Radiology Service Review
Final Internal Audit Report

October 2022

Cwm Taf Morgannwg University Health Board

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Acknowledgement

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Executive Summary

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Radiology service in relation to key assurance areas.

Overview

We identified a number of areas as outlined in Appendix A, that require improvement. The key points relate to:

- Reviewing policies and procedures to ensure all are up to date, accessible and standardised where relevant across sites.
- Having more comprehensive monitoring of the risk register in the relevant committees.
- Ensuring complete and accurate records are maintained to enable the management of absence.
- Undertaking Personal Develop Reviews (PDRs) for all staff annually.
- Confirming the accuracy of individual's mandatory training requirements and ensuring all staff complete training in line with those requirements.
- Reviewing and agreeing Consultant job plans on annual basis.
- Undertaking workforce planning to allow the service to better plan for the future.
- Having a greater control and awareness over medical agency use.

Assurance summary

Due to the wide range of areas covered in our Clinical Service Group reviews, we do not provide an overall assurance opinion. Instead, we have provided separate assurance opinions for each of the areas that we reviewed.

	Assurance Area	Assurance
1	Governance Arrangements	Reasonable
2	Risk Management	Reasonable
3	Workforce Management	Limited
4	Planning and Performance	Reasonable
5	Compliance with relevant FCPs	Reasonable

	Key Matters Arising	Assurance Area	Control Design or Operation	Recommendation Priority
Governance Arrangements				
1	Terms of Reference for Committees and Groups	1	Design	Medium
2	Conduct of Committees and Groups	1	Operation	Medium
3	Policies and Procedures	1	Operation	High
4	Declarations of Interest	1	Operation	Medium

Key Matters Arising		Assurance Area	Control Design or Operation	Recommendation Priority
Risk Management				
5	Risk Monitoring	2	Operation	High
Workforce				
6	Sickness Absence	3	Operation	High
7	Annual Leave	3	Operation	Medium
8	TOIL	3	Operation	Medium
9	PDRs	3	Operation	High
10	Mandatory Training	3	Operation	High
11	Consultant Job Plans	3	Operation	High
Planning and Performance				
12	Workforce Planning	4	Operation	High
13	Consistency in Monitoring Arrangements	4	Operation	Medium
Compliance with FCPs				
14	CRES target information	5	Operation	Medium
15	Medical Agency use	5	Operation	High

1. Introduction

1.1 Our audit of the Radiology Service was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Radiology, along with Pathology and Medical Records, form the Clinical Support Services Clinical Service Group (CSG), that is hosted by Rhondda Taf Ely Integrated Locality Group (ILG) on behalf of the Health Board. Radiology services operate from all three of the Health Board's localities and our review and testing focussed on the three main hospital sites of Royal Glamorgan Hospital (RGH), Princess of Wales Hospital (POW) and Prince Charles Hospital (PCH).

1.3 An Interim CSG Manager started in post a month before our audit fieldwork began. Prior to that time, the CSG has had a prolonged period of staff absence at that level, resulting in interim management arrangements in the form of the Clinical Director and Acute Services Manager taking on additional responsibilities to ensure the continued running of the service.

1.4 Over the last few years, as part of the Internal Audit programme, we have reviewed the management arrangements and compliance with key financial documents in a number of the Health Board's CSGs. This year's programme continues with this theme.

1.5 The relevant Executive Director lead for the assignment is the Chief Operating Officer.

1.6 The potential risks considered in the review were as follows:

- The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- Risks materialise as they have not been identified and / or addressed.
- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.
- CSG objectives are not achieved as a result of demand and capacity data failing to be properly used and monitored
- Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
- Inappropriate or unauthorised decisions due to non-compliance with legislation or corporate and operational policies.
- Financial expenditure unnecessarily incurred.

2. Detailed Audit Findings

Area for assurance 1: Governance Arrangements

Governance Committees and Groups

2.1 A number of committees and groups oversee the governance arrangements and operation of the Radiology service. The committees and groups structure is identified in a single document which maps the various meetings and reporting lines between them.

2.2 There have been recent revisions to the governance arrangements with the introduction of a Radiology Management Team Business Meeting. While we understand that this will be a pivotal group that all other committees and groups report into, at the time our fieldwork, the group had yet to meet. We note that subsequently a Terms of Reference (ToRs) has been finalised and the group has met.

2.3 We saw evidence of the ILG monitoring governance at a CSG level through the monthly Performance Review meetings. However, the meetings varied in coverage, with some focused on the Radiology service, and others including information on the other services in the CSG, such as Pathology and Medical Records. This lack of consistency in coverage has been highlighted in paragraph 2.34 as it has an impact on the ability to monitor Radiology performance effectively.

2.4 We note that there is no ToR for the Performance Review meeting. The ToR for the Radiology Quality, Improvement & Governance meeting pre-dates the merger with Bridgend. As such, the remit of these groups is not clear, meaning there may be duplication in coverage, or areas may not be getting the required level of scrutiny. **(Matter Arising 1)** Furthermore, the quarterly Quality, Improvement & Governance group has not met since September 2021 due to staffing constraints. **(Matter Arising 2)**

2.5 While the Radiology service is provided across all three localities, there does not appear to be a consistent approach to governance and monitoring arrangements across the sites. We understand that the PoW team have monthly governance meetings, although no documentation in relation them was provided to us. Since January 2022, RGH have held similar meetings, although the ToR has not yet been finalised. There is no equivalent meeting at PCH. **(Matter Arising 2)**

Policies and Procedures

2.6 Radiology policies and procedures are available to staff through localised SharePoint sites. However, we understand that numerous documents have passed their review date, and in many cases multiple versions of a document exist due to there being a version for the former Cwm Taf sites and a PoW site version. We note that management are undertaking an exercise to identify existing policies and procedures from across the three localities, with a view to reviewing, revising and amalgamating where necessary. However, progress has been slow due to resource constraints. **(Matter Arising 3)**

Declaration of Interest

2.7 Our testing identified that declarations of interest or 'nil' returns were not in place for all Radiology staff that should have completed them. **(Matter Arising 4)**

Conclusion:

2.8 We note that management are aware of some of the governance issues that the service is facing. The work to define the governance structure and introduce the Radiology Management Team Business meetings will be key to the success of the structure. Further work is needed to ensure that the committees and groups that feed into the Radiology Management Team Business meetings are aware of their responsibilities and meet regularly and consistently across the service. We acknowledge that the implementation of the Health Board's revised operating model may have some impact. We have provided Reasonable Assurance in this area.

Area for assurance 2: Risk Management

2.9 Management have been cleansing the risk register to ensure that only risks and not issues are captured. Risks, including lower scoring risks, are recorded in the Datix risk management module by the Superintendent Radiographer. There are twelve risks on the Radiology risk register, with seven relating to all three localities. Only one risk is categorised as a 'high risk', with the remaining eleven 'moderate' or 'low' risks.

2.10 Risks on the register include a number in relation to the demand placed on the service and the related capacity issues. Linked to this is the risk of the impact on patient diagnosis and treatment if the service is unable to report radiology examinations in a timely manner. We note that these risks are categorised as Health Board wide risks, but our review of performance data shows that the backlog is greater for some localities than in others. Therefore it may be more appropriate to have these risks captured on locality risk registers, to allow reflection of the different level of concern in each area.

2.11 Our review of risks in Datix confirmed that all had evidence of review by the designated risk handler within the last four months. However, it was not always clear what that review entailed, as in many cases the narrative outlining the controls that are in place had not been updated for some time. **(Matter Arising 5)**

2.12 In line with the Risk Management Policy, we saw evidence of the one high scoring risk being monitored at an ILG level during the monthly Performance Review meetings. We are also aware that managing risk is a standard agenda item for the Quality, Improvement & Governance Group. However, as the group has not met since September 2021, we were unable to see where moderate and low risks, and the risk register in its entirety, is being monitored. **(Matter Arising 5)**

2.13 Furthermore, we did not see evidence of risks being discussed at a locality level in governance departmental meetings (where they exist). Some demand and capacity related risks are more of an issue in certain localities, therefore a more

granulated approach to these risks, and monitoring at a locality level, may be more beneficial. **(Matter Arising 5)**

Conclusion:

2.14 We can see that the Datix system is regularly being used to manage risk. However, the lack of narrative updates within the system and evidence of review in meetings makes it hard to determine the level of review that is taking place and to establish how risks are escalated and de-escalated through the service. We have provided Reasonable Assurance in this area.

Area for assurance 3: Workforce

Sickness Absence

2.15 We tested a sample of staff absences from across the three localities to ensure compliance with the All Wales Managing Attendance at Work Policy. The level of documentation to confirm compliance with the policy varied, and we were not provided with supporting information for our sampled items from PCH. At RGH and POW, where more information was available, our testing identified: a number of discrepancies between paper records and ESR; incomplete records; and a lack of information to evidence that repeated absences had been managed in line with the 'prompts' set out in the policy. **(Matter Arising 6)**

Managing Leave

2.16 All sites have principles in place setting out how many staff at each band can take leave at any one time. When reviewing the rosters, we could see that in the main, these principles were being followed.

2.17 RGH and PCH use Health Roster, therefore annual leave is booked and approved via the rostering system, with automatic feeds into ESR. As such we did not test this process. At the time of our fieldwork POW were in the process of migrating from paper annual leave records to using ESR, and were 'parallel running' both systems while staff familiarised themselves with ESR. However, staff continue to use paper records and our testing identified a small number of minor errors that would not have occurred if the leave had been booked directly on ESR. **(Matter Arising 7)**

2.18 We understand that TOIL is not used at PCH. If staff work additional hours, they are paid overtime or use the hours against their 'make up' shift. However, a report from Health Roster shows staff with hours owing to them and vice versa. We understand that these balances are linked to the way the rostering system is being used in PCH to capture information, as opposed to it being TOIL balances. The same report shows 18 RGH members of staff had a TOIL balance, the highest value being 7.5hours, suggesting that TOIL, is in the main being effectively managed. However, when reviewing the Health Roster system with a member of staff some discrepancies were identified that required further investigation. **(Matter Arising 8)**

2.19 As POW do not use Health Roster, manual TOIL records are maintained. Whilst our testing did not identify any obvious errors, the forms were heavily annotated and

difficult to review, making them more susceptible to errors. We also note due to covid staff have had high TOIL balances over the last few years, which more recently staff have been able to take the time back. **(Matter Arising 8)**

PDR & Mandatory Training Compliance

2.20 The service is struggling to achieve the required compliance levels both for PDRs and mandatory training. Whilst compliance data has been provided to the service at their request, or when asked by workforce to improve compliance rates, more recently the service has asked for data each month.

2.21 At the time of our fieldwork approximately 57% of staff did not have an up-to-date PDR, with some staff not having had a PDR meeting since before the pandemic. There are also a number of staff without PDRs that are due increments in the forthcoming year. The lack of a PDR logged in ESR could have an impact on staff being moved to their next pay point. **(Matter Arising 9)**

2.22 The mandatory training compliance rate against the Health Board core modules was 52%. Some staff must complete additional levels in the core modules. Management have expressed concerns that some of these additional allocated levels are inappropriate for the role. In addition, some staff will have professional qualifications over and above their ESR requirements, but this information is not captured in ESR.

2.23 Aside from some potential inaccuracies in the ESR requirements impacting on compliance rates, our testing has identified that there remain a number of staff who are not undertaking their mandatory training. In an effort to overcome this, the Interim CSG manager has introduced a 'module of the month' as a way to encourage staff to update their training. **(Matter Arising 10)**

Staff Rosters

2.24 There are two different rostering systems in place across the three sites. RGH and PCH use Health Roster, while POW use spreadsheets. All sites have roster templates, however the shift patterns adopted varies in approach. Our testing showed that where possible, rosters are created in line with the templates, although this is not always possible where there are staffing vacancies. Agency staff are used if available, but given the speciality of the service, this is not always possible.

2.25 We confirmed that rosters are generated in a timely manner ahead of the period start date. Where possible the roster creators ensure fixed working patterns, annual leave requests, and day off preferences are granted.

2.26 Our testing in relation to TOIL has highlighted some inaccuracies with the way in which information is being captured in Health Roster at PCH, as some staff had extremely high or low TOIL balances. **(Matter Arising 8)**

Consultant Job Plans

2.27 The pause in requirements to undertake annual consultant job plan reviews, coupled with the management resource issues faced by the service, has had a direct impact on the job planning compliance rates. At the time of our review, we understand that the low compliance rate has yet to be addressed.

2.28 Through our discussions we identified errors with the data held in the Allocate system. We also established that the recently published job planning procedure was not being used by management to progress the job plans of the Consultants that are not signing them off in a timely manner. **(Matter Arising 11)**

Conclusion:

2.29 Our testing in relation to workforce across the three sites has identified a number of issues at site level and had also highlighted the different operating practices in place across the service. We have provided Limited Assurance in this area.

Area for assurance 4: Planning and Performance

Planning Arrangements

2.30 For 2022/23 the Health Board stood down its localised IMTP planning process due to ongoing covid pressures. There was no requirement for the Radiology Service or the wider Clinical Support Services CSG to create an IMTP or annual plan. Instead, planning took place at an ILG level, with a focus on the completion of finance templates. CSGs were required to identify key priorities for the 2022/23 for monitoring through their Performance Review meetings, although there was no funding for service developments. They were also involved in developing their Cash Releasing Efficiency Savings (CRES) plans.

2.31 In addition, formal workforce plans have not been required for 2022/23. There has been no workforce planning outside of IMTP requirements to enable the CSG to more effectively manage its workforce in terms of vacancies and future retirements. **(Matter Arising 12)**

Monitoring Performance

2.32 The monthly Performance Review meetings monitor against the carried forward IMTP priorities; quality measures including concerns, complaints, Serious Incidents and harm reviews; workforce key indicators such as sickness levels, PDR and mandatory training compliance rates and job planning completion rates; and service delivery performance rates. More detailed monitoring of quality matters happens at the Integrated Quality & Governance Group, but this group has not met since September 2021.

2.33 Our analysis of the workforce performance data identified that some of the target compliance rates varied from month to month and were not in line with the WG targets. **(Matter Arising 13)**

2.34 We also note that the format of some of the workforce, quality data and service delivery data contained in slide decks varied between months. Some had granulated information on the Radiology service, or information broken down by

locality, but this was not always available, and some months contained no data for the CSG as a whole. As such, it is difficult to identify the performance position of the Radiology service. **(Matter Arising 13)**

2.35 As noted above there are governance meetings in two of the three localities, although we have only sighted papers for one locality. It is during these meetings that we would expect to see more granulated performance monitoring taking place. Whilst we could see performance being discussed at the RGH governance meeting, detailed reports and data is not taken to the meetings to facilitate performance monitoring. We acknowledge that this group is in its infancy and is yet to develop a Terms of Reference. **(Matter Arising 13)**

Conclusion:

2.36 As a hosted service, we have reviewed aspects of the service provision in all three ILGs and there are clear differences across the sites for example the approach to performance monitoring. We acknowledge that the CSG manager staffing issues have probably exacerbated this. However, going forward, the changes to the operating model should help Radiology address a number of the matters that we have identified. We have provided Reasonable Assurance in this area.

Area for assurance 5: Compliance with FCPs

Budgetary Control

2.37 The Interim CSG Manager is the overall budget holder for the Radiology Service, although the Superintendent Registrars, and three site leads, also have responsibility for budget monitoring. For 2022/23 there was no requirement for budget holders to formally agree and sign off acceptance of their budget, as in the main they were rolled over from 2021/22. The only changes were to allow for inflation and the new CRES targets.

2.38 The service area has a close working relationship with its Finance Business Partner, who provides information and support to the senior managers when requested.

2.39 The Interim CSG Manager receives a monthly finance pack, and along with other senior staff has access to QlikView where finance and staff reports can be reviewed, and they can drill down to analyse cost information in more detail. QlikView training has recently been provided by the Finance Business Partner to the senior staff.

2.40 High level budget monitoring was seen to take place at the monthly Performance Review meetings. However, we noted that information in relation to the CRES target and plans is not clear to understand and lacks any detail to be meaningful. **(Matter Arising 14)** During the course of our audit, the Interim CSG Manager re-introduced monthly Business Meetings. The Finance Business Partner was seen to be in attendance at the two meetings held to date, where finance updates were provided.

Medical Variable Pay

2.41 Due to vacancies, the service regularly needs to use medical agency staff. However, a reduction in agency staff spend is highlighted in the monthly Performance Review reports as an opportunity to help achieve the CRES target.

Our testing has identified that there appears to be a lack of oversight in relation to agency usage. Numerous staff had to be contacted in order to determine who some of the agency staff being paid were, and to confirm details of the days worked. This lack of oversight appears to be the cause of a large accrual for an agency medic that did not work for the service as planned. **(Matter Arising 15)**

2.42 For the sample of agency staff we reviewed, we were unable to obtain any documentation to confirm that rates of pay paid to agency consultants was below the WG price cap or that appropriate authorisation had be sought to exceed the cap. **(Matter Arising 15)** However, we have seen an email exchange for a future agency booking that was being arranged as we were undertaking the audit. In this case it was acknowledged that the rate of pay was above the WG price cap and ILG Director is seen to challenge the rate in comparison to usual rates and request confirmation that the cost is being covered by existing vacancies.

Conclusion:

2.43 The resource issues around the lack of a CSG Manager earlier in the year have potentially had an impact on the level of oversight and scrutiny that was applied to expenditure including on medical agency staff. We have seen that more robust processes are now being introduced with budget monitoring training being arranged and challenge of agency use and rates. We have provided Reasonable Assurance in this area.

Appendix A: Management Action Plan

Governance Arrangements

<table>
<tr><th colspan="3">Matter Arising 1: Terms of Reference for Committees & Groups (Design)</th><th>Potential Impact</th></tr>
<tr><td colspan="3">In relation to the key groups within the CSG, we identified the following:
• There was no Terms of Reference (ToR) for the Radiology Performance Group meeting. This is a key meeting that reports on risk, quality, financial and workforce information to the ILG. The group meet each month and key CSG staff and Business Partners attend. As there is no ToR it is unclear if the right people attend, the quoracy arrangements, or if the group is fulfilling its intended purpose.
• The ToR for the Quality, Improvement & Governance group was due for review in January 2022 and pre-date the April 2020 operating model. The ToR do not reflect that Radiology is a service hosted by RTE and does not identify how quality improvement assurance is provided by the two other ILGs.</td><td>The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>1.1</td><td colspan="2">The Terms of Reference for all groups and committees should be reviewed to ensure they are up to date and relevant, including information such as purpose and remit of the group, attendees and quoracy arrangements, frequency of meetings and arrangements for rescheduling.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Actions</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>1.1</td><td>Due to the HB restructure, the previous Radiology Performance Meeting Forum has been stood down and replaced with a weekly Care Group Radiology Performance Review. ToR to be sourced from the Executive Office to reflect attendees, quoracy and frequency of the meetings while the care group structure beds in.

A Radiology Quality, Improvement & Governance Structure Meeting has been arranged to update the governance meeting arrangements, reporting structure and review of ToR on 9/11/2022.</td><td>31 December 2022

9 November 2022</td><td>Executive Office

Clinical Service Manager
Senior Superintendents</td></tr>
</table>

			Clinical Lead for Quality and Governance Health and Safety Leads

Matter Arising 2: Conduct of Committees & Groups (Operation)		Potential Impact
Through our review of agendas, minutes and action logs of the key groups we identified: • The Quality Improvement & Governance group, which should meet quarterly, has not met since September 2021, due to staff availability including the Chair. We also note that there is no Vice Chair in place. • There are monthly departmental meetings at RGH, and while we understand that there are similar meetings at PoW, we have seen papers relating to these meetings. No similar meeting takes place at PCH. The committee and groups structure diagram identifies that these meetings feed into the overarching Radiology Management Team Business Meeting. • While there is an action log relating to the Performance Review meetings, we did not see evidence of the process for following up the actions at subsequent meetings to ensure they have been implemented or carried forward.		The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendations		**Priority**
2.1	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	**Medium**
2.2	Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	**Medium**
2.3	It should be ensured that action logs generated after meetings are followed up at future meetings, to confirm that work has been undertaken and the action closed or carried forward.	**Medium**

Agreed Management Actions		Target Date	Responsible Officer
2.1	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re-arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	30th November 2022	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads
2.2	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	31st December 2022	Clinical Service Manager
2.3	A review of the action log will be a standing item on all meeting agendas. This is currently in operation for the Radiology Quality, Improvement & Governance Meetings. The new Care Group Performance Review produces an action log following the meeting, which can be evidenced.	Complete	Clinical Service Manager Executive Office

Matter Arising 3: Policies and procedures (Operation)			**Potential Impact**
Management are undertaking a review of Radiology policies and procedures across the three localities. Since the merger with Bridgend, limited work has been carried out to refine the policies and procedures. Management is aware that there may be duplication, processes across sites not standardised and many policies and procedures are out of date or no longer valid. At the time of our review, management were working to identify all of the existing policies and procedures within Radiology before undertaking a review. We note that staff have access to policies and procedures via their local SharePoint sites.			Inappropriate or unsafe decisions made due to operational polices being out of date and not reflecting current legislation or best practice. Inconsistencies in working practices across sites.
Recommendations			**Priority**
3.1	a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.		**High**
3.2	Consideration should be given to having a standard agenda item during the Radiology Management Team Business Meeting in relation to policies and procedures, to ensure that all staff are aware of what is due for review and to ensure that there is consistent communication in relation to new policies or policy updates following changes in legislation or guidance.		**Medium**
Agreed Management Actions		**Target Date**	**Responsible Officer**
3.1	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A	June 30th 2023	Senior Superintendents Clinical Leads

	Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via Sharepoint underway.	June 30th 2023	Superintendent Radiographers Clinical Leads Health & Safety Leads
3.2	The Radiology Management Team Business Meeting agenda will be changed on the 17th October 2022 to ensure that is a standing item relating to policies and procedures to review and ratify.	Completed	Clinical Services Manager

Matter Arising 4: Declaration of interest (Operation)		**Potential Impact**
We identified 44 staff members who should have completed a declaration of interest or nil return for 2021/22. However, we were only able to confirm returns for eleven members of staff. We note that there were a small number of new employees that came into post after these dates, so would not be included in the committee reports. Furthermore, we understand that other members of staff had completed declarations, but were not showing in the reports. It is unclear why this was the case. We note that no reminders had been sent to prompt staff to complete their returns.		Personal interests are not considered meaning inappropriate decisions are made.
Recommendations		**Priority**
a) Acknowledging that for 2022/23 the Standards of Behaviour Policy has been amended, and less categories of staff will be required to make a return, relevant staff within Radiology should be reminded of the relevance of the policy and the requirement to comply with it and complete an annual return. Where individuals fail to make a return, managers should continue to prompt staff to do so. b) Management should work with the Committee team to identify any gaps in the declaration of interest reporting.		**Medium**
Agreed Management Actions	**Target Date**	**Responsible Officer**
a) The register of the declaration of interest information is maintained by the Corporate Service Department and submissions are registered and updated through this Department. A request for any outstanding declaration of interest will be made to the Corporate Services Department to identify those individual where these are outstanding and the relevant staff will be prompted to complete. b) A system of review will be agreed with the Corporate Services Department.	31st December 2022	Corporate Services Manager/Clinical Service Manager

Risk Management

Matter Arising 5: Risk monitoring (Operation)	Potential Impact
The Radiology risk register contains 12 risks ranging in score from 2 to 16. One risk is assigned to a member of staff that has left the CSG. This is a low scoring risk. Monitoring in Datix We looked at the risks on Datix and confirmed that they had evidence of review in the past four months. However, in most cases it appeared that 'controls in place' entry had not been updated. For five risks the controls information had not been updated since 2021, and there was one risk with no review date recorded against the controls. For example: • One risk cites as a control, the purchase of equipment with 2021/22 capital funds, at which point the risk can be closed. The risk remains open, and there is no update to state that the equipment wasn't purchased. • One risk refers to a pilot project that started in 2020. In March 2021 the pilot is recorded as 'ongoing', but there is no further information. Monitoring in committees The Quality, Improvement & Governance Group agenda has a standard item on managing risk. Our review of minutes from the meetings that took place in 2021 identified that their focus was on cleansing the register. The group has not met since September 2021 so it is not clear where the risk register, and more specifically where moderate rated risks, are monitored. As stated in Matter Arising 2, we understand that monthly departmental meetings are held at POW and RGH, though not at PCH. We have not been given papers for the POW meetings, so cannot establish if the risk register and risks specific to that site are discussed. We did not see risk being discussed in the papers of the RGH meetings. From our review of performance data we note that certain demand and capacity issues impact some localities more than others. Therefore, more granulated risk registers and localised monitoring would be beneficial.	Risks materialise as they have not been monitored and action taken not taken to address them or escalate where necessary.

Recommendations		Priority
5.1	When risks are reviewed within Datix, the narrative in the 'controls in place' or notes section should be updated for changes since the previous review.	**Medium**
5.2	A risk management monitoring structure should be established, ensuring that the risk register is a standing agenda item for relevant committees or groups. Lower scoring and more localised risks should be monitored at the localised departmental meetings, with the moderate and higher scoring risks, along with oversight of the whole risk register considered at Quality Improvement & Governance Group and where appropriate, reported to the ILG Radiology Performance Review Group. There should be a clear escalation process between the groups.	**High**

Agreed Management Actions		Target Date	Responsible Officer
5.1	A review of the risk register will be undertaken to establish those that can be closed and a regular review of the Datix and the controls in place scheduled into monthly meetings. Advice will be taken from the newly centralised corporate Governance Team in relation to management of the Risk Register.	30th November 2022	Superintendent Radiographers Clinical Service Manager Care Group Service Director
5.2	As described above a risk management monitoring system will be established with the Quality Improvement & Governance Group having oversight of the register and an escalation process for moderate and high risks.	31st December 2022	Clinical Lead for Quality and Governance Senior Superintendents

Workforce

<table>
<tr><th>Matter Arising 6: Absence Management (Operation)</th><th>Potential Impact</th></tr>
<tr><td>
Each locality is at a different stage of transferring their paper-based staff personal files to electronic personal folders, to allow easier management access. At the time of our review the files were still mostly paper-based.
To ensure compliance with the All Wales Managing Attendance at work policy, we tested a sample of absences across the three localities based on their levels of sickness. We identified:
<u>PCH</u>
We were unable to test the five periods of sickness that we sampled as no self-certification forms, RTW forms or other paperwork relating to the absences had been completed. For two of the employees, the period of absence would have triggered a prompt under the policy, but there was no documentation in relation to this.
<u>RGH</u>
For the seven periods of sickness we sampled, a number of discrepancies were identified. These were:

Self-certification forms - 3/7 the absence end dates did not reconcile to ESR, 2/7 the reason for absence was not recorded, 2/7 the form was not signed by the manager, 1/7 the form was completed four weeks after the RTW date, as opposed to when the absence took place.
RTW forms - 3/7 were not completed within 7 days of the actual return to work, though we acknowledge that shift patterns had an impact on this. 1/7 was not signed by the manager.
Medical certificates - 3/7 required medical certificates. In one case the certificates did not cover the full period of absences with 10 days being uncertified.
Prompts - 2/7 a prompt had been met, but an informal or formal interview was not carried out. We also saw other instances where prompts were not instigated at management discretion, however the rationale for this was not documented.

<u>POW</u>
We selected five periods of sickness to review, although one employee remained absent at the time of our fieldwork. From the remaining four a small number of discrepancies were identified.
</td><td>
Sickness is not properly recorded resulting in incorrect pay.
Sickness is not properly managed resulting in additional costs as shifts have to be covered by agency or bank staff.
Sickness is not well managed so effecting staff wellbeing.
</td></tr>
</table>

- Self-certification forms - 3/4 the absence end dates did not reconcile to ESR; 1/4 the form was not signed by the manager.
- Prompts - where prompts had been met, we were informed of the reason why a decision had been made to not progress through an informal or formal interview, however the reasons were not always documented.

	Recommendations	Priority
6.1	In order for absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.	**High**
6.2	Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	**Medium**
6.3	The roll out of electronic staff files across the service should progress with all electronic files fully populated with documentation scanned from hard copy files. Consideration should be given to replicating the Standard Operating Procedure developed in other CSGs (such as CAMHS) in relation to the set up and use of electronic staff files.	**Medium**

	Agreed Management Actions	Target Date	Responsible Officer
6.1	All superintendents will be advised of the need to maintain comprehensive and accurate documentation in relation to each episode of sickness absence and ensuring that all documentation is completed in a timely manner in line with the Managing Attendance Policy. A request will be made to workforce for Sickness/Absence Management Training.	31st December 2022	Site Superintendent Radiographers

6.2	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	31st December 2022	Superintendent Radiographers
6.3	The service will liaise with other recommended CSGs who have implemented areas of good practice based on previous findings to establish a Standard Operating Procedures for the electronic files.	31st January 2023	Clinical Services Manager

<table>
<tr><th colspan="2">Matter Arising 7: Annual leave (Operation)</th><th>Potential Impact</th></tr>
<tr><td colspan="2">At the time of our audit fieldwork staff at POW were in the processes of transitioning from paper annual leave records to the use of ESR. The two systems were to run in parallel whilst staff got used to using ESR. However, when we undertook a small amount of testing of the annual leave records, we identified that the majority of staff were using paper records and not ESR.

We identified a small number of errors when reviewing the paper records, including one member of staff who had requested and had authorised the same leave day twice. We also saw errors in the carry forward balances. These errors may not have occurred if the ESR system was used to manage annual leave.</td><td>Inaccurate records exist resulting in staff taking too much or not enough leave in a year.

Services are not effectively planned.</td></tr>
<tr><th colspan="2">Recommendation</th><th>Priority</th></tr>
<tr><td colspan="2">Management should remind staff of the importance of using ESR for requesting and authorising annual leave. Once management are assured that the correct opening balances are captured within ESR, the use of paper records should cease, to prevent confusion and duplication.</td><td>Medium</td></tr>
<tr><th>Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>The teams will be encouraged to ensure all leave is recorded on ESR system and if any problems are encountered will escalate to ESR team and Care Group Service Director.</td><td>30th November 2022</td><td>Clinical Service Group Manager

Superintendent Radiographers</td></tr>
</table>

Matter Arising 8: TOIL (Operation)	Potential Impact
As PCH and RGH use Health Roster, TOIL should be calculated in the system, though there is a need for management to manually adjust times when someone works longer hours and accrues time or when hours are taken back. Through our review we identified: • PCH do not appear to be capturing hours correctly as the values showing in the system seemed excessive. • At RGH, we identified some discrepancies in relation to the balances for one group of staff that would suggest that some manual adjustments were not being input. Furthermore, forms should be completed by staff when requesting to take back TOIL. There was no supporting documentation for the small sample that we tested. Whilst managers will be aware that TOIL has been taken, as they make the adjustment on Health Roster, this will not be until after the event. The forms allow for approval in advance. As POW Radiology staff do not use Health Roster manual records are maintained. The records that we reviewed did not appear to be fit for purpose as they were annotated and difficult to follow. There were no boxes on the forms to capture basic information such as the employee's name, the reason for working the additional hours, brought forward or carry forward balances, signature of employee or manager when requesting / approving entries. Whilst this information was mostly present on the forms, it was often in the form of handwritten notes added to the form. Of the 42 staff who have TOIL balances, eleven had each built up more than 30 hours of TOIL, with one staff member having a balance of 69 hours. Our analysis shows these balances have built up over a number of years and more recently staff have been able to take back some of the hours they are owed.	Time is inappropriately accrued and taken off causing an impact on the provision of the service or the need to backfill shifts with bank / agency staff.

Recommendations		Priority
8.1	a) A review on the approach to how TOIL is managed across the service should be undertaken to ensure there is some level of consistency (between accruing hours and being paid overtime) and staff are being treated equally, whilst meeting the needs of the service in each area. b) Consideration should be given to the number of hours staff are able to accrue as TOIL, given that resource constraints can impact the ability for staff to take the hours back.	**Medium**

8.2	Where Health Roster is in use, it should be ensured accurate entries and adjustments are made in order for the system to capture meaningful data that staff and management can use to manage TOIL.		**Medium**
8.3	Where paper records remain in use, they should be reviewed and updated to ensure they are fit for purpose and capture all relevant information in format that allows staff and management to manage TOIL effectively.		**Low**
Agreed Management Actions		**Target Date**	**Responsible Officer**
8.1	a) A review of the approach to TOIL will be undertaken across the three localities to ensure a consistency of approach. b) An agreement will be established to the maximum number of hours that can be accrued as TOIL considering the impact of the ability to take back hours and the potential impact of the service.	February 2023	Clinical Service Manager Site Superintendent Radiographers
8.2	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	February 2023	Clinical Service Manager Site Super intendent Radiographers
8.3	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	February 2023	Clinical Service Manager Site Super intendent Radiographers

Matter Arising 9: PDRs (Operation)	**Potential Impact**
We were provided with a July 2022 PDR compliance report which showed that 57% of staff did not have an up-to-date PDR. Analysis by locality shows:	Staff performance is not effectively assessed and addressed.

Locality	% of PDRs out-of-date	Number of out-of-date PDRs	Number where last PDR is before 2020	Number that has an out-of-date PDR and an increment in 2022
PCH	67%	51	26	32
RGH	75%	43	6	25
POW	40%	59	9	39

As the table demonstrates, compliance rates are low across all three localities. There are numerous staff who have not had a PDR for many years, including from the years prior the pandemic. There are also many staff who are due increments but have not had a PDR. This is concerning as it is our understanding that the automatic progression through increment points is ceasing, and progression will not happen if ESR is not showing that a PDR has been completed within the last year.

From our conversations with managers in all localities, it was clear that whilst they are aware of their PDR compliance rates, each locality was receiving data in different ways. Some were requesting reports from Learning & Development, whilst others were sent data from their Workforce Business Partners, though this tended to be ad hoc when they were being chased to improve compliance, as opposed to regular reports.

In some localities we evidenced PDR planners created to tackle the backlog and ensure reviews are carried out 8–12 weeks ahead of increment dates. However, staff resourcing issues have meant most reviews are cancelled to maintain clinical services.

Recommendation	Priority
In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. We acknowledge that the service will always need to prioritise clinical activity, but in order to achieve set targets, the service should develop an action plan outlining a realistic approach to tackle the backlog, prioritising those with future increment dates. Consideration must also be given to developing a sustainable way of maintaining PDR compliance rates once the backlog has been cleared. As part of addressing the backlog, staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	**High**

Agreed Management Action	Target Date	Responsible Officer
An action plan will be developed to address the backlog of PDRs and establishing a sustainable system of maintaining PDR compliance in line the with WG and Health Board targets. Robust monitoring arrangements at corporate and at Care Group level will need to be implemented. All staff will be reminded of the importance of having a PDR, including the need for pay progressing, and the need to engage meaningfully in the process.	January 2023	Clinical Service Manager Super intendent Radiographers

Matter Arising 10: Mandatory training (Operation)	**Potential Impact**
Welsh Government has identified 10 core training modules that all NHS staff should complete, and an 85% compliance target has been set. The Health Board has identified, based on roles, additional levels of training against some of the core modules. For example, Infection, Prevention and Control has four levels of training. The July 2022 Core Mandatory Training report shows that Radiology has an overall compliance rate of 52% against the 10 core modules at all levels. The breakdown for the main sites was: PCH – 53%; POW – 50% and RGH – 44%. During our fieldwork, management expressed their concerns that staff are required to complete additional levels that may not be relevant to their role, or having up to seven levels in one module to complete. There is an appeals process that allows managers to inform the Learning & Development (L&D) team if the requirements set up in ESR are not appropriate for the role. Furthermore, it is our understanding that if training at the higher levels of a module is completed, then ESR will automatically update to show completion at the lower levels. So, having additional levels allocated should not impact overall compliance rates if each person completes their highest-level training. In addition, professional training may exceed core training, but staff still have to do the core training in order to demonstrate compliance. For example, the core module on resuscitation may not be necessary for a person in a clinical role who has been professionally trained in this area. As noted above, we understand that it is possible for managers to contact the L&D team so that training and qualifications outside of the core modules can be captured in ESR and reflected in the compliance reports. In summary, there are likely to be some cases where staff have had additional training modules or levels inappropriately added to their ESR record, there are also likely to be some staff that are professionally trained above the mandatory training requirements. However, there are also a number of staff who are just not completing the mandatory training as required. Our analysis across the 10 modules shows: • Highest compliance rate was for Equality, Diversity & Human rights – 75% (1 Level) • Lowest compliance rate was for Resuscitation – 26% (7 levels) – this could be linked to clinical professional training superseding ESR requirements. • Information Governance is the only other module with only 1 level of training and the compliance rate for that was 52%, so compliance in this case is not linked to the number of levels or professional clinical training.	Staff performance is not effectively assessed and addressed.

Recommendations		Priority
10.1	Work should be undertaken to ensure the training requirements and achievements captured in ESR are accurate: • Management should identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Management should identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • If management feel staff are professionally qualified above the requirements of any of the ESR modules then they should liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.	**High**
10.2	The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	**High**

Agreed Management Actions		Target Date	Responsible Officer
10.1	The Service will undertake a review of the training requirement and achievements captured in ESR to: • Identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right	March 2023	Clinical Service Manager Super intendent Radiographers

	level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • Identify staff are who are professionally qualified above the requirements of any of the ESR modules and liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.		
10.2	The Service will remind staff that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role and that staff are provided with the opportunity to undertake their mandatory training. Ongoing support at Executive Level will be required to address role requirements.	March 2023	Clinical Service Manager Super intendent Radiographers

Matter Arising 11: Consultant Job Plans (Operation)	**Potential Impact**
Consultant job planning requirements were paused during the pandemic. In addition, the Clinical Director, who has a key role in the job planning process, was heavily involved in the general running of the CSG as there was no manager in post, which impacted on job planning activity. A report from the Allocate system identifies 34 members of staff who have job planning requirements, of which seven had been signed off, with the remainder either 'in discussion' or 'awaiting sign off' by the Consultant. However, it appears that the report was not accurate as at least four members of staff listed, had retired or left the service. Our analysis shows that of those reported as 'in discussion' or 'awaiting sign off', one had been at the Consultant sign off stage since November 2019, with the most recent awaiting sign off by the Consultant since November 2021, suggesting that these were not awaiting sign off as a result of recent job planning review meetings. Management were unaware of the recently produced job planning procedure, that allows job plans to be automatically signed off as agreed, if Consultants fail to agree them in a timely manner. Since our fieldwork, management have been in contact with the Allocate team to invoke this process, also to request retired staff be removed from the system and new staff be added to the system. They have also asked for support in relation to some specific queries. It is our understanding that these requests remain unresolved. We reviewed a schedule of job planning appointments between May and July 2022 for the POW Consultants. We note that appointments had been rearranged and where they had happened the Allocate system did not appear to have been updated. There is no similar schedule for PCH or RGH Consultants.	Disputes may arise between the Health Board and Consultants where signed contracts are not in place. Splits between clinical sessions and personal development sessions are not in line with WG guidance, leaving the Health Board with a deficit in capacity.

Recommendations		**Priority**
11.1	Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	**High**
11.2	Management should ensure that the recently produced job planning procedure is made available. Once planning meetings have taken place, if there are delays in sign off, the steps outlined in the procedure should be followed, to ensure timely sign off. The CSG should continue to liaise with the Allocate team to ensure the data in the system is accurate, all users have the required access and queries get resolved.	**Medium**

Agreed Management Actions		Target Date	Responsible Officer
11.1	A programme of reviewing consultant job plans has commenced with a target date of completing these by January 2023 and a system is established to ensure that these are reviewed on annual basis.	January 2023	Clinical Director Clinical Service Manager
11.2	The hierarchy on Allocate is now a true reflection of the consultant establishment and as job plans are being scheduled access to Allocate is being arranged.	January 2023	Clinical Director Clinical Service Manager

Planning and Performance

Matter Arising 12: Workforce Planning (Operation)		**Potential Impact**
Due to the change in IMTP / Annual Planning requirements for 2022/23, CSGs were not asked to produce detailed workforce plans to feed into the wider IMTP process. We note that due to the previous CSG management staffing issues there is no localised workforce plan, which would be helpful given the workforce issues faced by the service. We understand that work has begun to develop a plan, although this has yet to be formalised. A risk has been added to the risk register in relation of this matter.		The CSG's objectives are not achieved, and services not delivered effectively.
Recommendations		**Priority**
A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	30th November 2022	Care Group Service Director Care Group Medical Director

Matter Arising 13: Consistency in monitoring arrangements (Operation)	**Potential Impact**
Our testing confirmed that monitoring against non-financial performance targets was taking place in a number of the groups and committees within the CSG. However, we note the following points: • Updates on the previous IMTP priorities are included in the slide packs presented to the Performance Review meetings. A table, listing the priorities, a RAG rating and the actions required for the next period is included. However, the 'action in next period' is not always an action but a status update. Furthermore, where there are actions, it is difficult to identify where these are captured in the meeting action log. As reported in Matter Arising 2 it does not appear that the action logs are reviewed in future meetings to ensure work has taken place to address the tasks. • In relation to workforce information presented to the Performance Review meeting, some slide packs presented the data for Radiology and Pathology separately, whereas in more recent months, the data was for the whole CSG, including Medical Records. This made it difficult to determine the performance position of just the Radiology service. The workforce compliance targets appear to need a greater level of clarity. For example, in March and April 2022 the PDR compliance target was 49% and 51% respectively. Both months were then reporting achievement of the target. It is assumed that these are internal targets, set by the CSG, as the Welsh Government (WG) target is 85%. So, RAG rating these as green, does not show the true picture against WG's targets. Conversely, for mandatory training, the targets in March and April 2022 were stated as 97% and 100% whereas the WG target is 85%. • The format of the quality data and information varied between the Performance Review meetings. More recent meetings had less detail and the information was about the CSG as a whole, with no split into the constituent parts as appeared in earlier meetings. • Monitoring against cancer targets and Referral to Treatment (RTT) targets data was split by POW and RGH/PCH. We acknowledge that this is linked to the different data systems that information is held on. However, this makes it difficult to monitor performance at each locality. • The May 2022 Performance Review meeting had no workforce data and very little quality performance information.	Corrective action is not taken if management are not provided with accurate and consistent performance information.

- The minutes of the September 2021 Integrated Quality & Governance Group states against the mandatory training agenda item that they were 'not aware of any specific items for discussion'. Yet at that time the compliance rate was only 49%.
- We have only been able to evidence departmental governance meetings taking place in RGH. Whilst we could see workforce performance discussed, no data was presented at the group. It is at departmental meetings we would have anticipated seeing key performance data specific to that locality being discussed. We acknowledged that the RGH group is in its infancy.

Recommendation	Priority
To allow more effective monitoring, improvements should be made to the data and reporting format of information taken to the Performance Review meetings, including: • Having a level of consistency in the data so that management can differentiate between the data of the constituent services within the CSG. Similarly, where necessary the breakdown of data across localities should be in place. • Performance data on areas such as workforce and quality should be presented at every meeting. • Where performance targets are included, it should be clear if the target is an internal CSG one. Any Health Board and Welsh Government targets should also be included and reported against to allow comparisons to other CSGs. • IMTP priority updates and actions should be better articulated to determine what is actually an action, with the action log for that meeting capturing the required work. There should be a clear link between the higher-level performance information discussed at the Performance review Meeting and what is disseminated down to the Integrated Quality and Governance Group and the departmental / locality governance groups. Departmental (locality) meetings should be used to monitor performance such as PDRs and mandatory training at a more granular level.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
A new system of Performance Review across the Care Group has now been established with weekly meetings with the Chief Operating Officer and monthly Business Meetings. The exact format of the Business Meetings has yet to be finalised but it is anticipated that they will: • Have a level of consistency and accuracy in the data so that management can differentiate between the data of the constituent services within the CSG and plan to address gaps. • Report Performance data on areas such as workforce and quality and risks at every meeting. • Include any Health Board and Welsh Government targets and trajectories towards achieving them. • Include any IMTP priorities and actions in the wider health board IMTP.	31st December 2022	Care Group Director

FCP Compliance

<table>
<tr><th colspan="2">Matter Arising 14: CRES target information (Operation)</th><th>Potential Impact</th></tr>
<tr><td colspan="2">Our review of the Performance Review meeting slide decks for April and May 2022 identified that a high-level financial update is provided. This incorporates information on the CRES target. However, we note the following:
• In the finance summary slide, the value recorded as the 'Annual Budget' is not the annual CRES target for the service, but the balance of what remains to be achieved in the remainder of the year. The use of the term 'annual budget' could be misinterpreted by the report reader.
• There is no information in relation to what schemes have been identified to achieve the CRES target, therefore we could not determine if plans are in place for achieving the whole target. Similarly, there is no information on likelihood of achieving the savings for those schemes that have been identified. There is also no information on how the monthly budget values have been generated. They do not appear to be one twelfth of the annual budget.
The CRES information in its current format should be more detailed to help the reader clearly interpret the information.</td><td>Decisions are made based on inaccurate or mis-understood information. Corrective action is not taken, where full information is not available.</td></tr>
<tr><th colspan="2">Recommendation</th><th>Priority</th></tr>
<tr><td colspan="2">A review of the format of the CRES information presented during the Performance Review meetings should be undertaken, to ensure the data is more meaningful and easier to interpret. Details about the CRES schemes that have been identified in the relation to the overall target, and progress and likelihood of achieving each scheme should also be presented.</td><td>Medium</td></tr>
<tr><th>Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>A review of the format of the CRES information presented during the Performance Review meetings will be undertaken, to ensure the data is more meaningful and easier to interpret.</td><td>31st December 2022</td><td>Finance Business Partner
Clinical Service Manager</td></tr>
</table>

Matter Arising 15: Medical agency use (Operation)	**Potential Impact**
A report from the Oracle finance systems showed that nearly £97k had been spent on agency staff in quarter one. Our analysis identified that the costs mostly related to two individuals. We attempted to carry out testing to confirm that the correct authorisation process, had been followed, namely budget holder approval to seek agency use and appropriate authorisation if the hourly rates exceeded the WG price cap. In both cases we were not able to determine if the correct process had been applied. Whilst the standard hourly base rate of pay for both consultants was the same, and below the WG price cap value, the total hourly rate in the finance system exceeded the WG cap. The FCP states that the cap rate is based on the total rate to be paid to the agency including all additional costs such as agency commission, allowances for holiday pay, travel costs and accommodation costs. Despite contacting various staff within the CSG and the Workforce Business Partner, we were not able to obtain documentation to support what appears to be payments above the WG cap rate. For one of the consultants in the sample, we identified an accrued cost for 70 hours work. It transpired that while this person was booked to work these hours, they actually worked one day. While the financial impact had only been accrued and not paid, it showed within the financial position of the Radiology service, and the discrepancy was not identified until we undertook our testing. Furthermore, the finance reports show two identical payments in consecutive weeks for this consultant. Given only one day was worked, we have questioned with finance if this is a duplicate payment, but have yet to receive a response. Whilst undertaking our testing, we saw numerous emails from multiple people within the CSG and workforce across multiple sites in an attempt to be provided with information. It is clear that there is no single point of information or knowledge in relation to the use of agency staff across Radiology and to ensure the service is complying with the medical variable pay FCP.	Inconsistent approaches to the engagement of medical agency workers and their rates of pay. Inappropriate or unauthorised payments made at higher rates.

Recommendations		**Priority**
15.1	Staff who engage medical agency staff should be familiar with the requirements set out in the Medical Variable Pay Financial Control Procedure and ensure that they can demonstrate the rates that will be paid to agency staff and the appropriate authorisation where rates exceed the WG pay cap.	**High**
15.2	Consideration should be given to having a single point of contact within Radiology for managing the engagement of medical agency staff. This should allow a more co-ordinated approach to agency usage and	**Medium**

	reduce the risk of non-compliance with the FCP, errors with payments and financial records and potentially greater opportunity for agency staff to be utilised across multiple sites as demand fluctuates.		
Agreed Management Actions		**Target Date**	**Responsible Officer**
15.1	Staff who engage medical agency staff are familiar with the requirements set out in the Medical Variable Pay Financial Control Procedure and it can demonstrated the rates that will be paid to agency staff is appropriate to level of authorisation where rates exceed the WG pay cap. The evidence required is held by Retinue.	Completed	N/A
15.2	There are two individuals who engage medical agency staff in the Service. The Interim Radiology Service Manager (RGH and PCH) and the Superintendent Radiographer (POW) These individuals provide cross cover for each other.	Completed	N/A

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment

Appendix C – Detailed Scope and Objectives

Governance arrangements

- Appropriate governance structures are in place with clear reporting lines that support the key operational functions of finance, workforce, planning and performance, and quality and patient safety.
- The committees and groups within the governance structure are operating effectively with support from business partners.
- There are appropriate mechanisms in place to ensure new legislative, regulatory and patient safety information received is disseminated and actioned on a timely basis, with policies and procedures owned and kept up to date. The
- Declarations of interest (or nil returns) are submitted for all relevant staff and the clinical service group is aware of the declarations made.

Risk management

- The CSG has applied the Health Board's risk management strategy, ensuring risks are appropriately identified, assessed and recorded, with risk owners identified for each risk and mitigation plans in place where appropriate.
- Risk is monitored and reported on within key groups in the CSG.
- Risks associated with demand and capacity and quality and patient safety are appropriately captured.

Workforce management

- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Managing Attendance at Work policy.
- Annual leave is appropriately planned, requested, recorded and authorised.
- Flexi time and Time off in Lieu (TOIL) is appropriately monitored and managed in accordance with local procedures and processes.
- The PDR process is actively monitored and managed.
- Mandatory training compliance is actively monitored and managed.
- Staff rosters are planned and approved in line with agreed templates to ensure optimum workforce deployment and minimum use of overtime or agency staff to achieve safe staffing levels.
- Consultant job plans are reviewed and agreed annually and monitored to ensure that clinical activity is delivered in line with the agreed job plans.

Planning and performance

- The CSG has appropriate arrangements in place to ensure that its annual plan is developed in accordance with the Health Board's corporate planning framework.

- Budget holders and other relevant staff are appropriately engaged in the development of the CSG's annual plan.
- Workforce planning arrangements exist to establish and plan for known future changes to the CSG. For example, key staff due to retire within three years.
- Budget holders have agreed efficiency plans in place and monitor performance against the targets. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
- The CSG has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce and quality. These are formally reviewed and reported on a regular basis. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
- Demand and capacity plans are regularly used as business planning tools for managing the CSG and are monitored and reported on to ensure they remain fit for purpose.

Compliance with FCPs

- The Radiology Service's compliance with relevant Financial Control Procedures (FCPs) and the associated elements of the Scheme of Delegation. (Focus to be on the Budgetary Control and Medical Variable Pay FCPs)

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