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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

FINAL INTERNAL AUDIT REPORT

2019/20

Swansea Bay University Health Board

GP Out of Hours Services: Quality Standards Reporting (SBU-1920-012)

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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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.

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

Please note:
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1 INTRODUCTION

1.1 Background

This assignment originates from the 2019/20 internal audit plan.

The out of hours medical service, usually referred to as the GP Out of Hours Service provides urgent primary care services to the population of Swansea Bay University Health Board, and Bridgend residents of the Cwm Taf Morgannwg University Health Board under a service level agreement, across 115 hours each week in conjunction with the 111 Wales service (111). The 111 service is delivered by the Welsh Ambulance Services NHS Trust (WAST) and provides a single telephone number for members of the public to access health advice and the GP Out of Hours Service [OoH] following a telephone clinical triage by a nurse.

The 111 service was launched in October 2016, and a comprehensive set of standards were in place that provided targets and parameters for how the service should operate.

On 21st March 2019 the Health Board received formal notification that a single "universal" suite of standards and quality indicators had been created and issued for adoption by all health boards for the OoH / 111 service. The New Standards and Quality Indicators for 111 and Out of Hours are based on the existing standards and have been refined working with key service stakeholders, drawing on expertise from both clinicians, and those managing the OoH / 111 service. Some standards must be reported monthly, whilst others will be expected quarterly, six-monthly or annually. The Health Board and WAST are required to submit one combined reporting template to Welsh Government on a monthly basis.

1.2 Scope and Objectives

The overall objective of this audit was to review arrangements in place to manage and monitor the provision of GP Out of Hours Services, and it focused on the Health Board's performance against the Standards (in particular the arrangements in place to report performance against the quality standards).

The scope agreed initially included consideration of the following:

- Arrangements in place to ensure the population of the reporting tool with all the information required, and its timely submission, including liaison with WAST partners as appropriate:

  - Part A: Telephony, Clinical Triage (CT) and Face-to-Face (F2F) standards
  - Part B: Quality standards.
- The development of arrangements to report against those Part C standards required less frequently, and compliance with submission of those required to date:
  - Quarterly: Serious Incidents & Clinical Audit (current)
  - Bi-Annual: Equality (future)
  - Annual: Eight Standards (future).
- Management review & monitoring of performance information and action taken to address issues in respect of the information itself and/or performance highlighted.
- Mechanisms in place to provide assurance to the Board in respect of GP Out of Hours Services performance against its standards.
- Arrangements in place to monitor delivery of the Health Board's obligations under its service level agreement with Cwm Taf Morgannwg University Health Board, and to share performance information with the latter accordingly.

However, during the course of fieldwork, we became aware of issues in respect of reporting arrangements affecting wider NHS Wales organisations using the 111 service, that have given us reason to close the audit and report the position.

1.3 Associated Risks

The following inherent risks associated with this subject area were considered at the outset of the audit:

- Reporting of uncorrected inaccurate or incomplete information, in the absence of appropriate management review.
- Incomplete provision of information due to the lack of effective reporting systems.
- Untimely submission of information to Welsh Government, due to weaknesses in internal processes and/or liaison arrangements with WAST partners.
- Service performance issues may continue uncorrected if not subject to appropriate management monitoring and action.
- Board assurance may be reduced by ineffective reporting arrangements.

2 CONCLUSION

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.

During the course of fieldwork, we have identified issues in respect of the reliability of reporting arrangements that affect not only Swansea Bay UHB but other NHS organisations using the 111 service. The solutions to these issues are not solely within the power of SBU to address, though it needs to work with its partners to resolve them. We are aware that this is progressing and there is ongoing engagement with colleagues within Welsh Government.

In view of the wider issues identified and partnership input required to resolve them we have not assigned an assurance rating but closed our work and reported the position below, together with recommendations to ensure appropriate management assurance is communicated to the Health Board regarding progress.

3 AUDIT FINDINGS

3.1 On 26th March 2019, the Senior Information Manager at Welsh Government (WG) emailed representatives of Health Boards/Trusts responsible for GP Out of Hours provision and WAST, a copy of the reporting template for monthly submission of quality performance data. The recipient within SBU was the OOH Operational Performance Manager. The template provides a common form in which to present data on a subset of the new Standards:

Part A (fully included)
- Telephony
- Clinical Triage
- Face-To-Face

Part B (only one element included)
- Quality Indicators – Outcome Activity (only)

It was understood by WG that the telephony data could not be separated out against individual Health Boards, so it was accepted that WAST would use the combined Health Board 111 service figures in each of the Health Board submissions for information.

The correspondence indicated a change to process for 2019/20, requiring WAST to complete the template with the required data and then send it on to Health Board for validation and verification before submitting to WG. This was to ensure that Health Boards have sight of and sign off the data.

Data is held in two systems. Some of the data required to support the GPOOH reporting requirements is held within the WAST CAS

system and SBU ADASTRA system. ADASTRA is a system provided by an external supplier for the management of the GP Out Of Hours Service. It generates regular feeds into a database managed locally by SBU. The data provided relates not only to SBU GPOOH service, but that of the SBU Acute GP Unit and Hywel Dda's GPOOH service. Automated scripts have been employed to split the data so that the SBU GPOOH data is provided by routine transmission to WAST to supplement data held with WAST's CAS system.

3.2 There have been issues with the data and submission process. Whilst the process above was set out in March 2019, the April 2019 data (submitted in May 2019) was sent directly to Welsh Government by partners in WAST without opportunity for Health Board sign off. Correspondence from Welsh Government to WAST in May 2019 highlighted the correct process for future submissions.

In June 2019, the SBU GPOOH Operational Performance Manager (OPM) contacted WAST requesting the data before its submission to WG. This was received on 14th June. The SBU OPM responded on 18th June, requesting a meeting to discuss anomalies. This was followed on 19th June by correspondence to WAST from the WG Senior Information Manager, copying in SBU and other Health Boards, requesting to meet to discuss the same.

A meeting was arranged for 29th July 2019, comprising representatives from WAST, 111, Health Boards/Trust (including SBU) and NWIS. Whilst no minutes could be provided by SBU OOH management, correspondence supports the Health Board's engagement with partners to promote compliance with the expected process and to verify the accuracy of data prior to submission. It was clear from the identification and escalation of issues that the SBU team were engaged in its review as part of the submission process. Issues were not resolved at the close of audit fieldwork, but it is evident that Welsh Government was aware and engaged in the process of resolving matters with the various NHS organisations involved.

3.3 Data provided by WAST to date has included only that which is required to support the Part A standard. Outcomes, median times, patterns of referral from the service, and prescribing activity have not been provided yet (only the first of these is included within the reporting template). Discussion and review of ADASTRA with the GPOOH Service Manager and a review of the information provided internally on the Health Boards online primary care dashboard indicated that the system recorded & reported the outcome of patient contacts internally. This information is required by Welsh

Government, but we are aware that the resolution of provision of data in respect of Part A standards is the first priority.

3.4 Information on prescribing patterns, referrals by GP/Cluster and "median" response times are not included on the current reporting tool. Internal Audit understands that there is to be further discussion within Welsh Government on the mechanisms for collecting and reporting this information and Part C standards.

3.5 Whilst the GPOOH Service Manager indicated that he had briefed the Unit Nurse Director (UND), our review of papers of meetings within the Unit and corporately did not identify issues being highlighted or discussed at any formal groups.

3.6 In the meantime, data has been provided for inclusion within the *Timely Care* section of the Health Board's performance scorecard relating to two of the standards. Whilst it was submitted for inclusion with caveats in the email regarding its reliability this was not clear within the scorecard.

4 RECOMMENDATIONS

4.1 It is clear from our review and discussions with management that reliable quality performance data is not yet being received by Welsh Government from the Health Board and that SBU is not alone in this respect. It is evident that provision of this data requires the Health Board to work with its partner organisation (WAST) and that there is ongoing engagement from SBU, other Health Boards, WAST and Welsh Government colleagues to address requirements together.

Whilst action is in hand and Welsh Government colleagues are aware of issues, there has been no formal reporting in respect of issues faced or progress in addressing them within the Unit or corporately.

R1 We would recommend that a mid-year report be presented to the Unit Management Board and Executive Directors to update them on the development of reporting against each of the expected quality standards and action being taken with partner organisations and Welsh Government to address issues.

4.2 Data reported to the Board on quality measures to date is unreliable.

R2 We would recommend that reporting against the GP Out of Hours Quality Indicators is stopped until issues are resolved, or

footnotes included within reports to present indicate the caveats in respect of figures presented.

5 MANAGEMENT COMMENTS

The Service Director (PCS) has highlighted the following points which have been made by the service leads:

a) There should be recognition of the lack of resource attributed in SB UHB IT Department to the development and maintenance of performance information for GPOOH in comparison to other performance information requirements in the Health Board. The Business Intelligence Information Manager has been immensely helpful in working with OOH Management to rectify the problem with the information and put in place more robust procedures but this is not necessarily a main part of his role. Our understanding is that with there are more dedicated resources / teams in IT allocated to other information requirements, such as PAS.

b) There should be recognition of our reliance on *Advanced* as the private sector provider of *Adastra* to provide a data feed into SB UHB IT systems so that the performance information can be developed. As an example of the problems this sometimes presents, we have not had data flowing through to our warehouse now since last Thursday and this is causing us problems operationally in that we are unable to report on things that are usually daily reports. The Business Intelligence Information Manager is picking this up with *Advanced* but obviously it does present problems with the data flow.

c) Whilst the audit report recognises the interrelationship between 111, other Health Boards and ourselves on gaining robust information, we would also highlight our reliance on the performance of Nurses in 111, as well as our GPs in GPOOH, in providing timely response to definitive clinical assessments in order to achieve the standards

Actions to address issues raised are incorporated into the action plan at Appendix C.

Audit Assurance Ratings

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

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

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

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

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

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.