Medical and Dental Rostering

Internal Audit Report

Cwm Taf Morgannwg University Health Board

2019/20

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NHS Wales Shared Services Partnership

Audit and Assurance Services

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

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1. Introduction and Background

Our review of rostering for medical and dental staff will be completed in line with the 2019/20 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

An electronic rostering system allows health boards a more efficient and effective way to produce rosters than previous paper methods. They enable health boards to manage their workforce more flexibly and to quickly build rosters ensuring the correct skills and staffing levels of a clinical area or department.

In previous years, we have reviewed the electronic rostering system in place for nursing staff. This review focused on the rostering systems in place for medical and dental staff.

The Allocate software system ('Allocate') has a number of modules that are being used to varying extents across the Health Board. Currently the nursing HealthRoster module is used across the Health Board and the medics HealthRoster module is used by a small number of directorates to produce their rosters for medical and dental staff. Other directorates, including those at the Princess of Wales (PoW) site, use other software packages or spreadsheets.

Other Allocate modules are used for consultant job planning and 'Employee on line', which allows staff online access via a home computer, tablet or smart phone to book leave and manage absence. Both of these modules can feed into the rostering module.

There is also a Clinical Activity tool for use in those areas where HealthRoster is used. This allows the analysis of clinical activity data held within the system, although we understand that this function is not currently in use.

The relevant leads for the review are the Interim Director of Workforce and Organisational Development and the Medical Director.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for rostering process of medical and dental staff. The review seeks to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

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

<u>Project management</u>

- There is an understanding of the different rostering systems in place across the Health Board (including the PoW site) for medical and dental staff.
- There is a project plan for the implementation of a single electronic rostering system.

- Where the HealthRoster module is currently in use, feedback has been sought to allow lessons to be learnt ahead of future roll out.

Use of the current electronic rostering systems

- There are procedures and processes for using the systems, including drawing up of rosters and subsequent use.
- Training has been provided for roster creators, approvers, managers and end users.
- When rosters are created they incorporate the correct level of cover at the correct grade required for that ward / department, with alignment to the consultant's job plan and compliance with legislation (such as the European Working Time Directive).
- Rosters are generated far enough in advance of the shift and are appropriately approved. This will include ensuring that approvals are timely, and there is evidence of checks for clinical safety and budgets.
- Non-work activity such as annual leave, sickness and Supporting Professional Activity (SPA) sessions are input correctly and correlate to ESR and job plans.
- Amendments after rosters are generated are minimal, with appropriate reasons for variations recorded.
- Monitoring on roster usage takes place and non-compliance with processes challenged.

3. Associated Risks

The potential risks considered in the review are as follows:

- The efficiency benefits of having a single electronic rostering system, that links to other Health Board systems is not realised where multiple, disparate systems are used.
- Ineffective use of the system where appropriate guidance and training is not available.
- Greater clinical risk if the correct staffing levels and skill mix are not applied.
- Inefficiencies caused by poor utilisation of existing staff and higher usage of agency and locum staff.
- Poor decisions made and ineffective monitoring taking place where inaccurate management information is in place.
- Reputational implications associated with non-compliance with legislation such working time directives.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the medical and dental rostering process is **limited assurance**.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

Over the last few years the Health Board has rolled out the Allocate HealthRoster module to all nursing areas to allow their rosters to be electronically compiled in a consistent and efficient way. This is supported by a Nursing HealthRoster policy.

The Health Board's attempts to roll out the rostering system for medical and dental staff has been less successful. We understand that the creation of medical and dental rosters may be more complex due to the need for them to align to consultant job plans and the variation in services and therefore roles that exists between However, if the HealthRoster module was being used more comprehensively, then consultant job plans, which are recorded within another module of the Allocate system, should feed into the roster creation process. This of course means that consultant job plans need to be up to date.

A project plan has been developed for the roll out of the HealthRoster module across relevant medical and dental areas. At the time of our fieldwork the project plan indicated that the HealthRoster module should have been rolled out to approximately nine areas within the Health Board,

with a number of other areas in the latter stages of implementation. However, as at January 2020 only two areas within the Health Board are fully using the HealthRoster module to generate medical rosters: Obstetrics & Gynaecology; and Accident & Emergency. Other areas continue to use other systems including previously purchased rostering systems specific for their speciality, through to Microsoft Word and Excel documents.

Integral to the roll out of the system is a supporting policy and procedure document. A roster policy exists and provides guidance for the nursing rosters, however, currently there is no equivalent roster policy for medical and dental staff.

Our testing has focussed on the roster creation process within Obstetrics & Gynaecology, who use HealthRoster, Dental who use Microsoft Word, Radiology who use Excel spreadsheets, and Anaesthetics who use the CLW anaesthetics rostering system. However, within anaesthetics we were unable to test the roster creation process including, alignment to consultant job plans, recording of non-work activities or amendments to rosters, as we were not provided with roster documentation as requested.

The results of our audit testing identified a number of issues and it was clear that each area reviewed operated very differently. Some had no roster guidance notes in their area which was often coupled with reliance on a few key members of staff who have the knowledge to prepare rosters. One area appears to have poor processes for approving leave, resulting in multiple staff being off at the same time. We also saw instances where rosters did not align to the agreed consultant job plans, with differences between both the number of Direct Clinical Care (DCC) sessions and Supporting Professional Activity (SPA) sessions.

Some of the issues that we identified clearly link to the functionality of the system being used. For example, for those using spreadsheets, there is no capability within the system to record data relating to annual leave and sickness absence and there was a lack of an evidence trail within the system to show roster amendments.

For a number of the areas that we visited, there was a general enthusiasm to use the HealthRoster module albeit incrementally, such as by rolling out for annual leave and on-call rosters in the first instance before rolling out full roster usage. Therefore, at the current time the efficiency benefits of having a single electronic rostering system that links to other Health Board systems is not realised as multiple, disparate systems are currently in use.

From our audit testing, we feel a major factor contributing to the lack of progress in rolling out the system relates to the resource that has been allocated to the project. At the current time the Workforce Rostering Team are overseeing the roll out, but also continue to provide support to those areas that have switched to using the system for their rosters and a number of other departments who have chosen to use elements of the system for on-call rosters and managing annual leave. They also provide to support to all nursing areas using the HealthRoster module.

5. Assurance Summary

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

Assurance Summary					
Project Management					
1	Systems used			✓	
2	Project plan		✓		
3	Lessons learnt			✓	
Use of current electronic rostering systems					
4	Procedures and processes		✓		
5	Training			✓	
6	Level of cover and alignment to job plans		✓		
7	Timely roster generation				✓
8	Non-work activity recorded		✓		
9	Roster amendments			✓	
10	Monitoring		✓		

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

Design of Systems/Controls

The findings from the review has highlighted one issue that is classified as a weakness in the system control/design for the medical and dental rostering process.

Operation of System/Controls

The findings from the review have highlighted nine issues that are classified as weaknesses in the operation of the designed system/control for the medical and dental rostering process.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: There is an understanding of the different rostering systems in place across the Health Board (including the PoW site) for medical and dental staff.

We note the following area of good practice:

- The Workforce Rostering Team have a record of the systems that are in use within the Health Board for producing medical and dental rosters.

We identified the following finding:

- There are a number of different systems and approaches being used for the formulation of medical and dental rosters within the Health Board.

  The Workforce Rostering Team only provide support to areas that use the HealthRoster module for producing rosters. As there are a number of roster processes there is a risk that rosters are produced in inconsistent ways, with inconsistent centralised support. Whilst local experts exist within these departments there may be an over reliance on those few key individuals.

Objective 2: There is a project plan for the implementation of a single electronic rostering system.

We note the following area of good practice:

- A detailed project plan to roll out the HealthRoster module is in place for the period April 2019 to May 2020.

We identified the following finding:

- The roll out of the HealthRoster module to departments within the Health Board has not progressed in line with the project plan due to resource constraints. The Workforce Rostering Team are trying to move forward the roll out whilst also providing support to existing users of the system, which includes support for nursing rosters.

  The project plan did not contain any information relating to the roll out of the HealthRoster module at PoW Medical and Dental staff due the roll out for Nursing staff.

Objective 3: Where the HealthRoster module is currently in use, feedback has been sought to allow lessons to be learnt ahead of future roll out.

We note the following area of good practice:

- The Workforce Rostering Team have actively engaged with the two main areas within the Health Board that are using the medical HealthRoster module in order to gain their feedback. Historically, when more departments were using the system, there were plans to set up a Medic User Group to allow ongoing feedback.

We identified the following finding:

- Some areas of the Health Board have attempted to adopt parts of the HealthRoster module, such as on-call rosters and annual leave management, prior to full roll out. From our testing, some areas stated that they experienced difficulties in using these aspects of the system due to inaccuracies in the set up for their department. It appears that many of these issues were never able to be resolved due to resource constraints and as such the departments stopped using the system for annual leave monitoring and 'on-call' rosters.

Objective 4: There are procedures and processes for using the systems, including drawing up of rosters and subsequent use.

We note the following area of good practice:

- The Workforce Rostering Team have produced HealthRoster module guides. These include how to create rosters, how to update annual leave, adding a new starter, viewing and printing a roster. There are similar 'how to' guides incorporated within the CLW anaesthetics rostering system developed by the Anaesthetics Directorate.

We identified the following finding:

- The Health Board does not have a Medical and Dental Staff Rostering Policy, although there is a Nursing Rostering Policy that has been aligned to the Allocate system.

  There were no procedures or desk top guidance notes in place for preparing and using rosters in two of the four of the areas that we visited.

Objective 5: Training has been provided for roster creators, approvers, managers and end users.

We note the following areas of good practice:

- As part of the project plan, training in relation to roster creation and roster use has been provided for those areas currently using HealthRoster, with further training planned as the system is rolled out into more areas. Training has also been provided to other departments on the use of 'on-call' and annual leave functions within HealthRoster.

- Anaesthetics utilise the CLW system for producing rosters and staff within the anaesthetics team were provided with training when the system was first set up. The staff member that inputs rosters into CLW provides training to the new doctors and Consultants on the system.

We identified the following finding:

- Training has been provided for roster creation in the areas of Dental and Radiology (December 2019). Whilst the training has been provided, Radiology have chosen not to use the software being used to create the rosters but have chosen to use Microsoft Word and Excel. As a result, the process behind compiling them can be more complex, often with a reliance on a few key staff.
- Our testing identified that rosters were created by staff of different bands. Some areas use personal assistants and operational support managers, whereas in other areas medical staff create the rosters.

Objective 6: When rosters are created they incorporate the correct level of cover at the correct grade required for that ward / department, with alignment to the consultant's job plan and compliance with legislation (such as the European Working Time Directive).

We note the following areas of good practice:

- Processes are in place for the Medical Workforce Support Officer to review rosters and ensure that they are in line with the European Working Time Directive.
- Where an area had a requirement for certain numbers and grades of staff to be in place such as in Radiology, our testing confirmed that this was the case.

We identified the following findings:

- Our review of Radiology rosters identified that on a number of occasions consultants were granted annual and study leave at the same time, with no clear visibility and evidence of consideration of the shifts to be covered.
- In a number of instances, we were unable to reconcile the DCC and SPA sessions agreed on consultants and doctors' job plans to the rosters for the period that we sampled.

Objective 7: Rosters are generated far enough in advance of the shift and are appropriately approved. This will include ensuring that approvals are timely, and there is evidence of checks for clinical safety and budgets.

We note the following area of good practice:

- For the three areas that we sampled where we were provided with copies of rosters, we were able to confirm that all had been produced

far enough in advance. Many are based on set timetables that are only amended when consultant job plans are updated or if leave requests are made, as such there is no requirement for checks to budgets to be carried out or for the roster to be formally approved.

We did not identify any findings under this objective.

Objective 8: Non-work activity such as annual leave, sickness and Supporting Professional Activity (SPA) sessions are input correctly and correlate to ESR and job plans

We identified the following findings:

- For those areas where there is no interface between the rostering system and ESR, we could not see evidence of ESR being used to request and record annual leave or to record any sickness absence. We established that there is no process in place for managing sick leave as there is no documentation completed and the sick leave is not recorded.
- Our testing reported under objective 6 highlighted a number of differences between the SPA sessions recorded on job plans and those on the rosters.

Objective 9: Amendments after rosters are generated are minimal, with appropriate reasons for variations recorded.

We note the following area of good practice:

- We were able to verify changes to the roster on HealthRoster within the Obstetrics & Gynaecology Directorate, as there was an audit trail of the changes made and a reason given for any changes on the system.

We identified the following finding:

- There was no audit trail of changes made to Radiology and Dental rosters as they use Microsoft spreadsheets and Word documents to compile their rosters. Testing could not be carried out in Anaesthetics as copies of rosters were not provided at the time of our fieldwork.

Objective 10: Monitoring on roster usage takes place and non-compliance with processes challenged.

We identified the following finding:

- Whilst we acknowledge that there was some localised monitoring, we identified that there is no centralised monitoring of rosters being undertaken for medical and dental staff.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**5**	**5**	**0**	**10**

Project Management

Finding - 1 - Systems used and support (Operating effectiveness)	Risk
The Workforce Rostering Team maintain a record of the rostering systems that are used within the Health Board to produce medical and dental staff rosters. There are a number of systems in use including the HealthRoster module in the Allocate system, CLW (an Anaesthetics rostering system), and departments using spreadsheets and word documents. The HealthRoster module was purchased by the Health Board a number of years ago. Despite previous work to roll the system out in various departments across the Health Board, at the time of our fieldwork the only areas using it were Obstetrics & Gynaecology and Accident & Emergency. The Workforce Rostering Team only provide support in the roster creation process to areas that use HealthRoster and therefore consistent support is not provided to the creation of rosters across the Health Board. Furthermore, as the systems and formats used vary, there could be an over-reliance on the few key individuals who become the 'local experts' producing the roster for that area.	The efficiency benefits of having a single electronic rostering system, that links to other Health Board systems is not realised where multiple, disparate systems are used. There are inefficiencies and inconsistencies in medical and dental rostering due to the different approaches used.
Recommendation	**Priority level**
The Health Board should continue to move to using a single medical and dental rostering system that would allow efficiencies in usage, especially where links can be made to other Health Board systems such as consultant job planning. This	**High**

will also enable the Workforce Development team to provide consistent support across the Health Board.	
Management Response	**Responsible Officer/ Deadline**
Allocate Health Roster has now been rolled out for the whole of the UHB with the exception of ACT and PoW ED. In particular, the rollout was extended to Princess of Wales (PoW) medics during April and May. ACT currently use a separate rostering product called CLW and have for many years. This is also the case in a number of Health Boards and Trusts as the rostering features have been specifically designed for Anaesthetic rosters. Historically, and prior to the transfer on 1 April 2020 POW Emergency Department have used a separate rostering product. For ED POW and ACT to move over to Health Roster, the additional functionality needed would require the purchase of 2 additional modules from Allocate. The 2 modules are Medic on Duty (MOD) and Activity Manager (AM). In addition, this would require further discussions with Consultants and directorate colleagues as their current processes are considered to be perfectly suitable and adequate for their rostering arrangements and would not be a priority. The link of eJob Planning to health roster is the ultimate gold standard and is fully supported. For this to be possible it requires the purchase of the additional e-rostering products, to allow for the interface and indeed for all business areas to be using the Activity manager.	Paul Harrison June 2020 – Approval sought and authorisation given to purchase: Medic on Duty and Activity Manager. December 2020 – Start to roll out the Rostering module - Activity Manager. This project would take approximately 12 months and would be dependent on buy-in from the Consultants and supporting resource.

In order to roll out Activity Manager effectively, the rostering team would be required to revisit all ILGs to ensure Health Roster is being used effectively for annual leave, study leave and sickness. This will be subject to dedicated resource being identified.	

Finding 2 - Project Plan (Operating effectiveness)	Risk
The Health Board has a project plan for the period May 2019 to April 2020 to roll out the HealthRoster module for medical and dental staff rostering across the organisation. For each directorate or service area, the plan covers the key stages of implementation. It also includes the current level of system usage in each area, as some are already partially using HealthRoster for managing 'on-call' rosters and recording absence. However, we note the following: • The plan suggests that by January 2020, the module should have been fully rolled out to nine areas within the Health Board, with a further three areas in the latter stages of implementation, and further work ongoing in nine other areas. However, we understand that there are resource constraints within the Workforce Rostering team, who are unable to facilitate the roll out of the system to this many directorates and service areas, in addition to providing support to those medical areas already using the system and providing support to all nursing areas using the system. • The plan does not reference the Princess of Wales Hospital and the approach to roll out for services on that site. • There appears to be some inaccuracies in the plan. For example, for the area Oral and Maxillofacial the plan states the current roster usage is for recording absence, and in Radiology it states the current usage is for managing 'on-call' rosters. However, our testing identified that this level of usage is not in	The efficiency benefits of having a single electronic rostering system, that links to other Health Board systems is not realised where multiple, disparate systems are used.

place in either of these areas. Furthermore, the plan makes reference to a lead member of staff within the Workforce Rostering team, but they have left this role.	
Recommendation	**Priority level**
1) The current project plan should be reviewed and updated so an accurate plan can be put in place with achievable timeframes for the roll out of the HealthRoster system to medical and dental staff. 2) An analysis of the resource requirements needed to roll out the rostering system to all medical and dental areas, whilst also providing support to those areas (including nursing) that are already using the system, should be carried out. 3) There should be a process of ongoing monitoring and review of the project plan to ensure it remains a current, live document, with delays around roll out escalated as necessary.	**High**
Management Response	**Responsible Officer/ Deadline**
A programme board has been discussed and agreed with the Medical Director, Finance Director and W&OD Director to ensure oversight of the Rostering project. Rostering forms one strand of the Medical Efficiency programme which will be monitored through highlight reports a PID and Project Plan. Within the rostering project plan, the resource, time requirements and milestones will be set.	Paul Harrison October 2020 – Programme Board to be established for Medical Efficiency

A live record of the project will be maintained and presented to the programme board to demonstrate progress against the plan.	September 2020 – Resource requirements presented to Exec Board for approval and subsequent recruitment.

Finding 3- Lessons learnt (Operating effectiveness)	Risk
At the time of the review there were two departments (Obstetrics & Gynaecology and Accident & Emergency) that were fully using the medical HealthRoster module to produce their rosters. Following the roll out, in May 2019 the Workforce Rostering Team held meetings with staff in both areas to understand how teams felt the system was working. The outcome of the meetings was to set up a Medics User group to obtain feedback from the users of the system. However, we understand that this will not happen until more departments start using the full rostering system. In addition, the Workforce Rostering Team obtained feedback when the annual leave and 'on-call' roster elements of the HealthRoster module were rolled out. We understand that a number of issues were identified relating to the setup of staffing structures within the module but have not been fully resolved due to resource constraints. This has resulted in two of the departments we visited reverting to their previous methods of recording annual leave and producing on-call rosters.	The efficiency benefits of having a single electronic rostering system, that links to other Health Board systems is not realised where multiple, disparate systems are used.
Recommendation	**Priority level**
1) Management should ensure that the Medics User Group is set up as HealthRoster starts to be implemented within each of the departments to ensure that the Workforce Rostering Team is receiving feedback on the system and to help to resolve any issues ahead of roll out to other areas of the Health Board.	**Medium**

2) Where feedback is received from departments, a process should be in place to capture this feedback and ensure it is acted upon.	
Management Response	**Responsible Officer/ Deadline**
A medics user group is no longer considered to be the most appropriate forum for discussing generic issues. Moreover, given the current ILG structure, it is more appropriate for ILG leads to be identified as super users, who in turn would provide constructive feedback to the rostering lead. The super users would need to be identified in each business area.	Paul Harrison November 2020 identify super users in each ILG/Business area.

Use of current electronic rostering systems

Finding 4 - Policy and procedures (Control design)	Risk
Policy The Health Board has a rostering policy in place relating to Nursing staff, but there is no equivalent policy for medical and dental staff that gives guidance on how rosters should be developed, with consideration for agreed consultant job plans and service demands. Procedures Our testing focussed on four departments within the Health Board, all using different systems for producing their medical and dental staff rosters. We asked what procedures or guidance notes were in place and who produced the rosters. We identified: • Obstetrics & Gynaecology - use the HealthRoster system and 'how to guides' are in place that were produced by the Workforce Rostering Team. These documents would be beneficial for training purposes when the system is rolled out to other areas. • Anaesthetics - use the CLW system and there are 'how to' guides within the system for areas such as leave requests, how to annotate and make notes in the system, and for producing productivity reports. • Radiology - use spreadsheets to produce their rosters and there are no procedures or guidance notes in existence.	Ineffective use of the system where appropriate guidance and training is not available

• Dental - use Word documents to produce their rosters and there are no procedures or guidance notes in existence. While we acknowledge that the systems used by Radiology and Dental are straightforward, there are often complex processes that need to take place to prepare the rosters, taking into account the approved job plans for consultants and SAS doctors, work plans of junior doctors, annual and study leave requirements and ensuring safe levels of cover.	
Recommendation	**Priority level**
1) The Health Board should develop a rostering policy specific to medical and dental staff. To ensure consistency and no conflict or duplication, consideration should be given to any other related policies and future financial control procedures such as medical variable pay. The policy should also give clear guidance on the alignment between the roster development process, consultant job plans and service demands. 2) The current set of HealthRoster 'how to' guides should be reviewed to ensure they are comprehensive and can be used in all areas of the Health Board as HealthRoster is rolled out. It should be ensured that any procedures or guides created align to the roster policy and cover both the use of the system to create rosters and the use of the system by medical and dental staff to manage their time. For example, booking annual leave and making amendment requests. 3) For areas where the roll out of HealthRoster is not imminent, separate 'how to' guides on that system should be developed. The guides should include the	**High**

step by step process for creating the rosters and also guides for users of the system, allowing consistency during unexpected periods of absence.	
Management Response	**Responsible Officer/ Deadline**
A rostering policy will be developed in a collaboration with the ILGs to ensure they are bought into the guidance. Sitting alongside this a separate 'medical establishment' project which will identify the funded posts in each of the ILGs. This is critical to inform the true and accurate development and recording of rosters. There are user guides on how use Health Roster within the Allocate Health Roster system so further guidance would not be relevant. If there is a requirement to refine this guidance, following feedback from Super Users, only then will the Allocate guidance be further developed.	Paul Harrison September 2020

Finding 5- Recording of annual leave and sick leave on ESR (Operating effectiveness)	Risk
Each of the four areas sampled use a different system for producing its medical and dental roster and therefore has different methods for recording annual leave and sickness. For the three areas where we were provided with copies of rosters, we identified that as Obstetrics & Gynaecology use the HealthRoster system, there is an interface between the system and ESR, so annual leave and sickness records are uploaded to ESR. The Dental and Radiology Directorates use spreadsheets and word documents, so there is no interface with ESR. Whilst we understand Dental staff record annual leave requests on ESR, our testing saw no evidence of this. Likewise, ESR contained no sickness data for Dental staff, nor does ESR contain annual leave or sickness data for Radiology medical staff. As such, it is unclear if there is oversight or monitoring of annual leave and sickness levels.	Greater clinical risk if the correct staffing levels and skill mix are not applied. Inefficiencies caused by poor utilisation of existing staff and higher usage of agency and locum staff.
Recommendation	**Priority level**
Annual leave and sick leave should be recorded on Health Roster which interfaces with ESR for Consultants and Middle Grade staff, thus allowing sickness to be managed appropriately.	**High**
Management Response	**Responsible Officer/ Deadline**
The addition of PoW (excluding ED and ACT) to Health Roster has already moved a significant way towards achieving consistent recording of absences. The next	Paul Harrison

phase however is to meet with each business area to ensure absences are being recorded on the system, which in turn feeds into ESR. There is a reliance on directorate colleagues in the ILGS to administer the system however regular checks and reporting may also expose where the data is not being inputted. This would be an ongoing exercise and could not be a one-off meeting with the directorate rota administrators and would be reliant on additional rostering resource.	Revisit recording of absences on a rolling programme from September 2020

Finding 6 - Monitoring of rosters (Operating effectiveness)	Risk
Unlike for Nursing rosters, the Workforce Rostering Team do not carry out any formal monitoring of medical and dental rosters. We have been informed that there is a Clinical Activity tool within HealthRoster that will allow analysis of clinical activity data held within the system, but until more areas are using HealthRoster to produce their rosters, this tool is not in use. We have been able to confirm that there is some level of roster monitoring within some of the departments we visited, for example staffing levels within Dental are reviewed. However this is not consistent and as such there is no clear oversight or identification of potential issues such as compliance with job plans, correct taking of annual leave, or the proper management of absence.	Poor decisions made and ineffective monitoring taking place where inaccurate management information is in place.
Recommendation	**Priority level**
Management should ensure that there are processes in place for monitoring the rosters including reviewing aspects such as ensuring medical and dental staff are undertaking the correct hours and working in line with the job plans.	**High**
Management Response	**Responsible Officer/ Deadline**
The monitoring of hours worked against the planned rota is the responsibility of the Directorate and Roster managers. Workforce will provide KPI data to the Directorates through the ILG Medical Workforce Efficiency meetings setting out	Paul Harrison

time frames for requesting leave, sickness data and study leave. The comparison of agreed job plans against rota is again a matter for the ILG Directorates as noted above.	November 2020 - Medical Workforce to provide regular reports/KPIs to ILGs.

Finding 7 - Training on rostering systems (Operating effectiveness)	Risk

The level of training provision on the use of the rostering system and preparation of rosters varied for each of the areas we visited.
• In Radiology and Dental, where spreadsheets and word documents are used to create the rosters, there has been no need to provide system specific training to medical and dental staff on using the system. However, there has not been any training on the production of the rosters.
  ○ Within Radiology, a personal assistant within the department produces the rosters based on job plan information received from the Consultants' Personal Assistants and authorised annual leave requests.
  ○ Within Dental, rosters are drawn up by a consultant, doctor and the operational support manager.
• In Anaesthetics the departmental secretary and other staff who prepare rosters were involved in implementing the CLW system so did not need training. They also provide training for any new staff on the use of the system.
• In Obstetrics & Gynaecology, HealthRoster is used and the Operational Support Manager is the key member of staff within the team for producing the rosters. The individual previously worked in the Workforce Development Team and therefore has a sound understanding of the system, and provides training to others on how to create rosters in the module and to medical staff within the directorate on how to use the module.
	Ineffective use of the system where appropriate guidance and training is not available

Whilst we acknowledge that the complexity of the rosters can vary from department to department, only a small number of staff within each area are involved in producing the rosters and have been trained on the process in place. Coupled with the lack of written guidance notes for most areas, this could pose a risk to departments during times of staff absence or should staff leave the area. Rosters appear to be produced by different staff within the Health Board. In some areas the responsibility lies with personal assistants and secretaries whereas in other areas the medical staff are involved in roster preparation.	
Recommendation	**Priority level**
1) While the current systems remain in use, each department should have enough members of staff with the relevant skills and knowledge to prepare rosters and provide training to roster users where applicable. The Health Board should be clear as to who within departments are best placed to produce rosters, so that resources are used effectively. 2) As plans are taken forward to roll out HealthRoster to more areas, users of the system should be provided with training relevant to their needs, including re-training on elements of the system such as recording annual leave and on-call roster if roll out is going to be incremental. Enough staff within each team should be trained on roster creation to ensure suitable levels of cover and consistency during periods of absence.	**Medium**

Management Response	Responsible Officer/ Deadline
The ILGs are responsible for identifying the relevant resource to administer rosters. If in turn the ILG resource requests additional training, this will be provided however as part of the comprehensive revisit of all other areas of the UHB, training will be given to colleagues where the system is not utilised. Every area (excluding ACT and PoW ED) that has been introduced to Heath Roster has been trained on the use of the system. This has also taken place with the PoW roll out. Everyone who has received training in PoW has been recorded in eRostering. The eRostering team will compile a comprehensive list of all staff trained in roster creation for Medics and ensure there is enough representation in each area.	Paul Harrison Review roster utilisation and confidence in using system with ILG roster administrators- November 2020

Finding 8 - Annual leave and study leave approval (Operating effectiveness)	Risk
From the three areas where we provided with copies of rosters, we undertook testing to ensure suitable processes are in place for approving leave requests. We did not identify any issues in relation to Obstetrics & Gynaecology or Dental staff. Radiology rosters are prepared on a two-week rolling basis and a process is in place for staff to request leave six weeks in advance. However, we identified instances where multiple staff are granted leave for the same date. It appears that annual leave is approved in 'isolation' without giving consideration to the shifts that need to be covered, and more significantly other leave that has been approved. We reviewed the roster for the period covering the February school half-term. We note that 8/18 (44%) of consultants had booked annual leave. Similarly, we reviewed the roster for the week the Christmas week in December 2019 and 10/18 (61%) of staff were on annual leave. While we acknowledge that less staff may be required to work over the Christmas period, an absence of over half of consultants may have an impact on service delivery. It was also evident from reviewing the roster for the week commencing the 2 December 2019, that there were a number of employees that were given study leave at the same time. We understand that the responsibility for agreeing annual leave and study leave has recently transferred to a different member of staff. We understand that they have reflected on the previous approach and will make changes to ensure that levels of leave are appropriate.	Greater clinical risk if the correct staffing levels and skill mix are not applied. Inefficiencies caused by poor utilisation of existing staff and higher usage of agency and locum staff.

Recommendation	Priority level
1) Management should ensure that on granting annual and study leave to staff, that consideration is taken to ensure there is enough Consultants in place to cover all shifts and they are not all granted leave at the same time. 2) The process for requesting and approving annual and study leave should be clearly set out in departmental procedure notes so that all are clear on the expectation of the department.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A policy has recently been finalised covering study leave entitlements across CTM. This clarifies how much is available and how to record it via the Health Roster system. This policy is awaiting ratification by the LNC. Once all areas are using Health Roster fully, rules can be set on the roster to ensure the correct amount of staff are permitted to be off per day/Week.	Paul Harrison November 2020

Finding 9 - Alignment to job plans (Operating effectiveness)	Risk
We tested 21 staff from three departments where we were provided with rosters, to ensure that the sessions agreed on the individual's job plan aligned to the monthly roster for that department. There were three instances where we noted a difference between the agreed job plan on the Allocate system and the roster. • For one instance in Dental we note there was 53.75 SPA sessions on the job plan, but only 37.5 on the roster. • Two instances relating to two individuals within Obstetrics & Gynaecology. In one case we note 71 DCC sessions on the job plan, but 86 DCC sessions on the roster. In contrast, in the other case, there were 86 DCC sessions on the job plan, but only 56.25 on the roster. In all three cases we have contacted the relevant departments to try and establish reasons for these variations, but no responses have been received. We also selected a sample of 20 staff from the three departments that we had rosters for and compared the SPA sessions from the job plans to the rosters in more detail. We identified: • Dental - in 3/7 cases there were differences between the job plans and the timetables that are used to produce the rosters. • Radiology - in 1/8 cases there was a difference between the job plan and roster.	Greater clinical risk if the correct staffing levels and skill mix are not applied. Inefficiencies caused by poor utilisation of existing staff and higher usage of agency and locum staff.

• Obstetrics & Gynaecology - in 2/5 cases there were differences between the job plans and rosters.	
Recommendation	**Priority level**
Management should ensure when they are producing the rosters that the SPAs and DCC session align to the agreed job plans.	**Medium**
Management Response	**Responsible Officer/ Deadline**
If the Medic on Duty and Activity Manager modules are purchased and integrated into the process, this can automate the upload of the Job Plan into HealthRoster. This will demonstrate whether or not there is a reflection of the agreed job plan. However, this does need to be enforced and managed by each of ILG management teams, not by Workforce. ILG management will need to ensure that actual job plans reflect what is shown on the Roster.	Paul Harrison Roll out of MoD and AM from December 2020

Finding 10- Amendments to rosters (Operating effectiveness)	Risk
After rosters are prepared they may be amended to take account of sickness or late requests for annual leave or study leave. We reviewed rosters for the three areas provided to determine the process and reason for amendments. We were able to verify changes to the roster on HealthRoster within the Obstetrics & Gynaecology Directorate as there is an audit trail of the changes made and a reason given for the change on the system. However, we were unable to test this process for Radiology and Dental as they use spreadsheets and word documents for their rosters. As such, there is no audit trail of changes. It is our understanding that the CLW system used by Anaesthetics also has the functionality to record changes to rosters. However, we were not provided with rosters for this area, although they had been requested from the Anaesthetic Directorate during our fieldwork, so no testing was undertaken. It is clear that the more basic systems used in some areas of the Health Board to produce rosters do not have the functionality to record amendments, therefore do not allow the ability to monitor levels and frequency of changes to the rosters.	Inefficiencies caused by poor utilisation of existing staff and higher usage of agency and locum staff.
Recommendation	**Priority level**
Where changes are made to rosters an audit trail should be place to show the amendments and the reason for the change on the roster.	**Medium**

Management Response	Responsible Officer/ Deadline
HealthRoster provides various ways to audit changes to the roster. 1. Notes can be added to shifts. 2. If rosters are approved you can then run a roster stats report to show how much of the roster has been changed. 3. A unit audit report can be run to show in depth all changes that have happened on the roster. Once all business areas are using HealthRoster for their rosters, any subsequent changes will be visible as noted above as opposed to being recorded on separate spreadsheets.	Paul Harrison Local Roster Manager & Directorate Manager. November 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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