

## **Agenda – Public Accounts Committee**

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Meeting Venue:	For further information contact:
Committee Room 3 – Senedd	Fay Bowen
Meeting date: 1 October 2018	Committee Clerk
Meeting time: 13.00	0300 200 6565
	<a href="mailto:SeneddPAC@assembly.wales">SeneddPAC@assembly.wales</a>

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**(The Committee agreed on 24 September 2018, a motion under Standing Order 17.42 to resolve to exclude the public from Items 1 & 2 of this meeting)**

- 1 Care experienced children and young people: Consideration of draft report**  
(13.00 – 13.45) (Pages 1 – 61)  
PAC(5)–25–18 Paper 1 – Draft Report
- 2 Implementation of the NHS Finance (Wales) Act 2014: Consideration of draft letter**  
(13.45 – 14.00) (Pages 62 – 69)  
PAC(5)–25–18 Paper 2 – Draft Letter  
PAC(5)–25–18 Paper 2a – Welsh Government Written Statement: NHS Wales Escalation and Intervention Arrangements (21 August 2018)
- 3 Introductions, apologies, substitutions and declarations of interest**  
(14.00)
- 4 Paper(s) to note**  
(14.00 – 14.50) (Pages 70 – 71)
  - 4.1 Implementation of the NHS Finance (Wales) Act 2014: Correspondence from Abertawe Bro Morgannwg University Health Board**  
(Pages 72 – 105)



- 4.2 NHS Wales Informatics Services: Correspondence from Cardiff & Vale University Health Board and Cwm Taf University Health Board**  
(Pages 106 – 108)
- 4.3 NHS Wales Informatics Services: Additional information from the Welsh Government (29 August 2018)**  
(Pages 109 – 116)
- 4.4 NHS Wales Informatics Services: Additional information from Andrew Griffiths, NWIS (29 August 2018)**  
(Pages 117 – 126)
- 4.5 The Welsh Government's initial funding of the Circuit of Wales Project: Letter from the Welsh Government (15 August 2018)**  
(Pages 127 – 131)
- 4.6 Medicines Management: Letter from the Welsh Government (15 August 2018)**  
(Pages 132 – 135)
- 4.7 Intra-Wales – Cardiff to Anglesey – Air Service: Letter from the Welsh Government (20 August 2018)**  
(Pages 136 – 137)
- 4.8 The 21st Century Schools and Education Programme: Letter from the Welsh Government (21 August 2018)**  
(Pages 138 – 146)
- 4.9 The Welsh Government's Supporting People Programme: Letter from the Welsh Government (24 August 2018)**  
(Pages 147 – 151)
- 4.10 Audit of Cardiff and Vale University Health Board's Contractual Relationships with RKC Associates Ltd and its Owner: Letter from Cardiff and Vale University Health Board (3 September 2018)**  
(Pages 152 – 175)

## **Break**

(14.50 – 15.00)

- 5 Natural Resources Wales: Scrutiny of Annual Report and Accounts 2017–18**  
(15.00 – 15.45) (Pages 176 – 179)  
Research Briefing  
  
David Sulman – UK Forest Products Association
- 6 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:**  
(15.45)  
Items 7, 8 & 9
- 7 Natural Resources Wales: Scrutiny of Annual Report and Accounts 2017–18: Consideration of evidence received**  
(15.45 – 16.00)
- 8 Primary care out-of-hours service: Auditor General for Wales Report**  
(16.00 – 16.15) (Pages 180 – 238)  
Research Briefing  
PAC(5)–25–18 Paper 3 – Auditor General for Wales’ Report  
PAC(5)–25–18 Paper 4 – Welsh Government response to the Auditor General for Wales’ Report (1 August 2018)  
PAC(5)–25–18 Paper 5 – Welsh Government response to the Auditor General for Wales’ Report (14 August 2018)
- 9 Managing the impact of Brexit on EU Structural funds: Auditor General for Wales Report**  
(16.15 – 16.30) (Pages 239 – 285)  
Research Briefing  
PAC(5)–25–18 Paper 6 – Auditor General for Wales’ Report

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# Agenda Item 2

By virtue of paragraph(s) vi of Standing Order 17.42

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**WRITTEN STATEMENT  
BY  
THE WELSH GOVERNMENT**

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**TITLE**        **NHS Wales Escalation and Intervention Arrangements**

**DATE**        **21 August 2018**

**BY**            **Vaughan Gething, Cabinet Secretary for Health, Well-being and Sport**

In March 2014, the joint Escalation and Intervention Arrangements were launched. Under these arrangements, the Welsh Government meets the Wales Audit Office and Healthcare Inspectorate Wales twice a year to discuss the overall position of each health board and NHS trust. A wide range of information and intelligence is considered to help identify any issues to help them be resolved effectively.

This statement informs Assembly Members about the outcome of the latest meeting that was held on 18 July 2018.

The framework has four escalation levels:

- Routine arrangements;
- Enhanced monitoring;
- Targeted intervention;
- Special measures.

As a result of the discussions, the Welsh Government, Wales Audit Office and HIW agreed all organisations will remain at their current escalation level as set out in the table at annex 1.

I have already provided members with an update on Betsi Cadwaladr University Health Board.

With regard to the three organisations in targeted intervention, over the last 12 months, progress has been seen, with both Cardiff and Vale and Hywel Dda University Health Boards achieving performance milestones. In Hywel Dda, the outstanding issue remains finance, though the recent baseline review will help the organisation.

In Abertawe Bro Morgannwg University Health Board, a new Chief Executive has been appointed and there have been changes to the Executive Team. There has been a gradual improvement in performance and I expect this to be sustained. I recognise there is still

further work to do across all three organisations and my officials continue to work closely with them.

I continue to have expectations for improvement from each of the escalated organisations and their progress will continue to be monitored through formal accountability arrangements and discussions with officials.

#### Annex 1

<b>Organisation</b>	<b>Previous Status</b>	<b>Current Status</b>
Abertawe Bro Morgannwg UHB	Targeted intervention	Targeted intervention
Aneurin Bevan UHB	Routine arrangements	Routine arrangements
Betsi Cadwaladr UHB	Special measures	Special measures
Cardiff and Vale UHB	Targeted intervention	Targeted intervention
Cwm Taf UHB	Routine arrangements	Routine arrangements
Hywel Dda UHB	Targeted intervention	Targeted intervention
Powys tHB	Routine arrangements	Routine arrangements
Public Health Wales NHS Trust	Routine arrangements	Routine arrangements
Velindre NHS Trust	Routine arrangements	Routine arrangements
Welsh Ambulance Services NHS Trust	Routine arrangements	Routine arrangements

This statement is being issued during recess in order to keep members informed. Should members wish me to make a further statement or to answer questions on this when the Assembly returns I would be happy to do so

# Agenda Item 4

## Concise Minutes – Public Accounts Committee

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Meeting Venue:

Committee Room 3 – Senedd

Meeting date: Monday, 24 September  
2018

Meeting time: 14.51 – 17.02

This meeting can be viewed  
on [Senedd TV](#) at:

<http://senedd.tv/en/5032/>

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### Attendance

Category	Names
Assembly Members:	Nick Ramsay AM (Chair) Mohammad Asghar (Oscar) AM Neil Hamilton AM Vikki Howells AM Adam Price AM Lee Waters AM Mike Hedges AM
Witnesses:	Clare Pillman, Natural Resources Wales Peter Garson, Natural Resources Wales Kevin Ingram, Natural Resources Wales
Wales Audit Office:	Adrian Crompton – Auditor General for Wales Derwyn Owen Dave Rees
Committee Staff:	Fay Bowen (Clerk) Claire Griffiths (Deputy Clerk)



## **1 Introductions, apologies, substitutions and declarations of interest**

- 1.1 The Chair welcomed Members to the Committee.
- 1.2 The Chair welcomed Adrian Crompton, Auditor General for Wales, to his first formal Committee meeting.
- 1.3 Mike Hedges AM substituted for Rhianon Passmore AM.

## **2 Natural Resources Wales: Scrutiny of Annual Report and Accounts 2017–18**

2.1 Members scrutinised Clare Pillman, Chief Executive, Kevin Ingram, Executive Director for Finance and Corporate Services, and Peter Garson, Head of Commercial Operations, Natural Resources Wales on Natural Resources Wales' Annual Report and Accounts 2017–18.

2.2 Clare Pillman agreed to send details of:

- How much timber produced in Wales was processed in Wales in 2017–18;
- Write with details of how the former Chief Executive's settlement agreement was calculated and who approved it.

## **3 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:**

3.1 The motion was agreed.

## **4 Natural Resources Wales: – Consideration of the evidence received**

4.1 Members considered the evidence received.

# Agenda Item 4.1



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board

Our Ref: AD/DE/kj/NRamseyPAC

ABMU Health Board

Headquarters

Date: 20<sup>th</sup> July 2018

One Talbot Gateway, Seaway Parade,

Port Talbot

SA12 7BR

Nick Ramsay AM

01639 683302

Chair of the Public Accounts Committee

WHTN: 1787 3302

National Assembly for Wales

Cardiff Bay

Cardiff

CF99 1NA

Dear Mr Ramsay

I am writing to follow up on the evidence provided to the Public Accounts Committee on 9th July by ABMU Health Board and to respond, in particular, to the points raised in respect of the former Chief Executive of the Health Board which is set out at paragraphs 172 to 198 of the transcript.

The Chief Executive left the organisation in March 2017 under the terms of a Compromise Agreement. The value of the payment was £187,096.81 which comprised £50,000 in lieu of notice, £3,452.06 in lieu of Annual Leave and £113,213 ex gratia payment. The process was approved by the Board's Remuneration Committee and Welsh Government.

As my Chief Executive indicated to the Committee, this is not a matter that she, nor Lynne Hamilton or Sian Harrop-Griffiths, were in a position to be able to respond to. I am happy to attend the Committee and to set out the Board's position on the handling of this matter if this would be helpful.

Yours sincerely

**ANDREW DAVIES**  
**CHAIRMAN**

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• Chairman/Cadeirydd: **Andrew Davies**

• Chief Executive/ Prif Weithredydd: **Tracy Myhill**

ABM Headquarters/ Pencadlys ABM, One Talbot Gateway, Seaway Parade, Baglan Energy Park, Port Talbot. SA12 7BR.

Telephone: 01639 683344 Ffon 01639 683344 FAX: 01639 687675 and 01639 687676

Bwrdd Iechyd ABM yw enw gweithredu Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg

ABM University Health Board is the operational name of Abertawe Bro Morgannwg University Local Health Board

[www.abm.wales.nhs.uk](http://www.abm.wales.nhs.uk)



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board

Our Ref: TCM/DE/kj/NRamsay/PAC

Date: 20/07/18

ABMU Health Board  
Headquarters  
One Talbot Gateway, Seaway Parade,  
Port Talbot  
SA12 7BR

01639 683302  
WHTN: 1787 3302

Nick Ramsay AM  
Chair of the Public Accounts Committee  
National Assembly for Wales  
Cardiff Bay  
Cardiff  
CF99 1NA

Dear Mr Ramsay

Thank you for the opportunity to provide evidence to the Public Accounts Committee at your meeting held on 9<sup>th</sup> July 2018. As promised I am writing to provide further information to the Committee on a number of points.

## 1. Former Chief Executive of ABMU Health Board.

Our Chairman, Andrew Davies, has written under separate cover on this issue.

## 2. Digital Strategy

We noted at the evidence session that we have ambitious plans to be a digital organisation. I have attached our strategy 'Destination Digital' which was developed in 2017 and aligns with the national strategy. We have a detailed work programme in place that is monitored through an Informatics Board. I have also attached a summary of the Programme for the next 6 months which highlights the wide range of projects underway across the Health Board to modernise our approach, and deliver benefits in terms of the quality and safety of our services, as well as improvements in both staff and patient experience. We are fully supportive of "Once for Wales" principles and are working in collaboration with NWIS and other Health Boards/Trusts across Wales as well as our Local Authority partners in Western Bay. We are leading on a number of key initiatives to provide learning to the national way forward, including: the implementation of hospital

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• Chairman/Cadeirydd: **Andrew Davies**

• Chief Executive/Prif Weithredwr: **Tracy Myhill**

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www.abm.wales.nhs.uk

electronic prescribing and medicines administration across two hospital sites; an 'at scale' demonstration of citizen held records, which has gone live in Bridgend this month; and mobilisation of the community workforce. We would be happy to provide more detail on any of these initiatives if that would be helpful to the Committee.

### 3. Referral to Treatment (RTT)

On reviewing the transcript, we have identified some factual inaccuracies which relate to the discussion on Referral to Treatment (RTT) funding. Firstly, Mohammad Asghar's question set out in paragraph 60 of the transcript indicated that ABMU had received £7.4m to meet targets for RTT. We can confirm that ABMU received £10.07m in 2017/18 to meet referral to treatment times. The figure of £7.4m was the amount of funding clawed back by the Welsh Government. In responding to Mr Asghar's question (paragraph 61), we inadvertently advised that the amount of clawback funding in 2017/18 was £6.9m when the actual figure was £7.4m. The subsequent paragraphs 62, 63 and 64 are therefore also incorrect. We apologise for the oversight in not identifying and correcting this during our evidence session.

Thank you once again for the opportunity to present our evidence to the Public Accounts Committee.

Yours sincerely



**TRACY MYHILL**  
**CHIEF EXECUTIVE**



# CHANGING FOR THE BETTER

# 07

MAY 2017



NEWID ER GWELL  
 CHANGING FOR THE BETTER  
 Comisiynu ar gyfer Ansawdd  
 Commissioning for Quality

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## Destination: Digital our digital strategy

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## FOREWORD

Welcome to the first digital strategy for this Health Board.

This document is especially for you if you are a citizen in our Health Board area, a patient with us, or an employee of our organisation or of any organisation with which we work.

Digital is a way for all of us to get jobs done that will help address the many challenges in health, care and well-being that we all face.

In the following pages, we hope to inspire you about the benefits that digital healthcare can bring you.

We also hope that you will be encouraged to make the most of the opportunities that digital offers.

We have produced this strategy now because we believe the time is right to be able to take the actions needed to make it a reality.

Looking forward to seeing you on the journey to Destination: Digital.

## WHAT IS 'DIGITAL'?

Digital is about the means by which we all interact with each other and with everything around us, as shown in the model below. In healthcare, using digital technology, citizens and patients will be able to receive and share information online about their health and well-being, communicate by audio, video, secure email and messaging, and participate in peer-to-peer support groups, in trials, and in health and care decision-making with their clinicians. Health and care teams will use digital technology to become more data-driven and evidence-based, with a robust and ever-expanding decision-support capability.

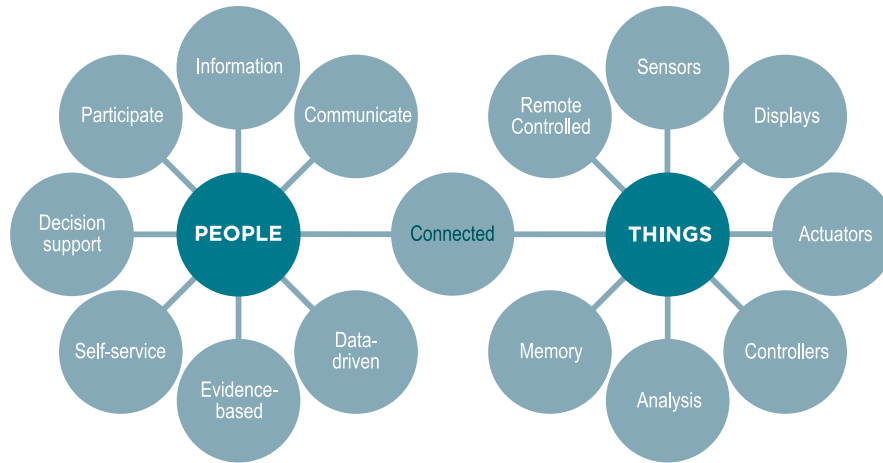


Figure 1: Model depicting the interaction of people and things in a digital context



At the same time, almost everything we can think of will be made digitally-interactive, with sensors, displays, moving parts and controls, on-board analysis and memory, and the ability for remote control. Most important, they will be connected to us, either attached or implanted for a specific purpose or more casually wearable, and able to transmit to central units for storage of data or further analysis possibly in real time e.g. to provide targeted advice, or to raise an alert about an urgent need or situation.

Management of our health and well-being is ideally suited to being served, and likely is only able to be supported sustainably, with digital technology. Digital technology can provide the capability for professionals to serve citizens and citizens to support themselves at times and in places which are more convenient for them and their families or carers.

To become a digitally-enabled organisation we will all need to adopt new health and care digital-related behaviours, in terms of the way we do things, and in terms of those with whom we work or interact. People's different life experiences with digital (our collective cognitive diversity) are vital to us helping each other to achieve the new health and care system that digital technology enables.

The use of digital technology spans a continuum from being a substitute for paper-based information to being an agent for valuable new services not possible by any other means. Digital technology is poor at just replicating the use of paper in a previously manual process. It can even increase non-value-adding processing time.

However, once information on paper needs to be comparable

customisable

editable

organisable

remotely accessible

reproducible

researchable

searchable

shareable

standardisable

storable

transportable, a digital alternative starts to create value. Blend

digital technology ingredients and use digital technology to manipulate immense data repositories and large real-time data flows predictively and prescriptively, and achieve interoperability between digital systems and digital connectivity between people, and entirely new health and care capabilities emerge...

**BLEND DIGITAL TECHNOLOGY INGREDIENTS:**

- **Information**  
Healthy living, patient record, wayfinding maps, images, test results, prescriptions, item location, vital signs
- **Communication**  
Messages, interactive video, telecommunications, secure email, dictation
- **Entertainment**  
During care as an aid to recovery (using our own devices connected to free public WiFi)
- **Workflow**  
Clinical and business process documentation chain - asynchronous telemedicine, diagnostic and treatment record keeping, prescribing, bed and medicines management, rostering
- **Intelligence**  
Needed to run the organisation
- **Analytics**  
Needed to learn, adapt and improve
- **Device agnosticism, artificial intelligence, interoperability, connectivity, security, apps and bots**



**... GET NEW HEALTH AND CARE CAPABILITIES:**

- **Citizen/patient engagement**  
Self-service, self-help exercise/nutrition/control programmes, self-management of self-limiting conditions, more meaningful participation in health and care
- **Proactive health, care and well-being**  
Risk stratification by community, targeted advice, patient monitoring in real time, future state prediction
- **Coordinated care**  
View information at any time, transact remotely in real time, collaborate on care planning and scheduling
- **Systematic care**  
Clinical information decision support, knowledge management tools, standardised workflows, automation
- **Specialist access**  
Virtual clinics, professional-to-professional consultation
- **Resource management**  
Manage patient flow, match capacity to demand, push then pull, connect mobile community workers, organise action
- **Improvement and innovation**  
Continually learning organisations, better research and trials approaches, increasingly individualised medicine

Figure 2: Blend digital technology components on the left hand side to get new health and care capabilities on the right hand side

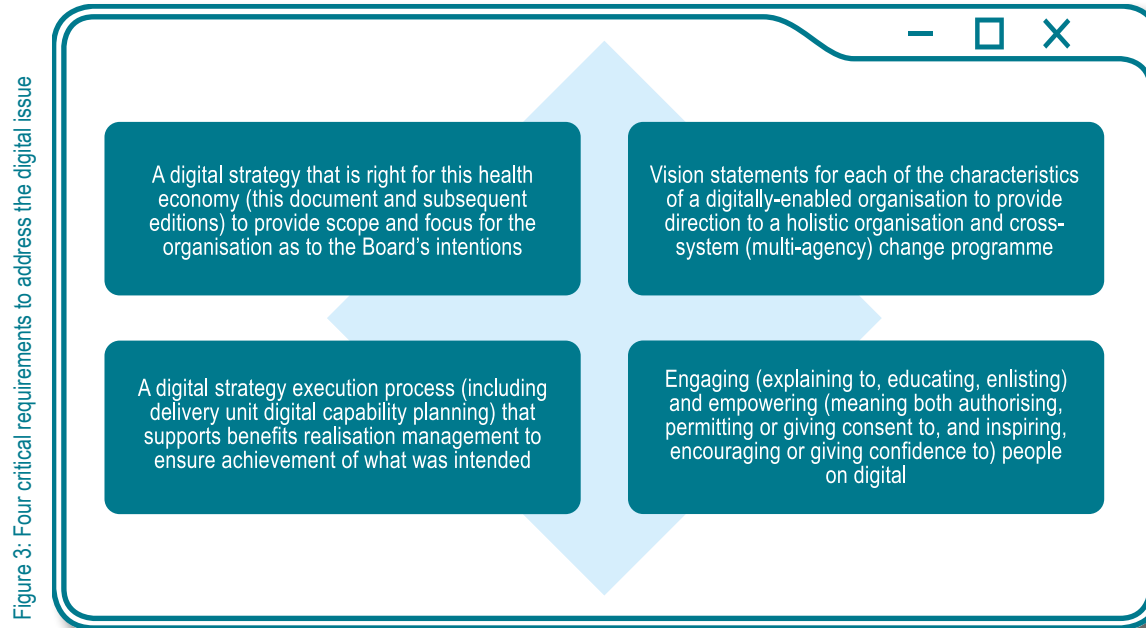
## WHY WE NEED A DIGITAL STRATEGY

**There is a real and complex strategic issue that we face with digital, the nature of which is summarised in these bullet points:**

**We will examine some of these in more detail in the sections on considerations for the system and the Health Board in executing the strategy.**

- The comprehensive application of digital technology to healthcare is relatively new as prospective components are evolving rapidly. More collaboration, research, development and integration are needed over time to influence, drive and benefit from a digitally-enabled health and care system and future digital technologies, with significant regional economic development potential as a result
- Much has been achieved by our Health Board in conjunction with Welsh Government and the NHS Wales Informatics Service in deploying digital services so far, but there are limited resources to execute a digital strategy alongside other priorities
- The current approach is programme- and project-based, not holistic or strategic, and often opportunistic. The strategy must be executed as part of an organisation change programme
- Digital access (to the internet and possession of the basic skills to use it) and participation levels are varied, both between urban and rural areas, and within urban areas, for a variety of reasons including age, ability, outlook and inequity e.g.. in network coverage, discretionary disposable income and/or education level
- There are many 'pockets of enthusiasm' for digital in the Health Board, and some exemplars that outstrip the Health Board's ability to fully exploit at this stage, but also many areas of limited engagement and implementations not sufficiently driven by or designed with the service users to achieve intended adoption and utilisation levels
- There is little visibility, and therefore understanding, of what becoming a digitally-enabled organisation entails or how and to what extent digital technology can address the challenges the organisation faces
- Public sector budget constraints and the current financial position of the Health Board impede cross-sector digital initiatives, acquisition of digital talent, front line time to participate in digital design, configuration and testing, and taking a longer term view in favour of short term imperatives.

Assessment of the issue that we face with digital has identified four requirements as critical:



These four requirements are related: a strategy only has value with its counterpart, execution; the two together enabling the delivery of intended results through a realisation methodology. Achievement of the aims of an effectively formulated strategy depends wholly on the quality of the strategy execution process and the excellence of the operational activity in support of the strategy. At the core of effective strategy execution management is the creation of a performance culture that engages people to lead, develop and operate with intent to achieve.

Digital is a means to an end, an enabler of improved health and care. Digital is not a patient or citizen health or care benefit, so a digital strategy is not an end in itself. A digital strategy is intended to fit with other strategies, supporting the organisation strategy, and guiding a portfolio of long term organisation-wide changes.

The contention that is shaping a digital strategy that will support our organisation strategy is that once the organisation is digitally-enabled, it will be more empowered, efficient and effective in realising the benefits intended from implementing the new health and care system, as shown in the diagram on the right. People with access to digital technology are more empowered, people following digital processes are more effective, and digital processes powered by digital technology are more efficient.

Our digital strategy also reflects our belief that, based on work already achieved in our health economy and by learning from others, it is possible to leapfrog some phases towards the advanced position that the organisations that have pioneered the digital health and care system globally have taken over 20 years to achieve. Some key characteristics of a digital health and care system are listed in the table below:

Figure 4: The benefit of digital: more empowered, efficient and effective

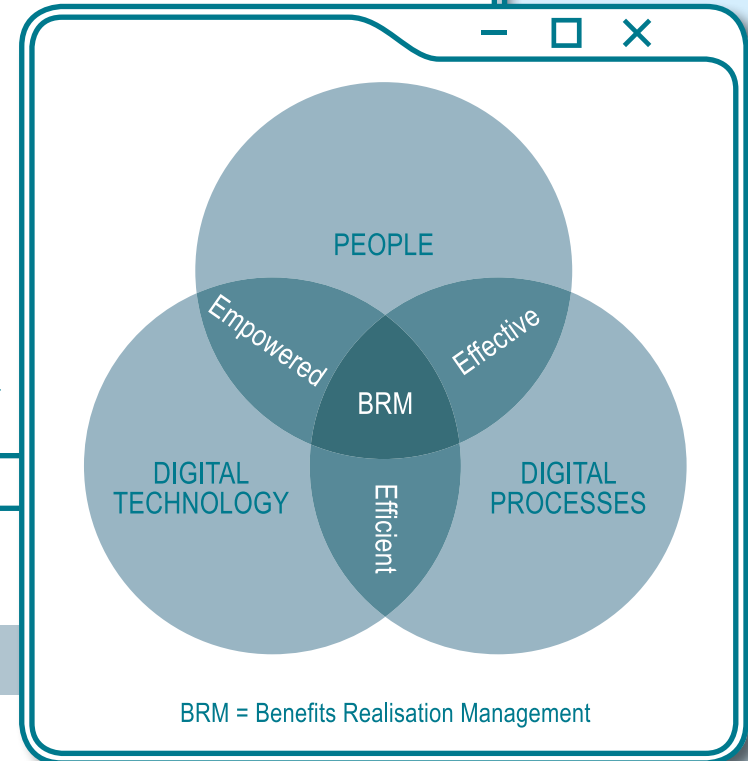


Figure 5: Key characteristics of a digital health & care system

**KEY CHARACTERISTICS OF A DIGITAL HEALTH AND CARE SYSTEM**

Increased participation by citizens in their health and well-being, and reduced non-attendance

More effective frailty and mental health self-care and long term condition self-management

Improved care coordination, reduced variation, waste and harm, and safer handovers between health and care professionals

Improved point of care decision support (real-world real-time data and evidence) and management of acutely ill or deteriorating patients

Accurate, agile analysis of population health data at community level for service commissioning and research

Run the system process and performance intelligence, and improve the system analysis and innovation

## OUR DIGITAL STRATEGY

Our digital strategy has the following three components:

### **The strategy statement:**

This is a brief sentence that summarises how we intend to respond to the strategic issue that we face with digital, and should be straightforward to remember and recall to help guide our day-to-day actions in accordance with our purpose, mission and values.

### **The high level aim of the strategy:**

This explains what this response is intended to deliver. In executing the strategy, we expect to keep asking the question “Which objective will achieve that objective?” in order to create actionable digital capability plans for each of us.

### **The vision:**

This is presented in the form of a digital maturity chart. For many reasons, there is a wide disparity in our current use of digital technology across our health economy. Some of our staff have no access to digital technology in the work they do for us, but are highly proficient with digital outside work. Our use of some of the more recently mainstream digital technology capabilities such as smart and mobile is limited even though we will soon be the first Health Board in Wales to provide free public Wi-Fi in all our hospitals. Therefore, we have sought to show from a strongest and weakest perspective where we are now and where we need to get to. Our vision is deliberately limited to five years in recognition that we should not pre-suppose what the digital landscape will be a decade from now, and therefore to emphasise the need to act now on delivering digital, and on improving our ability to influence, drive and benefit from new digital technology that is in the early stages of development now.

### **Our strategy statement is:**

“

HEALTH, CARE AND WELL-BEING  
ACTIVITIES CARRIED OUT BY EVERYONE IN  
OUR HEALTH ECONOMY WILL, WITH PACE AND  
SCALABILITY, BE ENABLED USING DIGITAL  
TECHNOLOGY WHEREVER OPTIMAL

”

The **triple aim of our strategy** is to:

1



Enable, with pace and scalability, our health and care teams to use digital technology to spend more time on their core competency - working with citizens and patients to improve outcomes - not managing paper or digital processes

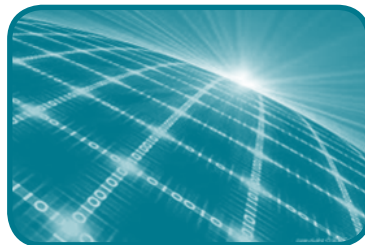
2



Realise the 'efficient productivity'\* benefits of digital technology investments already made and to come

\*actually doing more at the same or higher quality level with the same or fewer resources

3

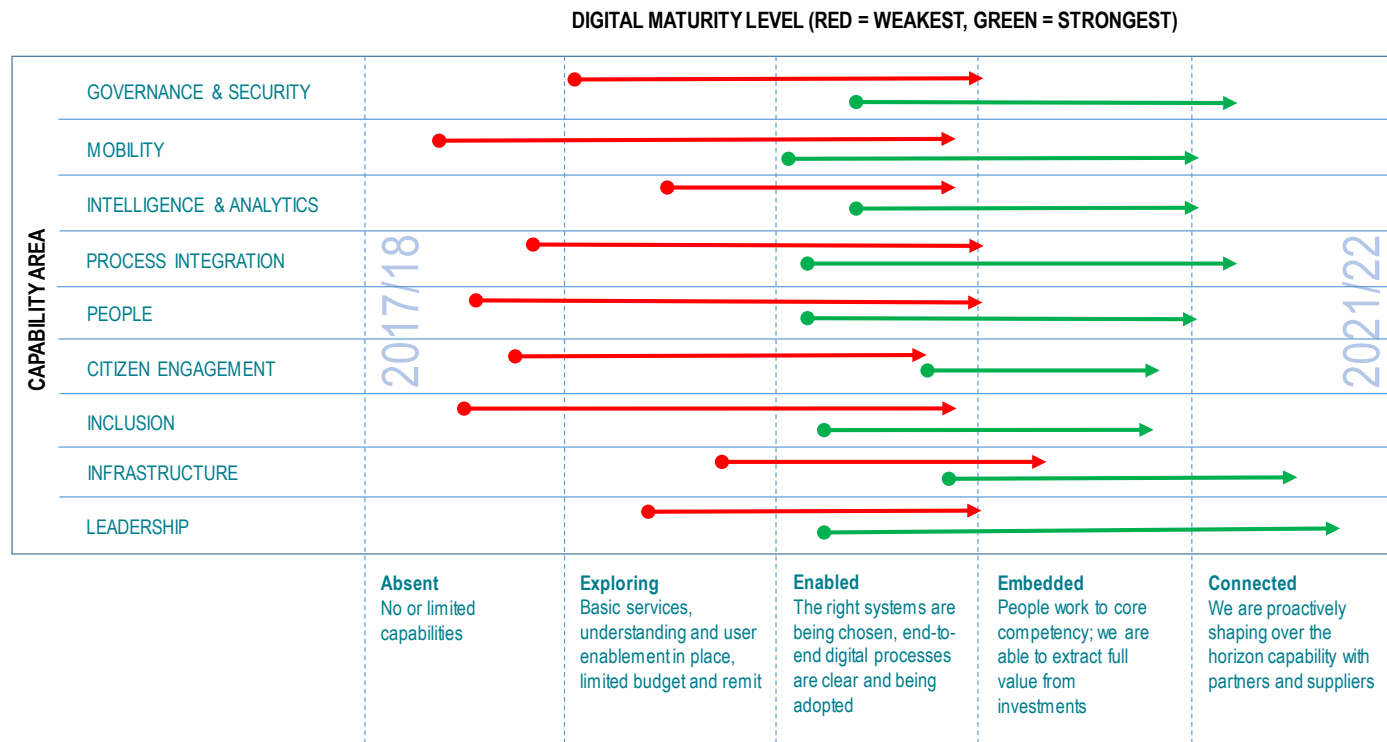


Better position this health economy to influence, drive and benefit from new digital technology, achieving the required ongoing cost economies

Figure 6: The triple aim of our digital strategy

Our vision for five years' time is a transformed digital maturity level for this health economy. The following chart plots the likely respective journeys required of the currently weakest (red lines) and strongest (green lines) components of each of the organisational elements listed

Figure 7: ABMU digital maturity - the left hand end of each line is the current position; the right hand end is the desired position



Our intention is two-fold. In five years, we intend all capability areas to have reached at least the 'Enabled' stage. In five years, we also intend to have established an ability to influence, drive and benefit from new digital technology by coherently developing the strongest components of our leadership, process integration, infrastructure and governance and security capabilities.

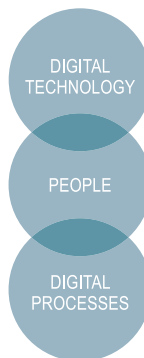
## FROM STRATEGY TO ACTION

Achievement of the aims of an effectively formulated strategy depends wholly on the quality of the strategy execution process and the excellence and completeness of the tactical activity in support of the chosen business change initiatives. At the core of effective strategy execution (benefits realisation) management is the creation of a storyline to the future and a performance culture that engages people to lead, develop and operate with intent to achieve.

### Principles:

With regard to this digital strategy, for execution of it to contribute effectively to achievement of the organisation strategy, there are some principles specific to becoming and being a digitally-enabled organisation that need to be incorporated in this unified approach. The diagram on the right lists three principles to be applied in using digital to support achievement of the Board's organisation strategy. It will be important to invest at least as much resources (time, quality of effort, and money) into the 'soft' aspects of:

- **user-centred design** – solving the problems of those who will use the digital technology
- achieving a digitally-enabled **culture**
- **process innovation** - rigorously and consistently applying a methodical approach to innovating the replacement of existing processes and tools with digital ones as into the technology itself, implementation, system interoperability, and governance and security of the data involved.



Digital enables the creation of new value not possible with paper

It's all about the people (citizens, patients, staff and partners) – a shared digital journey to be able to:

- operate in a digital world
- imagine what's needed
- design and deliver it

Processes will be digital wherever optimal, simplifying user journeys, improving user outcomes and experience, and increasing efficient productivity

Figure 8: Key principles to apply in executing a digital strategy

To show how the principles might be used to guide action to execute the digital strategy, in the following pages the Board has set out what the outcome of a digital strategy delivered following those principles might look like. Our reference point was a unique health and well-being system model, in which our citizens will try to improve or consistently maintain their health and well-being with our support to do so, and assessment, care or treatment and coaching whenever needed. Guided by that model, we created digital user journeys intended to achieve our organisation strategy and arranged them in four groups, to be accessed on any device:

- **SUPPORT ME** - an online interactive whole life health and well-being support planner
- **ASSESS ME** - an online interactive assessment and care plan creation manager
- **TREAT ME** - an online interactive care and treatment delivery coordinator
- **COACH ME** - an online interactive recovery, self-care or management coach

Some of the services are currently available but not consistently or comprehensively deployed, adopted and utilised in our health economy. Others are in development and expected to be deployed by NHS Wales organisations or their partners, or expected to be brought into public use by other organisations, in the next five years. In the next section, the digital user journeys in each group that **Citizens/Patients** will be able to undertake are described. The subsequent section shows the implications of these services for **Health and Care Teams**, together with digital user journeys that help those teams to do their work.

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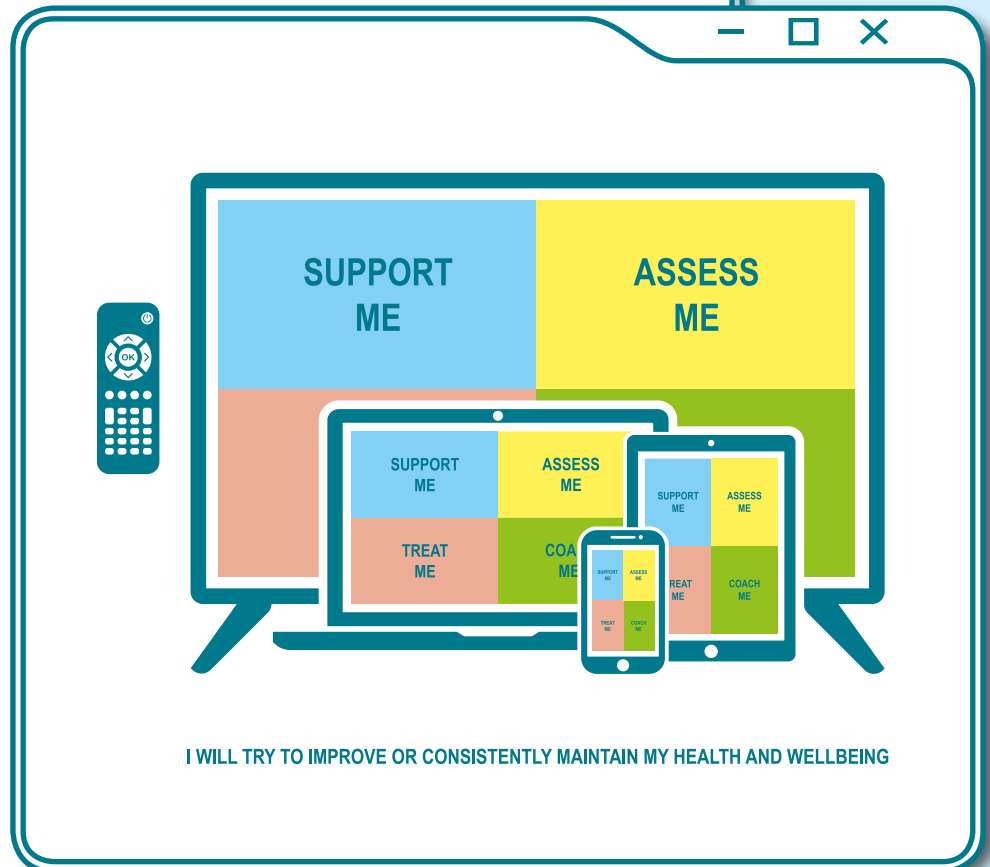


Figure 9: A platform for digital services

**FOR CITIZENS/PATIENTS**
▾

**SUPPORT ME** makes it simple for citizens to become actively involved in their health and well-being. A suite of purpose-designed tools, apps and bots increase health literacy and capability, and extend integrated care to a population health approach with targeted interventions:

<b>SUPPORT ME</b>	<b>ASSESS ME</b>	<b>TREAT ME</b>	<b>COACH ME</b>
I can view the record of my medical history and update my personal details, lifestyle choices and how I wish to be cared for in the future and maintain a personal health journal	With live assistance if needed, I am able to build my own self-help programme for physical and mental exercise, nutrition, and condition and medicine management, with reminders to keep me on track and rewards for success	There is a library of accredited health information and updates on public health that I can read and understand in order to be better informed about risks, conditions and care or treatment options	
There are activities that help me to learn about avoiding avoidable harms and positive steps to take to keep myself and my family healthy	We, and any devices that are wearable or installed around us, or attached to or implanted in us, can monitor progress against our self-help programme and add to our record as needed	Health and well-being support is provided proactively in accordance with my history and current status, or I can get help any time I feel unwell and am unsure what to do	
My history and state of health and well-being are compared with that of other people to provide specific information about my risk of health issues and what I can do to optimise my health over my whole life span	There are tools, activities and information for self-care and self-management that help me to have more confidence, capability and support to live a fuller life with my status and condition(s)	A community resources guide to places, groups, activities, opportunities, events and services reduces my social isolation and facilitates peer support contact	

**ASSESS ME** is the one-stop shop for all assessment requirements. It is as relevant to citizens attending a GP consultation as to patients who need assistive living services provided to enable them to return home, or to prevent them having to go into hospital or care in the first place:

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
I can choose with whom I share the record of my medical history, lifestyle choices and how I would like to be cared for in the future	The screening guides me through booking an appointment with the right person when it's necessary, with reminders in a format I can choose, and the ability to postpone or cancel so someone else can use the appointment slot		The outcome of the assessment is added to my record and discussed with me so that I understand risks, conditions, care or treatment options, and next steps, and we agree and put in place a care plan
I can complete self-assessment and pre-visit screening is available, in order to help identify any condition I have that is self-limiting, so that I can actively resolve it myself	As needed or at my convenience, the assessment can be at a clinic or the assessor can visit where I am, or will be, living, or it can be audio-visual during which I can transmit photographs or other information to aid the assessment		Information relating to next steps is provided, including waiting times for treatment and experience measures at treatment centres in my area, and outcome measures for treatments relevant to my condition/status
I may proactively be invited to a health and well-being assessment based on my history and current status or on an anomaly in data sent from a device or reported by me	I can receive updates as the assessment and care planning process progresses, and communicate with the health and care team via secure email and messaging as well as phone or face-to-face		In an emergency or following an accident you can access my record if I am unable to choose to share it with you

**TREAT ME** underpins the use of joined-up health and care treatment plans and care co-ordination centres for the purpose of delivering more types of treatment outside hospital, enabling hospitals to focus on emergency and acute treatment:

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
My relevant medical history, latest clinical statistics, lifestyle choices and how I wish to be cared for are curated for each point of care for a smooth process, a positive experience, and the best outcome	During my treatment and convalescence away from home, there is free public wi-fi so that I may use my device to view my choice of entertainment, or connect with family and friends as an aid to recuperation	If my health status is now lower, I can co-create a long term condition or palliative plan to better prepare me to return to and stay at home, and maintain my self-reliance or have help	
I am able to view my care plan which meets clinical and humanitarian standards for my circumstances, and amend bookings if essential	I can process a prescription for collection or delivery, get information on the next steps in my care plan to understand and be better prepared to play my part, and select my meals while in care	My care plan is available to everyone in real time in order to help them prepare so that the care process is smooth and effective, and I can report on my experience and outcome	
If I am self-reliant, self-check in, way-finder, and information and consent tools are available to help expedite the care or treatment process	I can co-create my discharge-to-enablement plan for my condition-related needs, medicines management, nurse and care visits, follow-up appointments and reablement tools that will help me regain my previous health status	Following assessment, any digital assistive living needs I have are implemented by the relevant body in collaboration with me, to integrate with any of my own lifestyle management equipment	

**COACH ME** is intended to support people's potential to self-manage their recovery or adjustment or to change their behaviours, or to increase their confidence in their ability to do so. Likewise it is intended to improve the self-efficacy of a person caring for someone:

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
My record of my medical history and lifestyle choices helps inform any coaching I or my carer need in order to help me to recover or to adjust to my new health status	I am actively participating in running my condition-customised post-discharge programme to minimise the number of follow up appointments I need to attend and reduce my risk of needing readmission	I can learn how to use digital technology to increase my self-reliance or seek support, and my GP can prescribe internet connection and equipment if I need it to support me	
I can access self-help information sources in order to aid my recovery or adjust to my new health status and revise my self-help programme in my health and well-being planner	There is telephone or audio-visual access to nurse-led health coaching, tailored advice and emotional support to help me recover or adjust to my new health status	A unified assistive living process covering case management, telehealth and health coaching helps me to understand my entitlement to and get and use the right services as my health status changes	
There are devices and applications that can help me re-mobilise from bed to day room to outdoors and with coaching I gain confidence to use them routinely in future	I can order repeat dispensing of medicine and am reminded about my responsibility for ensuring that my medicine provides the maximum assistance for my condition, which my self-help programme can support me to discharge	I can readily take part in research and trials, and provide timely input or feedback for my future benefit	

**FOR HEALTH AND CARE TEAMS**
▾

**SUPPORT ME** is about the citizen/patient having the right information at the right time to increase their knowledge and understanding of their health matters, and the right tools at the right time to enable them to take action for their own, or their family's benefit:

<b>SUPPORT ME</b>	<b>ASSESS ME</b>	<b>TREAT ME</b>	<b>COACH ME</b>
Public Health Wales commissions this national system for health and well-being and runs the campaign for its adoption and utilisation by citizens	A national live assistance service assists people to build their own self-help programme for physical and mental exercise, nutrition, and condition and medicine management	All health and care organisations in Wales have a single 'shop window' in this planner in which to present accredited information to citizens	
The Red Book online is part of this planner and we register citizens at birth or on first contact with health and care, and promote planner use	We can view the record of the individual's medical history, lifestyle choices and how he/she wishes to be cared for in the future at any time once he/she has chosen to share it with us	We can pool resources and form multi-disciplinary teams to help in designing and developing this well-being planner for citizen/patients and their carers	
Welsh population health information is segmented for health status, need and priority by community to provide specific information about the risk of health issues for individuals in this planner	Through this planner we can initiate and manage new proactive health and well-being support services and provide responsive services e.g. a 24/7 health and social care hub (or by telephone)	Public Health Wales works with local public services and the third sector to enhance and standardise information, advice and assistance provision	

**ASSESS ME** covers all assessment activities across general practice, hospitals, community, nursing home and social care, and mental health and learning disabilities, involving investigation, diagnosis, suggested treatment options and communication during assessment processes:

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
Clinicians have access to information and e-library services for the best up to date information to facilitate diagnosis	Point-of-care testing uses advanced devices with digital upload integration with the health record reducing assessment recording steps and increasing citizen/patient throughput	Clinician letters, and referrals and records transfer including cross-border are electronic, reducing process time and errors through process integration and automated process completion	
Primary care staff view citizen/patients' pre-visit screening information to ensure they see the right clinician for their needs	Clinicians use electronic test requesting, secure store and forward technologies, asynchronous telemedicine for image and test result reviews, and professional-professional telehealth consultation	Information is provided to me via a performance dashboard, including outcome comparisons with my peers and experience, to support appraisal and improvement	
New proactive assessment services emerge from combining community level analytics, medical history, current status and anomalies in data sent from a device or reported by a citizen/patient	We can add the assessment outcome to the person's record and discuss risks, conditions, care or treatment options and next steps in order to agree and create a whole pathway care plan for his/her clinical or support needs with metrics	Digital collaborative community assessment protocols for Primary Care, District and Community Nurses, Mental Health and Learning Disabilities, Social Services, Assistive Living staff facilitate timely care plans	

**TREAT ME** is principally about the professionals saying 'it's our job now', where the citizen/patient has entrusted him/herself to them. Confidently spoken, those four words impart huge reassurance, and the digital services here are intended to improve outcome and experience:

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
Clinical coordination centres with common care and referral protocols support information-sharing, need-capacity matching, admission, referral and community care bookings, and early discharge reviews	A stabilisation and treatment management system combining test results, ECG/physiological testing records and images with decision support helps identify patients requiring urgent/specialist care, prepares rapid admission pathways and books clinical expertise needed	We co-create discharge-to-enablement, long term condition management or palliative plans for condition-related needs, medicines management, nurse and care visits, follow-up appointments and reablement tools	
Clinical workflow tools allow more time with patients, with reliability and standardisation increased, scheduling and decision support improved, ordering/prescribing automated, and handover risk reduced	Intervention requirement prediction improves our ability to identify deteriorating patients and those at risk of infection earlier so we can collaborate to intervene preventively minimising divergence from the optimal care pathway	Data coding is automated and validated by clinicians and patients and in a standard format to inform audit, commissioning, clinical governance and quality improvement	
Whole pathway care plans let us manage the flow and performance of services end-to-end in real time	Asset, inventory and procurement management, and staff rostering and deployment tools remove administrative tasks from clinical staff	Community care, clinic and hospital management systems enable information needed at every level to be generated in real time or as required	

**COACH ME** requires a different kind of conversation to increase health-related quality of life and improve patient experience of the health system. For care providers, it covers coaching systems, and tools and training through academies and Health and Well-being campuses:

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
The individual's record of medical history and lifestyle choices helps inform my coaching decisions for recovery or adjustment to his/her new health status	Health and well-being centres include audio-visual and walk-in consultation facilities for digital health coaches to provide transition coaching including the use of technology-enabled care to help citizen/patients re-able	Real-time reflective practice tools using smartphones (audio-visual recordings) and internet e.g. forums enable staff to reflect on delivered care and build reflective practice into training, facilitating improvement	
All post-discharge coaching and rehabilitation services needed are included in the integrated care plan and scheduled automatically	The voluntary sector can align availability with demand through peer-to-peer brokerage services, and clinical partners can access and engage population cohorts to undertake research or trials for their future benefit	The creation of health and well-being campuses as a hospital/business infrastructure/education and skills development testbed can innovate coaching	
Using audio-visual or telephony we provide nurse-led health coaching, tailored advice and emotional support to help citizens/patients recover or adjust to their new status and reduce readmission risk	Coaching systems for healthcare organisation staff facilitate selection and prescribing of personalised content and tools e.g. care simulators, virtual coaching programmes etc	Assessment and diagnostic academies, and digitally-integrated genetics, pathology and surgical centres of excellence convert science to advanced clinical practice	



**CONSIDERATIONS FOR THE DESIGN OF THE SYSTEM**

**The intention is to provide services to citizens and professionals that are as intuitive and convenient to use as those in other aspects of their lives, and which they feel add value for them, in order to drive adoption and enduring use. This has system-level implications:**

SUPPORT ME	ASSESS ME	TREAT ME	COACH ME
There is cross-care settings access to citizen/patient information (which we keep online, with access logging) relevant to the point of care including child protection and mental health information	National clinical workflow systems will be used wherever optimal e.g. for consultations, referrals, orders, results and medicines management, increasing virtual capacity and availability in general practice and clinician interoperability	Whole system intelligence brings together financial, operational and clinical outcome data centred around patients to support population health management, effective commissioning, service re-design and research	
Device-software combinations are designed with and for the user and are touch-sensitive, responsive or assistive as needed for place-based working, with data capture, aggregation, analysis and response/command	Business management systems are interoperable where needed e.g. for need-capacity matching, planning, performance management and audit, and enable a comparable citizen/patient experience across equivalent care settings	There is a multi-agency approach to citizen identification across public service board organisations facilitating timely push or pull through their whole care pathway (e.g. using unique electronic identification wrist tags)	
A single set of information-sharing agreements is in place and all assessment outcome, treatment and discharge or withdrawal and transfer records, letters and notices are generated in a standardised and shareable way	A clear direction exists for the use of web portals and patient self-care/management exists so that technology-enabled care can be comprehensively available and consistently selected and deployed, and coaches consistently trained	The internet is there for all whenever required, information governance and cyber-security is resolved nationally so that records follow patients across borders, and staff are consistently trained for their protection	



For these system-level implications alignment with national and regional strategy and initiatives e.g. digital services, data centres etc., and collaboration e.g. on inter-operability and cross-organisational data-sharing, are essential, for economies of scale, to share scarce resources or to achieve best practice. We will examine some critical dependencies for our Health Board's digital strategy:

**Mitigating or resolving digital exclusion:**

Becoming digitally-enabled requires system users to have access (available internet and the skills to use it), and system providers e.g. our Public Service Board member organisations, to encourage ever-increasing digital participation by all citizens. On access, a Once for Wales approach to rapidly addressing internet availability and digital skills training in conjunction with Public Service Board member organisations providing assisted digital support to those who can't, don't or won't access digital services themselves should be adopted. On participation, imperatives for this Health Board to accelerate digital participation are growing:

- Trying to continue serving the rising demand and expectations and addressing the health inequities without digitally-enabled ways of working will become unaffordable for a reducing number of taxpayers to bear
- The current manual/paper-based ways of working will become operationally unsupportable due to the impact of demographics on our Health Board workforce, and the difficulties of attracting and retaining staff (yet there is more than enough capacity already if our staff are able to do just those things that only people can do, and we use technology to do the rest)
- As the use of digital technology becomes more pervasive in health and care, it is foreseen (Gartner, Dec 2016) that organisations not keeping up in utilising digital technology in the provision of individual health and care services will leave themselves open to medical malpractice litigation.

In this context, digital participation may be accelerated by (i) increasing and enhancing multi-agency collaboration in consistent user-centred design, (ii) expanding and augmenting current approaches to achieving participation, and (iii) mobilising more partner organisation staff in support.

**Digitising and sharing health records:**

Much of the digital strategy is dependent on the digitisation and sharing of each citizen's full health record, and on determining the correct information to be presented at each point of care, or enabling the health and care professional to access it. A single plan for full health record digitisation and sharing should be prepared.

**Information, intelligence and analytics:**

As our health and care economy evolves, we need a robust set of methodologies, processes, architectures and technologies to capture and transform raw data into meaningful and useful information. An organisation-wide business intelligence and analytics capability is integral to the successful realisation of the benefits of investment in a digital strategy. This capability involves always being able provide the right information in the right format to the right people throughout our learning organisation at the right time, for the creation, accumulation or enhancement, management and use of knowledge for health and care services.

It is envisaged that business intelligence and analytics processes will uncover insights about clinical pathways, experience and outcomes, and population health needs from the underlying data. By using information and analytics to support decision-making across health and care, our workforce will be able to transform knowledge into actions which reduce variation and improve our services and the health and well-being of our population. Population health intelligence will enable both increased health and well-being awareness and participation by our population by supporting informed citizen/patient interactions with targeted health and well-being campaigns, and improved health management by directing development of service provision where needed.

Currently deployed intelligence and analytics technology is primarily applied to structured data. However, as shown in the diagram to the right, emerging healthcare questions require implementation of newer technologies which allow deeper investigation of large volumes of semi-structured and unstructured data. At the same time, business users and clinicians increasingly need to test hypotheses and explore data before knowing exactly what they need. New data discovery and visual analysis tools give non-technical users capabilities for performing what-if analysis and creating visualisations themselves, driving demand for access to suitable data. However, results of analytics are often hard for users to consume without appropriate context. Dashboards and performance metrics can help users understand the significance of analytics for their roles, responsibilities and decisions.

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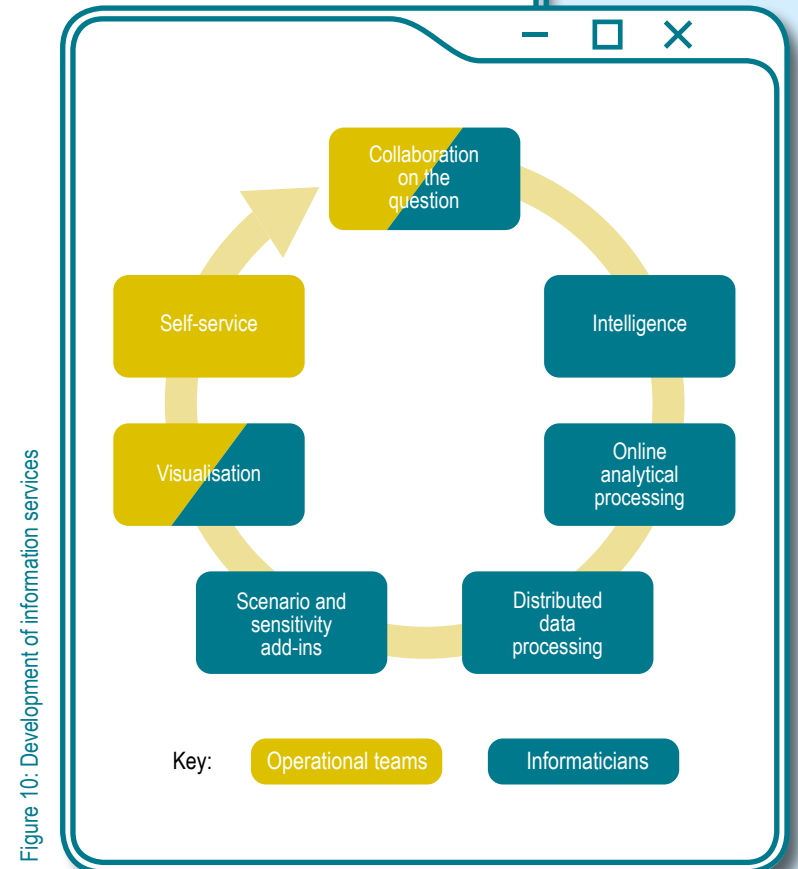


Figure 10: Development of information services

**Digital technology infrastructure:**

We rely on a combination of local and national infrastructure comprised of the underlying utilities and components, together with network resilience, cyber security and management of the technology, for the provision of digital services. The strategic remit includes the evolution (modernisation and standardisation) of our infrastructure and the introduction of new technology.

The core network connects and provides access to computers, telephony, video conferencing, medical equipment, surveillance cameras, building management systems and alarms, on a fixed line or wireless basis. It needs to be robust and resilient, and the equipment replaced and software updated regularly.

Computer servers provide access to email, document storage, administrative systems, clinical systems and business intelligence. Our own servers are kept in secure data centres with failover, and software patched with the latest security updates between new version releases. Cloud-hosted services offer an overall reduced total cost of ownership of ICT infrastructure and services together with improved performance, reliability and scalability. They often facilitate the provision of the 'at home' services described earlier.

A key deliverable envisaged in our digital strategy is the wide-scale move from traditional desktop and laptop devices (there are around 9,350 devices and 16,800 staff) to mobile devices and mobile applications. As described earlier, this will better enable staff to communicate, learn, do their work and participate in helping to tackle digital exclusion.

Our Wi-Fi platform is vitally important in delivering access to information and collection of data at the point of care as well as providing unified communications (telephony, video, instant messaging) across the Health Board. Our surveys show it enhances patient experience. To communicate with staff without access to their own Health Board computers (junior doctors, nurses, porters, estates staff etc.), we are giving Wi-Fi access to essential services such as email, intranet and other NHS web applications on individuals' own devices.

The use of video conferencing in administrative and clinical environments provides opportunities to transform patient care by enabling professionals to see citizens/patients at home remotely, supporting virtual multi-disciplinary team meetings, allowing two or more people to collaborate on the same information in a single system at the same time, and incorporating real-time presence information to let staff working in the community know which colleagues are available to provide advice or assistance.

Protecting our systems from cybercriminals involves educating staff, using modern security technical infrastructure, ensuring devices, networks and computer systems are operating on supported platforms with the latest security patches applied, and developing cyber-attack resilience plans to protect information assets should an attack occur.

## CONSIDERATIONS FOR THE HEALTH BOARD

As well as system-level implications, there are some important considerations for the Health Board in executing this strategy:

### **Digital maturity:**

In conducting its current state assessment as input to this digital strategy, the Health Board completed an initial digital maturity self-assessment to evaluate how well developed different aspects of the organisation's infrastructure, capability and readiness are. Some systems require further user-centred design revisions and development, however current limitations are principally in the capabilities of the organisation and its readiness to engage. Likewise, an initial baseline self-assessment undertaken against the Advisory Board business intelligence maturity model shows that in most aspects our Health Board is currently operating at an enterprise perspective level (in line with the majority of similar organisations), and the areas not achieving this level are data culture and the wider organisation's approach to data and analytics.

### **Pace and scalability:**

The digital strategy flows from the organisation strategy and has been developed to deliver the organisation's strategic objectives by guiding digital capability planning by and for the Health Board's Delivery Units. While we build the new digital capability, we will need to redevelop existing capability to overcome both generic and specific factors that will constrain the rate of progress in delivering this strategy, including:

- People – workforce development, risk attitude, availability of resources/skills, capacity in the context of the ambition of the strategy
- Process – change engagement, coordination of change, timeliness of components/decisions
- Technology – legacy systems, enterprise architecture, vendor engagement, increasing confluence of digital and medical technology

### **Communication:**

There is little visibility, and therefore understanding, of what becoming a digitally-enabled organisation entails or how and to what extent digital technology can address the challenges the organisation faces. At the same time, digital is an enabler of the new health and care system, not an end in itself. Whether to include an action under the DESTINATION: DIGITAL banner, or under a different organisation initiative requires consideration.

As well as the quality of the strategy execution process and the excellence and completeness of the tactical activity in support of the chosen business change initiatives, executing this digital strategy effectively requires deciding which user journeys to make digital and in what order. It also requires establishing a robust digital platform in and for the user community and an ecosystem for rapid, scalable experimentation and collaboration among provider organisations in our health economy and nationally in order to address dependencies explained earlier. The execution process will therefore need to identify the relevant collective milestones and codify and agree benefits realisation management. Where appropriate, this should include making progress in delivering and operating digital technology a part of commissioner and provider assurance, assessment and inspection regimes and provider assurance, assessment and inspection regimes.

## HOW THE STRATEGY WILL BE...

### **Communicated:**

This Digital Strategy will be promoted widely by the Board using existing internal and external communication channels, and the DESTINATION: DIGITAL name and logo were developed to facilitate this. Digital familiarisation will be part of induction and training, and referenced in job descriptions, objectives and appraisals. A webpage, Team Brief and regular bulletins will be used to update staff and our public of progress.

### **Implemented:**

We have developed and will undertake a robust execution process to translate strategy into actionable plans for all, with priorities set out in the Integrated Medium Term Plan, coupled to a rigorous benefits realisation management process intended to achieve the planned outcomes.

### **Delivered:**

The Executive Team will lead the delivery of this strategy through a portfolio of programmes which will complement the national initiatives underpinning 'Once for Wales'. They will exploit the capabilities of our strategic and tactical regional partnerships e.g. Swansea University and ARCH through a digital collaboration network that will address the broader determinants of health and well-being to increase gross value added.

### **Monitored for delivery:**

The Board has overall accountability for strategy but has delegated responsibility for the regular and detailed scrutiny of this area to its Strategy Committee. It will have oversight of how we will:

- Utilise a Digital Portfolio Board (which will include representatives from each Delivery Unit, each Commissioning Board, Primary Care, the voluntary sector and the key partnerships outlined above) to drive a service-led, benefits-driven Destination: Digital portfolio;
- Agree, implement and keep aligned prioritised work programmes comprising current and new projects, together with culture change, promotional activity, education, training, and workforce development;
- Evaluate the capability and capacity of our Informatics Directorate in order to create and then implement a development plan for it; and
- Determine success metrics and measure a baseline against them, manage progress and show at each review the extent to which the progress made is taking us towards becoming digitally-enabled.

### **Reviewed and evaluated:**

This Strategy will be reviewed and evaluated in accordance with NHS Wales guidance and Health Board practice.

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# ABMU Informatics Programme Plan – July 2018

Junior Doctor Induction

Aug

1<sup>st</sup>

July

Aug

Sep

Oct

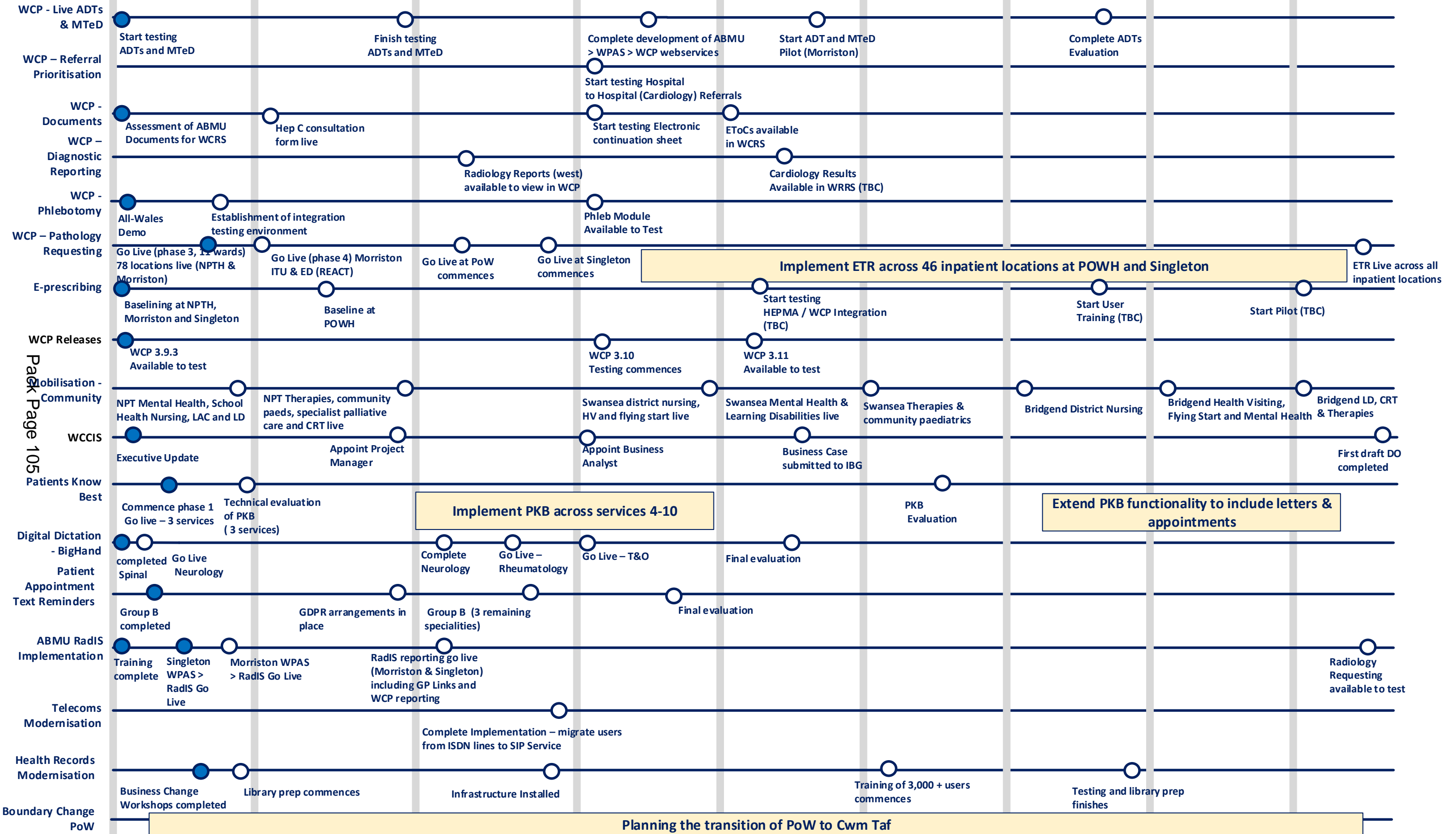
Nov

Dec

Jan

Feb

Mar



# Agenda Item 4.2



Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

Ysbyty Athrofaol Cymru  
University Hospital of Wales  
UHB Headquarters  
Heath Park  
Cardiff, CF14 4XW

Parc Y Mynydd Bychan  
Caerdydd, CF14 4XW

Eich cyf/Your ref:  
Ein cyf/Our ref: LR-jb-08-7012  
Welsh Health Telephone Network:  
Direct Line/Llinell uniongychol: 02920 745681

**Len Richards**  
**Chief Executive**

7 August 2018

Mr Nick Ramsay AM  
Chair  
Public Accounts Committee  
National Assembly for Wales  
Cardiff Bay  
Cardiff  
CF99 1NA

Dear Mr Ramsay

## **Impact Assessment National IT outages January 2018**

At the recent PAC committee I was asked to provide an update on Cardiff and Vale UHB's impact assessment, and why we had not responded to the NWIS emails asking for updates. I have discussed this with my IT department and am now in a position to provide this information.

Communication was highlighted as an area for improvement between NWIS and LHBs and this appears to have been an issue in this case. In following up why Cardiff and Vale did not respond to the requests from NWIS for an update regarding the impact of the outage, further communication issues have come to light.

An email was sent to us from NWIS, however it was not sent through our major incident channels. Unfortunately, the individual who received the email was off sick and so the organisation was unaware of the request.

The mitigation is that the second Assistant Director of Information (ADI) was fully aware of the outage that the issue of outages has been discussed at all ADI meetings since the outage. Our ADIs have worked collectively with other LHB ADIs through the Informatics Management Board (IMB) to inform the wider NHS of the impact. This also informed the update given to the Chairs and Chief Executives meeting by Steve Ham. Whilst no formal response may have been received by Gethin Bateman, the discussion has been very much alive and constructive at IMB. This led to IMB escalating the issue to ADIs and into IPAD.

Regarding the impact of the January outage, Cardiff and Vale UHB was not affected to the same level as other LHBs, as our local Cardiff Clinical Portal was still working, unlike the products aligned to the Welsh Clinical portal. We were therefore able to keep outpatients running and provide our normal CaV portal information. For this reason we did not call a major incident, even though services such as pathology needed to revert to their business continuity processes and significant disruption was experienced.

You may be aware that there was another national data centre failure between 3 and 5 August which affected all of Wales. We have therefore put in place a formal assessment of the regular downtime, the impact of interruptions and the costs incurred by the outages experienced this year.

Yours sincerely



**Len Richards**  
**Chief Executive**

## **Public Accounts Committee**

### **Inquiry into the NHS Wales Informatics Services**

#### **Additional Information from Cwm Taf University Health Board (10 August 2018)**

During the evidence session held on 2 July 2018, Cwm Taf University Health Board agreed to send further information regarding the proportion of savings which were non-recurrent in 2017-18.

Total savings achieved in 2016/17 were £13,402k, of which £5,303k was non recurrent (i.e. 40%). The source of this information is Cwm Taf's Monitoring return submission to Welsh Government.

Total savings achieved in 2017/18 were £15,913k, of which £6313k was non-recurrent (i.e. 40% again), with the source again being Cwm Taf's monitoring return to Welsh Government.

Therefore, the proportion of savings which were non-recurrent remained constant across the two years.

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/  
Prif Weithredwr GIG Cymru  
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/  
NHS Wales Chief Executive  
Health and Social Services Group



Llywodraeth Cymru  
Welsh Government

Nick Ramsay AM  
Chair  
Public Accounts Committee

29 August 2018

Dear Mr Ramsay

## **Implementation of the NHS Finance (Wales) Act 2014 and NHS Wales Informatics Services**

Following the Public Accounts Committee meeting on Monday 16 July 2018 regarding Implementation of the NHS Finance (Wales) Act 2014 and NHS Wales Informatics Services, please find below my response to the actions raised by the Clerk of the Committee.

**Note on whether from an NHS Wales perspective, there could be some additional opportunity within the performance management procedure to include probationary periods to review performance together with whether or not the current procedure supports managers enough to be able to deal with underperformance.**

I agreed to reflect on the proposal for probationary periods to review performance for new starters and the current performance management procedure. I will be considering this with NHS Employers and staff side colleagues and I will be asking the Welsh Partnership Forum, our Social Partnership group, if a probationary period would be desirable and add value for the NHS in Wales and how it interacts with the performance management system to balance the need for effect performance arrangements against continuing the need to attract the best possible people to work in NHS Wales. There are concerns that this would be inconsistent with practice across the NHS that may affect recruitment into Wales as an additional obstacle, particularly where we are not just recruiting locally, but sometimes nationally and internationally. At this stage, the recruitment market in Wales is highly competitive and we have outstanding vacancies. I will report back on this as it would represent a significant change.

**Note that the Cancer Network had seen the business case for the cancer delivery plan.**

As I outlined I can confirm that the Business Case for the replacement of CaNISC's functions is currently in development. Directors of the Wales Cancer Network attend and support meetings of the Cancer Implementation Group and its Cancer Information and

Intelligence Subgroup. An options paper for the proposed replacement of CaNISC functions was presented by NWIS and the development was discussed at meetings of these groups in March, May, June, September and November of 2017; as well as at meetings in January, April and July of 2018. As part of this process, the Cancer Information and Intelligence Subgroup made a recommendation to the Cancer Information Group, which agreed the approach and made a recommendation to the NHS Wales Informatics Management Board.

**Note that the Joint Emergency Services interoperability programme had been shared with each health board and that it had been considered as part of their business continuity arrangements.**

In a recent meeting of the NHS Wales Informatics Board, Abertawe Bro Morgannwg advised that they had adopted the Joint Emergency Services Interoperability Principles (JESIP) for managing business continuity arrangements during incidents, including incidents relating to digital issues.

Welsh Government officials have now shared this with NIMB members (NHS Executive Leads for Informatics), sharing a link to the principles, and asking that they consider them for use within their organisations to support business continuity.

The Wales Gold and Silver multi-agency courses include JESIP principles, therefore NHS Wales colleagues who attend the courses will have been exposed to, and have an understanding of, JESIP.

**Note on the Welsh Government technical standards on GDS and an explanation of the differences between that system and the GDS design principles.**

At its June meeting the Welsh Technical Standards Board agreed to adopt the GDS Design Principles (Annex 1), along with the Welsh Government's Digital Service Standard (Annex 2), for use across NHS Wales. In making a decision on the adoption of a Digital Service Standard, the Board considered both the UK Government Digital Service (GDS) and Welsh Government version of this standard.

The Government Digital Service (GDS) was established in 2012 to lead the transformation of central UK Government services. GDS's primary focus has been on UK Government services and has provided an advisory and guidance role to all devolved administrations. In April 2014 GDS launched its Digital Service Standard, which exists to help UK Government Departments build and run effective, user-focused digital services. It was last updated in 2015, and we are aware that GDS will be releasing a further updated version shortly.

The Welsh Government's Digital Service Standard is based on the UK Standard and comprises a set of criteria to help Welsh Government build and operate good digital services.

The main differences between the two standards are as follows:

- Standard no 13 - the UK Standard says "make the user experience consistent with GOV.UK" whilst the Welsh Government equivalent reflects the need for our services to adhere to the Welsh Government style guide and design patterns (which themselves are based on GDS standards);

- Standard no 18 - the UK Standard says “Test the service with the Minister responsible for it” whilst the Welsh Government standard requires services to be tested with senior management, and ideally the responsible Minister.

Following publication of the forthcoming updated GDS service standard Welsh Government will review its own to ensure alignment with best practice.

In addition to the information I have provided here, and as you have outlined, I know that Andrew Griffiths will be writing to you separately to address the issues raised. I hope this letter provides you with the information required.

Yours sincerely



**Dr Andrew Goodall**

**Government design principles:**

1. Start with user needs  
Service design starts with identifying user needs. If you don't know what the user needs are, you won't build the right thing. Do research, analyse data, talk to users. Don't make assumptions. Have empathy for users, and remember that what they ask for isn't always what they need.
2. Do less  
Government should only do what only government can do. If we've found a way of doing something that works, we should make it reusable and shareable instead of reinventing the wheel every time. This means building platforms and registers others can build upon, providing resources (like APIs) that others can use, and linking to the work of others. We should concentrate on the irreducible core.
3. Design with data  
In most cases, we can learn from real world behaviour by looking at how existing services are used. Let data drive decision-making, not hunches or guesswork. Keep doing that after taking your service live, prototyping and testing with users then iterating in response. Analytics should be built-in, always on and easy to read. They're an essential tool.
4. Do the hard work to make it simple  
Making something look simple is easy. Making something simple to use is much harder - especially when the underlying systems are complex - but that's what we should be doing. Don't take "It's always been that way" for an answer. It's usually more and harder work to make things simple, but it's the right thing to do.
5. Iterate. Then iterate again  
The best way to build good services is to start small and iterate wildly. Release minimum viable products early, test them with actual users, move from alpha to beta to live adding features, deleting things that don't work and making refinements based on feedback. Iteration reduces risk. It makes big failures unlikely and turns small failures into lessons. If a prototype isn't working, don't be afraid to scrap it and start again.
6. This is for everyone  
Accessible design is good design. Everything we build should be as inclusive, legible and readable as possible. If we have to sacrifice elegance - so be it. We're building for needs, not audiences. We're designing for the whole country, not just the ones who are used to using the web. The people who most need our services are often the people who find them hardest to use. Let's think about those people from the start.
7. Understand context  
We're not designing for a screen, we're designing for people. We need to think hard about the context in which they're using our services. Are they in a library? Are they on a

phone? Are they only really familiar with Facebook? Have they never used the web before?

8. Build digital services, not websites

A service is something that helps people to do something. Our job is to uncover user needs, and build the service that meets those needs. Of course much of that will be pages on the web, but we're not here to build websites. The digital world has to connect to the real world, so we have to think about all aspects of a service, and make sure they add up to something that meets user needs.

9. Be consistent, not uniform

We should use the same language and the same design patterns wherever possible. This helps people get familiar with our services, but when this isn't possible we should make sure our approach is consistent. This isn't a straitjacket or a rule book. Every circumstance is different. When we find patterns that work we should share them, and talk about why we use them. But that shouldn't stop us from improving or changing them in the future when we find better ways of doing things or the needs of users change.

10. Make things open: it makes things better

We should share what we're doing whenever we can. With colleagues, with users, with the world. Share code, share designs, share ideas, share intentions, share failures. The more eyes there are on a service the better it gets - howlers are spotted, better alternatives are pointed out, the bar is raised.

Much of what we're doing is only possible because of open source code and the generosity of the web design community. We should pay that back.

## Welsh Government - Digital Service Standard:

The Welsh Government's Digital Service Standard is a set of 18 criteria to help us create and run good digital services. It is used by many other Departments and is based on the Government Digital Service (GDS) Service Standard.

1) Undertake research of who the service users are, to understand user needs. Undertake research to develop a deep knowledge of who your service users are and what that means for the design of the service so that it:

- helps users do the things they want to do at the first attempt
- is built on your users' real needs, not your assumptions.

2) Have a plan in place for ongoing user research and usability testing. This will seek feedback from users to improve your service. Also it will ensure your service is helping users do the tasks they need to do, and to keep improving it based on their needs.

3) Have a multidisciplinary team.

Put in place a sustainable multidisciplinary team that can design, build and operate your service, led by a suitably skilled service manager with decision-making responsibility. This will help to:

- build your service
- keep improving it based on user needs
- make decisions quickly.

4) Build your service using agile iterative and user-centred methods.

Using agile methods helps you to build services that:

- meet the needs of your users
- are easy and convenient for people to use
- you can change easily if for example policy changes
- you can keep improving for example based on user feedback
- cost less and are more accountable.

5) Build a service that can be iterated and improved on a frequent basis and make sure you have the capacity, resources and technical flexibility to do so.

This will help to easily respond to changes in policy affecting the service and continues to make sure your service keeps meeting user needs.

6) Evaluate what tools and systems will be used to build, host, operate and measure the service, and how to procure them.

This will help you:

- check any risks or constraints associated with them
- avoid contracts that lock you in and stop you improving your service
- build a sustainable system which you can easily manage after your service goes live.

7) Understand security and privacy issues.

Evaluate what user data and information the service will be providing or storing, and address the security level, legal responsibilities, and risks associated with the service (the

Welsh Government's Project Managers' Security Handbook sets out more details on this). This will help your users to have confidence that you look after their information properly.

8) Consider making source code open and reusable, and, if appropriate, publish it under relevant licenses.

This will enable other services to reuse the software you've created.

9) Use open standards and common platforms where available.

This can save time and money by reusing things already available and give your users a more consistent experience of using government services online therefore building trust.

10) Test the end-to-end service.

Be able to test the end-to-end service in an environment identical to that of the live version on all common browsers and devices, using dummy accounts and real users.

11) Make a plan for being offline.

Have a back up plan. In the event of your digital service being taken temporarily offline, you need to have a plan for how your service will continue to operate, what to do, how your users will be affected and how to get it back online.

12) Create a service that's simple and intuitive that users succeed first time.

This will help ensure users are able to complete the task your service provides the first time they try, as quickly and easily as possible. Your service delivery plan needs to take account of users with disabilities and those who need assisted digital support. You will need an assisted delivery plan.

13) Make the user experience consistent with the rest of Welsh Government.

Build a service consistent with the user experience of the rest of Welsh Government services including using the design patterns and style guide. This will help users to trust Welsh Government services because they recognise the style.

14) Encourage everyone to use the digital service with assisted digital support if required.

Develop a plan to phase out non-digital channels/services. This will help to save money by reducing the numbers of people using non-digital channels and help users develop their digital skills.

15, 16 and 17) Identify your baseline information to measure performance, collect that information regularly and report on performance.

When designing your service, decide what performance data you wish to collect which could include 4 key performance indicators (KPIs):

- digital take up
- completion rate
- user satisfaction
- cost per transaction.

Setting performance indicators allows you to continuously improve your service by learning its strengths and weaknesses. Welsh Government has committed to open data and reporting on the performance of your service will help to make decisions on how to improve the service, demonstrate openness and transparency.

18) Test your service from beginning to end with your Director General, or ideally, your Minister.



Mr Nick Ramsay AM  
Chair, Public Accounts Committee  
National Assembly for Wales  
Cardiff Bay  
Cardiff  
CF99 1NA

Wednesday, 29 August 2018

Dear Mr Ramsay

**RE: WAO Report on Informatics in NHS Wales**

**I agreed to send a note on the total number and sorts of outages that have occurred from 1 January 2018 to the current date.**

There were a total of 21 outages - i.e. incidents logged via the NWIS service desk that meant that users were unable to access CaNISC, WLIMS or the National Data Centres (affecting access to WLIMS or CaNISC) - between 1st January 2018 and 31st July 2018,

Annex 1 is a table describing details of the outages, shown in relation to the service against which the incident was logged by the Health Board/Trust.

As I outlined in previous correspondence there were specifically three outages related to the data centres as a whole. We appreciate that the issues in the past twelve months, particularly with WLIMS and CaNISC and the three incidents that affected the data centres more widely, are a concern to the service. We are very focused on addressing the remedial actions as well as undertaking a more systematic review of the infrastructure and associated support services.

**I agreed to send a note on how the cloud has been embraced in NWIS.**

Over recent years, the IT industry has been shifting towards providing and consuming cloud computing services. This means that instead of all the computer hardware and software used to deliver IT services sitting inside an organisation's network, some or all elements of the solution are provided to the customer as a service by another company and usually accessed over the internet.

NWIS has been working on the adoption of cloud services for several years. We currently support more than 10,000 staff actively using Microsoft Office 365 cloud service for email, file storage (OneDrive), Skype and other services. This includes all GP staff, all NWIS staff and around 250 users





in the Welsh Ambulance Service Trust. Some LHBs are also working on using PowerBI (Business Intelligence services). In addition, the users in the new Health Education and Improvement Wales (HEIW) will be using Office 365.

One of the suppliers of GP systems for NHS Wales (Microtest) is using 'UKCloud' (<https://ukcloud.com/>) to host the systems for its GP practices. GP practices in Wales will be migrated during 2019 and 2020.

In addition to this, we have been working with Microsoft, our Microsoft reseller and NHS Wales organisations over the past 18 months to put the underpinning systems in place to allow NHS Wales organisations to be able to consume Infrastructure as a Service (IaaS) and Platform as a Service (PaaS) cloud services from Microsoft Azure. This work includes:

- Establishing the necessary governance arrangements around the safe storage and processing of sensitive information (e.g. Patient Identifiable Information) in cloud services. A document entitled "NHS Wales guidance: Cloud services" was developed by NHS Wales, in conjunction with Welsh Government, and approved by the NHS Wales Informatics Management Board (NIMB) in April 2018;
- Designing the structures within the NHS Wales Microsoft Azure tenancy to allow individual NHS Wales organisations to have control over their own servers/services that they use;
- Billing arrangements – to enable individual NHS Wales organisations to pay for Azure services they consume;
- Establishing secure network links from the NHS Wales Wide Area Network into Microsoft Azure. Establishing these links has required the re-engineering of parts of the network infrastructure and this has been completed.

The use of cloud services offers some significant benefits for NHS Wales. However, there are some key challenges that need to be considered, including:

- Funding – cloud services are revenue funded and IT hardware is currently mostly purchased from capital monies. This would require a significant change in funding profile, which forms part of our assessment of any future use;
- Increased management. Unless actively managed, cloud infrastructure services can result in higher overall costs than on-premises equivalents. This also requires that applications are designed and built to be able to support this requirement;
- Some systems are not suitable for hosting in cloud services because of the technologies being used, for example, older database systems that are not optimised and applications that have not been designed to take advantage of the cloud and the way the applications have been designed; Performance, resilience and availability requirements for some systems do not make them suitable for hosting in cloud services

As mentioned above, NWIS is currently building the required underpinning infrastructure services in Microsoft Azure and will be piloting some Infrastructure-as-a-Service (IaaS) within the next 12 months. More generally, cloud services will be actively considered as options for future



projects/procurement, but this will require the shift of capital expenditure into revenue as well as the readiness of suppliers to offer Software as a Service in the future.

The pace of adoption of cloud services will reflect a measured response to the risks and issues above.

**I agreed to send a note on the analysis undertaken for the costs involved in replacing the CaNISC infrastructure and software currently being run together with the updating of the physical infrastructure.**

### Costs of replacement for CaNISC

The Velindre Cancer Centre's "Welsh Patient Administration System in Velindre" Business Case and the Welsh Cancer Network's "Cancer Information System" Business Case (in development) support the replacement for CaNISC. The figures in the table below have been extracted from these Business Cases; they indicate the anticipated costs at this stage and will be subject to refinement as the projects progress.

		18/19	19/20	20/21	21/22	22/23	Total
Phase 1	VCC WPAS	1,115	736	0	0	0	1,851
Phase 2	Electronic Patient Record**	0	1,099	456	399	0	1,954
Phase 3	Development of Increased Functionality	TBC	TBC	TBC	TBC	TBC	TBC
<b>Total</b>		<b>1,115</b>	<b>1,835</b>	<b>456</b>	<b>399</b>	<b>0</b>	<b>3,805</b>

\*\* Early indicative costs

The Cabinet Secretary has approved the Velindre Cancer Centre's "Welsh Patient Administration System in Velindre" Business Case and NWIS is working with the Wales Cancer Network and the Cancer Implementation Group to finalise the business case for the Electronic Patient Record before submission to Welsh Government..

Costs in the table shown as 'TBC' will be developed as the specifications for these services are confirmed by the stakeholders and a full assessment of the options to deliver them can be undertaken.

**Costs of updating data centre infrastructure backlog**

NWIS estimates that the cost of updating the ageing infrastructure in the two data centres, would be in the region of £5.5 to £6million. This includes the cost of the kit itself, plus updating the services required to run it, for example cyber security.

Yours sincerely



Andrew Griffiths

Chief Information Officer NHS Wales  
Director of NHS Wales Informatics Service

Annex 1

Call	Logon	Title	Type	Service	Status	Summary of Cause
3903631	06/01/2018 18:35	OOH LIMS Support	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	A combination of defragmentation, synchronisation and purging occurred at the same time causing the servers to freeze. A restart of the affected servers restored access
3941086	24/01/2018 15:50	Data centre issue	Service Unavailable	Network Services	Closed	An error in the configuration of the network firewalls was the root cause, triggered by a routine application of a firewall rule. The supplier implemented a number of changes to the configuration which restored service
3955814	31/01/2018 13:30	canisc	Functionality Issue	Canisc	Closed	A number of issues with the configuration of the Citrix environment were identified as the root cause to this outage.
3957025	01/02/2018 08:42	Canisc - unable to launch	Functionality Issue	Canisc	Closed	A number of issues with the configuration of the Citrix environment were identified as the root cause to this outage.
4058623	21/03/2018 15:47	ESC Email/intranet unavailable	Service Unavailable	Hosted Messaging Services	Closed	The suppliers investigated the log files to try to identify the root cause of this incident, and were unable to determine or recreate in their environments. The impacted devices were stopped and restarted which restored service
4074744	29/03/2018 15:43	TCL unresponsive	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	There was insufficient capacity in the Citrix environment to be able to successfully manage a manually run backup. This caused the system to freeze and users to lose access. A reboot of the impacted servers, and the supplier issuing a number of thaw commands to the backup restored service
4106391	17/04/2018 12:21	Storefront unavailable	Service Unavailable	Canisc	Closed	An issue with the Citrix configuration meant that some user sessions failed as one from a pair of servers was unavailable. A restore of the correct configuration was applied which restored access
4123288	24/04/2018 16:54	Unavailability of Network	Functionality Issue	National Data Centres	Closed	it was identified that there was a corruption of the configuration of a switch which prevent access to systems. The configuration was restored which resolved the issue
4134166	30/04/2018 13:20	ESC Canisc - General Issue	Functionality Issue	Canisc	Closed	An unexpected shutdown of a server was identified as the root cause. When the server restarted automatically, manual intervention was then required to restore service
4134837	30/04/2018 15:25	TrakCare LIMS	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	A 'Write Daemon' issue with the WLIMS servers caused the system to freeze. A reboot of the servers was required, which restored service
4141650	03/05/2018 07:45	starts up then closes down straight away	Functionality Issue	Canisc	Closed	Following a planned failover, a number of configuration issues were identified with the secondary servers which prevented access to the system for some users. Changes to the configuration were made to mirror the production service which restored access.
4161255	14/05/2018 12:10	ESC Functionality Issue	Functionality Issue	Laboratory Information Management System (LIMS)	Closed	The services failed due to a temporary storage location being filled up after a Change was made against a biochemistry test set. A removal of all of the reference ranges applied as part of the change was undertaken which restored service.
4166115	16/05/2018 07:40	canisc down? message telling me file doesn't exist	Service Unavailable	Canisc	Closed	A failure of a number of Citrix servers following a SQL blip were identified as the root cause, which caused some users to be unable to access the system. Disconnecting those affected users, and getting them to reconnect restored access
4167272	15/05/2018 11:25	ESC LIMS has reached concurrent application limit	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	The Citrix servers ran out of capacity meaning the the servers were running at 100%, and subsequently failing. All users sessions were ended on the impacted servers, and the servers were restarted which restored access
4169168	17/05/2018 08:36	Canisc slow and appears unstable	Functionality Issue	Canisc	Closed	An ongoing issue with storage, and the rollout of a security patch, impacted the system, causing performance issues and loss of access. Re-applying the security patch across the entire Canisc infrastructure, and undertaking changes identified by the supplier on the storage network restored service
4229394	17/06/2018 05:35	OOH LIMS Support	Unclassified	Laboratory Information Management System (LIMS)	Closed	Following a planned failover of the WLIMS system, an issue with the Journal which impacted the WLIMS database. A fix was applied by the supplier which restored access
4232870	18/06/2018 18:10	OOH LIMS Support	Unclassified	Laboratory Information Management System (LIMS)	Closed	Following a planned failover of the WLIMS system, corruption of an index master table impacted user access. A rebuild of the master table by the supplier restored access
4271736	07/07/2018 08:35	OOH LIMS Support	Unclassified	Laboratory Information Management System (LIMS)	Closed	A configuration issue was identified by the supplier where the server settings in one data centre did not match those in the second data centre. These were reconfigured to match and access to the service was restored
4283261	13/07/2018 09:19	Canisc - General Issue	Functionality Issue	Canisc	Closed	The deployment of an anti-virus patch which blocked access to around 200 servers across the National Data Centres was identified as the root cause. The patch was uninstalled and access to service was restored
4284620	13/07/2018 13:25	CANISC ERROR HANDLER	Functionality Issue	Canisc	Closed	The SQL database failed over to the secondary server. Root Cause investigations identified that this was mistakenly failed over, following maintenance work which was being undertaken on a similarly named management server. Restoration of the server and a failover was undertaken to restore service
4303277	24/07/2018 07:20	Users cannot access Canisc	Functionality Issue	Canisc	Closed	It was identified that the Citrix Listener was offline, causing the SQL databases to lose synchronisation. A reboot of the node restored access to the listener, and then a manual synchronisation of the databases restored access to users



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Gwybodeg  
Informatics  
Service

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Mr Nick Ramsay AM  
Cadeirydd Pwyllgor Cyfrifon  
Cynulliad Cenedlaethol Cymru  
Bae Caerdydd  
Caerdydd  
CF99 1NA

Dydd Mercher, 29 Awst 2018

Annwyl Mr Ramsay,

**Cyf: Adroddiad WAO ar Wybodeg yn GIG Cymru**

**Rwyf wedi cytuno i yrru nodyn o'r nifer a'r mathau o ddifodiadau sydd wedi digwydd rhwng Ionawr y 1af a'r presennol.**

Roedd yno gyfanswm o 21 diffodiad - h.y. digwyddiadau cafodd eu nodi gan y ddesg wasanaeth oedd yn golygu nad oedd defnyddwyr yn gallu cael mynediad at CaNISC, WLIMS nac at Ganolfannau Data Cenedlaethol (yn effeithio mynediad at WLIMS neu CaNISC) - rhwng y 1af o Ionawr 2018 a 31ain o Orffennaf 2018.

Tabl yw atodiad 1 yn disgrifio manylion y difodiadau, yn cael ei ddangos yng nghyd-destun y gwasanaeth gafodd y digwyddiad ei gofnodi yn ei erbyn gan y Bwrdd Iechyd/ Ymddiriedolaeth.

Fel yr amlinellais mewn gohebiaeth flaenorol, roedd yno dri diffodiad penodol yn perthyn i'r canolfannau data yn gyfan gwbl. Rydym yn gwerthfawrogi fod y problemau dros y deuddeg mis diwethaf, yn enwedig gyda WLIMS a CaNISC a'r tri digwyddiad wnaeth effeithio'r canolfannau data yn fwy eang, yn bryder i'r gwasanaeth. Rydym yn barod i ganolbwyntio ar y gweithredoedd adferol yn ogystal â chymryd adolygiad mwy trefnus o'r rhwydwaith mewnol ac unrhyw wasanaethau cynnal cysylltiol.

**Roeddwn wedi cytuno i yrru nodyn ynglŷn â sut mae'r 'cloud' wedi cael ei dderbyn gan NWIS/ GGGIG.**

Dros y blynyddoedd diwethaf, mae'r diwydiant TG wedi bod yn troi tuag at ddarparu a defnyddio gwasanaethau cyfrifiadurol y 'cloud'. Mae hyn yn golygu, yn lle fod yr holl feddalwedd a chaledwedd cyfrifiadurol sydd yn cael ei ddefnyddio er mwyn darparu gwasanaeth TG yn eistedd tu mewn i rwydwaith sefydliad, bydd y cwsmer yn cael cynnig atebion yn rhannol neu yn gyfan gwbl gan gwmni arall ac fel rheol yn cael mynediad ato dros y we.



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Angerddol am wneud gwahaniaeth  
Darparu gwybodaeth a thechnoleg ar gyfer gofal gwell  
Passionate about making a difference  
Delivering information and technology for better care

Mae NWIS/ GGGIG wedi bod yn gweithio ar ddefnyddio gwasanaeth y 'cloud' am nifer o flynyddoedd. Rydym ar hyn o bryd yn cefnogi dros 10,00 o aelodau o staff drwy ddefnyddio gwasanaeth y cloud ar gyfer e-bost gyda Microsoft Office 365, cadw ffeiliau gyda OneDrive, Skype yn ogystal â gwasanaethau eraill. Mae hynny yn cynnwys holl staff Meddygon Teulu, holl staff NWIS/GGGIG a hefyd o gwmpas 250 o ddefnyddwyr yn yr Ymddiriedolaeth Gwasanaeth Ambiwylans Cymru. Mae rhai LHBs hefyd yn gweithio gyda PowerBI (Gwasanaeth Cyd wybodaeth Busnes). Yn ychwanegol, mi fydd y defnyddwyr Addysg a Gwella Iechyd Cymru yn defnyddio Office 365.

Mae un o ddarparwyr systemau meddygon teulu GIG Cymru (Microtest) yn defnyddio 'UKCloud' (<https://uk.cloud.com/>) er mwyn cynnal systemau ar gyfer ei feddygfeydd. Mi fydd meddygfeydd meddygon teulu yn cael eu mudo yn ystod 2019 a 2020.

Yn ychwanegol i hyn, rydym wedi bod yn gweithio gyda Microsoft, ein hail werthwyr Microsoft a sefydliadau GIG Cymru dros y 18 mis diwethaf er mwyn rhoi systemau craidd yn eu lle i alluogi GIG Cymru i ddefnyddio'r gwasanaethau 'cloud', Infrastructure as a Service (IaaS) a Platform as a Service (PaaS) gan Microsoft Azure. Mae'r gwaith hwn yn cynnwys:

- Sefydlu'r drefn lywodraethol angenrheidiol ar gyfer cadw a phrosesu gwybodaeth sensitif (e.e. Gwybodaeth Adnabod Cleifion) o fewn y 'cloud'. Mae yno ddogfen o'r enw "NHS Wales guidance: Cloud Services" wedi cael ei ddatblygu gan GIG Cymru, yn gysylltiedig gyda Llywodraeth Cymru, ac wedi ei gymeradwyo gan Fwrdd Rheolwyr Gwybodeg GIG Cymru yn Ebrill 2018.
- Dylunio'r strwythur o fewn y denantiaeth Microsoft Azure GIG Cymru i alluogi sefydliadau unigol GIG Cymru gael rheolaeth dros rwydwaith eu hunain a'r gwasanaethau maent yn eu defnyddio.
- Trefniadau bilio- i alluogi sefydliadau unigol i dalu am eu defnydd o wasanaeth Azure.
- Sefydlu cysylltiadau rhwydwaith cadarn o Rwydwaith Lleoliadau Eang GIG Cymru i mewn i Microsoft Azure. Er mwyn sefydlu'r cysylltiadau yma roedd rhaid ail beiriannu rhannu o isadeiledd y rhwydwaith, ac mae'r holl waith yno wedi ei gwblhau.

Mae defnyddio'r gwasanaethau 'cloud' yn fuddiol iawn i GIG Cymru. Ond, mae yno rhai heriau sydd angen eu hystyried, yn cynnwys;

- Ariannu - mae gwasanaethau 'cloud' yn cael eu hariannu gan refeniw, a chaledwedd TG yw un o'r prif bethau sydd yn cael ei brynu gyda chyfalaf busnesau yn bresennol. Bydd hyn yn golygu fod angen newid sylweddol yn y proffil ariannu, sydd yn rhan o'n hasesiad ni ar gyfer unrhyw ddefnydd yn y dyfodol.
- Cynnydd mewn Rheolwyr. Os nad yw'n cael ei reoli yn drefnus, gall gwasanaethau isadeiledd 'cloud' greu costau uwch na'r costau bysai'n cael eu creu wrth redeg systemau ar safle. Mae hyn hefyd yn gofyn i raglenni cael eu creu er mwyn gallu cynnal y gofyniadau.



- Nid yw rhai systemau yn addas ar gyfer cael eu rhedeg o fewn y 'cloud' oherwydd y dechnoleg sydd yn cael ei ddefnyddio, er enghraifft, hen systemau cronfeydd data a rhaglenni sydd ddim wedi cael eu dylunio i allu cael eu defnyddio o fewn y 'cloud'; hefyd mae lefel perfformiad, hydwythdedd ac argaeledd rhai rhaglenni yn eu gwneud yn anaddas ar gyfer cael eu defnyddio ar y 'cloud'.

Fel y soniwyd uchod, mae GGIG wrthi yn adeiladu'r isadeiledd craidd angenrheidiol yn Microsoft Azure ac yn llywio rhan o 'Infrastructure as a service' (IaaS) o fewn y 12 mis nesaf. Yn fwy cyffredinol, allai defnydd o'r cloud gael ei ystyried fel opsiwn ar gyfer prosiectau/ meddiannau yn y dyfodol, ond fydd hynny yn gofyn am symudiad o gyfalaf i mewn i gyllid, yn ogystal â pharodrwydd darparwyr i gynnig meddalwedd fel gwasanaeth yn y dyfodol.

Bydd dechrau defnyddio gwasanaethau'r cloud yn adlewyrchu ymateb mesuredig i'r problemau a risgiau uchod.

**Wnes i gytuno i yrru nodyn ynglŷn a'r dadansoddiad gafodd ei wneud ar gyfer y costau oedd yno i newid y meddalwedd CaNISC a'i redeg ochr wrth ochr â ddiweddarau y caledwedd materol.**

#### Costau newid CaNISC

Achos busnes "System Gweinyddu Cleifion Cymraeg yn Velindre" Canolfan Cancr Velindre ac achos busnes Rhwydwaith Cancr Cymru "System Gwybodaeth Cancr" (yn datblygu) yn cefnogi amnewidiad CaNISC. Mae'r ffigyrau yn y tabl isod wedi cael eu tynnu o'r achosion busnes yma; mae nhw'n dynodi y costau disgwylidig presennol a byddent yn cael eu newid wrth i'r prosiect ddatblygu.

		18/19	19/20	20/21	21/22	22/23	Cyfanswm
Cyfnod 1	VCC WPAS	1,115	736	0	0	0	1,851
Cyfnod 2	Cofnodion Electronig Cleifion**	0	1,099	456	399	0	1,954
Cyfnod 3	Datblygiad gallu gweithredol	TBC	TBC	TBC	TBC	TBC	TBC
<b>Cyfanswm</b>		<b>1,115</b>	<b>1,835</b>	<b>456</b>	<b>399</b>	<b>0</b>	<b>3,805</b>

\*\* Costau dangosol cynnar

Mae Ysgrifennydd y Cabinet wedi cymeradwyo achos fusnes "System Gweinyddu Cleifion Cymraeg yn Velindre" Canolfan Cancr Velindre ac mae GGIG/ NWIS yn gweithio gyda Rhwydwaith Cancr Cymru a'r Grŵp Gweithredu Cancr er mwyn gorffen yr achos fusnes ar gyfer y Cofnod Cleifion Electronig cyn ei anfon i Lywodraeth Cymru.





Mi fydd costau sydd yn cael eu dangos yn y tabl fel TBC yn cael eu datblygu wrth i fanylion ar gyfer y gwasanaethau gael eu cadarnhau gan hapddalwyr a pan fod modd i asesiad llawn o'r opsiynau er mwyn eu cwblhau gallu cael ei wneud.

### Costau tagfa diweddarau rhwydwaith y ganolfan ddata

Mae GGIG/ NWIS yn amcangyfrif mai cost diweddarau hen rwydweithiau yn y ddwy ganolfan fydd oddeutu £5.5 - £6 miliwn. Mae hynny yn cynnwys cost y pecynnau eu hunain, a hefyd gwella'r gwasanaethau sydd eu hangen er mwyn eu rhedeg, er enghraifft diogelwch ar lein.

Yn gywir,

Andrew Griffiths  
Prif Swyddog Gwybodaeth  
Cyfarwyddwr Gwasanaeth Gwybodeg GIG Cymru

Atodiad 1

Call	Logged	Title	Type	Service	Status	Summary of Cause
3903631	06/01/2018 18:35	OOH LIMS Support	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	A combination of defragmentation, synchronisation and purging occurred at the same time causing the servers to freeze. A restart of the affected servers restored access
3941086	24/01/2018 15:50	Data centre issue	Service Unavailable	Network Services	Closed	An error in the configuration of the network firewalls was the root cause, triggered by a routine application of a firewall rule. The supplier implemented a number of changes to the configuration which restored service
3955814	31/01/2018 13:30	canisc	Functionality Issue	Canisc	Closed	A number of issues with the configuration of the Citrix environment were identified as the root cause to this outage.
3957025	01/02/2018 08:42	Canisc - unable to launch	Functionality Issue	Canisc	Closed	A number of issues with the configuration of the Citrix environment were identified as the root cause to this outage.
4058623	21/03/2018 15:47	ESC Email/intranet unavailable	Service Unavailable	Hosted Messaging Services	Closed	The suppliers investigated the log files to try to identify the root cause of this incident, and were unable to determine or recreate in their environments. The Impacted devices were stopped and restarted which restored service
4074744	29/03/2018 15:43	TCL unresponsive	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	There was insufficient capacity in the Citrix environment to be able to successfully manage a manually run backup. This caused the system to freeze and users to lose access. A reboot of the impacted servers, and the supplier issuing a number of thaw commands to the backup restored service
4106391	17/04/2018 12:21	Storefront unavailable	Service Unavailable	Canisc	Closed	An issue with the Citrix configuration meant that some user sessions failed as one from a pair of servers was unavailable. A restore of the correct configuration was applied which restored access
4123288	24/04/2018 16:54	Unavailability of Network	Functionality Issue	National Data Centres	Closed	it was identified that there was a corruption of the configuration of a switch which prevented access to systems. The configuration was restored which resolved the issue
4134166	30/04/2018 13:20	ESC Canisc - General Issue	Functionality Issue	Canisc	Closed	An unexpected shutdown of a server was identified as the root cause. When the server restarted automatically, manual intervention was then required to restore service
4134837	30/04/2018 15:25	TrakCare LIMS	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	A 'Write Daemon' issue with the WLIMS servers caused the system to freeze. A reboot of the servers was required, which restored service
4141650	03/05/2018 07:45	starts up then closes down straight away	Functionality Issue	Canisc	Closed	Following a planned failover, a number of configuration issues were identified with the secondary servers which prevented access to the system for some users. Changes to the configuration were made to mirror the production service which restored access.
4161255	14/05/2018 12:10	ESC Functionality Issue	Functionality Issue	Laboratory Information Management System (LIMS)	Closed	The services failed due to a temporary storage location being filled up after a Change was made against a biochemistry test set. A removal of all of the reference ranges applied as part of the change was undertaken which restored service
4166115	16/05/2018 07:40	canisc down? message telling me file doesn't exist	Service Unavailable	Canisc	Closed	A failure of a number of Citrix servers following a SQL blip were identified as the root cause, which caused some users to be unable to access the system. Disconnecting those affected users, and getting them to reconnect restored access
4167272	15/05/2018 11:25	ESC LIMS has reached concurrent application limit	Service Unavailable	Laboratory Information Management System (LIMS)	Closed	The Citrix servers ran out of capacity meaning the the servers were running at 100%, and subsequently failing. All users sessions were ended on the impacted servers, and the servers were restarted which restored access
4169168	17/05/2018 08:36	Canisc slow and appears unstable	Functionality Issue	Canisc	Closed	An ongoing issue with storage, and the rollout of a security patch, impacted the system, causing performance issues and loss of access. Re-applying the security patch across the entire Canisc infrastructure, and undertaking changes identified by the supplier on the storage network restored service
4229394	17/06/2018 05:35	OOH LIMS Support	Unclassified	Laboratory Information Management System (LIMS)	Closed	Following a planned failover of the WLIMS system, an issue with the Journal which impacted the WLIMS database. A fix was applied by the supplier which restored access
4232870	18/06/2018 18:10	OOH LIMS Support	Unclassified	Laboratory Information Management System (LIMS)	Closed	Following a planned failover of the WLIMS system, corruption of an index master table impacted user access. A rebuild of the master table by the supplier restored access
4271736	07/07/2018 08:35	OOH LIMS Support	Unclassified	Laboratory Information Management System (LIMS)	Closed	A configuration issue was identified by the supplier where the server settings in one data centre did not match those in the second data centre. These were reconfigured to match and access to the service was restored
4283261	13/07/2018 09:19	Canisc - General Issue	Functionality Issue	Canisc	Closed	The deployment of an anti-virus patch which blocked access to around 200 servers across the National Data Centres was identified as the root cause. The patch was uninstalled and access to service was restored
4284620	13/07/2018 13:25	CANISC ERROR HANDLER	Functionality Issue	Canisc	Closed	The SQL database failed over to the secondary server. Root Cause investigations identified that this was mistakenly failed over, following maintenance work which was being undertaken on a similarly named management server. Restoration of the server and a failover was undertaken to restore service
4303277	24/07/2018 07:20	Users cannot access Canisc	Functionality Issue	Canisc	Closed	It was identified that the Citrix Listener was offline, causing the SQL databases to lose synchronisation. A reboot of the node restored access to the listener, and then a manual synchronisation of the databases restored access to users

**Grwp yr Economi, Sgiliau a Chyfoeth Naturiol  
Economy, Skills and Natural Resources Group**

**Cyfarwyddwr Cyffredinol - Director General**



**Llywodraeth Cymru  
Welsh Government**

Nick Ramsay AM  
Chair  
Public Accounts Committee

15 August 2018

Dear Chair

I am responding to your letter of 18 July in which you requested clarification of our response to a number of the recommendations in the Committee's report on the Welsh Government's initial funding of the Circuit of Wales project. I will address each of your points in turn.

I can confirm all of the recommendations within the Committee's report were accepted. In your letter, you specifically highlight our response to Recommendation 3, subsequently revised to Recommendation 1. This recommendation contains a number of elements. While I am content that there are appropriate controls in place to evidence value for money for the majority of our projects, I do accept that controls need to be strengthened to ensure value for public money in specific circumstances – for example, projects where contracts have not been exposed to competition or where payment is not dependent on delivery. This would include projects where there are linked companies or retainers being paid. We will take action to strengthen specific controls in those instances.

We have already implemented increased controls for funding provided via the Business Finance grant and raised the importance of checking linked companies when providing funding.

**Escrow Account**

You have asked about the timing of Welsh Government actions to recover the funds placed in the escrow account for the purchase of land.

Parc Cathays/Cathays Park  
Caerdydd/Cardiff  
CF10 3NQ

The escrow deposit issue was highlighted in the AGW's report in April 2017 and lead officials were subsequently requested to investigate whether funds could be recovered by Welsh Government, either from the escrow account or Heads of the Valleys Development Company (HOVDC). At that time, the project remained a live proposal and the developers had ambitions to deliver the project without Welsh Government support. As such, and as the contract between HOVDC and the Marquis of Worcester for the land purchase was not due to expire until the end of December 2017, Welsh Government did not consider it appropriate to pursue any recovery action at that point.

In June 2018, officials requested the formal contract for the purchase of the land from Geldards in order to clarify the position regarding the escrow account. Geldards were the lawyers undertaking the legal due diligence on the Circuit of Wales project on behalf of Welsh Government.

The contract was provided to officials by Geldards in late June 2018. At that time, Geldards also informed Welsh Government officials the entire contract had been shared by HOVDC in February 2016, as part of a large volume of documents placed in an electronic data room in order to facilitate the legal and technical due diligence of the project. Although the contract between HOVDC and the Marquis of Worcester was included in this data room, it was only accessible by a limited number of people in order to maintain commercial confidentiality. Welsh Government officials with access were not aware the contract was amongst the documents provided.

The content of the contract for the purchase of the land was reviewed by officials on its receipt from Geldards in June 2018. The contract refers to an initial payment of £200,000 from the buyer (HOVDC) to the seller (Marquis of Worcester), £100,000 of which was released immediately to the seller, with the balance of £100,000 to be held in an escrow account by the seller's conveyancer until completion of the deal or the end of the contract period. The contract states that the seller has no liability to repay the monies held in escrow except in the event of seller default. As HOVDC were unable to complete the purchase by the end of December 2017, the contract lapsed and the seller's solicitor released the remaining £100,000 to the seller as required by the contract.

We have taken legal advice on this matter which confirms that £200,000 was expended in relation to the acquisition of the land, that payments were in accordance with the purchase contract, that the initial payment of £100,000 was not refundable in any circumstance and that the further £100,000 held in the escrow account would not have been repayable to HOVDC other than in the event of seller default, which did not occur. On that basis, neither the £200,000 nor any part of it is repayable to HODVC or subsequently, to the Welsh Government. Delay in dealing with this escrow issue did not therefore adversely impact on the Welsh Government's ability to recoup the funding.

The points made in the AGW's report about returnable deposits are still accurate but the detail of the entire contract provided by Geldards in June 2018 increased the understanding of both

Welsh Government officials and Wales Audit Office staff. Having seen the contract, it is now understood that the deposit was repayable only in the event of a seller default, not a buyer default.

The contract was not provided to the Welsh Government officials who provided oral evidence to the Committee in June 2017, and they were not aware that the document had previously effectively been made available to the Welsh Government in the data room. The information provided by Welsh Government officials to PAC at the evidence session in June 2017 was given in good faith and there was no intention to withhold evidence or mislead the Committee.

Legal advice has also been taken as to whether any of the Property Development Grant (PDG) could be clawed back by the Welsh Government but no grounds have been identified for doing so.

Welsh Government accepts that the full contract for the purchase of the land should have been obtained from HOVDC and recorded prior to any payment of the PDG. Lessons have been learnt from this investigation and increased controls will be implemented when escrow is used to ensure all appropriate evidence is obtained from funding recipients in a timely manner, so that we have a full understanding of the agreement to which it relates and ensure funding conditions provide for appropriate recovery.

### **Recommendation 6**

You asked for the number of instances there have been in recent years in which officials have raised concerns about instructions from authorising officers to make payments. Following the debate in the chamber on 11 July 2018, the Cabinet Secretary for Economy and Transport issued a letter, dated 27 July, to you on this topic. A copy of the letter is attached (Annex 1) and details the processes available for officials to raise concerns of this type. The whistleblowing process was reviewed and strengthened in 2015/16 to increase the robustness of the process. The table below details the number of cases considered by the whistleblowing process since 2015/16.

<b>Financial Year</b>	<b>Number of cases considered</b>
2015/16	4
2016/17	6
2017/18	4

### **Recommendation 13**

You asked about the degree of security the Welsh Government is expecting to achieve to safeguard its £7.3m debt from HOVDC arising from the Welsh Government loan guarantee.

The Welsh Ministers currently have a fixed and floating charge over the assets of HOVDC and all its subsidiaries. HOVDC has entered into a Company Voluntary Arrangement (CVA) with

its non-secured debtors and has insufficient assets to enable the Welsh Government to recoup its debt. The debt to Welsh Government is estimated to be £12.62m in July 2018. It is likely that Welsh Government will only be able to recoup a very small proportion of the debt if the status of the company remains unchanged.

To date, no formal request has been received from any prospective developers to release our security from HOVDC. If such a request was to be received, then the Welsh Government would expect either a significant financial contribution or a financial stake in the organisation requesting release of the security. Due consideration would be given to the type of financial stake offered, its status and priority relative to other investors and creditors, and the implications for the level of security provided to the Welsh Government. In such circumstances, expert advice would be sought.

Yours sincerely



**ANDREW SLADE**  
Director General  
Economy, Skills and Natural Resources

**Ken Skates AC/AM**  
Ysgrifennydd y Cabinet dros yr Economi a Thrafnidiaeth  
Cabinet Secretary for Economy and Transport



Llywodraeth Cymru  
Welsh Government

Nick Ramsay AM  
Chair  
Public Accounts Committee

27 July 2018

Dear Nick

I am writing following the debate in the chamber on 11<sup>th</sup> July on the Public Accounts Committee's report on the Welsh Government's initial funding of the Circuit of Wales project.

In my response I agreed to write to you with further information with regard to Recommendation 6 of the report outlining how many instances there have been in recent years where concerns about instructions from authorising officers to make payments have been raised, and some explanation of how these processes have proven to be robust.

Staff have a number of options of how to raise concerns should they arise, starting with their own line manager. If the member of staff does not feel comfortable raising concerns with their own line manager and wishes to proceed on an informal basis then they can discuss the matter further up the management chain, with an HR or Finance Adviser, with their Trade Union representative or with the Director of Governance, HR Director or Finance Director.

The Welsh Government also has a formal Whistleblowing Panel where concerns can be raised via one of the nominated officers of the Panel. The Whistleblowing policy and processes are regularly reviewed to ensure that they are robust and comply with the Public Interest Disclosure Act 1998.

Approaches to the Panel are recorded however we do not keep statistics on issues raised through informal channels. The Whistleblowing statistics are published annually in the Welsh Government Accounts (<https://gov.wales/about/civilservice/how-we-work/facts-figures/ourfinance/welsh-government-consolidated-accounts/?lang=en>).

**Ken Skates AC/AM**  
Ysgrifennydd y Cabinet dros yr Economi a Thrafnidiaeth  
Cabinet Secretary for Economy and Transport

Bae Caerdydd • Cardiff Bay  
Caerdydd • Cardiff  
CF99 1NA

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[Correspondence.Ken.Skates@gov.wales](mailto:Correspondence.Ken.Skates@gov.wales)

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

# Agenda Item 4.6

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/  
Prif Weithredwr GIG Cymru  
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/  
NHS Wales Chief Executive  
Health and Social Services Group



Llywodraeth Cymru  
Welsh Government

Nick Ramsay AM  
Chair  
Public Accounts Committee  
National Assembly for Wales  
Cardiff Bay  
Cardiff  
CF99 1NA

16 August 2018

Dear Mr Ramsay,

## Medicines Management

Thank you for your letter of 19 July seeking clarification on a number of issues set out in the Welsh Ministers' response to the Public Account Committee's report entitled Medicines Management.

I welcome the Committee's recognition of the good progress that has been made against many of the recommendations in the Auditor General for Wales' report of 2016. Regarding the specific issues you raise, I hope the Committee will appreciate that on this occasion there were a small number of recommendations where, whilst we agree with the intention of the recommendation, we reject the specific course of action favoured by the Committee. The decision to either accept or reject these recommendations was finely balanced and I am therefore pleased to have the opportunity to provide clarification on the specific points in your letter.

I trust the additional information in Annex A clarifies the position in relation to the particular recommendations you highlight.

Yours sincerely

**Dr Andrew Goodall**

cc: Andrew Evans, Chief Pharmaceutical Officer, Welsh Government  
CGU Mailbox  
Cabinet Mailbox



## Annex A

### **Clarifications relating to the Welsh Ministers' response of 2 July 2018, to the Public Accounts Committee report Medicines Management**

**Recommendation 1:** The Welsh Government produce an annual report detailing information on improvements in medicines management across all Health Boards to increase accountability and ensure the profile of medicines remains high on the agenda of Health Boards.

It was our interpretation that this recommendation stemmed from recommendation three of the Auditor General for Wales' report which concluded "*prescribing and medicines management need a higher profile within health bodies*". In our response we wholly supported the view that the Board of every health body in Wales should regularly scrutinise all aspects of medicines management.

It is apparent from the Committee's recommendation that we are entirely agreed on the desired outcome, Boards of health bodies being more accountable for delivering improvements in medicines management; for this reason we accepted the Committee's recommendation. I understand in accepting the recommendation our response which goes on to decline to produce a Welsh Government report on medicines management, may give the impression we do not accept the recommendation. I can assure you this is not the case. Our intention is to raise the profile of medicines management issues at a Board level. We consider the most appropriate way to achieve this is to improve the existing All Wales Medicines Strategy Group (AWMSG) annual report, by broadening the content and producing individualised health board reports information, ahead of publication of the 2018-19 annual report.

**Recommendation 4:** The development of a database to quantify the numbers of pharmacists and pharmacy technicians working in Wales, and to help plan their training requirements.

From October 2018, the planning for workforce needs in the health sector will be the responsibility of Health Education Improvement Wales (HEIW). To achieve this, HEIW will need to maintain and develop intelligence and information regarding the health workforce, including data relating to pharmacists and pharmacy technicians.

In establishing HEIW it is implicit the Welsh Government is committed to an improved, strategic approach to planning and commissioning of the future workforce. Our response to the Committee relates therefore to the specific recommendation to develop a database. It will be a matter for HEIW to determine how it discharges its functions which may be through new systems or be based on the existing databases referred to in the Welsh Ministers' response to the Committee.

**Recommendation 7:** The use of smart packaging technology to permit the safe re-use of unopened medicines, and reduction in wasted medicines.

We are pleased the Committee recognises the legitimate challenges associated with the reuse of medicines. Please accept my apologies if our response seemed dismissive of the issue, I can assure you medicines waste is a matter we take very seriously and health boards already have local policies and procedures in place to maximise the reuse of medicines within the controlled environment of hospitals in Wales.

We like the Committee, recognise there have in recent years been increasing calls for returned medicines to be reused and we appreciate that on face value reusing medicines may appear to be a solution to the problems of returned medicines. We would dispute that our response is *largely silent* on the matter of medicines waste.

Medicines waste is a complex issue, whilst it most obviously manifests itself as medicines returned to pharmacies. There is likely to be far greater waste in the form of hidden opportunity costs associated with unnecessary prescribing and dispensing and the suboptimal management of disease leading to avoidable morbidity. The Welsh Ministers' response of 2 May commits the Welsh Government to:

- Increasing the accountability of Boards for the effective use of medicines across all NHS bodies;
- Deliver a national campaign to raise public awareness of medicines management issues including waste;
- Reduce the over-prescribing of medicines known to have limited clinical value; and
- Reduce the over-ordering of prescriptions through the production of a compendium of best practice in repeat prescription ordering, including ordering by care homes.

These actions set out in the Welsh Ministers' response to recommendations 1, 2, 11 and 12, as well as our continuing commitment to include clinical pharmacists as an integral part of the general practice teams are a response to the root causes of medicines waste.

**Recommendation 5:** Evaluation of cluster pharmacists specifically in relation to funding models and recruitment.

We fully agree there is merit in the sharing of learning and good practice within and between health boards. General practice based clinical pharmacists from across Wales are given the opportunity to meet regularly to share best practice through a community of practice established and overseen by Public Health Wales' 1000 Lives Improvement Service.

The role of Welsh Government and health boards is to ensure primary care clusters deliver improvements in the health and wellbeing of the citizens they serve. Whilst this may include providing clear direction on the types of interventions and arrangements which are shown to be effective, it will be for clusters to determine the most appropriate delivery arrangements. The role of clinical pharmacists in GP practices supports improvement in the safety and quality of prescribing in primary care. Welsh Government will continue to measure such improvements using our developing suite of national prescribing indicators.

## **Other matters**

In relation to **recommendation 2**, we have agreed with all health boards that Cwm Taf University Health Board will lead the work on a campaign to raise public awareness of

medicines management issues. This work will be based around the most successful elements of the *Your Medicines Your Health* campaign. We are currently discussing the detail of the campaign and how progress and the benefits will be monitored. We now envisage preparatory work will be concluded in 2018-19 with the public awareness element being delivered in 2019-20. I will include further information in the update we have committed to provide in early 2019.

I can assure you Welsh Government officials are in frequent contact with the NHS Wales Informatics Service to progress the business case and action plan for e-prescribing as described in **recommendations 16 and 17**. When I attended the Committee on 6 March 2017, I outlined how the capital costs associated with implementing e-prescribing are likely to be substantial and will require prioritisation over other investments; it is in this important context we are committed to getting the business case absolutely right.

A further update on progress will be provided early in 2019.

# Agenda Item 4.7

Grŵp yr Economi, Sgillau a Chyfoeth Naturiol  
Economy, Skills and Natural Resources Group

Cyfarwyddwr Cyffredinol - Director General



Llywodraeth Cymru  
Welsh Government

Nick Ramsay AM  
Chair  
Public Accounts Committee

20 August 2018

Dear Chair

I am responding to your letter of 19 July in which you requested further information on the intra Wales air service.

While it is true the subsidy being paid to the current operator of the air service is greater than the subsidy paid to the previous operator, the comparison is not like-for-like, not least because the previous operator's business failed. Our visibility on the previous operator's costs, passenger revenues, overhead allowances and minimal profits suggest the level of subsidy being paid was too low to establish a viable service, on sustainable terms.

The current temporary contract was awarded on an emergency basis, and we do not hold an empirical estimate for the value of the premium being paid for the temporary arrangement. When the temporary contract was awarded to Eastern Airways, officials acknowledged that the increase in costs was largely the result of the short term nature of the rolling contract. However, in value for money terms, officials assessed that the increased cost of the temporary contract with Eastern Airways (compared to costs under the Van Air contract) would be lower than the expected increased costs of attempting to restart the PSO following a break in service. Previous experience had shown that a break in service would likely cause significant long term damage to the route, with a need to rebuild passenger numbers once again. In addition to this, as you have rightly pointed out, under the temporary contract Eastern Airways are providing for the use of a larger plane than the previous operator, with access to a more mature ticketing distribution network and improved passenger service.

We have now launched a full open procurement for the intra Wales air service and we are confident that this will allow the market to compete and respond appropriately to our competition. We do not as yet know how the subsidy cost per passenger under the new contract will compare to the current contract arrangements, or how future subsidy arrangements will be phased. These are details subject to the forthcoming tender and negotiation processes.

Parc Cathays/Cathays Park  
Caerdydd/Cardiff  
CF10 3NQ

Turning to the other information you have requested, the contract with Eastern Airways sets a maximum price cap of £90 per ticket with at least 60% of the total capacity of the aircraft to be sold at a maximum price of £60. Within those constraints, applied to retain the accessibility of the service for social travel purposes, the pricing strategy is a matter for the airline. We expect the current and future operators to work with us to continue to grow passenger numbers on the route.

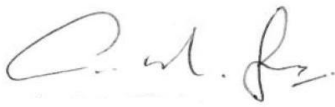
As part of the procurement for the new contract, bidders will be asked to demonstrate how they intend to market the service and this will be assessed during the evaluation. The much improved marketing currently being deployed by Eastern Airways demonstrates the positive impact on passenger growth an effective strategy can have.

Finally, I can confirm that Welsh Government has not yet published subsidy costs per passenger, as we indicated we would in responding to the Committee's previous report on the air service. I understand this was an oversight and will be corrected, with subsidy costs per passenger being published on the Welsh Government's website for the previous two years as follows:

	Total subsidy	Passengers	Subsidy per passenger
2016/17	£1.08m	10,039	£108
2017/18	£1.84m	13,845	£133

This information will in future be updated annually, alongside an assessment of the value for money of the service.

Yours sincerely



**Andrew Slade**  
**Director**  
Economy, Skills and Natural Resources

# Agenda Item 4.8



Llywodraeth Cymru  
Welsh Government

**Tracey Burke**

Cyfarwyddwr Cyffredinol / Director General

Y Grŵp Addysg a Gwasanaethau Cyhoeddus  
Education and Public Services Group

21 August 2018

Dear Mr Ramsay,

**Re: Public Accounts Committee follow up to meeting on 25 June: 21st Century Schools and Education Programme**

Thank you for your letter of 24 July 2018 in which you raised some issues for clarification following the scrutiny meeting on 25 June.

I am pleased to enclose a paper which provides a response to the areas outlined by the Committee which has been drawn together with input from colleagues across the Welsh Government.

I note your request for an update in January 2019 on Band B including the issues in this response and the Auditor General's recommendations, as well as an update on the Band A position at that point.

Yours sincerely

**Tracey Burke**  
Director General, Education and Public Services



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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

## WRITTEN RESPONSE TO THE PUBLIC ACCOUNTS COMMITTEE

### 21<sup>st</sup> CENTURY SCHOOLS AND EDUCATION PROGRAMME

#### Introduction

This paper provides an initial response to the letter from the Chair of the Public Accounts Committee of 25 June which details specific areas where the Committee would like some further assurance.

#### Mutual Investment Model

We note that the Committee's main concerns relate to the Mutual Investment Model (MIM). The Committee felt there was an inconsistency in evidence as to whether MIM was mandated for the Further Education sector, quoting Colegau Cymru as saying that, for larger projects, MIM was 'the only game in town'.

In response, we would strongly emphasise that capital remains an option for both local authorities and Further Education Institutions (FEI) for all large-scale projects, as we are investing some £1.8 billion of traditional capital funding in Band B (50% Welsh Government contribution and 50% from our delivery partners), which the MIM will complement, not supplant.

MIM has most certainly not been mandated. All stakeholders were given the option within their strategic outline programmes for Band B to choose whether they wanted to deliver their schemes via MIM or Capital. MIM is really only suitable for 100% new build projects of mainstream schools and FEI, due to the obligation on the contractor to design, build, fund and maintain the building over twenty five years.

In some instances, the MIM option has been chosen by stakeholders due to the fact that their capital budgets are constrained. In other cases, local authorities and FEI see the long term benefit in the ongoing maintenance and lifecycle provided under the MIM contract. In addition the 75% Welsh Government contribution for MIM is attractive to local authorities and FEI in comparison to the 50% Welsh Government contribution for capital and this goes some way to explain the large take-up of MIM by the Further Education sector.

We recognise that more work needs to be done to explain the approach and the potential benefits of the MIM to both local authorities and FEI that might wish to avail themselves of MIM funding. It is a model designed with additionality as its *raison d'être*. We would all wish for more capital, as the WLGA has pointed out in its evidence to you. But with the continued constraints on our capital budget by the UK Government, our choices are to live within that budget or to innovate and do more. We have chosen the latter. Should local authorities and FEI make the same choice – and the choice really is theirs – we will do all we can to help them make a success of their respective MIM schemes.

The Committee sought reassurance on three areas in relation to the MIM and whether it represents the best value in the round:

***The alternative options – capital and supported borrowing had been fully exhausted before embarking on a novel, risky and potentially more expensive model.***

On the question of whether capital and supported borrowing has 'been fully exhausted' - from a budgetary perspective, supported borrowing has the same effect as traditional capital. It is not additional. It therefore does not provide an attractive option for the pursuit of significant, additional investment in the Programme.

As the Cabinet Secretary for Finance has made clear in the Assembly, the Welsh Government will always use conventional capital first to fund public infrastructure, making sure to use every penny of it. Next, we use all the capital we get through the European funds which come to Wales. We will then make use of the new capital borrowing powers – our budget shows we will use all the capital borrowing available to us over the next budget period. We will then seek to enable investment by other bodies in Wales. When we have exhausted all the courses of action above, we still have major public needs that cannot be covered. This is exactly why we have devised the MIM – to do more.

In 2010, at the outset of the Programme, it was estimated that circa £5 billion was needed to get just the schools building stock up to good repair. The additionality of MIM enables us to accelerate £500 million of investment targeted, in the main, to the areas of greatest need (i.e. those buildings in the poorest condition) which would otherwise not happen for sometime due to the constraints of capital budgets.

In response to the comments that the MIM is 'novel' and 'risky', this is not a view shared by the Welsh Government. We advise that the MIM incorporates the best of the Scottish Non-Profit Distributing (NPD) model – such as optimum risk allocation, whole-life costing, and performance-based payments – while ensuring that new investment is classified to the private sector; and is therefore genuinely additional to investment from other public sources. Furthermore, the approach, which was market-tested at two major engagement events in 2017, is considered bankable by contractors and funders alike.

***That the Welsh Government as a whole has identified that the school building programme is the most appropriate programme for using the MIM. In particular, that there is a clear assessment that the Welsh Government's borrowing powers would not be better used for building schools and MIM for road building schemes, such as the M4 relief road.***

We can confirm that 'the Welsh Government as a whole has identified that the school building programme is the most appropriate programme for using the MIM', alongside completing the dualling of the A465 and redevelopment of the Velindre cancer centre. The schemes to be included in the MIM were agreed by Cabinet, prior to the launch of the model in the Assembly in February 2017.

***That there is an appropriate ‘pause and review’ moment. Over time, for understandable reasons, the original aspiration to use a form of the Non-Profit Distributing model has changed significantly. We would like assurance that as the details are finalised and before committing to going ahead, there will be an opportunity for reflection in the round as to whether MIM is indeed a good value for money method for building schools and colleges.***

We recognise the good sense of a ‘pause and review moment’ prior to proceeding with new and innovative ventures. We can assure you that we have taken many opportunities to pause and review developments with the MIM since the adverse Office of National Statistics (ONS) decisions on Scottish NPD schemes in 2015. We spent the following year developing the MIM, subjecting the model to peer review by experts at the European Investment Bank, subsequently submitting it to the ONS in October 2016. After receiving assurance that the model would be classified to the private sector, we paused again, as additional assurances were sought from Eurostat – a process which constituted more than a year of further review.

The process of review will not stop with Eurostat’s endorsement of the ONS decision. We want to continue to learn, and evolve the model. The Cabinet Secretary for Finance has said repeatedly that promoting the public interest and value for money must be at the heart of the MIM. The real test of value for money will be on the individual projects that we undertake – how efficiently we develop and procure them and manage the benefits over the long run. Our approach to these things will be tested rigorously through departmental review of each project’s business case, through independent government Gateway reviews, and through the Commercial Approval Point (CAP) checks that we have developed in Wales as an additional tier of constructive challenge to project teams.

## **Other areas**

The Committee also sought assurance in six areas - collaborative ethos, demand for places, energy performance, technical support, community benefits and active travel.

## **Collaborative ethos**

***Where there was a discrepancy between the WLGA evidence and that of Welsh Government. Would want to see that the joint working and collective ownership continues into Band B.***

The evidence from the WLGA acknowledges that the collaborative arrangement between Welsh Government, the WLGA and local authorities is, to date, one of the most successful examples of genuine co-construction and central-local relations.

We can assure the Committee that the WLGA’s role will continue in Band B in the same way as in Band A of the Programme, with representation on the Programme Board and involvement in policy decisions. The success of the Programme to date has been down its collaborative nature, as the WLGA commented in its evidence to

the Committee. We have no intention to erode this success by undermining the culture of collaboration.

However, as has been the case in Band A of the Programme, the Welsh Government will continue to make its own investment decisions for its contribution to the Programme as will local authorities and FEI.

## **Demand for places**

***We were not convinced on the responses we received around the flexibility of the programme to adapt to changes in the birth rate. In particular, we wanted to know whether the programme was factoring in technical solutions to the fabric of schools that mean they can build in flexibility – for example to open and close or re-purpose classrooms - as the demographics change.***

Anticipated increases or falls in the birth rate are highlighted as part of the advice on business cases for investment in terms of provision of school places. The 21<sup>st</sup> Century Schools and Education team also works closely with local authorities, to be aware of emerging trends.

In addition, local authorities already flex school configuration as demographics change. They employ various design techniques such as: removable partitions between rooms; learning streets to provide group space; and flexible library and IT facilities which can be reconfigured as needed.

Any technical advances in the construction industry, where appropriate, will be factored into the delivery of Band B. Any changes to the Programme's delivery will be done with the joint approval of the Welsh Government, local authorities and FEI. This is part of the collaborative ethos of the Programme.

## **Energy performance**

***We were not convinced that the Welsh Government understood the concerns on energy efficiency savings. Your evidence said you were good at specifying the savings up front but those specifications are not leading to the cost savings expected. We think there is a wider issue of the realism of the potential savings from energy efficiency that needs to be factored into plans up front. We would like to see the Welsh Government take a lead role in challenging the industry if industry specifications are not actually delivering the sorts of financial and environmental benefits you would like to see. The WLGA has suggested that MIM contracts would look to transfer risks associated with the energy efficiency of the design of buildings to the private sector and we would also welcome clarification of how the Welsh Government expects that risk transfer to work.***

The issue of energy efficiency is given serious consideration within the Programme and we commissioned a report giving details of how to avoid the performance gap.

The resulting Best Practice Guidance has been shared with delivery partners via our website and presented at a series of seminars with stakeholders.

Facilities delivered under MIM will be maintained by the private sector Contractor for 25 years. The MIM Education Project Agreement will contain provisions that ensure that the Contractor retains design risk for the energy performance of the building for the 25 year contractual term. Broadly speaking, the contract will allow for performance deductions to be made against the Contractor if a building does not perform efficiently. The full details of the strategy are currently being developed.

We are also monitoring energy reduction targets in stakeholders' post completion reports which are submitted approximately 18 months following project completion. Due to the long lead in time from project conception to completion the majority of these reports are yet to be received. In addition, the Programme has established a five-year evaluation process which seeks to gather feedback from completed school projects. This will be used to demonstrate the reduction in the performance gap over the five year funding period. The data will be monitored and lessons learned shared with all delivery partners.

The issue of energy performance is however, as much a matter of how buildings are occupied, managed and maintained as it is about design and build. We will request local authorities and FEI as asset owners to address this.

## Technical support

***We had evidence from the Design Commission Wales whose services are clearly not being used as they could be to support the delivery of the Programme. We would like the Welsh Government to rethink how it can make best use of the Design Commission to support the successful delivery of Band B alongside its consideration of the wider technical support that is needed. While you explained that the support that has been provided to date by Constructing Excellence Wales was for three discrete projects, members remain concerned about whether sufficient technical support will be available to support delivery of the Programme in the next wave. It is for the Welsh Government to decide who provides that support. However, we would welcome an update on your plans in the context of recommendation 10 in the Auditor General's report and taking account of the lessons learned from the impact of the technical support provided during Band A and any capacity/capability constraints in the organisations responsible for project delivery.***

We regularly review the need for and provision of advice and support to our delivery partners. Lessons from Band A will be fed into Band B. As we develop the MIM element of the Programme we are reviewing the expertise required to enable its delivery. We will provide an update on this support once the plans are developed.

We used the Design Commission to provide input at the beginning of Band A, and we intend to do the same for Band B. This is against the backdrop of increased standardisation in the Programme to achieve greater efficiencies. The Director

General for Education and Public Services met with the Chief Executive of the Design Commission for Wales in August to discuss the Design Review Service, understand the issues as they saw them, and consider opportunities and ways to renew the working relationship.

In addition, during the evidence session on 25 June, the Director General also undertook to discuss the position of Constructing Excellence in Wales (CEW) with Welsh Government colleagues.

CEW was established as a company limited by guarantee to promote improved efficiency in the construction industry, following the Egan report 'Rethinking Construction'. It is designed to champion collaborative working and best practice across the construction industry, encouraging individuals and organisations to share their experiences, knowledge and information with the wider construction industry.

Core funding has been provided to CEW by Welsh Government since 2003 with CEW being reliant on this funding to undertake a number of activities. In 2017, a decision was taken to cease grant funding to CEW from the end of September 2018. The current grant funding to CEW is to enable them to become more commercial in nature.

The previous work undertaken by CEW on 21<sup>st</sup> Century Schools was procured and CEW provided specific services to the programme. Moving forward, the services that CEW offers remain available to be procured competitively alongside other organisations.

## **Community Benefits**

***We welcome the commitment to community benefits. It is clear that there are complexities involved in making school facilities more available to the communities. We recognise that ultimately it is the governing body's responsibility. However, the Welsh Government and councils have significant leverage through the funding provided through the programme. We would like to be assured that the Welsh Government is using that leverage to full effect to ensure that wherever possible and feasible, schools funded from the programme make their facilities open to community use.***

Schools and colleges sit at the heart of the communities they serve and so we are working across the Welsh Government to maximise the use of school facilities by the community as part of *Prosperity for All*.

We have established a task and finish group that is looking at ways to overcome or remove barriers; to encourage the wider community use of educational assets; to disseminate best practice and funding.

We are also investigating potential changes to the grant award letter to make community use of facilities a more binding and sustained commitment.

Community benefits are wider than just community use of assets. For example, we ensure that during the construction phase of our projects we look at opportunities to create jobs, apprenticeships, training opportunities and STEM engagement with our schools.

## **Active travel**

***Active travel – we are not convinced that the Active Travel (Wales) Act 2013 is being given sufficient consideration. Your recent letter appears to acknowledge a need for greater scrutiny and challenge in this respect and we would ask for clarification of what this will mean in practice. If the Welsh Government can highlight specific examples where Active Travel opportunities have been maximised then we would be interested to learn of them. Similarly, examples of where poor consideration of active travel access in business cases has been addressed.***

We have updated our business case guidance to incorporate key messages with respect to active travel so that our partners consider this aspect carefully when developing their projects. This is tested during the business case assessment process when the cases are scrutinised by a wide range of policy areas within the Welsh Government; this includes input from the Active Travel team. Any questions or concerns raised by policy officials are referred to the delivery partner for additional information. Policy officials need to be satisfied that appropriate actions have been taken before the case is taken forward to the Cabinet Secretary for Education for consideration.

For example, in the last month, challenges to our delivery partners have included asking the local authority to actively explore how they could improve facilities for access on foot and by bicycle as part of the new project.



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Welsh Government

## Tracey Burke

Cyfarwyddwr Cyffredinol / Director General  
Y Grŵp Addysg a Gwasanaethau Cyhoeddus  
Education and Public Services Group

Nick Ramsay AM  
Public Accounts Committee Chair  
National Assembly for Wales  
Cardiff Bay  
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24 August 2018

## Welsh Government's Supporting People Programme

Dear Nick

I am responding to your letter of 30 July and am grateful for the opportunity to clarify matters you raise. For ease of reference, I will follow the format of your letter to order my response.

### **On Recommendation 1 – you sought further clarification regarding the delay to publishing guidance and its impact, as well as the timetable for fresh guidance should there be an integrated grant.**

Our original timeline for this work aimed for publication of the guidance in Spring 2018. A consultation exercise seeking comment on a draft of the guidance closed in August 2017 and a report of the key responses to the consultation questions and points raised at an associated workshop was published in March 2018. One particular issue raised during the consultation process required detailed consideration as to whether the issue could be addressed within the guidance.

I accept that the revised guidance could have been produced and published more quickly. However, the consultation exercise and subsequent work to revise the draft guidance coincided with work to establish the Flexible Funding Pathfinders. We felt at the time that the sector would be assisted by receiving clear messages about the significant structural change which was being tested through the Funding Flexibility Pathfinders before they received updated guidance which might be understood as a 'business as usual' approach to Supporting People. In order to avoid confusion we



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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

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prioritised the provision of guidance for Funding Flexibilities, given that this was a new approach and most stakeholders' questions were about how those changes affected them. As soon as pathfinders were established, our attention reverted to the Supporting People guidance which has now been finalised and published. We have remained in regular contact with Supporting People providers and commissioners to minimise the impact of this delay and ensure, in particular, that delivery was focused on the priority to prevent homelessness.

For the Committee's information, the revised guidance can be found below:

<https://gov.wales/topics/housing-and-regeneration/services-and-support/supporting-people/publications/sppgguide/?lang=en>

<https://gov.wales/topics/housing-and-regeneration/services-and-support/supporting-people/publications/sppgguide/?lang=cy>

Going forward, Ministerial decisions have not yet been taken in relation to a potential single grant and, consequently, we have not mapped out the timetable for publishing any related guidance. However, I understand the Committee's desire for reassurance, given the delay mentioned above. What I can say at this stage is that the grant integration work has been about delivering more of the aims and objectives of the 10 programmes that are within scope of the proposed Early Intervention, Prevention and Support (EIPS) Grant. What we are seeking to deliver will continue irrespective of any possible changes to the funding mechanism. As a result, the fundamentals of the existing programme guidance would largely remain unchanged if a single grant were to go ahead.

It may also provide some reassurance to the Committee if I outline the approach followed for 2018-19 for the pathfinders. Guidance relating to the single grant was developed with input from the pathfinder local authorities and other stakeholders during November and December. This guidance was issued to the relevant local authorities in January alongside their indicative grant offer letters. The specific guidance to support the EIPS grant in 2018-19 included a preliminary outcomes framework to help steer pathfinder local authorities in the development of their plans. Guidance relating to each of the programmes encompassed by the grant was not amended.

Should the decision be taken to develop a new single grant, it would continue to be a collaborative process with any new guidance being developed in conjunction with stakeholders.

## **On Recommendation 2 – you sought an explanation of how we are engaging with stakeholders to make their views known in an open environment.**

I was concerned to read your comments regarding the informal feedback received by Members of the Committee that some stakeholders have not felt able to raise their views with Welsh Government Officials. It is one thing for some stakeholders to hold differing views than us on policy or delivery approaches. It is quite another thing for some stakeholders to say they feel unable to raise those views.

As the Committee has noted, our approach to engagement has been extensive. We have heard from a diverse range of organisations with a wide range of views. These encompass stakeholders who would like to see all grants de-hypothecated and



transferred into the Revenue Support Grant, through to those stakeholders who view separate grants as an important safeguard to ensure that the priority attached to the related policy is not diminished.

Stakeholders have raised a number of concerns with us about the proposals for a single grant and I believe that we have responded to these in a constructive manner during this pathfinder phase. For example, we have considered and discussed potential safeguards that could be built into the arrangements for a single grant to address some of the potential risks posed. We are also considering the merits of alternative grant arrangements which might involve distinguishing between housing and non-housing programmes which has also been raised with us.

In addition to the engagement processes being undertaken by officials, Ministers have had extensive engagement with many organisations and delivery partners and there are frequent opportunities to discuss the possible new grant. In particular, Ministers are sensitive to the concerns of the housing sector. The Minister for Housing & Regeneration has attended the Supporting People National Advisory Board on two separate occasions, she has also visited a wide range of SP supported services across Wales talking to service users as well as providers and a number of Cabinet Secretaries and Ministers have had representations from the housing sector.

Supporting People providers also take part in the pathfinder group through a representative of Regional Collaborative Committees and take the opportunity to make their views known through the group.

So it is disappointing and concerning to hear you have received this informal feedback. As I hope you can see from the above examples, I can assure you that we welcome all contributions to the debate on the best way to support our most vulnerable citizens and we will continue to make that known.

### **On Recommendation 7 – you sought clarification of the reasons for our rejection of the recommendation and details of the extent of evidence about potential efficiencies available to support decision making**

I need to make clear that the ‘rejection’ of the initial recommendation should not be read to mean that we are not interested in evidence of savings that might be achieved through an integrated grant. Rather we believe that the work to develop that evidence is best led by local authorities and not Welsh Government. We will gather that evidence together through the mechanisms of our formal evaluation.

Local authorities have made the case to us that fewer grants would mean less bureaucracy. It is important to note, however, the driver behind funding flexibilities is to enable local authorities to work more innovatively to deliver better service outcomes. We are seeking to test a number of the assertions made by local authorities as we go through the pathfinder year and the financial aspect is just one.

We are keen to understand the evidence base around this area and have asked the Society of Welsh Treasurers to provide an evidence of potential efficiency gains. To understand the levels of potential efficiencies that might be made through a different way of working requires a level of detail about the inner workings of local government

that is not available to Welsh Government. However, we will continue to work with local government and the Society of Welsh Treasurers to establish the evidence base we are all seeking.

Additionally, we are also using the independent evaluation to establish an indication of the efficiencies that may be available for potential changes in ways of working.

**On Recommendation 8 – you sought further detail on how we expect the Regional Collaborative Committees (RCCs) to engage with the flexible funding pathfinders.**

As you know from our previous response, we are keen to learn from and build on progress to date in regional working by RCCs or indeed other regional working arrangements in place across other grants within the scope of the flexible funding pathfinder programme.

The guidance relating to the single grant that was issued to the pathfinder local authorities states that local authorities should “continue to engage with Regional Collaborative Committees in the same way as at present”. We expect that local authorities should continue to submit their assessments and plans to the RCCs and take part in the joint arrangements with other authorities as they have been doing to date.

We can also confirm the independent evaluation includes RCCs in the survey work to ensure their views are captured. We will continue to work with RCCs to ensure we identify best practice that can contribute positively within any new grant arrangements.

**On Recommendation 13 – you sought an indication of the relevant timescales for the actions and whether we expect an outcomes framework to be developed from the outset for any new integrated grant.**

An initial outcomes framework was developed to support the work of the local authority pathfinders and to guide their planning for 2018-19. This largely mirrors the individual outcome frameworks for the programmes that make up the single grant.

I acknowledge that this is very much a ‘work in progress’ and more needs to be done to develop an outcomes framework that could support the move to a single grant should that decision be taken.

The development of an outcomes framework should be an iterative process and depending on Ministerial decisions as to the future grant arrangements, we would look to consult more widely on a draft framework in order to seek views, and this engagement will include more detailed timescales.

We are undertaking a piece of work to build on the initial outcomes framework to understand the key outcomes for a single grant, and the indicators to support them. Wavehill who are evaluating the pathfinder local authorities are, as part of their evidence gathering, looking to provide us with information to assist with this. We anticipate that guidance and training will be in place to support consistent implementation of any new outcomes framework or monitoring arrangements from the outset.



I hope that my responses to your points have provided the additional clarification you and the Members of the Committee have sought. If additional information would be helpful, then please do let me know.

Yours sincerely



Tracey Burke



# Agenda Item 4.10



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**Maria Battle  
Chair**

31 August 2018

Mr Nick Ramsay AM  
Chair Public Accounts Committee  
National Assembly for Wales  
By email: [SeneddPAC@assembly.wales](mailto:SeneddPAC@assembly.wales)

Dear Mr Ramsay

## **Audit of Cardiff and Vale UHB's contractual relationships with RKC Associates Ltd and its Owner**

I write further to your letter of 25 April 2018 to provide you with an update on progress with the remaining actions.

### **Action plan progress**

At the time of last writing, 4 of the 26 actions contained within the action plan provided to the Committee were outstanding and one action was partially complete.

- Review of the procedures used to recruit Executive Directors and other Senior Managers – the Committee will recall from our previous correspondence that even though the review of the procedures was complete, the Recruitment and Selection Policy and Procedure needed amendment to reflect changes in practice and fully conclude this action. The learning from this incident was that at every level, the recruitment process should remain wholly transparent and objective. Also, there was a need to strengthen the process around senior appointments managed via the offices of the Chair and Chief Executive, to ensure compliance with processes and that satisfactory documentation is maintained.

The relevant documents have now been revised and were approved by the UHB's Strategy and Delivery Committee on 28 June 2018; they are enclosed for the Committee's perusal. The Policy now includes a clearly defined role for the Executive Director of Workforce and Organisational Development and/or the Director of Governance in supporting and advising the Chief Executive or Chair in the appointment of Executive Directors.

In addition, all interim or agency Executive posts are now considered by the Remuneration and Terms of Service Committee to ensure independent oversight.

- Full implementation of the no purchase order no payment system – the initial date set for completion of this action was extended to ensure that there were no unintended consequences to patients or impact on continuity of service. I am pleased to advise that the no purchase order no payment system was fully implemented in June 2018, this significantly reduces the risk of non-compliance with procurement processes as manual payments will not be processed.

The statutory compliance report continues to be provided at each Audit Committee to include our compliance with and exceptions to recruitment requirements, Standing Orders and Standing Financial Instructions.

- Development of an internal protocol providing a system for senior leaders to raise concerns – the enclosed Standard Operating Procedure (SOP) has been developed by the Working Group and sets out the system for all staff, including senior leaders, to raise a concern. The SOP was received and approved by the UHB Management Executive on 16 July 2018 and is now being disseminated throughout the organisation.

The SOP outlines the various routes via which staff can raise concerns, the Working Group recognised the importance of having multiple routes open to staff so that they feel they have a choice when raising concerns, and feel safe to do so. It also establishes a triage system to consider each concern received and the responsibility for management of the staff concerns process now sits with the Director of Corporate Governance who will receive the final outcome of each investigation to ensure an accurate audit trail and regular reporting to Board.

The Working Group continues to progress this important work and re-launch of the ways in which staff can raise concerns is set for September 2018. However we recognise the importance of maintaining communication and prominence of this message throughout the UHB if we are to improve this culture.

We continue to focus on embedding the Values and Behaviours we have set as organisation and all our communication platforms are utilised to keep the significance of the Values and Behaviours alive throughout the UHB. A series of events and promotional activity, supported by leaders in the organisation, has also taken place to demonstrate how we are practising the values day to day.

As an organisation, this is an ongoing commitment to supporting cultural change and enabling staff to work in an organisation where they feel valued, supported for the work they do, respected and feel that they are treated respectfully. As such the Values and Behaviour work is being introduced as a central theme to the Transformation and Improvement programme led by the Deputy CEO.

- Circulation of a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance – this is contained as a permanent message on the IT platform used by Board members to access their meeting papers. A pocketbook resource has also been developed so that key corporate governance principles, including the Nolan principles, are easily accessible to all UHB staff and this will be ready for dissemination in September 2018.

- Standing Financial Instructions and Standing Orders – revision will take place to reflect the model Standing Financial Instructions and Standing Orders being developed on an All Wales basis. I am advised by Health and Social Services colleagues at Welsh Government that a programme of work to take this forward will be agreed in November 2018.

A closure report with completed action plan will be presented to the December Audit Committee and I will share the same with the Public Accounts Committee. I will also advise the Committee of the outcome of the Internal Audit review of contracts, and NHS Counter Fraud Service Wales investigation of the two contracts referred to it once concluded.

Yours sincerely



**Len Richards on behalf of  
Maria Battle  
Chair**

Encs:

- Recruitment and Selection Policy and Procedure
- Standard Operating Procedure for Managing Concerns from Staff

<b>Reference Number:</b> UHB 416 <b>Version Number:</b> 1	<b>Date of Next Review:</b> 24 <sup>TH</sup> May 2018 <b>Previous Trust/LHB Reference Number:</b> part of UHB 220 (policy)
<b>RECRUITMENT AND SELECTION PROCEDURE (NON-MEDICAL STAFF)</b>	
<b>Introduction and Aim</b>  <p>The recruitment and selection of staff is a key responsibility for all Cardiff and Vale University Health Board (UHB) managers. This procedure supports the Recruitment and Selection Policy by setting out a fair, consistent and effective approach to the recruitment and selection process.</p> <p>By following this Procedure and the overarching Policy, recruiting managers can be assured that they are operating within the confines of current employment legislation, and they are able to avoid discrimination and recruit safely without putting the UHB or our patients at risk.</p>	
<b>Objectives</b> <ul style="list-style-type: none"> <li>• To ensure that recruiting managers and applicants are clear about their role and the role of other stakeholders in the recruitment and selection process</li> <li>• To ensure that recruiting managers and applicants are clear about the principles underlying the recruitment and selection processes</li> <li>• To support managers in appointing the best candidate for each position</li> <li>• To ensure that all necessary steps are taken before a new member of staff starts with the UHB</li> <li>• To promote the UHB Values and Behaviours and ensure that these are embedded into the recruitment and selection process</li> </ul>	
<b>Scope</b>  <p>This procedure applies to all managers and staff who are involved in the recruitment and selection of staff employed under Agenda for Change Terms and Conditions and any other employees except for doctors and dentists.</p> <p>Separate procedures apply when recruiting medical and dental staff. Advice on these procedures can be obtained from Medical Workforce.</p>	
<b>Equality &amp; Health Impact Assessment</b>	<p>An Equality &amp; Health Impact Assessment has been completed – this covers the Recruitment and Selection Policy and any accompanying procedures, including the Recruitment and Selection Procedure and Fixed Term Procedure.</p>

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	The EHIA found there to be a positive impact.
<b>Documents to read alongside this Procedure</b>	Recruitment and Selection Policy Recruitment and Selection Procedure for Medical and Dental Staff <a href="#">NWSSP Recruiting Manager Pack</a> Disclosure and Barring Service <a href="#">Policy</a> and <a href="#">Procedure</a> <a href="#">Secondment Policy</a> Fixed Term Contract Procedure <a href="#">Professional Registration Policy</a> <a href="#">Organisational Change Policy</a> Redeployment <a href="#">Policy</a> and <a href="#">Procedure</a> <a href="#">New and Changed Jobs Protocol</a> <a href="#">Supporting Transgender Staff Procedure</a>
<b>Approved by</b>	Employment Policy Sub Group
<b>Accountable Executive or Clinical Board Director</b>	Executive Director of Workforce and OD
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<b><u>Disclaimer</u></b> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the <a href="#">Governance Directorate</a> .	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	24/05/18	04/07/18	New document. Procedural elements were previously contained in the Recruitment and Selection Policy. Key changes are: <ul style="list-style-type: none"> <li>- applicants added to objectives</li> <li>- applicants responsibilities added</li> <li>- Section on values based recruitment strengthened and updated to reflect revised UHB Values</li> <li>- Reference made to the New and Change Jobs process. This must be followed whenever changes are made to a JD/PS</li> </ul>

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			<ul style="list-style-type: none"> <li>- Sessional work with a responsibility allowance added to exceptional posts which do not have to use NHS Jobs/Trac</li> <li>- Legal Framework (Appendix 1) updated and strengthened. Victimisation and harassment added.</li> <li>- Appendix 2 (starting salaries) updated to provide greater clarity. Reckonable service to be used to determine incremental credit for voluntary moves to a lower pay band.</li> </ul>
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## 1 RESPONSIBILITIES

**Applicants** are responsible for:

- Submitting an accurate and complete application
- Notifying the recruiting manager if they are unable to attend an assessment
- Providing the appropriate documentation to enable pre-employment checks to be undertaken

**Managers** must:

- Ensure that they follow this Procedure and adhere to the recruitment and selection principles set out in it
- Act in a way that ensures the organisation's recruitment, selection and appointment of staff is done in a fair, anti-discriminatory and safe manner, and that the UHB values and behaviours are considered as an integral part of the recruitment process
- Understand their role as appointing officer and the role played by Workforce and OD and the NHS Wales Shared Services Partnership (NWSSP) – Employment Services Team and ensure that those elements of the process that they are responsible for are completed thoroughly and in a timely way
- Seek advice from the Workforce and OD function before making an offer of employment if they are unsure about the appointment or starting salary

The **Workforce and OD function** is required to:

- Provide advice on the vacancy approval process and the appropriate documentation that must be submitted
- Provide advice on legislation and the principles that govern the recruitment and selection process
- Provide advice on starting salaries
- Ensure that managers have adequate information, guidance and support to fulfil their role in the recruitment and selection of staff
- Offer support and guidance to managers to help them meet the Disability Confident requirements
- Maintain close links with NWSSP to ensure compliance, quality and efficiency in all aspects of the recruitment and selection process

**NHS Wales Shared Services Partnership** provides recruitment services for all non-medical and dental appointments in NHS Wales. The Employment Services team within NWSSP is responsible for advertising and recruiting into vacant posts in a professional, timely manner and ensuring that all the required pre-employment checks take place.

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## 2 VALUES BASED RECRUITMENT

Values based recruitment (VBR) is an approach to help attract and select employees whose personal values and behaviours align with those of the Health Board values and behaviours. It is about enhancing existing processes to ensure that we recruit the right workforce not only with the right skills and in the right numbers, but with the right values to support effective team working and excellent patient care and experience.

VBR can be delivered in a number of ways, for example through pre-screening assessments, values based interviewing techniques or assessment centre approaches.

Within Cardiff and Vale UHB we have defined our Values as:

- Kind and Caring
- Respectful
- Trust and Integrity
- Personal Responsibility

## 3 RECRUITMENT AND SELECTION PROCESS

The UHB aims to work at all times within current employment legislation and best practice guidelines to ensure a fair and equitable recruitment process. At each stage of the recruitment process due consideration must be paid to the legal framework attached as Appendix 1.

All UHB employees involved in the recruitment and selection process have a duty to adhere to the principles set out below:

- 3.1** Before deciding to advertise a post, managers should be certain that a real vacancy exists and be clear about the requirements of the job. Like for like replacements should not be taken for granted. Consideration should be given to whether or not there is scope for modernisation or skill mix before replacing posts – when determining this managers may want to explore information from exit questionnaires, benchmarking, consultation with staff/trade unions and feedback from service users. If a skills mix is under consideration there should be a clear delineation of the differences in tasks between the new job and the old one.

Each job should have a written job description, person specification and KSF outline. These should be reviewed every time a vacancy occurs to ensure that they remain relevant and flexible, including making reasonable adjustments should people with disabilities apply.

Person specification should outline the genuine minimum requirements and, where appropriate, any genuine occupational qualification (GOQ – see Appendix 1) necessary for the job to be done effectively. Emphasis should be placed on quality

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rather than length of experience, and consideration should be given to experience gained outside of paid employment and using other suitable qualified, professions.

If any changes are made to the job description and person specification the New and Changed Jobs process must be followed to ensure that the changes have not affected the pay band of the post.

For further information and guidance please refer to Annex X of the Agenda for Change Terms and Conditions Handbook.

**3.2** When the manager is satisfied that the vacancy details and job description are correct they should submit this for approval. Posts cannot be advertised until the appropriate permission is obtained.

**3.3** All posts, including internal only posts, must be advertised via NHS Jobs or Trac recruitment. Jobs must not be advertised locally by email etc within a department.

The only exceptions to this must be part of a recognised organisation restructure in line with the Organisation Change Policy or sessional work with a responsibility allowance e.g. Clinical Director.

**3.4** Applicants must provide detailed information regarding their full employment history to date in all cases.

**3.5** All applicants will be shortlisted for interview on the basis of the information they provide on their application form. It is the responsibility of the appointing officer to oversee the shortlisting process to ensure that all decisions are based on the criteria set out in the person specification for the post and that the decisions are valid, justifiable and fair.

Candidates who do not meet all of the essential criteria should not be shortlisted. In situations where there is a high volume of candidates meeting the essential criteria, the recruiting manager can use the desirable criteria to produce a manageable number of candidates to interview.

In order to ensure a fair and transparent process, reasons for the selection or rejection of all candidates must be recorded.

Equal Opportunity Monitoring information is obtained from applicants and held by NWSSP but is withheld from the shortlisting panel, along with the names of applicants, and therefore does not impact on the shortlisting process.

**3.6** The UHB has signed up as a 'disability confident' employer. This means we actively look to recruit and attract disabled people, provide a fully inclusive and accessible recruitment process, offer an interview to disabled people who meet the minimum criteria for the job, and are flexible when assessing people so disabled job applicants

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have the best opportunity to demonstrate that they can do the job. We also proactively offer and make reasonable adjustments as required.

The UHB is Stonewall Diversity Champion and also supports the DWP Age Positive Campaign. This means that the UHB is committed to ensuring it does not discriminate on the basis of sexual orientation or age in its recruitment and selection processes.

As a Mindful Employer the UHB is committed to increasing awareness of mental health at work and offering a positive approach in the recruitment and retention of staff living with mental health issues.

- 3.7** All applicants must have a formal interview before an appointment can be made, This is essential as it provides an opportunity to discuss the candidate's application and employment history fully, and explore any areas of doubt or concern prior to an appointment being made. Any reasonable adjustments needed or criminal record disclosures can also be discussed at this time.

Discriminatory questions must be avoided (see Appendix 1 for guidance on the types of discrimination). To avoid discrimination during an interview, managers should bear in mind the following guidelines:

- candidates should not be asked about their marital status, family commitments and/or domestic arrangements, nor should they be asked about any actual or potential pregnancy/maternity leave
- ensure that questions focus on the applicant's ability to perform the role, not on potential difficulties he or she might have on account of an actual or potential disability
- frame questions in a positive way so as to avoid the risk of the applicant believing you are looking for or anticipating problems
- remember that there is no duty on applicants to voluntarily disclose a disability to a prospective employer and that it is unlawful to ask about an applicant's health (including any disability) before offering him or her a job, except in a limited set of circumstances
- don't place too much importance on length of experience as this will place younger applicants at a disadvantage. Instead, concentrate on the interviewee's type and breadth of experience, and their skills, competencies and talents.

- 3.8** Pre-employment checks seek to verify that an individual meets the preconditions of the role they are applying for. There are six NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions. All offers of employment are therefore conditional and subject to the following pre-employment checks (as applicable to the post):

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- Identity checks
- Professional registration and qualification checks
- Employment history and references checks
- Right to work checks
- Work health assessments
- Criminal record checks (DBS)

These checks are carried out by NWSSP Recruitment Services on behalf of the UHB, and must be completed before the new employee can start work.

**3.8.1** A reference provides a factual check of previous employment and should confirm information the applicant has already provided. There is legal requirement for references to be accurate and fair, with reasonable grounds to support any statements made. If a reference for a successful candidate is unsatisfactory advice should be sought from Workforce and OD before taking further action.

**3.8.2** Disclosure and Barring Service (DBS) checks are an important tool in ensuring safer recruitment practices and patient safety. The Disclosure and Barring Service (DBS) Policy and accompanying Procedure provide guidance on how requests for Disclosure must be managed, the levels of disclosure required and how to manage information provided by the DBS. Anyone involved in the recruitment and selection processes must familiarise themselves with this Policy and Procedure.

The employment of staff from abroad is subject to the same recruitment procedures as for UK staff, except that where an individual has worked outside the UK, they are responsible for obtaining a satisfactory Certificate of Good Standing from their local police force prior to commencement in the post.

**3.8.3** All staff are required to comply, at all times, with the relevant codes of practice and other requirements of the appropriate professional organisations e.g. NMC, HCPC etc. or the All Wales Health Care Support Worker (HCSW) Code of Conduct if they are not covered by a specific code through professional registration. It is the post holder's responsibility to ensure that they are both familiar with and adhere to these requirements.

#### **4 RECRUITMENT AND THE WELSH LANGUAGE**

The UHB is committed to providing quality healthcare through the medium of Welsh and Welsh language skills must be actively considered as part of the recruitment process.

Where Welsh has been identified as essential or desirable on the job description, posts must be advertised and recruited to on that basis, provided all other professional qualifications and experience are suitable.

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## 5 EVIDENCE REQUIRED TO MAKE A SALARY OFFER

Guidance on how to determine the applicant's starting salary is attached as **Appendix 2**.

## 6 INDUCTION

It is vital for line managers to prepare for how a new recruit is welcomed into their role and the UHB. Failure to do this can create a poor impression and undo much of the work which attracted the candidate to the job. As soon as the successful applicant accepts the job offer, managers should start to organise a carefully planned programme to settle them into the role, team and organisation, so they become effective as soon as possible, and want to stay. Managers should complete the local induction checklist as part of this process to ensure all mandatory elements are covered.

In addition, the Learning, Education and Development (LED) Department delivers a one day Corporate Induction Programme which is suitable for all new staff and which must be completed within 8 weeks of starting employment. Line Managers must ensure that new starters are given time to undertake this programme.

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## Appendix 1

### LEGAL CONSIDERATIONS

At each stage of the recruitment process due consideration must be paid to the legislation enacted to ensure the elimination of discrimination.

#### Discrimination

In law, four types of discrimination are defined:

- **Direct Discrimination** is treating someone less favourably than another in comparable circumstances e.g. not appointing a pregnant woman to a role because of financial concerns connected with covering the role during her absence due to maternity leave.
- **Indirect Discrimination** is where it was not the intention of the employer to discriminate against an employee, but nevertheless the outcome results in one group being disadvantaged in comparison to another, e.g. insisting on higher language standards than the necessary for safe and effective job performance would tend to disqualify people for whom English is not their first language.
- **Associative Discrimination** is where an individual is treated less favourably because they are associated with a person with a protected characteristic (e.g. a carer).
- **Perceptive Discrimination** is where an individual is treated less favourably based on a perception they have a protected characteristic when they do not.
- **Victimisation**  
Victimisation occurs when an employee is treated badly because they have made or supported a complaint or raised a grievance under the Equality Act; or because they are suspected of doing so. An employee is not protected from victimisation if they have maliciously made or supported an untrue complaint.
- **Harassment**  
Harassment is "unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual". Employees will now be able to complain of behaviour that they find offensive even if it is not directed at them, and the complainant need not possess the

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relevant characteristic themselves. Employees are also protected from harassment because of perception and association.

### **Genuine Occupational Requirement (GOR)**

This issue used to be known as a 'genuine occupational requirement' ("GOR") or a 'genuine and determining occupational requirement'. However, the Equality Act 2010 leaves out 'genuine' and 'determining' from the provisions. The Explanatory Note to the Act states that: *'The requirement must be crucial to the post, and not merely one of several important factors. It also must not be a sham or pretext.'*

Thus, it must still be genuine, even if it is not stated on the face of the Act.

A Genuine Occupational Requirement means that it is lawful for an employer to require a job to be done by someone with a particular protected characteristic, (in terms of their age, disability, gender reassignment/identity, race, religion/belief, sex or sexual orientation) if having this characteristic is an occupational requirement to fulfil a specific role, e.g. stating that a member of a particular racial group is required for a role in the provision of a service to that racial group. A GOR should be stated in the advertisement.

One example of a GOR is a peer support worker who is required to have a 'lived experience' of Mental Health or other services.

### **Equality Act October 2010**

The Act defines unlawful discrimination as less favourable treatment because of a protected characteristic. These are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race (includes colour, nationality and ethnic or national origins)
- Religion or Belief
- Sex
- Sexual Orientation

It should be noted that though not a protected characteristic, having caring responsibilities is also covered by the Act.

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## **Rehabilitation of Offenders Act 1974**

The aim of the Act is to prevent discrimination against those with previous criminal convictions. A conviction is classed as “spent” if there is no further offence committed after a specified period of time. The NHS is exempt from provisions of this Act, and applicants are required to declare all convictions, including “spent” convictions, on their application of employment.

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## Appendix 2 - STARTING SALARY GUIDANCE

### 1 Scope of Guidance

This guidance is intended to assist managers with the process of placing new staff on to the appropriate salary. It is to be applied to all new appointees (excluding Medical and Dental) who gain employment within the Health Board, where their last employment was:

- outside the NHS
- another NHS employer and they move to Cardiff and Vale UHB
- another post within Cardiff and Vale UHB

This guidance is to be used by all appointing officers within the Health Board. Additional advice can be sought from Workforce and OD.

### 2 Information for Appointing Officers

Potential employees must provide the appointing officer with evidence of their current salary **before** any offer of appointment can be made. Where possible, the evidence must be in the form of the employee's most recent payslip. The guidance on reckonable service and incremental credit (below) should then be used to determine the applicant's starting salary.

#### 2.1 New employees from outside the NHS

The expectation is that employees from outside the NHS will usually start at the bottom of the pay band and work their way up. However, employers have the discretion to take into account any period or periods of employment outside the NHS where these are judged to be relevant (reckonable service). If recognised, this will equate to one increment for each complete year of reckonable service which can be evidenced. The purpose of this assessment is to consider relevant reckonable service and not to consider 'matching' the existing salary.

Appointing managers will need to contact the Directorate Manager (or equivalent) and Head/Assistant Head of Workforce and OD as soon as possible following the interview if they wish to make a case to increase the starting salary of a new employee from outside the NHS.

Formal approval must be obtained from the Directorate Manager and Head/Assistant Head of Workforce and OD **before** a written or verbal offer of a salary above the bottom of the band is made to a candidate.

The appointing manager must be able to justify their decision on the basis of evidence such as application forms, references, previous job descriptions and

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payslips. Consideration will need to be given to any 'time lapse' in the relevant experience and the appropriate professional standards.

Any decision taken must also take into consideration the impact on other staff already in post in the department or similar staff grouping. Care must be taken to ensure that incremental credit in recognition of previous relevant experience only recognises completed years of experience at the level of the pay band. Incremental credit will not be awarded for part-years. If necessary, advice can be sought from Workforce and OD.

Incremental credit will not be given for reasons other than relevant experience. Where there are difficulties in recruiting because of market forces, a Recruitment and Retention Premium may be applied for.

It is the Manager's responsibility to ensure that the relevant paperwork is completed by all parties and sent to Payroll in a timely manner. If this does not occur, Payroll will automatically place the new employee on the minimum of the scale.

The incremental date will be the anniversary of their new appointment.

## **2.2 Employees who gain permanent promotion within the NHS**

Pay on promotion must be set at the minimum of the new pay band, or if this would result in no pay increase, the first pay point in the band which would deliver an increase in pay (by reference to basic pay plus any recruitment and retention premium, if applicable).

If on promotion, the working pattern remains substantially the same, staff will move to the first incremental point producing an increase when the basic pay, long-term recruitment and retention premium and the percentage enhancements for unsocial hours are combined. If the working pattern changes on promotion, pay should be set either at the minimum of the new pay band or if this would result in no pay increase, the first pay point in the band which would deliver an increase in pay.

The incremental date will be the anniversary of their promoted appointment.

## **2.3 Employees who gain temporary movement into a higher pay band and within the organisation**

The pay of employees who move into a higher pay band on a temporary basis will either be set at the minimum of the scale or if this would result in no pay increase, the first pay point in the band which would deliver an increase in pay.

Where temporary movement into a higher pay band results in only one extra

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pay point the incremental date remains the same. Where temporary movement results in more than one extra pay point the incremental date for the period of the temporary movement becomes the date the movement began.

#### 2.4 Employees who transfer to a new post on the same pay band

Employees who are already employed within the NHS and gain new employment on the same pay band will transfer on that point, retaining their incremental date.

If their previous employment was outside of NHS Wales and they were employed on different pay scale they should start on the nearest pay point which does not lead to financial detriment. Managers should be aware that this could potentially lead to new starters being on a higher pay point than other staff with the same number of years completed service. Advice on how to manage this situation can be sought from Workforce and OD.

#### 2.5 Employees who voluntarily transfer to a lower pay band

Moving into a lower pay band on a voluntary basis should not put an employee in a better position than other employees who have gained experience and are working in a similar role within the same discipline or speciality.

The pay point of employees who voluntarily move to a post in a lower pay band in the same discipline or speciality will be determined by an assessment of their relevant reckonable service. The incremental point paid on commencement in the lower pay band will be determined by the number of completed years relevant service achieved in that same pay band or higher band. It should not be based on the monetary value of the salary in the higher pay band.

##### Example

*If a Band 5 employee, paid on the **second** pay point, is promoted to a Band 6 but decides, after 12 months to apply for a Band 5 post, their 1 year service as a Band 6 would be taken into consideration for pay purposes. Accordingly, they would be re-appointed and paid on the **third** Band 5 pay point. If they had been in the Band 6 post for less than 12 months, they would be re-appointed and paid on the **second** pay point, but their incremental date will be amended.*

#### 2.6 Employees who move to a different post as a result of Organisational

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## **Change**

Employees who are required to move to a different post which incurs a detrimental change of salary as a result of organisation change will be entitled to protection of earnings as set out in the NHS Wales Organisational Change Policy.

### **2.7 Employees re-joining the NHS after a break in service**

Where an employee is re-joining the NHS after a break in service of 12 months or less, they will be allowed to retain the incremental pay point in their previous Pay Band if they are re-joining the same pay band as they occupied before the break in service.

If the break was for less than 3 months and they are re-joining the same pay band they will also be able to retain their incremental date (deferred by the number of days break). However, if the break in service has been for more than three months their incremental date will be the anniversary of the date they re-joined the NHS.

Where an employee is re-joining the NHS after a break in service of more than 12 months, the reckonable service provisions outlined in section 2.1 will apply.

## **3 Confirmation of previous salary from another NHS Organisation**

An inter-authority transfer will be undertaken by Payroll to confirm existing/previous NHS service if the new member of staff transfers from another Health Board, Trust or Health Authority. The inter-authority transfer will also confirm previous salary, sickness absence and parental leave. In the interim, if the individual transfers on the same pay band or receives promotion to the band above, a copy of the last NHS pay slip can be used to confirm the starting salary for Payroll before the inter-authority transfer is received. A copy of this pay slip should be sent to Payroll along with the enrolment form.

**Reference Number:** UHB 220  
**Version Number:**2

**Date of Next Review:** 28<sup>th</sup> June 2021  
**Previous Trust/LHB Reference Number:**  
TR56

## **RECRUITMENT AND SELECTION POLICY**

### **Policy Statement**

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that the recruitment and selection of staff is conducted in a systematic, comprehensive and fair manner, promoting equality of opportunity at all time, eliminating discrimination and promoting good relations between all.

### **Policy Commitment**

Cardiff and Vale University Health Board (the UHB) recognises that its employees are fundamental to its success. In view of this, the UHB is committed to attracting, appointing and retaining qualified, motivated staff with the right skills and experience to ensure the delivery of a quality service and support its values. In order to achieve this we will:

- Provide a well-defined Policy and supporting Procedure for managers to work within and ensure they are clear about the principles underlying the recruitment and selection processes
- Promote the values of the UHB and ensure that this is reflected in the selection of candidates
- Work at all times within current employment legislation and best practice guidelines to ensure a fair and equitable recruitment process
- Consider, before a job is advertised, whether there is scope for modernisation or skill mix to enable improvement
- Ensure that every post has a written job description, person specification and KSF outline / Job Plan (as appropriate)
- Endeavour to engage workers as employees whenever possible. If this is not possible the preferred route will be through the Temporary Staffing Office (Bank) / Agencies. Self-employed contractors will only be engaged if the usual routes are not possible, and will be subject to the Off Payroll Procurement Process to ensure compliance with the Off Payroll Working in the Public Sector legislation which was introduced in April 2017
- Employ staff on permanent contracts of employment as the norm, with fixed term contracts only used where necessary and appropriate. Any employee engaged on a fixed term contract will be entitled to terms and conditions of employment that are no less favourable on a pro-rata basis than the terms and conditions of a comparable permanent employee, unless there is an objective reason for offering different terms. Fixed term employees will be treated in the same way as comparable permanent employees in relation to opportunities for training, promotion, transfer and appraisal

Policy Title: Recruitment and Selection Policy		Date of Review: 28 <sup>th</sup> Jun 2018
Reference Number: UHB 220		Next Review Date: 28 <sup>th</sup> Jun 2021
Version Number: 2		Date of Publication: 4 <sup>th</sup> Jul 2018
Approved By: Strategy and Delivery Committee		

- Make reasonable adjustments should people with disabilities apply
- Shortlist applicants for interview on the basis of the information they provide on their application form against the criteria set out in the person specification for the post
- Ensure that all shortlisted applicants have a formal interview before an appointment can be made. No discriminatory questions will be asked.
- Ensure that all offers of employment are conditional and subject to pre-employment checks, including Disclosure and Barring checks and professional registration (if appropriate)
- Ensure that the Executive Director of Workforce and OD and/or the Director of Governance are actively involved in supporting and advising the Chief Executive or Chair in the appointment of Executive Directors
- Actively consider Welsh language skills as part of the recruitment process to help meet the UHB's commitment to providing quality healthcare through the medium of Welsh
- Provide information for managers on starting salaries (including when reckonable service or incremental credits apply) and the evidence required to make a salary offer
- Ensure that new staff are welcomed and settled into their role in the organisation, and enable them to become as effective as soon as possible, through a carefully planned induction programme

### Supporting Procedures and Written Control Documents

This Policy and the supporting Procedure describe the following with regard to recruitment and selection:

- Roles and responsibilities
- Principles governing recruitment and selection
- Recruitment and the Welsh Language
- Evidence required to make a salary offer
- Induction

### Other supporting documents are:

- Recruitment and Selection Procedure
- Recruitment and Selection Procedure for Medical and Dental Staff
- Recruitment & Selection Toolkit for NHS Managers
- Disclosure and Barring Service Policy and Procedure
- Secondment Policy
- Fixed Term Contract Policy
- Professional Registration Policy
- Organisational Change Policy
- Redeployment Policy and Procedure
- New and Changed Jobs Protocol
- Supporting Transgender Staff Procedure

Policy Title: Recruitment and Selection Policy		Date of Review: 28 <sup>th</sup> Jun 2018
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Approved By: Strategy and Delivery Committee		

## Scope

This Policy applies to all managers who are involved in the recruitment and selection of staff.

<b>Equality and Health Impact Assessment</b>	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. Key actions have been identified and these have been incorporated within this policy/supporting procedure.
<b>Policy Approved by</b>	Strategy and Delivery Committee
<b>Group with authority to approve procedures written to explain how this policy will be implemented</b>	Employment Policy Sub Group
<b>Accountable Executive or Clinical Board Director</b>	Executive Director of Workforce and OD

### Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).

## Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	04/03/14	09/04/14	Updated from Trust document to reflect change in process due to Shared Services
2	28/06/18	04/07/18	<ul style="list-style-type: none"> <li>• Policy and Procedure separated in line with UHB format.</li> <li>• Policy now covers all staff, not just those under AFC terms and conditions</li> <li>• Reference to self employed contractors included</li> <li>• The Executive Director of Workforce and OD and/or the Director of Corporate Governance are actively involved in supporting and advising the Chief Executive or Chair in the appointment of Executive Directors</li> </ul>

# Standard Operating Procedure for Managing Concerns from Staff

Signpost to support available e.g. Employee Wellbeing Service,, Trade Unions etc.

**STEP 1: Concern raised** through one of the following routes – previous routes have been exhausted or no alternative is available

Raising Concerns Procedure (formal stage – manager or senior leader)

F2SU

Safety Valve

Anon. letters

External agency

## STEP 2: Log Concern

ALL formal concerns must be logged with Director of Corporate Governance – check for duplication before proceeding (n.b. if concern involves Director of Corporate Governance it will be referred directly to the Chief Exec and logged there)

## STEP 3: Concern triaged

Concerns will be triaged by the Director of Corporate Governance and Chair/ relevant Executive Director on the day that it is received

## STEP 4: concern passed to identified individual for action

n.b. if the concern relates to an Exec it goes to the Chief Exec, if it is about the Chief Exec it will be raised with the Chair, if it is about the Chair it will be raised with the Cabinet Secretary.

## STEP 5: Investigation, Action and Feedback

Method/frequency of communication & confidentiality agreed with concern raiser

Investigation manager appointed and supplied with information by 'identified individual'

Fact finding/investigation conducted – includes witness interviews, examination of documents etc

Investigation manager feeds back to 'identified individual'.

Appropriate action taken

Feedback given to concern raiser

If individual is not content that the issue is resolved they may wish to raise their concern again through a different route or with a more senior manager

## STEP 6: Log Outcome

The outcome of ALL formal concerns must be logged with Director of Corporate Governance and will be reported to Board

**'Blowing the whistle'** or 'making a disclosure in the public interest' gives the individual certain protections. This takes place when an individual discloses that they reasonably believe that one or more of the following is either happening, has taken place, or is likely to happen in the future, and it is in the public interest:

- Someone's health &/or safety has been put in danger by action or inaction
- Damage has been caused to the environment
- A criminal offence has been committed
- A legal obligation has been breached
- There's been a deliberate attempt to cover up one of the above

# Agenda Item 5

By virtue of paragraph(s) vi of Standing Order 17.42

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# Agenda Item 8

By virtue of paragraph(s) vi of Standing Order 17.42

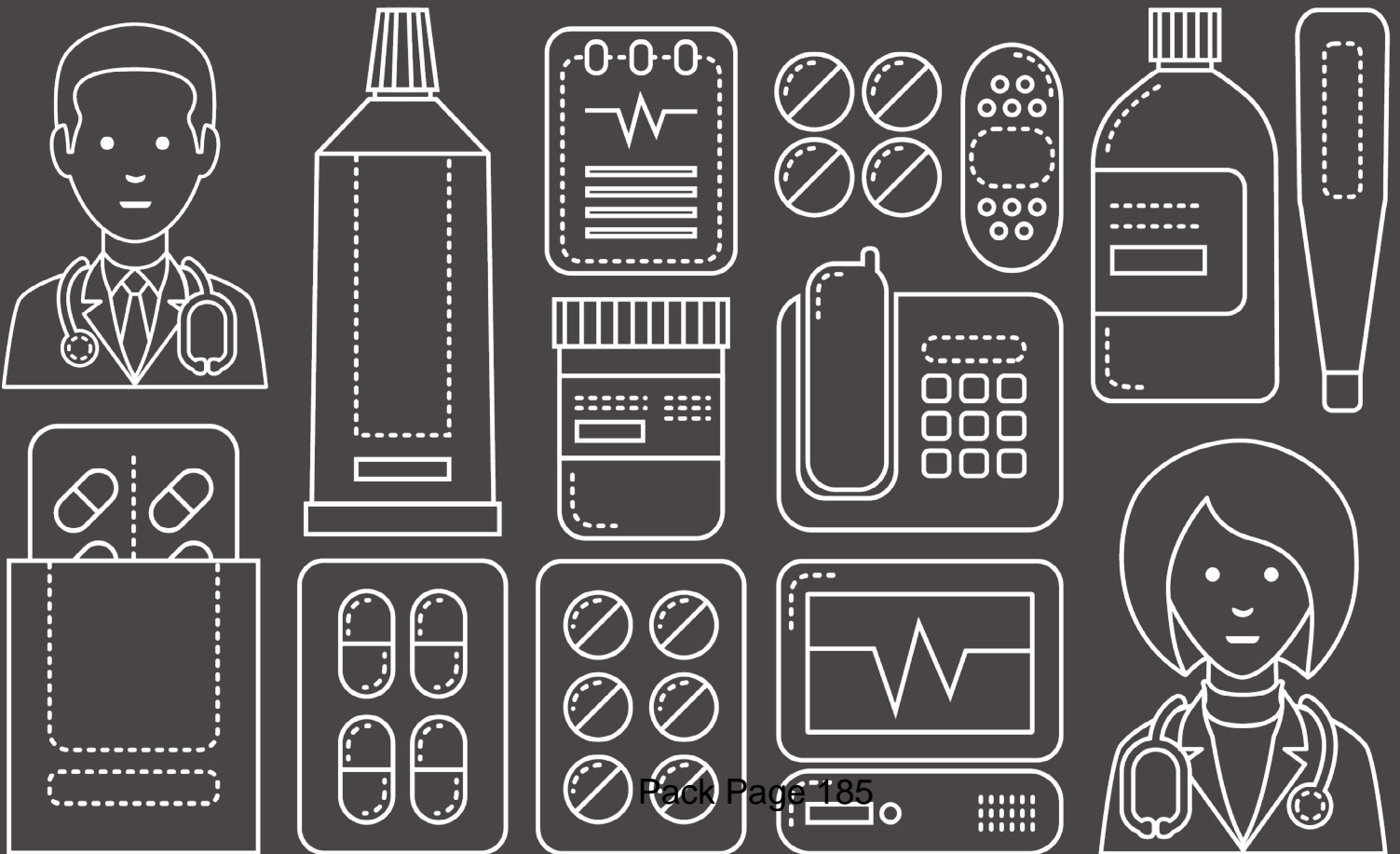
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Archwilydd Cyffredinol Cymru  
Auditor General for Wales

# 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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The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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**Mae'r ddogfen hon hefyd ar gael yn Gymraeg.**

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## Detailed report

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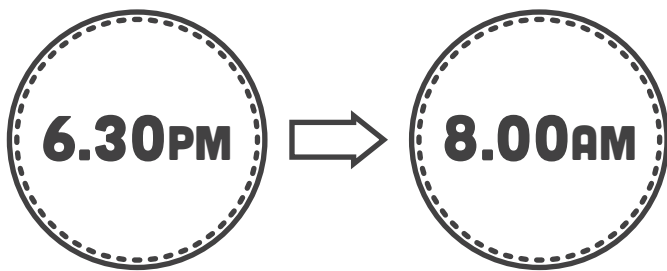
# Background

- 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

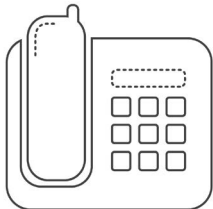


**Plus weekends and public holidays**

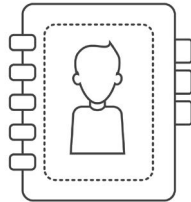
### Who is responsible for providing out-of-hours services?

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**).

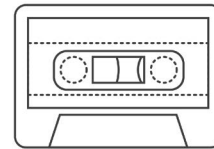
## How do out-of-hours services work?



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



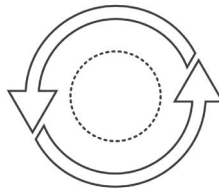
People call their GP  
surgery's number,  
or  
the out-of-hours  
service's direct number,  
or  
in some areas people  
can now call 111.



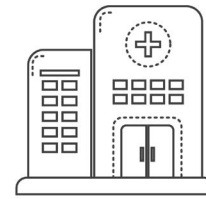
**Recorded message**  
A welcome message  
signposts patients to  
alternative services.  
Hold the line to speak  
to the out-of-hours  
service.



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



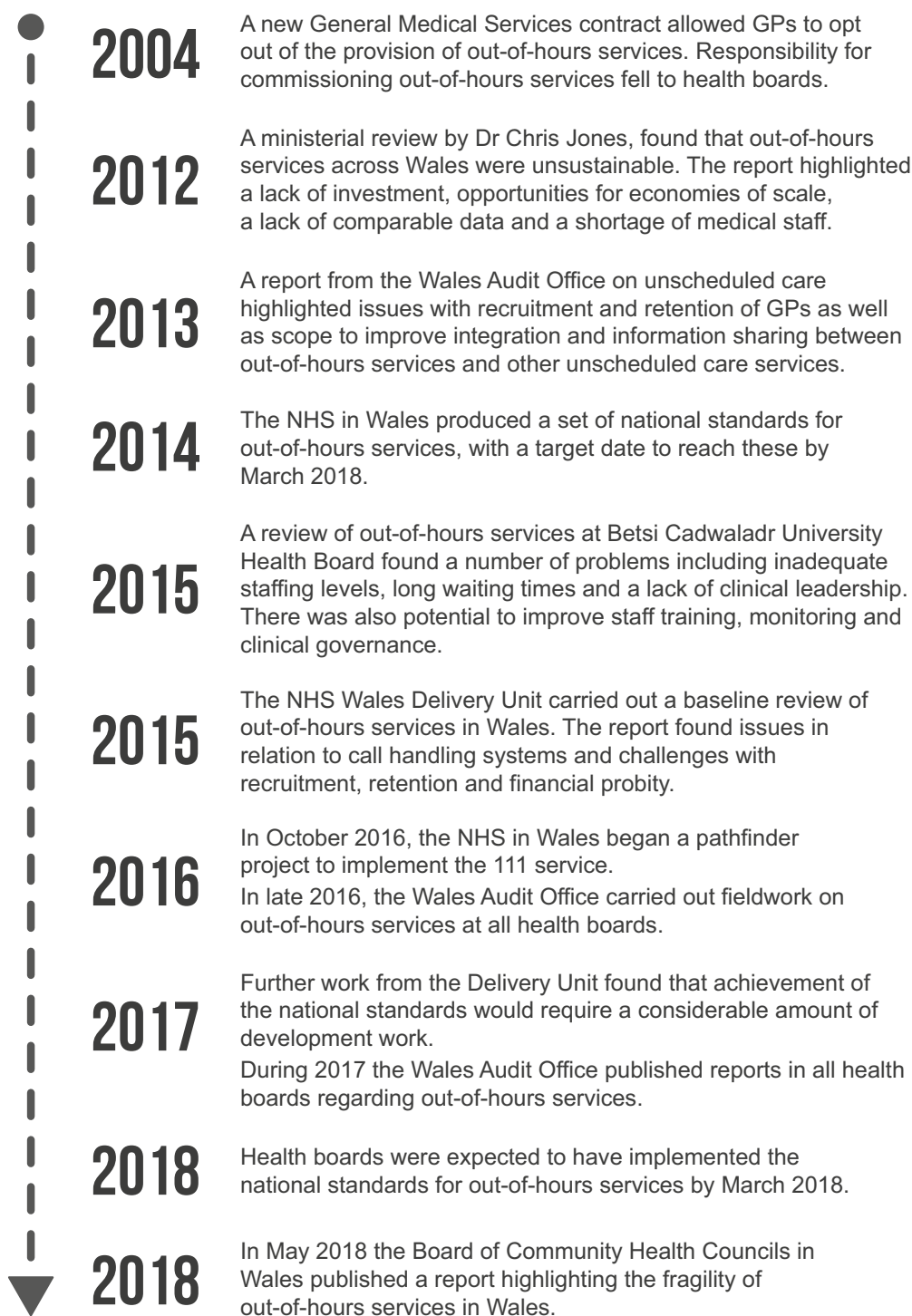
**Call back**  
A doctor, nurse or  
paramedic often calls  
the patient back.



**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**



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](http://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

# 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<sup>1</sup> 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.**

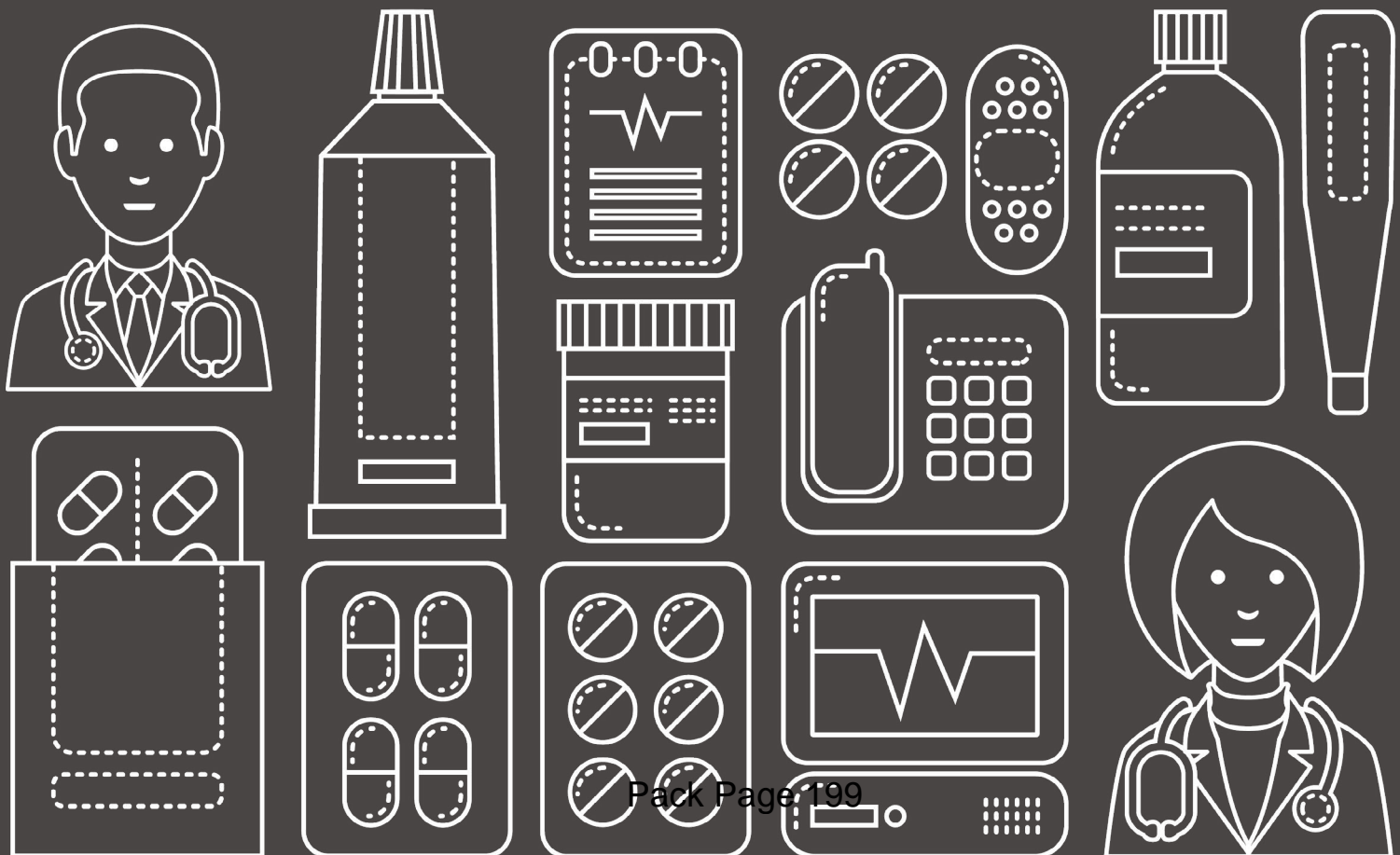
- 19 The introduction of the 111 service provides a key opportunity to improve integration of out-of-hours with other services. The 111 service will provide 24-hour call taking, information and advice. Importantly, it will provide integrated call taking and triage for out-of-hours plus NHS Direct Wales. 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



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

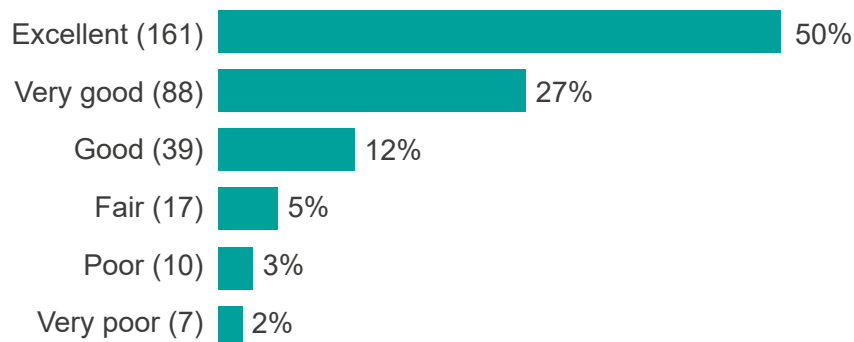
## Our patient survey suggests people have generally positive views about out-of-hours services

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.

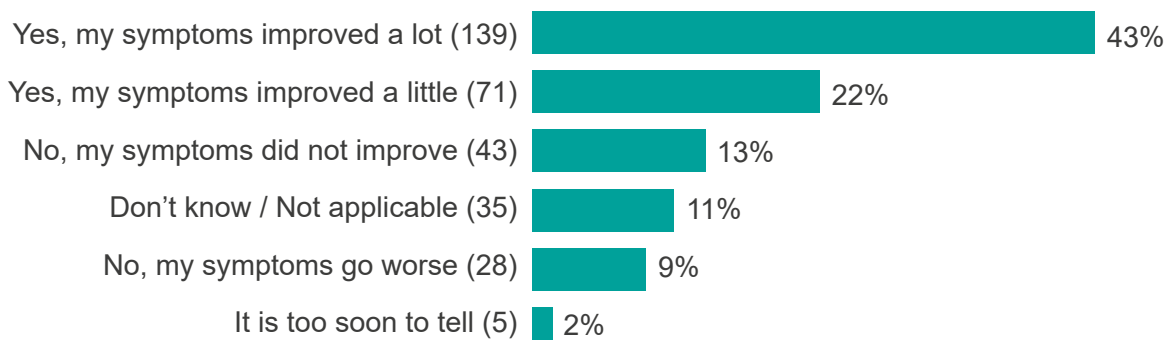
### Exhibit 4 – Results of our patient survey

#### 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.’

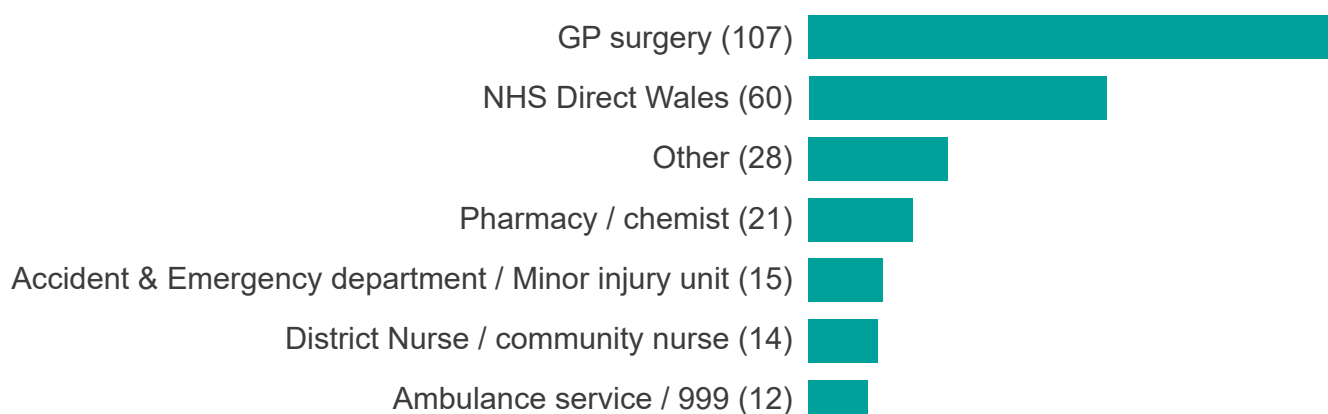
Source: Wales Audit Office survey of out-of-hours patients

## 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

**Before you contacted the out-of-hours service, did you contact or visit any of the services below? Please tick all that apply**



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<sup>2</sup>. 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

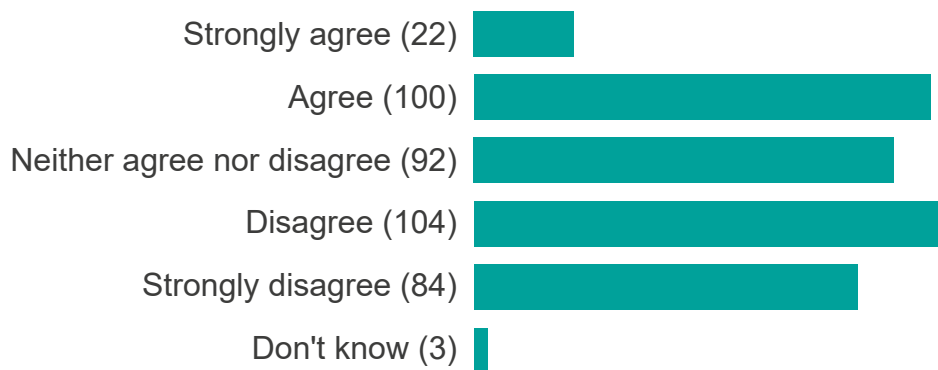
Notional funding from the Welsh Government has fallen in real terms and services are strained due to morale and staffing issues that threaten the resilience of services

### 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

### **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<sup>3</sup>. When inflation is taken into consideration, this equates to a 21% decrease in real terms<sup>4</sup>.

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:

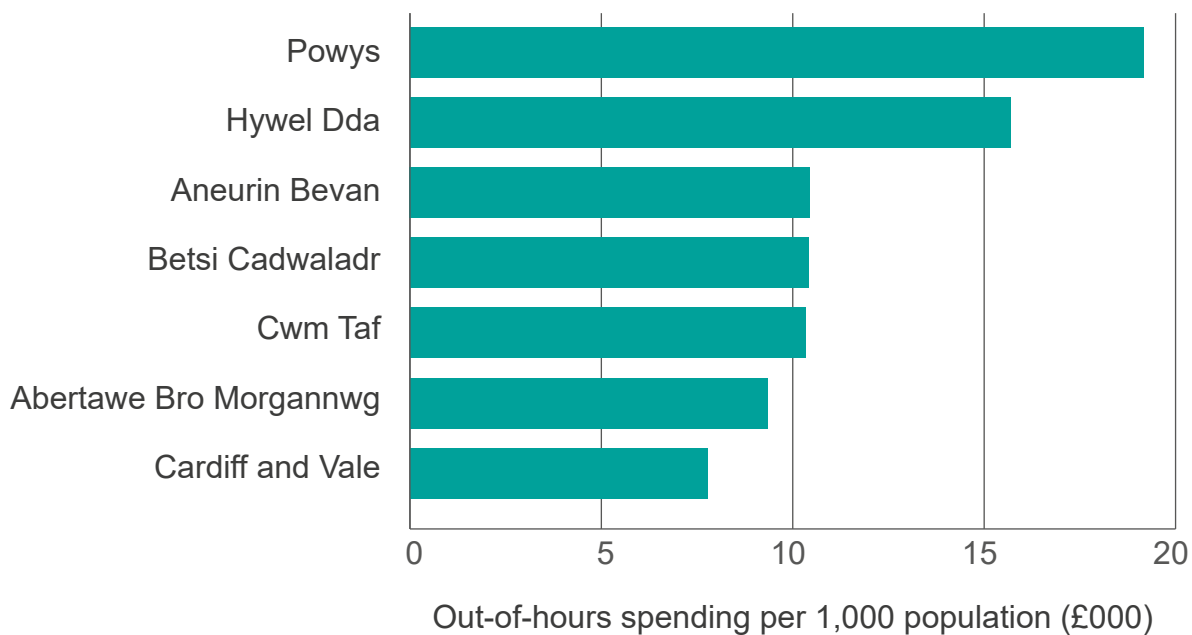
- **Geography:** Large, rural health boards may need more primary care centres and staff to cover larger geographical areas.
- **Population:** Areas with large, dense populations may be able to benefit from economies of scale.

<sup>3</sup> 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.

<sup>4</sup> 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<sup>5</sup>. 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<sup>6</sup> 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.

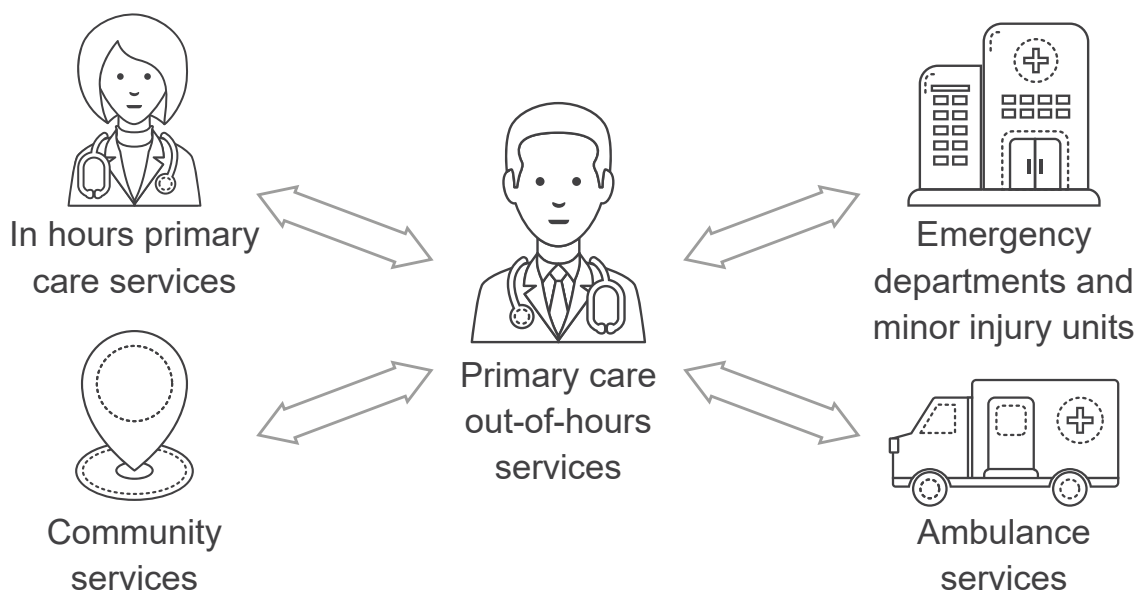
6 Cardiff and Vale University Health Board and Hywel Dda University Health Board.

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.

## 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 sit 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.<sup>8</sup> 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<sup>9</sup>, 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.

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

<sup>9</sup> 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.

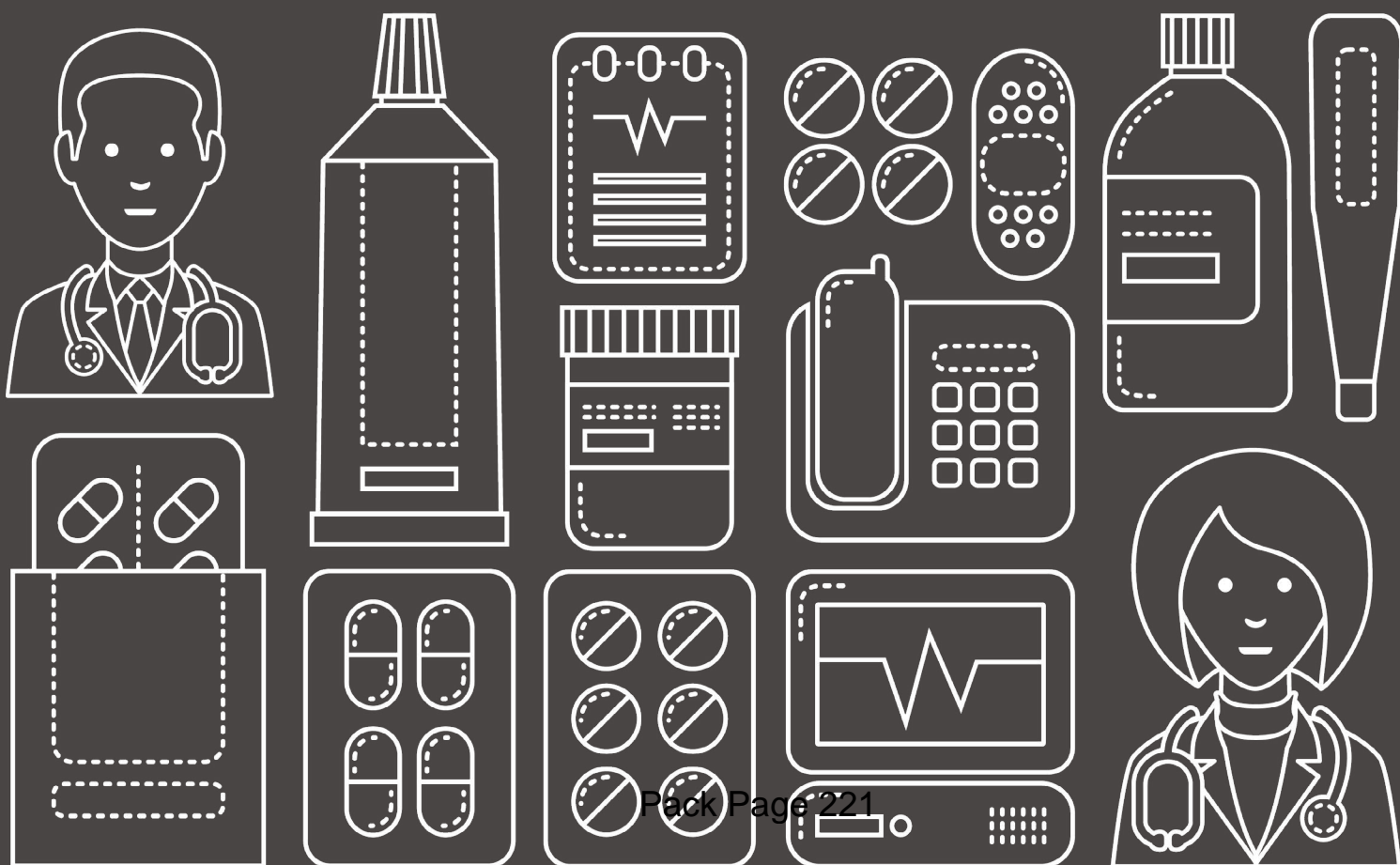
- 1.51 In November 2017, the NHS in Wales produced its Strategic Development Plan for 111, which aims to roll out a standardised model of 111 across the country. The plan sets out a range of potential benefits including simpler access to services with seamless transfer of information between clinicians. 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 to 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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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 responsibility 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).

- 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

<u>Allocation (2004)</u>		<u>17-18 Audited spend</u>
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
<b>Total</b>	<b>£28.739m</b>	<b>£35.826m</b>

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 clarify 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/uniquesigf31510284af2ec6dcfb998c39315f7a88ce2223c1263895620e9f9605280fdf2/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 it 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

A handwritten signature in black ink, appearing to read 'Andrew Goodall', written in a cursive style.

**Dr Andrew Goodall**  
**Director General/ Chief Executive NHS Wales**

cc:

Frank Atherton, Chief Medical Officer for Wales

Jean White, Chief Nursing Officer for Wales

Andrew Havers, Senior Medical Officer, Primary Care

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Mr A Crompton  
Auditor General for Wales  
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14 August 2018

Dear Mr Crompton

### **Primary Care Out of Hours (OOHs) Services – All Wales Summary Report - Update**

Further to my letter of 1<sup>st</sup> August I wanted to take this opportunity to provide you with some further information on a number of the recommendations made in your report '*Primary Care Out of Hours Services*'. The Welsh Government accepts the 8 recommendations and will continue to work with the NHS to ensure that they are addressed.

The Welsh Government acknowledges the factual accuracy of the report, but feels it is important that our response provides the context around the issues and that we are able to demonstrate where work is already underway to address the points made. Co-production is an important concept, therefore working with partners and stakeholders' means that specific processes and outcomes cannot be predetermined, and that Welsh Government and the NHS needs to take full account of all the evidence, including stakeholder views before it can act.

I confirmed in my previous letter that I had asked Judith Paget to take the strategic lead for Out of Hours. Her newly formed group has now met twice, and is developing working to develop a strategic plan for Out of Hours. Your report will provide work going forward, and I look forward to updating you regarding the output later in the year.

The following provides some further information relating to a number of the specific recommendations:

**Recommendation 2** I can confirm that we have received all the annual reports from health boards. These provide a self assessment against the existing Out of Hours standards. We will be repeating this process on an annual basis and will look to build on both the style and content as we move forward.

**Recommendation 3** The peer review process is well underway. Dates have now been agreed with all health boards and the timetable is shown below



Heath Board	Peer review
Hywel Dda UHB	23/08/2018
Cwm Taf UHB	17/09/2018
Cardiff and Vale UHB	28/09/2018
Abertawe Bro Morgannwg UHB	23/10/2018
Betsi Cadwaladr CU HB	25/10/2018
Aneurin Bevan UHB	07/11/2018
Powys THB	13/11/2018

The output from the peer reviews will be a local action plan, with workforce being a central component. This will be jointly produced and agreed at the end of, and immediately following, each peer review. As a consequence, the outcomes cannot be pre-determined at this stage. Hywel Dda has agreed to act as a pilot to inform the later reviews.

Alex Howells, Chief Executive, Health Education and Improvement Wales (HEIW) has also agreed to look at out of hours workforce as a priority as the organisation develops its work plan.

**Recommendation 5** The GP OOH Forum Quality and Safety Committee have now met twice and have agreed its terms of reference. It is in the process of implementing these, and is developing a work programme. This committee will provide feedback to the GP OOHs Forum, to support learning and development. Judith Paget's group will give consideration to the establishment of robust reporting lines into the national structure to ensure lessons can be learnt and shared on a consistent basis across Wales.

**Recommendation 7** The GP OOH Forum is developing its role as a mechanism to share good practice and improve the out of hours service. It provides a structure to engage with both management and clinical colleagues and Welsh Government now have observer status on both the Forum, and the Quality and Safety Committee.

**Recommendation 8** I can report that the national IT system to support the 111 service in Wales is progressing well. The competitive dialogue is continuing and on track with the timetable agreed with the Infrastructure Investment Board (IIB). Shortlisting will take place in the autumn to select three suppliers for the final round. The timetable thereafter is as follows:

Legal and governance considerations	Summer 2019
Final decision on supplier	November 2019
Implementations begins	January 2020
'Go Live'	October 2020

Further to my earlier letter, I would like to reiterate that the appointment of a national strategic lead is timely, and will provide strong leadership moving forward. The Peer Review process, Transformational Model for Primary Care and the *Policy Framework for*

*Unscheduled Care*, being developed over the coming months, will help to provide a robust guide to how the Out of Hours service and services provided in the out of hours period will function in the future.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Andrew Goodall', written in a cursive style.

**Dr Andrew Goodall**  
**Director General/ Chief Executive NHS Wales**

cc:

Frank Atherton, Chief Medical Officer for Wales

Jean White, Chief Nursing Officer for Wales

Andrew Havers, Senior Medical Officer, Primary Care

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Archwilydd Cyffredinol Cymru  
Auditor General for Wales

# Managing the impact of Brexit on EU Structural Funds



WALES AUDIT OFFICE  
SWYDDFA ARCHWILIO CYMRU



I have prepared and published this report in accordance with the Government of Wales Acts 1998 and 2006.

The Wales Audit Office study team comprised Mark Jeffs, Chris Pugh and Seth Newman under the direction of Matthew Mortlock.

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**Mae'r ddogfen hon hefyd ar gael yn Gymraeg.**

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# Summary report

## Summary

- 1 Since 2000, Wales has been eligible for £10.2 billion of EU Structural Funds, which are two of several EU funding programmes available to Wales. The current round of EU Structural Funds is part of the 2014-2020 programme although EU rules mean Wales would actually have until 2023 to commit<sup>1</sup>, spend and claim the funding<sup>2</sup>.
- 2 Wales is eligible for around £2.1 billion of EU funding under the current round. There is an additional £1.1 billion of 'match funding' from the private, voluntary and public sectors<sup>3</sup>. The Welsh European Funding Office (WEFO) is responsible for delivering the programme as the 'Managing Authority'<sup>4</sup>.
- 3 The European Structural Funds 2014-2020 programme is made of up of four Operational Programmes. There are two funds: the European Regional Development Fund (ERDF) and the European Social Fund (ESF). There is around £1.2 billion of ERDF for research and development, for infrastructure projects, such as improving roads, for renewable energy and energy conversation, and for supporting small business. There is around £860 million of ESF for supporting the development of skills for youth and adults, both for those in employment and for those seeking work. The funding is split between West Wales and the Valleys, which gets the majority of the funding due to lower levels of economic output, and East Wales (Figure 1 and Appendix 2). The funding aims to achieve a wide range of economic, environmental and social benefits. Appendix 2 sets out the intended outcomes and outputs under each of the funding priorities.

- 1 For this report, we mean that the funding is committed to a specific project following approval by WEFO and acceptance of the grant offer letter by the project sponsor.
- 2 The EU sets expenditure targets which start three years after the Operational Programmes are agreed (the framework is known as N+3). The N+3 targets are cumulative and rise each year to 100% of funding which must be spent by 2023.
- 3 Match funding can come in form of cash and time, for example, the value of volunteer contributions can be used to match EU funding contributions.
- 4 WEFO is part of the Welsh Government and is responsible for the shared management of European Structural Funds in Wales, in partnership with the European Commission. As 'Managing Authority', WEFO is responsible for the efficient management and implementation of the programme.

Figure 1: key facts about the 2014-2020 EU Structural Funds Programme

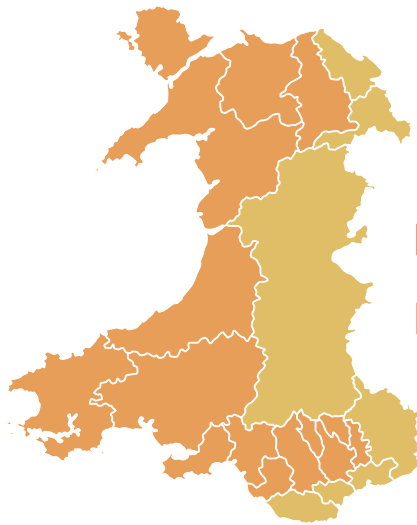
### EU STRUCTURAL FUNDS



= £2.1 BILLION



= £1.1 BILLION



		EU grant (£m)	Match funding (£m)	Total (£m)
West Wales and the Valleys	ESF	687.7	236.4	924.1
	ERDF	1,030.9	533.1	1,564.0
East Wales	ESF	173.8	179.1	352.9
	ERDF	173.8	173.7	347.5

#### ERDF

#### ESF

**Connectivity and Urban Development**

Total Expenditure: £734.4M  
EU Grant: £469.4M

**Skills for Growth**

Total Expenditure: £580.9M  
EU Grant: £378.9M

**Research & Innovation**

Total Expenditure: £541.0M  
EU Grant: £334.2M

**Youth Employment and Attainment**

Total Expenditure: £383.8M  
EU Grant: £260.5M

**OPEN SME competitiveness**

Total Expenditure: £353.0M  
EU Grant: £211.9M

**Tackling poverty through Sustainable Employment**

Total Expenditure: £286.9M  
EU Grant: £204.9M

**Renewable Energy & Energy Efficiency**

Total Expenditure: £248.6M  
EU Grant: £165.1M

**Technical Assistance**

Total Expenditure: £25.4M  
EU Grant: £17.2M

**Technical Assistance**

Total Expenditure: £34.6M  
EU Grant: £24.1M

Figures based on a conversion rate of £1:€1.17

Source: WEFO data

- 4 On 23 June 2016, the UK voted in a referendum to leave the European Union. In March 2017, the UK Government served notice of its intention to leave the EU. In line with the two-year timetable set out under EU law, the UK will leave the EU at 11pm on 29 March 2019.
- 5 The impact of 'Brexit' on EU Structural Funds depends on whether the UK leaves the EU with a 'deal'. EU law allows for the UK and EU to agree a 'Withdrawal Agreement' which sets out the terms of the UK's departure<sup>5</sup>. In March 2018, the UK and EU published a draft Withdrawal Agreement<sup>6</sup>. The draft Withdrawal Agreement set out a range of areas where the UK and EU agree as well as some key areas of disagreement. Among the areas of agreement are that the UK will continue to participate in the 2014-2020 EU Structural Funds programme until its end.
- 6 However, there are some key areas of disagreement, including the Republic of Ireland/UK border and the role of the European Court of Justice. There is a chance that if the areas of dispute are not resolved, the UK will leave the EU without a Withdrawal Agreement. In a no deal scenario, Wales would rely on a UK Government guarantee. Until recently, WEFO had been working to a guarantee announced in October 2016<sup>7</sup>, to replace EU funding for projects that have been 'signed before the UK leaves the EU'. On 24 July 2018, shortly before we finalised this report, the UK Government extended the guarantee to cover Wales' (and the rest of the UK's) allocation for Structural Funds under this EU budget period to 2020. **Figure 2** sets out at a high level the two key scenarios – 'deal' and 'no deal'.

5 Article 50 of the Treaty Founding the European Union is the section of EU law dealing with how members states leave the EU.

6 UK Government and European Commission, **Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community**, March 2018.

7 In August 2016, the UK Government announced an initial UK wide guarantee to fund projects signed before the Chancellor's Autumn Statement. The October 2016 announcement followed the Autumn Statement and extended the guarantee to all projects signed before the UK leaves the EU.

Figure 2: UK/EU Withdrawal agreement – latest deal and no deal scenarios for Structural Funds in Wales



7 This report considers whether WEFO is effectively managing the risks and opportunities for Structural Funds posed by Brexit. [Appendix 1](#) sets out our audit methods. This report focuses at a high level on the key risks. We have not reviewed the overall management of the programme in depth. Nor have we reviewed the Welsh Government's broader response to the risks and opportunities of Brexit. In April 2014, the Auditor General reported in detail on the 2007-2013 EU Structural Funds Programme ([Box 1](#))<sup>8</sup> and where relevant we have drawn from that report to support our findings.

8 Auditor General for Wales, [European Union Structural Funds 2007-2013](#), April 2014.

### Box 1: the Auditor General's 2014 report on Structural Funds 2007-2013

The Auditor General concluded positively on the progress with the programme and improved management arrangements. While it was too early to be certain about the overall impact of the programme, there were positive indications from ongoing evaluations.<sup>9</sup> WEFO has taken action to address all of the issues covered by our recommendations.

- 8 The report is structured around the key risks to EU funding and opportunities as a result of Brexit. **Figure 3** sets out the key risks and opportunities and our conclusions in relation to how WEFO is managing them. Our work initially focussed on WEFO's progress in light of the previous UK Government guarantee. The precise impact of the UK Government's announcement of an extended guarantee is being discussed and the UK Government intends to issue new guidance shortly. Nonetheless, it is clear that the extended guarantee significantly reduces the risk that Wales will lose funding in a no deal scenario. Our report needs to be considered in that context. At the time of drafting this report, it is not yet clear how this announcement will impact on WEFO's previous plans for committing funding by March 2019.

**Figure 3: key risks and opportunities related to EU Structural Funds in Wales as a result of Brexit**

Risk/opportunity	Conclusion
Key risk: That Wales loses out substantially on funding.	Despite WEFO's positive efforts to commit all EU funding before Brexit, Wales faced a significant risk of losing some funding in a no deal scenario without the UK Government amending the terms of its guarantee.
Key risk: That WEFO lowers its standards in order to sign-up projects and spend EU money before Brexit.	WEFO has maintained robust checks and balances despite the intention to increase the pace of project approvals and spending ahead of Brexit.
Key opportunity: To apply lessons learnt from years of managing structural funds in Wales to any replacement scheme.	The future of regional funding post-Brexit is unclear but WEFO and the Welsh Government are trying to shape debate.

<sup>9</sup> WEFO has since published a review of the 2007-2013 round, *Ex Post Evaluation of the 2007-2013 Structural Funds Programmes in Wales, December 2017* which sets out in detail the impacts of the 2007-2013 round of funding.

- 9 In relation to the risk that Wales loses out on funding in a no deal scenario, under the previous guarantee, the precise amount would have depended on the extent to which WEFO was able to commit all funding by March 2019. It would also have depended on the extent to which projects subsequently go ahead as planned and spend all of the funding allocated. For every 1% of the total available funding that WEFO does not commit or which is underspent, Wales would have lost around £21 million.
- 10 Given our generally positive overall conclusions and the high-level nature of our review, we are not making any specific formal recommendations. However, there are some key issues for WEFO and the Welsh Government to manage even with the extension of the guarantee:
- a Keeping in view wider economic changes, including in relation to Brexit, and adapting the programme where necessary in response
  - b Increasing the rates of commitment, working with potential project sponsors to address concerns, including around the availability of match-funding
  - c Increasing the rate of spending by encouraging projects to submit their claims for EU funding more promptly
  - d Working with project sponsors to minimise project underspends that could result in funding being lost to Wales
  - e Recruiting and retaining staff at a time where there is significant uncertainty about some of the roles within WEFO and potentially increased workload as a result of an increase in the pace of project assessments
  - f Sustaining robust checks and balances
  - g Ensuring that during the transition to any replacement for structural funds, WEFO's expertise in robust project appraisal and oversight is retained either in the replacement programme or in the wider Welsh public service

## Part 1

Despite WEFO's positive efforts to commit all EU funding before Brexit, Wales faced a significant risk of losing some funding in a no deal scenario without the UK Government amending the terms of its guarantee



- 1.1 This part of the report looks at how WEFO has been managing the risk that Wales loses EU funding as a result of Brexit. In particular it looks at the deal or no deal scenarios for Brexit. In the no deal scenario, we look at the risks associated with the UK Government's previous guarantee to fund projects that have been signed at the point of Brexit (29 March 2019). We then consider the consequences of the 24 July 2018 UK Government announcement extending the guarantee to cover Wales' allocation for Structural Funds under this EU budget period to 2020. In the deal scenario we consider the impact of the draft Withdrawal Agreement and any residual risks to EU funding in that scenario.

## WEFO is making progress with committing funding but recognised that it was a challenging target to commit all EU funds in the shortened timescale to March 2019

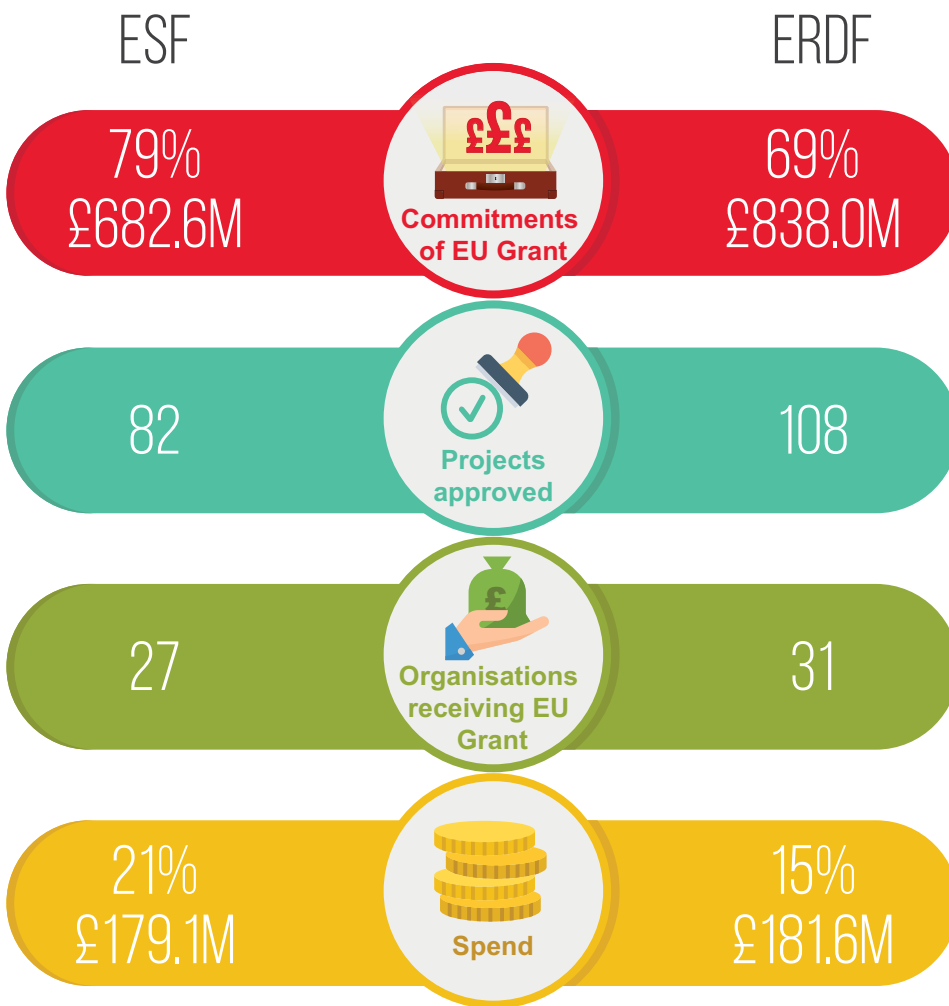
- 1.2 Under EU rules, WEFO has until the end of December 2023 to commit and spend all of the £2.1 billion in EU funding<sup>10</sup>. In practice, given the time taken to approve and deliver projects, WEFO initially aimed to commit all funding by December 2020. This would have allowed WEFO the three years between 2020 and 2023 to focus on ensuring all the committed funding was spent. However, following the UK Government's October 2016 guarantee, WEFO aimed to commit 100% of EU funding by 29 March 2019<sup>11</sup>. WEFO's aim was very ambitious. To meet the aim, WEFO had three years and nine months less to commit all of the funding than it did in previous rounds. In the 2007-2013 round, WEFO had committed 86% of the funding at the equivalent point in the programme. To meet the March 2019 timescale, WEFO would have needed to commit funding significantly more quickly than in the past.
- 1.3 WEFO got off to a good start. Even before the EU issued its guidance, WEFO worked with stakeholders to develop its priorities, which ended up very similar to those of the previous round. As a result of this early work, Wales was the first part of the UK to have its programmes approved by the European Commission. However, progress in committing funding has been slightly slower than in the previous round. By mid-way through June 2018, WEFO had committed 74% of the total EU grant (£1.6 billion out of £2.1 billion). This is behind the 81% commitment level that WEFO had achieved at a broadly equivalent point in the previous round.

<sup>10</sup> WEFO also has some flexibility to make amendments after 2020, for example, to respond to changes in the exchange rate or move funding between projects to manage underspends.

<sup>11</sup> Unlike previous rounds, the EU did not set commitment targets and WEFO did not set its own internal commitment targets at the outset.

1.4 **Figure 4** shows that WEFO faced a particular challenge to commit ERDF funding, although commitment of ERDF was slower than ESF under the previous round as well. WEFO has highlighted a number of factors that have made it difficult to commit funding to date (**Box 2**).

**Figure 4:** position of the 2014-2020 EU Structural Funds programme at 18 June 2018



Source: WEFO data

## Box 2: factors affecting WEFO's ability to commit funding to date

### Uncertainty about Brexit

WEFO reports that some sponsors have not been coming forwards with projects as they are unsure as to whether the funding would be available if their project were to run beyond the point the UK leaves the EU.

### Commencement of programme

Although WEFO was ahead of many Managing Authorities in getting the programme approved, factors largely outside of WEFO's control meant that the approval was around four months later than the previous 2007-2013 programme. Those issues included late agreement of the EU regulations and budgets and delays associated with needing to have a UK-wide strategic documents in place.

### Exchange rate volatility

The maximum level of funding available to Wales is set in Euros at the beginning of the programme period. The drop in the value of the pound earlier in the programme means that the expected value of the EU funding in pounds is now £132 million higher than first thought. As a result, WEFO currently has more grant available to commit than it initially expected.

### Increase in value of funding for East Wales

Changes in the way the programme is applied at a UK level meant that there is three times more funding for East Wales than in the previous programme. WEFO has already committed more grant to East Wales than under the entire 2007-13 round but is behind the commitment levels at the same point because it has more funding to commit.

### Changes in the economic environment

WEFO reports that the low unemployment rate means there is less demand for projects to increase employment. It also reports that previous investment in projects to boost skills means there are fewer people with no or very low skills. WEFO is working with potential project sponsors to encourage more projects aimed at developing the skills of people who are already in work but it is taking time for these to be developed.

## Box 2: factors affecting WEFO's ability to commit funding to date

### Increased focus on results

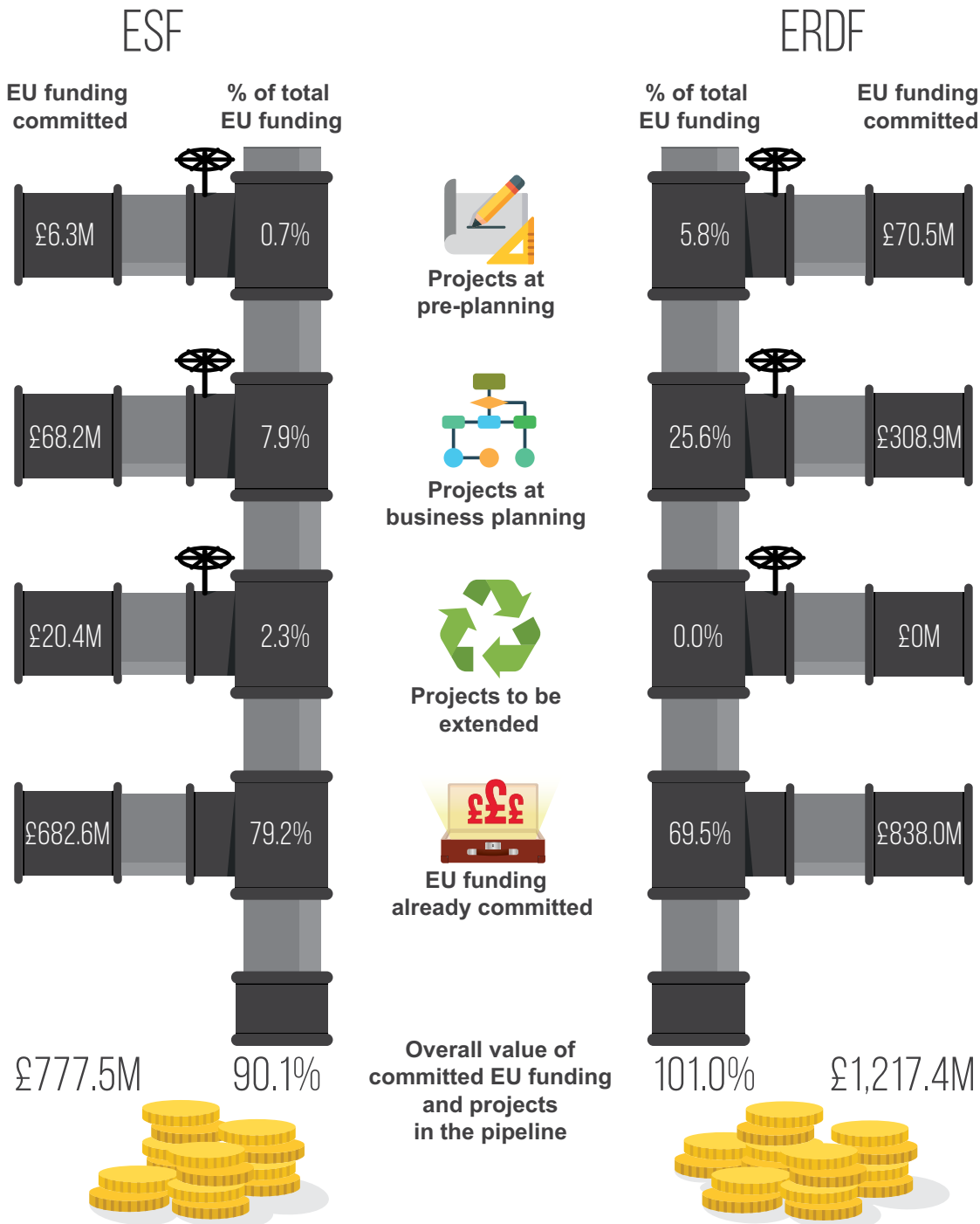
WEFO reports that the programmes have strengthened requirements for projects to demonstrate clearly how they will achieve specific results in line with the programme objectives and economic opportunities (paragraph 2.2). While, ultimately, this approach is intended to achieve longer-term benefits, project sponsors are taking time to adapt and come forwards with sufficiently clear proposals.

- 1.5 WEFO was still intending to commit all of the funding by March 2019. It has projects at various stages of the formal approval process, which would take it to 100% commitment of ERDF and 90% of ESF if they are all approved. Figure 5 shows that as of the middle of June, WEFO has projects worth £77 million at the more tentative pre-decision phase, while £377 million are at the more advanced business planning phase<sup>12</sup>. Some of the projects in the pipeline involve renewing existing projects, such as work-based learning schemes<sup>13</sup>.

<sup>12</sup> Paragraphs 2.3 to 2.4 and Figure 8 set out the approval stages in more detail.

<sup>13</sup> Following a recommendation from the European Court of Auditors, WEFO decided to let contracts for some projects for three to four years rather than the full seven years of the programme.

Figure 5: WEFO's committed funds and project pipeline at the middle of June 2018



Source: WEFO data

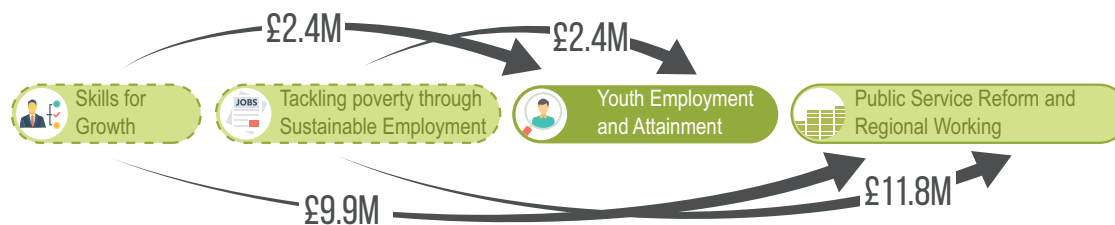
1.6 To bridge the gap in the ESF programme, WEFO is in early talks with sponsors of existing projects to expand them and to develop new projects. These talks have not yet reached the formal pre-planning stage. If all these tentative discussions were to result in the projects going ahead and being approved, WEFO could commit up to £80 million and the remaining gap would be fully filled.

1.7 WEFO wants to amend the programme to help it to increase commitment levels. WEFO proposes to move approximately £64.1 million between existing priorities and to create a new priority around public service reform and regional working (Figure 6 and Appendix 3). WEFO believes that these changes will help it to attract more projects and commit more funding. Changes to the programme are routine and WEFO has made changes in previous funding rounds. WEFO sent its proposals to the European Commission in June 2018. It is hoping for approval by December 2018. WEFO is working with potential project sponsors to develop new projects that will be ready for approval if the European Commission approves the changes. The potential projects for ERDF are included in the 'pre-planning' figure in Figure 5. The potential projects for the ESF programme are at a much earlier stage and not yet fully factored in to WEFO's calculations.

Figure 6: summary of WEFO's proposed amendments to the Structural Fund Operational Programmes

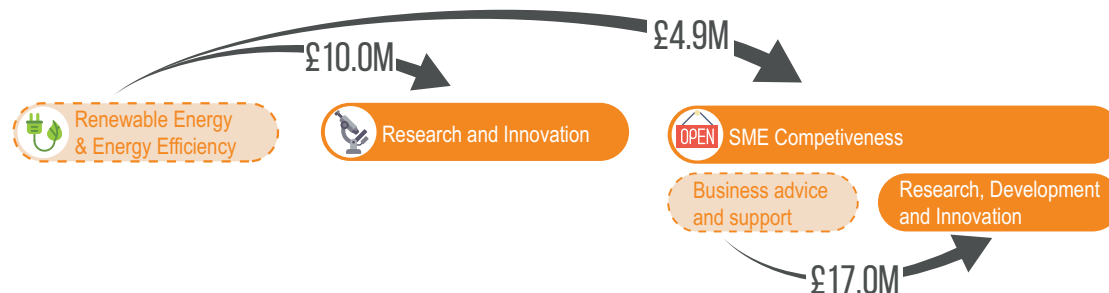
## EUROPEAN SOCIAL FUND

WEFO is proposing taking £14.3 million out of the priority to tackle poverty through Sustainable Employment and another £12.3 million out of the priority skills for growth and putting £21.7 million of it into a newly created priority called Public Service Reform and Regional Working. The remaining £4.9 million is being put into the priority focused on youth employment and attainment.



## EUROPEAN REGIONAL DEVELOPMENT FUND

WEFO is proposing moving £14.9 million from the priority focused on renewable energy and energy efficiency and reallocating £10.0 million of it to the priority focused on research and innovation and a further £4.9 million to the priority focused on SME competitiveness. WEFO is proposing a further £17.0 million is relocated between 'Thematic Objectives' within the SME Competitiveness priority.



Figures based on a conversion rate of £1:€1.17 which may change

Source: WEFO

- 1.8 Although WEFO has committed just 74% of EU funds as at June 2018, it has committed funding worth 92% of the total value of the programme, taking account of match-funding. This situation has occurred because the projects WEFO has approved have a higher proportion of match-funding than is required by EU rules<sup>14</sup>. WEFO commits funding to projects on the basis of need. That means EU funding is set as the minimum required to fill the gap between the total cost of the project and the match-funding that a project-sponsor can provide. WEFO has chosen not to commit EU funds to projects at the maximum level for various reasons. These reasons include ensuring EU funds can be spread across a larger number of projects. Also, having a higher rate of match-funding allows some flexibility to manage risks around changes to exchange rates and eligibility of expenditure.
- 1.9 It is too early to judge the likely impact of the funding and whether the original expectations or targets will be achieved overall. WEFO measures and reports progress against a wide range of detailed measures. **Figure 7** sets out the key performance measures that WEFO reports having achieved by the end of March 2018.

<sup>14</sup> For each of the four Operational Programmes, there is an agreed 'intervention rate'. This sets out what proportion of the Operational Programme will be funding from EU funds and what proportion must come from domestic match-funding. WEFO can set individual intervention rates for each project but these must balance out to ensure that each Operational Programme remains within the agreed rates.

Figure 7: WEFO's key indicators for the Structural Funds programme as at 14 July 2018

	Progress	Target
Enterprises supported	4,903	45,512
Enterprises created	830	7,400
Employment increase in supported enterprises	6,065	26,980
Amount of research funding secured	£48 million	£230 million
Increase in level of exports	£48 million	£233 million
Additional capacity of renewable energy production*	0	28
Number of households with improved energy consumption classification*	0	9,700
Public transport services created or improved*	0	2,900,000 vehicle km
People assisted	143,435	434,100
Young people assisted	39,637	150,000
People supported into employment	9,651	40,642
People gaining qualifications	42,875	194,633

Note: \* As part of the proposed changes to the programme (paragraph 1.7) WEFO intends to remove these three indicators. WEFO has not made progress towards the targets because it has not approved any projects that would directly contribute towards these measures.

Source: WEFO data

There was a significant risk of Wales losing out on some funding in a no deal scenario until the UK Government very recently extended its guarantee

Under the previous terms of the UK Government guarantee, there was a significant risk of Wales losing funding if there is no Withdrawal Agreement in March 2019

- 1.10 If the UK leaves the EU without a deal in March 2019, EU funding to Wales will immediately stop. The UK Government's guarantee had said that it would replace funding for 'all structural and investment projects' that have been 'signed before the UK leaves the EU'. As previously drafted, the guarantee only covered funding for projects approved by 29 March 2019.
- 1.11 WEFO has projects in progress to help move towards the 100% commitment target by March 2019. However, there is a risk that some projects will not make it through the application process and some may be delayed beyond March 2019. Some of the projects are complex and depend on other organisations for match funding that is not yet secure. There are some large projects in the pipeline, notably transport and renewable energy projects. If a small number of those dropped out or slipped behind the March timescale, there would be a significant gap. And several of the projects are at a very early stage of discussion and development.
- 1.12 WEFO has been alert to the risks of projects dropping out and has some projects from over-subscribed schemes that it is asking project sponsors to keep under consideration. These contingency projects could potentially replace projects that drop out. The value of these contingency projects is around £47 million. However, as time moves on, it would get increasingly difficult for WEFO to be able to get the contingency projects through the approval processes ahead of Brexit.
- 1.13 As a result of the likelihood of some projects not making it through to full approval and the growing difficulties of replacing them as the Brexit date approaches, we think there was a significant risk that WEFO would not commit 100% of funding before March 2019. For every 1% of funding that WEFO did not commit, Wales would have stood to lose around £21 million.

1.14 There could also have been losses to Wales due to a lack of flexibility to move funds around between projects after Brexit. In a programme of this size, some projects will inevitably spend less than they planned. WEFO has previously been able to redirect underspends to other projects. However, it was not clear that the UK Government guarantee, which was specifically related to approved projects, would allow flexibility to move funding between projects. We estimate that in the previous round underspends were around 6% of the total value of the funding.

**The UK Government has recently extended the guarantee with the new terms significantly reducing the risk of Wales losing funding in a no deal scenario**

1.15 On 24 July 2018, the UK Government announced that it was extending its guarantee of EU funding to cover Wales' (and the rest of the UK's) allocation for Structural Funds under this EU budget period to 2020. As drafted, this extension of the guarantee significantly reduces the risks associated with both not committing funding and underspends in a no deal scenario. However, the precise impact will become clearer as the UK Government sets out further details on how the guarantee will work in practice.

1.16 WEFO, along with other parts of the UK, had tried to clarify the UK Government's interpretation of the previous guarantee. **Box 3** sets out the areas where WEFO had asked for further detail. Some of these issues remain relevant even with the extended guarantee. The UK Government had produced draft guidance on the previous guarantee which was under discussion with the devolved governments and other stakeholders. The UK Government intends to produce updated guidance on the extended guarantee in the near future, which we understand will address some of the issues that WEFO has raised. Ultimately, the scope of the guarantee is a decision for the UK Government.

### Box 3: key areas where WEFO had sought clarity over the UK Government's previous guarantee

#### **Project variation flexibility**

Will the UK Government permit variations to agreed projects committed at 29 March 2019 and still regard varied commitments to be covered by the guarantee?

#### **Impact on other funding**

Can the UK Government confirm the guarantee will not impact on any other funding earmarked for Wales?

#### **Overall value of guarantee**

How and when will the UK Government determine whether there is a Sterling value of the ceiling on its guarantee?

#### **Regulations**

What existing EU regulations does the UK Government expect to retain and what audit and inspection process will be required post Brexit?

#### **Cut-off point**

Will the UK Government meet any amounts that are in the system at the point of Brexit?

#### **Technical assistance**

Will the UK Government continue to fund WEFO staffing and other training, advice and support costs under the guarantee?

- 1.17 Although this report focuses on the risks to Wales, there is a wider risk to the UK funding position in a no deal scenario. In a no deal scenario, the gap in funding for signed projects would be covered by the UK Government. The size of that gap depends in part on the amount of EU funding that Wales (and other parts of the UK) are able to claim from the EU before Brexit. In order to draw down funding from the EU, projects need to first spend the money, then submit a claim to WEFO. WEFO then submits claims to the European Union to draw down the funding.

- 1.18 WEFO has encouraged project sponsors to submit claims promptly in order to draw down EU funding. WEFO's plans for draw-down are primarily driven by the EU's annual spending targets. To the end of 2017, WEFO has significantly exceeded the spending targets. WEFO has already exceeded the targets for 2018 in three out of the four operational programmes<sup>15</sup>.
- 1.19 Although it is meeting its targets, WEFO recognises that project sponsors are not submitting claims as promptly as they could. WEFO attributes this to several factors:
- Some project sponsors taking extra time to check their claims and verify all of their expenditure and eligibility paperwork before submitting claims.
  - Despite prompting from WEFO, some parts of Welsh Government prefer to use their own domestic funding upfront and then claim EU funding in the latter stages.
  - One part of Welsh Government having a large claim pending for work-based-learning activity, which is delayed while it resolves problems with the computer systems that verify the eligibility of the expenditure.

<sup>15</sup> The West Wales and the Valleys programme has not yet met the 2018 targets but it has until December 2018 to do so. WEFO expects that some of the financial targets for The West Wales and the Valleys programme has not yet met the 2018 targets but it has until December 2018 to do so. WEFO expects that some of the financial targets for this operational programme will be reset if the EU approves proposed changes to the programme.

## If there is a Withdrawal Agreement, EU structural funding will continue largely unchanged so there is a limited risk of Wales losing out substantially

- 1.20 If the draft Withdrawal Agreement is agreed between the UK and EU, the UK Government guarantee will not be needed. Under the terms of the draft Withdrawal Agreement, Wales will continue to be able to participate in the 2014-2020 programme until its end. WEFO will have until December 2023 to commit all funding and to submit claims for funding. Although WEFO is behind where it was in the previous round, it is confident that it will commit all of the funding by the end of the programmes in 2023.
- 1.21 Even with a Withdrawal Agreement in place, Wales could lose out on some funding if projects underspend. WEFO manages the risk of underspends by overcommitting. In the previous round, WEFO committed 106% of the value of the programme but actually spent 99.98% of the funding. In the past WEFO has had a fall-back position that if underspends and over-commitments do not balance out and there is a shortfall of funding, projects can be rolled over into the next round of EU funding. However, due to Brexit, Wales will not be participating in the next round of funding, so this fall-back position is not an option. WEFO may need to be more cautious about over-commitment, thereby increasing the risk that it is unable to balance out and redistribute underspends. For each 1% of the value of the EU funding underspent, Wales would lose around £21 million.

## Part 2

WEFO has maintained robust checks and balances despite the intention to increase the pace of project approvals and spending ahead of Brexit



- 2.1 This part of the report looks at the risk that WEFO lowers its standards in order to approve projects and spend EU money more quickly before Brexit. It considers at a high-level the arrangements in place to:
- a ensure that only good and eligible projects are selected to get EU funding;
  - b ensure that projects only use money in line with EU rules; and
  - c monitor progress with the overall programme.

## **WEFO has strengthened its approach to approving projects and only commits to those which meet strict criteria and match its strategic priorities**

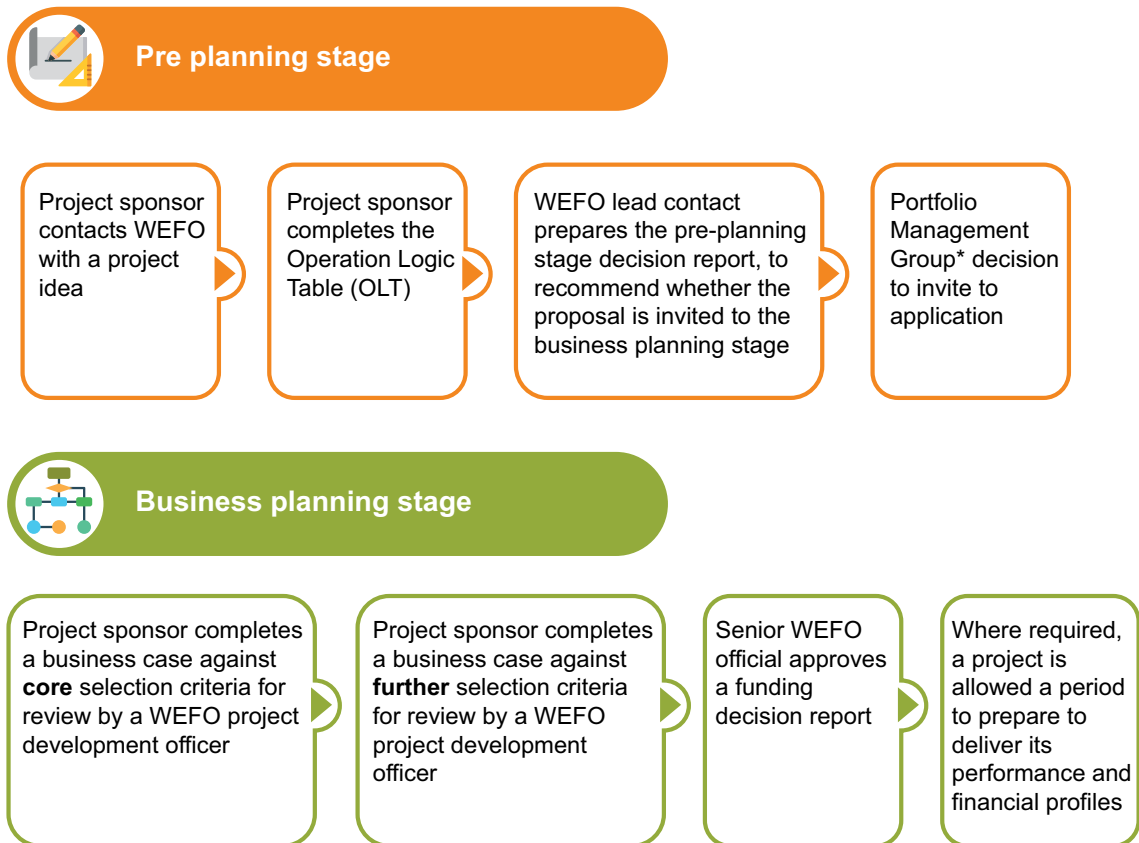
- 2.2 WEFO introduced a new approach to help to choose and prioritise projects in the 2014-2020 programme. Our April 2014 report on the 2007-2013 programme found that WEFO already had a robust system in place for selecting projects. Since then it has strengthened its approach further. As with previous rounds, the Operational Programmes are driven by their priorities and the underpinning objectives. Following a 2013 review by Dr Grahame Guilford, WEFO introduced a cross-cutting Economic Prioritisation Framework<sup>16</sup>. The framework sets out seven thematic opportunities for the Welsh economy and three regional opportunities<sup>17</sup>. The framework aims to put project proposals in the context of wider efforts to improve the economy of Wales.
- 2.3 WEFO has a two-part approach to deciding whether to approve project proposals (Figure 8). WEFO initially discusses an idea with project sponsors before asking them to complete an 'Operation Logic Table'. The Table must set out exactly how proposed projects would deliver one or more programme objectives and how that would be measured. In completing the Table, project sponsors must set out how their project would align with the economic opportunities in the Economic Prioritisation Framework.

<sup>16</sup> Welsh Government, **The Economic Prioritisation Framework – Version**, June 2015.

<sup>17</sup> The seven themes are: energy; food and farming; climate change and resource efficiency; exploitation of ICT assets and the digital marketplace; advanced manufacturing; life sciences and health; tourism, recreation and leisure. The regional opportunities set out the major investments that projects should align with in three regions of Wales. For example, WEFO has highlighted the opportunities in South West Wales related to the Swansea Bay City Deal and alternative energy generation, including the potential tidal lagoon in Swansea.

2.4 This early work and challenge helps to sift out projects that are unlikely to meet the objectives and criteria, although WEFO’s systems do not enable us to readily identify how many proposals were sifted out this way. In other cases, the early challenge helps project sponsors improve their proposals before WEFO reviews them in depth. If they get through this stage, project sponsors will need to develop a full business case. Alongside a range of criteria, WEFO requires project sponsors to set out how their project supports sustainable development<sup>18</sup>. WEFO then carries out a range of detailed appraisals and checks before final approval.

Figure 8: process for selecting and approving projects



Note: \* The Portfolio Management Group is responsible for ensuring there is a sufficiently diverse range of operations to maximise delivery of the Structural Funds Programmes and for determining which proposed projects should, and should not be invited into the Business Planning Stage.

Source: WEFO data

18 The four operational programmes and the Economic Prioritisation Framework predate the Well-being of Future Generations (Wales) Act 2015 which sets out a range of duties for named public bodies, including pursuing sustainable development. Nonetheless, WEFO expects project sponsors to set out and monitor their contribution to sustainable development and the national wellbeing objectives.

- 2.5 The Auditor General's 2014 report on EU Structural Funds made several recommendations aimed at clarifying the guidance to sponsors, to explain the requirements and different stages. WEFO has made progress with these recommendations and has updated its guidance. It now provides detailed guidance to potential project sponsors so that they can understand the checks and balances at each stage of the process. We have not tested with project sponsors whether the updated guidance has been helpful in making the processes clearer.
- 2.6 Overall, we consider that WEFO's project selection and approval process is thorough. It can be a lengthy and challenging process. But it helps to ensure that only good quality projects receive funding. If WEFO were to approve poor quality projects, it would expose itself to the risks of severe financial penalties by the EU. We can take assurance from the independent European Funding Audit Team (EFAT)<sup>19</sup> work showing that WEFO's processes for selecting and approving projects were operating effectively.
- 2.7 Two 'intermediate bodies' – the Welsh Government's Department for Economy Skills and Natural Resources and Wales Council for Voluntary Action – deliver part of the 2014-2020 programme on WEFO's behalf. These intermediate bodies run grant schemes that support the voluntary and private sectors. To date the grant schemes have a value of £141 million. EFAT's most recent review found that the intermediate bodies' approaches to selecting and approving projects were operating effectively.

<sup>19</sup> Appendix 1 explains EFAT's role and work.

## WEFO has robust checks to ensure that projects can only claim funding if they can show they have complied with all eligibility and delivery requirements

- 2.8 WEFO has strengthened the checks it carries out to ensure that projects only spend EU money in line with strict criteria. During the previous 2007-2013 programme, European Commission auditors found some technical problems in the way WEFO approached its checks on project spending. The auditors also found some problems with guidance WEFO provided to project sponsors. As a result, the EU temporarily suspended payments to Wales during 2014. WEFO responded quickly to strengthen its checks and the EU resumed payments. EFAT's 2018 annual control report sets out that WEFO's control systems are operating effectively.
- 2.9 WEFO's controls over funding mean that it has a very low 'error' rate. In its 2018 annual control report, EFAT found that just 0.05%<sup>20</sup> of audited expenditure had an error. This overall error rate is significantly below the 2% 'materiality level' which would trigger challenge and intervention from the European Commission. It is also an improvement on the 0.39% error rate at the end of the previous round.
- 2.10 WEFO has been pro-active in ensuring that recent difficulties with staff shortages do not impact on its approach to checking spending claims. WEFO plans on the basis of having 190 full-time equivalent staff. Between March 2017 and March 2018, WEFO had a staff shortage varying between 11% and 16%. WEFO told us that during this period staff worked overtime to ensure that all of the required checks on projects were completed. In addition, uncertainty around Brexit means some staff do not know whether they will still be needed after March 2019 and have been looking elsewhere for jobs. WEFO is alert to these risks and is taking action. WEFO's options had been limited by Welsh Government restrictions on recruitment and promotion. However, in early 2018, the Welsh Government approved WEFO's business case, allowing it to recruit and appoint staff within its existing budget.

<sup>20</sup> The 0.05% is a projected error based on a statistical sample of project expenditure and calculated in line with European Commission guidance.

## There are clear arrangements in place for monitoring and reporting progress with the overall programme

- 2.11 WEFO has good information to track the progress of the programme. Our April 2014 report on the 2007-2013 Structural Funds Programme found that the introduction of the Project and Programme Information Management System (PPIMS)<sup>21</sup> made it much easier for WEFO to manage its programme finances. PPIMS also records the information on the outputs and outcomes of projects. EFAT's 2018 annual control report confirmed that the financial data in PPIMS was accurate and complete<sup>22</sup> in regard to the figures audited to support the accounts submitted to the European Commission.
- 2.12 The data from PPIMS is used to monitor and report through WEFO's various layers of programme oversight ([Appendix 4](#)). We have not tested the arrangements in detail. However, we did observe two meetings of the overarching Programme Monitoring Committee. We found that the information presented on Structural Funds was comprehensive, although the volume and complexity of the material can make it difficult to identify the most important areas for scrutiny. WEFO is currently amending the format of the papers to give a clearer summary of the key issues. Committee members provided a good level of challenge on finances, delivery and wider issues. The WEFO staff that attended were knowledgeable and able to provide detailed answers to queries.

21 PPIMS is a bespoke system used by WEFO to record and store in computerised form data on each operation necessary for monitoring, evaluation, financial management, verification and audit.

22 EFAT has not carried out tests on the non-financial data.

## Part 3

It is not yet clear what will replace structural funds post-Brexit but WEFO and the Welsh Government are trying to shape debate



3.1 This part of the report looks at emerging plans for replacing EU Structural Funds post-Brexit. This section does not comment on the merits of the plans. At the time of drafting this report, the Finance Committee of the National Assembly for Wales is holding an inquiry into the replacement of EU funds. We have set out the position of the UK Government and the Welsh Government on the future of regional funding at the time of drafting. Ultimately, the question of which tier of government is responsible for any replacement scheme is a political and constitutional matter to be resolved between the UK Government and the devolved governments.

### The UK Government intends to introduce a Shared Prosperity Fund but has not set out key details about the value of the fund or how it will operate

3.2 To replace the EU funding stream, the UK Government intends to develop a UK Shared Prosperity Fund. At the time of drafting this report, there are very few details as to what the Shared Prosperity Fund will look like. In a letter to the Chair of the UK Parliament's Work and Pensions Committee, the Department for Work and Pensions stated that: 'We are also keen to ensure that the [Shared Prosperity] Fund design minimises bureaucracy and is as administratively simple and straightforward as possible for recipients to engage with.' The UK Government intends to commence consultation on its proposals for the Shared Prosperity Fund in autumn 2018. Some of the key uncertainties for Wales are:

- a whether the Fund will be a single scheme run by the UK Government or whether the devolved governments will determine for themselves how the scheme will run in their respective parts of the UK; and
- b the value of the Fund, whether it will match or exceed the current EU funding levels and what rules and requirements there may be, for example, in relation to match funding.

### The Welsh Government has set out its vision for the future of regional investment and wants full control and funding to be devolved

3.3 In December 2017, the Welsh Government produced a policy paper on **Regional Investment in Wales after Brexit**. The paper set out the Welsh Government's objection to the Shared Prosperity Fund as a UK-wide programme. It made a case for funding to be devolved and to match the levels provided by the EU as a minimum. The paper also called for the development of regional policy to be devolved to the Welsh Government.

- 3.4 In setting out its thinking on the future of regional investment, the Welsh Government has sought to learn lessons from WEFO's experience in managing Structural Funds. The Welsh Government's policy paper is clear that the Welsh Government does 'not want to replace EU funds like for like. It identifies a number of opportunities to improve the replacement scheme as well as building on lessons learnt. In particular, it identifies opportunities to improve joint-working between agencies and geographical areas, with a stronger focus on regional working, by reshaping funding criteria.
- 3.5 The Welsh Government and WEFO have engaged with a range of organisations at events in north and south Wales and ran an open online survey to gather views on a set of proposed principles (**Box 4**) for future regional investment. WEFO has commissioned independent evaluators to analyse the views. WEFO published a report setting out the analysis at the end of June 2018 which concluded that the overall approach set out by the Welsh Government was broadly welcomed.

#### **Box 4: the Welsh Government's principles for future regional investment**

- Strengthening partnership working.
- Long-term multi-annual programming approach to provide investor confidence.
- A mix of complementary national, regional and local investment.
- Greater role for regional partnerships and associated alignment of resources.
- Greater integration of different policy areas focussing on people and places.
- Integration of funding sources and funding models.
- Strengthened focus on outcomes, ensuring they include inequality, wellbeing, inclusion and environmental sustainability.
- Strengthened monitoring and evaluation but introducing simplification and proportionality.
- Simplifying rules and criteria whilst ensuring level playing field for all.
- Greater risk encouraged to attract private sector investment and innovation.
- Promotion of cross-border collaboration.

3.6 The future for WEFO is inevitably uncertain until there is clarity on what will replace the Structural Funds in Wales. If responsibility for any replacement scheme is devolved to Wales, we think that there is merit in retaining the positive benefits of rigour in project appraisal and monitoring, and the skills and experience garnered over many years by WEFO staff. In the event that the replacement programme is not devolved, there is merit in ensuring that WEFO's expertise is used to strengthen projects and programmes elsewhere in the Welsh public sector.

# Appendices



# Appendix 1 – Audit methods

## Document review and data analysis

We reviewed a wide range of documentation including:

- WEFO guidance documents
- Independently commissioned reviews of the Programmes
- European Commission audits
- Financial and performance data provided by WEFO
- Ministerial briefings
- Minutes from various meetings including the Programme Monitoring Committee

## A self-assessment completed by WEFO

WEFO completed a self-assessment against a set of questions we posed, related to its management of the programme, in light of the risks and opportunities of Brexit. The questions covered lessons learned from previous reviews, the overall strategic direction, and management of the programme including progress with committing funding and drawing down funding from the EU. It also included questions around plans for the future of regional development after Brexit.

## European Funding Audit Team (EFAT) reports

WEFO are required by the European Commission to appoint an independent audit body to oversee the efficient running of the management and monitoring of the control system for the programme. The European Funding Audit Team (EFAT) is part of the Welsh Government's corporate governance and assurance division and acts as the Audit Authority for EU Structural Funds programmes in Wales. We reviewed a number of EFAT reports, in particular annual control reports and reports on WEFO's systems for appraising project applications, monitoring the progress of projects, paying grant claims and project verification and inspection.

## Interviews

We have discussed the administration of the programmes with WEFO and Welsh Government senior officials and held a series of interviews to discuss emerging findings and clarify key aspects of the programmes and queries arising from WEFOs self-assessment.

## Observations

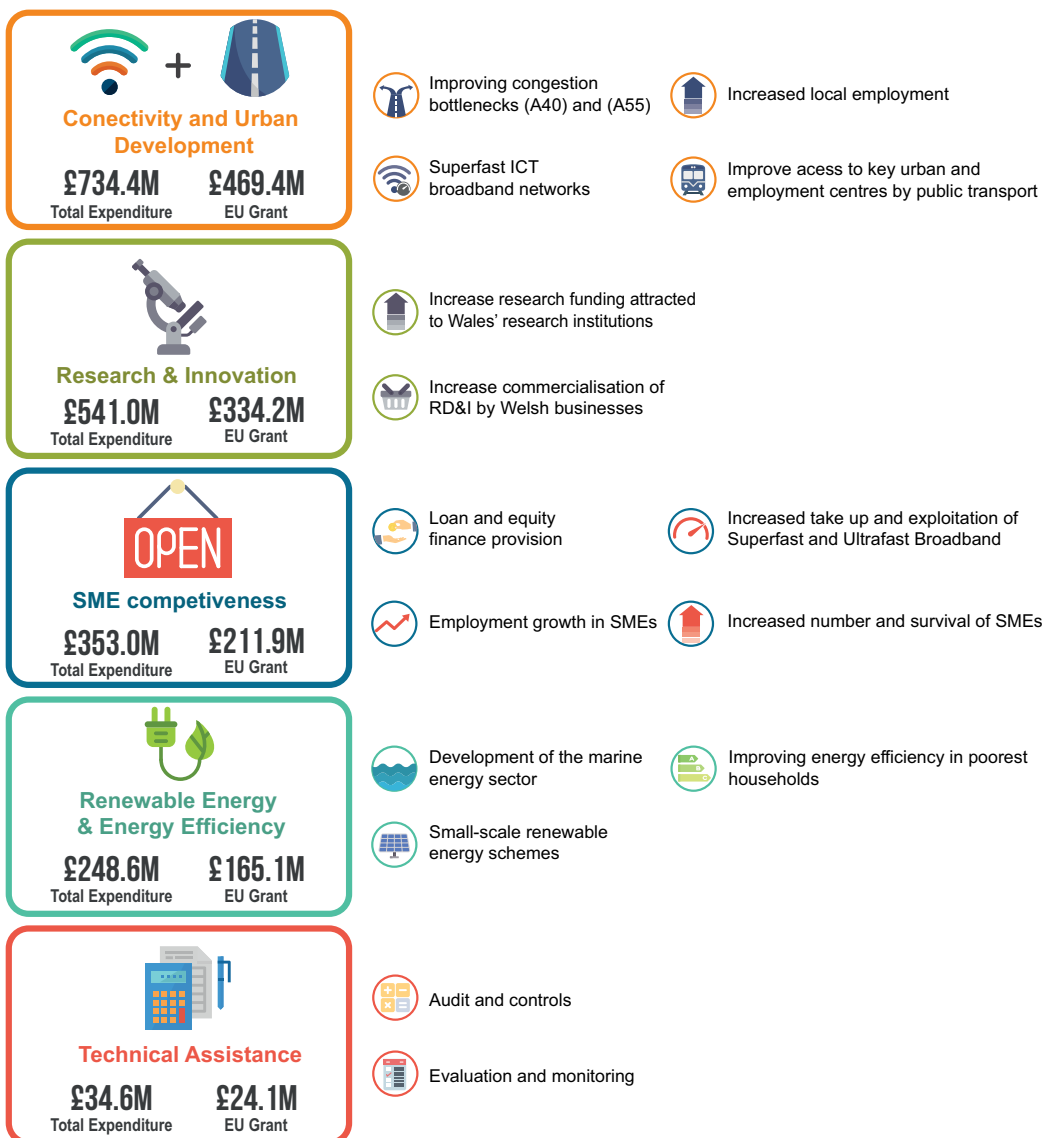
We attended and carried out observations at the December 2017 and May 2018 Programme Monitoring Committee meetings and the South Wales stakeholder engagement event held by WEFO in February 2018 to consult on views for what regional investment in Wales after Brexit should look like.

# Appendix 2 – EU Structural Funds priorities and intended outcomes and outputs

Figure A1 sets out WEFO’s five priorities for the European Regional Development Fund and Figure A2 sets out the four priorities for the European Social Fund. For each priority, WEFO has set out the ‘changes’ that the investment is intended to deliver. In some cases, the changes are based on outcomes such as increased local employment, in others they are outputs or actions, such as loan and equity finance provision.

Figure A1: European Regional Development Fund priorities and intended outcomes and outputs

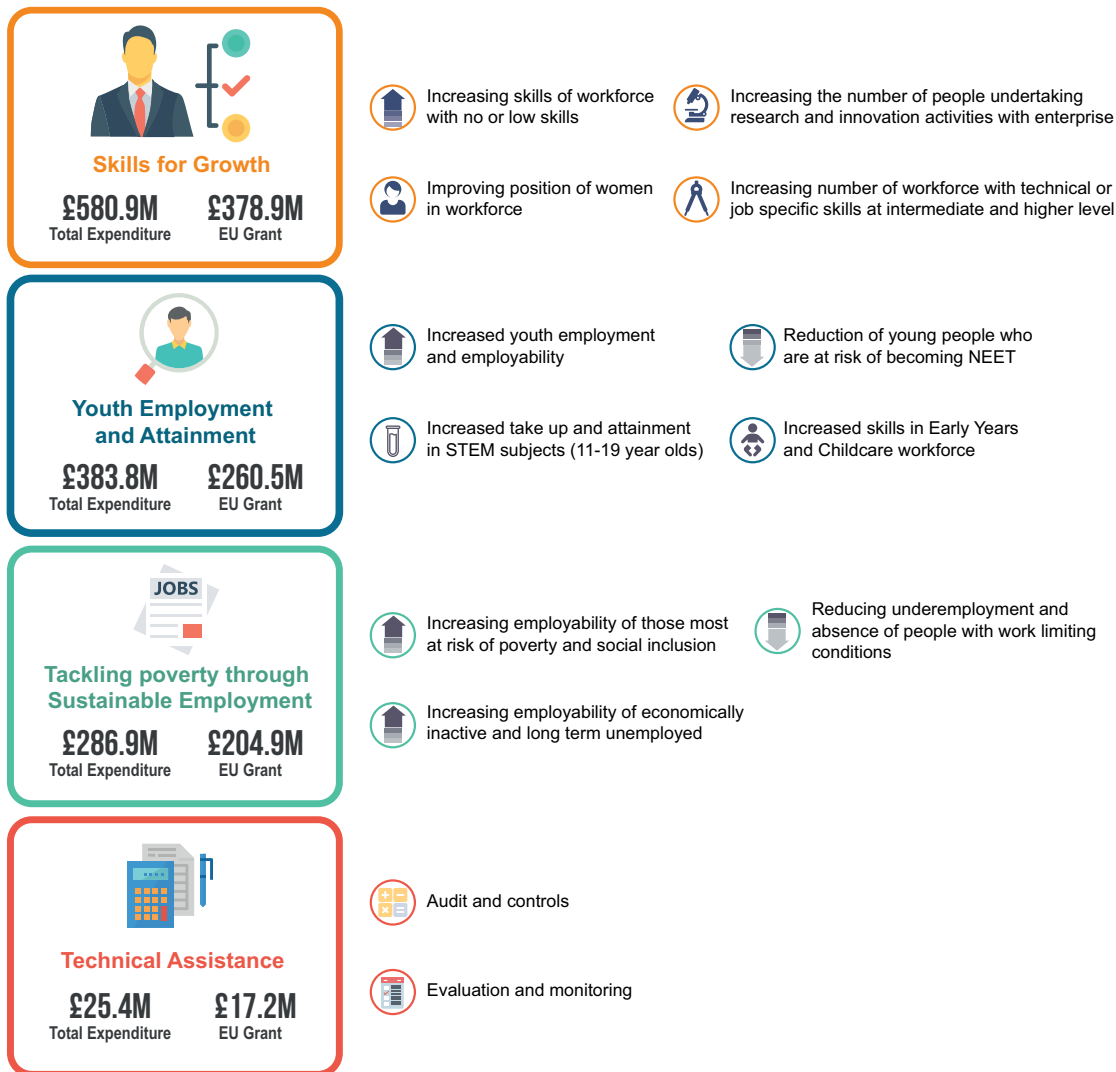
## EUROPEAN REGIONAL DEVELOPMENT FUND



Source: WEFO data

Figure A2: European Social Fund priorities and intended outcomes and outputs

## EUROPEAN SOCIAL FUND



Source: WEFO data

# Appendix 3 – WEFO’s proposed changes to the programme

Figure A3 sets out in more detail the proposed changes to the operational programmes described in paragraph 1.7 and Figure 6. These changes are being proposed in light of progress to date and in order to create a new priority around regional working. The changes are still to be formally approved by the European Commission.

Figure A3: proposed changes to the operational programmes

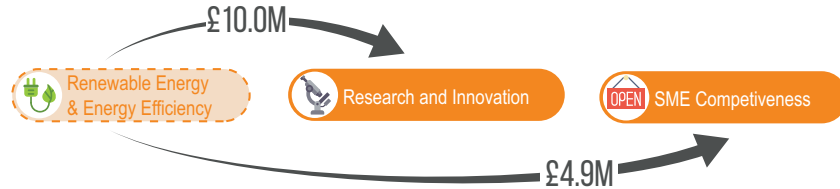
## WEST WALES AND VALLEYS EUROPEAN REGIONAL DEVELOPMENT FUND

WEFO is proposing reallocating £17.0 million within the priority focused on the competitiveness of SMEs. It is proposing moving this funding from business advice and support and using it to boost the equity finance for research, development and innovation under the financial instrument managed by the Development Bank of Wales.



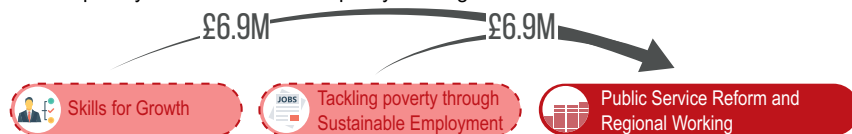
## EAST WALES EUROPEAN REGIONAL DEVELOPMENT FUND

WEFO is proposing moving £14.9 million from the priority focused on renewable energy and energy efficiency and reallocating £10.0 million of it to the priority focused on research and innovation and a further £4.9 million to the priority focused on SME competitiveness.



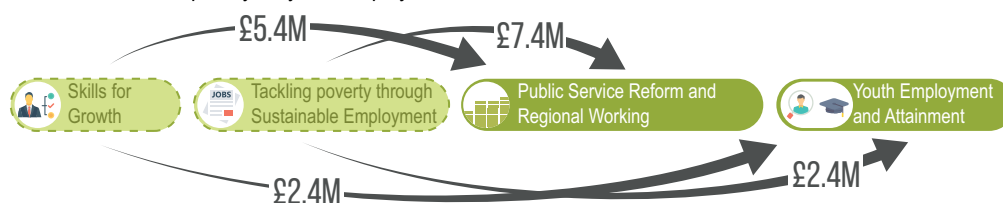
## WEST WALES AND VALLEYS EUROPEAN SOCIAL FUND

WEFO is proposing taking £6.9 million out of the priority to tackle poverty through Sustainable Employment and another £6.9 million out of the priority skills for growth and putting the total of £13.9 million into a newly created priority called institutional capacity building.



## EAST WALES EUROPEAN SOCIAL FUND

WEFO is proposing taking £10.0 million out of the priority to tackle poverty through Sustainable Employment and a further £7.9 million out of the priority skills and growth and putting £12.9 million of it into a new priority called institutional capacity building and regional working. WEFO is also proposing putting the remaining £4.9 million into the priority for youth employment and attainment.



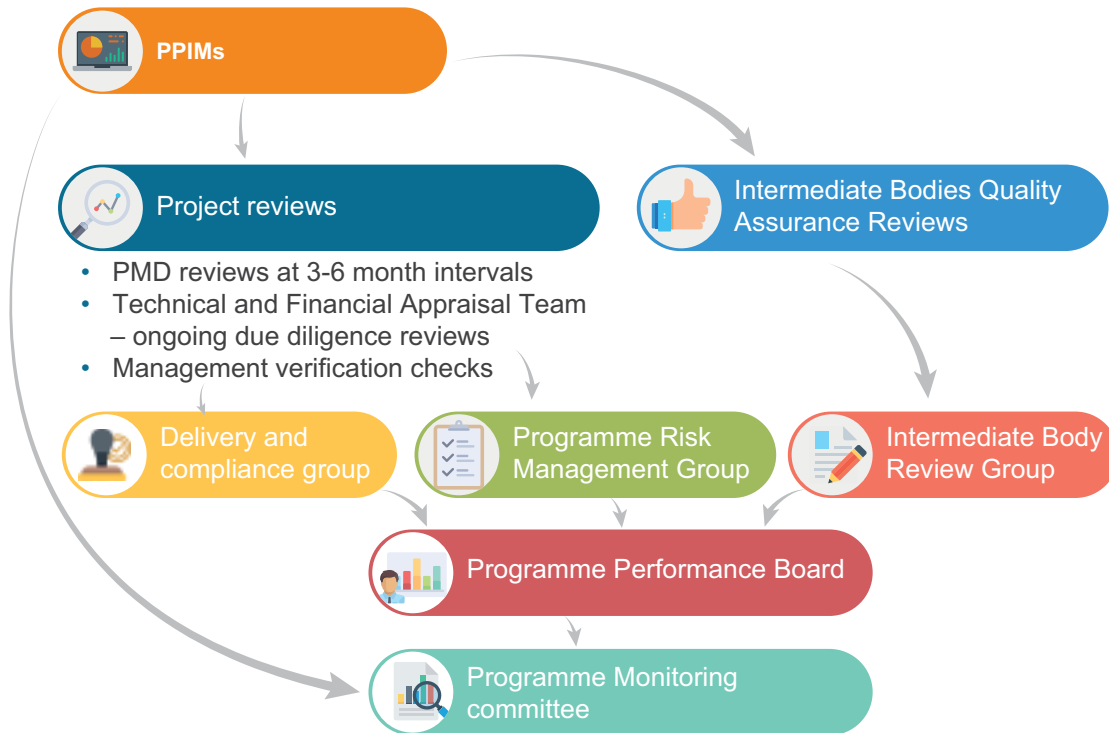
Figures based on a conversion rate of £1:€1.17 which may change

Source: WEFO data

# Appendix 4 – Programme oversight and monitoring

Figure A4 sets out more detail on the oversight and monitoring arrangements, referred to in paragraph 2.12.

Figure A4: WEFO oversight and monitoring structure



<b>PPIMs</b>	WEFO’s IT system that contains all approval, financial and performance information relating to projects.
<b>Programme Management Division (PMD)</b>	WEFO has put in place a team of officers who work within this division. Their role is to work with beneficiaries from an early stage in the development of operation ideas to advise on how successfully it might contribute to the programme level outputs
<b>Technical and Financial Appraisal Team (TFAT)</b>	WEFO’s TFAT provides support to PMD staff responsible for appraising and selecting operations. TFAT has a number of qualified accountants to ensure beneficiaries have the financial capacity to run their operations

<b>Project reviews</b>	<p>PMD – continuously review the performance and progress of each operation. This includes – following the submission of each claim to WEFO – the performance to-date against agreed profiled expenditure, output and results indicators. In addition to indicators/ profiles, PMD consider the overall effectiveness and impact of the operation’s activities to ensure that the desired outcomes are likely to be achieved. PMD identify and monitor risks and issues throughout the lifetime of an operation and meet with the beneficiary following the submission of each claim, along with relevant WEFO teams, to discuss progress, performance and issues.</p> <p>TFAT – review the financial information of potential and current beneficiaries to ensure that they have the financial capacity to run their operations.</p> <p>Management verification checks – operate a framework of checks and controls on claims received from beneficiaries and through site visits, to ensure that the expenditure included in the drawdown requests from WEFO are compliant with the rules.</p>
<b>Intermediate Bodies (IBs) quality assurance reviews</b>	<p>WEFO review claims submitted by IB’s before including expenditure in draw down from the EC.</p>
<b>Intermediate Body review group</b>	<p>WEFO have established an IB review group to discuss the projects delivery, and identify any risks and actions needed. The group also reviews the Quality Assurance reviews and systems audits of WEFO’s IB’s.</p>
<b>Programme Risk Management Group (PMG)</b>	<p>PMG monitors risks and processes across the programme through numerous risk registers.</p>
<b>Delivery and compliance group</b>	<p>The Group considers and reviews delivery and compliance issues affecting programme. The Group is made up of both internal and external stakeholders and usually meets on a quarterly basis.</p>
<b>Programme performance board</b>	<p>Responsible for planning, monitoring and directing the delivery of programmes.</p>
<b>Programme monitoring committee</b>	<p>Under EU regulations, Member States are required to appoint monitoring committees to check that operational programmes are being correctly implemented. It is chaired by WEFO and has regional, economic and social partners.</p>

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