods

Appendix 3 – National standards for out-of-hours services



Appendix 1 – Locations and call handling arrangements for out-of-hours services

The table below shows the location of each health board's out-of-hours primary care centres, and provides details of the out-of-hours call handling arrangements.

Health Board	Primary Care Centres	Details of call handling arrangements
Abertawe Bro Morgannwg	3 – Morriston Hospital, Neath Port Talbot Hospital, Princess of Wales Hospital	Out-of-hours call handling provided by 111.
Aneurin Bevan	3 – St Woolos Hospital, Newport, Ysbyty Ystrad Fawr, Ystrad Mynach, Nevill Hall Hospital, Abergavenny	Call handling and triage in call centre shared with the Welsh Ambulance Services NHS Trust.
Cardiff and Vale	3 – Barry Hospital, University Hospital of Wales, Cardiff Royal Infirmary	Call handling is provided directly by the health board.
Cwm Taf	2 – Royal Glamorgan Hospital, Prince Charles Hospital	Call handling is provided directly by the health board.
Powys	5 – Brecon, Welshpool, Llandrindod Wells, Newtown, Ystradgynlais Hospital	The Shropdoc doctors' cooperative provides out-of-hours services in most of the area. Abertawe Bro Morgannwg University Health Board provides out-of-hours services at Ystradgynlais Hospital.
Hywel Dda	5 – Prince Philip Hospital, Glangwili Hospital, Withybush Hospital, Bronglais Hospital, Llynyfran Surgery	Out-of-hours call handling provided by 111 (in Carmarthenshire only).
Betsi Cadwaladr	3 – Ysbyty Gwynedd, Ysbyty Glan Clwyd, Wrexham Maelor Hospital	Call handling is provided directly by the health board.

Appendix 2 – Our methods

We reported on out-of-hours services in each health board during 2017. The majority of our local fieldwork took place between June and November 2016. We carried out our national-level fieldwork in late 2017 and early 2018. Details of our approach are set out below.

Exhibit 12 – Our methods

Method	Detail
Health board questionnaire	We used a questionnaire to gather corporate-level data from each health board.
Document review	We reviewed key documents relating to out-of-hours at each health board, as well as national-level documents.
Interviews	We interviewed a range of staff at each health board including executives, senior managers, operational managers, clinical leaders and operational staff. At a national level, we interviewed a range of staff from Welsh Government, the 111 Programme, Delivery Unit, bodies representing out-of-hours clinicians, and the All Wales Out-of-Hours Forum.
Survey of out-of-hours staff	We carried out an online survey of all staff that work in the out-of-hours service. We had responses from 408 people.
Survey of patients	We carried out a postal survey of 1,990 randomly selected patients in Wales that had contacted the out-of-hours service in July 2016. We received responses from 330 patients, giving a response rate of 16.6%.
Survey of Board members	As part of our structured assessment work, we surveyed NHS Board members. We included a small number of questions relating to out-of-hours services.
Review of health board websites	We reviewed the health boards' websites to assess the effectiveness of information provided on how and when to access out-of-hours services.
Mystery shopping: GP practice phone lines and websites	We made telephone calls, after practice closing times, to a sample of 10 practices in each health board. We assessed the answerphone message for effectiveness in information provision to patients. We also assessed GP practice websites to assess the signposting to the out-of-hours service.

Appendix 3 – National standards for out-of-hours services

Exhibit 13 – National standards for out-of-hours services

Standard	Summary of requirements
Standard 1. To ensure that services respond in a timely manner	This standard covers timeliness of introductory messages, call taking, appointments and referrals to other services.
Standard 2: Accessible	There should be a single phone number in each health board area, and patients should be able communicate in their own language. Provisions should be made for people with disabilities and sensory impairments and call handlers should have up-to-date information to signpost patients to other services.
Standard 3: Knowledgeable	Staff should have a pre-employment check and an induction programme. There should be an annual review of training and annual appraisals. Services should also have access to patients' medical history.
Standard 4: Effective	Clinical assessments should be in line with national guidelines. Services should use a quality improvement methodology and learn from all significant events. A minimum of 1% of clinical contacts should be audited by the service, with a minimum of 4 cases per clinician per year.
Standard 5: Care is safe	Services should have arrangements for risk management, governance, accountability, complaints handling and serious incident reporting. Services should ensure timely transmission of relevant patient information to their own GP practice. The standards say there should be compliance with the local antibiotics formulary and a controlled drugs policy should be in place.

Standard	Summary of requirements
Standard 6: Consistent	Services should flex to meet periods of high demand, using business continuity and escalation plans. Planning should be on the basis of 4 consultations per hour for face-to-face appointments.
Standard 7: Acceptable	Services should have policies for equality, diversity, human rights, dignity and respect. Services should demonstrate they take patient views into account.
Standard 8: Relevant	Clinical pathways should be in place and agreed with various stakeholder groups.
Standard 9: Efficient	Financial probity should be assured and services should be cost effective.

Source: Wales Audit Office summary of the Wales Quality and Monitoring Standards for the Delivery of Out-of-Hours Services, May 2014

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Director General Health and Social Services/
NHS Wales Chief Executive
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Mr A Crompton
Auditor General
Wales Audit Office
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1 August 2018

Dear Mr Crompton

Primary Care Out of Hours (OOHs) Services – All Wales Summary Report

Thank you for providing a copy of the above report which you published on 12 July 2018. I accept it is a challenging, and yet largely balanced report, which reflects the very difficult environment within which OOHs operates. The report does, however, need to be seen in the context of workforce issues in the ‘out-of-hours’ period that are commonly felt across the UK, and not just in Wales.

The recommendations in the report call for greater involvement and leadership from both the Welsh Government and the NHS in the transformation of urgent primary care. The recommendations place an expectation on Welsh Government to lead a range of work, working with health boards, who have a statutory responsibly for the delivery of primary care services in the ‘out of hours’ period.

While the majority of the field work was concluded at least 12 months ago, Welsh Government recognises the OOH service is still fragile. It is ready to make a strong commitment to improve it, and has begun to do so through the following:

- The next few months will see a Peer Review process for OOHs being supported both by Welsh Government and the service. The Peer Reviews are clinically led learning sessions to support change. Seven workshops will be held across all LHBs over the autumn period to better understand the issues and develop an action plan, with workforce being the central component.

- The establishment of a national strategic lead, Judith Paget, CEO at ABUHB, will help to drive the strategic direction of the OOH service. This brings with it an opportunity to bring primary care, 111 and OOHs under the leadership of a single Senior Responsible Officer (SRO).

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- The 111 service in Wales is being rolled out and the work plan for 2018-19 and 2019-20 was agreed by the 111 Implementation Board recently. 2018-19 will see the remainder of Hywel UHB, Powys and Aneurin Bevan UHB all ‘going live’ with 111 in their localities, and work with North Wales to develop a clinical support hub to better support the OOH service over the winter period, ensuring that patients have better access to expert advice and treatment.

I know the WAO reviewed OOH services at the local level last year, and that each health board received their individual report. Health boards have a statutory responsibility for the delivery of primary care services, and will have worked to address the issues raised. Their board’s will have monitored progress through their quality and safety committees and it is pleasing to acknowledge that OOHs has begun to feature more strongly in the winter plans, in Joint Executive Team meetings, and during regular performance scrutiny.

I welcome this report. It is challenging but it will help us focus on what is a priority and drive forward the changes and improvements for the OOH services in Wales that are required.

General

The WAO patient survey revealed ‘generally positive views about the OOH service where ‘half of all respondents rated the service as excellent and 89% as excellent or very good’. While the report highlights the fragility of the service, I am pleased that we are beginning to address the areas highlighted in the recommendations.

While the report focusses on the ‘Out of Hours’ service, our future direction of travel will look at the provision of, and access to, a wider range of services in the out of hours period, and also the 24/7 model for primary care.

The transformational model for 24/7 primary and community care is key to these improvements. The model will be supported with a multi disciplinary team (MDT). The MDT will work to support patients, aim to deal effectively with unplanned care needs to enable people to remain at home wherever possible, and provide more support to enable faster discharge when people do need secondary care.

We are also developing a new *Policy Framework for Unscheduled Care* to set out the government’s expectations and ambitions for unscheduled care in Wales. Much has changed in the ten years since the publications of *Delivery Emergency Care Services (DECS)* in 2008, and this will provide an opportunity to set out how OOHs services can be further integrated into the new offer of 24/7 primary care.

Funding

The **notional** funding described in the WAO press release relates to the funding repatriated as part of the new GMS contract agreed in 2004. The report stated that this had not changed in the intervening period. While this may be accurate technically in terms of the defined national budget, it is not accurate in terms of actual expenditure; in 2017/18 LHBs actually spent £35.8m on Out of Hours delivery compared to the notional allocation of £28.7 – approximately 25% more than the notional funding (noted in paragraph 1.17).

*Funding

Allocation (2004)		17-18 Audited spend
ABMU HB	£4.533m	£5.066m
AB HB	£4.736m	£6.613m
BCU HB	£7.169m	£7.222m
C&V UHB	£3.048m	£3.768m
CT HB	£2.447m	£3.211m
H Dda HB	£4.826m	£6.913m
Powys HB	£1.980m	£3.034m
Total	**£28.739m**	**£35.826m**

There are eight recommendations in the report and I have taken the opportunity to consider and respond to each of these in turn.

Recommendation 1 - Access to OOHs and it's scope

In parallel with the national roll out of the 111 telephone service, the Welsh Government should lead work to standardise the way that NHS websites, GP phone lines and other NHS information sources refer and signpost out-of-hours services. The work should also aim to provide a clear, nationally agreed definition of the scope of out-of-hours services and the circumstances in which the public should access them.

The roll out of 111 provides an opportunity to simplify the message to the public about how they access care at times of unexpected need. The 111 number is easy to remember and free to use, both of which benefit the patient.

GPC Wales has agreed to improve the standard of messaging on GP practice answerphones, to help direct people to the most appropriate place when their surgery is closed. Welsh Government, working with the NHS, is developing guidance to clarity of key points that should be included in answerphone message to provide greater consistency across Wales.

Technological changes are happening fast and work is underway, through the 111 programme, to replace the current OOH IT system with a new pan Wales system. The procurement of this system has started and is due to conclude at the end of 2019.
In 'A Healthier Wales' we outlined how digital is a key enabler of transformational change and set out our ambition to provide an online digital platform for citizens. This will provide people with a new, digital way of accessing health and care services and information, enabling them to become more active participants in their own health and well-being. A key aspect of this will be the single National Directory of Services across health, social services and the third sector, which will help citizens make informed choices by signposting users to the most appropriate service for their needs, including OOHs. An 'App' to support this is currently being developed.

With the work to develop a 24/7 primary care model, it becomes increasingly important to define 'urgent primary care' and to re-shape the approach to 'Out of Hours' services. This has been picked up through the National Urgent Care Group and the National Primary Care Board. Improving access and reducing the pressure in other parts of the unscheduled care

system is a key objective, and options to address this at the GP Cluster level are being explored with GPC Wales.

Recommendation 2 - OoHs Standards and an Annual Report

The Welsh Government is carrying out work to update the national standards for out-of-hours, to make sure that the standards fit with the new ways of working between 111 and out-of-hours. The Welsh Government should introduce an annual report to describe the health boards' progress in implementing the new national standards.

The NHS and Welsh Government are working together in a clinically led process to redefine and finalise the national standards for 111. This will ensure they are clinically focused, outcome driven and have greater consistency over a 24/7 period. These new standards will be subject to the governance process through the Welsh Informatics Standards Board (WISB). The new standards will be introduced by spring 2019, and will supersede the existing OOHs standards and interim 111 standards.

In summer 2017, Welsh Government commissioned the NHS Delivery Unit to review and support health boards in the delivery of the OOHs standards. These standards, developed in 2014, were to be achieved by March 2018. The Delivery Unit produced an all Wales summary report for the Welsh Government, providing a position statement on where the LHBs were against the standards. This report has subsequently been published on HOWIS.
https://wg.wales.nhs.uk/uniquesigf31510284af2ec6dcfb998c39315f7a88ce2223c12638956 20e9f9605280fdf2/uniquesig0/sitesplus/407/page/71281

In summer 2018, Welsh Government has commissioned a self-assessment annual report from each LHB to assess their progress in delivering the new standards. These are in the process of being analysed and a summary report will be produced by Welsh Government by September 2018.

Recommendation 3 - OoHs - An Attractive Place to Work

To make out-of-hours services more attractive places to work, the Welsh Government should work with the health boards to carry out a national project to engage with out-of-hours staff, to identify and address the factors that are causing poor morale and deterring staff from working in those services.

Welsh Government have been working with health boards, professional bodies, clinicians and GPC Wales over the last 12 months to better understand how to make OOHs a more attractive place to work. Some LHBs - Powys tHB and Aneurin Bevan University Health Board - have established Clinical Reference Groups to improve engagement with their OOH workforce, which appear to be working well.

Welsh Government, working with NHS Chief Executives and the Strategic Lead for OOHs has agreed a national programme of peer reviews. These reviews will be chaired by Dr CDV Jones, supported by up-to-date information, and will engage with out-of-hours clinicians in developing local plans for the way forward. The first of the peer reviews will be held in Hywel Dda as a pilot in mid August, the remaining LHBs will conduct their peer reviews by November 2018, ahead of the winter 2018/19.

Recommendation 4 - Workforce

The Welsh Government should work with the health boards, ambulance service and the 111 Programme to develop a national workforce plan for out-of-hours services. This should build on the engagement work in Recommendation 3. The plan should set out the mix of skills and competencies that multi-disciplinary out-of-hours teams need in future, and the national-level actions required to deliver that mix of skills.

OOHs are part of a wider system, and need to be seen in the context of the transformational model for Primary Care This focuses on developing a 24/7 primary care service which uses the skill set delivered by multi-disciplinary professionals and new technology. Most LHBs have already been developing their OOH clinical teams to include a range of health professionals.

Workforce plans are generated from the annual planning process and significant effort is being made to ensure that these plans include urgent care and primary care components that include OOHs. We would agree that this process needs improvement and the action plan emanating from the peer review will include a specific component on workforce planning.

Recommendation 5 - Service Quality - OoHs

The Welsh Government should work with health boards to introduce a regular national assessment of quality in out-of-hours services, to consider clinical audit, learning from incidents and patient experience. The assessment should also lead to a set of national and local improvement actions for the NHS in Wales.

The GP Out of Hours Forum, a clinically led group comprising OOHs clinicians and managers, have now established a 'Quality and Safety Committee' to consider audit findings and derive learning from incidents and patient experience. This is chaired by Dr Roger Diggle, Associate Medical Director, Hywel Dda UHB.

Health boards must consider how to increase levels of corporate support to the primary care OOHs, and support from IM&T and patient experience teams is especially important.

Recommendation 6 - Best Practice, Local Management and a Local Model for face-to-face Services

The Welsh Government should work with the health boards, ambulance service and relevant all-Wales groups to test and spread innovative practice in the provision of out-of-hours face to face appointments and home visits. This work should result in a clear model of face-to-face services for the NHS to implement locally or regionally.

While in the longer term call handling and first line triage will be undertaken by the 111 service, the provision of the face to face element is likely to remain the statutory responsibility of the LHBs.

The new national Urgent Care Group, chaired by the Strategic Lead for OOHs will consider various models of care which can offer flexibility depending on local circumstances. However, the Group will also investigate the opportunities provided by regional working and new technologies.

The Peer Reviews will investigate local management arrangements; and will require LHB executives to introduce the process, and be in attendance for the session debrief, involving all participants. The resulting action plan will be developed by and owned by the LHB, to deliver change.

Health boards must ensure that workforce planning of OOHs is a priority for the corporate planning team; and that is features as a core service in the Health boards' Unscheduled Care Plans, winter plans and IMTPs.

Recommendation 7 - National Leadership

Welsh Government should review the national leadership arrangements for out-of-hours services. The review should consider whether there is a need for more specific leadership of out-of-hours at a national level. The review should also consider the role of the national Out-of-Hours Forum and whether its work is sufficiently joined up with that of the other national NHS groups.

Welsh Government supports the direction of travel in the report, encourages greater national leadership for OOHs, and the call for a strategic plan to develop sustainable clinical triage / treatment arrangements.

Welsh Government accepts that it will need greater involvement in the process and that accountability issues need to be clarified.

The Chief Executive of the Aneurin Bevan UHB has taken on the national strategic lead for Out of Hours. Ms Paget will work with the NHS and Welsh Government to transform the way services are delivered over the next few years. As a first step a National Urgent Care Group has been set up, which will align, support and scrutinise work being undertaken by the NHS and Welsh Government. This group will link closely with the National Primary Care Board, the 111 Board and the National Programme for Unscheduled Care.

Recommendation 8 - 111

Welsh Government and the 111 Programme should clarify the timescales for finalising and assessing the business case for the integrated computer system to replace the existing systems in 111 and out-of-hours services, to ensure decisions on affordability are taken as soon as possible.

The Business Case for the integrated computer solution for 111 is making good progress, and is following the timetable agreed as part of the capital investment process. Over the next three years OOHs will increasingly be provided through the NHS 111 service.

As the 111 programme rolls out it is expected to help the support for primary care OOHs, and with it greater national alignment for the call handling and clinical triage. The 111 team are supporting the development of regional working to meet the demand for clinical advice and treatment at peak times.

I accept the points where more leadership is called for, but I also believe that we have made progress on many of the calls for action. The establishment of a strategic lead is timely, and provides strong leadership moving forward. The Peer Review process and the *Policy Framework for Unscheduled Care* being developed over the coming months will help to provide a robust guide to how OOHs service should function in the future.

Yours sincerely

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Director General/ Chief Executive NHS Wales

cc:
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Archwilydd Cyffredinol Cymru
Auditor General for Wales

5.3

Review of Estates– **Aneurin Bevan University Health Board**

Date issued: November 2018

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

The person who delivered the work was David Poland.

Contents

The Health Board is taking positive steps to improve estate management but would benefit from introducing a strategic plan which reflects its vision for future healthcare provision.

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Background

1 The National Health Service in Wales' (NHS Wales) estate exists to support the provision of health care services. Buildings and infrastructure are valuable resources that can directly influence health service performance. They need to be of an appropriate type, condition and location, but can be costly to run and maintain.

2 Health boards across Wales typically have a diverse estate with numerous buildings, geographically dispersed, and of varying age and condition. Aneurin Bevan University Health Board has an estate portfolio of 71 properties (March 2014) that range from complex campus sites such as Royal Gwent Hospital, to small clinics and health centres This makes it one of the largest and most diverse of the LHB's in Wales, with a property value of £395M based on District Valuation. The estate occupies 120 hectares (296 acres) in total, with buildings having a gross internal area of 311,692m² (3,355,024 sq. ft). (Source: Draft Estates Strategy 2015-2020)

3 While major investments have replaced several hospitals and clinics, the Health Board still retains and operates sites that have buildings over 100 years old. It has infrastructure such as power distribution, drainage and heating that struggle to sustain the services being operated from within them. They also have deteriorating fabric. 46% of the estate is over 40 years old.

4 Successful estate management requires input and effort from health boards, and involves two broad activities:

- strategic management of the estate – important for making sound decisions about current use and future development of estates. The board, supported by relevant professionals, should determine what estate is needed to support service delivery, approve plans to deliver this, and provide oversight. The Health Board's Integrated Medium-Term Plan (IMTP) will be a key influence on this. Without a strategic approach, there is a risk that estate management and service development decisions are not coordinated. This creates a further risk that financial investment in the estate may be misdirected.
- operational management of the estate – important for ensuring the estate remains fit for purpose on a day-to-day basis, and that professionals can acquire, modify, and dispose of parts of the estate as required.

5 Effective and efficient management of the estate should deliver value for money. However, insufficient attention to either strategic or operational matters can result in money being wasted and sometimes substandard service delivery to users.

6 Our 2017 structured assessment highlighted that the Health Board doesn't have an estates strategy, estates plan or up to date condition surveys of its buildings. Therefore, the Health Board could make decisions around the acquisition, disposal and investment in buildings from an individual, not whole estate, perspective. The

lack of an estate strategy can also result in the Health Board retaining ownership of unused properties and incurring unnecessary extra costs. The Health Board is preparing for the opening of the Grange University Hospital and new community-based services. This is in line with its Clinical Futures Strategy (CFS). It is important that the Health Board reviews its current and future needs for buildings and makes appropriate changes.

7 The Health Board notes, in its draft Estates Strategy, that the CFS programme will result in major changes to its estate and will have far reaching consequences for future capital investment. Any emerging Strategy will also need to set out an approach to contingency planning. This is essential to ensure that services can be provided safely and effectively should plans not go ahead as currently envisaged.

8 Our review has sought to answer the following question: is the Health Board managing its estates effectively? To answer this question, we have considered whether:

- the Health Board's strategic approach to estates management is robust; and
- the Health Board is continuing to make improvements in key areas.

Key findings

Our overall conclusion is that the Health Board is taking positive steps to improve estate management but would benefit from introducing a strategic plan which reflects its vision for future healthcare provision. Exhibit 1 sets out our key findings in more detail.

Exhibit 1: our main findings

Our main findings
The Estates Team is involved in strategic planning through the IMTP process, but the Health Board lacks an agreed Estates Strategy. • The Health Board does not have an agreed Estates Strategy. • The Estates team is involved in strategic planning through the IMTP process. • The Health Board is piloting a new approach to assessment and reporting of its estate but is taking longer than initially expected to complete. • There is clarity around accountability, roles and responsibilities for Estate Management. • There are systems in place to record asset data and to support maintenance.
The Health Board continues to improve its management of Estates and Facilities in key areas. • The Health Board performs well against national indicators compared to the All Wales averages. • There are clear systems for managing performance but there is scope to make better use of service user feedback and post-work inspections. • The Health Board spends a high proportion of its maintenance budget on reactive repairs which reflects the age and condition of the current estate. • The board has a clear policy for the disposal of an asset once it has become redundant and it uses national and local guidance to dispose of assets. • The Health Board is aware of risks and prioritises actions using feedback from users.

Our main findings
• The Health Board actively ensures that staff and contractors have the skills and behaviours required to deliver an effective service. • Management is taking positive steps to improve staff satisfaction and sickness absence levels.

Recommendations

Recommendations	
R1	The Health Board should develop a fully costed Estates Strategy as soon as possible as recommended in our Structured Assessment 2017 (December 2017).
R2	The Health Board should finalise the 'Six-Facet' survey report to inform the Estates Strategy.
R3	The Division should include a range of Key Performance Indicators in its Performance Dashboard. These should include user satisfaction and completion targets.
R4	The Health Board should ensure that it completes post-inspections for a percentage of repairs as part of a systematic quality control process. It should include the results in its local performance management dashboard.

Detailed report

5.3

The Health Board's approach to estates management continues to develop but this is not reflected in a strategic plan agreed by the Board.

The Health Board does not have an agreed Estates Strategy.

9 The Health Board does not have and agreed Estates Strategy. We were provided with a copy of the draft Estates Strategy 2015-2020. This contained information that is out-of-date. For example, the performance data related to 2014-15 and there is no financial information.

10 Despite this, the strategic intention for the Estates function is set out in the Health Board's Integrated Medium-term Plan (IMTP) 2018-19 to 2010-21. There is also a Capital Programme which details the capital spend required over the next year. As at July 2018 the All Wales Capital Programme for the Health Board was £126,512,000. This included £126m for the Grange University Hospital development and £512,000 for the '111' programme.

11 The Capital Programme includes statutory allocations (£625,000); ongoing commitments from 2017-18 (£3,314,000); Informatics National priority (£1,223,000); Imaging national priority (£1,210,000) and Service developments (£1,033,000), High risk divisional priorities such as 'essential works and environment' and 'equipment replacement' have a combined total of (£2,161,000). Against a total capital funding of £10,814,00, there is a proposed spend of £9,556,000 which leaves a balance unallocated of £1,248,000.

12 Our fieldwork has confirmed that the need for an agreed Estates Strategy is understood by senior managers and Executives. In our Structured Assessment 2017 report (December 20017), we highlighted our concern that the Health Board did not have an estates plan or up to date conditions survey of its buildings. Decisions around the acquisition, maintenance and disposal of the Board's Estate were not strategically managed. We were informed that the Health Board was developing a 'six facet' survey to improve the accuracy of condition surveys. Once completed, this would be used to support the development of an agreed Estates Strategy and help target backlog maintenance work for the existing estate.

13 In our Structured Assessment 2017 we made the following recommendation:

> 'The Health Board should develop an Estates Strategy that reflects the current condition of its buildings and supports delivery of the Clinical Futures Strategy'.

14 The Health Board's Management response to our recommendation was

'The Health Board has recently completed a Six Facet condition survey of all premises to provide guidance and evidence for a full strategic estates review.

This will be developed into an overarching board estates strategy to sit alongside the clinical futures programme and the IMTP'.

15 Our review has determined that little progress has been made in achieving this recommendation. We were informed that the '6 facet' survey had been completed and would be used to inform the development of the Estates Strategy, but we have found little evidence of this.

The Estates team is involved in strategic planning through the IMTP process.

16 The main strategic issue impacting on Estates is the development of the Grange University Hospital. As noted above, it has now been agreed that the Grange development will proceed with WG funding of £126m. As a result, the Health Board is now in the process of developing an Estates Strategy based on the Clinical Futures Strategy.

17 The Health Board agreed a 3-year IMTP in June 2018 with the Cabinet Secretary for Health and Social Services. The WG response stated that the IMTP demonstrated a 'balanced and achievable three-year plan' with 'a growing maturity' in its planning arrangements. The response also stated that WG was 'looking forward to seeing the progress of transformational service change that these organisations have set out in the plans over the next three years'.

18 The Estates team was involved in the development of the IMTP. There is a separate section in the Plan on Capital and Estate as an enabler for the strategic Service Change Plans. The Capital and Estates section includes the Capital Funding outlook for the Health Board over the next three years leading up to the opening of the Grange University Hospital. It includes the emerging issues and risks. It also describes the work of the Strategic Capital and Estates Work stream and the management of the Health Board's Capital Programme.

19 The Estates Team developed its own IMTP, along with every other Division. These were fed into the overall board level plan. The Estates team was further involved in the overall IMTP process as all divisional IMTP's are circulated to every other division for information and comment. This process is also used to inform the Capital Programme. The Estates team 'sense checked' the IMTPs from other divisions and their capital requirements.

20 The process ensures that there are estates elements in each divisional IMTP as well as the overall Health Board IMTP. There is, therefore, engagement between the Estates Division and IMTP planning. This is important as the final Estates Strategy should be linked to the IMTP development process.

21 The Estates and Facilities IMTP 2018-19 to 2020-21 helps to set the strategic direction for the division. The priorities for the division include:

- Develop an Estate strategy based on outputs from the '6 facet' survey
- Introduce sustainable catering model at St Cadocs, County and St Woolos hospitals
- Ensure decontamination and sterilisation service able to support GUH and subsequent service reconfigurations
- Improve car parking capacity at Nevill Hall Hospital and seek alternative provision at Royal Gwent Hospital to replace Whiteheads site.
- Develop and implement a sustainable workforce plan for the Division post GUH commissioning
- Implement an Integrated IT management solution for Catering, Portering, Maintenance, Estate Management and Cleaning

22 The Estates and Facilities Divisional IMTP recognises the need to develop a full Estates strategy to consider the long-term targets of the Health Board. However, this strategy is taking time to develop. Therefore, the Health Board will address a range of estates related factors which affect patient choice and the delivery of activity targets. These factors include: -

- Improving the physical state of the Health Board premises and environment.
- Strive to reduce hospital acquired infections.
- Improve privacy and dignity for patients.
- Provide Facilities that can be cleaned to the required standards.
- Address backlog maintenance.
- Conclude and implement targets in line with the Six Facet Survey.
- Address top five risks year on year.

The Health Board is piloting a new approach to assessment and reporting of its estate but is taking longer than initially expected to complete.

23 As noted above the Health Board is piloting the '6 facet' survey for ways to improve reporting. It will be the first in Wales to do this. The Health Board will use the survey to appraise property. This will be used to assess fitness for purpose of health care buildings in terms of use, condition and compliance. The six facets which are assessed and ranked are:

- Facet 1: Physical Condition Survey (Fabric & M&E): The physical condition of the estate is assessed on three elements; the internal and external building fabric, mechanical systems and electrical systems.
- Facet 2: Statutory Compliance Audit (Inc. Fire): Fire, health and safety are assessed on the property's compliance to statutory legislation.

- Facet 3: Space Utilisation Audit: Space Utilisation is assessed on a series of judgements made on the intensity of use i.e. the number of people using it and the frequency with which they use it.
- Facet 4: Functional Suitability Review: Functional suitability is assessed on three elements; internal space relationships, support facilities and location.
- Facet 5: Quality Audit: Quality is assessed on three elements; amenity, comfort and design.
- Facet 6: Environmental Management Audit: Environmental management is assessed on the overall efficiency of the property, with energy being a critical factor.

24 Each facet is broken down into building systems and fabric elements as well as highlighting information about the property. Following reviews, scores are provided for all major property facets. This can then be used to inform Estates Strategy updates (and or property rationalisations and investment plans) as described by Estatecode - and as referred to in the Department of Health's 'Developing an Estate Strategy'.

25 The report will summarise findings and provide indicative investment costs. All backlog condition surveys (the 'Physical condition' facet) are based on the Department of Health's risk-based approach to assessing backlog maintenance.

26 The early release of the 6-facet survey report is crucial to the development of the Estates Strategy. It will provide the Health Board with a clear indication of the state of property portfolio to assist strategic decision making. The work has taken longer than expected to complete but when available the final report is expected to:

- Quantify an increased backlog maintenance cost
- Identify significant redundant estate
- Identify and quantify space under-utilisation
- Identify areas where functionality fails to meet current needs
- List and locate improvement opportunities for energy efficiency

There is clarity around accountability, roles and responsibilities for Estate Management.

27 The Board-level Executive Director with overall operational responsibility for Estates and Facilities is the Chief Operating Officer (COO). He discharges this function through a Divisional Director of Estates and Facilities.

The Director of Planning and Performance is responsible for Capital Planning and the Capital Programme. The Director of Planning and Performance is the chair of the Strategic Capital and Estates Group and the Capital Programme Group.

28 Ultimate responsibility for estates management and capital expenditure lies with the Health Board but it has a range of committees to support it in these functions.

29 The Board has started a major reconfiguration exercise to prepare for the opening of the Grange University Hospital and new community-based services. This is in line with its Clinical Futures Strategy (CFS). To help achieve this the Health Board has established a Clinical Futures Sites Group to manage the Estate Portfolio. The Group has the following functions:

- lead the work associated with the disposal of surplus sites including the requisite reports and approvals;
- oversee and support the site acquisition work required for the provision of sites for Clinical Futures Capital developments and ensure that appropriate approval and reporting mechanisms are in place; and
- ensure that good practice as set out in Estatecode[1] and elsewhere is always used.

The Group is accountable to Clinical Futures Strategic Board which, in turn, reports to the Health Board.

30 There are clear lines of accountability for estates. The COO chairs meetings of the six Divisions within the Health Board - including the Estates and Facilities Divisional Board. Each Division has an Estates lead. This ensures clear lines of communication on Estates issues to the board through the COO.

31 The COO chairs an Assurance Meeting (attended by HR and Quality representatives) as well as a monthly meeting with the Chief Executive. In addition, the Estates and Facilities Divisional Board has a six-monthly review meeting and an annual review meeting with the Executive Team. There is challenge at these meetings from corporate departments, including from the Finance Team.

32 There is an Independent Member to represent Estates at Board level and to provide appropriate challenge.

The Divisional Director of Estates and Facilities chairs a monthly Senior Management Board Business Meeting within the Division and a monthly Senior Management Board Finance Meeting. Action notes record actions that officer must take. The notes are then reviewed and followed up at the subsequent meeting. Despite there being no overall estates strategy, service leaders are aware of the priorities for the service.

[1] Estatecode is a user manual for NHS organisations managing the healthcare estate for current and future use. It includes advice on a broad range of estates topics, including land transactions, town planning issues and guidance on baseline assessments of the condition of the estate, as part of corporate planning and investment decision making processes and procedures.

There are systems in place to record asset data and to support maintenance.

33 The Health Board uses the MICAD Property Management System to store information on the estate. It also includes information on Statutory Compliance issues (e.g. Control of Asbestos, decontamination, electrical safety and legionella). The system holds a range of information including risk, lease breaks of properties, operational estates and a planned and reactive maintenance database. Information is available by hospital site, building and room location.

34 Welsh Government (WG) Hazard Notices are circulated within the Estates Team once logged onto MICAD. Staff are required to report on actions taken before they can be signed off as completed. All are reported to the Statutory Compliance Group which meets every two months. If not signed off they are placed on the Backlog Maintenance Risk Register for escalation within the Health Board.

35 Planned Preventative Maintenance (PPM) is generally statutory and reactive maintenance is undertaken according to prioritisation. This is usually carried out by internal staff. By exception contractors may be used.

36 In addition to MICAD, the Health Board also manages its property database through a system called E-PIMS (electronic Property Information Mapping Service). This contains details for all leased and freehold buildings. It shows the property description, terms of any leases and expiry dates as well as any covenants on the land.

37 The Health Board also has the LAPP (Land and Property Portfolio) system which provides even more detail on properties than e-PIMS.

38 The Health Board will link the results of the 6-facet survey when available to MICAD. This will be piloted for the whole of Wales and the combined data will ultimately be stored in MICAD.

The Health Board continues to improve its management of Estates and Facilities in key areas.

The Health Board performs well against national indicators compared to the All Wales averages.

39 The Health Board completes the NHS Wales Estates and Facilities Performance Management Systems returns. The NHS Wales Estates and Facilities Performance Management System (EFPMS) was set up in 2002. The system encourages a disciplined approach to data collection, dissemination and review and supports strategic decision making at both a local and national level.

40 The EFPMS allows NHS bodies to enter and interrogate data in real time and to compare performance against other NHS bodies, not only in Wales but also in England. NHS Wales Shared Services Partnership - Specialist Estates Services (NWSSP-SES) provides support and guidance on the completion of EFPMS returns and has a role in challenging and validating the information submitted. Using the data, NWSSP-SES produces annual reports on the estates and facilities performance of the Welsh NHS estate, presenting data at both an organisational and hospital site level.

41 Exhibit 3 shows the Health Board's performance on the NHS Wales' estates dashboard for 2016-17. This shows that the Health Board performs well overall especially in terms of fire safety compliance, functional suitability and space utilisation.

42 Exhibit 4 shows how 2016-17 performance against the NHS Wales' estate dashboard compares with the previous year - and how it compares with the All Wales average. Performance against the 5 measures remained constant with a slight reduction in 'statutory and safety compliance' from 90% to 89%. All indicators were rated 'amber' or 'green'.

Exhibit 3: performance against NHS Wales' estate dashboard 2016-2017

National Key Performance Indicators-Percentage of the Estate that is of a reasonable standard and therefore falls within Estatecode 'b'/'f' or above.

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD	79	90	100	90	97
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	89	89	95	90	90
BETSI CADWALADR UNIVERSITY HEALTH BOARD	74	78	79	85	88
CARDIFF & VALE UNIVERSITY HEALTH BOARD	80	87	91	57	89
CWM TAF UNIVERSITY HEALTH BOARD	85	87	85	97	97
HYWEL DDA UNIVERSITY HEALTH BOARD	87	89	93	92	99
POWYS TEACHING LHB	62	77	70	72	94
VELINDRE NHS TRUST	85	95	94	88	99
WELSH AMBULANCE SERVICES NHS TRUST	36	90	90	36	99

Source: NHS Wales Estate Condition and Performance Report 2016-17

Exhibit 4: performance against NHS Wales' estate dashboard 2016-2017 compared to 2015-16 and All Wales average.

Assessment criteria	2015-16 score	2016-17 score	All Wales Score 2016-17	2016-17 RAG rating
Physical condition	89	89	80	Amber
Statutory and safety compliance	90	89	86	Amber
Fire safety compliance	95	95	90	Green
Functional suitability	90	90	82	Green
Space utilisation	90	90	93	Green

RAG ratings: Red up to 75%, Amber 75-89%, Green 90% or above.

Source: NHS Wales Estate Condition and Performance Report 2016-17 and 2015-16

Exhibit 5: performance against NHS Wales' estate dashboard 2016-2017- Energy Efficiency

Energy Performance and Carbon Dioxide (CO_2) Emissions

	Net Energy Consumption (kWh/m²)	CO_2 Emissions* (kg/m²)
ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD	436	117
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	352	92
BETSI CADWALADR UNIVERSITY HEALTH BOARD	442	114
CARDIFF & VALE UNIVERSITY HEALTH BOARD	337	96
CWM TAF UNIVERSITY HEALTH BOARD	426	106
HYWEL DDA UNIVERSITY HEALTH BOARD	489	119
POWYS TEACHING LHB	312	78
VELINDRE NHS TRUST	420	130
WELSH AMBULANCE SERVICES NHS TRUST	153	51

*Target to be agreed

Source: NHS Wales Estate Condition and Performance Report 2016-17

43 Exhibit 5 shows that the Health Board is meeting its Energy Performance target and is placed as the third best performing health body in Wales for managing CO2 emissions at with a 'score' of 92. In 2015-16 it was at 99. Energy performance was 363 in 2015-16 and this improved to 352 in 2016-17.

Exhibit 6: performance against NHS Wales' estate dashboard 2016-2017-Backlog Maintenance Costs

Backlog Maintenance Costs

*Target to be agreed

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD	1,015,000	16,204,281	43,300,278	7,622,711	18,257,701
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	3,996,000	12,748,500	6,057,500	16,124,000	16,045,099
BETSI CADWALADR UNIVERSITY HEALTH BOARD	20,030,275	16,616,312	31,889,721	14,700,767	40,147,041
CARDIFF & VALE UNIVERSITY HEALTH BOARD	1,117,157	26,293,141	18,751,045	5,622,420	28,636,986
CWM TAF UNIVERSITY HEALTH BOARD	57,851	5,035,705	7,600,208	897,531	5,775,712
HYWEL DDA UNIVERSITY HEALTH BOARD	2,878,571	39,406,378	11,312,260	7,221,290	43,385,515
POWYS TEACHING LHB	1,000,233	4,233,702	3,462,963	308,575	5,384,787
VELINDRE NHS TRUST	25,313	781,752	412,180	915,653	831,429
WELSH AMBULANCE SERVICES NHS TRUST	2,829,060	6,779,568	2,761,445	1,860,192	9,778,335

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

Source: NHS Wales Estate Condition and Performance Report 2016-17

Exhibit 6 indicates that the Health Board has significant backlog maintenance costs. These are broken down into

- 'High Risks' (£3.996m),
- 'Significant Risks' (£12.749m),
- 'Moderate Risks' (£6.058m), and
- 'Low Risks' (£16.124m).

44 The Risk Adjusted cost is reported as £16.045m which is the fifth highest of the nine health bodies in Wales. The largest backlog maintenance costs within the UHB are at the Royal Gwent Hospital at £2,866,000 and at Nevill Hall Hospital at £831,000.

45 There are no specific Estates and Facilities (KPIs) Key Performance Indicators in the main Board Report. However, the Estates and Facilities Division is developing a performance/compliance report to be made quarterly to the Divisional meeting. This will include data from the maintenance data base. Efficiencies are looked at internally through the Continuing Improvement Process.

46 The 2016-17 EFPMS report for the Health Board contains information on the costs of certain services at the Health Board compared with the All-Wales average. Exhibit 7 below shows the cost of services compared with the All Wales Average

Exhibit 7: cost of services v All Wales Average

Area	ABUHB	All Wales Average
Cleaning Service Costs – (per sq. m)	£31.14	£32.98
Catering Service Costs- (per patient meal)	£3.03	£3.28
Portering Service Costs – (per sq. m)	£12.17	£14.36
Laundry & Linen Service Costs – (per piece)	£0.2965	£0.34

Source: HB Estates and Facilities Division Annual Review- May 2018 (Based on EFPMS Data 2016-2017)

There are clear systems for managing performance but there is scope to make better use of service user feedback and post-work inspections.

47 Performance management standards for response times are set out in the Health Board's Maintenance Policy. These are:

- Emergency Response- within 2 hours
- Priority Response – within 24 hours
- Routine Response- within 72 hours or 3 working days
- Non-Essential Response- within 168 hours or 7 days.

In addition, there are SLA work order priorities for contractors which are similar to the above. Contractors working on PPM are managed against the priority standards by operational Estates Managers.

48 Performance management is supported by the use of technology. This is through a system called MICAD. This is a property management system that is used as both a document store and has a risk assessment module. MICAD is used for the performance management of statutory obligations such as water management,

legionella and asbestos which is part of Planned Preventative Maintenance (PPM). There is a list of PPM tasks which are RAG rated following inspection by contractors.

49 The Division operates a call centre for all sites in the Health Board area. It is managed through an IT system called PLANET. Calls are for reactive work (although the system also logs statutory work) and are assessed by a supervisor and then allocated to an operative via a hand-held PDA. Following assessment at the job it will either be completed or require a 'follow on'. Any booking to an operative includes travel time and jobs are often batched to an operative in one area to save time and resources.

50 PLANET includes an audit trail of the job so that progress can be monitored and occasionally supervisors will check the quality of work undertaken. The system can generate several reports including timesheets for operatives. The use of PLANET ensures that repair requests are categorised appropriately. At the time of our review we were informed that there was 'work in progress' to align the target times in the maintenance policy with PLANET so that this can be performance managed automatically.

51 It is good practice to post-inspect a percentage of repairs to ensure repairs are carried out to a high standard. The Health Board undertakes a large amount of repairs each year; however, post inspections are not conducted systematically. Spot checks on the quality of work undertaken are carried out at random and local supervisors are required to carry out two inspections per week. A Quality Assessment Form is used which provides details of the job undertaken and by whom, whether the job was completed on time and brief client feedback.

52 The form is signed off by the Inspecting Officer and is used for both PPM and reactive maintenance. The Health Board has no formal system to assurance itself that repairs undertaken are of a good quality or that repairs are being undertaken because of poor previous repairs. We recommend that the service inspects a percentage of all repairs each month as part of a systematic quality control process. The results of the inspections should be included in the local performance management dashboard.

53 An efficient and user-focused estates service will provide services that consistently exceed the expectations of customers and know what customers think of the service. There are no user satisfaction targets. However, every 10th call made via helpdesk generates a satisfaction form. This is reviewed by help desk staff and the result reported to local management.

54 The monthly Divisional meeting report contains a range of performance information including financial performance and workforce KPIs. The report provided to us did not contain any KPIs on estates performance. It was reported that these would be provided quarterly in the future following agreement between the COO and the Divisional Director. The Dashboard included in the report contained only data on workforce such as sickness absence, staff in post, turnover, PADR (Personal

Assessment and Development Review), statutory and mandatory training and agency and bank staff usage.

55 The dashboard should be extended to consider other KPIs. For example, completion of capital works, performance against backlog maintenance, compliance with statutory compliance inspections and customer satisfaction with estates.

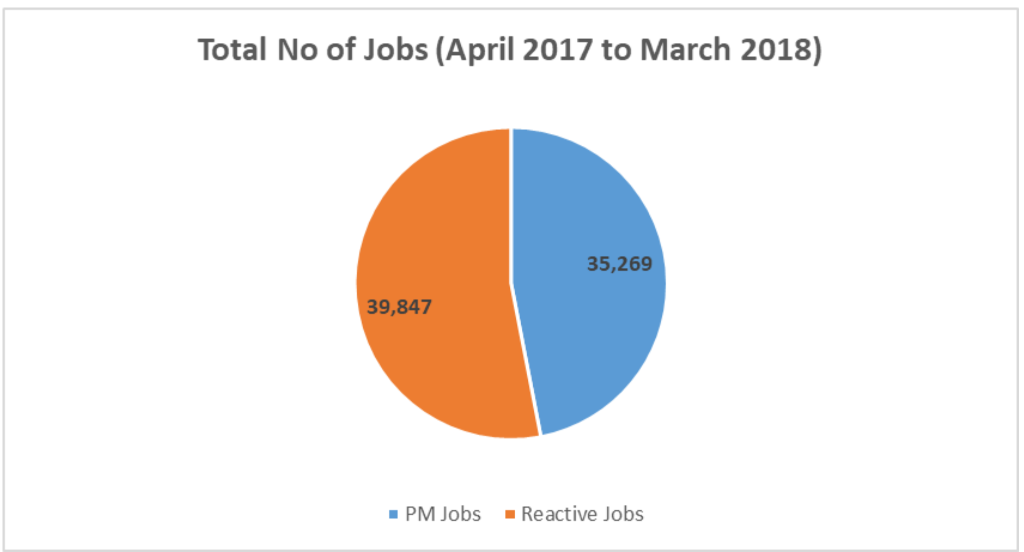
The Health Board spends a high proportion of its maintenance budget on reactive repairs which reflects the age and condition of the current estate.

56 The Health Board does not have a maintenance strategy that balances workload between reactive and planned work. Reactive repairs, that is, unplanned, are generally more expensive than planned maintenance. In the long term, more planned work should lead to less reactive work and to fewer catastrophic faults. However, over maintaining could be a drain on internal resources.

57 Estates departments should periodically review the levels of reactive and planned work to ensure that there is an efficient balance between the two. Although there is no agreed NHS good practice benchmark, local government maintenance departments generally hold that the split between planned and reactive repairs should be between 70:30 and 60:40 by value.

58 The Division undertook 35,269 (47%) planned maintenance tasks and 39,269 (53%) reactive requests between April 2017 and March 2018 (see Exhibit 8). This shows that there is an imbalance between planned and reactive repair tasks when compared to the benchmarks indicated above. The higher number of reactive tasks is also an indication of the poor state of repair and age of the estate. We are not made aware of any immediate plans to move towards more planned maintenance, but we understand that this is likely to change with the proposed new development at the Grange and the disposal of ageing assets.

Exhibit 8: split between reactive and PPM tasks carried out 2017-2018



Source: HB Estates & Facilities Department

59 The Health Board spent £1.216m on planned maintenance and £0.979m on reactive maintenance between April 2017 and March 2018. This represents a 55%:45% split with most being spent on planned maintenance. It was reported to us that during 2018-19, the Division was also funding additional estates staff to the value of £250k to support PPM to increase the % of PPM and to reduce the reactive spend.

60 The Health Board told us that future maintenance costs were not always considered when planning new builds. The Chartered Institute of Building Service Engineers advice is that newer buildings have less maintenance costs than older buildings is only partially correct. Newer buildings should be less prone to breakdowns but are more complex than older buildings. Therefore, newer buildings are potentially more expensive to maintain in the long term and may need some different skills.

61 The failure to make provision for the maintenance costs of new builds will contribute to future budget pressures in the long term. To address this, the Health Boards includes maintenance costs in the business case sign-off procedures as part of the RCCS (Revenue Consequences of Capital Schemes). This has been the case for the planning of the Grange University Hospital and was considered for both the recent Ebbw Vale and Ystrad Mynach developments.

The board has a clear policy for the disposal of an asset once it has become redundant and it uses national and local guidance when disposing of assets.

5.3

62 Specific guidance is provided by the Health Board in its rules and procedures governing the management of acquisitions, disposals and other property matters “Capital Procedure and Guidance Notes” dated January 2018. Additional guidance is provided in Health Board Standing Orders and in Estatecode.

63 The Health Board Land & Property Group is responsible for the management of acquisitions, disposals and other property matters even when such transactions are part of an approved scheme. The Health Board Land & Property Group is chaired by the Strategic Support Manager – Estates & Facilities, and is required to report to the Health Board and Welsh Government on a regular basis.

64 Guidance makes it clear it that all acquisitions and disposals of land/property of any limit must receive the written approval of the Welsh Government (WG) before being agreed. For acquisitions, disposals and leases, WG consent must be requested by a submission to the WG Capital Estates and Facilities Branch after ABUHB Board level approval. Detailed guidance has been provided by the HB for the disposal of assets. The draft Estates Strategy contains a list of recent disposals (pages 7 and 8). In total 34 properties were reported to be disposed of. Additionally, the public board meeting reported in May 2018 the disposal of 29 properties.

The Estates team is aware of risks and prioritises actions using feedback from users.

65 The Health Board has both a Corporate Health & Safety Risk Register and Divisional Risk Registers. Corporate risks are reported to the bi-monthly Full Board meetings as part of the Strategic Risk Dashboard. The Estates and Facilities report is reviewed at 6 monthly intervals in December and June at the Divisional Board meeting. Any risks not dealt with at the Divisional meeting are escalated to the Board via the Capital Group. Certain risks go through the corporate risk register and then the board is required to decide on its relative priority.

66 In the Estates and Facilities Risk Register for December 2017, a total of 13 risks were identified as ‘RED’ risks when considering likelihood and severity. Only 3 of these were revised to ‘AMBER’ following management actions.

67 We reviewed the Strategic Risk Dashboard which was reported to the Health Board at its July 2018 meeting. The Dashboard contained only one RED risk relating to Estates and Facilities which was:

- complete or partial loss (outages) of Health Board ICT systems, either those provided nationally by third parties or locally provided systems.

68 In addition, three AMBER risks were included as follows:

- the Grange University Hospital is not delivered as per programme and within approved capital cost/cost profile;
- risk that the current Primary Care estate is not fit for purpose to meet the needs of the local population; and
- insufficient levels of capital funding for estate requirements.

69 Prioritisation for capital works is based on either risk or business continuity issues. All risks are processed through the Capital Group including any statutory requirements. The process for prioritisation and for managing risk is transparent and understood. It is communicated through the divisional structure via the COO's meetings. Inevitably, there will always be more demand for investment than resources available to meet that demand. The COO reports that he has a clear and agreed mechanism for dealing with this to ensure that the board's approach to prioritisation is consistent with the health board's risk management approach.

70 The prioritisation process takes account of patient related and service user feedback. This is evidenced by the Community Health Councils presence on the Primary Care and Community Care Groups as well as CHC representation at the main Health Board meetings with a regular agenda item for CHC reports.

71 The Estates team obtains feedback from users via the Hospital Environment Committee which is chaired by an Independent Member. The Committee undertakes audits and uses focus groups and questionnaires to get feedback from patients. This is fed into the planning process. The Committee also receives the Quality and Patient Safety Operational Group assurance report. The top issues are Car Parking, Food, Environment, aesthetics and 'meet and greet' services. Examples given of responses to issues raised include the removal of ligature points in hospitals following concerns raised by WG and the refurbished ward programme at Nevill Hall Hospital following concerns raised by the CHC.

The Health Board actively ensures that staff and contractors have the skills and behaviours required to deliver an effective service

72 One way to ensure that staff see customer service as essential is to use a code of conduct, service charter or similar. This makes clear what behaviour is expected of staff and provides a way to link together existing policies. The Health Board has a set of professional standards which all staff are expected to work to. The values are reiterated in the Health Boards Mandatory Code of Conduct for Contractors This sets out the behaviour expected of contractors while working in Health Board premises. There is also a 'notice of unacceptable health and safety performance notice' which can be used by staff to report incidents of unacceptable behaviour.

73 The consequences of the unacceptable behaviour notice can range from a verbal warning to the removal of the contractor from site. Health Board staff are subject to the Boards health and safety and behaviour procedures.

74 All directly employed labour are qualified and trained to the standards required by their trade and as a minimum to NVQ level 3. Dependent on their speciality, they are then trained in specific disciplines to perform the role of Authorised Person (AP) or Competent Person (CP) for those disciplines, eg medical gases, electricity, water management and legionella control, decontamination etc.

75 Competence for these appointments is evaluated by NHS Wales Shared Services Partnership - Specialist Estate Service. Compliance with the appropriate Heath Technical Memorandum (HTM) is a standard part of the assessment process. In addition to this, all maintenance staff are regularly trained, within the Health Board, in asbestos awareness, safe use of abrasive wheels, working at height etc.

76 Contractors are expected to conform to the same standards and are governed by the Health Boards Mandatory Code of Conduct for Contractors, an excerpt from which is below:

Competence

- All Companies working for ABUHB will be expected to meet all appropriate health and safety standards and hold the necessary professional qualifications, accreditations and training relating to their trades or professions. For example (not exhaustive or exclusive):
- All contractors should hold a SSIP (Safety Schemes in Procurement) certificate to demonstrate they have approved by an accredited body for assessing Health and Safety competence, eg CHAS, Safe Contractor etc.
- Electrical Contractors – National Inspection Council for Electrical Installation Contractors (NICEIC) approved Gas fitters/Plumbers – Gas Safe Ventilation - Heating and Ventilation Contractors Association (HVCA) Scaffolders – National Access and Scaffolding Confederation (NASC) Fire Alarms and equipment – British Approvals for Fire Equipment (BAFE)
- All individuals working for these companies must hold relevant professional qualifications, such as the appropriate grade of CSCS (Construction trades), JIB (Electrical), GAS SAFE, CCDO (Demolition), CIRS (Scaffolding)CPCS (Plant Operators), recognised apprenticeship/NVQ or equivalent.

77 These requirements are checked via a 'Contractors Checklist' every time a contractor arrives on site for the pre-requisite site induction before authorisation to work on site is given. Staff and contractors are suitably qualified, staff training and evidence of CPD recorded. Membership of bodies such as 'Gas Safe' are recorded on the MICAD System. Contractors are asked to provide proof of their level of expertise and the details are logged on MICAD. A contractor checklist is available on the system as is the Approved List of Contractors. Before a job commences contractors must be signed in before they receive an ID badge or permit to work.

78 A priority for the service is to ensure all staff have an annual Personal Appraisal and Development Review (PADR). The Division reported that in December 2017 that 79.96% of the workforce had an annual PADR against a target of 85%. The

lowest scoring areas were 'management' (41.67%) and 'rechargeable works' (42.86%). It is encouraging that the 'percentage of staff with a PADR' is one of the KPIs that forms part of the estates and facilities performance dashboard and this should continue.

79 Management of non-productive time (eg vacancies, sickness, etc) is monitored at the monthly divisional meeting. Adherence to the Health Boards sickness policy and management of travel time for maintenance work was reported as an ongoing piece of work. At the time of our review it was reported that these issues were being reviewed as part of a continuous improvement project undertaken to look at better time management, travel times and the handyman project roll-out

80 Health Board staff and external contractors are, therefore, suitably qualified to undertake their roles and is there evidence of continuing professional development for employed staff.

Management is taking positive steps to improve staff satisfaction and sickness absence levels.

81 The Health Board took part in the Wales NHS Staff Survey 2016. This is a bi-annual survey. The Estates Division considered its response to the survey In August 2017. The Division had returned 170 responses which equated to a response rate of 22% compared to a response rate of 33% for the Health Board as a whole. A possible reason given for the low return, related to the number of paper copies issued among this staff group, which was due to the limited computer access available to individuals within the Division.

82 The Division reported that in comparison with other Divisions, its results were at the lower end of the scale, but they were not the lowest. On a more positive note, they were generally better than those recorded for the same categories in 2013.

83 The Divisional report considered put some additional statistical context around those results, which at face value, appear to be disappointing. It was also noted that the survey took place in 2016 and that a year had elapsed since the survey.

84 Sickness levels are under 6% which are the best in Wales for the staff group. Until very recently the incidence of 'complex' HR issues, (Disciplinary, Grievance, Dignity), was running at a very low level, compared to some other Divisions and historically for the group of staff. The report concludes that the high-level indicators do not imply that employee satisfaction is low. Since the survey in 2016 there have been several actions and initiatives which are designed to bring a more positive perception of employment within the Division.

85 The Division launched a 'Senior Leaders 90 Day Change Challenge' initiative In May 2018. This is an opportunity for staff 'to understand what the Health Board's future means for them and the way they work so that they can be 'aligned to the ambition and take joint accountability for achieving it' This is an opportunity for staff to be involved in the change process that the Health Board is to go through to achieve its vision for the future.

Aneurin Bevan Health Board's management response to recommendations relating to estates

The Health Board's management response will be inserted once the response template has been completed. The appendix will form part of the final report to be published on the Wales Audit Office website once the report has been considered by the board or a relevant board committee.

Appendix 1 management response

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	The Health Board should develop a fully costed Estates Strategy as soon as possible as recommended in our Structured Assessment 2017 (December 2017).	Clarity of long term plans for the Estate to support decision making and to ensure that the estate assets are utilised efficiently.	Yes	Yes	Draft Estate Strategy produced. Report to ABUHB Executive Team on Monday 19 November, with following recommendation: 'The Executive Team is asked to consider the draft Strategy and advise of any material changes that need to be made prior to its consideration by the Health Board Development session on 19th December'	Dec 2018 / Mar 2019	Andrew Walker/ Glenn Evans

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	The Health Board should finalise the 'Six-Facet' survey report to inform the Estates Strategy.	The results of the survey will be used to inform and finalise the Estates Strategy. It will provide the Health Board with a clear indication of the state of property portfolio to assist strategic decision making.	Yes	Yes	6 Facet Survey information now available. Migration to Health Board preferred database ongoing. Survey data being utilised to inform Estate Strategy. Please see attachment in R1 above	Nov 2018	Bob Pratt / Darren Cann
R3	The Division should include a range of Key Performance Indicators in its Performance Dashboard. These should include user satisfaction and completion targets.	Key Performance Indicators are reported which provide an assessment of the quality and timeliness of the service provided.	Yes	Yes	Overarching Divisional KPI Dashboard is currently being developed which will incorporate performance data for each service discipline within the Division. Example of Estates Maintenance performance data attached, this datasheet will be revised to include user satisfaction and completion targets. Maintenance KPI Dashboard V5.1.xlsx	Jan 2019	Neil Pearce

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	The Health Board should ensure that it completes post-inspections for a percentage of repairs as part of a systematic quality control process. It should include the results in its local performance management dashboard.	The service inspects a percentage of all repairs each month as part of a systematic quality control process. The results of the inspections should be included in the local performance management dashboard.	Yes	Yes	Quality assessments to be undertaken for every 10 requests received, along with customer satisfaction form for completion. Feedback to be collated and reported into the Divisional KPI performance dashboard. PDF Estates Maintanance Qualit	Jan 2019	Neil Pearce

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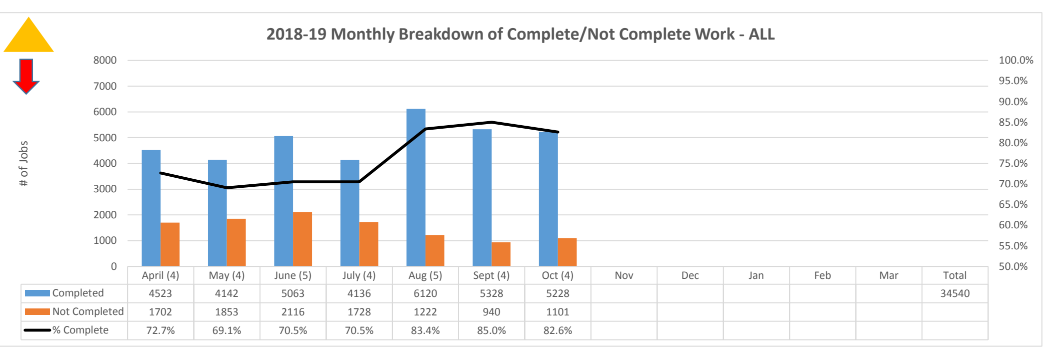
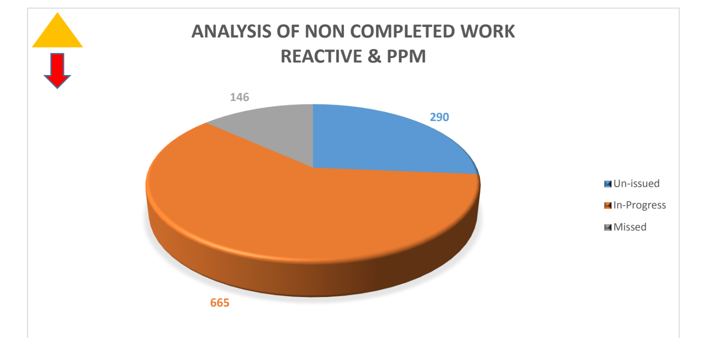
E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

OPS & MAINTENANCE FIGURES AS AT 12th NOVEMBER



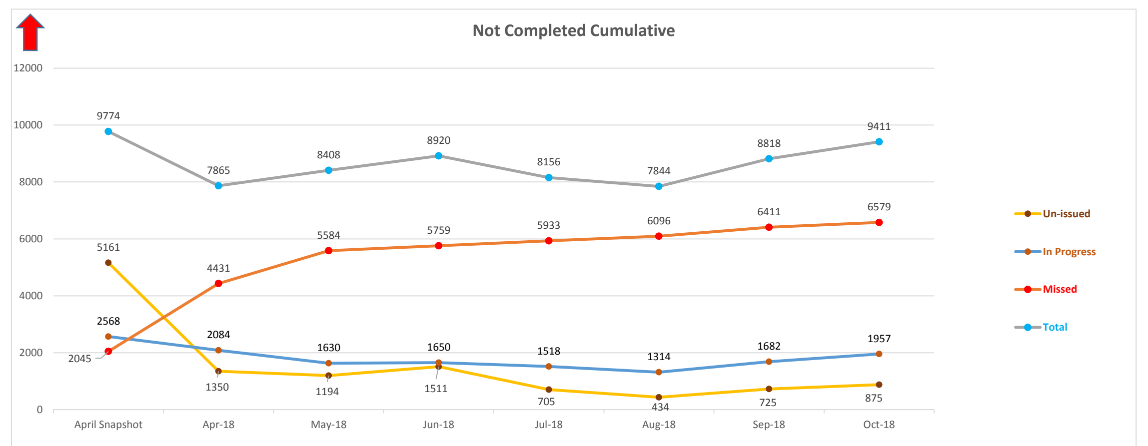


on or above Target

Within 10% of Target

Over 10% off target

		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
PM Priority 1	Unissued		137	21	30					
	In Progress		270	248	221					
	Missed		12	9	19					
	Sub-Total		419	278	270					
PM Priority 2	Unissued		34	6	12					
	In Progress		97	58	54					
	Missed		9	3	2					
	Sub-Total		140	67	68					
PM Priority 3	Unissued		56	8	17					
	In Progress		55	9	20					
	Missed		83	95	90					
	Sub-Total		194	112	127					
Reactive	Unissued		53	152	230					
	In Progress		389	288	366					
	Missed		27	39	35					
	Sub-Total		469	479	631					
	Grand Total		1222	936	1096					



Year to Date - Resolution time to Help desk calls				Total calls	16,654	
Resolution Times	Complete	% Workload	Cum % Overall	Target Cum	RAG	Trend
Within 30 days	13,874	83%	83%	85.0%		
Between 30 & 90 days	989	6%	89%	100.0%		
Over 90 days	272	2%	91%	100.0%		
Incomplete	1,519	9%		0.0%		

Year to Date - Resolution of PM				22179		
PM Type	Raised	Complete	Cum % Overall	Target Cum	% Workload	
Essential	15,923	15,099	95%	90.0%	68%	
Desirable	6,256	5,574	89%	>80%	25%	
Incomplete		1,506			7%	

Finance	Cum Budget £000's	Actual £000's	Bud-Act £000's	RAG	Trend
er					
People	Month %	Rolling %	Target %	RAG	Trend
StatTraining	89.9		85.0		
PADRS					
Sickness					
Health & Safety	Month Act	YTD actual	Target	RAG	Trend
RIDDORS	0	1	0		

Month	Completed	Not Completed	Un-issued	In Progress
April Snapshot	65462	9774	5161	2568
Apr-18	4523	1702	1350	2084
May-18	4142	1853	1194	1630
Jun-18	5063	2116	1511	1650
Jul-18	4136	1728	705	1518
Aug-18	6120	1222	434	1314
Sep-18	5328	940	725	1682
Oct-18	5228	1101	875	1957
Nov-18				
Dec-18				
Jan-19				
Feb-19				
Mar-19				
	100002	20436	11955	14403

Priority 1 PPM Data

			Un-issued	**In Progress**
Apr-18				
May-18				
Jun-18				
Jul-18	1285	119	7	103
Aug-18			137	270
Sep-18			21	248
Oct-18			30	221
Nov-18				
Dec-18				
Jan-19				
Feb-19				
Mar-19				

5.3

Missed	Total
2045	9774
4431	7865
5584	8408
5759	8920
5933	8156
6096	7844
6411	8818
6579	9411

Monthly Breakdown

	Completed	Not Completed	% Complete
April (4)	4523	1702	72.7%
May (4)	4142	1853	69.1%
June (5)	5063	2116	70.5%
July (4)	4136	1728	70.5%
Aug (5)	6120	1222	83.4%
Sept (4)	5328	940	85.0%
Oct (4)	5228	1101	82.6%
Nov			
Dec			
Jan			
Feb			
Mar			
Total	34540		

42838

Missed

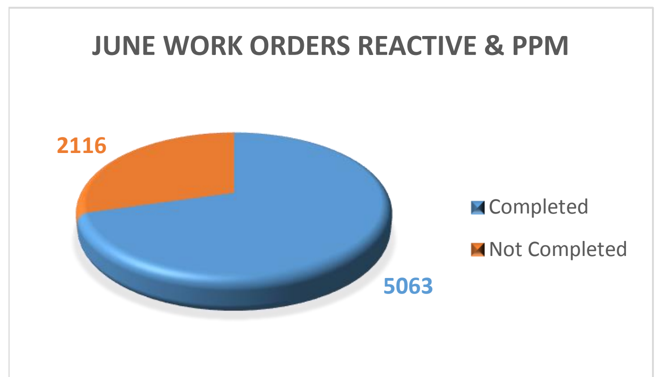
9
12
9
19

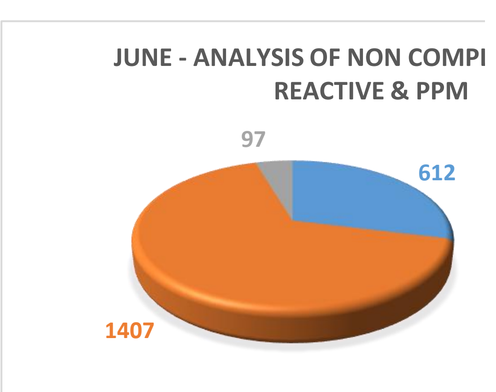
Un-issued	In-Progress	Missed at time
535	1039	128
628	1180	45
612	1407	97
407	1262	59
280	811	131
187	603	150
290	665	146

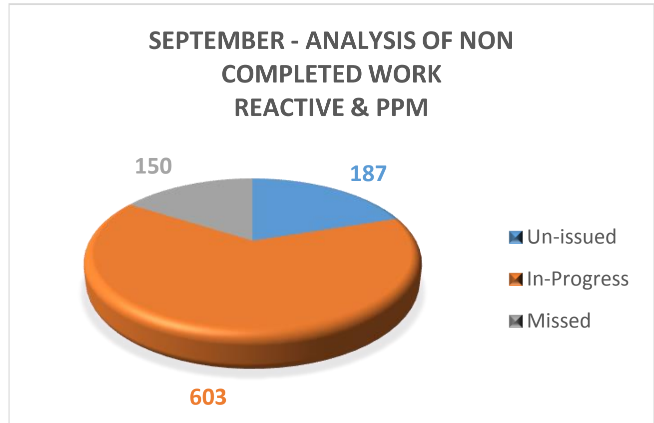
PRIORITY 1 PPM MISSED

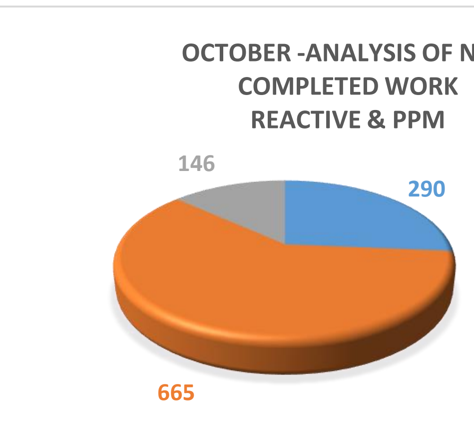
AUGUST 2018

REGION	WO Number	Site	Building	Floor	Room	Asset Code	Description	Status	Created	Closed	Issued	Reason Missed
RV	252251	7A6MB	TRINANT C	GRD FLOOR	06	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	16/08/2018	28/08/2018	20/08/2018	Missed - No time
RV	252327	TRINANT S	TRINANT S				PAT Yearly / Annual PAT Test	Missed	16/08/2018	06/09/2018	20/08/2018	No longer attend Trinant Surgery, only attend Trinant HC.
RV	252351	7A655	BARGOED CL	BASEMENT	PLANT RO(	CALOR 02	Calorifier / Calorifier Monthly	Missed	16/08/2018	31/08/2018	22/08/2018	missed
NHH	250282	7A6L4	BRYNMAWRCL	GRD FLOOR	BRY022	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	03/08/2018	07/08/2018		building not in use. PPM to be removed
NHH	250415	BRYNMWR RC	BRYNMWR RC	GRD FLOOR			Emergency Light Check Dental / Emerg Light Self Contained 12M	Missed	06/08/2018	29/08/2018	07/08/2018	This is a new build and annual PPM has come out beffore Monthly. Therefore missing this PPM monthly will be carried out
NHH	250416	BRYNMWR RC	BRYNMWR RC	GRD FLOOR			Emergency Light Check A / Emerg Light Self Contained 12M	Missed	06/08/2018	29/08/2018	07/08/2018	This is a new build and annual PPM has come out beffore Monthly. Therefore missing this PPM monthly will be carried out
NHH	250417	BRYNMWR RC	BRYNMWR RC	GRD FLOOR			Emergency Light Check B / Emerg Light Self Contained 12M	Missed	06/08/2018	29/08/2018	07/08/2018	This is a new build and annual PPM has come out beffore Monthly. Therefore missing this PPM monthly will be carried out
NHH	250418	BRYNMWR RC	BRYNMWR RC	GRD FLOOR			Emergency Light Check C / Emerg Light Self Contained 12M	Missed	06/08/2018	29/08/2018	07/08/2018	This is a new build and annual PPM has come out beffore Monthly. Therefore missing this PPM monthly will be carried out
NHH	250419	BRYNMWR RC	BRYNMWR RC	GRD FLOOR			Emergency Light Check D / Emerg Light Self Contained 12M	Missed	06/08/2018	29/08/2018	07/08/2018	This is a new build and annual PPM has come out beffore Monthly. Therefore missing this PPM monthly will be carried out
NHH	251150	BRYNMWR RC	BRYNMWR RC				Weekly Fire Alarm Test / Fire Alarm Weekly User Test	Missed	16/08/2018	05/09/2018	29/08/2018	pulled off job for meter reads
NHH	251190	7A6L4	BRYNMAWRCL	GRD FLOOR	BRY022	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	17/08/2018	23/08/2018	21/08/2018	AB1 22/08/2018 08:05 added: Arrived on site AB1 22/08/2018 08:05 added: Started work : no services
NHH	252013	7A6L4	BRYNMAWRCL	GRD FLOOR	BRY022	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	31/08/2018	06/09/2018		Building no longer in use. All Services Isolated
SEPTEMBER 2018												
NHH	252103	7A6FN	ADMIN	BASEMENT	ADB04		Weekly Flushing / Weekly Flushing	Missed	03/09/2018	18/09/2018	10/09/2018	job out of date
NHH	252104	7A6FN	EXTERNAL	GRD FLOOR			Weekly Flushing / Weekly Flushing	Missed	03/09/2018	18/09/2018	10/09/2018	job out of date
NHH	252298	7A64K	ABERLRY RC	GRD FLOOR	ARC001M	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	06/09/2018	17/09/2018		Unable to get to PPM in time
NHH	252467	BRYNMWR RC	BRYNMWR RC				Weekly Fire Alarm Test / Fire Alarm Weekly User Test	Missed	06/09/2018	18/09/2018		jobs out of date
NHH	252989	7A6L4	BRYNMAWRCL	GRD FLOOR	BRY022	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	14/09/2018	18/09/2018		building not occupied
NPT	459090	7A6AR					Critical Plant Check / Critical Plant Check	Missed	20/09/2018	14/10/2018	30/09/2018	didnt get time to do
NPT	459672	7A6G3	PENHOW	GRD FLOOR	P014	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	27/09/2018	02/10/2018	02/10/2018	property closed
NPT	459693	7A6G3	PENHOW				Temperature Monitoring Monthly / Temp Monitoring Monthly	Missed	27/09/2018	02/10/2018	02/10/2018	property closed
NPT	459851	7A6G2	BRIDGEVHSE	GRD FLOOR	L002	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	27/09/2018	02/10/2018	01/10/2018	property closed
OCTOBER 2018												
RV	255486	BRYNTIRION	BRYNTIRION	GROUND			Emergency Ligthing Checks / Emerg Light ExPowered Monthly	Missed	11/10/2018	16/10/2018		WO was marked as Missed for the following reason: Assets were not showing, problem resolved and ticket re-issued
NHH	254105	7A6AM	MAIN	MAIN THTR	TH 47A		Washer Disinfector Jade Theatr / Washer Disinfector	Missed	03/10/2018	10/11/2018	08/10/2018	Unable to get to PPM due to sickness
NHH	254201	7A6AM	MAIN	CSSD			Washer Disinfector CSSD Weekly / Washer Disinfector	Missed	04/10/2018	10/11/2018	08/10/2018	Unable to complete PPM due to Sickness
NHH	254211	7A6AM	MAIN	CSSD	CSSD 13	AUTOCLA\	Autoclave 1 CSSD / Sterilising & Ancillary Equip	Missed	04/10/2018	18/10/2018	08/10/2018	job out of date
NHH	254212	7A6AM	MAIN	CSSD	CSSD 13	AUTOCLA\	Autoclave 2 CSSD / Sterilising & Ancillary Equip	Missed	04/10/2018	18/10/2018	08/10/2018	job out of date
NHH	254213	7A6AM	MAIN	CSSD	CSSD 13	AUTOCLA\	Autoclave 3 CSSD / Sterilising & Ancillary Equip	Missed	04/10/2018	18/10/2018	08/10/2018	job out of date
NHH	254594	7A6AM	MAIN	MAIN THTR	TH 47A		Washer Disinfector Jade Theatr / Washer Disinfector	Missed	10/10/2018	10/11/2018	15/10/2018	Unable to get to PPM due to sickness
NHH	254817	7A6AM	THE LODGE	1ST FLOOR	NHHL 02	SHOWER	Thermostatic Mixing Valve / TMV Yearly	Missed	11/10/2018	18/10/2018	13/10/2018	lodge empty and drained down.
NHH	255134	7A6AM	MAIN	MAIN THTR	TH 47A		Washer Disinfector Jade Theatr / Washer Disinfector	Missed	17/10/2018	10/11/2018	22/10/2018	Unable to get to PPM in time due to sickness
NHH	255668	7A6G6	LAMB HOUSE	GEN COMP		GENERATC	Generator Check / Generator Weekly Checks	Missed	25/10/2018	10/11/2018	27/10/2018	Unable to get to get to PPM in time
NHH	255689	7A6AM	MAIN	CSSD	CSSD 13	AUTOCLA\	Autoclave 1 CSSD / Sterilising & Ancillary Equip	Missed	25/10/2018	05/11/2018	30/10/2018	job out of date
NHH	255690	7A6AM	MAIN	CSSD	CSSD 13	AUTOCLA\	Autoclave 2 CSSD / Sterilising & Ancillary Equip	Missed	25/10/2018	05/11/2018		job out of date
NHH	255691	7A6AM	MAIN	CSSD	CSSD 13	AUTOCLA\	Autoclave 3 CSSD / Sterilising & Ancillary Equip	Missed	25/10/2018	05/11/2018	30/10/2018	job out of date
NPT	460452	7A6F7	W&E AREA			GENERTOF	Generator Check / Generator Weekly Checks	Missed	04/10/2018	25/10/2018		out of date
NPT	460584	7A6G3	PENHOW	GRD FLOOR			Calorifier / Calorifier Monthly	Missed	04/10/2018	06/11/2018	09/10/2018	poroperty closed
NPT	461166	7A6G3	PENHOW	GRD FLOOR	P014	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	11/10/2018	30/10/2018	15/10/2018	Property closed
NPT	461350	7A6G2	BRIDGEVHSE	GRD FLOOR	L002	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	11/10/2018	30/10/2018	15/10/2018	Property closed
NPT	461955	7A6G3	PENHOW	GRD FLOOR	P014	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	18/10/2018	30/10/2018	18/10/2018	Property closed
NPT	462109	7A6G2	BRIDGEVHSE	GRD FLOOR	L002	F A P	Fire Alarm Weekly Test / Fire Alarm Weekly User Test	Missed	18/10/2018	30/10/2018	18/10/2018	Property closed









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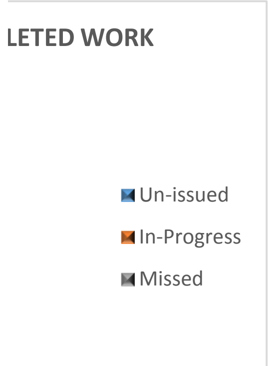
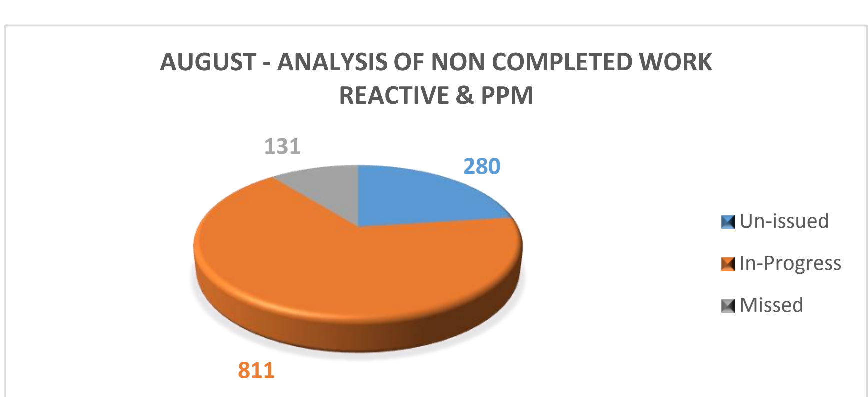
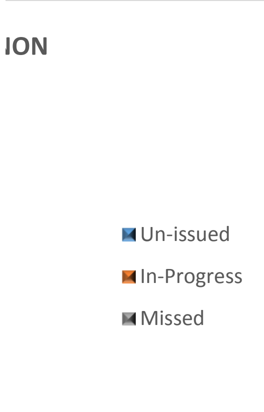

LETED WORK
Un-issued
In-Progress
Missed


AUGUST - ANALYSIS OF NON COMPLETED WORK
REACTIVE & PPM
131
280
811
Un-issued
In-Progress
Missed


ION
Un-issued
In-Progress
Missed

Works & Estates
Royal Gwent Hospital
Newport
NP20 2UB

Tel: 01495 765060

5.3

QUALITY ASSESSMENT FORM

Property Address: ABHQ room 036 Visit Number: 58

Job Description: Check on Contractor work in Office. D. Lucas - ceiling tiles, Eamonn Kilby Painting, TSF - Flooring

Date of Job: ______________

Initiating Officer: ______________ Contractor/In-house Operative: Lucas, Kilby, TSF

(Please tick the relevant boxes)

Response/Reactive Maint ☐ Planned Maint ☐ Other ☐

INSPECTING OFFICERS ASSESSMENT:

Work Satisfactory? Yes / No Paperwork in order/legible/correct? Yes / No

If not satisfactory, reason:

	Tick	Comments/Reason
Poor Workmanship		
Dangerous		
Incomplete		
Other		
Action Taken:		

CLIENT FEEDBACK:

	Yes	No	Comments
Satisfied with end product?			
Job completed on time?			

	Good	Bad	Comments
Contractor performance?			
Works & Estates performance?			

NAME: ______________ SIGNATURE: ______________

POSITION: ______________ DATE: ______________

Inspecting Officer: M. PLATT Signature: [signature]

Assessment of quality: Satisfactory / Unsatisfactory Date: 2-11-18

Return inspection needed: Yes / No

Works & Estates
Royal Gwent Hospital
Newport
NP20 2UB

Tel: 01495 765060

5.3

QUALITY ASSESSMENT FORM

Property Address: Casnewydd building toilets   Visit Number: 59

Job Description: NPT1466712 - replace flooring in two toilets,

Date of Job: 2-11-18

Initiating Officer: M Platt   Contractor/In-house Operative: A Walkers

(Please tick the relevant boxes)

Response/Reactive Maint ☑   Planned Maint ☐   Other ☐

INSPECTING OFFICERS ASSESSMENT:

Work Satisfactory? Yes / No   Paperwork in order/legible/correct? Yes / No

If not satisfactory, reason:

	Tick	Comments/Reason
Poor Workmanship		
Dangerous		
Incomplete		
Other	✓	remove adhesive a entrance Ladies WC
Action Taken: Alex Walker to reattend.		

CLIENT FEEDBACK:

	Yes	No	Comments
Satisfied with end product?			
Job completed on time?			

	Good	Bad	Comments
Contractor performance?			
Works & Estates performance?			

NAME: ____________ SIGNATURE: ____________

POSITION: ____________ DATE: ____________

Inspecting Officer: M Platt   Signature: MPlatt

Assessment of quality: Satisfactory / Unsatisfactory   Date: 2-11-18

Return inspection needed: Yes / No

6.1

INTERNAL AUDIT PROGRESS REPORT 2018/2019

17 January 2019 Audit Committee

NHS Wales Shared Services Partnership

Audit and Assurance Service

1. INTRODUCTION......3

2. PROGRESS AGAINST THE 2018/19 INTERNAL AUDIT PLAN.....3

3. SUMMARY OF FINDINGS......3

4. CONTINGENCY......4

5. PROPOSED CHANGE......4

6. ENGAGEMENT......4

7. RECOMMENDATION......5

APPENDIX A – STATUS SCHEDULE
APPENDIX B – KEY PERFORMANCE INDICATORS

6.1

1. INTRODUCTION

1.1 The purpose of this report is to highlight progress against the 2018/19 Internal Audit Plan at 10 January 2019 to the Audit Committee, together with an overview of other activity undertaken since the previous meeting.

2. PROGRESS AGAINST THE 2018/19 INTERNAL AUDIT PLAN

Number of audits in plan	36*
Of which:	
Number of audits reported as final	11
Number of audits reported in draft	4
Number of audits in progress	20
Number of audits to be deferred	1

* Total excludes AGS and G&A Module.

2.1 The following reports from the 2018/19 Internal Audit Plan have been issued since the previous meeting of the Audit Committee:

AUDIT ASSIGNMENT	ASSURANCE RATING
Patient Discharge Process	Limited
Divisional Review – Facilities	Reasonable
Budgetary Control	Reasonable

2.2 Appendix A details progress in respect of each of the reviews in the 2018/19 Internal Audit Plan.

3. SUMMARY OF FINDINGS

3.1 Limited assurance reports are considered by the Audit Committee in detail. The following summary provides the Audit Committee with the main messages from the reasonable assurance reports issued since the last meeting in October 2018:

Divisional Review - Facilities

3.2 This is a positive report with reasonable assurance overall and a number of areas with substantial assurance. We raised three recommendations aimed at improving PADR and sickness absence management. Overall, based upon the results of our testing, effective leadership in the Division appears to be contributing to meaningful improvement.

3.3 The use of a Divisional Business Unit to facilitate this improvement and monitor performance is a model that should be considered for appropriateness in other divisions.

Budgetary Control

3.4 We have reported reasonable assurance for budgetary control for many years and continue to do so this year. However, we have raised a high priority recommendation to ensure that regular budget meetings at which financial performance is challenged take place throughout the Scheduled Care Division and that these are fully documented. This was recognised and accepted by management with immediate action undertaken.

4. CONTINGENCY

There is a contingency element in the 2018/19 Internal Audit Plan. These days will be utilised in discussion with the Health Board in response to emerging risks.

5. PROPOSED CHANGE

5.1 The Project Implementation of Absence Drop-down audit has been deferred, due to the technical barriers facing the Health Board with introducing this specific functionality within Health Roster (E-Roster). The Workforce and OD Team has explored various avenues to develop this automated feature and, on an all-Wales basis, discussions are ongoing with the supplier to allow absence drop-down to become a feature that can be utilised.

5.2 Therefore, it is proposed that the audit scheduled for reviewing the project be deferred until such a time that the Health Board is in a position to commence the project.

6. ENGAGEMENT

ADDITIONAL MEETINGS HELD AND COMMITTEES ATTENDED DURING THE REPORTING PERIOD

6.1 Board/Sub Committee/other events

- Board;
- Quality & Patient Safety Committee;
- Information Governance Committee; and
- Finance & Performance Committee.

6.2 Meetings

- regular update meetings regarding the Clinical Futures Programme;
- planning meetings for the 2019/20 audit programme;
- audit scoping and debrief meetings;
- Chief Executive quarterly;
- Board Secretary bi-weekly;
- Assistant Director of Finance (Corporate Finance) monthly;
- Audit Committee Chair quarterly;
- Chair bi-annually;
- Well-being of Future Generations Act Steering Group; and
- Wales Audit Office, Health Inspectorate Wales and Ombudsman quarterly.

Additional activity

6.3 We have continued to liaise and consult with the Health Board on a range of audit matters and risks identified. For example, we have advised the Health Board on:

- the development of the board assurance framework;
- steps to take towards improving the quality of the Personal Appraisal and Development Review (PADR) process and the completion compliance rate;
- the process for managing bank workers' annual leave;
- staff plans for assisting with winter pressures; and
- the Health and Care Standards, as we continue to engage with them.

7. RECOMMENDATION

7.1 The Audit Committee is invited to approve the proposed change and note the above.

Planned output	Outline timing	Status	Assurance
Corporate Governance, Risk and Regulatory Compliance			
Governance, Leadership and Accountability (Health and Care Standards)	Q4		
Annual Governance Statement	Q4		
Risk Management and Assurance	Q4	Work in progress	
Board Assurance (Advisory)	Q3	Work in progress	
Corporate Legislative Compliance – Well-being of Future Generations Act	Q3	Work in progress	
Strategic Planning, Performance Management and Reporting			
Clinical Futures I – Governance	Q2, Q3	Draft report	Reasonable
Clinical Futures II – Making Change Happen	Q2, Q3	Work in progress	
Clinical Futures III – Critical Pathway	Q3, Q4	Work in progress	
Financial Governance and Management			
Budgetary Control Including Cost Improvement	Q3	Final report	Reasonable
Management of Balance Sheet Assets	Q2	Final report	Reasonable
Private and Overseas Patients Follow-up	Q2	Draft report	Reasonable

Planned output	Outline timing	Status	Assurance
Clinical Governance, Quality and Safety			
Annual Quality Statement	Q1	Final report	Reasonable
Learning Lessons from Incidents and Reports	Q2	Work in progress	
Patient Experience and Outcomes	Q2	Work in progress	
Patient Discharge Process	Q2	Final report	Limited
Nurse Staffing Levels	Q4	Work in progress	
Falls Prevention	Q2	Draft report	Reasonable
Clinical Audit Follow-up	Q3	Draft report	Limited
Information Governance and Security			
Cyber Security	Q4	Work in progress	
Global Data Protection Regulations (GDPR)	Q3	Work in progress	
Digitisation of Medical Records	Q1	Final report	Reasonable
IT Strategy	Q3	Work in progress	
Use of Digital Technology – Fit for the Future (Advisory)	Q2	Work in progress	

Tab 6.1 Internal Audit Progress Report

Audit Committee - 17th January 2019-17/01/19

Planned output	Outline timing	Status	Assurance
Operational Service and Functional Management			
Divisional Review - Facilities	Q4	Final report	Reasonable
Unscheduled Care Wards – Follow-up	Q1	Final report	Reasonable
Royal Gwent – Site Review	Q2	Final report	Reasonable
Nevill Hall – Site Review	Q2	Final report	Reasonable
Workforce Management			
Project Implementation of Absence Drop Down into ESR	Q3	Deferred	
Organisational Development and Training	Q3	Work in progress	
Flexible Working (Advisory)	Q4	Work in progress	
Equality, Diversity and Inclusion	Q4	Work in progress	
Medical Staffing	Q2	Work in progress	
Capital & Estates			
Carbon Reduction Commitment	Q2	Final report	N/a
Environmental Sustainability Report	Q2	Final report	N/a
Major Capital Projects	Q4	Work in progress	
Capital Systems	Q4	Work in progress	
Estates Assurance	Q4	Work in progress	
Grange University Hospital	Separate Plan	Work in progress	

INTERNAL AUDIT PROGRESS REPORT 2018/2019 Appendix B

KEY PERFORMANCE INDICATORS

31 December 2018

Indicator	**Status**	**Actual**	**Target**	**Red**	**Amber**	**Green**
Operational Audit Plan agreed for 2018/19		19 April 2016	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]		15 of 15	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		5 of 11	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		11 of 11	*80%*	v>20%	10%<v< 20%	v<10%

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	- + Green	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	- + Yellow	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	- + Amber	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	- + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

6.1

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James Quance (Head of Internal Audit) – 01495 300841

	Audit Committee 17th January 2019 Agenda Item: 6.2
Aneurin Bevan University Health Board	
IT Service Management Update	

Executive Summary

The internal audit of IT service management put forward 10 recommendations to improve service management in Informatics in June 2018.

The recommendations broadly focus on the need to develop Informatics services aligned to the needs of the organisation and to improve assurance and governance around change control.

There are 4 cross cutting themes from the recommendations:

1. Engagement with the organisation to align services to business need and the development of formal service level agreements (SLA)
2. Improvement in knowledge management and service knowledge management systems –including standard operating procedures (SOP)
3. Greater focus on supplier and contract management
4. Monitoring of Informatics performance

This report provides an update on Informatics Directorate progress in response to the Internal Audit report on IT Service Management.

While some progress has been made against the recommendations through additional resource and internal service improvement the Directorate recognised at the outset that meeting recommendations would be difficult to achieve at pace within the resource envelope of the service.

The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	X		
Executive Sponsor: Nicola Prygodzicz, Head of Planning and Performance			
Report Author: Matthew Mahoney**,** Head of ICT			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 3rd October 2018			
Supplementary Papers Attached:			

6.2

Purpose of the Report

In March 2018 internal audit completed a review of IT Service Management in ABUHB. A number of recommendations were made for improvement in the provision of IT service management.

The document highlights progress so far.

Background and Context

The internal audit of IT Service Management put forward 10 recommendations to improve service management in Informatics.

The recommendations broadly focus on the need to develop Informatics services aligned to the needs of the organisation and to improve assurance and governance around change control.

There are 4 cross cutting themes from the recommendations:

5. Engagement with the organisation to align services to business need and the development of formal Service Level Agreements (SLA)
   Recommendations 1, 2, 5, 6
6. Improvement in knowledge management and service knowledge management systems –including Standard Operating Procedures (SOP)
   Recommendations 1, 3, 4, 9, 10
7. Greater focus on supplier and contract management
   Recommendations 6, 11
8. Monitoring of Informatics performance
   Recommendations 6, 7, 8, 9

In 2018 Informatics Directorate submitted a business case seeking additional resource to address a range of operational risks which substantively address the recommendations of the audit. These included funding to reduce risks arising from project delivery, cyber slllecurity and management of Service Desk in line with IMTP objectives.

The Case was part funded and a decision was taken to prioritise cyber security risk management only at this stage. Project delivery and management of Service Desk remain unfunded. However, the resource identified within the funding does provide opportunity to progress some aspects of our service management plans.

1. Engagement with the Organisation

The Informatics Directorate is considering its Delivery Framework as part of finalising the Health Board's Digital Strategy development. A formal review of its working model will be undertaken in October 2018 and published as a part of the Digital Strategy before the end of 2018.

The Informatics Directorate, in line with the Directorate's IMTP, is developing a Communication and Engagement Strategy which will allow Informatics to reach out to the organisation and better align services to organisational need. Service Management development is a significant contributing element to this broader piece of work.

6.2

The Directorate is reviewing the opportunity to repurpose its Digital Technology Group (DTG) to act as the overarching ABUHB Service Management Board (SMB). These discussions are in its initial stages and will require a revised Terms of Reference and approval through the Transformation to Digital (T2D) Delivery Board procedures. The Chair of DTG will be writing to all SMB representatives in ABUHB to set up a workshop in Q3 in order to determine the best way forward.

2. Improvement in Knowledge Management, Service Knowledge Management & Standard Operating Procedures

An ICT Service Manager post was created and started on 1st September. The postholder is undertaking a gap analysis review and a programme of work to improve knowledge management, Standard Operating Procedures and out of hours on call service support. Completion of the knowledge management requirements will require additional resource or a reprioritisation of existing work. A business case for this will be developed when further detail is understood.

The service has undertaken a review of its Service Management Policy template and a new draft template has been devised and is being tested with a live system to support a systematic refresh of service management policies for all systems managed by the Informatics Directorate.

6.2

3. Greater Focus on Supplier and Contract Management

More robust contract management is mandatory under the Network and Information Services Directive (NISD) and Informatics has been working with Procurement and Legal to develop more robust contracts moving forwards. Primary contracts in place have been assessed and regular supplier meetings are held.

The Informatics Directorate is working closely with NWIS to develop better management of the NWIS Service Level Agreement. This involves reaching out to attendees from National Service Management Boards with a view to setting up local service management boards to review performance.

4. Monitoring of Informatics Performance

Service Point is the main application for collecting information about service requests and response to fault reporting. However, this national application has limited reporting capability. Access to data is slow and restricted. Alternative options are being assessed but technical difficulties alongside resource constraints have delayed this work.

The new service management policy template will allow specific key performance needs to be identified on a system by system basis. This will inform the needs for Service Point development or replacement.

Assessment and Conclusion
This report provides an update on Informatics Directorate progress in response to the Internal Audit report on IT service management. While some progress has been made against the recommendations through additional resource and internal service improvement the Directorate recognised at the outset that meeting all the

recommendations would be difficult to achieve over a short period of time within the resource envelope of the service.

Recommendation
Audit Committees members are asked to note this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*This section should outline an assessment of the potential risks, which may be associated with the area of work and proposals. (To include, information on clinical, organisational and financial risks)* *Consideration in this section should also be given to risk consequences and the impact on the LHB. Where appropriate, it should also identify the risk level and indicate that the risk has been placed on the LHB's corporate or operational Risk Registers.*
Financial Assessment, including Value for Money	*There are no direct financial implications arising from the report. Business cases will be brought forward where and when additional resource is required to meet the recommendations of the Audit Report*
Quality, Safety and Patient Experience Assessment	*There are no direct risks to quality and patient safety associated with this audit*
Equality and Diversity Impact Assessment (including child impact assessment)	*NA*
Health and Care Standards	*NA*
Link to Integrated Medium Term Plan/Corporate Objectives	*Links to the Informatics Directorate IMTP Top 10 objectives*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*NA*
Glossary of New Terms	*This section should provide a definition of any new terms contained within the report*
Public Interest	*All reports to the Board and Committee of the Board are routinely published – is there any reason why this document cannot be made public?* *No*

6.2

Patient Discharge Process

Final Internal Audit Report

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

6.4

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

Opinion and key findings

4. Overall Assurance Opinion 5
5. Assurance Summary 6
6. Summary of Audit Findings 7
7. Summary of Recommendations 10

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

Review reference: ABU-1819-16
Report status: Final
Fieldwork commencement: 9th August 2018
Fieldwork completion: 6th September 2018
Draft report issued: 10th September 2018
Management response received: 28th November 2018
Final report issued: 4th December 2018
Auditor/s: James Quance, Head of Internal Audit
Stephen Chaney, Deputy Head of Internal Audit
Nicola Jones, Audit Manager

Executive sign off Claire Birchall, Interim Executive Director of Operations

Distribution Martine Price, Acting Executive Director of Nursing
Dr Paul Buss, Medical Director
Chris O'Connor, Divisional Director for Mental Health & Learning Disabilities

Committee Audit Committee
Quality & Patient Safety 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.

6.4

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan 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 Patient Discharge Process was completed in line with the 2018/19 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedures are compliant with Health Board corporate and national policies.

Discharge is an essential component of the patient pathway, and minimising delays associated with it are a priority. The Health Board aims to provide a safe, effective and timely discharge of patients into an environment that is appropriate to the individual's needs.

A Discharge Policy is in place that applies to all health care professionals and support staff, and covers all clinical environments.

2. Scope and Objectives

The internal audit sought to assess the adequacy and effectiveness of internal controls in operation. Weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence. The audit considered the following requirements during the formulation of the audit objectives:

Specifically, it has sought to provide assurance on the following areas:

- discharge policies and procedures are documented and up to date and responsibilities of staff are clear;
- all patients have an expected date of discharge (EDD) set;
- an assessment of whether discharge is likely to be simple or complex is recorded;
- where it is appropriate (e.g. complex discharges), multi-disciplinary discharge planning commences as soon as possible after (or before) admission and the approach is recorded within patient notes;
- action has been taken to ensure ongoing care requirements are in place prior to discharge, and it is evidenced that these have been discussed with the patient, parent, family and/or carer;
- processes are in place to ensure patients ready for discharge are not delayed unnecessarily (i.e. use of the discharge lounge, transport is arranged if required);
- completion of discharge summaries and re-admission of discharged patients is monitored and action taken to improve and learn from any issues identified; and
- the Health Board receives regular information on discharge performance.

We visited a sample of wards across the Health Board's hospitals to review evidence of discharge planning patient notes and considered the arrangements in place to ensure patients that are fit are discharged without delay.

3. Associated Risks

The risks considered in the review are:

- discharge planning is not considered prior to or at the point of patient admission;
- expected date of discharge (EDD) is not reviewed regularly and ongoing care requirements are not actioned promptly, leading to a delay in discharge;
- relevant information relating to discharge is not captured in patient notes; and
- performance relating to discharge process is not regularly monitored.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. 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 Patient Discharge Process is **Limited** Assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Policies & Procedures		✓		
2	Expected Date of Discharge (EDD) set	✓			
3	Type of discharge (Simple / Complex) recorded			✓	
4	MDT planning			✓	
5	Ongoing care requirements			✓	
6	Processes are in place to ensure patients ready for discharge are not delayed unnecessarily.		✓		
7	Information monitored & actions taken.			✓	
8	Health Board information on discharge			✓	

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

Design of Systems/Controls

The findings from the review has highlighted one issue that is classified as a weakness in the system control/design for Patient Discharge Process.

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 for Patient Discharge Process.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

As part of our fieldwork, we discussed arrangements in place with Divisional / Assistant Divisional Nurses, and we reviewed the following wards within the Health Board:

Royal Gwent Hospital

- Ward B6 (Unscheduled Care)
- Ward C6E (Unscheduled Care)
- Ward (Schedule Care)

Nevil Hall Hospital

- Ward 2 (Scheduled Care)
- Nantyglo (Paediatrics)

St Cadocs

- Adferiad (Mental Health & Learning Disabilities)

County Hospital

- Hafan Deg (Mental Health & Learning Disabilities)

At each ward we discussed the discharge process with the Ward Manager, and reviewed a sample of patient nursing / medical notes in order to test compliance with the policy. We have also reviewed information provided to the Health Board via the Quality & Safety Committee and Operational Group.

Whilst we found there was evidence of discharge planning within all notes reviewed, the detail included varied between ward, and it was noted on

ward B6 (Complex Care) where there was a discharge liaison nurse in place, notes were more detailed.

The issues identified regarding lack of compliance with key discharge planning procedures and the lack of awareness of certain aspects of the Health Board's policy set out below have been considered together in arriving at the limited assurance opinion.

We identified **two high priority** issues that we consider require management's attention and provide scope for improvements to be made.

These concerned:

1) Expected Date of Discharge is not set

The Discharge Policy states that an expected date of discharge (EDD) should be set as soon as possible following admission. We visited seven wards and sampled 35 patients, reviewing the Clinical Work Station (CWS) system patient nursing and medical notes.

There was no EDD recorded in notes for 34 patients. One ward visited (C5 West) recorded EDDs on CWS which are reviewed by the ward manager. However, the dates for two of these (out of five patients sampled) had already passed.

2) Hospital Admissions Document completion

When a patient is admitted, the Hospital Admissions Document should be completed, which includes a needs assessment.

The document also includes a discharge checklist which should be completed prior to discharge. Discussions with ward managers confirm that this is not used, with the exception of Hafan Deg and Nantyglo where a different checklist is in place.

A review of Hospital Admissions Documents noted that they are often not completed fully. As well as the discharge checklist not being used, other areas are not completed, such as date of referrals / social services details. This information is included in patient notes. However, this is mainly on the communication sheets within patient notes. We also noted that the majority of documentation did not include the signatures of staff that had made entries in the document, which is noted on the document as a legal requirement.

We identified **two medium priority** issues that we consider require management's attention and provide scope for improvements to be made. These concerned:

1) Discharge Policy

There is a Discharge Policy in place for the Health Board. This was issued in 2015 and due for review in June 2017. The owner is stated as the Assistant Director of Patient Safety. However, since the policy was written this person has moved and there is currently no-one overseeing the responsibility for reviewing the policy. It was also identified as part of the Wales Audit Office (WAO) review of Discharge Planning (2017) that further work was required on discharge guidance. However, no progress has been made.

2) Monitoring compliance with the Discharge Policy

The Discharge Policy includes implementation criteria and a responsibility for Divisional Nurses to monitor compliance with the policy via qualitative and quantitative methods. There is currently no monitoring of the policy within the divisions / wards reviewed. There was a general lack of awareness of this requirement, which indicates that there was not sufficient consultation with key staff when the policy was drafted.

Good Practice

In addition to the findings summarised above, we identified the following good practice:

- All notes reviewed included some evidence of discharge planning. The amount of detail included in notes varied by ward. It was noted that in ward B6 (Complex Care Ward), where they have a discharge liaison nurse, there was more detail included in the notes.
- All wards have regular board and ward rounds, with updates detailed in patient notes. Staff at Hafan Deg in County Hospital include a detailed sheet with Multi-Disciplinary Team updates and actions in patient notes. No concerns were raised with the current level of medical staff available to make decisions on discharge.
- Reports detailing the completion of discharge summaries are produced and distributed on a regular basis.
- All patients are reviewed regularly, including whether they are potentially ready for discharge, which is evidenced in patient medical notes.
- Mental Health & Learning Disabilities (MH&LD) management monitor whether there is evidence of a discharge plan, telephone contact with

48 hours and communication with GP on the day of discharge for their discharged patients. This is also monitored by the Executive Team.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 Estimated Date of Discharge is not set (Operation)	**Risk**
The Discharge policy states "An expected date of discharge will be set as soon as possible following admission or at a multi-disciplinary team meeting or in many cases before admission for elective patients and communicated to the patient, parent, relatives, carers and or IMCA (as appropriate) including all health and social professionals involved with the patient." We visited seven wards and discussed with Ward Managers whether EDDs are set when the patient is admitted (or prior to admission if a planned admission). The majority of wards visited do not set EDDs. Hospital Admissions Documents, and where applicable, CWS were reviewed to establish if a date was set. Of the 35 patient records reviewed: • 34 did not have an EDD noted on the Hospital Admissions Document • five had an EDD set on CWS, however for two of these the date had passed **Breakdown by ward:** • Nantyglo - no EDDs set. • Ward 3-2- no EDDs set. • Adferiad - no EDDs set • Hafan Deg – no EDDs set • C5W – EDDs were set on CWS for five patients, however two were out of date. The EDD was included on the Hospital Admissions Document for one patient.	Non-compliance with the Discharge Policy. A failure to set EDDs when patients are admitted may lead to a lack of focus on patient discharge planning.

Action Plan

• C6E – no EDDs set • B6 – no EDDs set	
Recommendation 1	**Priority level**
Staff should be reminded of the requirement to set an estimated date of discharge for the patient as soon as possible following admission. Consideration should be given to updating the Discharge Policy with a timescale for setting an EDD. For example, another Health Board advise this should be set within 24-48 hours.	**High**

Management Response 1	Responsible Officer/ Deadline
• All ward managers, junior doctors and consultants reminded of the need to set EDD's within 24hrs of the patient's admission. The Board Round, Ward Round and MDT will be the means by which this is set and reviewed.	• Divisional Nurses/ Divisional Directors in each Division reporting through to the COO Completion 31st January 2019
• EDD's are often written on ward boards, however this information is not kept. EDD's assigned on board rounds must be captured on CWS for recording keeping and audit purposes – this should sit as a role for ward clerk	• Divisional Nurses for each Division reporting through to COO Completion 30th November 2018
• Monthly audit of EDD's to be undertaken centrally and reported to the Divisional Nurse for monitoring and action as required.	• Divisional Nurses in each Division Implementation Date 1st January 2019

• EDD will be added to paediatric discharge pro forma and discussed at ward manager level for dissemination to nursing staff • Mental Health and Learning Disabilities to review expectations for EDD across wards, due to the variation in average length of stay.	• Divisional Nurse Family & Therapies 31st December 2018 • Divisional Nurse MH&LD Completion 31st March 2019

Tab 6.4 Patient Discharge Process Internal Audit Final Report and Management Response Limited Assurance Report

Audit Committee - 17th January 2019-17/01/19

Finding 2 Hospital Admissions Document completion (Operation)	Risk
The Hospital Admissions Document for Adults includes a discharge checklist which details key actions to be completed prior to the patient being discharged, which includes areas such as whether transport is required/arranged, medication is ordered, care packages are in place etc. The majority of wards visited (five out of seven) do not use the discharge checklist that is within the Hospital Admissions Document. Two wards (Nantyglo and Hafan Deg) have a separate discharge checklist that they use for each patient. A review of the Hospital Admissions Document noted that they are often not completed fully. As well as the discharge checklist, other areas, such as date of referrals to Social Worker / Occupational Therapist / Discharge Liaison Nurse are not fully completed. This information is included in patient notes. However, this is mainly on the communication sheets rather than on the admissions document. We also noted that the majority of documents reviewed did not include the signatures of staff on the Signature Register at the back of the document, where it states that '*This section will serve as a record of your full signature and thus satisfy professional and legal requirements*'.	Wards are not fully completing current documentation, which could result in gaps in required patient information captured, and insufficient information to inform discharge planning.

Recommendation 2	Priority level
Staff should be reminded of the need to fully complete the Hospital Admissions Document, including the discharge checklist and all staff who make an entry in the document must include their details in the Signature Register. A monitoring process should be put in place by management in order to ensure that required records are completed in order to ensure that the approved practice is followed.	**High**

Management Response 2	Responsible Officer/ Deadline
1. Nursing staff to be issued with directive that all documentation must be signed for (name printed) to comply with policies and professional requirements for record keeping.	(1) Divisional Nurses in each Division Deadline Aim: 31st Dec 2018
2. Review of the discharge policy required	(2) Divisional Nurse Scheduled Care and Interim Deputy Director Operations 31st December 2018
3. Completion of the discharge checklist for all patients discharged to be encouraged and monitored	(3) Divisional Nurse for each Division Immediate
4. Senior Nurses to audit x5 sets of notes per week to monitor compliance. Immediate feedback to staff to enable correction of documentation.	(4) Divisional Nurse for each Division Implementation Date 1st Dec 2018
5. Fit for purpose discharge checklist to be developed	(5) Divisional Nurse for each Division Implementation Date 1st December 2018

6. Documentation audited at Divisional level for SC and USC though HACSA	Divisional Nurse for each Division Implementation date – 1st December 2018
7. Paediatric directorate consider the current discharge documentation fit for purpose as paediatric discharges tend to be far less complex.	Divisional Nurse Completion date 31st January 2019
8. Mental Health and Learning Disabilities Division to review range of discharge documentation used across all directorates.	Divisional Nurse MH&LD Completion Date end March 2019

Finding 3 Discharge Policy (Design)	Risk
A Discharge Policy for the Health Board is published on the ABUHB intranet site. The Policy was issued in June 2015 and was due for review on in June 2017. There is currently no person responsible for reviewing and updating the policy, as the person who wrote it has moved and it has not been passed to anyone to take ownership. Currently the responsibility for the Policy sits with the Executive Nurse Director, who has a professional responsibility for nursing staff. However, staff who are implementing the policy sit within Divisions. The responsibilities section (8) within the Discharge Policy states: *The Executive Nurse Director will take the lead responsibility on behalf of the Health Board for the strategic visioning, developing and implementation of the Discharge Policy. The Executive Nurse Director will be supported by the Divisional Nurses, Divisional Directors, Clinical Director and General Managers for the operationalisation of the Policy.* Also, the 'Discharge Against Advice – Policy, Procedures, Form and Information Leaflet' was issued in 2015 but has not been reviewed since. Whilst we have not reviewed training and awareness as part of this audit, there was a lack of awareness of the requirements of the policy (i.e. setting EDDs, monitoring requirements). The Wales Audit Office review included a	The Policy is out of date so staff may be unaware of the roles, responsibilities and current requirements.

Action Plan

recommendation relating to developing supporting tools for staff and training on discharge planning.	
Recommendation 3	**Priority level**
Responsibility for ownership of the Discharge Policy should be confirmed. The Discharge Policy should be reviewed, and include consultation with appropriate staff (Divisional nurses, discharge liaison nurses, MH&LD etc.) and relaunched to ensure its profile and to include stressing the importance of EDDs. Areas to consider including within the policy are: • timescales for setting and EDD (i.e. within 24-48 hours); • use of the Clinical Work Station to record the EDD; • discharge from A&E; and • flowcharts for staff. There should be clear responsibilities in the document for implementation and compliance with the policy. The 'Discharge Against Advice – Policy, Procedure, Form and Information Leaflet' should be reviewed and updated if required.	**Medium**

Tab 6.4 Patient Discharge Process Internal Audit Final Report and Management Response Limited Assurance Report

Audit Committee - 17th January 2019-17/01/19

Management Response 3	Responsible Officer/ Deadline
1. Once the policy has been reviewed, any subsequent changes in responsibilities will be updated	(1) Interim Director of Operations and Director of Nursing Complete 30th November 2018
2. The divisional nurse for scheduled care is taking the lead on re-writing the discharge policy, which will consider areas raised above and include consultation with appropriate staff, including Gwent Local Authorities	(2) Responsible Director as determined above Complete by 31st December 2018
3. Discharge policy to relaunched and all Divisions to be made aware of revision	(3) Director of Operations and Director of Nursing and Medical Director via Divisional Management teams Complete by 31st January 2019
4. Checklists and Discharge Against Advice documents to be updated within the policy, following liaison with Gwent Local Authorities	(4) Divisional Nurse Scheduled Care and

Action Plan

5. The Health Board could consider setting up a Discharge Steering Group with responsibility for review of all current policy's related to Discharge	Deputy Director of Operations. Complete by 31st December 2018

Finding 4 Compliance with Discharge Policy (Operation)	Risk
The Discharge Policy includes implementation criteria and includes a responsibility for Divisional nurses to '*develop an audit calendar, which will include discharge, ensuring that its qualitative effect is identified within the patient experience'*. There is currently no monitoring of the policy within the divisions / wards reviewed. There was a general lack of awareness of this requirement, which indicates that there was not sufficient consultation with key staff when the policy was drafted.	Lack of compliance with the Discharge Policy is not identified.
Recommendation 4	**Priority level**
Key contacts within the Health Board should be consulted when the policy is re-drafted. Requirements for monitoring should be agreed and documented within the policy, with clarity regarding who is responsible for undertaking these. Once agreed monitoring requirements should be adhered to.	**Medium**

Action Plan

Management Response 4	Responsible Officer/ Deadline
1. As part of the re-write of the discharge policy, requirements for monitoring and audit of the discharge process will be documented with clear responsibilities.	Divisional Nurses Scheduled Care and Deputy Director of Operations Complete by 31st December 2018
2. Compliance with component parts of Discharge Policy should be implemented into Divisional QPS agenda	Divisional Nurse for each Division Implement by 31st January 2019

Audit Assurance Ratings

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

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

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

No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

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

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation’s objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Aneurin Bevan University Health Board

Patient Discharge Process

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Office details:

MAMHILAD Office
Audit and Assurance
Cwmbran House (First Floor)
Mamhilad Park Estate
Pontypool, Gwent
NP4 0XS

Contact details

James Quance (Head of Internal Audit) – 01495 300841
Stephen Chaney (Deputy Head of Internal Audit) – 01495 300844
Nicola Jones (Audit Manager) – 01792 860592

NHS Wales Audit & Assurance Services

Health Board	Aneurin Bevan University Health board
Divison:	USC, SC, MH, F&T, Community

Patient Discharge Process
Final Internal Audit Report
Management Response

Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Estimated Date of Discharge is not set				
1.	All Ward Managers, Junior Doctors and Consultants reminded of the need to set EDD's within 24 hours of the patient's admission. The Board Round, Ward Round and MDT will be the means by which this is set and reviewed	SC/USC have relaunched the SAFER Patient Flow Bundle and will audit compliance using NHS Improvement template in January 2019.	Divisional Nurses / Divisional Directors/Patient Flow Managers	31st January 2019
2.	EDD's are often written on ward boards, however this information is not kept. EDD's assigned on board rounds must be captured on CWS for recording keeping and audit purposes – this should sit as a role for Ward Clerk Scheduled Care exploring formal Board Round/MDT attendance to reduce multiple enquiries throughout day. Scheduled Care Flow Manager supporting D7E, D2W and D5E to improve compliance.	SC/USC continue to use PSAG to capture EDD but when discharge is confirmed this transfers to CWS for wider communication.	Divisional Nurses/Patient Flow Managers	30th November 2018 15th January 2019
3.	Monthly audit of EDD's to be undertaken centrally and reported to the Divisional Nurse for monitoring and action as required. Scheduled Care will focus on D7E, D2W and D5E to push improvement in completeness and then compliance. Attendance daily at 0900 C7E MDT meeting to push EDD Review of Patient tracking boards on ward to include EDDs and allow focussed discussion Target 100% compliance of recorded EDDs on CWS on all Scheduled Care wards	CWS reports being run for SC/USC to determine compliance with EDD reporting.	Flow Managers/ ward Managers	1st January 2019 15th January 2019 31st January 2019

Health Board	Aneurin Bevan University Health board
Divison:	USC, SC, MH, F&T, Community

Patient Discharge Process
Final Internal Audit Report
Management Response

Number	Recommendation	Health Board Action	Responsible Officer	Timescale
4.	EDD will be added to paediatric discharge pro forma and discussed at Ward Manager level for dissemination to nursing staff	Following further discussion with Divisional Nurse for F&T adding EDD to the paediatric discharge pro forma will add no benefit so this action will not be progressed.	DN Family & Therapies	31st December 2018
5.	Mental Health and Learning Disabilities to review expectations for EDD across wards, due to the variation in average length of stay	On track	DN MH&LD	31st March 2019
Hospital Admissions Document Completion				
1.	Nursing staff to be issued with directive that all documentation must be signed for (name printed) to comply with policies and professional requirements for record keeping	All ward staff reminded of their NMC professional standards regarding record keeping which is covered by The Code.	Divisional Nurses/Senior Nurses	31st Dec 2018
2.	Review of the discharge policy required	Task and Finish Group established to review policy across all divisions and relaunch of the policy. Policy completed currently out for consultation prior to launching.	Interim Assistant Director of Nursing. Interim Deputy Director Operations	31st December 2018
3.	Completion of the discharge checklist for all patients discharged to be encouraged and monitored	USC/SC have developed a checklist which will be reviewed in March 2019	Divisional Nurses/Patient Flow Managers	March 2019
4.	Senior Nurses to audit x5 sets of notes per week to monitor compliance. Immediate feedback to staff to enable correction of documentation	SC/USC senior nurses will commence first documentation audit in January 2019.	Divisional Nurses	1st December 2018 completed
5.	Fit for purpose discharge checklist to be developed	See Number 3	Divisional Nurses	1st December 2018

Health Board	Aneurin Bevan University Health board
Divison:	USC, SC, MH, F&T, Community

Patient Discharge Process
Final Internal Audit Report
Management Response

Number	Recommendation	Health Board Action	Responsible Officer	Timescale
6.	Documentation audited at Divisional level for SC and USC through HACSA	HACSA already underway in SC/USC – all immediate actions rectified as part of the audit and action plans developed to address any outstanding issues	Divisional Nurses	1st December 2018
7.	Paediatric directorate consider the current discharge documentation fit for purpose as paediatric discharges tend to be far less complex	No further actions required	Divisional Nurses	31st January 2019
8.	Mental Health and Learning Disabilities Division to review range of discharge documentation used across all directorates	On track	DN MH&LD	March 2019
Discharge Policy				
1.	Once the policy has been reviewed, any subsequent changes in responsibilities will be updated	Responsibility has been reviewed and now sits with Director of Operations and Nurse Director	Interim Director of Operations Director of Nursing	30th November 2018
2.	The Divisional Nurse for Scheduled Care is taking the lead on re-writing the Discharge Policy, which will consider areas raised above and include consultation with appropriate staff	Completed, in draft format whilst out to consultation	Responsible Director	31st December 2018
3.	Discharge policy to relaunch and all Divisions to be made aware of revision	Awaiting feedback following consultation	Director of Operations Director of Nursing Medical Director via Divisional Management teams	31st January 2019
4.	Checklists and Discharge against advice documents to be updated within the policy	Included in new policy	Divisional Nurse Scheduled Care	

Health Board	Aneurin Bevan University Health board
Divison:	USC, SC, MH, F&T, Community

Patient Discharge Process
Final Internal Audit Report
Management Response

Number	Recommendation	Health Board Action	Responsible Officer	Timescale
			Divisional Nurse Unscheduled Care	
5.	The Health Board could consider setting up a Discharge Steering Group with responsibility for review of all current policy's related to Discharge	Under review	Director of Operations	31st December 2018

	Audit Committee 17th January 2019 Agenda Item: 7.1

Audit Committee
Update on Governance, Financial Control Procedures, Technical Accounting Issues, Single Tender Actions and Post Payment Verification

Executive Summary

This report gives the Audit Committee an update in relation to a number of standing items are which are reviewed in line with the committee's terms of reference and work plan:

- Governance Issues including standing orders, SFI's and financial control procedures
- Technical accounting issues
- Public Sector Payment Policy compliance
- Single Tender Actions
- Post Payment Verification
- Payments Exceeding £100K

The Audit Committee is requested to note this report and approve the write off of irrecoverable debts.

The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	✓		
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Glyn Jones, Director of Finance and Procurement			
Report Author: Estelle Evans, Head of Financial Services and Accounting			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 21st December 2018			
Supplementary Papers Attached: **Appendix 1 – Single Tender Actions** **Appendix 2 – Post Payment Verification**			

Purpose of the Report

This report gives the Audit Committee an update in relation to a number of standing items are which are reviewed in line with the committee's terms of reference and work plan:

- Governance Issues including Standing Orders, SFI's and financial control procedures
- Technical accounting issues
- Public Sector Payment Policy compliance

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- Single Tender Actions
- Post Payment Verification
- Payments Exceeding £100K

Background and Context

This report includes a number of standing items that are to be reviewed in accordance with the Audit Committee's annual work plan which in turn has been developed from the terms of reference of the Committee. The report also includes a section relating to the Public Sector Payment Policy which the Committee has historically asked to be routinely reported.

Assessment and Conclusion

1. Review of Standing Orders, SFI's and Scheme of Delegation.

No update to report.

2. Financial Control Procedures (FCPs)

A number of policies are currently under review as follows:

- Stores and Stock
- Budgetary Control (FCP)
- Capital Assets and Charges
- Capital Procedures & Guidance Notes

The Recovery of Overpayments to Employees has been amended following a period of consultation with managers and trade unions. It is was considered by the Workforce & OD Policy Group on 6th November 2018. The group requested a number of further changes to be considered in conjunction with the trades unions. It is anticipated that these changes will be agreed in early 2019 allowing the policy to be finalised in time for approval at the next Audit Committee meeting.

3. Technical Accounting Issues

In preparation for 2018/19 accounts this section reviews the main accounting policies of the Health Board in line with the Committee's work plan.

Accounting policies are determined from international financial reporting standards (IFRS) that cover all areas of accounting. WG issue a 'Local Health Board's Manual for Accounts' annually which has specific guidance that is formulated in turn from HM Treasury guidance and is compliant with IFRS. When specific issues of accounting arise reference to relevant accounting standards is made and interpretation formulated and discussed with external auditors.

New Accounting Policies

- **IFRS 9 Financial Instruments**

This is a new financial reporting standard that is being implemented in 2018/19. It has been developed in response to the financial crisis of 2007/8. It has a limited impact on the health sector but does affect the way bad debt provisions are quantified and estimates for income impairments are developed. The approach to developing an income impairment model and bad debt provision has been agreed as a common approach across Wales to ensure compliance with the accounting standard. It will mean that existing bad debt provisions will increase in 2018/19

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but the financial impact will be accounted as a prior period adjustment and not affect the reported financial position of the Board.

- **IFRS16 Leases**

As reported at the last Audit Committee meeting the proposed implementation date for this accounting standard within the public sector was 1 April 2019. However at the FRAB meeting on the 22nd November 2018 Financial Reporting Accountancy Board (FRAB) confirmed HM Treasury's recommendation to defer the implementation of IFRS16 until 1st April 2020 on the basis that FRAB still needs to confirm:

- The subsequent measurement of the right of use
- Whether to include guidance for the arrangements with nil consideration

The deferral will be strictly limited to one year and FRAB expect entities to continue their implementation efforts thought-out 2019.

The implementation of IFRS16 brings a significant change to existing lease accounting by removing the distinction between operating and finance leases and introducing a single lessee accounting model.

Operating and Finance leases are currently accounted on the following basis:

- Finance lease – is recognised as an asset and a liability
- Operating lease – the lease value/charge is charged straight to income and expenditure over the lease term

Work is ongoing to identify a comprehensive list of leases within the Health Board affected by the accounting rule changes. As reported at the last Audit Committee there could be an impact on the capital programme funding if leases currently accounted as revenue are capitalised under the new accounting standard and consequently be counted against the capital programme budget. Clarity on this issue is still awaited from HM Treasury through Finance colleagues at Welsh Government.

The following table shows a summary of some of the main accounting policies of the board where measurement has a degree of interpretation:

Accounting Area	**Brief Summary of Policy**
Property, Plant & Equipment (fixed assets)	Expenditure is capitalised if greater than £5K and expected to be used for more than 1 year. Depreciated over expected life of asset. Valuation at initial cost and subject to revaluation – land & buildings. The District Valuer revaluation of the estate every 5 years was carried out in 2017/18. There is no indexation being applied to assets in 2018/19.
Non-current assets held for sale	Shown as 'held for sale' at the point when the asset sale is highly probable.
Leases	Classified as finance leases when substantially all risks and rewards of ownership are transferred to lessees. Finance leases are accounted as though the asset is owned by the organisation and is shown 'on balance sheet'. There are currently no finance leases. Other leases are classified as 'operating leases' and charged to revenue when costs incurred. Often referred as being 'off balance sheet'.

PFI Schemes	These are disclosed separately from leases in the accounts and include PFI schemes at Chepstow, NHH day surgery unit, Monnow Vale Health and Social care facility and two energy schemes. From an accounting perspective the Chepstow, NHH and Monnow Vale schemes are treated as finance leases and are 'on balance sheet' with both energy schemes in the Royal Gwent and Nevill Hall deemed to be 'off balance sheet'.
Inventories (stock)	The main store supplying ABUHB based in Cwmbran, is now accounted on the balance sheet of NHS Wales Shared Services (NWSSP) hosted by Velindre NHS Trust. Hospital pharmacy stock is measured on 'average price' basis and valued on a continual inventory system basis. Other stocks are counted at year end and valued following stock takes using a first in first out basis and valued at lower of cost and net realisable value.
Provisions	A provision is an estimated financial liability that exists as at the balance sheet date. Provisions are measured as the best estimate of expenditure required to settle the obligation taking account of risks and uncertainties. **Continuing Healthcare Claims** Claims for reimbursement of costs incurred by some individuals for the cost of continuing health care are subject to claims across Wales on the basis that they should have been funded by the NHS. There will still be a level of unsettled claims and estimate of the outstanding liability will be included in the 2018/19 accounts. **Funded Nursing Care Costs** A provision was made in last year's accounts to recognise the Supreme Court judgment regarding health board's contributions for FNC payments to local authorities. Payments are being processed and this liability should largely be discharged by the end of the financial year. **Medical Negligence and Personal Injury Provisions** Accounting estimates are based on an assessment by NWSSP Legal Services of the likely outcome and financial liability of litigation cases together with legal defence fee estimates. **Early Retirement and Personal Injury Benefit Provisions** This is a financial estimate of future liabilities for former staff who retired early many years ago who are in receipt of early retirement or personal injury benefit payments. Payments are made on a quarterly basis to the Pensions Agency and the provision is a calculation of future liability. Provisions are based on life expectancy estimates and current payments are discounted to present values. There is a change in 2018/19 to the discount rate to be applied to these provisions advised by HM Treasury from 0.10% to 0.29%.

3.4.2 Key Dates for Annual Accounts and Public Disclosure Statements 2018/19

The main deadlines, proposed Audit Committee review and Board approval dates for the accounts, Governance Statement and Accountability Report are shown in the following table:

Annual Accounts 2018/19 - Key Dates	**2019**	
Draft Accounts Submission to Welsh Government	Fri	26-Apr
Draft Accounts and Report to Audit Committee Members	Fri	03-May
Audit Committee meeting to Consider Draft Accounts	Thu	09-May
Final Accounts and Report to Audit Committee Members	Fri	24-May
Audit Committee meeting to Consider Final Accounts	Tue	28-May
Board meeting to approve Final Accounts	Thu	30-May
Final Accounts Deadline for Submission	Fri	31-May

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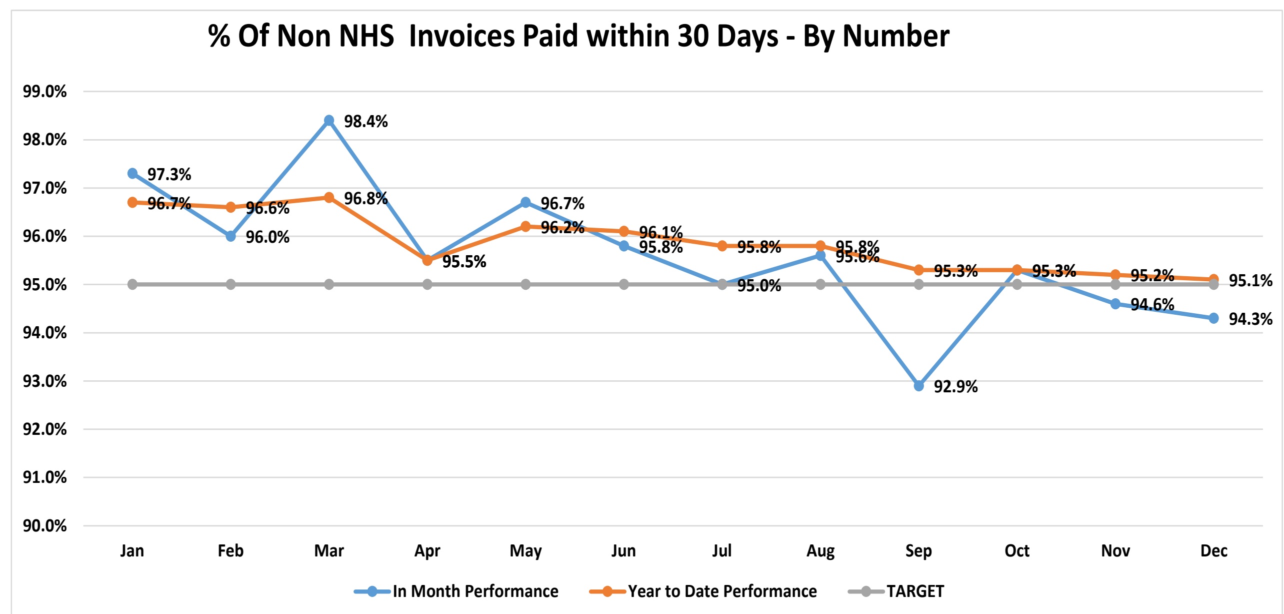
The Audit Committee is asked to note the dates for review of draft and final accounts.

4. Public Sector Payment Policy

The following table shows the Public Sector Payment Policy performance over the last 12 months on a monthly and year to date basis to December 2018. The target of 95% has been achieved on a year to date basis but was missed in December with a figure of 94.3%.

The main issue causing the dip in both November and December was related to processing of pharmacy invoices. Pharmacy ordering and payment authorisation is managed through the Pharmacy Dept. The executive team recently considered a case to support additional investment in the department which included an additional post to help deliver improved compliance with the 30 day target.



5. Single Quotation and Tender Actions – 3rd October 2018 to 17th December 2018

It is a requirement of Aneurin Bevan University Health Board Standing Financial Instructions that all requests for a Single Tender Action or a Single Quotation action are submitted to the Chief Executive for consideration and also reported to the Audit Committee.

The Audit Committee should note the detail of the attached table (Appendix 1) and monitor the number and value of business that is being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be carried out in a fair, transparent and open manner, ensuring that competition is sought wherever possible. Therefore, the number of single action requests should be kept to a minimum.

There have been 6 requests submitted which have been approved during the period with an annual value of £135K. This includes 1 single tender action that was approved in August but omitted from the October Audit Committee report.

Of these 6 approved requests, all 6 were classified as either licensing or maintenance/ service type arrangements, the scope of which could cover the on-going servicing / support of medical equipment, ICT Hardware/Software or general licensing.

6. Post Payment Verification

This section summarises the Post Payment Verification report for the period April – December 2018, produced by the PPV team. The full report is attached for information in Appendix 2.

General Medical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
30	18	12	30	0

The PPV team has recovered £7516 from completed visits to GMS contractors in the Aneurin Bevan UHB area due to errors identified in contractor's enhanced service claims. Recoveries are also to be made from on-going visits. The overall claim error rate for the locality was 4.21% from all claims sampled. Three practices stand out as outliers for GMS services

Practice 8 – this was a revisit with only 15 claims so the percentage would naturally be higher. The clinical director for Primary Care was present at the visit and the practice no longer perform or claim for the service that was verified.

Practice 13 – The practice have a new practice manager in place who did not submit the claims for the time we were reviewing. There will be a revisit to the practice in 12 months to provide further assurance on the claims but we will not see a true reflection of the new practice manager until we do another routine visit in years to come.

Practice 28 – This was a revisit for Minor Surgery claims. There were 28 recoveries made out of the 238 claims we verified so the percentage isn't a major concern given the sample size.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
23	14	9	23	0

The PPV team has recovered £3808 from completed visits to GOS contractors in the Aneurin Bevan UHB area due to errors identified in contractors' GOS claims. The overall claim error rate for the locality was 3.32% from all claims sampled. The majority of claim errors identified so far this financial year are consistent with previous year's findings and relate to the Eyecare Health Examination Wales (EHEW) programme. Any significant variances should they arise will be investigated.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
29	26	3	29	0

The PPV team has recovered £954 from completed visits to GPS contractors in the Aneurin Bevan UHB area due to errors identified in contractor's Medical Review Use claims. The overall claim error rate for the Health Board was 2.29% from all claims sampled. There is one outlier –

Practice 22 – there was an issue with the practice documenting a particular piece of information, they have now been informed of the requirement. The practice will be receiving a revisit within the next 12 months to give further assurance on this matter. The Primary Care team and Community Pharmacy Wales both had input on this file.

7. Payments In Excess of £100K
The Committee requested that, rather than a separate report, this item would be covered by exception.

The Health Board has made 86 payments in excess of £100,000 during the months of September, October & November 2018, totalling £153.3m. 65 of the payments were regular and specifically identified within the scheme of delegation. 21 other payments were identified as requiring additional approvals prior to payment. Contracts were in place for all payments made to private sector suppliers. Therefore there were no exceptional issues to report.

Recommendation
The Audit Committee is requested to note this report and approve the write off of irrecoverable debts.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*No applicable*
Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant to this report*
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs- Standing Financial Instructions* *SOs- Standing Orders*

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Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	pproved / Rejecte	CEO Approval Date
9/17/2018	Single Quotation	288	Ultrasound ED Probe	£6,000.00	Sonosite Fugifilm Ltd	Goods	Probe required for ED to use with existing Sonosite Ultrasound System. Transducer is used for imaging of abdomen, Heart and Lungs and also used for obstetric imaging and Transcranial dopplar imaging essential for swift and accurate assessment of any injuries.	Required for compatibility reasons	Yes	10/3/2018
11/28/2018	Single Quotation	297	Sigmacon Surgical Systems	£11,000.00	Signicon Surgical Systems	Goods	Already using the equipment - the handpieces are part of a full kit to use handpieces from other suppliers a total kit change would be required	Required for compatibility reasons	Yes	11/28/2018
12/6/2018	Single Quotation	299	Binding Site Maintenance	£6,766.50	Binding Site	Maintenance	The Optilite equipment was placed in ABUHB on a reagent rental agreement for provision of the Free Light Chain Assay. This work was previously carried out for us by CAV, bringing the service in house has both financial and clinical benefits. A service and maintenance contract is required for the instrumentation to ensure service continuity. The manufacturer of the instrument is the only supplier able to fulfil this need. When supplying an Optilite analyser to ABUHB, The Binding Site specified the provision of an annual maintenance and service contract provided by them, the use of alternative maintenance would remove Binding Site responsibility for equipment performance	Binding Site are the original equipment manufacturer (OEM) and as such need to be commissioned for the maintenance	Yes	12/11/2018
8/28/2018	Single Tender	285	Enabling works for Mobile Theatres RGH	£29,994.00	Vanguard	Service	Provision of civil works to accommodate a mobile theatre at RGH for a three-month period, due to the urgency of the works this needs to be started on 29/8/18. We have used this supplier previously, so we know they provide an excellent standard of work and given the time limitations, they can complete the enabling works in line with the time restrictions.	The supplier has been used previously and are most suitable for the requirements and quick turnaround of the nature of work	Yes	8/28/2018
11/7/2018	Single Tender	297	Smart Solutions Drivers and Call Handlers	£52,461.91	Smart Solutions	Service	This is for the provision of admin and clerical agency staff to the ABUHB Urgent Primary Care Service. Smart Solutions are an organisation based locally who are known to the service. They have provided staff to the urgent primary care service in the past at short notice so that the service can maintain back room office functions at time of high staff sickness and unexplained absences. Smart Solutions offer a high quality service at a very short notice which reduces the risk of the service having to operate with staff deficits whilst additional staffing shortages are mitigated. ABUHB staff bank cannot always provide staff for an immediate start which results in additional payment for additional hours worked.	A one off use of this supplier was required to backfill staff shortages that have now been mitigated by the recruitment of permanent staff members	Yes	11/6/2018
12/12/2018	Single Tender	299	Medical Gases Pipeline System	£29,097.96	M&M Medical	Service	Health Technical Memorandum (HTM) 02-01 Medical Gas Pipeline Systems requires that contractors working on the MGPS are assessed as “Competent Persons” (CP MGPS). M&M are the HB’s approved competent persons to work on the HB’s MGPS, have provided all relevant proof of competency and BS EN ISO 9001/ BS EN ISO 13485 as specified in HTM 02-01. They have a working knowledge of the systems at the RGH, are specified as the preferred contractor for new build such as the Grange University Hospital and hold all the up to date drawings relating to the MGPS which they update upon completion of the works.	Use of M&M is appropriate due to them being the Health Board's "competent contractor" for the specialist nature of works	Yes	12/17/2018

Aneurin Bevan University Health Board

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Post Payment Verification Progress Report

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

Aneurin Bevan University Health Board

Issued: December 2018
Prepared by: Mr Scott Lavender (All Wales PPV Manager)

This document has been prepared for the internal use of Aneurin Bevan 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 Aneurin Bevan 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
30	18	12	30	0

During the period 1st April 2018 to 31st December 2018, the PPV team has visited 30 GMS contractors as per the visit plan agreed with Aneurin Bevan UHB. The PPV team have recovered £7,516.19 from completed visits to GMS contractors in the Aneurin Bevan 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 4.21% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

As has been previously reported, the PPV team are still identifying GMS errors in relation to Near Patient Testing, Anti-coagulation Monitoring and Minor Surgery.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
23	14	9	23	0

During the period 1st April 2018 to 31st December 2018, the PPV team have visited 23 GOS contractors as per the visit plan agreed with Aneurin Bevan UHB. The PPV team have recovered £3,807.60 from completed visits to GOS contractors in the Aneurin Bevan 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 3.32% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in appendix four of this report.

The majority of claim errors identified so far this financial year are consistent with previous year's findings and relate to EHEW's.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
29	26	3	29	0

During the period 1st April 2018 to 31st December 2018, the PPV team has visited 29 GPS contractors as per the visit plan agreed with Aneurin Bevan UHB. The PPV team have recovered £953.94 from completed visits to GPS contractors in the Aneurin Bevan UHB area due to errors identified in contractor's Medical Review Use claims. A summary of the GPS visits can be found in appendix five of this report.

The overall claim error rate for the Health Board was 2.29% from all claims sampled.

A summary of the PPV teams findings from visits by service can be found in appendix five of this report with a graphical representation of the error rates by service can be found in appendix six.

The majority of claim errors identified so far this financial year are in relation to Medical Use Review's.

4. Collaborative working

The PPV team and Primary Care team have a heavy involvement with each other in communication of practice findings and any issues outlined. The PPV team will always seek advice where uncertain on anything, especially of a clinical nature, and this produces good results for all involved.
The PPV team are pleased that the new appeals process document has been a success as it was a service need identified within this HB Primary Care team. The PPV team was also pleased with the collaboration surrounding producing a training event for GOS contractors.
One of the most pleasing pieces of work for the PPV team came from this Primary Care team where we sat and discussed new specifications and what PPV would need to capture for verification, which has proven very fruitful in helping our department work in a streamline fashion.

We currently undertook training for GMS practice managers where they could attend a presentation and ask questions. This proved to be a success that the practice managers found to be quite useful and enjoyed. Following this we then booked in some one-on-one training with practice managers who requested it and they have found this to be particularly helpful.

5. Conclusions and recommendations

The PPV department is working hard to strongly collaborate with contractors, Health Board members and other stakeholders to ensure understanding and confidence in the specifications. We offer training and also have provided documents to the contractors to aid them in the process of PPV.

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.

As we begin to approach the final quarter of the financial year we will start to piece together plans for the upcoming financial year and we will look to work in collaboration with the Primary Care team for this.

Aneurin Bevan University Health Board
GMS PPV Progress Report: 2018/19
APPENDIX 1 PPV

Completed GMS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	165	7	1.21%	4.24%	£277.94	3 x Minor Surgery, 1 x Contraceptive services, 1 x Administration of Gonadorelins and 2 x Flu
Practice 2	Routine	163	15	11.66%	9.20%	£686.75	2 x Minor Surgery, 1 x Administration of Gonadorelins, 5 x Pertussis, 6 x Care Homes and 1 x Anti-coagulation monitoring
Practice 3	Routine						File in progress, initial report sent to practice
Practice 4	Revisit						File in progress, initial report sent to practice
Practice 5	Routine	116	2	11.00%	1.72%	£51.68	2 x Administration of Gonadorelins
Practice 6	Routine	222	3	0.45%	1.35%	£148.05	1 x Minor Surgery and 2 x Anti-coagulation monitoring
Practice 7	Routine						Visit scheduled for 18th December 2018.
Practice 8	Revisit	15	4	0.00%	26.67%	£283.24	4 x Network Minor Surgery
Practice 9	Revisit						File in progress, initial report sent to practice
Practice 10	Revisit	875	26	15.09%	2.97%	£527.36	15 x Contraceptive services and 11 x Pertussis
Practice 11	Routine	131	10	5.34%	7.63%	£519.04	1 x Administration of Gonadorelins, 1 x Flu, 6 x Minor Surgery and 2 x Near Patient Testing
Practice 12	Revisit						File in progress, final report sent to UHB
Practice 13	Routine	221	24	28.96%	10.86%	£1,112.36	1 x Near Patient Testing, 7 x Anti-coagulation monitoring, 5 x Contraceptive services, 8 x Minor Surgery and 3 x Flu* (Flu recovered whole quarter due to error in claiming)
Practice 14	Revisit						File in progress, remote access underway
Practice 15	Routine	317	7	3.79%	2.21%	£263.66	2 x Minor Surgery, 1 x Flu, 1 x Lithium, 1 x Pertussis and 2 x Denosumab
Practice 16	Routine	177	6	15.25%	3.39%	£277.82	3 x Anti-coagulation monitoring, 2 x Minor Surgery and 1 x Near Patient Testing
Practice 17	Routine	111	7	0.90%	6.31%	£225.95	3 x Contraceptive services, 2 x Denosumab and 2 x Minor Surgery
Practice 18	Revisit	1236	63	0.65%	5.10%	£1,056.14	6 x Minor Surgery and 57 x Flu
Practice 19	Routine	199	7	0.50%	3.52%	£283.24	1 x Near Patient Testing, 1 x Lithium, 2 x Minor Surgery, 1 x Administration of Gonadorelins, 1 x Denosumab and 1 x Care Homes
Practice 20	Routine						File in progress, initial report sent to practice
Practice 21	Revisit	322	4	0.00%	1.24%	£80.92	4 x Near Patient Testing
Practice 22	Routine	237	1	4.64%	0.42%	£9.80	1 x Flu
Practice 23	Revisit						File in progress, initial report sent to practice
Practice 24	Revisit						File in progress, initial report sent to practice
Practice 25	Revisit						File in progress, initial report sent to practice
Practice 26	Routine	209	5	0.00%	2.39%	£384.79	1 x Contraceptive services, 2 x Minor Surgery and 2 x Learning Disabilities
Practice 27	Routine	246	0	27.64%	0.00%	£0.00	All claims were verified
Practice 28	Revisit	238	28	0.42%	11.76%	£1,327.45	28 x Minor Surgery
Practice 29	Routine						File in progress, initial report sent to practice
Practice 30	Routine						File in progress, initial report sent to practice
UHB average		**5,200**	**219**		**4.21%**	**£7,516.19**	

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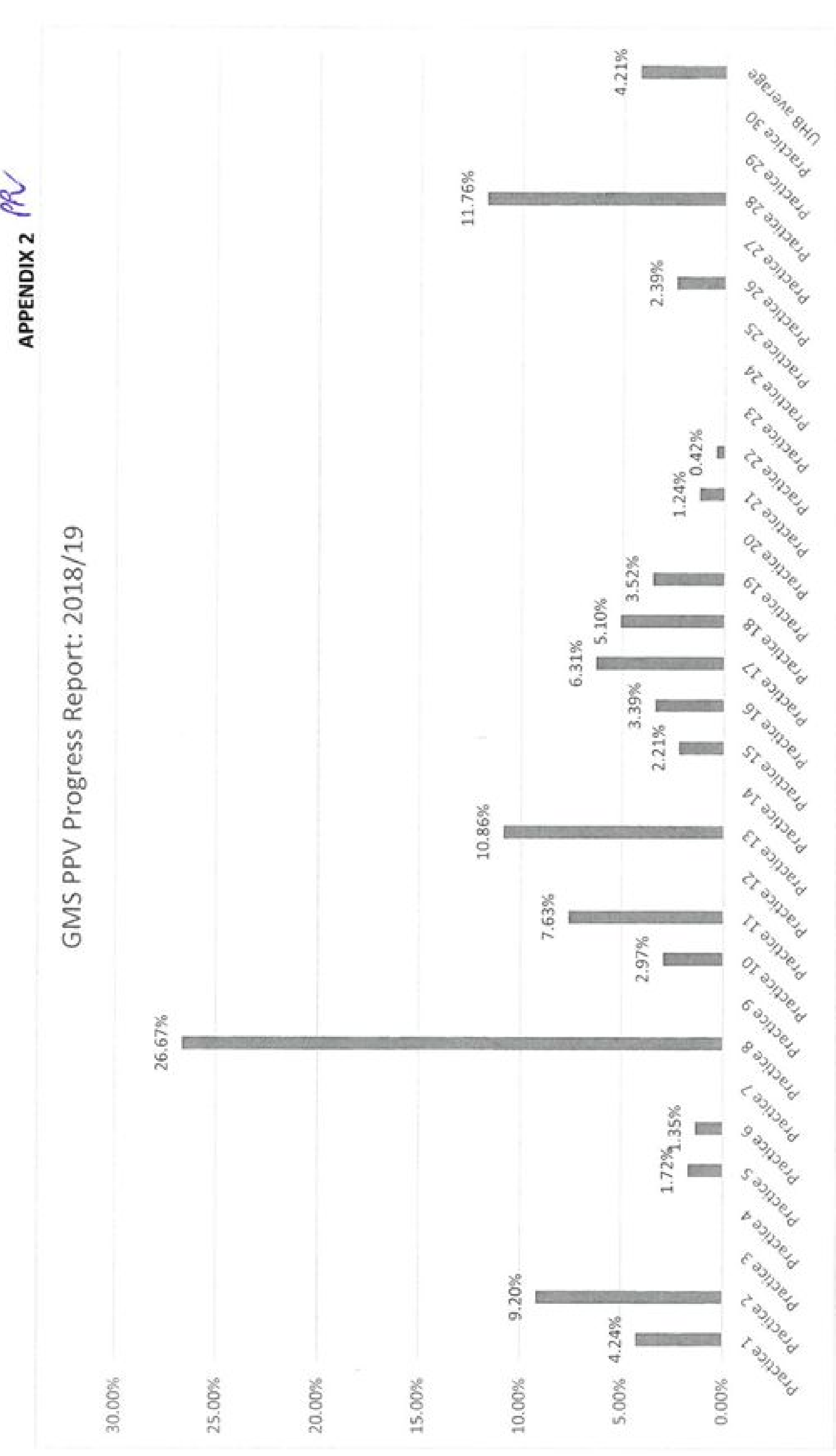

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Aneurin Bevan University Health Board
GOS PPV Progress Report: 2018/19

APPENDIX 3

Completed GOS visits

Practice Name	Practice Code	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	242	Routine						File in progress, initial report sent to practice
Practice 2	176	Routine						File in progress, initial report sent to practice
Practice 3	243	Revisit						File in progress, initial report sent to practice
Practice 4	270	Routine	103	1	5.83%	0.97%	£40.40	1 x EHEW
Practice 5	105	Routine	103	1	19.00%	0.97%	£20.20	1 x EHEW
Practice 6	134	Routine						File in progress, initial report sent to practice
Practice 7	174	Routine	103	2	14.56%	1.94%	£69.40	1 x EHEW and 1 x Tint on GOS 3
Practice 8	202	Routine	103	1	9.71%	0.97%	£8.80	1 x Tint on GOS 3
Practice 9	207	Routine						Visit scheduled for 17th December 2018
Practice 10	217	Revisit	300	4	5.00%	5.00%	£120.00	4 x EHEW
Practice 11	117	Routine	103	3	4.85%	2.91%	£78.20	3 x GOS 4
Practice 12	201	Routine	103	10	13.59%	9.71%	£365.70	1 x GOS 3, 3 x GOS 4 & 6 x EHEW
Practice 13	220	Revisit	151	16	5.30%	10.60%	£743.40	16 x EHEW
Practice 14	262	Revisit	300	12	10.00%	4.00%	£541.20	12 x EHEW
Practice 15	161-262	Routine			23.30%	28.16%	£1,517.80	File in progress, final report sent to UHB
Practice 16	109	Routine						File in progress, final report sent to UHB
Practice 17	116	Routine						File in progress, initial report sent to practice
Practice 18	179	Revisit						File in progress, initial report sent to practice
Practice 19	182	Routine	103	1	5.83%	0.97%		File in progress, initial report sent to practice
Practice 20	231	Routine	103	7	34.95%	6.80%	£241.90	1 x GOS 3, 4 x GOS 4 and 2 x EHEW
Practice 21	198	Revisit						File in progress, initial report sent to practice
Practice 22	139	Routine	100	0	15.00%	0.00%	£0.00	All claims were verified
Practice 23	233	Routine	103	1	0.00%	0.97%	£60.60	1 x EHEW
UHB average			**1,778**	**59**		**3.32%**	**£3,807.60**	

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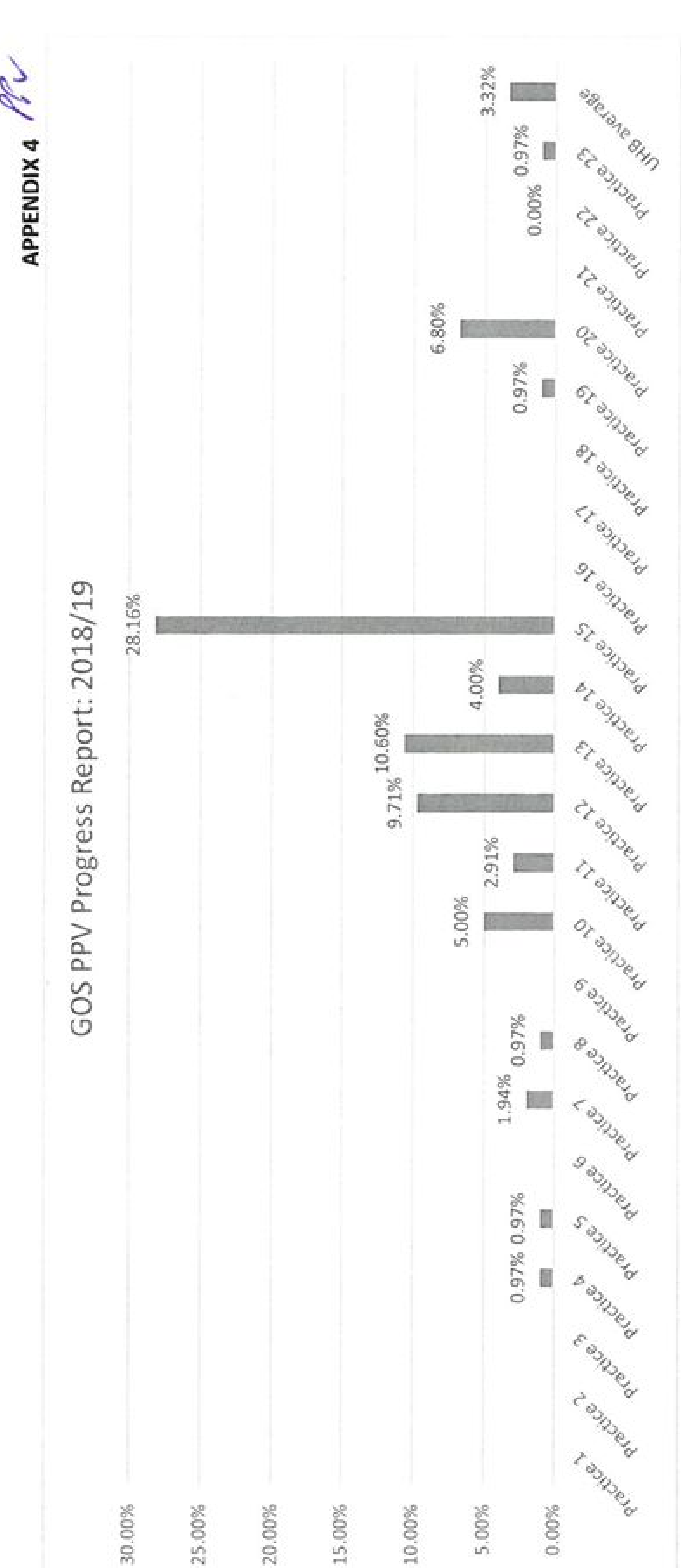

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Aneurin Bevan University Health Board
GPS PPV Progress Report: 2018/19

APPENDIX 5

Completed GPS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	20	0	0.00%	0.00%	£0.00	All claims were verified
Practice 2	Routine	92	0	5.43%	0.00%	£0.00	All claims were verified
Practice 3	Routine	36	0	13.89%	0.00%	£0.00	All claims were verified
Practice 4	Routine	89	4	10.11%	4.49%	£88.10	2 x MUR & 2 x Flu
Practice 5	Routine	91	4	13.19%	4.40%	£112.00	4 x MUR
Practice 6	Routine	99	3	25.25%	3.03%	£84.00	3 x MUR
Practice 7	Revisit						File in progress, final report sent to UHB
Practice 8	Routine	52	0	0.00%	0.00%	£0.00	All claims were verified
Practice 9	Routine	100	0	0.00%	0.00%	£0.00	All claims were verified
Practice 10	Routine	20	0	0.00%	0.00%	£0.00	All claims were verified
Practice 11	Routine						File in progress, initial report sent to practice
Practice 12	Routine	100	2	6.00%	2.00%	£32.10	2 x Flu
Practice 13	Routine	72	2	6.94%	2.78%	£56.00	2 x MUR
Practice 14	Routine	2	0	0.00%	0.00%	£0.00	All claims were verified
Practice 15	Routine	100	0	12.79%	0.00%	£0.00	All claims were verified
Practice 16	Routine	86	0	20.00%	0.00%	£0.00	All claims were verified
Practice 17	Routine						File in progress, final report sent to UHB
Practice 18	Revisit	28	1	0.00%	3.57%	£15.96	1 x Flu
Practice 19	Routine	77	0	16.88%	0.00%	£0.00	All claims were verified
Practice 20	Routine	80	3	6.25%	3.75%	£84.00	3 x MUR
Practice 21	Routine	100	0	7.02%	0.00%	£0.00	All claims were verified
Practice 22	Routine	92	23	38.89%	93.33%	£425.78	6 x MUR & 17 x Flu
Practice 23	Revisit	82	1	20.73%	1.22%	£28.00	1 x MUR
Practice 24	Routine	86	0	42.19%	0.00%	£0.00	All claims were verified
Practice 25	Routine	87	0	17.19%	0.00%	£0.00	All claims were verified
Practice 26	Routine	80	0	17.50%	0.00%	£0.00	All claims were verified
Practice 27	Routine	84	0	22.50%	0.00%	£0.00	All claims were verified
Practice 28	Routine	84	0	20.94%	0.00%	£0.00	All claims were verified
Practice 29	Routine	80	1	1.25%	8.75%	£28.00	1 x MUR
UHB average		**1,919**	**44**		**2.29%**	**£953.94**	

APPENDIX 6

GPS PPV Progress Report: 2018/19

100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
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0.00% 0.00% 0.00% 4.49% 4.40% 3.03% 0.00% 0.00% 0.00% 2.00% 2.78% 0.00% 0.00% 0.00% 3.57% 0.00% 3.75% 0.00% 93.33% 1.22% 0.00% 0.00% 0.00% 0.00% 0.00% 8.75% 2.29%

Practice 1, Practice 2, Practice 3, Practice 4, Practice 5, Practice 6, Practice 7, Practice 8, Practice 9, Practice 10, Practice 11, Practice 12, Practice 13, Practice 14, Practice 15, Practice 16, Practice 17, Practice 18, Practice 19, Practice 20, Practice 21, Practice 22, Practice 23, Practice 24, Practice 25, Practice 26, Practice 27, Practice 28, Practice 29, UHB average

7.1

	Audit Committee 17th January 2019 Agenda Item: 7.2

Audit Committee
Losses and Special Payments Report

Executive Summary

- **Purpose**
  To provide Audit Committee with information in relation to financial losses and special payments made by the Health Board between September and December 2018.

- **Background and context**
  Losses and Special payments are reported in the financial position each month monthly relating to cash payments for clinical negligence, personal injury claims, ex gratia payments and bad debt write offs. Losses are to be reported to the Audit Committee in line with the Committee's terms of reference.

- **Assessment and Conclusion**
  Audit Committee is asked to note that the net charge to the accounts at the end of December 2018 was £1,119K (inclusive of defence fees) which consisted of:

  Clinical Negligence £826k
  Personal Injury £256k
  Minor Losses £37k

- **Recommendation**
  Audit Committee is asked to note the content of this report.

The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Glyn Jones, Director of Finance			
Report Author: Estelle Evans, Head of Financial Services and Accounting			
Report Received consideration and supported by :			
Executive Team	**n/a**	**Committee of the Board [Committee Name]**	**n/a**
Date of the Report: 7th January 2019			
Supplementary Papers Attached: Appendix 1 – Assurance Framework			

1

Purpose of the Report

The purpose of the paper is to provide the Audit Committee with information in relation to financial losses and special payments made by the Health Board for the period September to December 2018. The report covers clinical negligence, personal injury and other payments that constitute a loss to the organisation.

Background and Context

1 Background

Losses and special payments are reported in the financial position each month. The amount charged to the accounts each year consist of cash payments for clinical negligence, personal injury claims, other ex gratia payments and bad debt write offs. An assessment is also made about the level of outstanding financial liability at the period end date and any increase or decrease in this 'provision' is charged to the accounts together with cash payments.

This report will provide information as at 31st December 2018.

2 Issues

2.1 Assurance Framework

The current organisational structure and membership for the review of losses and special payment cases is set out in Appendix 1 which also identifies any significant issues highlighted in recent meetings.

2.2 Financial Analysis of Losses

Table 1 below shows analysis of the estimated liability for losses as at 31st December 2018 compared to the position reported at 31st August and 31st May 2018. It also identifies the out turn position for March 2018.

Table 1

Clinical Negligence & Personal Injury Provision				
	31-Mar-18 £000	31-May-18 £000	31-Aug-18 £000	31-Dec-18 £000
Clinical Negligence	89,822	80,158	100,502	111,987
Personal Injury	3,674	3,568	3,530	3,656
	93,497	**83,725**	**104,032**	**115,643**
Income From Welsh Risk Pool	-88,034	-78,551	-98,890	-110,361
Net Liability	**5,463**	**5,174**	**5,142**	**5,282**

7.2

Table 1 reflects the estimated liability in relation to cases advised by NWSSP Legal Services for both clinical negligence and personal injury with the provision updated to reflect new or changed cases.

The key points are:-

- The net provision required for Clinical Negligence and Personal Injury cases as at 31st December 2018 compared to the 31st August 2018 has increased by £140k.
- There was an increase of £11,485k in the Clinical Negligence provision since August as a result of the revised assessment of the likely outcome of these cases by NWSSP Legal Services with an associated increase in the anticipated income from the Welsh Risk Pool. One case accounted for £11,000k of this increase following reappraisal of the probable settlements.

The number of cases provided for are shown in Table 2.

Table 2

	31-Mar-18	31-May-18	31-Aug-18	31-Dec-18
	No. of cases	No. of cases	No. of cases	No. of cases
Clinical Negligence	288	265	250	234
Personal Injury	68	78	83	79
	356	**343**	**333**	**313**
Income from Welsh Risk Pool	96	94	92	94

The amount charged to the revenue budget of the Health Board comprises of the cash paid out in the period as interim or final settlement of cases together with the overall movement in the provision from the previous year. Table 3 summarises the total amount charged:

Table 3

YTD Expenditure Charged to the Accounts (incl Defence Fees)				
	31-Mar-18	31-May-18	31-Aug-18	31-Dec-18
	£000	£000	£000	£000
Clinical Negligence	7,857	688	2,514	5,245
Personal Injury	326	41	109	293
Irrecoverable Debts	0	0	0	0
Other	141	5	16	37
	8,324	**735**	**2,639**	**5,575**
Income From Welsh Risk Pool	-7,069	-675	-2,201	-4,456
Net Expenditure	**1,255**	**60**	**438**	**1,119**

7.2

The net charge to the accounts as at the end of December was £1,119k. This compares to a net charge to the accounts of £1,255k for the 2017-18. There is currently an underlying increase in the net expenditure compared to last year due to higher revaluations of provisions.

The following table 4 illustrates more clearly the figures up to the end of December 2018. The figures are inclusive of defence costs:

Table 4	Payment Made	Accrued Income from WRP	**Net**	Change in Provision	**Net Charge to Accounts**
	£000	**£000**	**£000**	**£000**	**£000**
Clinical Negligence					
Previously Reported Apr 18 To Aug 18	2,680	-2,180	499	-166	334
Current Year to Date Apr 18 To Dec 18	5,288	-4,419	870	-43	826
Personal Injury					
Previously Reported Apr 18 To Aug 18	68	-21	48	41	89
Current Year to Date Apr 18 To Dec 18	168	-38	130	126	256
Other					
Previously Reported Apr 18 To Aug 18	16	0	16	0	16
Current Year to Date Apr 18 To Dec 18	37	0	37	0	37
Total					
Previously Reported Apr 18 To Aug 18	2,764	-2,201	563	-125	438
Current Year to Date Apr 18 To Dec 18	5,493	-4,456	1,037	82	1,119

Commentary on Table 4

During the period September to December 2018 the following payments have been made:

Payments have been made totalling £2,608k for Clinical Negligence cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £2,239k of income.

The £2,608k paid is analysed as follows:

- £1,943k (20 payments) – Settlements

7.2

    - £1,033k – relates to a patient who was unhappy with care provided and a delay in diagnosis.
    - £266k – relates to a patient where paramedics requested a GP home visit. GP Home visit was 7 hours later (despite additional calls) by which time the patient had died.
    - £220k – relates to a patient who died following stroke.
    - £200k – relates to a patient who suffered a stroke during pregnancy.
    - £224k related to 16 payments ranging in value up to £88k
- £472k (30 payments) – Claimants Solicitors Fees
    - £472k related to 30 payments ranging in value up to £75k.
- £116k (107 payments) - Providing medical expertise
- £53k (46 payments) – Counsel fees incurred
- £3k (2 payments) – Professional fees incurred
- £8k (1 payment) – Compensation Recovery Unit
- £11k (23 payments) – Other payments

Payments have been made totalling £100k for Personal Injury cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £17k of income.

The £100k paid is analysed as follows:

- £22k (7 payments) - Settlements
- £31k (6 payments) - Claimants solicitors fees
- £43k (12 payments) – NWSSP Legal & Risk costs
- £2k (3 payments) – Providing medical expertise
- £2k (2 payments) – Counsel Fees

Other Losses

Minor losses incurred during the period September to December 2018 totalled £21k. These relate to settlements with regards to Ombudsman cases, an employment tribunal and other minor losses including patients' property. Lessons learnt reviews have been undertaken for each case and the Divisions and Departments of the organisation are actively responding to these reviews.

2.3 Redress

During the period September to December 2018, 21 payments were made in relation to redress cases totalling £93k. Funding will be requested from NWSSP to cover the costs incurred by the

Health Board in relation to these redress cases with the exception of £8k in relation to claimant's solicitor's costs which are not reimbursable by NWSSP.

Recommendation

The Audit Committee is asked to note the contents of the report.

APPENDIX 1

Losses and Special Payments Assurance Framework

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
Audit Committee	*Board*	***Independent members only:*** *Chair – Catherine Brown* *Vice Chair – Shelley Bosson* *IM - Katija Dew*	*Advise* and *assure* the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the LHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the LHB's objectives, in accordance with the standards of good governance.	**Quarterly**	**11th Oct 2018** **Next meeting 17th Jan 2019**	
Quality & Patient Safety Committee	*Board*	*Chair – Professor Dianne Watkins* *Vice Chair – Frances Taylor* *IM – Emrys Elias,* *Richard Clark*	**Receive at each meeting:** • Bi Monthly complaints reports Contains details of total numbers, numbers by Division , trends, performance and details of second stage complaints • SI reports Contains new serious incidents by area and date, current under investigation including details of remedial actions and closed incidents with details of actions taken and lessons learnt. **Receive Twice Yearly** • Six Monthly Claims Report	**Bi Monthly**	**21st Nov 2018** **Next meeting 7th Feb 2019**	The Annual PTR report was due to be presented at the Committee but was deferred until the next meeting on the 7th February 2019.

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
			Total numbers, numbers by area, trends and themes and lessons learnt following claim. **Receive Annually** Annual Summary from Learning Committee re key lessons learnt and actions taken to reduce risks resulting from patient safety concerns across the Health Board. **Periodically** WAO Reports WRP Reports PTR/Redress Reports			
Litigation Committee	Board	*Chair – Ann Lloyd* *Vice Chair – Emrys Elias* *IM – Professor Dianne Watkins* *IM – Catherine Brown* *CEO - Judith Paget* *Medical Director - Dr Paul Buss*	• To review and approve in conjunction with Welsh Health Legal Services major claims (exceeding £100K). • Consider inquests • Approve polices in relation to claims • Consider cases referred to trial	**3 meetings a year**	**3rd Dec 2018** **Next meeting 13th Mar 2019**	Review of claims. Consideration of appeals for minor losses
Quality & Patient Safety	*Quality & Patient*	Operational group no non	Highlight reports from each Division.	**Bi Monthly**	**10th Dec 2018**	The PTR Annual report was presented at the QPSOG on the

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
Operational Group	*Safety Committee*	officer members	Progress reports from Learning Committee, WRP and complaint /SI reports which need to be highlighted to the group for consideration re escalation		**Next meeting 19th Mar 2019**	10th December. The next meeting is on the19th March. The top three risks for each division were discussed and documented.
Learning Committee	*Divisional QPS Meetings*		• Discuss themes and trends and take learning across all Divisions of the Health Board to ensure health Board wide learning • Agree solutions and ensure escalation as needed. • WRP Claims Reviews • Claims trends/themes • SI and Serious complaint Action plans to cascade learning across Health Board • Second Stage Action Plans – (themes)	**Quarterly**	**Next Meeting 9th Jan 2019**	Bronagh Scott has now left the Health Board therefore this meeting did not take place in November 2018. A concerns workshop is being held on the 9th January 2019 and a lead will be identified to take the Learning Committee forward.
Divisional / Locality Quality & Patient Safety	*Learning Committee*		• Ensure divisions take their learning forward through review of Divisional Concerns and claims • Trends and themes and agree remedial actions		**Next Meeting 9th Jan 2019**	A Concerns workshop is being held on the 9th January with attendance from all Divisions and a Service Improvement Plan will be implemented.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment	*Financial implications stated in Table 3 above*
Quality, Safety and Patient Experience Assessment	*See Appendix 1*
Equality and Diversity Impact Assessment (including child impact assessment)	*N/A*
Health and Care Standards	*See Appendix 1*
Link to Integrated Medium Term Plan/Corporate Objectives	*N/A*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*N/A*
Glossary of New Terms	*None*

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	Audit Committee 17th January 2019 Agenda Item: 7.3

Audit Committee
Risk Management Review and Assurance Framework Development Report

Executive Summary
The following paper is intended to provide an update on progress made to date and will be further refined following the final interviews and analysis that are currently being undertaken. The final report for Risk Review will be presented in March 2019. This paper also outlines that plans have been developed to use the outputs of the review to support the Health Board's finalisation of its Board Assurance Framework and a redevelopment of its Risk Appetite Statement, which will be considered at the February Board Briefing Session with a plan for approval at the Board Meeting in March 2019.

The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			✓
Executive Sponsor: Richard Bevan, Board Secretary			
Report Author: Richard Bevan, Board Secretary and Jeff Brown, Review Lead			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 9th January 2018			

Purpose of the Report
This report gives the Audit Committee an update in relation to the current work on the risk management review and initial feedback and also a timeline for the finalisation of the Assurance Framework and Risk Appetite Statement.

Background and Context
Risk Management Landscape Review: The following paper is intended to provide an update on progress made to date and will be further refined following the final interviews and analysis that are currently being undertaken. The final report following conclusion of the review will be presented in March 2019.

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Project Overview

A review was commissioned in September 2018 to undertake a high level Risk Management Landscape review of the Health Board and this is being facilitated and delivered by JBS Solutions Limited on behalf of the Health Board.
The review's primary objectives are to:

- Gather intelligence from across the Health Board to better understand current risk management approaches and practice and to use this to identify any opportunities or barriers that would enhance or limit the improvement of the Health Board's approach to risk management that is required, which was identified in an Internal Audit Report for 2107/2018 and also the Wales Audit Office Structured Assessment.
- To use a survey, 121 interviews and development workshops, to build capability and knowledge around good/notable risk management practice.

The project has focused on the frameworks/structures and approaches that feed into the current risk committee structures rather than the Board and its Committees. However, it is clear that a redeveloped and redefined risk management framework and approach will assist the Health Board in taking forward its Board Assurance Framework arrangements and also assist the Board in re-determining its risk appetite and framing an update Risk Management Statement. Therefore, this project is also intended to complement the ongoing work being undertaken by the Corporate Team to review the current Health Board assurance frameworks. The final deliverable for this work will be a high level briefing paper. However, it is recognised that improvement identified as part of this review is already being taken to ensure that that the Health Board continues to improve its position.

Project Activity update:

Project step	Project deliverables	Status
Step 1	Design and execution of a pan Health Board Risk Management Survey	Completed
Step 2	121 interviews with (30) Risk Management champions	Completed
Step 3	Design and facilitation of two Risk Management Development sessions	In – progress - Due 22nd Feb and 4th March (2019)
Step 4	Drafting of a high level briefing paper	In progress – Due Mid to late Feb 2019

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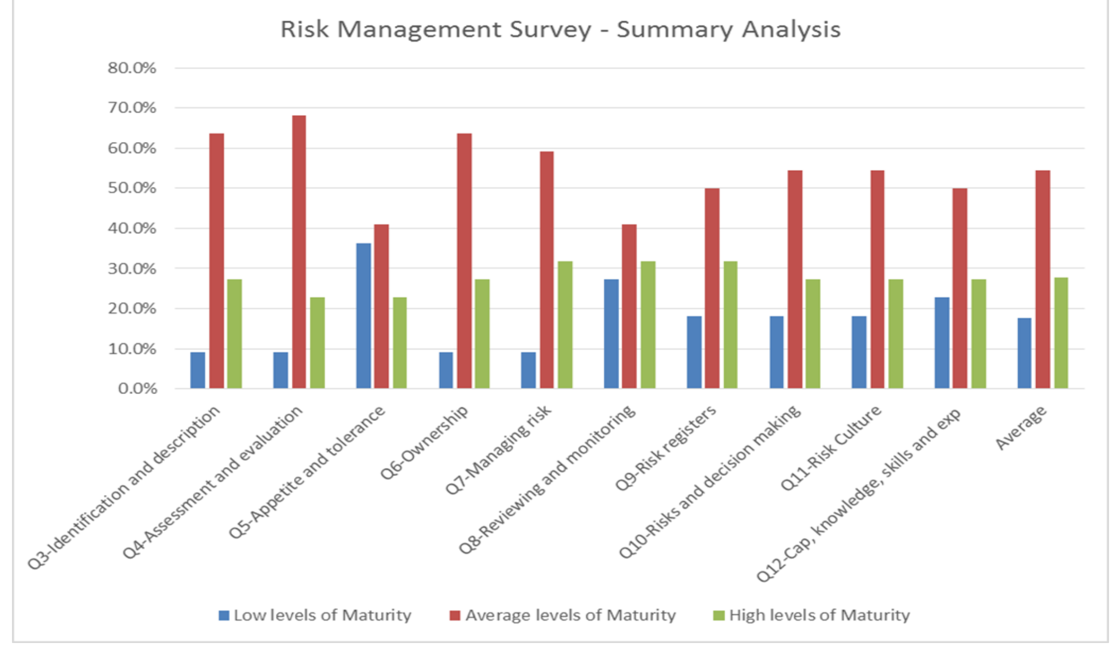
Emergent themes/findings (Please note that these findings are initial feedback and will be refined further as the additional evidence from the one to one interviews is assessed)

1. **Survey results**
   The survey was based on a Maturity framework around ten key Risk Management areas
   - Very good response rate - 21 out of a possible 30 = 70% - with high levels of helpful narrative comments
   - Currently the result showed that there are variable ways in which risks are recorded across the organisation – approx. 50% on DATIX and 50% on spreadsheets
   - Above average confidence in Risk Management informing planning and decision making
   - Across all 10 areas of the survey, self-assessed responses were 55% have average levels of maturity. However, almost 18% have a low level of maturity and nearly 27% a high level of maturity.
   - The areas where maturity was highest were:
     - Q7 - Responding to and managing risk
     - Q8 – Reviewing and monitoring risks
     - Q9 - Risk registers
   - The areas where maturity was lowest were:
     - Q5- Risk appetite and risk tolerance
     - Q8 - Reviewing and monitoring risks (this area also included those with the highest levels of maturity – very dispersed results)
   - A significant number of helpful developmental comments were provided even where respondents had selected average or above average maturity scores



2. One to One Interviews

Overarching themes

1. **A recognition by staff that Risk Management is an important part of the business and a willingness to work to get it right.**

2. **Variable confidence in and understanding of the current Risk Management framework**
   - Understanding of Risk Management Structures/process/tools
   - Arrangements for feedback/feedback loop mechanisms
   - Clarity over risk types (clinical v non clinical risks). Need for a holistic organisation-wide approach to risk management
3. **Balancing everyday delivery with effectively identifying and managing risk**
   - Cultural differences across the Health Board impact on approach
   - Understanding of risk impacts on other divisions
   - Central point for risk management excellence/support and advice
4. **Line of sight between objectives (either at the strategic or divisional level) and risks**
   - Relationship between risk management and improvement
   - Connections between Divisions and the corporate risk process need further clarification

The table below provides initial feedback form the survey and the interviews undertaken so far.

Initial Opportunities for improvement	Perceived and actual barriers
• Extending the DATIX Risk Management module to other Divisions following its piloting. However, with a stronger pilot/business case/benefits articulated • The cross Divisional risk work on Brexit might provide a method for other cross divisional working around risk • Good practice approaches in Finance, Families &Therapies Division and Clinical Futures, to considering, capture, reporting and monitor risk – to be shared more widely • Potential to link improvement around Health and Care Standards and risks (improvement plans and links to Risk Management module in DATIX) • A genuine wish by those on the ground to get this right – enthusiasm to get involved in facilitated cross organisational working. • Opportunity to map the assurance and bring together current disparate risk governance structures with a focus on escalation and de-escalation	• Clarity for some on the connectedness of the Health Board's Risk Management arrangements • Having many layers of risk classification – Health and Care Standards, SCPs, Corporate priorities, strategic risk areas can make the current framework seem overwhelming. • Misunderstanding of risk versus issues and in consistently describing risks to facilitate grouping and comparison • Some parts of the organisation still only see risk from a clinical Q&PS perspective rather than wider risks corporate risks and impacts • Cultural issue in some part of the organisation that the benefits of Risk Management are not seen as an aid to manage the business • Clearer articulation of the links between risks and delivering corporate priorities is required • Risk capture/management being overly bureaucratic and not adding value

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• Opportunity to use "Qlik sense" (data visualisation tool introduced to the organisation to make better use of risk data. • Opportunity to better integrate the current improvement agenda and clinical audit and risk management as part of the current Q&PS assurance review • Opportunity to further explore collaborative approaches to risk identification and management with partners through the Public Service Board and Regional Partnership Board.	• Connection between Clinical Futures risks and operational risks • Taking personal accountability for and managing risk • Variety of tools used to capture Risks • Need to consider partnership/shared risks with partners.

Next Steps:

The initial feedback will continue to be worked upon to facilitate the finalisation of the report. Further engagement will also be undertaken with as planned with the two planned workshops on the 22nd February and the 4th March 2019. This content of the final report will be used to inform further work with the Executive Team and Board to support the finalisation of the Board Assurance Framework and the sources of assurance work.

Further work will be undertaken with the Board, using the feedback form the review, to discuss the finalisation of the Board Assurance Framework and also a process to revised and rework the current Risk Appetite Statement of the Health Board. This will be undertaken at the Board Briefing Session planned for the 20th February 2019 in readiness for approval of the Assurance Framework and the Risk Appetite Statement at the Board Meeting planned for the 27th March 2019.

Recommendation

The Audit Committee is requested to note this report, the progress made thus far and the planned next steps.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Boards overall assurance framework.
Financial Assessment, including Value for Money	There may be financial consequences of individual risks however there is not direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual risks and assurance requirements contained within this report.
Equality and Diversity Impact Assessment	There are no equality issues associated with this report at this stage, but equality impact assessment will be a feature

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(including child impact assessment)	of the work being undertaken as part of the risks and assurance framework.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The risks and assurance arrangements will be fundamental elements against delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual risk and the assurance arrangements, as outlined.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

	Audit Committee 17th January 2019 Agenda Item: 7.4

Aneurin Bevan University Health Board
High Level Audit Recommendations Tracker

Executive Summary

At the Audit Committee Meeting in April 2018, it was agreed that the current Audit recommendations Tracker would be fully reviewed with the Executive Team. This was undertaken in readiness for the July 2018 Audit Committee Meeting and was again reported to the October 2018 meeting.

This report provides the Audit Committee with an update on the progress with the tracker. Twenty-four recommendations are currently covered by the tracker.

At the Audit Committee Meeting in July, it was agreed that the Tracker would be submitted to each Audit Committee Meeting, that the categorisations used would be changed to better indicate progress. It was also agreed that the source of the reports i.e. Internal Audit or Wales Audit Office would be shown for each action.

This report provides information on the current status of the recommendations following extensive review by the Executive leads and also at the Executive Team meeting on the 7th January 2019. The tracker indicates those recommendations in the opinion of the Executive Team that have been completed and are proposed to be taken off the tracker, those that have made significant progress but are still not fully complete and those where some progress has been made but a number of factors still remain which prevents the action being fully completed. There is also one that is yet to reach its deadline date, however, current progress is still shown.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Richard Bevan, Board Secretary

Report Author: Richard Bevan, Board Secretary

Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 9th January 2019

Supplementary Papers Attached: December 2018/January 2019 Audit Tracker Update

Purpose of the Report

To present to the Audit Committee for compliance and assurance purposes the tracking database of the current agreed actions for Internal Audit and Wales Audit Office high level recommendations.

Background and Context

The Audit Committee agreed in 2014 that in order to closely monitor progress with the programme of internal audits reports undertaken at the Health Board and the subsequent organisational responses to recommendations, that a tracking arrangement would be established, which would be monitored by the Executive Team. A detailed tracking database was set-up initially to record the progress of all the recommendations contained in each of the Internal Audit reports completed since the establishment of the Health Board.

The Committee subsequently agreed that the Wales Audit Office (WAO) report recommendations should also be included within the tracker in order to provide assurance that those recommendations were also being progressed, monitored and completed.

There are currently 24 recommendations within the database, as per the table below:

Red	12	Some progress, but outside the target deadline.
Amber	0	In progress, but further action required to finalise the agreed action by the deadline date, which falls in the next monthly review period.
Green	11	The Action has been completed and it is proposed that the action is withdrawn from the tracker.
Purple	1	Action yet to reach its target date.

11 high level actions have been assessed by the Executive Team as completed, or are complete and are proposed to be withdrawn from the tracking database with the agreement of the Audit Committee.

Further work is underway to ensure that the remaining actions on the database are completed as agreed.

Recommendation

The Audit Committee is asked to note this report and green recommendations can be withdrawn from the database.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational actions for audit activity are key elements of the Health Board's overall assurance arrangements.
Financial Assessment, including Value for Money	There may be financial consequences of individual actions however there is no direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual actions and assurance requirements contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the actions.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The actions will be aspects of the delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual actions.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
1. (IA)	Medicines Homecare Services Management Arrangements Audit *October 2015*	The clinical check requires a Pharmacist to review the current list of drugs prescribed to a patient to confirm that the newly prescribed drug will not affect the patient adversely when taken in combination with the patient's existing prescription. While the clinical check forms an integral part of the homecare process for Tecifera, no clinical check is undertaken for the other 7 drugs delivered through the homecare service. We understand that, due to the large number of patients receiving homecare drugs, there is not sufficient Pharmacist resource available to undertake all of the required checking.	March 2016	Clinical Director for Pharmacy Executive Lead: Chief Operating Officer	**December 2018 Update:** Adalimumab is one of the main historical homecare medicines that does not currently have a clinical check. Following approval of a business case by the Executive Team in December 2018, further pharmacy resource has been secured to support the implementation of biosimilar adalimumab. This will facilitate the clinical checking to be undertaken, as this is a requirement of the new service level agreement. Full implementation is dependent on recruitment and transition to the biosimilar and therefore it is expected that improved compliance will be achieved by April 2019 and will be monitored as part of KPIs presented to the homecare committee.	The Executive Team determined that the additional investment has responded to the original recommendation and that the recommendation can be turned green and taken off the tracker.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
7. (IA)	IT Access and Environmental Controls *February 2017*	All server rooms should have appropriate equipment installed to enable the effective combat of fire. Equipment should also be regularly maintained and inspected in line with the manufacturer's guidance.	May 2017	Operations Manager - ICT Executive Lead: Director of Planning, Digital and IT	**December 2018 Update:** All work is complete with the exception of Royal Gwent Hospital, integrity testing revealed that the designated room was not fully suitable and work is being taken forward to correct, otherwise this would have been completed in July 2017, as previously reported. A meeting is taking place on the 11th January to arrange for these issues to be reviewed and a plan for a resolution to be put in place. Expected to be progressed and resolved in February 2019.	Good progress made. However, the one remaining element means the action cannot be fully completed at this stage.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
13. (IA)	Theatres *May 2017*	Management should undertake a complete review of the current arrangements in place with regards to loan equipment and ensure that there are effective controls in place to mitigate the risks associated with this area, such as: • establishing a documented procedure/process for loaning equipment from suppliers or loaning kit out to other Hospitals/Health Boards; • implementing a tracking mechanism to monitor the location and status of loan equipment; • consider a recharge mechanism for loan equipment in order to recoup costs and balance potentially excessive expenditure; and • ensure that there is effective budgetary control concerning loan equipment to ensure that value for money is achieved and costs to the HB are minimised where possible.	September 2017	Chief Operating Officer/ Director of Operations	**December 2018 Update:** Business case developed for a spend to save post (Loan Kit Co-ordinator B5). Role to work across the Health Board on all aspects of loan kit ordering, returning on a timely basis without additional late charges being attributed in some cases. Also, restocking of all consumable items and auditing and checking all invoice /payments using a single point of contact data base. This work is important with the introduction of Omnicell units. Further being undertaken on the impact of Omnicell.	The Executive Team noted that work had progressed, but had not yet completed the required recs. The Executive Team considered this a key priority to compete the actions and requested an update within a month.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
15. (IA)	Private Patients and Overseas Visitors *May 2017*	R1 - The policy should be updated regularly to ensure that it reflects the latest legislation and it should go through the required review and approval process before it can be issued. In addition, once it has been approved, it should be uploaded onto the intranet so that the latest version is made available to all relevant individuals at all times.	June 2017	Chief Operating Officer/ Director of Operations	**December 2018 Update:** The policy was approved by the Executive Team in November 2018 and published according to organisational process.	Completed November 2018 – The Executive team agreed that this is now removed from the tracker.
16. (IA)	Private Patients and Overseas Visitors *May 2017*	R2 - All the individuals should be trained to ensure the appropriate information is recorded. They should be provided with the procedures to be followed based on the latest legislation. These procedures should be uploaded to the intranet. The Health Board should review the resources allocated to overseas patients' administration to ensure that all the required information is captured and that they are billed appropriately.	June 2017	Chief Operating Officer/ Director of Operations	**December 2018 Update:** The Overseas Visitor Policy is now on the Intranet. The development and design of a package relied on the final policy. The Private Patient Manager is liaising with NHS Shared Services regarding a on-line training package for front-line staff regarding the Policy and their responsibilities. This is to be completed by the end of January 2019. Roll-out of the training to follow.	Policy now approved – progress made with the on-line training package. Further work required to roll-out training. Given the progress this could be seen as amber, but rec past its deadline date should be marked red. The Executive Team was confident that the training could be rolled-out within the timescale identified.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
20. (IA)	Clinical Audit – May 2017	R3 - An effective mechanism for the identification and follow-up of actions arising from a clinical audit undertaken locally and nationally, should be implemented as soon as possible, in order to provide assurance that effective action is being undertaken to mitigate clinical risk.	November 2017	Medical Director	**December 2018 Update:** The Internal Audit Service has undertaken a follow-up review of this original Clinical Audit Internal Audit. It has remained 'limited' assurance. An assessment and update report is to be submitted to Executive Team (January 7th 2019) to indicate progress made and determination of next steps.	This recommendation remains red until assurance can be given that the original 2016/2017 recommendations have been completed. The Executive Team considered in detail a report at its 7th January Meeting. An update report is being submitted to the Audit Committee on the 17th January 2019. Executive Team identified this area as a high priority and has required a further update
38 (IA)	Combined follow up of Informatics and Communications Technology Audits	R2 - in conjunction with NWIS and the national LIMS supplier, the UHB should develop and implement a plan to transition from the legacy Masterlab and Telepath pathology systems to National LIMS system located in the National Data Centres.	Revised Deadline – December 2018	Director of Planning, Digital and IT	ABUHB Cytology services went live on the national LIMS on 25th April 2016. Histology and Mortuary services went live with national LIMS in October 2017. Blood transfusion services in ABUHB were successfully consolidated onto MasterLab at the end of August 2018 to remove the risk of Telepath failure. Transfer of Blood transfusion services to LIMS has been delayed nationally with the first health board to go live	The Executive Team determined that the original recommendation had been responded to as much as possible in organisation. The Health Board has put in place mitigating actions through the commissioning of the Master Lab Services. Therefore it was agreed that this should be green and removed.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					planned for December 2018. ABUHB has requested to go live later in the implementation due to the assurance achieved with the move to MasterLab. A LINC Business Case will be submitted to the Board in January 2019 for the next stage national proposals.	
40 (WAO)	Medicines Management in Acute Hospital Settings *October 2015*	R1e - Ensure individual patient funding request panels have two lay members.	Revised Timeline - End Feb 2019	IPFR Manager	**December 2018 Update:** The existing lay member has stepped down from the panel. The IPFR team has advertised for a new lay member(s). Recruitment issues same across Wales.	The Executive Team agreed that as arrangements had been made for Lay members from other organisations to be used on panels to mitigate issue until recruitment was completed, that the recommendation has been responded to and was now green and should be removed.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
53 (WAO)	Outpatients Follow Up *July 2017*	Improve the range of performance information regularly reported to the Quality and Patient Safety Committee, ensuring that it covers a broader range of specialties and clearly reports clinical risks associated with delayed follow-up appointments.	December 2015	Medical Director and Chief Operating Officer	**December 2018 Update:** A new Quality and Performance Dashboard has been developed and reported to the Quality and Patient Safety Committee. This uses Qlik Sense. This covers a range of performance and clinical information. Delayed Follow Up improvement profiles agreed by Directorates and implementation tracked through monthly performance meeting. Improvements made against the >52 week position. Transformation work being delivered across Divisions now to better manage pathways. AB contribute to the national Planned Care Programme and have detailed action and delivery plans against the national priorities (ENT, T&O, Ophthalmology, Urology)– the progress is tracked through the UHB Planned Care Board.	The Executive Team agreed that with the introduction of the new dashboard facilitated by Qliksense. The rec can now be moved from red to green and be removed from the tracker.

Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
56 (WAO)	Outpatients Follow Up July 2017	Consider and identify the change management arrangements to accelerate the delivery of the long-term Outpatient Transformation Programme which should include consideration of: • clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; and • internal and external engagement with stakeholders.	March 2016	Medical Director and Chief Operating Officer	**December 2018 Update:** The Outpatient Collaborative work continues and is led via the Collaborative Faculty co-chaired by two consultants. A successful and well-attended Learning Session 5 took place in early-December 2018. The collaborative work is further complemented and enhanced by ongoing delivery of our Improvement Coach (IC) and Measurement Lead (ML) training packages. IC Cohort 5 and ML Cohort 4 both completed in late-2018 with outpatient services well represented on both courses. Further training cohorts and learning sessions are scheduled for early-2019.	The change management arrangements have been designed and are progressing. Therefore, the Executive Team agreed this recommendation is now green and can be removed from the tracker.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
76 (WAO)	Structured Assessment 2017	**R3 - Risk management** The HB should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	Ongoing End of May 2018	Board Secretary Board Secretary	**December 2018 Update:** The Health Board has fully reviewed its Corporate Risk Register in September 2018 and has updated its Risk Reporting arrangements. Technically, aligned to the recommendation, the required responses have been completed. However, the Health Board wide risk landscape diagnostic is also underway to further inform this improvement work and streamline and standard risk management activity. Therefore, it might be appropriate to leave this on the tracker until that fully report during March 2019.	In progress – further work undertaken on risk management. Organisational risk diagnostic underway. Original recs have been responded to, but for further assurance – the Executive Team agreed that this needs to be left on the tracker until diagnostic review is complete – completion date March 2019.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
77 (WAO)	Structured Assessment 2017	**R4 - Internal control** The Health Board should ensure that clinical audits provide assurance within an assurance framework, linked to the organisation's strategic objectives	End of May 2018	Medical Director	**December 2018 Update:** The Medical Director has presented updated work on the Management and Reporting of Clinical Audit. This report has been made to the Audit Committee and the Quality and Patient Safety Committee. The Deputy Director of Therapies and Health Science is leading work with Executive Team colleagues to create a Quality and Safety Assurance Framework in which clinical audit will play a key role, aiming to bring a proposal for consideration by the QPSC by January 2019.	The Executive Team discussed the further work being undertaken on the Quality and Patient Safety Assurance Framework. However, this remains red as original timescale has passed. Further consideration will be given at the next review – as Executive Team considers this a priority area for completion within this financial year.
79 (WAO)	Structured Assessment 2017	**R6 - Estate management** The Health Board should develop an Estates Strategy that reflects the current condition of its buildings and supports delivery of the Clinical Futures Strategy.	September 2018 Timetable revised to March 2019.	Chief Operating Officer	**December 2018 Update:** The draft Estate Strategy went to the Board Development day on 19th December and will be submitted to the Board for approval at the end of January 2019.	The Executive Team agreed that given the current status and planned approval at January Board, that this is green and removed.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
83 (IA)	Risk Management April 2018	We recommend that the risk management strategy includes an 'Action Plan and Priorities for the year' where the Executive Team and Board agree the developments required over risk management and resources and timescales are set and monitored to ensure their achievement.	June 2018 Original timescale revised to March 2019, in line with agreed Risk Manageme nt Review.	Board Secretary	**December 2018 Update:** A Health Board wide risk landscape diagnostic is underway to further inform this improvement work and streamline and standard risk management activity, which is due to report by March 2019. However, feedback is being used to inform improvement work as the review progresses. The Action Plan will be a key output of the review.	In progress – further work undertaken on risk management. Organisational risk diagnostic underway. Original recommendations have been responded to, but for further assurance – the Executive Team agreed that this needs to be left on the tracker until diagnostic review is complete – completion date March 2019.
84 (IA)	Estates Assurance (Fire Safety) Scott Taylor	**R2** Fire Manuals will be prepared for all sites. (D) **R3** Review dates for Fire Manuals will be appropriately monitored and updated on a timely basis. (O)	July 2018	Head of Health & Safety	**December 2018 Update:** A new template fire manual has been developed for Ysbyty'r Tri Chwm. This template was utilised for the review of fire manuals for all ABUHB premises. All hospital fire manuals have been reviewed and updated as appropriate. The fire management dashboard includes monitoring of fire manuals. This is regularly monitored by the Fire Safety Team and the ABUHB Fire Safety Committee.	The Executive Team agreed that this was completed in December 2018 and should be removed from the tracker.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
85 (IA)	Estates Assurance (Fire Safety) Scott Taylor	**R6** The review/updating of local fire policies/procedures, fire manuals and risk assessments will be **appropriately** monitored and managed. (O)	July 2018	Head of Health & Safety	**December 2018 Update:** All fire risk assessments for patient care areas, including sleeping risks (in-patient areas) have been reviewed and updated. A plan has been developed to review all the remaining overdue fire risk assessments for low risk areas. This will be completed by June 2019. Interviews for x3 Fire Safety Advisers are planned for 11th January 2019. On successful recruitment of these posts the Health Board will increase its resource in the Fire Safety Team which will support the delivery of the priority improvement plan. The fire management dashboard which monitors compliance with fire risk assessments, local policies and fire manuals is regularly monitored by the Fire Safety Team and the ABUHB Fire Safety Committee.	The Executive Team noted the good progress has been made. However, as the original timescale had now past, this remained red. It was recognised that this is a wide ranging and complex rec and a range of key elements have been achieved, but given the importance of this area of risk – the Executive Team agreed to review progress within a month.

Audit Committee
17 January 2019
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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
86 (IA)	IT Service Management	**R1** Formal SOPs should be developed for operating the service desks that cover the following key items: - objectives; - definition of types of calls and routing of these; - roles and responsibilities; - process for recording and monitoring calls received; - service level targets and metrics; - process for handling calls received; and - classification and prioritisation schema. Formal SOPs should be developed for change control. Formal SOPs should be developed for release and deployment management.	October 2018	Director of Planning, Digital and IT	There are significant issues in recruiting staff to vacant posts within ICT – the NHS Wales remuneration scales for ICT specialists are not attractive to the calibre of candidates required. ICT is still seeking a Service Management Specialist. An ICT service manager post was created and started on 1st September. The post holder is undertaking a gap analysis review and a programme of work to improve knowledge management, standard operating procedures and out of hours on call service support. A Service Management team has been setup within Informatics to progress the Service Management agenda. A Service Management training programme is underway and all Informatics support staff that deal with Incidents and Service Requests are receiving formal ITIL training relevant to their role. This will be completed by	The Executive Team noted the good progress that has been made. However, as the original timescale had now past, this remained red. It was recognised that this is a wide ranging and complex rec and a range of key elements have been achieved, but given the importance of this area of risk – the Executive Team agreed to review progress within a month.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					end March 2019 with all ICT and CAIST staff having a formal Service Management qualification related to their role. SOPs are being developed for Service Desk along with process flows.	
87 (IA)	IT Service Management	**R2** Informatics should seek to identify the Informatics service needs of the organisation. This should be done by identifying customers' desired outcomes and recognition of value and should include an assessment of customer need, impacts recovery objectives etc. Services should be designed/ restructured to appropriately match these needs and the services provided should be recorded in a service catalogue.	October 2018	Director of Planning, Digital and IT	The Informatics Division is considering its delivery framework as part of finalising the Health Board's Digital Strategy development. A formal review of its working model will be undertaken in October 2018 and published as a part of the Digital Strategy before the end of 2018. The Informatics Directorate, in line with the Directorate's IMTP, is developing a communication and engagement strategy which will allow Informatics to reach out to the organisation and better align services to organisational need. Service Management development is a significant contributing element to this broader piece of work. The digital transformation strategy is integrated with the	The Executive Team noted the good progress that has been made. However, as the original timescale had now past, this remained red. It was recognised that this is a wide ranging and complex recommendation and a range of key elements have been achieved, but given the importance of this area of risk – the Executive Team agreed to review progress within a month.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					Clinical Futures Programme. The development of the operational clinical models was due to complete December 2018. Once this has been completed then the current draft digital transformation strategy will be refined to align with the clinical models. This will then be go to Transformation to Digital (T2D) Delivery Board for sign off before presenting to Executive Board for final approval.	
88 (IA)	IT Service Management	**R3** Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	October 2018	Director of Planning, Digital and IT	There are significant issues in recruiting staff to vacant posts within ICT – the NHS Wales remuneration scales for ICT specialists are not attractive to the calibre of candidates required. ICT is still seeking a Service Management Specialist. The service has undertaken a review of its service management policy template and a new draft template has been devised and is being tested with a live system to support a systematic refresh of service management policies for all systems managed by Informatics Directorate.	The Executive Team noted the good progress that has been made. However, as the original timescale had now past, this remained red. It was recognised that this is a wide ranging and complex recommendation and a range of key elements have been achieved, but given the importance of this area of risk – the Executive Team agreed to review progress within a month.

Audit Committee
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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
89 (IA)	IT Service Management	**R4** A Change Advisory Board should be established for Informatics.	October 2018	Associate Director Informatics Heads of Informatics Services	The Directorate is reviewing the opportunity to repurpose its Digital Technology Group (DTG) to act as the overarching ABUHB Service Management Board. These discussions are ongoing and will require a revised Terms of Reference and approval through the Transformation to Digital (T2D) Delivery Board procedures. The Chair of DTG is will be writing to all SMB representatives in ABUHB to set up a workshop in order to determine the best way forward.	The Executive Team noted the position. However, as the original timescale had now past, this remains red and further assurance is required by the Executive Team within a month.
90 (IA)	Staff Performance Management and Appraisals	**R1** The PADR Process should be fully adhered to and PADRs fully completed with staff. Each division should ensure that all members of staff are provided with protected time or staff to complete the PADR process. As the PADR process should be ongoing, consider holding the formal PADR during a quieter period of the year, for	June 2018	Chief Operating Officer General Managers	**December 2018 Position:** Divisional Plans continue to be reviewed to understand the benefits of aligning PADR dates with incremental dates and to consider if this will impact on timely completion. Current Divisional PADR plans and trajectories have been reviewed and revised to identify the opportunity to undertake additional PADRs during the summer period. We have also piloted group PADRs in Scheduled Care and are sharing	The Executive Team agreed that positive progress had been made against the content of the recommendation and that this has been completed. Agreed to move to green and remove from the tracker.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
		example during the summer months. The divisions should utilise the corporate resources available to them, provided by Workforce & OD. In particular, the tools included on the PADR section of the intranet.			good practice from Facilities who are over 80% compliant. A specific module on PADR has been included in the new Middle Managers Programme currently being finalised.	
91 (IA)	Staff Performance Management and Appraisals	**R2** For each staff member a key part of the process is to assess performance and set achievable objectives, linked to job descriptions. It should be clear for a staff member as to what constitutes failure and success for each of their objectives. For example, a clinical member of staff may be undertaking additional duties and knowledge for a medical device is required or a budget holder may be required to reduce spend by 1% in their area or implement a Health Board wide savings plan. Such expectations/deliverables	June 2018	Chief Operating Officer General Managers Director of Workforce & OD	**December 2018 Position:** Divisions implement this recommendation by continuing to disseminate local objectives clearly and regularly. Workforce & OD continue to work with Divisional PADR Champions to drive up quality and PADR completions, with a particular focus on SMART objectives. The PADR documentation is being reviewed to enhance the objective page including additional information on SMART objective setting and enable the clear recording of the objectives in a SMART format.	The Executive Team agreed that positive progress had been made against the content of the recommendation and that this has been completed. Agreed to move to green and remove from the tracker.

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
		should be clearly detailed within the PADR. When managers meet with staff throughout the year to discuss performance, this should be documented, particularly in the case where improvement is required. Managers should ensure that they understand the Health Board's objectives and relevant risks and incorporate these into a PADR. For example, there may be emerging infection prevention issues, which may be measured within clinical areas. The divisions should utilise the corporate knowledge and tools available, to ensure a complete PADR is undertaken. W&OD should continue to reach out to poor performing divisions and educate managers on the routes available for improvement.			We have also piloted group PADRs in Scheduled Care and are sharing good practice from Facilities who are over 80% compliant.	

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Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
92 (IA)	Medical Locum and Agency Payment Caps	The Health Board should examine some of the underlying reasons as to why the process is not followed and if required, make the necessary amendments. In the absence of sufficient rationale, each division should ensure that the agreed approval process that has been put in place by the Executive is adhered to. As part of future reviews of the process, the Health Board should consider how technology can streamline the process, by providing an effective solution for authorising shifts swiftly.		Assistant Medical Director/ Head of Specialist Medical & Dental Workforce & Job Evaluation – Immediate and Ongoing September 2018 for option appraisal	**December 2018 Position:** The Deputy Medical Director continues to reinforce that the process should be followed with the General Manager. The Health Board is currently implementing Patchwork (previously Locum tap) as a pilot within Unscheduled Care. The IA team is just about to re-audit and will test this progress.	The Executive Team agreed that positive progress had been made against the content of the recommendation and that this has been completed. Agreed to move to green and remove from the tracker.

Audit Committee
17 January 2019
Agenda Item: 7.4

Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
93 (IA)	Management of Balance Sheet Assets	We recommend that the Health Board introduces tagging/identity marking of all relevant assets in order to facilitate the identification and physical verification of assets against the asset register.	March 2019	Kelly Jones, Head of Capital Finance	For clarification, whilst capital assets are not tagged with the individual Fixed Asset Register number, a significant proportion of assets are tagged by other departments such as Medical Electronics and IT. Current processes involve the asset register being updated with serial numbers and the appropriate Medical Electronics reference, however, this information is not available for all historic assets. To improve the security of assets, and identification as part of the annual verification process, the Capital Team will, in consultation: • Develop a policy for asset tagging which defines where tagging is appropriate; • Investigate options for the purchase of an asset tagging system, considering existing systems in use in ABUHB and potential for linking to the Medical Electronics database and research the systems employed at other health boards and trusts;	Deadline not yet reached.

Audit Committee - 17th January 2019-17/01/19

Audit Committee
17 January 2019
Agenda Item: 7.4

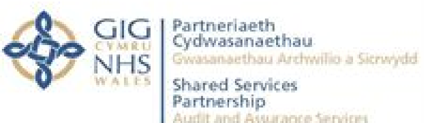
Audit Recommendations – December 2018/January 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
					• Develop a business case and plan for the implementation of a preferred option in 2019/20 including outline specification, cost/benefits analysis, procurement options, funding requirements and resource implications.	

Aneurin Bevan University Health Board

Draft Audit Committee Work Plan 2019

	Frequency	17th January	3rd April	9th May	28th May	18th July	10th October
		Business	Business	Draft Annual Accounts	Final Accounts	Business	Business
Audit Committee Members Private Meeting with Auditors and Counter Fraud							
Internal Audit			√				
External Audit						√	
Counter Fraud		√					√
Governance & Assurance							
Review of Standing Orders, SFI's, and Scheme of Delegation	Annually	√					
Development of Financial Procedures	Each Business Meeting	√	√			√	√
Finance and Governance Updates	Each Business Meeting	√	√			√	√
Divisional Assurance	Each Business Meeting	√	√			√	√
Corporate Assurance (Risk Report at every meeting)	Each Business Meeting	√	√			√	√
Update on PPV	Annually					√	
Financial Management & Control Systems							
Single Tender & Single Quotations	Each Business Meeting	√	√			√	√
Losses & Special Payments	Each Business Meeting	√	√			√	√
Invoices > £100,000	Each Business Meeting	√	√			√	√
Interim Review of Governance Statement	Annually		√				
Tracking of Audit Recommendation Actions	Each Business Meeting	√	√			√	√
Annual Accounts							
Lessons learnt form accounts process	Annually						√
Annual Accounts Plan	Each Business Meeting	√	√			√	√
Accounting Policies Review	Annually			√			
Draft Accounts Review	Annually			√			
Approval of Annual Accounts	Annually				√		
Approval of Governance Statement	Annually			√			
Clinical Audit							
6 monthly update on Clinical Audit	Every 6 months	√				√	
External Audit							
Annual Audit Fee	Annually		√				
Approval of Annual Audit Plan	Annually	√					
Progress Reports	Each Business Meeting	√	√		√	√	√
ISA 260	Annually				√		
Final Accounts Memorandum	Annually				√		
Annual Audit Report	Annually						
NWSSP Audit & Assurance - Internal Audit							
Approval of Annual Plan	Annually					√	
Progress Reports	Each Business Meeting	√	√			√	√
Receipt of Individual Reports	Each Business Meeting	√	√			√	√
Receipt of Annual Report	Annually			√			
Interim Head of Internal Audit Opinion	End of Quarter 3	√					
Head of Internal Audit Opinion	Annually			√			
NWSSP Audit & Assurance - Specialised Unit							
Approval of Annual Plan	Annually		√				
Progress Reports	Each Business Meeting	√	√			√	√
Receipt of Individual Reports	Each Business Meeting	√	√			√	√
Receipt of Annual Report	Annually			√			
Counter Fraud & Post Payment Verification							
Approval of Counter Fraud Annual Plan	Annually		√				
Counter Fraud Progress Report	Quarterly	√					√
Counter Fraud Annual Report	Annually		√				
Annual PPV Report	Annually		√				
Planning & Review							
Agreement of Committee Annual Work plan	Annually		√				
Review of Committee Effectiveness	Annually		√				
Production Of Audit Committee Annual report	Annually		√				
Review Of Audit Committee Terms of Reference	Annually		√				



Divisional Review - Facilities

Final Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Opinion and key findings

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

8.2

Review reference:	AB-1819-25
Report status:	Final
Fieldwork commencement:	29th November 2018
Fieldwork completion:	12th December 2018
Draft report issued:	19th December 2018
Draft report clearance meeting:	18th & 20th December 2018
Management response received:	7 January 2019
Final report issued:	8 January 2019
Auditor/s:	James Quance – Head of Internal Audit Stephen Chaney – Deputy Head of Internal Audit Clare Shaw – Principal Auditor
Executive sign off	Claire Birchall – Interim Executive Director of Operations
Distribution	Gareth Hughes, Divisional Director – Facilities Wayne Hicks, Statutory Compliance Manager Michelle Key, Service Improvement Manager

Committee	Audit Committee Quality and Patient Safety 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.

8.2

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan 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 2018/19 Internal Audit Plan included the audit Divisional Review - Facilities. The review sought to provide assurance that the Facilities Division within Aneurin Bevan University Health Board (the 'Health Board') is compliant with corporate policies.

The Facilities Division is responsible for maintaining and developing its sites and buildings, managing its property portfolio and providing a wide range of facilities management services across the entire geographical coverage of the Health Board. The work of facilities includes catering, sterile supplies, fleet services, laundry, porters and the receipt and distribution of stores. The division employs 1,130 staff and has a budget of c.£59m.

2. Scope and Objectives

The internal audit sought to assess whether the Health Board has effective controls in place to ensure that a sample of workforce policies are being adhered to and health and safety risks are managed, in particular the audit assessed the following objectives:

Personnel Management

- to ensure that staff sickness is reported, recorded, approved and monitored in accordance with the All Wales Sickness Policy;
- to ensure that annual leave is requested, recorded, approved and monitored in accordance with the Annual Leave Policy;
- to ensure that personal appraisal and development reviews (PADRs) are completed, recorded and monitored in accordance with the Policy for Personal Appraisal and Development Review Process;
- to determine if statutory and mandatory training requirements are monitored and where low compliance is identified, action is taken accordingly;

Health and Safety

- to ensure that statutory compliance programme is monitored and in particular, to determine if statutory inspections are taking place;
- to ensure that site / system specific risk assessments are being completed on a timely basis; and
- to review whether recommendations raised by the Health and Safety Executive (HSE), following a power outage at the Royal Gwent Hospital, have been incorporated into a work programme.

The Facilities Division is currently undertaking a review and implementing new processes within the General Offices throughout the Health Board. Whilst this was originally included within the outline scope of the audit, the General Offices will now be audited within a future programme of audit work, to allow the completion of the current exercise underway.

3. Associated Risks

The risks considered in the review were as follows:

- non-compliance with corporate policies;
- poor compliance with statutory and mandatory training requirements; and
- failure to comply with legislation.

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 Divisional Review – Facilities is **Reasonable** Assurance.

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

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

The overall performance of departments examined demonstrated good compliance across each of the objectives. Whilst some exceptions exist, as detailed within Appendix A, there has been a reinforced drive within these areas with the introduction of the Divisional Business Unit (DBU) who monitor and manage some of the workforce areas. The improvements of this can be seen through the sickness absence levels of 5.1% in August 2018, decreasing from 6.98% in August 2017.

There has been significant progress in the completion of PADRs compared to the 2017/18 Staff Performance and Management Appraisals audit when 72.65% of PADRs had been completed, this has increased to 88.94%, exceeding the 85% target set by the Health Board. In addition, the process under review and the dates that PADRs are completed are being aligned to incremental dates to ensure that staff have every opportunity to receive the related pay increase. Furthermore, objectives are being reviewed and additional suggested objectives are being prepared for lower grade staff to ensure that they understand how the work they carry out aligns with business objectives and requirements.

The embedded DBU within Facilities is focussing on service improvement and in particular workforce matters, through a centralised approach. This enables a consistent application of each key workforce policy and advice and assistance to line managers, where required. Ultimately, the proactive approach of the DBU is increasing the benefits throughout the Division, with improved sickness absence rates and PADR compliance over a 12 month period.

In recent months, the Facilities Division has targeted key statutory and mandatory modules (e.g. manual handling), which are important for the range of duties that the staff are responsible for undertaking. The prioritisation of modules has led to significantly improved compliance rates with these. The next step is to focus on the remaining statutory and mandatory modules to improve the overall compliance rate for the Division.

Additionally, Facilities operate an embedded Health and Safety Team, which works in conjunction with the Corporate Health and Safety Team, but primarily specialises in specific risks, due to the complex nature of each of them. Examples include, legionella, asbestos and noise at work.

Whilst the audit, Health and Safety was completed last year, the objectives focussed on the requirements of the Occupational Health and Safety Policy within the Health Board and in particular those managed by the Corporate Health and Safety Team. This audit considered the specialised risks referred to above, which are managed within the Facilities Division and a sample listed on the Divisional Risk Register and thus, outside of the remit of the Corporate Health and Safety Team.

5. Assurance Summary

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

Assurance Summary					
1	Personnel management – staff sickness absence			✓	
2	Personnel management – annual leave			✓	
3	Personnel management - personal appraisal and development reviews (PADRs)			✓	
4	Personnel management - statutory and mandatory training				✓
5	Health and Safety - statutory compliance programme				✓
6	Health and Safety - site / system specific risk assessments				✓
7	Health and Safety - recommendations raised by the Health and Safety Executive (HSE)				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as a weakness in the system control/design for the Divisional Review - Facilities.

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 for the Divisional Review – Facilities.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

The audit found two **Medium priority** issues which we consider requires management's attention and provides scope for improvements to be made. These concerned:

1) Personal Appraisal Development Review (PADR)

Testing of 24 PADRs identified the following exceptions:

- the use of an old form had been used in one incidence;
- five of the sample where the date that the last PADR was carried out was not completed;
- 14 forms where the incremental date had not been completed;
- six forms had not documented whether the prior year objectives had been met;
- 13 forms did not have a date of the meeting, which should be scheduled three months prior to an incremental date;
- seven forms where the date the manager communicated the outcome of the PADR had not been completed; and
- one PADR was recorded as completed, but there was no copy of the PADR to view.

We were informed that some suggested objectives for lower grade staff are being developed by the DBU. This is to ensure that staff are being evaluated on the work that they do as well as training and future aspirations.

We were informed that some staff do not see the PADR process as a review of their work and as such, band 2 and 3 staff may not understand how their job links to the higher objectives of the organisation. It is hoped that these suggested objectives will help clarify the process and provide links to the objectives of the organisation.

Furthermore, we understand that there is ongoing work to improve the overall quality of the PADR process within the Facilities Division, through the assistance of the DBU.

2) Sickness Absence Management

It was found that for all absences where a return to work form had been completed, the section to review frequent sickness absence had been completed. However, there were examples, where staff remained at the informal discussion stage on more than one occasion and were not escalated to the next stage of first formal, following the next applicable episode of sickness absence. The policy states that it should be exceptional circumstances for escalation to not take place.

In addition, we raised one low recommendation, which was an example of minor non-compliance where annual leave is being booked and authorised via paper slips, rather than logged (and authorised) directly into ESR.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**1**	**3**

Finding 1 Personal Appraisal Development Review (PADR)	Risk
PADRs should be completed in line with the PADR Process. Whilst it can be seen that significant improvements have been made in the completion of PADRs (2017/18 completion 72.65%, November 2018 88.94%) the quality of the returns could be improved. Testing of 24 PADRs identified the following exceptions: • the use of an old form had been used in one incidence; • five of the sample where the date that the last PADR was carried out was not completed; • 14 forms where the incremental date had not been completed; • six forms had not documented whether the prior year objectives had been met; • 13 forms did not have a date of the meeting, which should be scheduled three months prior to an incremental date; • seven forms where the date the manager communicated the outcome of the PADR had not been completed; and • one PADR was recorded as completed, but there was no copy of the PADR to view.	An ineffective Personal Appraisal Development Review (PADR) could result in staff feeling de-motivated, not supported and devalued. This will have a direct impact on organisational performance, quality and patient care.

We were informed that some suggested objectives for band 2 and 3 staff are being developed by the DBU. This is to ensure that staff are being evaluated on the work that they do as well as training and future aspirations. We were informed that staff do not see the PADR process as a review of their work and as such, lower grade staff do not understand how their job links to the higher objectives of the organisation. It is hoped that these suggested objectives will help clarify the process and provide links to the objectives of the organisation. Furthermore, we understand that there is ongoing work to improve the overall quality of the PADR process within the Facilities Division, through the assistance of the DBU.	
Recommendation 1	**Priority level**
Management should issue an instruction to departments to ensure that PADRs are fully completed and that relevant personal objectives are set. Once the instruction has been communicated, managers should actively monitor the quality and take action where exceptions are identified. Where further training / support is required this should be provided.	**Medium**

Management Response 1	Responsible Officer/ Deadline
We accept this recommendation and the instruction will be communicated all managers by 12th January, the process to get further training and support will be detailed in the communication.	12th January 2019 by Michelle Key Workforce Service Improvement Manager.

Action Plan

Finding 2 Sickness Absence Management	Risk
A sample of 38 sickness absences were tested across Facilities and minor issues with compliance with the 'All Wales – Sickness Absence Policy' were identified, which are detailed below: **Self Certification** • two incidences of a self certification form not being completed (one of which was followed by a period covered by a sick note, which had been correctly completed and recorded, therefore it was not signed and not possible to determine the reason for the original absence); • eight incidences where no details had been kept on the personnel file to confirm that the individual had notified their line manager of their sickness absence; • two of the sample had not been recorded on Health Roster; • two incidences where the return to work interview was not carried out promptly; • one of the sample had not been recorded on ESR; and • 12 of the sample had dates that were not exactly the same on Health Roster and ESR. This is mainly caused by actual sick days recorded onto	Non-compliance with the 'All Wales - Sickness Absence Policy'. Adverse impact upon resources within the ward / service area. Negative impact upon service delivery, employee / patient care. A pro-active, consistent and fair approach is not maintained with regards to sickness absence management.

ESR, whereas on Health Roster, the dates tend to be the first day of absence to the date they return, even if this includes non working days - thus increasing the number of sick days. **Fit Notes** • there was one incidence where no records of this period of absence were available on file or held centrally by DBU; and • there was one of the sample where the fit note did not cover all of the absence period (three days not covered). **Frequent Absence** Two examples were identified of staff that would normally be progressed to a first formal warning, for frequent sickness absence, but they remained on an informal warning. The details are as follows: • following a sickness absence one employee was advised that they would progress through the stages if there were any further periods of absence. There were two further periods of absence and the escalation through the informal / formal warning process did not occur until the second period of sickness. • following a second period of sickness absence, an initial discussion was held with the employee and they were notified that any further periods	Increased financial and reputational damage due to negative publicity and tribunal cases

of absence would trigger a formal discussion. However, there has been a further three sickness absences and no further action has been taken.	
Recommendation 2	**Priority level**
Management should issue an instruction to departments reminding them of their responsibilities for complying with the 'All Wales - Sickness Absence Policy'. This instruction should make reference to the Sickness Management Toolkit which is available on the Health Board's intranet site. This includes a number of templates / pro forma documents that will ensure compliance with the policy, where they are utilised to manage employee sickness absence. Once the instruction has been communicated, managers should actively monitor the content of return to work discussions / other key stages of the process and take action where exceptions are identified.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
We accept the above recommendations and the need to ensure the correct process with Health Boards's policies, and toolkits are utilised will be re-iterated to all staff that manage the sickness process. This process will be actively monitored by regular audits.	12th January 2019 by Michelle Key Workforce Service Improvement Manager

Tab 8.2.1 Divisional Review - Facilities
Audit Committee - 17th January 2019-17/01/19

Finding 3 Annual Leave	Risk
Annual leave is being requested using paper slips at the Royal Gwent, Nevill Hall and Ystrad Mynach (YYF), these are approved by a local manager and then input onto ESR. Following the introduction of the ESR app, it would be more efficient for staff to input annual leave onto this and for the approval to take place electronically by the managers. This would result in less potential errors, staff being aware of how much leave they have remaining, more accurate monitoring of annual leave and greater efficiency.	Ineffective management of annual leave by the employee and line manager.
Recommendation 3	**Priority level**
Management must ensure that the annual leave has been inputted onto ESR at the point of approval.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
We accept the recommendations. As a division we are working towards fully utilising the E-Systems the Health Board has adopted as part of an ongoing programme. This a 3 year rolling programme due to the challenges of the workforce demographic.	2022 by Michelle Key Workforce Service Improvement Manager

Audit Assurance Ratings

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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.

8.2

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Budgetary Control including cost improvement

Internal Audit Report

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

8.2

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Appendix B Assurance opinion and action plan risk rating
Appendix C Responsibility Statement

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Review reference:	ABUHB-1819-10
Report status:	Final
Fieldwork commencement:	24th October 2018
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Executive sign off	Glyn Jones, Director of Finance
Distribution	Rob Holcombe, Assistant Director of Finance Sian Jenkins, Assistant Director of Finance Claire Birchall, Interim Executive Director of Operations
Committee	Audit Committee Finance & Performance Committee

ACKNOWLEDGEMENT

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

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Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan 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 Budgetary Control, including cost improvement was completed in line with the 2018/19 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedures are compliant with Health Board corporate policies.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation. Any weaknesses are brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The objectives of the review were to assess:

Policies and Procedures

- that policies and procedures are available to staff, are up-to-date and reflect current working practices; and
- relevant sections of the Budgetary Control Policy are adhered to, including, but not limited to:
    - delegation and accountability;
    - virements; and
    - budget holder authority.

Divisional IMTPs and Budget Setting

- the budget set for each division is clearly aligned with the respective integrated medium term plan and relevant service change plans;
- consistency of budgets with the Health Board's IMTP; and
- how major service change decisions are encapsulated within future budgets and profiled appropriately.

Savings Plans

- whether appropriate savings programmes to minimise expenditure are developed throughout all divisions / directorates; and
- the implementation of each savings plan and the level of cost improvement achieved.

Management of Budgets

- sufficient, relevant, reliable information is available to budget holders, including non-financial information and forecasts of the year end position; and

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- issues are identified and raised with budget holders through structured meetings and addressed or escalated appropriately.

The current year audit did not individually follow up prior year recommendations because the areas in which they were raised were re-examined in this audit.

3. Associated Risks

The risks considered in the review are as follows:

- non-compliance with the Budgetary Control Policy and other associated procedures / policies;
- budgetary issues are not analysed, investigated, explained and acted upon due to insufficient line management and accountability of budget holders; and
- savings plans are not in accordance with the IMTP and / or sustainable.

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 Budgetary Control including cost improvement is **Reasonable** Assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
Policies and Procedures					
1	Available to staff and up-to-date			✓	
2	Relevant sections are adhered to			✓	
Divisional IMTPs and Budget Setting					
3	the budget set for each division is clearly aligned with the respective integrated medium term plan and relevant service change plans			✓	
4	consistency between budgets and IMTP and major service change decisions are encapsulated within future budgets and profiled appropriately			✓	
Savings plans					
5	appropriate savings programmes to minimise expenditure are developed throughout all divisions / directorates			✓	
6	the implementation of each savings plan and the level of cost improvement achieved.			✓	

Assurance Summary					
Management of Budgets					
7	sufficient, relevant, reliable information is available to budget holders, including non-financial information and forecasts of the year end position			✓	
8	issues are identified and raised with budget holders through structured meetings and addressed or escalated appropriately		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for Budgetary Control including cost improvement.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Budgetary Control including cost improvement.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan in Appendix A.

We identified one **High priority** issue that we consider requires prompt management action. This concerned:

- ensuring regular budget meetings at which financial performance is challenged take place throughout the Scheduled Care Division and that these are fully documented.

We identified one **Medium priority** issue that we consider requires management's attention and provides scope for improvements to be made. This concerned:

- ensuring that budget holders sign their budget delegation letters on a timely basis.

We identified one **Low priority** issue for management consideration. This concerned:

- implementing some simple improvements to the virement journal register.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Action Plan

Finding 1 Budget holder financial reviews (Operation)	Risk
We sampled the Scheduled Care and Primary Care & Community Divisions and directorates within them, then sought and examined evidence of budget performance review. **Divisional level financial performance review** We noted for both divisions selected that Finance Business Partners report monthly finance performance to their divisional management teams and we saw examples of finance assurance reports and meeting minutes confirming these reviews had been taking place in 2018/19. **Directorate level financial performance review** *Primary Care & Community Division* Finance Business Partner teams support directorate budget holders in the management of their budgets through regular finance performance meetings with directorate budget holders. Records of the sample directorates of the Primary Care & Community Division meetings evidenced the following finance performance review activity: • The Health Board's six Community Hospitals met between three and five times in the six months to August 2018, although there was one outlier hospital where only one meeting was held in that period. Sample meetings for each evidenced meeting minutes and actions are recorded.	Overspends may not be identified nor solutions designed to address them.

Tab 8.2.2 Budgetary Control
Audit Committee - 17th January 2019-17/01/19

• Neighbourhood Care Networks (NCN) meetings of all clinical leads with divisional management and finance took place and were evidenced each month from March to September of 2018, although we did note that finance updates did not feature in the minutes of the meetings of June and July. *Scheduled Care Division* Finance Business Partner teams support directorate budget holders in the management of their budgets through their involvement in directorate budget holder and divisional line manager meetings in a 'challenge and support' role. Records of the sample directorates of the Scheduled Care Division meetings indicated the following finance performance review activity: • Core service review meetings incorporating selected sample directorates of General Surgery, Theatres and Pathology involving directorate, division and finance staff at which budget performance is reviewed had not run to the planned monthly frequency in the period being audited. We could not determine how many had been missed as we were unable to obtain full records of any of the meetings that had taken place. It is noteworthy that all three directorates were forecast to overspend for the year at the time of audit. • Financial summaries prepared by directorate managers for these service review meetings that we have seen (General Surgery and Theatres) were in most cases brief and provided minimal explanation of the causes of the variances to forecast that they reported or what measures would be taken to address these.	

• There was no evidence of formal review by the Division's Finance Business Partner team of the financial summary reports of the directorates of General Surgery, Theatres and Pathology.	
Recommendation 1	**Priority level**
We recommend that directorate budget monitoring meetings take place monthly, that minutes and actions of these are recorded in all cases and that in the Scheduled Care Division, the Finance Business Partner team introduce a process of critical review of the financial summary reports that the directorates submit.	**High**
Management Response 1	**Responsible Officer/ Deadline**
Agreed	Business Partner Accountant – Scheduled Care Division/ Immediate.

Finding 2 Budget delegation letters (Operation)	Risk
Our prior year report identified that budget holders did not always sign their budget delegation letters on a timely basis (20 of the 30 tested) or had not signed them at all (10 of the 30 tested). Examining this area again in the two sample divisions of Scheduled Care and Primary Care & Community, the current year audit found the following: • 1 of the 15 letters issued by the Scheduled Care division had not been returned by the budget holder at the time of the audit (return date requested 4th June 2018); • for the same division, as return dates were unavailable, it wasn't possible to determine whether 2018/19 budget letters had been signed and returned by the date requested; and • due to the division undergoing a significant re-structure and because priority had been given to agree & action some budget virements internally before completing letters, we were advised that for the Primary Care & Community division there had only been a few budget letters issued to key budget holders. We were not able to ascertain dates of issue or budget holder return in any of these cases.	Budgets may not be realistic or achievable. Budget holders may not take appropriate responsibility for budgetary performance.

Action Plan

Recommendation 2	Priority level
Budget holder letters should be issued as a priority to budget holders as soon as new year budgets have been determined, ideally on a date before commencement of the new year but in any event, to be no later than the end of quarter 1. Divisions should remind budget holders of their requirement to confirm acceptance of the delegated budgets and to return signed copies of the letters by the dates stipulated.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Agreed	Primary and delegated budget holders/in line with timetable in budgetary control policy.

Finding 3 Virements register (Design)	Risk
The Central Management Accounts ('CMA') team has taken over responsibility in 2018/19 for processing budget virements. This encompasses keeping a central register of all virements and ensuring that appropriate authorisation is obtained, including using virement forms where funds transfer into or out of a budget holder's control. We tested a sample of ten virement journals from the register and found the following: • the virement journal register does not record any ledger codes or posting values, or consistently any narrative description; • one of the three transactions of the ten sampled recorded in the register as needing a virement form was not supported by that document; • for two journals in the sample it was recorded in the register that there was no requirement for any evidence to be provided (and did not provide any) but the reason given was brief and we were unable to confirm its validity; and • virement register links to supporting e-mails do not direct to a specific document but rather to a page on which a document library is located where there's a lack of cross referencing (e.g. virement journal reference) between the register entries and supporting e-mails.	Budget virements may be processed without the appropriate authorisation and audit trail.

Action Plan

Recommendation 3	Priority level
We recommend that the CMA team consider the issues identified and enhance the register design and monitoring to address them.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
Agreed	Head of Central Management Accounts (CMA) Team/end February 2019

Audit Assurance Ratings

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Budgetary Control including cost improvement

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