Agenda – Public Accounts and Public Administration Committee

Meeting Venue:
Video Conference via Zoom
Meeting date: 22 September 2021
Meeting time: 08.45

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(Private Pre-meeting)

(08.45 – 09.00)

In accordance with Standing Order 34.19, the Chair has determined that the public are excluded from the Committee's meeting in order to protect public health. This meeting will be broadcast live on www.senedd.tv

1 **Introductions, apologies and substitutions – Public Accounts and Public Administration Committee**

(09.00)

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

(09.05)

Items 3 – 10

3 **Auditor General for Wales Report: In-sourcing the Welsh Government's ICT service**

(09.05 – 09.20) (Pages 1 – 51)

4 **Auditor General for Wales Report: Test, Trace and Protect**

(09.20 – 09.35) (Pages 52 – 95)

5 Auditor General for Wales Report: Procuring and Supplying PPE for the COVID-19 Pandemic

(09.35 - 09.50) (Pages 96 - 182)

6 Auditor General for Wales Report: Welsh Health Specialised Services Committee governance arrangements

(09.50 - 10.00) (Pages 183 - 219)

7 Auditor General for Wales Report: Rollout of the COVID-19 vaccination programme in Wales

(10.00 - 10.15) (Pages 220 - 254)

8 Auditor General for Wales Report: An overview of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board: A Summary of progress made against recommendations

(10.15 - 10.25) (Pages 255 - 292)

9 Committee procedures and ways of working: Public Administration Remit

(10.25 - 10.55) (Pages 293 - 300)

(Break)

(10.55 - 11.00)

10 Committee procedures and ways of working: Questioning Technique Training

(11.00 - 12.30)

Agenda Item 3

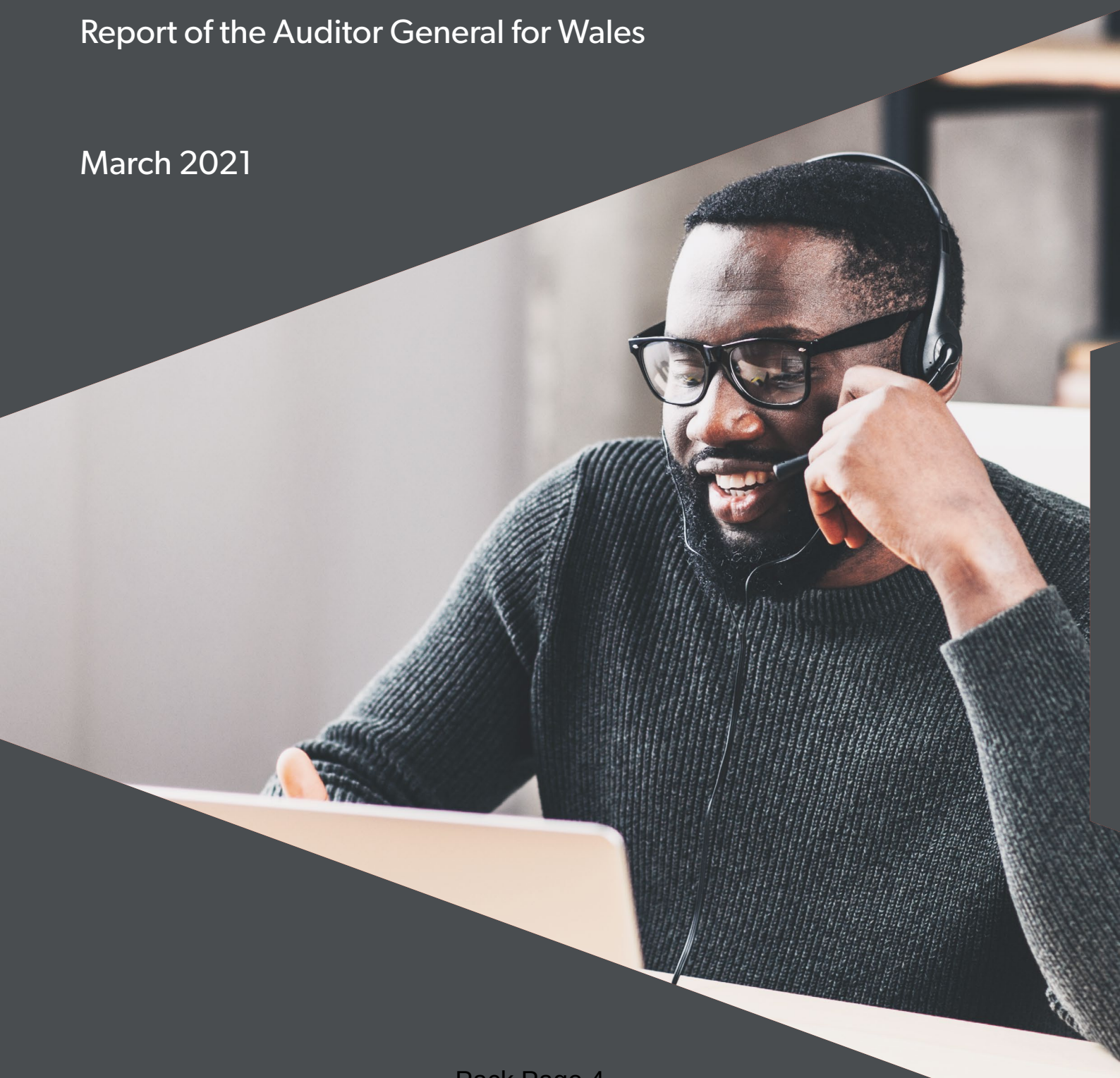
Document is Restricted

Archwilio Cymru
Audit Wales

In-sourcing the Welsh Government's ICT service

Report of the Auditor General for Wales

March 2021



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

Contents

Key messages

1 The Welsh Government's decision to in-source its Information and Communications Technology (ICT) services represents a significant change, after many years of out-sourced ICT. The intentions were to reduce costs, increase control and flexibility of services, improve resilience and enable more flexible working for staff. Our work focused on whether the transition to an in-house service was well managed and on track to deliver the intended benefits. **Appendix 1** describes our audit approach and methods.

The in-sourcing project has been managed well and delivered on time. Some benefits are being achieved but the full benefits have not yet been realised

2 In 2017, the Welsh Government decided in principle to end its out-sourced ICT contract (the Merlin contract) and bring ICT services in-house. Officials prepared a business case that recommended in-sourcing all main ICT service areas, with selective out-sourcing for infrastructure and project services such as technical upgrades. There were clear investment objectives and a mix of financial and non-financial benefits that the in-sourcing should deliver. The business case was comprehensive, and the objectives aligned well with the Welsh Government's wider ICT modernisation programme.

3 In planning the transition, the Welsh Government carried out extensive work to understand the needs of different user groups within the organisation. The Welsh Government also took the positive step of contacting four other public bodies to learn from their recent experiences of in-sourcing.

4 Some aspects of the governance and leadership arrangements adopted by the Welsh Government were not 'textbook' but this did not appear to impact negatively on overall delivery. Divided lines of accountability are now resolved with the Chief Digital Officer being solely responsible for the central ICT function. The Chief Digital Officer also now reports directly to the Executive Committee and Board, which should address the need to raise the profile of ICT issues at a senior level.

5 Financial resources allocated to the programme have proved adequate. The transition was partly funded through an invest-to-save approach and was delivered broadly within its revenue and capital budgets of £12.7 million over the two years to 31 March 2019. The transition was also staffed effectively, with the Welsh Government using redeployment and external contractors to provide the required expertise.

6 The Welsh Government's approach to programme and project management was largely effective, with implementation proceeding broadly in line with planned timescales. Because the transition was treated as a process rather than an event, the phased approach allowed ample time for the Welsh Government to learn and adapt before phasing in further changes.

7 Gateway Reviews concluded that risk management was sub-optimal but managers considered the approach to be sufficient given the fairly stable risk environment. Ultimately, the Welsh Government managed the risks effectively to ensure the transition was delivered on time. However, one high-level risk has materialised, namely insufficient operational staffing to fill the ICT team structure set out in the Target Operating Model (TOM). Since the transition, staffing levels in the ICT team have been 15-20% short of the TOM and some staff have been working significant overtime to fill gaps.

8 There is scope for the Welsh Government to strengthen the way it monitors ICT service performance. The performance indicators used to monitor performance need to be updated to reflect the new in-house service model and to consider performance in the context of widespread homeworking from service users. There is also scope for more challenge of ICT service performance through more frequent, high-profile scrutiny.

9 Financial savings were a fundamental part of the business case for bringing ICT services in-house. Some of the intended benefits are now being delivered but the full savings have not yet been realised. Savings of £4.9 million were delivered in 2019-20 but not the full £8.1 million anticipated in the business case. The shortfall was largely due to an increase in costs for software and unfilled posts resulting in higher-than-anticipated costs for contractors.

10 In addition to financial savings, the business case anticipated a range of non-financial benefits. Some, but not all, of the non-financial benefits are being delivered, although it is difficult to judge success because the Welsh Government did not set specific targets for these. While there has been a gradual decline in the number of serious ICT incidents since the transition, there has also been a dip in ICT service desk performance, which is most likely due to understaffing. However, user satisfaction with ICT services has improved since the transition and the rollout of new laptops. The rollout of new laptops to most staff by the end of 2019 has clearly been a key factor allowing flexible and homeworking during the COVID-19 pandemic.

It is good to be able to report in positive terms on an ICT change programme that has served the Welsh Government well as it has faced the challenge of a different way of working in response to the COVID-19 pandemic. The job is not complete, however, with further action required to secure all of the intended benefits, to address the pressures caused by understaffing, and to ensure lessons are learnt for future projects.

Adrian Crompton
Auditor General for Wales

Key facts

11 The infographic below summarises the key facts from our report.

Overall Welsh Government expenditure on ICT services

- £13.9 million in 2019-20

Budget for the implementation programme

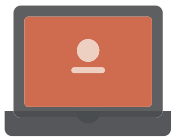
- £12.7 million over two years

Staffing

- 54 contractor staff transferred to the Welsh Government ICT team
- The ICT team now has 87 permanent staff plus 4 contractors covering permanent posts
- 15-20% shortfall in ICT staffing since the transition

Savings

- £8.1 million savings planned in 2019-20
- £4.9 million savings achieved in 2019-20



Wider benefits

- 6,000 new laptops rolled out to staff
- £23,000 reduction in travel costs (and much larger reductions are likely from 2020-21 onwards)
- 8,000 staff now able to connect remotely at the same time

User satisfaction

- 85% user satisfaction in March 2020 (up from 56% in October 2018)

ICT service desk performance

- 67% first-time fix rate in the 22 months to October 2020 (down from 74% in the 12 months to January 2019)
- 72% 20-second call answer-rate in the 22 months to October 2020 (down from 94% in the 12 months to January 2019)
- 12% of calls abandoned after 30 seconds in the 22 months to October 2020 (up from 3% in the 12 months to January 2019)

Source: Audit Wales summary of data from the Welsh Government

12 The timeline below shows the key dates relating to in-sourcing.

September 2004

The Welsh Government signs the ten-year 'Merlin' contract with Siemens Business Services (subsequently taken over by Atos) for out-sourced ICT

September 2014

The Welsh Government extends the Merlin contract for five years

November 2017

The Welsh Government in-sources a small team of corporate application services staff, as a pilot for larger ICT in-sourcing

In-principle decision to in-source most ICT services from January 2019

February 2018

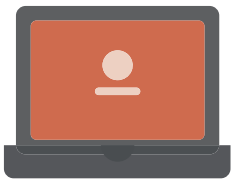
Independent Gateway Review gave the overall programme a traffic-light risk rating of 'amber'

March 2018

Business case approved to bring ICT services in-house, starting a ten-month transition phase

October 2018

Publication of another Gateway Review, which again rated the overall programme as 'amber' and the in-sourcing element as 'amber-green'



11 January 2019

In-sourcing happens as planned, with staff transferred successfully from Atos to the Welsh Government

March/October 2019

Rollout of 6,000 laptops to staff

4 Recommendations

The table below sets out our recommendations to the Welsh Government.

Recommendations

Tracking of benefits and costs

R1 We recommend that, in future business cases and change programmes, the Welsh Government clearly profiles the delivery of its intended financial and non-financial benefits by setting clear target levels and milestone dates. This would make it easier to assess whether programmes are on track to deliver as intended.

R2 We recommend that the Welsh Government schedules a formal review of the delivery of the benefits from the in-sourcing, at three years after the transition, to ensure medium-term impacts are recorded and reported on.

R3 We recommend that the Welsh Government develops a more robust mechanism to measure the true cost of projects to inform project planning, monitoring and evaluation. This should include a proportionate approach to measuring the cost of significant internal resources spent on projects, including the time of its own staff.

Recommendations

Operational performance management

R4 We recommend that the Welsh Government updates the key performance indicators and operational targets for ICT services, to ensure they reflect the new model of in-house service provision, including increased home and flexible working and reduced travel.

R5 We recommend that a summary dashboard covering ICT service performance is considered by the Executive Committee as a standing agenda item for challenge and scrutiny.

R6 We recommend that the Welsh Government introduces benchmarking of its ICT service performance and structures to allow comparison with other organisations.

R7 We recommend that the Welsh Government introduces a formal, annual review of user satisfaction of ICT services, to assess whether improvements are being sustained in the long term.

Staffing levels

R8 We recommend that the Welsh Government revisits the staffing levels set out in its Target Operating Model for ICT and develops an action plan for achieving the required staffing. Without taking such steps, there is a risk that the full benefits of the transition will not be delivered.

Background to the in-sourcing

01

The business case to in-source ICT services set out clear objectives and a mix of financial and non-financial benefits

13 Under the Merlin contract, Atos maintained the Welsh Government's ICT systems, undertook development work (sometimes referred to as 'project services') and provided infrastructure, equipment and expertise. However, when variations to the contract were needed, negotiations were time-consuming. The Welsh Government also had concerns about the cost of the contract, and what it considered to be variable service standards[1].

14 Our 2011 report on the Merlin contract noted that the contract was delivering core ICT services effectively[2]. However, the report also found that the Welsh Government could not demonstrate that all expenditure under the contract represented value for money.

15 In 2014, the Welsh Government extended the Merlin contract but with a view to progressively in-sourcing services. The extended contract also allowed the Welsh Government to procure from alternative suppliers for project services and infrastructure[3].

16 In November 2017, a small team of Atos staff dealing with corporate application services was transferred into the Welsh Government, which provided a small-scale testbed for further in-sourcing. Later in 2017, the Welsh Government decided in principle to end the Atos contract when it expired in 2019 and bring remaining services in-house.

1 In advance of publication, we invited comments on our draft report from Atos. Atos noted that while it did not wish to raise any formal comments at that stage, it did not necessarily agree with some of the Welsh Government's assertions about the previous out-sourced arrangements that we have included in this report.

2 Auditor General for Wales, **The delivery of ICT services and ICT projects under the Merlin contract**, August 2011

3 Specialist services (eg project management, technical solution design) for new ICT development work and procurement of equipment and other ICT assets.

17 In March 2018, the Welsh Government's Executive Committee approved a business case for in-sourcing. Officials had prepared the detailed business case in line with the 'five case business model' recommended in HM Treasury guidance, and the case included the following investment objectives:

- to **reduce ICT service costs from 2019**, at lower-than-market prices for a comparable service, at a level of user satisfaction that benchmarks well against peer group averages;
- to **reduce project services costs** at rates below the market average for comparable services;
- to **improve services** through a move to portable devices with less hardware renewal and with higher levels of user satisfaction; and
- to **improve flexibility of location** through more flexible ICT, with reduced travel costs and travel time.

18 The business case provided a comprehensive assessment of the strategic context and set out six options for the next steps following the expiry of the Merlin contract. The six options were assessed against the investment objectives and six critical success factors, which were:

- **business needs:** how well the option satisfied the existing and future business needs of the Welsh Government;
- **strategic fit:** how well the option fitted with the Welsh Government ICT Strategy 2016-2021;
- **benefits optimisation:** potential return on expenditure in terms of business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation) and contribution to improving overall value for money (economy, efficiency and effectiveness);
- **potential achievability:** the Welsh Government's ability to manage the required level of change, the level of risk and the need for supporting skills;
- **potential affordability:** the organisation's ability to fund the required revenue and capital expenditure; and
- **business continuity:** ability to manage and reduce risk through the transition period.

19 The business case also identified a mix of financial and non-financial benefits and set out the estimated costs, timescale and management arrangements for the project. We describe these benefits in detail in **Part 3** of this report.

20 To achieve these benefits and investment objectives, the business case set out a preferred option, described as a 'hybrid model'. **Box 1** provides details of this model.

Box 1: The 'hybrid model' was the preferred option in the business case

The model proposed in the business case was to in-source most ICT services with selective out-sourcing of certain specialist technical services (design or technical solutions and technical subject expertise) where potentially beneficial. This was described as a 'hybrid model' whereby the Welsh Government ICT team retains control of key functions and service delivery but also has flexibility to acquire specialist expertise from external contractors where it would not be practical or cost-effective for the Welsh Government to maintain the skills in-house.

21 We concluded that the business case provided a clear rationale for the selected option. We also concluded that the investment objectives in the business case aligned well to the Welsh Government's 'Future ICT' portfolio, a broad suite of changes to technology and ways of working that reflected developments in the external environment. The programme involved a shift to cloud-based technologies and rolling out laptops[4] to all staff to enable flexible working at any location.

22 These changes could have been delivered through an out-sourced model but the Welsh Government believed that this would have taken longer and would have been more expensive. As part of the in-sourced model, the Welsh Government believed decisions could be made or amended more easily without the constraints of contract negotiations and the divergent incentives of a customer-supplier relationship. A further benefit of the in-sourced model was to develop in-house expertise and thus build the resilience and long-term maturity of the Welsh Government's ICT function.

4 In the vast majority of cases, the new laptops replaced staff members' desktop computers, thereby enabling staff to flex their location. In some cases, the new laptops were a better replacement for existing laptops.

Management and implementation of the transition

02

Planning of the transition was based on a robust assessment of needs and the phased implementation allowed ample time for learning and adjustment

The Welsh Government planned the transition having carried out a robust assessment of need and having learnt from other organisations

23 The Welsh Government carried out an extensive programme of work to understand the needs and preferences of different user groups for the future provision of ICT. This work included the development of user profiles, a staff survey with 1,600 responses, staff workshops to explore issues in more depth, and a task and finish group to discuss the opportunities and requirements for new devices and changes in the service model. The feedback from these exercises was used to inform the universal provision of laptops to staff, the shift to web-based applications and the introduction of video-conferencing technology.

24 The staff surveys highlighted the need for an improved support service that better supported staff with particular requirements, such as homeworkers and those using assistive technology. The surveys also identified a need for staff to be able to obtain help with ICT matters through additional routes as well as the traditional call helpdesk.

25 This staff engagement did not consider the question of in-sourcing specifically. Officials told us that staff views about the current service were clear and well-established; staff were unhappy with the service and the quality and functionality of equipment. The business case for the in-sourcing rested on value for money and the potential for service improvement, so it was not deemed necessary to engage widely with staff in order to justify this approach.

26 Officials did consider the experiences of four other public sector organisations[5] that had in-sourced their ICT services. These experiences indicated that significant savings and a more flexible, responsive service could be achieved if services were in-sourced, but the transition needed to be planned well in advance with significant preparation time. The Welsh Government allowed ten months to deliver the transition after approval of the business case. Officials also consulted the UK Government Digital Service, which confirmed that the Welsh Government's emerging plans were in line with UK Government policy to in-source ICT services.

5 Driver and Vehicle Licensing Agency (DVLA), Natural Resources Wales, Swansea Council and the Department of Business, Energy and Industrial Strategy.

Some aspects of governance and leadership arrangements were not 'textbook' but this did not impact negatively on overall delivery

27 In large part, the Welsh Government adopted a governance system for the in-sourcing in line with established project and programme management protocols. The Chief Digital Officer was the senior responsible officer for the Future ICT portfolio, which was split into two programmes:

- a technical programme headed by the Chief Technology Officer[6] to implement various projects and workstreams to deliver technical solutions; and
- a Target Operating Model (TOM) implementation programme headed by the Chief Digital Officer[7] to oversee the transition to an in-sourced service.

28 The implementation programme had its own programme board, known as the Transition Board, with representatives from across the Welsh Government. The Transition Board met regularly to discuss progress and risks and make key decisions. It received appropriate information on progress, risks and key issues.

29 Governance structures evolved over time as plans became firmer and requirements clearer. Once the business case for in-sourcing ICT services was approved, the implementation programme was delivered through subject-specific workstreams, as shown in **Exhibit 1**.

6 The Chief Technology Officer's role is to own and develop the Welsh Government's technology strategy, oversee the ICT service, and support the Chief Digital Officer.

7 The Chief Digital Officer's role is to deliver the Welsh Government's agenda for Digital, Data and Technology. The postholder reports directly to the Permanent Secretary.

Exhibit 1: The four workstreams of the implementation programme

TOM Design To develop staff structures, roles and responsibilities, service definition and design, ICT process and policy design.	**Organisational Design** To manage the transfer of staff from Atos and other sub-contractors into the Welsh Government, and to oversee the move of all relevant staff into the new TOM.
Commercial To replace contracts[8] held by Atos and to ensure that Atos' exit terms and conditions were met, including the settlement of all outstanding debts and disputes.	**Tooling** To identify ICT tools and products to support the TOM.

Source: Audit Wales

30 Each workstream had its own leader responsible for delivering a work plan. However, the Organisational Design workstream was the only one to have a project board. The Chief Digital Officer felt that project boards were unnecessary for the other workstreams as their risk and complexity did not justify the additional administrative overhead. The main risks and issues were reported to the Transition Board, which made all key decisions, and the absence of project boards did not appear to hamper delivery of the programme.

31 An independent Gateway Review[9] commissioned towards the end of the programme commented on the variety of arrangements in place for managing projects and suggested that they should be rationalised. However, the review concluded that changes were unnecessary for the remainder of the transition as progress was being 'controlled by a coalition of competent and willing participants: it is not 'textbook' but it works for now'. Officials whom we interviewed concurred that the arrangements worked well in practice and the Programme Closure Report considered the evolution of governance arrangements to be a strength of the programme.

8 Atos had numerous contracts with software suppliers and other contractors for services used by the Welsh Government that needed to be novated (moved over) to the Welsh Government.

9 A Gateway Review is an independent peer review, by experienced practitioners, of a programme or project at key decision points in its lifecycle to provide assurance on whether it can proceed successfully to the next stage. The reviews provide a snapshot at a point in time and are part of a broader formal assurance framework.

32 Our work raised some concerns about top-level leadership and engagement. The Director General who acted as the 'ICT champion' on the Board left in 2017 and was not replaced. There was consensus among programme staff that this led to a loss of profile for the Future ICT portfolio and ICT issues generally. Many ICT matters were delegated to the Operations Committee, a sub-committee of the Board, and its replacement with a 'People and Corporate Services Committee' reporting to the Executive Committee diluted the focus on ICT issues. No-one from the ICT function was on the Executive Committee (the Welsh Government's top-level management team chaired by the Permanent Secretary). There were also divided lines of accountability, with the Chief Technology Officer and Chief Digital Officer reporting to different Directors-General, although both had responsibility for different aspects of the Future ICT portfolio.

33 The Project Closure Report commented that these sub-optimal arrangements impacted negatively on reporting, speed of delivery and morale, until corrective measures were put in place by creating the People and Corporate Services Committee. In practice, however, these issues did not have much practical impact on the day-to-day running of the implementation programme once funding was in place and the business case was approved. As of April 2020, the Chief Digital Officer has complete responsibility for the central ICT function (some specific applications are managed locally by the relevant Welsh Government divisions). He now sits on the Executive Committee, which should raise the profile of ICT and create a clear management structure with a single line of accountability to the Board.

The Welsh Government allocated adequate financial resources to the programme and it was delivered broadly on budget

34 The total estimated cost of the implementation programme was £12.7 million over two years to 31 March 2019. However, the precise cost cannot be determined as time spent on projects by Welsh Government staff outside the Office of the Chief Digital Officer was not measured. In addition, the overlapping objectives of the Future ICT Programme and 'business as usual' ICT work meant that some activities were difficult to classify against a particular budget. We also found that most project evaluations and lessons-learned exercises did not include an assessment of the project cost.

35 The central ICT function's core budget had been constrained for many years and the Welsh Government concluded there was not enough headroom in the core budget to fund the implementation programme. The absence of approval for the funding had been a key risk for the programme and would have prevented it moving forward.

36 The funding was secured, partly through an invest-to-save bid of £6.4 million approved by the Finance Minister in November 2017. Further funding came from the core budget for ICT services. In addition, the Enabling Government programme provided £12.95 million to meet the costs of other projects in the Future ICT portfolio. The funding was intended to deliver long-term savings by enabling a programme of work to modernise ICT infrastructure in preparation for the end of the Atos contract, improve digital services and manage data more effectively.

37 The funding proved sufficient to deliver the transition on time and the programme delivered broadly within its revenue and capital budgets. Total expenditure by the Office of the Chief Digital Officer on the Future ICT portfolio (which included a broader range of projects than those covered by the invest-to-save bid) in the three years to 31 March 2019 was £19.5 million, £112,000 less than budgeted, with a slight overrun on revenue expenditure and a small underspend on capital spending.

Contractor staff were transferred on time as planned, despite some slippage during the preparation process, but understaffing of the ICT team remains a significant issue

38 The Organisational Design project was a particularly important part of the transition. The project comprised the transfer of contractor staff into the Welsh Government, the design of a new staffing structure for the TOM, and a restructuring of the central ICT function. The aim was to create a 'one team ethos' with all staff working towards the new model from day one.

39 Fifty-four staff employed by Atos and two sub-contractors were transferred into the Welsh Government's employment. The transfer was governed by Transfer of Undertakings (Protection of Employment) (TUPE) regulations, which protect employees' contractual terms and prevent adverse changes by the new employer. Restructuring of the ICT function at the same time as the TUPE process was an ambitious and challenging aspect of the project because of dependencies between the various stages.

40 The restructure required all jobs in the new structure to be graded using the Civil Service's job evaluation scheme, JEGS, which determines the salary scale for employees. This stage was delayed by missing or out-of-date job descriptions from the contractors and a lack of Welsh Government staff to complete the large volume of job evaluations. The Welsh Government recovered the situation by asking the contractor staff to complete their own job descriptions, moderated by Welsh Government managers.

41 There was further delay as some staff appealed the outcome of their job evaluation. These appeals were unsuccessful, and the process of matching people to posts in the new structure was completed by December 2018, in time for the transfer on 11 January 2019. The process was facilitated by a pragmatic decision to modify the TOM in some respects to a 'receiving operating model' or 'Day 1 operating model' with a post for each person currently employed by the contractors or in the central ICT service of the Welsh Government.

42 The Welsh Government was able to agree terms for the TUPE transfer with employee representatives of all three contractors. All transferred staff were enrolled into the Civil Service Pension Scheme, which was more favourable than the Atos pension scheme. Contractor staff then had two options:

- move to Welsh Government terms and conditions; or
- remain on their current salary and existing terms and conditions, as modified in negotiations with employee representatives.

43 The Welsh Government was unable to replicate some features of Atos' employment offer, notably company cars and private medical insurance, and offered to buy out these benefits. However, Atos staff were disappointed with this offer as the cost of purchasing equivalent benefits privately was significantly more expensive. Several staff were disappointed with the outcome of the job evaluation, which resulted in considerably lower salaries under the Welsh Government's pay and grading system. These staff chose to retain their salary by remaining on their existing terms and conditions but it is likely to be several years before Welsh Government salaries for their jobs have caught up with their current protected salary. The Welsh Government was not able to provide us with details of the overall cost or saving arising from the TUPE process.

44 **Exhibit 2** shows the main findings from the Welsh Government's lessons-learned exercise in relation to the transfer. The exercise also raised concerns that the Welsh Government's temporary ban on permanent promotion, introduced immediately before the transfer, would make it more difficult to recruit the right people to new posts in the TOM. The Welsh Government had promoted the potential for career progression as one of the selling points for the transfer to contractor staff, and the project team feared that the policy decision (which applies to the whole Welsh Government and was outside their control) would damage morale.

Exhibit 2: Lessons learned from the Organisational Design project

Conclusion on the overall implementation of the project

The three separate but linked TUPE transfers were completed and at the same time, two Welsh Government divisions were restructured. Against a tight timescale, these five elements were transitioned to a completely new structure and to a common timeline with no noticeable disruption to delivery. The risks identified through the project were successfully managed and the successful delivery of this complicated project by the Organisational Design project team has been widely acknowledged.

Strengths

- Governance structure worked well, especially the project board.
- Staff engagement activity and consultation process.
- Negotiation of the TUPE transfer measures.
- Project team worked well together.

Weaknesses/missed opportunities

- Inadequate job descriptions from the contractors led to months of wasted time and adversely affected relationships for a time.
- Engagement with shared services and HR business partner teams could have been improved to assist in the transition to business as usual.
- A communications plan with adequate resources from the outset would have ensured stakeholders were regularly kept up to date with progress.
- There would have been benefits from being able to call on more resources during peaks in the project team's workload.
- The Welsh Government had managed several TUPE transfers in recent years, but each implementing team had needed to learn about the requirements from scratch. A dedicated resource within the Welsh Government might have been helpful.

Source: Welsh Government, **OD Project: In-sourcing ICT Services – Lessons Report**, February 2019 (unpublished)

45 Since the transition, the Welsh Government has found it challenging to fully staff the service. The ICT division has been understaffed by 15-20% since the transition[10]. Such understaffing increases the pressure on existing staff and potentially damages morale. As described in **paragraph 58**, the understaffing is also likely to be impacting on service desk performance levels and contributing to the fact that not all intended benefits are being realised.

46 Retaining ICT staff has been a challenge since transition and a small number of staff have moved elsewhere within the Welsh Government. Another contributing factor to the understaffing is the hold on external recruitment (unless a specific business case is agreed) that the Welsh Government introduced in March 2020 due to financial constraints and due to the difficulties of recruiting during the pandemic.

47 In mid-2020, the Welsh Government appointed a number of permanent ICT service desk staff and is currently recruiting a Chief Technology Officer. The division has also now had approval to recruit to seven ICT posts in various teams.

48 Currently, there is no workforce plan for the central ICT division to set out measures for developing skills and recruiting staff to deliver the TOM. However, officials intend to develop a workforce plan for the whole digital, data and technology (DDaT) function across the Welsh Government. The process is currently at an early stage, but is likely to consider staff progression, apprenticeships and changes to the operating model to adjust to changes in the external environment including technical changes.

10 Posts filled by contractor staff are not counted as vacant in these calculations.

The project management approach was largely effective and the phasing in of changes allowed time to learn and adapt

49 The in-sourcing of ICT has been a process rather than a single event. Since 2014, the Welsh Government has procured much of its project services and infrastructure requirements outside the Atos contract, and in 2017 it transferred a small team of Atos staff into the Welsh Government (**paragraph 16**). Based on advice from the UK Government Digital Service and the experience of other government departments that had attempted similar changes, officials spent considerable time planning the transition as part of a broader Future ICT portfolio. This gradual approach allowed officials to learn from experience and avoided a 'big-bang' approach.

50 The Welsh Government used both the PRINCE2 methodology and the Agile Scrum approach to project manage the technical aspects in the Future ICT portfolio. Officials told us that the approach worked well. The approach was a hybrid between a traditional PRINCE2 'waterfall' method, which requires detailed planning at the outset of the project, and Agile, which is more flexible and better suited to technical projects where service design needs to be adapted during the project rather than planning it in detail at the start. Agile was deemed less suitable for the commercial and HR workstreams where specific legal requirements needed to be met and much of the work needed to be done in a particular order. These commercial and HR workstreams used a waterfall approach.

51 The Welsh Government established a programme management office, a temporary function to co-ordinate planning and reporting across the implementation programme and to act as a secretariat for the Transition Board. Officials developed detailed delivery plans for each workstream and began work immediately on delivery. Progress was reported to the Transition Board in regular highlight reports, which summarised key issues and rated confidence in successful delivery as red, amber or green, depending on progress and risks. The Gateway Reviews and the Project Closure Report concluded that day-to-day programme management disciplines were effective.

52 The implementation programme proceeded broadly in line with planned timescales so that key milestones were achieved. Importantly, terms and conditions were agreed for all staff transferring from the contractors to the Welsh Government in time for the transition date of 11 January 2019. Once it became clear that the transfer of staff could take place on time, programme managers changed their rating of the implementation programme from 'amber' to 'amber-green'.

53 A Gateway Review in October 2018 concurred with this rating for the transition of services from Atos but was less confident about the overall Future ICT portfolio, rating it as 'amber'. The review noted that officials had made a conscious effort to focus on the immediate Merlin transition, which had de-risked that element of the programme. However, the review was concerned that financial constraints, diluted reporting lines and segmented responsibilities would hinder progress towards achieving the aspirations of the TOM. For example, financial constraints and recruitment restrictions would make it difficult to recruit for key posts in the TOM, and the segmentation of responsibility for ICT across the Welsh Government could limit efficient service provision.

There was scope to improve risk management and there is an ongoing resourcing risk to the achievement of the Target Operating Model, but ultimately risks were managed effectively to meet the transfer deadline

54 The Welsh Government took a standard approach to risk management. Risks were identified in a risk workshop, and the main risks were recorded and monitored at programme level in regularly updated risk registers. Each risk was rated on a five-point scale of how likely it was to occur and the severity of its impact if it did occur. The resulting score, out of a maximum of 25, was classified as red (requiring immediate action), amber or green. The registers included broadly defined actions to reduce the risk to levels that were 'amber' or 'green' in all cases. Each risk was assigned an owner who was responsible for managing the risk, and risks were monitored by the programme board.

55 The first Gateway Review in February 2018 commented that key staff were aware of key risks but there was little evidence of 'a structured and controlled approach to mitigation', and the programme management office was not resourced to track risks effectively. The second Gateway Review in October 2018 found little evidence of substantial improvement and concluded that risk management was sub-optimal due to complicated governance and 'a confused picture surrounding planning and resource control'. These criticisms were most relevant to high-level and longer-term risks rather than the specific project risks affecting the successful achievement of the transfer deadline.

56 Welsh Government officials that we interviewed acknowledged that a more structured and in-depth approach to risk management could have been taken. However, they considered the arrangements sufficient in the context of a fairly stable risk environment. Ultimately, the risks were managed effectively to deliver the transition on time and meet all key milestones.

57 The main risks for the transition were related to the transfer of staff from Atos to the Welsh Government, due to potential delays in the job evaluation and matching process or problems engaging successfully with the contractors and their staff. In addition, the extra cost of pension provision for transferred staff was highlighted as a risk that the Welsh Government chose to accept. More broadly, the risk registers highlighted the need for adequate staff resources and training to ensure that the restructured ICT function would provide a seamless and high-quality service, including the need to recruit externally to fill vacant posts in the TOM.

58 Insufficient resourcing to deliver the TOM is the one high-level risk that has clearly materialised. As described in **paragraph 45**, many posts have not been filled, including some key technical roles, and staff are stretched with some working significant overtime.

There is scope to strengthen the way performance is monitored by more regularly scrutinising an improved set of indicators

59 The Welsh Government currently monitors ICT service performance through a set of indicators that it regularly records and reports. However, given the transition and its resulting changes to the nature, methods and arrangements for delivering ICT services, there is now a need for the Welsh Government to review its operational ICT service level targets and indicators.

60 The Welsh Government is carrying out work to develop a new organisational Key Performance Indicator framework. The current draft of the framework already includes a small number of ICT-related metrics. However, there is scope to consider further metrics that cover the performance of the whole in-house ICT service, and provide a focus on the greater provision of cloud services, increased flexible/home working, plus new ICT applications, tools and equipment for staff.

61 When the Welsh Government reviews its ICT indicators, it should also consider how performance compares with external comparators, including other UK Government departments. Benchmarking is a gap in the current performance monitoring arrangements.

62 There is also scope for the Welsh Government to improve its scrutiny of ICT service performance. ICT performance indicators are monitored at an operational level within the ICT services division management team. ICT matters are also reported to the Executive Committee on an exception basis. However, given that technology, digital and ICT are such key enablers for the Welsh Government, there would be benefits from presenting a summary of ICT performance at a senior level, to increase scrutiny and challenge, on a more formal and regular basis. During our work, the Welsh Government was changing its reporting arrangements, with the Chief Digital Officer becoming a member of the Executive Committee. This presents a key opportunity to increase both the profile and scrutiny of digital and ICT matters.

Delivery of the intended benefits

03

Some of the intended benefits are being delivered but there have been fewer savings than anticipated in 2019-20

Savings are being delivered but not to the extent planned, largely due to a shortfall in the ICT staffing levels and increases in the estimated software and contractor costs

63 Financial savings were a fundamental part of the business case for bringing ICT services in-house. **Exhibit 3** shows that while the Welsh Government has not secured all of the savings it had hoped for, it has claimed savings of £4.9 million in 2019-20. For context, the Welsh Government's overall expenditure on ICT services in 2019-20 was £13.9 million.

Exhibit 3: Expected and actual savings from the transition, 2019-20

Higher-than-expected savings are shown in green and lower-than-expected savings are shown in red.

Business case objective	Expected savings	Actual savings
Reduce ICT project services costs	£6 million	£3 million
Reduce ICT service costs	£2 million	£1.25 million
Reduce business operating costs:		
• Managed print services	£100,000	£443,000
• Data centre	No target set	£155,000
Improve flexible working:		
• Reduced travel costs	No target set	£23,000
Total	**£8.1 million**	**£4.9 million**

Source: Unaudited financial data provided by the Welsh Government

64 The Welsh Government has reduced ICT project services costs by £3 million. This was a conservative estimate based on the final year of the contract. It achieved this by using internal ICT Services Division staff (and contractors) in the delivery of ICT projects, instead of using the out-sourced managed service contract. The Welsh Government told us that the full £6 million savings target was not met because the ICT division has not established a fully functioning programme management office, which could have been used by the wider organisation to reduce its use of contractors and third parties. These matters are described further in **paragraph 69a**.

65 Savings of £443,000 were secured in 2019-20 by centralising managed print services at Welsh Government offices. This involved reducing the numbers of desktop printers and providing a number of centralised or shared printing services. The Welsh Government has made greater savings than planned due to further reductions in printers and staff producing lower volumes of printing than expected.

66 The business case included an aim of reducing the reliance on data centres and reducing the physical, on-premise ICT infrastructure, by moving services to the cloud. The Welsh Government had planned to close its Data Centre 2[11] in 2020-21 but this was decommissioned earlier than planned, at the end of 2019. This resulted in savings of £155,000 on data centre electricity and maintenance costs.

67 Flexible working arrangements enabled by the new laptops have resulted in reduced travel costs of £23,000. This was largely realised for the Bedwas and Merthyr office locations, where the new laptops were rolled out first. The Welsh Government had not set a target for reduced travel costs in 2019-20, and these savings will have increased significantly in 2020-21 as the COVID-19 pandemic has caused many more staff to work from home. Substantial savings are expected in future on travel and subsistence costs. However, there will also be additional costs incurred in assisting staff in their homeworking arrangements by providing equipment such as monitors and keyboards.

68 The Welsh Government has reduced ICT service costs by £1.25 million in 2019-20. However, the actual costs were different to those estimated in the business case. We have identified some of the key areas where there were variances and these are summarised in **Exhibit 4**. When producing the business case in early 2018 the Welsh Government used the actual costs incurred from 2017-18 to estimate the ICT service costs and overheads for 2019-20.

11 Data Centre 2 was located on Newport Road, Cardiff, within a Home Office building. The data centre included key departmental and administrative ICT systems, and it was part of the Welsh Government's off-site backup arrangements to make copies of the organisation's data.

Exhibit 4: Key areas of variances in the expected and actual ICT service costs

ICT service costs	Estimated costs 2019-20 (business case – March 2018)	Actual costs – 2019-20
Software and tools	£6.1 million	£8.4 million
Consultancy costs	£0	£0.7 million
Platform services	£1.2 million	£1.3 million
Professional Support Office	£1.6 million	£0.8 million
Service operations	£1.8 million	£1.7 million
Senior management	£0.5 million	£0.2 million

Source: Unaudited financial data provided by the Welsh Government

69 The bullet points below provide some further explanation of the variances in **Exhibit 4**:

a staff costs were lower than anticipated, largely because the ICT team has been understaffed by 15-20% since transition to the in-house service. A programme management office was due to be created to provide programme and project management and business support to ICT infrastructure and application projects. However, it was never fully formed. While this has resulted in savings of £773,000, the lack of the programme management office does mean that the service is more reliant on contractors than planned, and that the full service of the programme management office has not been available to the wider organisation.

b senior management costs were £248,000 lower than anticipated in the business case due to changes in the ICT management team structure and due to the vacant Head of Professional Services post. Costs to deliver the core service and operations, such as the ICT service desk, as well as the problem, change and asset management teams, were £152,000 lower than expected. However, consultancy costs were £741,000 higher than anticipated, with contractors being used to staff some positions in the ICT service desk and for the new laptop rollout programme.

c software costs were considerably higher than anticipated, partly because there has been greater consumption of software licences than originally expected. The Welsh Government also underestimated some price increases across the software marketplace and price rises in relation to the preferential supplier rates previously delivered under the Atos contract.

d an increase in applications moved to the cloud and increased data usage resulted in costs being £133,000 higher than originally estimated.

70 While we have not completed a full audit of the savings figures reported by the Welsh Government, we did complete a high-level sense check on the figures included in the project's benefits tracker. We found a small number of issues and errors in the tracking of savings, which the Welsh Government has now addressed[12].

71 We also found scope for the Welsh Government to make improvements to the tracking and profiling of savings and benefits, for example by profiling the intended delivery of non-financial benefits for future years. The Welsh Government maintains an internal spreadsheet to track the delivery of benefits every month. While the Welsh Government had originally planned to produce in-depth mid-year benefits assessments, it has since decided to carry out this in-depth reporting at the end of the financial year, to avoid duplication of effort. The benefits tracker for 2019-20 was due to be presented to the Executive Committee for scrutiny in February 2021.

72 In addition to the savings detailed above, the business case included an intention to avoid capital costs for replacing certain ICT infrastructure. The Welsh Government had expected to save £4 million per year, for five years from 2019-20, in relation to capital expenditure on ICT infrastructure. This cost avoidance is possible because the Welsh Government no longer needs to refresh as much on-premise ICT infrastructure and devices, because this work is now covered within cloud services hosted by third parties. Due to the reduction in on-premise infrastructure, additional costs for cloud platform services have been incurred. These costs had been estimated at £1.15 million for 2019-20 but the actual costs were higher by £133,000.

12 Two errors related to miscounting of between £15,000 and £20,000 in savings. The third error related to double counting of savings on print costs of £100,000. These have since been corrected.

Some, but not all, non-financial benefits are being delivered, although it is difficult to judge success because specific targets were not set

73 In addition to financial savings, the business case said that in-sourcing ICT services would lead to a range of non-financial benefits. However, the Welsh Government did not set specific targets for these, making it difficult to measure success. **Exhibit 5** lists each of these benefits and summarises the Welsh Government's progress so far. The Welsh Government has made some progress towards achieving the non-financial benefits but further improvements are required.

Exhibit 5: summary of progress in achieving non-financial benefits

Benefits	Summary of progress
Remote access Resolving remote access issues to reduce the volume of calls made to the ICT service desk from ICT users for this type of issue	Calls to the ICT service desk for remote access issues reduced after in-sourcing, from an average of 368 per month in 2018 to an average of 225 in 2019. While call volumes increased in 2020 (to an average of 621 per month in the first five months of 2020) this is likely to be due to the new homeworking arrangements during the pandemic. In March 2020, the month that the first lockdown was announced, the number of calls spiked at 1,080.
Application management Resolving application management issues by introducing an application support service to develop new applications and bring these into service	The intended role of the application management and support service is to develop new ICT applications for Welsh Government departments and bring these into service to meet business needs. The purpose of these applications varies but an example could be to enable electronic forms to replace paper documents in some internal processes. The Welsh Government had not delivered an application management and support service at the time of our work. A number of application support engineer posts were being recruited in late 2020, with the intention of commencing the service at the start of 2021.

Benefits	Summary of progress
Virtual private network (VPN) Improving resilience in remote access capacity by increasing the number of staff who can concurrently connect to the VPN	The Welsh Government has improved its resilience in remote access capacity by increasing the numbers of staff who can connect remotely at the same time from 2,000 in 2019 prior to the pandemic to 8,000. This should provide more than enough capacity, given that the Welsh Government has approximately 6,000 staff.
Flexible working Flexible working benefits allowing staff to work at home or another office location away from their main office base	New laptops have enabled more flexible working, which has been hugely beneficial given the new working arrangements necessary during the pandemic. The COVID-19 disruptions have shown that effective ICT and digital tools are a key enabler for flexible working and collaboration within teams. The Welsh Government's rollout of new laptops to all 6,000 ICT users by November 2019 significantly increased business resilience and allowed staff to carry on working flexibly from home. The timing of the laptop rollout was key to giving staff the opportunity to become familiar with the new laptops and software tools prior to the March 2020 lockdown.
Avoiding travel Avoiding the need to travel and reducing time spent travelling	New laptops and video conferencing solutions are resulting in avoided journeys. The Welsh Government expected travel time to reduce in 2019 but has not measured this. It is clear that travel time has reduced considerably during the pandemic.
Carbon reduction Reduced carbon emissions by reduced printing activity and by closing a data centre	While this benefit was not specifically listed in the business case, the Welsh Government claims that its reduction in printing activity (referred to in **paragraph 65**) has reduced carbon dioxide emissions by nearly 700 kg when comparing the period June 2019 to February 2020 with the period March 2020 to November 2020. The Welsh Government claims an additional reduction in carbon emissions as a result of closing Data Centre 2 and will be reporting formally on this at the end of the 2020-21 financial year.

Source: Audit Wales analysis of information from the Welsh Government

While there has been a gradual decline in the number of serious ICT incidents, understaffing is the most likely cause of the dip in service desk performance after the transition

74 The Welsh Government had hoped that the in-sourcing would enable the ICT team to provide a better service through the ability to flex resource and respond quickly to business needs. One measure of overall service performance is the number of serious incidents that the service responds to. The number of these so-called 'Impact Level 1' incidents[13] has gradually declined between January 2018 and December 2020. However, some indicators show a reduction in service desk performance in the six months after the transition. Whilst performance started to recover slightly in late 2019, this performance remained below operational level targets in 2020. **Exhibit 6** compares service desk performance in October 2020 with the performance before the transition.

Exhibit 6: service desk performance before and after transition

Indicator	Target	Pre-transition performance	Post-transition performance
First-time fix rate following calls to the ICT service desk	70%	74%	67%
20-second service-desk call answer-rate	95%	94%	72%
Service-desk calls abandoned after 30 seconds	5%	3%	12%
Incident management resolution rate	95%	98%	89%

Source: Welsh Government data. Note: Some of the targets have changed during the period covered in the exhibit.

Note: The pre-transition performance covers the 12-month period up to January 2019 and the post-transition performance covers the 22-month period up to October 2020.

13 Impact Level 1 incidents are defined as ICT incidents that affect more than 1,000 users.

75 The most obvious reason for this dip in performance is that the ICT team has been understaffed by 15-20% since transition. The transition away from an out-sourced model means that the risks associated with resource gaps in the ICT service have transferred to the Welsh Government. These risks have materialised since the transition and there have been difficulties staffing the ICT service desk since January 2019. Several ex-contractor staff took the opportunity afforded by the transfer to obtain posts elsewhere in the Welsh Government, placing further pressures on resources and increasing the use of agency staff.

User satisfaction with ICT services has improved since the transition and the rollout of new laptops

76 Another key measure of service performance is the satisfaction of service users, which has improved since the transition. The Civil Service People Survey of October 2018 found that 56% of Welsh Government staff agreed or strongly agreed 'I have the technology (ICT/IT) I need to do my job effectively'. When staff were asked the same question in March 2020, 85% agreed or strongly agreed.

77 The Welsh Government also ran an ICT user and tools survey in January 2020, which largely focussed on the laptop rollout, use of new digital tools and how these have led to behaviour change. Eighty-nine per cent of staff responded positively to the statement 'I have the technology to do my job effectively'. The survey also found:

- 88% of staff were satisfied with the new laptop rollout process and approach;
- 93% of staff had started to use the new laptop to work flexibly from home and 49% of staff used laptops when travelling; and
- 90% of staff responded positively that they have the ICT equipment to support them to work smartly.

78 The January 2020 survey showed that the new laptops and applications were proving to be a catalyst for behavioural change:

- 77% of staff were using their laptop in meetings instead of printing meeting papers;
- 89% were using instant messaging to communicate with colleagues rather than email; and
- 63% were using collaborative tools, for example, Skype, to hold virtual meetings.

79 The survey also highlighted a number of improvement suggestions from ICT users, including:

- training should be provided for ICT users on the knowledge, use and awareness of the new software and business applications on the new laptops;
- staff suggested there was scope to improve collaborative working with external stakeholders, for example, through the use of Skype with other organisations; and
- scope to digitise business processes, for example, by removing paper forms and replacing them with electronic forms and processes.

80 The Welsh Government's ICT service has taken action to address some of these issues by allowing virtual Microsoft Teams meetings with external organisations since April 2020. Furthermore, in July 2020 the Welsh Government agreed a two-year training contract with a company to deliver training to staff on the new Microsoft Office software, collaboration tools and virtual meeting software. The training has begun and it will continue through to June 2022.

Appendices

Audit approach and methods

Audit approach and methods

Under the previous Merlin contract, the Welsh Government paid a private company to provide it with ICT services. The Merlin contract was the subject of a report from the Auditor General in 2011.

In 2017, the Welsh Government took the decision in principle to in-source ICT services. In March 2018, the Welsh Government approved a business case to bring ICT services in-house, starting a ten-month transition phase. The in-sourcing was part of a broader suite of changes to technology at the Welsh Government, called the Future ICT portfolio. Our work focused on the in-sourcing rather than the broader portfolio.

The transition to an in-sourced service happened as planned in January 2019 and we did not begin any work until January 2020, to ensure a full year had passed and to allow enough time for the changes to bed in. We carried out the bulk of our fieldwork in the second half of 2020.

Our review considered whether the Welsh Government's transition to an in-house ICT service was on track to deliver the intended benefits. Our scope covered the strategic approach to planning the transition, the management and implementation of the transition, the delivery of intended outcomes, and the arrangements for oversight and performance monitoring. **Exhibit 7** sets out the audit methods we used.

Exhibit 7: audit methods

Document and data review	We reviewed documents relating to the planning and delivery of the transition including the business case, project plans, highlight reports, benefits realisation outputs and minutes of relevant forums.
Interviews	We carried out a range of interviews with staff involved in leading, planning and implementing the transition. During the course of our work, there were changes to the posts of Chief Digital Officer and Chief Technology Officer within the Welsh Government. We engaged with the incumbents as well as their predecessors.

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4 June 2021

Management response to Audit Wales report: In-sourcing the Welsh Government's ICT service

Dear Adrian

I am writing in response to the Audit Wales report on the in-sourcing of Welsh Government's ICT service. Can I first of all apologise for the delay in this response.

The report provides a fair and accurate evaluation of the transition programme and the delivery of the intended benefits and I am pleased you have recognised the successful delivery of this programme by my colleagues and predecessors.

I am also very grateful for the constructive manner your team engaged with us over the period of the audit.

Our management response to the recommendations are included in Appendix 1.

Yours sincerely,

Glyn Jones
Prif Swyddog Digidol, Llywodraeth Cymru
Chief Digital Officer, Welsh Government

Appendix 1: Response to recommendations

R1 We recommend that, in future business cases and change programmes, the Welsh Government clearly profiles the delivery of its intended financial and non-financial benefits by setting clear target levels and milestone dates. This would make it easier to assess whether programmes are on track to deliver as intended.	Accept. We agree this should be best practice for major business change programme, to ensure potential financial and non-financial benefits are clearly articulated and monitored. These benefits should also be defined and documented in a manner which allows them to be measured over the long term as those involved in the original project move roles. We recognise that there is existing guidance readily available to appraise and develop projects and programmes, namely, HMT's Green Book and the Better Business Cases (BBC) guidance. We also recognise that there is scope for a more robust application of the guidance, including with regards assurance and the scrutiny and approvals process. As advocated in the BBC guidance this will include the proportionate use of Gateway Assurance Reviews and the application of programme and project management methodologies for delivery.
R2 We recommend that the Welsh Government schedules a formal review of the delivery of the benefits from the in-sourcing, at three years after the transition, to ensure medium-term impacts are recorded and reported on.	Accept. The Chief Digital Officer's team are maintaining the benefits tracker work that has been in place since in-sourcing and will report to Exco with an updated review of financial and non-financial benefits by the end of 2021-22.
R3 We recommend that the Welsh Government develops a more robust mechanism to measure the true cost of projects to inform project planning, monitoring and evaluation. This should include a proportionate approach to measuring the cost of significant internal resources spent on projects, including the time of its own staff	We agree with the need to understand the whole life cost of projects in delivering major projects. We also agree to achieve this we need a good understanding of internal resource time, including the time of our own staff, as well as external revenue and capital costs. However we would need to consider how this could be achieved in a proportionate manner given the range of people across the organisation generally involved in corporate projects, particular as we currently have no mechanism for capturing this information. It will need to be assessed on a project by project basis in a manner where the level of detail considered is proportionate to the expected costs and benefits. As described earlier under recommendation 1 we also recognise there is scope for a more robust application of the BBC guidance, including the proportionate use of Gateway Assurance Reviews and the application of programme and project management methodologies for delivery.
R4 We recommend that the Welsh Government updates the key performance indicators and operational targets for ICT services, to ensure they reflect the new model of inhouse service provision, including increased home and flexible working and reduced travel.	Accept. The Chief Digital Officer has asked a senior statistician to lead a Task and Finish group involving colleagues from ICT services, corporate research and the future digital programme to develop a new suite of metrics during this financial year reflecting the new model of in-house service provision as well as ongoing digital transformation work.

R5 We recommend that a summary dashboard covering ICT service performance is considered by the Executive Committee as a standing agenda item for challenge and scrutiny.	Accept. However we propose the standing item is instead considered at the Finance and Corporate Services sub-committee of the Executive Committee (Exco) for discussion, challenge and scrutiny on a routine basis. At the same time we will ensure the data are made available to Exco members, and the Chief Digital Officer will present this to Exco on an annual basis.
R6 We recommend that the Welsh Government introduces benchmarking of its ICT service performance and structures to allow comparison with other organisations.	Accept. However benchmarking with other organisations is notoriously difficult due to the different size, scope and services they provide. We will consider the most appropriate mechanism for benchmarking, and what will be possible, as part of the work of the Task and Finish group. Nevertheless our priority for this financial year will be to develop a series of metrics that are workable within a Welsh Government context. As part of the wider Civil Service people survey, we are already able to compare two headline measures* with other Civil service departments. *staff satisfaction with “having the tools they need to do their jobs”; and whether “technology used by my organisation enables me to connect and collaborate with colleagues”
R7 We recommend that the Welsh Government introduces a formal, annual review of user satisfaction of ICT services, to assess whether improvements are being sustained in the long term.	We accept the need to consider user satisfaction of ICT services on a regular basis. We already monitor annually through the Civil Service people survey which asks the headline questions described above. We will consider with our corporate research team how additional work could be undertaken to provide more in-depth analysis of user satisfaction, particularly given the expectation of continued blended working approaches. This will need to be balanced against our range of other corporate research priorities and may not be possible to undertake on an annual basis. Through our future digital programme we will also be embracing the principles of user-centred design which will provide more meaningful and in-depth user feedback during the design of digital services.
R8 We recommend that the Welsh Government revisits the staffing levels set out in its Target Operating Model for ICT and develops an action plan for achieving the required staffing. Without taking such steps, there is a risk that the full benefits of the transition will not be delivered.	Accept. Exco has accepted the requirement to ensure IT services are resourced effectively and additional resource is identified to support the future digital programme and maximising the wider benefits of the in-sourcing model. Plans are being developed to recruit to the required operating model on an iterative basis. As time has moved on since the original Target Operating Model, the exact detail of the skills and structure required within the overall staffing levels will be based on the impact of remote working on our IT services model and our future workforce requirements. For example, we have already over the last year identified the need to prioritise Cyber Security resource within our

	operating model and Exco has agreed the recruitment of 3 additional posts in this area. A plan is also being developed to take forward work on the DDAT profession more widely, and a DDAT workforce plan will be developed to ensure there is a clear talent pipeline for DDAT resource into the organisation as well as a clear progression framework for existing staff.

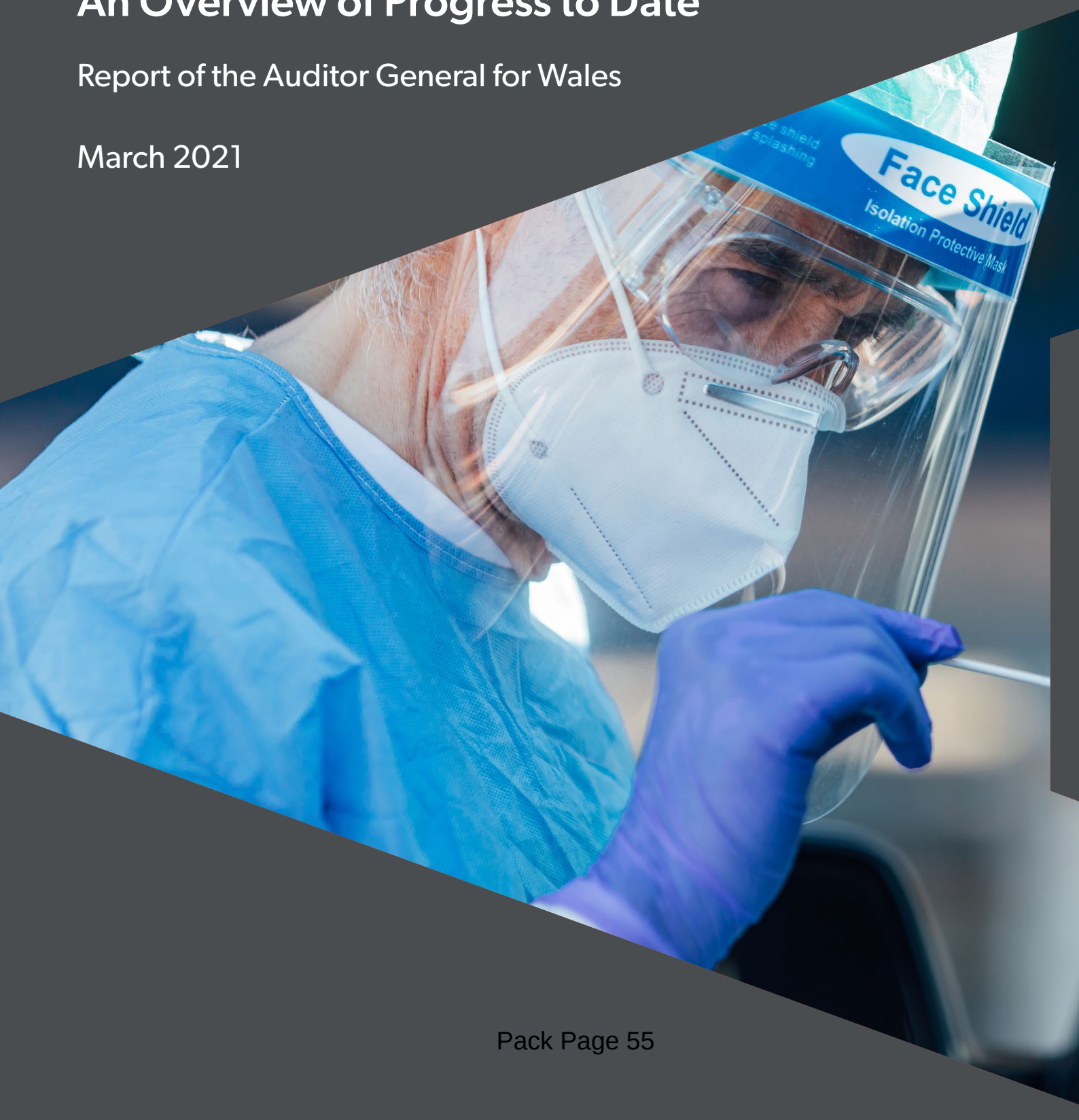
Document is Restricted

Archwilio Cymru
Audit Wales

Test, Trace, Protect in Wales: An Overview of Progress to Date

Report of the Auditor General for Wales

March 2021



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

Introduction

1 Test, Trace, Protect (TTP) is a crucial part of the Welsh Government's approach to limiting the spread of COVID-19 and reducing the need for restrictions on people's lives. The TTP programme was developed rapidly from scratch through the partnership arrangements put in place when the pandemic first hit in March 2020 and forms part of the wider response to the virus, set out in the Welsh Government's **Coronavirus Control Plan for Wales**.

2 The Welsh Government's **Test, Trace, Protect** strategy sets out the key elements of the programme which comprise:

- identifying and testing people who may have COVID-19;
- tracing people who have been in close contact with someone who has tested positive for COVID-19; and
- providing advice and guidance to protect the public and supporting people to self-isolate where necessary.

3 **Exhibit 1** provides further information on how TTP works in Wales.

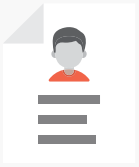
Exhibit 1 – how TTP works in Wales

The Welsh Government sets the priorities and provides funding and oversight of TTP with advice from Public Health Wales NHS Trust (PHW)

Test

- Health boards and local authorities work with partners to provide testing facilities where swabs are taken and then sent for analysis.
- Welsh NHS (PHW) labs analyse some of the tests. Some are analysed by private labs known collectively as the UK Lighthouse Labs. The Lighthouse Labs are managed by a partnership led by the UK Government[1].

Trace



- Where relevant[2], the details of people who tested positive for COVID-19 are sent to local contact tracing teams in the area where they live. Teams are coordinated regionally by health boards and local authorities.
- Contact tracing teams speak to people who tested positive to identify anyone they may have infected.
- Contact tracing teams try to reach anyone who came into contact with the person who tested positive. They advise people who have symptoms to get tested and self-isolate. They send regular text messages to contacts without symptoms to see if they have developed symptoms.

Protect

- Contact tracing teams ask people whether they need help to self-isolate and pass their details onto local authority teams.
- Local authority teams and the third sector support people who need help to self-isolate.

Source: Audit Wales

1 The partnership includes Medicines Discovery Catapult (a UK Government funded organisation), the UK Biocentre, the University of Glasgow, the University of Cambridge, and private companies: AstraZeneca, GSK, and PerkinElmer.

2 There are people whose details do not go to contact tracing teams, for instance people in care homes, prisons, or hospitals.

About this report

4 This report sets out the main findings from the Auditor General's review of how public services are responding to the challenges of delivering TTP services in Wales. It is a high-level overview of what has been, and continues to be, a rapidly evolving programme. The evidence base for our commentary comes from document reviews, interviews with staff in health boards, local authorities, NHS Wales Informatics Service (NWIS), Public Health Wales (PHW) and the Welsh Government between September and December 2020, and analysis of key metrics that show how well the TTP programme has been performing. As well as commenting on the delivery of TTP up to and including December 2020, the report sets out some key challenges and opportunities that will present themselves as part of the ongoing battle to control COVID-19.

Key messages

5 The TTP programme has seen different parts of the Welsh public and third sector work together well, in strong and effective partnerships, to rapidly build a programme of activities that is making an important contribution to the management of COVID-19 in Wales.

6 The configuration of the TTP system in Wales has a number of strengths, blending national oversight and technical expertise with local and regional ownership of the programme, and the ability to use local intelligence and knowledge to shape responses.

7 Arrangements for testing and contact tracing have evolved as the pandemic has progressed. But maintaining the required performance in these areas has proved challenging in the face of increasing demand.

8 TTP is a crucial part of the Welsh Government's approach but has not been the only way it is trying to prevent the virus spreading. Despite increased testing and tracing activity, the virus has continued to spread. In Wales, as in other parts of the UK and internationally, testing and tracing has needed to be supplemented with increasingly stringent local and national lockdown restrictions in an attempt to reduce transmission rates.

9 Lockdowns have only provided temporary solutions to controlling transmission and regardless of progress with vaccines, the TTP programme will remain a key tool in Wales's battle with the virus for some time to come.

10 Testing volumes increased significantly in response to increasing incidence of COVID-19, and results have generally been turned around quickly. The tracing workforce has expanded rapidly. But when demand has risen across regions at the same time, there has been insufficient contact tracing capacity to meet the increased demand.

11 Most importantly of all, the public has a huge role to stop the virus spreading by following guidance and self-isolating when necessary. There is now good information to show the breadth and range of services and support adopted across Wales during the pandemic. But it remains difficult to know how well the 'protect' element of TTP has been working in supporting people to self-isolate. This will become increasingly important as 'lockdown fatigue' sets in with its associated challenges for emotional, physical and economic well-being.

12 These key messages are explored further in the following sections.

> Wales has developed a Test, Trace, Protect service largely from scratch and at unprecedented scale and pace.
>
> It has been particularly encouraging to see how well public sector partners have worked together at a national, regional, and local level to combine specialist expertise with local knowledge, and an ability to rapidly learn and adjust the programme as we've gone through the pandemic. It's important that the positive learning is captured and applied more widely.
>
> There have been times when the Test, Trace, Protect service has been stretched to the limit, but it has responded well to these challenges. The programme needs to continue to evolve, alongside the rollout of vaccines, to ensure it remains focused on reaching positive cases and their contacts, and supporting people to self-isolate to keep the virus in check.

Adrian Crompton
Auditor General for Wales

Main findings

01

How well are various agencies working together to deliver TTP in Wales?

1.1 The various organisations involved in delivering TTP in Wales have worked incredibly hard, in strong and effective partnerships, at a rapid pace and together have established a range of activities that have been making important contributions to the management of COVID-19 in Wales.

1.2 The scale of the challenge has been significant. With the exception of localised arrangements that have been previously enacted to respond to public health outbreaks, TTP arrangements were non-existent prior to the pandemic. The following exhibit provides an indication of the scale of the TTP programme during the second peak in COVID-19 cases.

Exhibit 2 – comparison of TTP activity at the week ending 2 January

40 testing sites in place, carrying out **96,000** tests per week → Equivalent to the average number of outpatients seen by Cardiff & Vale University Health Board every two months

2,400 staff appointed, trained, and onboarded to provide contact tracing → Equivalent to just under half of the total workforce employed by the Welsh Government

8 regional teams in place, tracing, providing advice to, and following up on **14,000** positive (index) cases and **31,200** close contacts per week → Equivalent to the average number of 999 calls made to the Welsh Ambulance service each month

Source: Welsh Government and Public Health Wales

1.3 Whilst roles and responsibilities within the system were not fully understood by all in the early stages of the pandemic, they became clearer as the programme evolved and responded to the challenges of incidents, outbreaks, and rising transmission rates.

1.4 The configuration of the TTP system in Wales has a number of strengths, blending national oversight from Welsh Government, with the technical expertise and experience that sits within PHW, health boards, local authorities, third sector and NWIS. Crucially, the TTP model in Wales has given PHW, health boards and local authorities' ownership of the process, and the ability to use local intelligence and knowledge to shape responses to the pandemic.

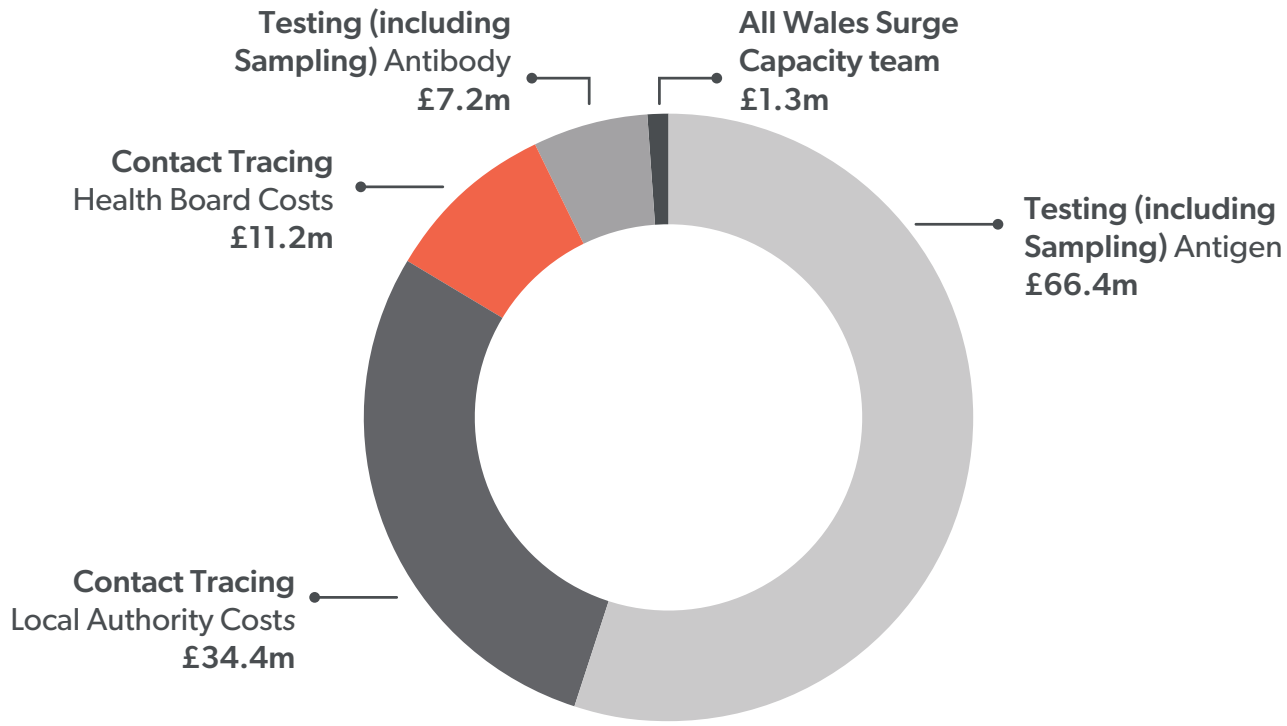
1.5 The programme has demonstrated that it can adapt and evolve quickly, learning lessons from the management of early outbreaks and trying to effectively marry Wales specific and UK-wide arrangements. However, this has, and continues to be, a challenge and officials we spoke to described it as trying to 'design, build and fly an aircraft all at the same time'. The new variants of the virus also present a significant challenge and are increasing the pressure on the TTP programme to remain agile.

1.6 The fact that Wales has not had sole control over all the elements of the TTP programme has caused some operational challenges in respect of access to tests. Wales relies heavily on the UK Lighthouse Laboratories (Lighthouse Labs) and in September, the UK Government unilaterally announced that it was capping daily testing capacity in Lighthouse Labs in response to high demand for tests. Whilst the UK Government quickly released more tests for Wales, the episode highlighted some of the challenges associated with the hybrid testing system. This issue is explored further in **paragraph 1.21**.

How much is TTP costing?

1.7 The Welsh Government element of the TTP programme is expected to cost over £120 million during 2020-21, of which almost three-quarters is on testing (**Exhibit 3**). The actual costs to the taxpayer are considerably higher because Wales does not pay directly for its share of testing sites or laboratory facilities which are commissioned by the UK government (**see section on testing**). Health boards, local authorities, PHW and the Welsh Government have also redeployed staff to deliver TTP which is not included in the all-Wales spending figures. The exact expenditure relating to the 'protect' element of the programme is also not included as associated costs are part of wider service provision costs for local authority and third sector organisations.

Exhibit 3 – all-Wales TTP expenditure for 2020-21 (£ million) based on actual expenditure to month 10 and forecast to year end. This chart does not include all TTP expenditure



Source: TTP Monthly monitoring returns[1] – based on 'Month 10' submission

1 Health boards and trusts submit the monitoring returns to Welsh Government for review.

How well is testing for COVID-19 working in Wales?

1.8 At the start of the pandemic, the level of available lab capacity across Wales was below that required to meet expected demand from its TTP programme. The UK-wide network of Lighthouse Labs has provided significant additional capacity since May which the Welsh public sector would not have been able to secure on its own. Plans to further increase Welsh public sector provided lab capacity were announced in August supported by additional Welsh Government funding of £32 million.

1.9 When compared to other countries, the UK and Wales has had some of the highest population testing rates in the world[2]. The extra investment helped to support an additional 6 'hot labs' to enable rapid test analysis, and to support 24-hour provision of Welsh NHS laboratories. This required the recruitment of additional laboratory staff.

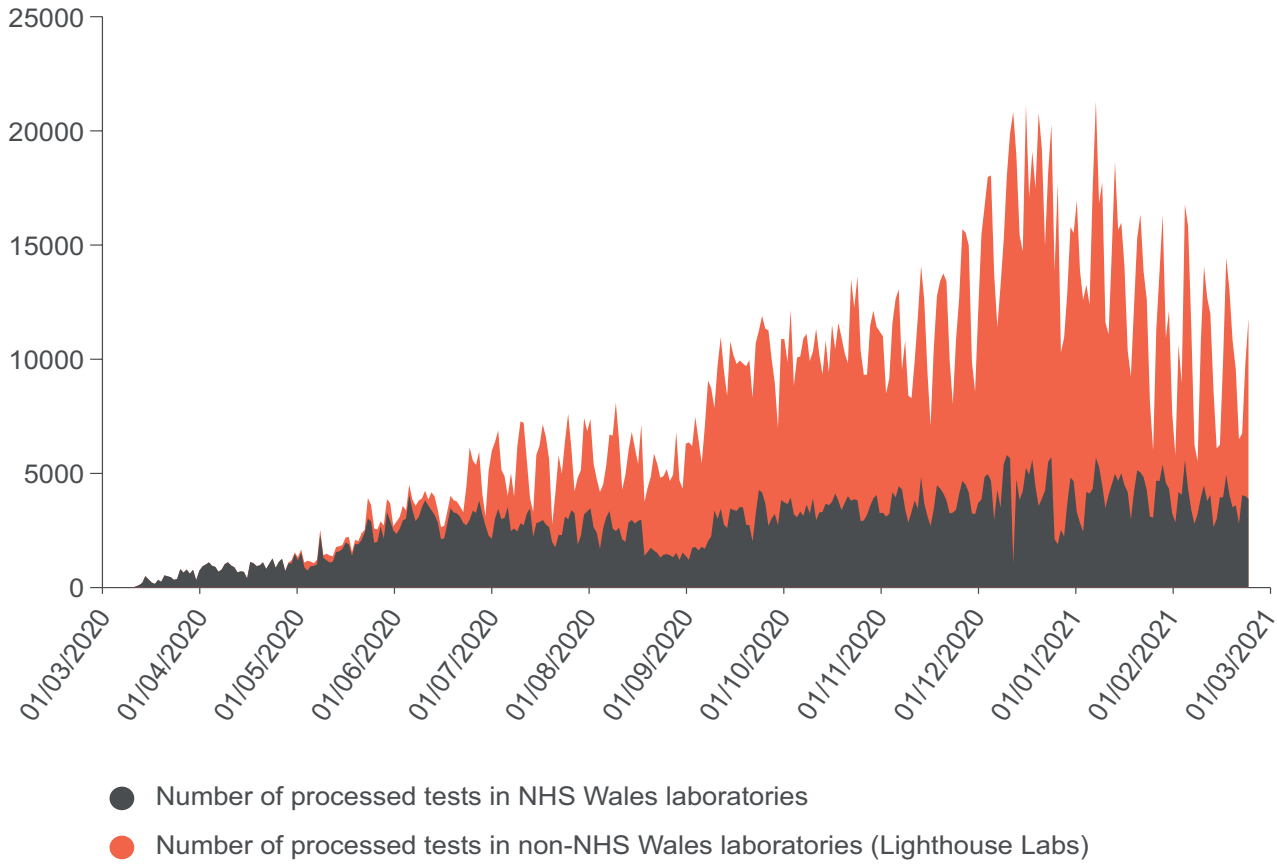
1.10 Significant sampling capacity has also been put in place since May. This continues to expand, including local testing sites and mobile testing units which can be moved to areas of need. A number of sampling facilities are run by private contractors as part of the UK testing programme. But health boards, and the Welsh Ambulance Services NHS Trust have increasingly been providing additional sampling capacity.

1.11 The pathway for sampling and analysis of tests has varied depending on who is having the test and includes a level of complexity (**Appendix 1**). The Lighthouse Labs provide basic positive or negative results but have been able to respond to high demand and analyse large volumes. Welsh NHS laboratories provide tests which provide greater detailed analysis, but they have been unable to respond to high demand. These arrangements have and will continue to change when new swabbing and lab services are introduced, and new tests are developed and introduced.

1.12 **Exhibit 4** shows a significant growth in the level of testing done between mid-March and February 2021. It also shows that a significant proportion of the demand for tests across Wales has been met by the Lighthouse Labs.

2 At the time of our fieldwork we looked at the top 30 countries with the most cases. Since the start of the pandemic, the UK had the second highest rate and Wales had the sixth highest rate of testing (antigen and antibody).

Exhibit 4 – total processed tests for Welsh residents split by NHS Wales and Lighthouse Labs provision up to 25 February 2021

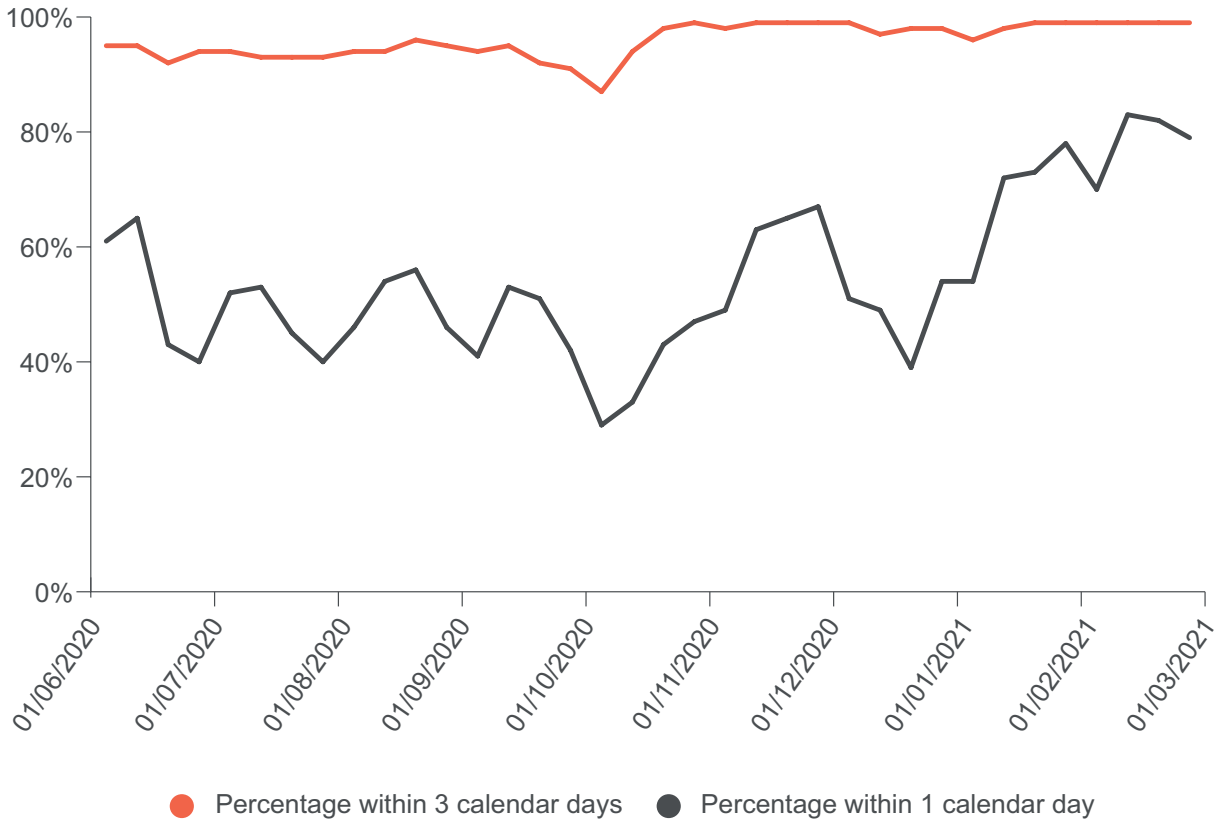


Source: Public Health Wales

1.13 Timeliness is crucial to containing the spread of the virus. A quick turnaround for a positive test result allows contact tracing teams to reach that person's contacts sooner and tell them to self-isolate to prevent further spread. A quick turn-around on a negative result also reduces the impact on individuals and on the wider economy, for example, by allowing them to return to work.

1.14 **Exhibit 4** indicates that by late September, laboratories were processing over 10,000 tests a day for Welsh residents. At that time, there were increasing rates of COVID-19 across a number of county areas, significant increases in demand for tests as a result of schools reopening, and the onset of seasonal illnesses with similar symptoms. The effect of the above factors contributed to a reduction in the proportion of tests that were turned around within the 'gold' standard of one calendar day, although turnaround within three calendar days has largely been maintained. The additional testing capacity across Wales has helped improve the performance over recent months (**Exhibit 5**).

Exhibit 5 – percentage of tests reported within one calendar day and within three calendar days (both Welsh and Lighthouse Labs) up to 1 March 2021



Source: Public Health Wales

1.15 The time between people giving a sample and the results being reported by the lab (turnaround times), however, has varied quite significantly depending on the location of the test and where it has been analysed. We found that:

- Welsh NHS lab turnaround times for hospital tests, and more latterly community and mass tests[3], have generally performed well with over 80% of hospital tests, and over 70% of community tests turned around within one calendar day.
- Welsh NHS lab turnaround times for asymptomatic key workers (including care home staff) and care home residents within one calendar day has been as low as 25%. But more recently increased to around 50%, although it is important to note that the expected turnaround times for this cohort is three calendar days. Although performance dipped during the September period, almost all results have been turned around with three calendar days.

3 This includes regional drive-through, mobile, and local walk-in test centres supported by Welsh NHS labs, as well as community testing sites for outpatients and symptomatic key workers.

- Lighthouse Lab turnaround times for community testing[4] performed well until September. But then timeliness sharply declined when demand increased (as set out in **paragraph 1.14**), with an average of just 30% of tests turned around within one calendar day at the end of October. Performance has since improved and was running at 98%.
- Lighthouse Lab turnaround times for tests kits, either via the organisation portal for care homes, or for home-testing, within one calendar day has been low at around 30% and has been consistently since August albeit a slight improvement for portal tests during November. Note that the expected turnaround time for this cohort is also three calendar days. Although performance was around 50% during the summer period, almost all results are now being turned around within three calendar days.

1.16 When considering the points above, it is worth recognising the logistical challenges associated with transporting swabs from some geographically isolated sampling locations to labs in Wales and in England can contribute to longer turnaround times. The timeliness of home test kits is also reliant on swabs being posted back to the labs in a timely manner. The volume of testing in the UK and in Wales is also high in comparison with other countries with similar case numbers. However, these challenges need to be overcome as success of the TTP programme is critically dependent on timeliness of test results. As a result, a Lighthouse Lab was opened in Newport in October, and a consolidation centre opened in Cardiff in January to enable faster transportation.

1.17 The frequency of in-hospital testing has improved since the start of the pandemic but needs to be strengthened further. Hospital outbreaks of COVID-19 have clearly been a risk which could have been reduced through effective testing regimes, both before and on admission, as well as more frequent testing during a patient's hospital stay.

4 This includes regional drive-through, mobile, and local walk-in test centres supported by Lighthouse Labs.

1.18 PHW figures show that compared to the first wave of the pandemic, hospitals have been testing proportionately more patients on admission[5], increasing from 24% in the first wave to 54% in October, but there remains considerable room for improvement. Data on the **PHW website** provides further detail and indicates that levels of testing has varied significantly across Wales, with Hywel Dda University Health Board testing approximately 24% of patients in October compared to 64% in Betsi Cadwaladr University Health Board. Variation between health boards narrowed during November, with all health boards more recently testing between 50-60% of all admissions, with the exception of Cardiff and Vale which has been at a lower rate of around 40%. Once tested on admission however there has been no regular testing during a patient's hospital stay unless patients have developed symptoms. This has been with the exception of patients discharged to care homes, which has required patients to have had two negative test results before being discharged.

1.19 The levels of risk have varied in different areas of Wales because of different prevalence of disease in the communities, However, it has been clear that once an in-hospital outbreak occurs, spread of COVID-19 as a result of hospital transmission has placed a significant burden on hospital capacity and resulted in very poor outcomes for patients.

1.20 The number of people who have got COVID-19 in hospital has been relatively low across Wales (approximately 8% of all cases during the week commencing 8 February) but there had been an increasing number of outbreaks over recent months. It is important that testing regimes within hospital settings are designed to meet this challenge and reduce the risk of hospital acquired coronavirus infections.

5 PHW figures exclude confirmed positive cases and elective patients who are tested prior to admission.

What factors are affecting testing?

1.21 The Lighthouse Lab arrangements have created some challenges for Wales given that the UK Government make the decisions about the use of lab capacity. Up until October, regions in Wales were not sighted on the Lighthouse Lab capacity available to them in their retrospective areas. During that time, increased demand in other parts of the UK as well as decisions made by the UK Government impacted on the availability of testing across Wales. This included:

- the decision to cap the number of tests available during September to manage demand through the Lighthouse Labs, resulted in reduced slots available and underuse of test centres which meant not everyone who needed a test could get one.
- the decision by the Lighthouse Labs to hold back on analysing swabs from the regular programme of asymptomatic care home testing which resulted in those swabs no longer being valid for analysis.
- the setting up of the UK Government's portal for booking tests which directed residents to the geographically nearest testing site with available capacity. This resulted in English residents travelling into Wales for tests, sometimes into areas that were in local lockdown, reducing the number of tests available for Welsh residents. It also resulted in Welsh residents being offered tests in other parts of the UK.

1.22 All regions now have access to the Lighthouse Lab capacity available to them on a daily basis, and for the week ahead to enable capacity to be deployed to the right areas. Mileage restrictions have also now been placed on tests booked through the UK Government portal to minimise the flow across countries, as well as the flagging-up of local restrictions to stop travel into lockdown areas. Where there have been community outbreaks, regions have also been able to take some control of the booking arrangements to ring-fence privately run sampling capacity to local communities where appropriate, although this has been reliant on health board's having alternative booking systems in place.

1.23 Current service performance management data focuses on the time from which a sample is taken to the time when the result is reported. Information on the testing capacity is also available, as is the extent that the capacity has been utilised. This operational information is useful to manage what are a complex set of services that are provided by distributed test site and lab units. However, there has been no information on the number of people that try to get a test but are unable to get one. This, if available, would give a picture on unmet demand.

1.24 Similarly, no information is reported on the time taken from when people identify the symptoms to the time when they have a test. This would be important to establish delays in accessing tests, particularly at times of high demand, as well as understanding population behaviours and potentially 'soft' barriers that are delaying people going for tests. This could include for example a person showing a symptom of the disease but not going for a test until their symptoms exacerbate. This information is captured as part of the contact tracing process but has not been reported.

1.25 Since the early part of December the Welsh Government, with the regional partners, have been utilising rapid testing. This includes the Lateral Flow Device, which gives results within 30-40 minutes. This was used in the recent pilot in Merthyr Tydfil and Lower Cynon, to understand the rate of infection. Rapid testing is now providing some significant benefits, for example, testing care home visitors, emergency department patients and key workers to enable rapid decisions and action to be taken. It is also providing benefits by reducing the elapsed time for contacts to be traced and told to isolate, as the rapid results enable the positive cases to inform their contacts immediately.

1.26 However, the rapid tests have come with some challenges, as they are not as accurate as the swab tests analysed through the labs. Until recently, people who returned a positive lateral flow test were advised to have an additional swab test to confirm the positive result and for their details to then be added to the contact tracing system. This had the potential to create additional demand on the testing system when applied to asymptomatic populations. The level of 'false positives' to date, however, has been very low and the decision has since been taken to directly record the rapid test result on the contact tracing system to enable tracing. There remains a risk, however, that some people who have the virus get a 'false negative' result and inadvertently infect more people. It should be noted that the risk of 'false negative' results also applies to lab-based tests as well as rapid lateral flow tests.

How good is contact tracing?

1.27 It is internationally recognised that contact tracing is a well-established mechanism to control the spread of infectious disease. It involves contacting and providing advice to people who have tested positive, finding out who their close contacts have been, and reaching those close contacts to advise them on what they need to do. Contact tracers try to build trust to find out who people have been in contact with, especially where they may be reluctant to admit they have broken the rules. Tracers also play a key role in advising people of the importance of self-isolating, and to flag up with wider public and third sector services where additional support may be needed.

1.28 While some small-scale public health control and outbreak tracing arrangements were in place prior to the pandemic, the pace at which new tracing services have been introduced, as well as the scale of them, has been significant. This has included:

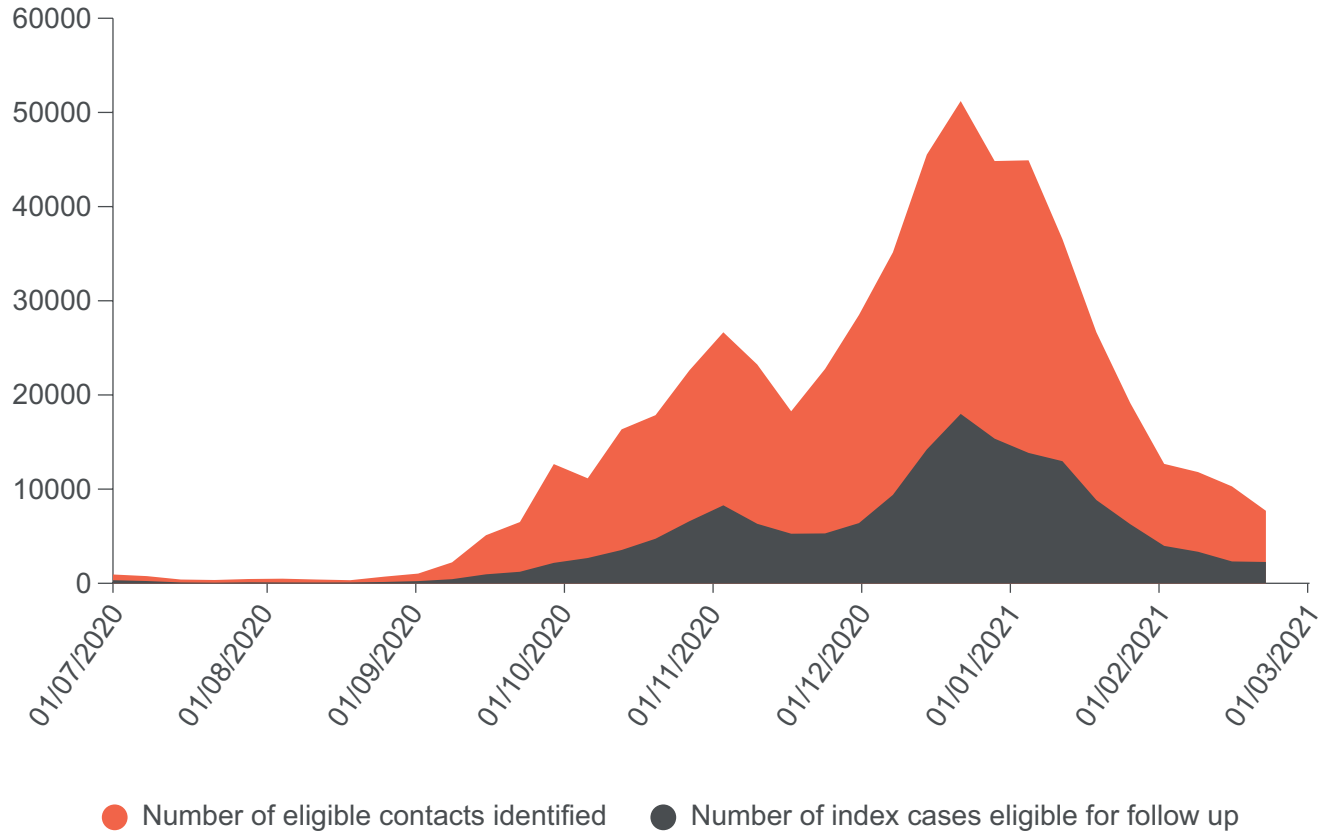
- development of all-Wales processes, guidance and scripts;
- the procurement, development and rollout of an IT system within a six-week period; and
- the local recruitment and training of a workforce which, by December 2020, was 2,400 strong.

1.29 The scale of these contact tracing arrangements has never been seen in Wales before. This was enabled by strong and effective partnership working within and across local authorities and health board regions.

1.30 Irrespective of the scale of the tracing service introduced, the challenge presented by the pandemic has been immense. Contact tracing services in Wales have generally performed well but the timeliness of tracing activity has seen some deterioration at periods of high demand, when services have needed to respond to increasing infection rates during the autumn and winter. **Exhibit 6** shows the significant weekly growth in the numbers of eligible[6] cases and their contacts that need to be traced by the service.

6 An eligible index (positive) case is one that requires contact. There may be instances where the case is not eligible, for example they are an inpatient in a hospital (and therefore all contacts are known and informed through internal processes), or it may be a repeat or duplicated test.

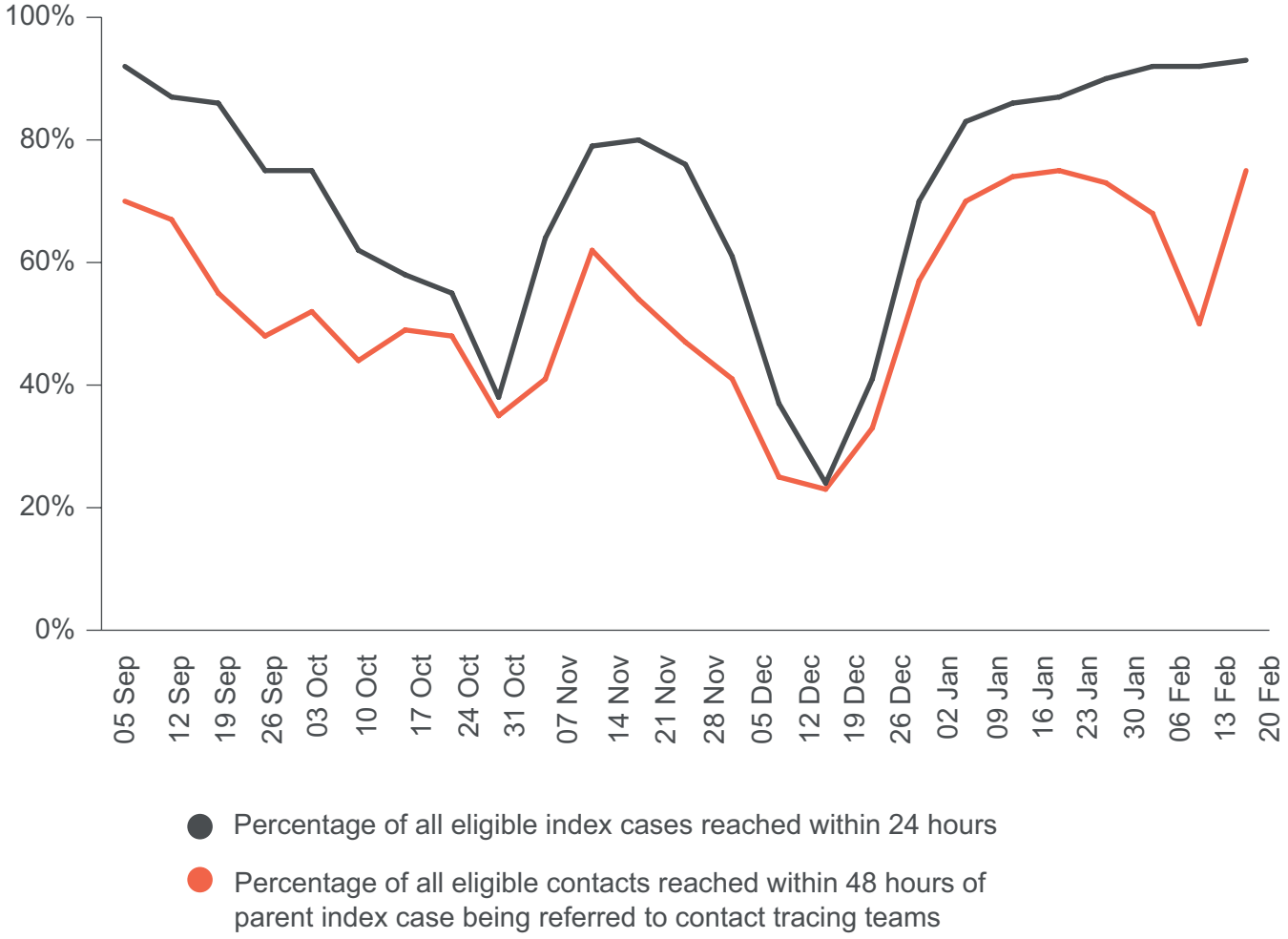
Exhibit 6 – all-Wales number of eligible cases needing to be contacted up to 21 February 2021



Source: Welsh Government

1.31 At the beginning of September tracing teams were reaching most positive 'index' cases in 24 hours. The time taken to reach index cases is measured from when their details are uploaded into the digital tracing system to the time tracers successfully make contact. For close contacts, the clock starts both when a close contact is identified by a positive case, and also from the point when the related index case was referred onto the contact tracing system. The clock stops when successful contact has been made. Whilst index cases know they have tested positive and should self-isolate, their close contacts may have the virus and be unaware of it. Therefore, the longer it takes to reach contacts, the more likely they are to unwittingly spread the virus. **Exhibit 7** shows how the timeliness of tracing activity can deteriorate when demand on contact tracing teams increases. At 19 December, 24% of all eligible index cases were reached within 24 hours, compared with 93% at 20 February. Also, at 19 December, only 23% of all eligible contact cases were reached within 48 hours of the index case being reported to the tracing teams, compared with 75% at 20 February.

Exhibit 7 – all-Wales timeliness of contact tracing (within 24 and 48 hours) up to 21 February 2021



Source: Welsh Government

1.32 Even though the TTP system has been contacting a high proportion of both positive index cases and their close contacts, a small proportion of people have not been reached at all. This has been for a number of reasons which includes incorrect contact details or a reluctance of contacts to respond to the call. At 20 February, 625 index cases (0.4%) and 21,482 close contacts (5%) had not been reached at all. It is important to note that only people going through the TTP system will have been traced, Members of the public who have reported symptoms through other means, such as the **ZOE symptom app** or tested positive by undertaking a private test will not have been traced.

What factors are affecting contact tracing?

1.33 The capacity within tracing teams has been a key determinant of their ability to reach positive cases and their close contacts. At the start of the TTP programme in June, the Welsh Government made £45 million available for health boards and local authorities to set up contact tracing teams across Wales. Plans were developed to manage peaks and troughs in demand for contact tracing with a flexible workforce that included staff redeployed from other services which had closed down because of the pandemic.

1.34 Over the summer, some staff returned to their main job when services started operating again, and health boards and local authorities started recruiting new staff to boost their tracing capacity. In November, the Welsh Government provided an additional £15.7 million to nearly double the tracing workforce in Wales from 1,800 to 3,100. By December 2020, there were 2,400 people[7] working in tracing teams.

1.35 Recruiting new staff, including bilingual staff, into local tracing teams at the same time as redeployed staff were returning to their normal job resulted in a greater degree of churn than expected for some teams and created some gaps in tracing skills and experience. New staff can take longer to process tracing cases. We are also aware that introducing new staff in some regions created problems such as data entry errors by inexperienced staff. There was also a heavy reliance on the existing expertise of public health protection and environmental health specialists who needed to deal with the more complex outbreaks, alongside their wider work supporting the application of social distancing measures in various settings.

1.36 Effective training has therefore been an important part of the work to build the capacity of contact tracing teams. In the Cardiff and Vale region there has been a dedicated tracing trainer whilst in other regions training has been provided by an existing member of the contact tracing team alongside their existing tracing duties.

1.37 It is important to note that whilst training of new contact tracing staff is clearly important, each local and regional team will have been working within an operating framework that was developed by PHW, who also wrote the ‘scripts’ for contact tracing teams.

7 Full time equivalents.

1.38 A positive feature of the way contact tracing has operated in Wales is the concept of ‘mutual aid’ where caseload work has been shared between regions if one region has been experiencing particular pressures due to rapid rises in positive cases. This mutual aid played a part in the management of the early outbreak in Anglesey and more latterly when case numbers rose sharply in the Cwm Taf Morgannwg area. The Welsh Government has also set up a new all-Wales ‘surge’ team which, along with mutual aid arrangements, has been used to manage peaks and troughs in demand for tracing activity. It is also been conducting an efficiency review of tracing across Wales to ensure best performance.

1.39 Within each region there has also been a central contact tracing team which includes specialist staff drawn from NHS and local authority partners to help deal with the more complex issues such as contact tracing within care homes and hospital settings. More detailed contact tracing to understand the exact source of the transmission has also taken place as capacity has allowed. This has required the reshaping of the work of public protection, the wider cohort of environmental health officers and local authority health and safety teams to work with businesses and communities found to be at the source of the outbreak, and apply enforcement notices where relevant.

1.40 The tracing workforce in Wales has increased rapidly, but during December, tracing teams struggled to meet demand from the surge in infection rates. To meet the demand, some teams temporarily prioritised cases to be traced and asked people who had tested positive to speak to close contacts themselves.

1.41 Since 9 June, all tracing teams have used the same digital Customer Relationship Management (CRM) information system. NWIS procured the CRM system and negotiated a software licensing contract where the number of users could be scaled up or down, which helped to control costs. The CRM system links to the Welsh laboratory information system and updates every 30 minutes with new positive cases. The system allocates positive cases to the tracing team where they live. Tracing teams then record information about positive cases and their contacts in the CRM system. Information can be extracted from the CRM system to gauge how well contact tracing is performing and to understand the spread of the virus.

1.42 Contact tracing teams have encountered some practical challenges since the launch of the CRM system. For example, one region reported that system functionality resulted in ‘shadow lists’ on the system where some positive cases were recorded but were not visible in the tracing queue. These types of issues are, however, quickly resolved. Concerns, however, have remained with the unreliability of the telephony system, which supports calls from the CRM system. This is resulting in contact tracers, for example, not being able to make calls when they need to because of connectivity issues.

1.43 Some tracing teams have also reported that the batch processing of lab results and the subsequent upload of positive cases onto the CRM created a peak of cases to follow up. Whilst this was to be expected, the uploads particularly at the end of the day made it difficult for tracing teams to meet timeliness targets, as many cases would not have been followed up until the next working day.

1.44 The quality of the information coming from the system has depended on the accuracy of information entered by contact tracing teams. It has also relied on having skilled data analysts to extract the information and use it in meaningful ways, but at the time of our review some regions lacked data analyst capacity.

1.45 There have been other practical challenges that contact tracing teams have encountered as the pandemic has progressed. There have been outbreaks in commercial work settings where many employees did not speak English. There have also been incidences of contact details being incorrectly recorded either deliberately or because the systems for recording information were rudimentary (ie handwritten details with associated problems with legibility).

1.46 All of these challenges have been worked through with lessons learnt and shared as part of the ongoing evolution of the TTP programme. These challenges have also been worked through quickly, reflecting the ability of the service to respond to issues and where relevant make changes to working processes or policies, at pace.

What is being done to support people who need to self-isolate?

1.47 Despite the positive recent news about vaccine development and roll out, Wales still finds itself in a position where cases of COVID-19 are circulating widely. It is therefore absolutely vital for people to self-isolate if they have tested positive for the virus, or if they are a contact of somebody who has tested positive.

1.48 However, for many people self-isolation has brought numerous practical, financial and well-being challenges. The 'protect' element of TTP has been about providing the necessary support and information to those who need to self-isolate.

1.49 Whilst the initial Prevention and Response Plans[8] at a regional level lacked detail on what would be done to support people to self-isolate, our work has found that numerous initiatives have been in place to provide such support. Typically, these have been collaborative initiatives at a regional and local level involving public sector bodies and various agencies from the voluntary sector, often supported by community volunteers. These services have looked to provide practical help such as food shopping, medicines collection and wider support for those at risk of loneliness and social isolation. Work has also been undertaken to provide support to specific population groups such as university students and tourists travelling into Wales during periods when lockdown restrictions are lifted so they are aware of local measures that are in place and where to go to for support.

1.50 In response to the financial challenge associated with self-isolation, from 1 November, people on low incomes in Wales have been able to apply for a £500 payment if they have tested positive for COVID-19 or told to self-isolate. A similar scheme has been available to social care workers as a top-up payment to their statutory sick pay. Self-isolation payments have recently been extended to some parents and carers on low incomes who have had to look after children who are self-isolating. Local authorities received just under 20,000 applications between November and January 2021 with around 50% of those eligible for payment. The scheme was being reviewed at the end of January, but there was clear recognition that there remained a need to financially support those in most financial need to allow them to comply with self-isolation requirements.

8 The Welsh Government required health boards, local authorities, and their partners to submit the plans setting out how they would limit the spread of the virus in their region.

1.51 The peaks in community virus transmission which have followed periods of lockdown raise questions about the extent to which the public have been willing to observe the necessary social distancing. PHW's weekly '**How are we doing in Wales**' provides a good summary of how people in the community are feeling, their opinion on policy, and the extent they understand and follow COVID-19 guidance and legislation. This survey showed compliance with the Welsh Government's restrictions was falling amongst respondents. It is not clear to what extent a failure to comply with self-isolation requirements associated with contact tracing has contributed to rises in community transmission. So far, limited information exists to understand the scale of any non-compliance with self-isolation requirements or indeed the reasons for it. PHW has been conducting two pieces of research to understand whether people are self-isolating after being contacted by tracers.

1.52 Clearer information on the level of need for 'protect' services and how well existing services have been meeting that need, would help with the identification and targeting of resources at both a regional and national level. Nevertheless, there is now good information on the range of support services that have been introduced across Wales, often through partnership working. On 16 December, Welsh Government published a review of the **support arrangements for non-shielding vulnerable groups**. As well as identifying support activity, the report also identified lessons learnt, including early engagement with local authorities on shielding guidance, mental health support, more support for digital inclusion, and the long-term benefits of maintaining the momentum that has built up around volunteering. Welsh Government is undertaking an additional survey of local authority protect teams and has established a 'Protect Leads' group. These are focused on understanding the nature of protect requests arising, improving the range of support provided and sharing practice and learning.

1.53 As the TTP programme developed in response to the pandemic, national oversight arrangements have tended to focus much more strongly on the testing and tracing components of the programme. There has been less national oversight of what is needed by way of support for people to self-isolate and an absence of information to know whether those services are effectively influencing public behaviour.

1.54 Self-isolation for people who test positive, and their close contacts, will continue to be a key part of the approach to keeping the spread of the virus in check whilst vaccination programmes are rolled out during 2021. Ensuring that the 'protect' element of TTP gets the focus it needs will therefore be crucial if the programme is going to eventually help us get on top of the virus.

1.55 There is good practice to build upon and adopt more widely, such as the self-isolation helpline that was launched in the Cwm Taf Morgannwg region in November 2020. The helpline is a partnership venture between the Health Board, local authorities in the area, PHW, the Regional Partnership Board and the voluntary sector. It provides help and advice for people who are asked to self-isolate and was set up following analysis of intelligence from the regional TTP programme that showed there was considerable confusion about self-isolation and what support was available, leading to non-compliance with measures to control the spread of COVID-19.

1.56 Other important activities are also underway such as work the Welsh Government is undertaking with the Welsh Local Government Association (WLGA) to develop a monitoring framework that maintains a clearer overview of support needs of people who are required to self-isolate. Welsh Government officials have also been working with NWIS to improve the information captured in the CRM system about people who need help to self-isolate.

Looking ahead: key challenges and opportunities

02

Having better information to improve efficiency and evaluate the impact of TTP

2.1 The performance in one part of the TTP system will determine how effective other parts of the system are. For instance, quick turnaround times for testing are necessary for contact tracing to be effective. Similarly, the ability of contact tracing teams to reach the right people quickly will help identify those who need to self-isolate before they spread the virus further. While there is information about how well different parts of the TTP programme have been working, there has been no performance information that looks at the whole programme, from the moment someone requests a test to the point their contacts are traced, to demonstrate how quickly it is identifying and isolating infected people. Such information could be a powerful tool to help know what is needed to enhance the efficiency and effectiveness of the overall programme.

Ensuring testing activities are fit for purpose and meet increasing demand

2.2 Notwithstanding some of the challenges set out earlier in the report, testing and tracing arrangements have responded reasonably well to the challenges posed by the virus. However, testing and tracing capacity will need to continue to respond to demand in 2021. Tests need to be easy to access and results must be returned quickly to help control the spread of the virus. There is also a considerable risk that if people think it is hard to get a test, or fast results, they may not bother to get tested.

2.3 As highlighted in **paragraph 1.25**, at the time of our review, the Welsh Government had started using new testing technologies such as lateral flow devices and the Lumira DX test. The tests provide quick results and can support large scale testing of asymptomatic populations or screening for health and social care staff. As the demand for these rapid tests increase across both the public and private sectors, the Welsh Government will need to think clearly about which sectors have priority as part of the roll-out, taking into account the known limitations with the accuracy of these tests,

2.4 Testing arrangements within hospital settings is also an area that needs some consideration. Although testing in hospitals has improved since the first peak, hospital patients typically only get tested at the point of admission unless they develop symptoms. To minimise the spread of the virus from patients who may have tested negative at the point of admission but then go on to develop symptoms, there are opportunities to expand the frequency of testing within hospitals as well as ensuring that infection control regimes are as effective as they can be.

Creating a skilled, resilient workforce to deliver TTP

2.5 As with other parts of the public sector, many staff involved in overseeing and delivering TTP have been under considerable pressure for several months. We heard that many staff have been working long hours with limited opportunities to take leave. Organisations have put some measures in place to ensure resilience including recruiting or redeploying additional staff, reallocating work, and putting weekend rotas in place. But there is still considerable pressure on many staff, including those in leadership and specialist roles. Public bodies are also managing competing demands on their workforce associated with the wider impact of the pandemic, the COVID-19 vaccination programme, and the ongoing consequences of Brexit[9]. Irrespective of how quickly the general public can be vaccinated against COVID-19 it is a reasonable assumption that TTP services will be needed at least until the middle of this year and most probably longer. Many new staff have only been recruited until 31 March to align with the current funding availability. It is important that a commitment to fund services into 2021-22 is made as soon as possible to enable staff to be retained and the workforce to remain stable.

2.6 Some staff, including officials leading TTP, have been redeployed and adapted quickly and successfully to new roles outside their previous area of expertise. There may be opportunities to move more staff from other areas to support TTP. There are a number of difficult to recruit to roles and specialists in PHW and some regional teams are looking at how they can increase colleagues' skills to deliver non-specialist work. There are opportunities to look more broadly at which tasks can only be done by public health protection and environmental health specialists, and which can be done by other officials. There could also be opportunities to reduce specialist attendance at meetings by providing guidance outside meetings or identifying areas where non-specialist support is 'good enough'.

9 **Our letter on preparations for the end of Brexit** describes some of the workforce pressures associated with Brexit.

Influencing the public to follow public health protection guidance and requirements

2.7 It is crucial that people who test positive or are told to self-isolate by TTP services follow the rules to avoid infecting anyone else. We found local, regional, and national examples of approaches to influence public behaviour. But without information on whether people are self-isolating it has been difficult to judge the success of this aspect of TTP. Even if effective, TTP is only part of the response to limiting the spread of COVID-19. Since April, the Office for National Statistics has worked with partners to test and survey a sample[10] of people living in the UK to understand more about COVID-19. In October, **the survey** showed that only 34% of people who tested positive for COVID-19 reported any symptoms. These results would suggest that a significant number of people with the virus would not go through TTP at all. It is therefore essential that the population understand and comply with wider measures to prevent infection.

2.8 Many of the professionals we spoke to told us influencing public behaviour has been a huge challenge, particularly as the public grow weary of the pandemic and restrictions on their everyday lives. We also heard that the public have been confused by changing rules, especially when the rules differ across the UK nations. Local intelligence shows that people who do not follow the rules fall into various age groups and are from various backgrounds, in different parts of Wales. Health boards, local authorities, PHW and the Welsh Government have been trying to influence public behaviour in various ways, but getting people to do the right thing remains a considerable challenge. There is a further risk that once people receive their vaccination against COVID-19, they will think there is less need to comply with social distancing and other measures to control the spread of the virus.

10 From October the sample was 150,000 people.

Applying the learning from the TTP programme to other programmes and future ways of working

2.9 Although COVID-19 has presented unprecedented challenges, the pandemic has also provoked significant positivity in the way in which public and third sector organisations have responded. These are evident throughout the TTP programme.

2.10 The scale and challenge of the pandemic has brought organisations together with a common goal of limiting the spread of the virus and protecting the population of Wales. True partnership has been displayed with organisations sharing skills and resources to put teams in place to deliver the TTP agenda, and staff redeployed across a whole spectrum of activities regardless of the organisation in which they may normally work. The concept of mutual aid between different organisations and across different parts of Wales has provided much needed support to parts of the system that may be under increased pressure and sharing the load across Wales as a whole, regardless of organisational and geographical boundaries.

2.11 Processes have been put in place in a matter of days, which in normal times, would have taken months or years. New roles have also been created, with new staff recruited, onboarded, and trained within weeks. A single once-for-Wales IT solution was procured, developed, and implemented within six weeks, enabling organisations to connect to each other and provide a single source of information. It is worth contrasting this with what has typically happened in the past with IT solutions taking years to develop and then implement, with public sector bodies frequently using different versions of the system which struggle to connect to each other.

2.12 The TTP programme has clearly demonstrated that the public service has the ability to work well across organisational and professional boundaries, and to work at pace to get things done. As the attention moves on to different responses to the pandemic, such as the current vaccination rollout programme, and then ultimately, the recovery and resetting of services once the significant peaks in the pandemic start to reside, it is important that the positive learning from the TTP programme is captured and used to shape the way that public sector organisations work together and tackle challenges in the future.

Appendices

1 Sampling and testing analysis pathway for Wales (as at December 2020)

1 Sampling and testing analysis pathway for Wales (as at December 2020)

Who can have the test?	Where are the samples taken?	Where are the samples analysed?	
		Lighthouse Labs	Welsh NHS labs
Symptomatic residents in the community	Regional drive-through testing unit	Most samples	Some samples
Symptomatic residents in hotspot or outbreak areas (including care homes)	Mobile testing unit	Most samples	Some samples
Symptomatic residents in the community	Local walk-in unit	Most samples	Some samples
Symptomatic residents in the community	Home testing kits	All samples	
Symptomatic care home residents and staff	Care home test from the UK government portal	All samples	
Asymptomatic care home staff tested on a weekly basis	Satellite units	Most samples	Some samples
Hospital inpatients	Hospitals		All samples
Hospital outpatients	Community testing unit		All samples
Key workers[11]	Community testing unit		All samples

11 A list of key workers are set out at **gov.wales/coronavirus-critical-key-workers-test-eligibility**. Some key workers may access the testing pathway by presenting as a symptomatic resident in the community.

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Llywodraeth Cymru
Welsh Government

Adrian Crompton
Auditor General for Wales
24 Cathedral Road
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Our Ref: AG/LC

4 June 2021

Dear Adrian

Test Trace Protect – Response to Audit Wales Report

I welcome the report from Audit Wales into Test Trace Protect (TTP) and note the recognition that the programme is 'making an important contribution to the management of COVID-19 in Wales'. I would like to re-iterate that this is testament to the hard work, passion and dedication shown by teams across Wales in responding to the pandemic. The strength of the programme continues to be demonstrated with the recent report from the Technical Advisory Group highlighting that TTP reduces *R* by at least 0.4[1]. This is a significant impact on transmission which has prevented and continues to prevent onwards infection and deaths within our communities. High levels of trust and engagement amongst the Welsh public with TTP has been vital to preventing transmission.

I note that, as with any report, the Audit was undertaken at a point in time and the programme has continued to evolve and adapt to the changing circumstances. The scale of testing required has been unprecedented. To build additional resilience into the testing system an investment of £32 million was made in August 2020. This enabled 24/7 operations at regional laboratories across Wales and the establishment of 6 hot labs within hospitals for rapid processing of COVID tests. We have seen significant improvements in turnaround processing times via our NHS Wales laboratories through this investment. We have sought to maximise our strengths and resilience through adopting a hybrid testing system which utilises both our domestic testing and Lighthouse laboratory capacity.

[1]Technical Advisory Group, 'Modelling the current Welsh Test, Trace, Protect system', Technical Advisory Group: modelling the current Welsh Test, Trace, Protect system | GOV.WALES, March 21, (Accessed 18/05/21)

A hybrid system has enabled us to access higher volumes of testing capacity via the Lighthouse lab system whilst building on domestic capacity to support testing within hospitals and outbreak situations. We now have the capability to actively and further flex our resources more effectively across Lighthouse Lab channels and PHW channels. Arrangements with the lighthouse laboratory at IP5 have also enabled us to increase the positive samples that are genomic sequenced which helps identify new and current variants of concern. As we look towards recovery from the pandemic and easing in lockdown restrictions it will become increasingly important to quickly identify variants of concerns and prevent them from spreading. Enhanced testing options are available for deployment where variants of concern are identified. Extensive local planning has taken place to quickly operationalise and deploy additional testing, tracing and protect activity where needed. This has factored in the requirements for the end-to-end TTP service and the need to actively engage, communicate and support communities.

A hybrid testing system has increased the resilience of the service were there to be capacity challenges within the Lighthouse lab network across the UK. We were aware of challenges in September 2020 with individuals being unable to book tests via the UK digital booking platform. These were resolved at pace and our local health boards provided and advertised alternative booking routes during this time to ensure that all those who required a test could access one. We have substantial testing capacity available to us via the Lighthouse Lab network and PHW laboratory network and are assured that we can plan and meet future demand.

Noting the challenges for nosocomial transmission in the report, a Patient Testing Framework[2] was launched to provide a clear approach on testing to help prevent outbreaks and nosocomial transmission within secondary care. The Patient Testing Framework includes guidance on approaches using rapid testing technology and Point of Care devices. Additional safeguards have been put in place across sectors including the NHS through our regular asymptomatic testing programmes utilising Lateral Flow Devices (LFD). The scale of our asymptomatic programmes and access to validated new testing technology has been made possible through close collaboration with the UK government.

Research has demonstrated that 1 in 3 cases of COVID-19 are asymptomatic. Our asymptomatic LFD programmes have helped to identify and isolate these asymptomatic cases and prevent onwards transmission. This has helped us to break chains of transmission and provide early indications of where enhanced targeted testing may be required. LFD tests can provide a result in under 30 minutes enabling quicker, targeted interventions and isolation of cases before the virus can gain a foothold. We have substantially increased access to asymptomatic testing capability through the launch of our LFD Collect and LFD Direct channels alongside workplace

[2] Gov.Wales, 'Framework for COVID-19 testing for hospital patients in Wales' 42350 Community testing framework English (gov.wales), March 21, (Accessed 18/05/21)

testing programmes. Rolling out of LFDs in a targeted manner has provided a different way to engage and encourage testing take up and provided additional safeguards as we move to ease lockdown restrictions. No test is 100% accurate and the use of LFD's has helped routinely identify asymptomatic positive cases that we would not have known about. Using these new technologies as part of a screening and test to find approach helps us to mitigate the challenges of 'false negatives and positives'. Each testing technology deployed in Wales has a unique use providing options for different testing approaches. Direct comparisons between tests fail to recognise the different context and use in which each test is taking place. Use of LFD's aid faster contact tracing which has also evolved since production of the report.

Since launching in June 2020, our contact tracing service has successfully contacted and advised over 170,000 index cases and over 355,000 close contacts reaching 99.7% of positive cases eligible for follow up and almost 95% of close contacts eligible for follow up. The service has continued to develop and improve over time. Using an evidence-based modelling approach, capacity was significantly enhanced in preparation for the Winter peak with over £60 million allocated to health boards and local authorities over the 20/21 financial year to support contact tracing at scale. In response to unprecedented volumes we introduced innovative new measures at pace to keep on top of demand. This included a national roll-out of an electronic form for individuals to record their close contact details to aid contact tracing activity. An All-Wales surge team was rapidly recruited and established to provide support to regions in managing demand. This funding established a total contact tracing workforce of 2,500 full time employees. The contact tracing workforce has since reduced to 2,000 full time employees due to turnover and reducing case volumes.

An additional £32 million has recently been allocated to have a contact tracing service in place until the end of March 2022[3] bringing the total funds allocated to contact tracing to £92 million for 21/22. The contact tracing workforce have also been supporting the wider pandemic response including: monitoring of returning travellers from amber list countries; delivering the interim Welsh Vaccination Certificate Service; and supporting the vaccination programme. They have also been offering extra support and guidance to businesses and local employers as restrictions have eased. Going forward the service will provide more tailored support to people who need to isolate. Noting the importance of adherence to self-isolation requirements we have strengthened our Protect offering and continue to work closely with local partners to more effectively tailor and target our support.

The report highlights the challenges for those disadvantaged in society to adhere with the legal requirement to self-isolate. The financial burden for those required to self-isolate has been prominent since the start of the pandemic. We have sought to

[3] Welsh Gov, Written Statement: Contact tracing extended to March 2022, 2nd June 2021, Written Statement: Contact tracing extended to March 2022 (2 June 2021) | GOV.WALES

address this through the launch of the Self-Isolation Support payment scheme. The scheme has received over 12,500 successful applications since launching in October 2021. This equates to a value of over £6 million being issued to support individuals to self-isolate. The scheme is closely monitored and upon review in February 2021 the eligibility criteria were expanded to those either:

- In receipt of Statutory Sick Pay or New Style Employment and Support Allowance or less; and/or
- In receipt of £500 NET personal income a week or less.

This increased the numbers of those eligible for payments if asked to self-isolate by an estimated 170,000. The scheme continues to be actively promoted to ensure continued awareness and applications from those who are eligible. Building on good practice, regions have rolled out self-isolation support helplines in line with the successful approach in Cwm Taf Morgannwg. This support is helping to address challenges to self-isolation through signposting to local provision and providing tailored guidance and advice to those self-isolating. Additionally, we are utilising research from the PHW ACTS and CABINS surveys[4] and insight from delivery partners to help shape our approach to Protect going forward. We have trialled additional support for food and essential items to help people self-isolate in Cwm Taf Morgannwg during their community testing programme and have built on this learning to develop a series of pilots in North Wales. We are piloting Enhanced Protect Support hubs across the region which will build upon existing projects and each of the pilots will be located within some of our most deprived communities. The enhanced Protect offer will provide support across 6 core areas: food poverty, fuel poverty, financial inclusion, access to testing services, mental health support and digital inclusion. We will apply learning from these pilots at a national level to ensure there is holistic support for those impacted by COVID-19 and updated guidance for delivery partners will be published in June to ensure a consistent Protect offer is available across Wales.

As our vaccination coverage increases we are continuing to see stable levels of those presenting for testing. It is paramount that individuals still access testing as we know the vaccine is not 100% effective and the more the virus spreads the greater the opportunities it has to mutate. We have advanced genomic sequencing capabilities in Wales which our TTP service has effectively integrated with. This has increased our epidemiological surveillance capabilities providing early insight and identification of variants of concern enabling targeting of enhanced testing activity. As we move into the next stage of the pandemic and begin to focus on recovery planning our TTP service will be guided by a set of revised strategies. This will

[4] Richard G. Kyle, Kate R. Isherwood, James W. Bailey, Alisha R. Davies, 'Self-isolation confidence, adherence and challenges: Behavioural insights from contacts of cases of COVID-19 starting and completing self-isolation in Wales', March 21, https://phw.nhs.wales/publications/publications1/self-isolation-confidence-adherence-and-challenges-behavioural-insights-from-contacts-of-cases-of-covid-19-starting-and-completing-self-isolation-in-wales/

ensure we have a clear guiding approach to TTP with a service that continues to evolve to meet current and future needs. A crucial element of this will be to retain and build upon our experiences in preparation for future pandemics and leave a lasting legacy.

Yours sincerely

Dr Andrew Goodall

Document is Restricted

Archwilio Cymru
Audit Wales

Procuring and Supplying PPE for the COVID-19 Pandemic

Report of the Auditor General for Wales

April 2021

This report has been prepared for presentation to the Senedd under the Government of Wales Acts 1998 and 2006.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Key messages

Context

1 This report looks at the procurement and supply of Personal Protective Equipment (PPE) during the COVID-19 pandemic. PPE is essential for protecting those who get close to infected people. It can also prevent people spreading the virus amongst each other and to those they are caring for.

2 Our report focuses on the national efforts to supply health and social care in Wales. These efforts have been led by the Welsh Government, working with partners in the NHS Wales Shared Services Partnership (Shared Services) and local government. Shared Services has taken on an expanded role in securing PPE for the whole health and social care sector. **Appendix 1** describes our audit approach and methods.

3 We have not reviewed arrangements for local procurement of PPE by NHS and local government bodies, nor the logistical arrangements in place locally to distribute PPE directly to frontline staff. We have, however, reflected evidence collected by professional bodies about the views of front-line staff. In carrying out this work, we have been mindful of the work by the National Audit Office (NAO) in England on the supply and procurement of PPE. Where possible, we have sought to align our scope, albeit in a devolved context.

Overall conclusion

4 In collaboration with other public services, Shared Services overcame early challenges to provide health and care bodies with the PPE required by guidance without running out of stock at a national level. It is now in a far stronger position, with stockpiles of most PPE equipment and orders in train for those that are below 24 weeks. Some frontline staff have reported that they experienced shortages of PPE and some felt they should have had a higher level of PPE than required by guidance. The Welsh Government and Shared Services put in place good arrangements overall to procure PPE that helped manage risks and avoid some of the issues reported on in England. However, Shared Services did not publish contract award notices for all its PPE contracts within 30 days of them being let.

Key findings

5 The challenge facing the NHS and social care at the start of the pandemic was stark. The stockpile developed for a flu pandemic was inadequate for a coronavirus. Global supply chains had fragmented as countries competed for scarce supplies and some imposed export controls.

6 Public services across Wales responded in an increasingly collaborative way. Shared Services took on an expanded role in supplying PPE to the wider NHS, including independent contractors in primary care (GPs, dentists, pharmacies and optometrists). Shared Services then worked closely with local government to understand demand in social care and then took on an increasing role supplying PPE. Shared Services now supplies almost all social care PPE needs. We recognise the huge individual and collective effort involved in the work to source and supply PPE to frontline staff.

7 Shared Services data shows that, nationally, stocks did not run out although stocks of some items got very low. At times, Wales drew on mutual aid from other countries but ultimately gave out significantly more than it received. The health and care system is now in a much better position, with buffer stocks of most PPE items in place and orders due on key items where stocks are below target.

8 Surveys carried out by the Royal College of Nursing and British Medical Association suggest confidence in the supply of PPE grew shortly after the start of the pandemic, but concerns remain. While we cannot be sure how representative these views are, some frontline staff reported shortages of specific items of PPE, with a small minority saying at times they had none at all. In some cases, staff concerns relate to the fact that they want a higher level of PPE than required under the guidance.

9 A range of bodies were involved in sourcing PPE globally and in responding to, and working with, local manufacturers. In contrast to the position described by the NAO in England, we saw no evidence of a priority being given to potential suppliers depending on who referred them.

10 Overall, Shared Services developed good arrangements to rapidly buy PPE, while balancing the urgent need to get supplies for frontline staff with the need to manage significant financial governance risks in an area of rapidly growing expenditure. These risks included dealing with new suppliers, having to make large advance payments and significant quantities of fraudulent and poor-quality equipment being offered.

11 Time pressure meant due diligence could not always be carried out to the level it would outside of a pandemic in a normal competitive tendering process. But, for each contract we reviewed, we found evidence of key due diligence checks. And while costs were generally higher than before the pandemic, we saw evidence of Shared Services negotiating prices down.

12 However, Shared Services did not meet the requirements under emergency procurement rules to publish contract award notices within 30 days. Shared Services told us that its staff needed to prioritise sourcing PPE and that there were other administrative reasons for delays.

13 Shared Services' plan for PPE ran until March 2021. There are now some key decisions to make about the future strategy for PPE, including the size and nature of the stockpile going forwards and the role of Welsh manufacturers.

Procuring and supplying PPE in these times has been far from business as usual. The challenges, risks and pressures have been higher, and a huge individual and collective response has been needed.

NHS Shared Services, working with others, has responded well to develop and maintain the national stock and to supply health and care bodies. However, despite competing pressures, Shared Services should have moved more quickly to publish details about the contracts it let.

While the overall picture painted by my report is relatively positive given the difficult circumstances, we cannot ignore the views expressed by some of those on the frontline about their own experience. There are also lessons for the Welsh Government and Shared Services to learn – about preparing for a future pandemic as well as addressing some current challenges.

Adrian Crompton
Auditor General for Wales

Key facts

630 million

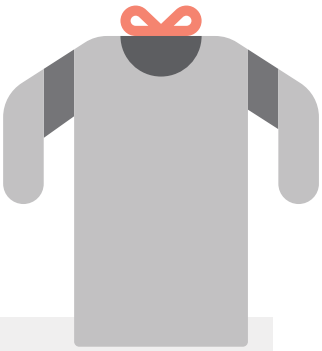
the number of items of PPE issued by Shared Services between 9 March 2020 and 7 February 2021

Less than 2

the lowest number of days' worth of national stock of visors, Type IIR face masks and surgical gowns at points during April 2020

£8 million

the annual amount NHS Wales would typically spend on PPE before the pandemic



Over £300 million

the total amount expected to be spent on PPE for Wales during 2020-21

£880 million

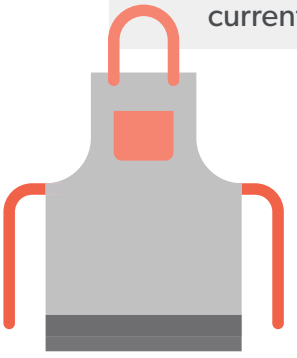
our estimate of how much the Welsh Government has received so far through the Barnett formula as a result of spending on PPE in England

24

the number of weeks' worth of PPE stock Shared Services currently aims to hold

67

the number of suppliers Shared Services has contracted with to supply the NHS and social care with PPE since the start of the pandemic



4 Key roles and responsibilities

Appendix 2 sets out the main organisations and groups involved in the national supply and procurement of PPE. At a higher-level, the key roles are:

Welsh Government – provides a lead on the pandemic response and policy, including liaison with the UK Government, and funds PPE

Shared Services – responsible for procuring and supplying PPE to hospitals, took on an expanded role for procuring and supplying primary care and social care

Public Health Wales – responsible for developing and issuing, with other UK countries, the infection prevention and control guidance that determines what PPE is needed and in what circumstances

4 Recommendations

Recommendations

Preparedness for future pandemics

R1 As part of a wider lessons learnt approach, the Welsh Government should work with other UK countries where possible to update plans for a pandemic stockpile to ensure that it is sufficiently flexible to meet the demands of a pandemic from different types of viruses.

R2 In updating its own plans for responding to a future pandemic, the Welsh Government should collaborate with other public bodies to articulate a set of pan-public sector governance arrangements for planning, procuring and supplying PPE so that these do not need to be developed from scratch.

R3 Shared Services should work with NHS and social care bodies to maintain an up-to date stock management information system that provides timely data on local and national stocks of PPE that can be quickly drawn upon in a future pandemic to support projections of demand and availability as well as providing a robust source of information for briefing stakeholders.

Recommendations

Procurement strategy for PPE

R4 In updating the strategic approach to PPE, Shared Services and the Welsh Government should work together to develop a clear direction in terms of:

- a return to competitive procurement and an end to emergency exemptions.
- fuller consideration of the wider criteria usually applied to procurement, such as sustainable development and policies on modern slavery.
- the intentions and aspirations in relation to the domestic PPE market, including the balance between the potential benefits of resilience through local production capacity against the potentially increased costs compared to international manufacturers.
- the size and nature of the pandemic stockpile it intends to hold, considering the benefits and costs of holding and maintaining stock and the timing of purchases given the ongoing disruptions to the PPE market.

Recommendations

Transparency

R5 To increase confidence in stocks and supplies at the national level, Shared Services should work with the Welsh Government to publish details of the amount of stock it holds of each item alongside the regular publication of data on the numbers of items issued.

R6 Shared Services should: check that it has published contract award notices for all contracts where it is required to do so; review those that it has published to ensure they are accurate; and ensure that it publishes contract award notices within the required timeframe for future contracts.

R7 The Welsh Government should review whether the Sell2Wales site needs updating to allow bodies to publish retrospective contract award notices more efficiently without relying on suppliers to sign-up.

R8 Given public interest in the awarding of PPE contracts and to promote confidence in the procurement system, the Welsh Government and Shared Services should publish details of the contracts awarded under emergency exemptions in a single place that is easy to access.

The supply of PPE

01

1.1 This part of the report covers the supply of PPE. In particular, it looks at the extended role that Shared Services took on for supplying hospitals, primary care and the whole social care sector. It covers the supply of PPE to those bodies in health and to the local government stores that distribute to social care. We did not look at local processes within hospitals or in local government for getting PPE to frontline staff. We have, however, reflected evidence collected by professional bodies about the views of front-line staff.

UK-wide arrangements for an influenza pandemic proved inadequate for the demands of dealing with the coronavirus and the Welsh Government quickly decided to secure its own PPE supplies through Shared Services

1.2 The Welsh Government and other nations of the UK have long-standing plans for an influenza pandemic. These included a 2011 Influenza Pandemic Preparedness Strategy, agreed by all four UK nations. Following the swine flu outbreak in 2009, the UK Government and Welsh Government developed and maintained a national stockpile in preparation for an influenza pandemic.

1.3 In addition to medicines and other countermeasures, the Pandemic Influenza Preparedness Programme (PIPP) held a stock of PPE, based on estimates of need for an influenza pandemic. The PIPP involved a physical stockpile of items, stored in South Wales, plus UK-wide contracts in place for additional stock to take the PIPP to 15 weeks of supply if required. However, due to a lack of supply in the global market, these 'just-in-time' contracts did not deliver as fully as expected with none of the FFP3 respirators being received. To mitigate some of these issues, equipment that was close to, or past, its expiry date was tested and had its expiry date extended.

1.4 The Welsh Government quickly realised that the PIPP would not be adequate for a coronavirus pandemic. The PPE would need to be used at a faster rate to deal with the specific demands of COVID-19. Some items – notably gloves and aprons – were below the estimated requirement for a flu pandemic and would not last as long as needed for COVID-19. Surgical gowns were not held in the PIPP stockpile.[1] These items proved to be critical for hospital staff treating COVID-19 patients. The NAO's report on the supply of PPE confirms the inadequacy of the UK stockpile for the demands of a coronavirus.

1 As reported by the NAO, the UK Government's scientific advisors had recommended in 2019 that gowns and visors be added to the stockpile, but the UK Government was still deciding which gowns to procure when the pandemic started.

1.5 The Welsh Government initially anticipated there would be a UK Government led approach to find additional supplies. However, this arrangement proved challenging in practice. The global market was fragmented, countries around the world were competing for scarce supply and some imposed export controls. The NAO has set out the challenges the UK Government faced just to secure PPE supplies for England.

1.6 The Welsh Government decided in late March 2020 that it would continue to work with the other UK administrations, where possible, but would procure and supply PPE for itself. We consider the work to procure PPE for Wales in **Part 2**.

The Welsh Government established effective arrangements for coordinating the supply effort although it took time to develop collaboration between health and social care

1.7 A small team of Welsh Government officials coordinated the PPE supply effort, working very closely with Shared Services. Daily meetings during the early stages of the pandemic discussed issues such as stock levels, likely demand, distribution of available stock and procurement of new supplies. Shared Services took day-to-day charge of delivery and collated information for Welsh Government officials to brief senior colleagues and ministers, and to respond to wider scrutiny.

1.8 The Welsh Government established two key groups to oversee PPE arrangements and provide a formal framework for joint working specifically on PPE:

- a ‘health counter-measures group’ started meeting on 12 February 2020 to secure and deploy PPE supplies in line with ministerial policy and public health guidance. The group included Welsh Government officials responsible for health and social care, Shared Services and Public Health Wales. It reported to the Planning and Response Group, which was set up in March to coordinate the overall health and social care response to the pandemic and chaired by a senior Welsh Government official. The Welsh Government suspended the health counter-measures group on 1 June 2020 once it judged the emergency phase had passed.
- an ‘executive leads group’ met from late April 2020 and brought together a senior officer from the Welsh Government, Shared Services, each health board, Velindre University NHS Trust, Welsh Ambulance Services NHS Trust and Public Health Wales to exchange information on local issues and the national response. Before formalising this group, there was already extensive communication between senior NHS executives and Welsh Government officials through other mechanisms.

1.9 During March 2020, joint working was not as developed between Shared Services, local government and the social care sector. Shared Services' core work is to supply services delivered directly by health boards and trusts, and it had not previously been responsible for supplying independent primary care contractors and social care. The Welsh Government wrote to local authorities on 19 March 2020 stating that social care providers could obtain PPE from Shared Services for the treatment of symptomatic residents if they were unable to secure it from other sources.

1.10 The Welsh Local Government Association (WLGA) and the Welsh Government set up a working group on COVID-19 procurement, bringing together local government procurement leads and the Welsh Government's National Procurement Service. This group met daily from 23 March 2020 to the end of June 2020 when the meetings then became less frequent. The Planning and Response Group had a social care sub-group where representatives from the WLGA and social care organisations could raise issues about PPE supply. However, the WLGA told us that local authorities did not feel sufficiently involved in a collective health and social care response until 9 April, when Shared Services joined the procurement group.

1.11 Nonetheless, people we interviewed reported that collaboration and partnership working was much stronger than it had been during normal times. This collaboration was helped by already having a single public body responsible for supplying PPE to much of the NHS and existing networks and relationships between the Welsh Government, NHS bodies and local government. The position in Wales contrasts with the position in England. The NAO reported that prior to the pandemic many more organisations were involved and there was more distance between the government and the agencies responsible for procurement, supply and stock management, much of which was contracted to the private sector.

Public health guidance determined what PPE was needed and formed the basis of efforts to work out how much PPE would be required by health and social care

Guidance

1.12 Before the first UK case, public health authorities across the UK were working out PPE requirements. In January 2020, the four nations agreed that COVID-19 should be classified a High Consequence Infectious Disease (HCID). Guidance issued on 10 January 2020 set out infection controls, including the isolation of COVID-19 patients and use of PPE.

1.13 After reviewing emerging information, including the fatality rate, the virus was declassified from an HCID on 19 March 2020. As a result, the guidance changed from advising that anybody entering the room of an isolating patient wear a gown, long gloves, respirator masks (FFP3) and eye protection to tailoring the guidance to the setting, whether the patient was known or likely to have COVID-19 and what procedures were being undertaken.

1.14 The core infection prevention and control guidance are issued jointly by all four UK nations, although individual nations issue supplementary guidance where there are differences. Those developing the guidance, including representatives from Public Health Wales, have access to expert advice[2]. In its July 2020 report, the Senedd Health, Social Care and Sport Committee reported some early uncertainty among providers about the guidance, notably in social care. It noted that updated guidance issued on 2 April 2020 had provided greater clarity.

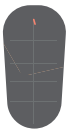
1.15 **Exhibit 1** sets out the PPE requirements at the time of drafting this report. Overall, there have been over 30 changes to the guidance since it was first issued in January 2020. One key change came on 10 April 2020 when the guidance was updated to reflect that non-symptomatic patients could be contagious. The updated guidance provided more detailed information about what PPE should be worn by health and social care staff when treating all patients, not just confirmed or suspected COVID-19 patients. On 21 August 2020, the guidance was updated to include a COVID-19 risk pathway to support returning services.

1.16 On 17 April 2020, Public Health England issued separate guidance to allow for the re-use of PPE in the case of acute shortages until confirmation of adequate re-supply. The same day, Wales' Chief Medical Officer shared the English guidance with NHS and social care bodies in Wales but noted that he did not envisage re-use being needed in Wales. On 27 April, the Public Health England guidance on re-use of PPE was incorporated into the jointly issued UK infection prevention and control guidance.

1.17 By 3 May, the separate Public Health England guidance on re-use included a note from Public Health Wales (and the public health agencies of Scotland and Northern Ireland) stating that single use PPE should not be reused, and that reusable PPE should only be reprocessed in line with manufacturer instructions. This note was never included in the UK infection prevention and control guidance. The re-use section of the UK guidance was removed in August 2020.

2 Including from the Scientific Advisory Group on Emergencies (SAGE) and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG).

Exhibit 1: PPE used to manage COVID-19

	Type of PPE	Further detail
	Aprons	A single-use apron is used when providing direct care within two metres.
	Body bags	Used by those managing the human remains of COVID-19-related deaths.
	Clinical waste bags	Used across all health and care settings, at all times and for all patients or individuals, for the safe disposal of used PPE.
	Eye or face protectors	These visors or safety spectacles are used during aerosol generating procedures and otherwise if blood and/or body fluid contamination to the eyes or face is likely.
	Face masks	Non-fluid-resistant face masks (Type II masks) are used by health and care workers when entering a hospital or care setting. Fluid-resistant face masks (Type IIR masks), are used when delivering direct care within two metres of a suspected or confirmed COVID-19 case
	Gloves	Worn during patient contact where there is a risk of exposure to body fluid.

	Type of PPE	Further detail
	Gowns or coveralls	Used (during aerosol generating procedures and otherwise) to withstand penetration by blood and/or body fluids when an apron provides inadequate cover for the task.
	Hand hygiene	The use of alcohol-based hand rub is part of hand hygiene in all health and care settings, at all times and for all patients or individuals.
	Respirator masks	Respirator masks are used to prevent inhalation of smallv airborne particles during an aerosol generating procedure. Respirator masks are known as a filtering face piece (FFP) mask. There are three categories of FFP mask (FFP1, FFP2, FFP3). FFP3 masks should be worn when performing an AGP. Workers should first be fit-tested for an FFP3 mask to ensure an adequate seal. In some circumstances FFP2 masks can be used as a safe alternative to FFP3 masks.

Note: An aerosol generating procedure is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract.

Source: Based on NAO analysis of official guidance reported on page 15 in The supply of personal protective equipment (PPE) during the COVID-19 pandemic, November 2020

Modelling

1.18 Initially, Shared Services worked with NHS bodies to obtain information on local stocks and estimate short-term demand. Each health board had its own systems for projecting demand and managing stocks. Local authorities came together to try to work out the demand for care homes and domiciliary care, but this proved difficult and early estimates of demand quickly grew as guidance on the use of PPE changed.

1.19 The Welsh Government secured support from a military logistics team. The team reported on 2 April 2020 recommending central modelling of demand. With help from the NHS Wales Finance Delivery Unit, Shared Services started to develop its working model, drawing on the rate of items being issued. This proved challenging as guidance and policy were changing during the first few weeks, for example to expand the scope of provision to optometrists and dentists. The analysts found it difficult to obtain reliable information on the number of primary care providers, staff and treatment sessions, the principal drivers of demand. Information on social care was also incomplete, especially for the large number of independent providers commissioned by local authorities. Shared Services obtained feedback and tested assumptions with NHS bodies. The WLGA and local authorities were involved in developing the demand model for social care.

1.20 Shared Services hired Deloitte in late April 2020 to review the modelling and suggest further improvements. Deloitte helped to develop a more detailed and formal supply and demand model, adding reporting functionality that Shared Services did not have the capacity to deliver and helping Shared Services staff develop their modelling skills. The model developed iteratively, with the final model (model 1) largely ready by late May with some further refinement in June. Shared Services, working with Deloitte, developed a second version (model 2) to incorporate the planned return of routine health services from August 2020. This resulted in an increase in projected demand that informed the PPE Winter Plan (**paragraph 1.36**) and stockpiling to carry health and social care through the winter.

1.21 The models were an important planning tool. Actual PPE distribution by Shared Services differed considerably from the projections for some items. In general, Shared Services issued to the NHS more stock than projected by model 1, but less stock than projected by model 2. However, this varied considerably by product. For example, Shared Services has issued more aprons than anticipated but fewer FFP3 respirators. In social care, the number of items issued was well below those projected under both models through to the end of 2020.

1.22 Shared Services highlighted a number of reasons for the variations in healthcare. The models are based on assumptions about the scale of activity and interaction with patients or residents, based on a reasonable worst-case scenario. Many routine face-to-face services that had been expected to resume from August 2020 did not do so as the second wave took hold, or they were replaced by remote consultations using video technology. Shared Services also identified increased staff sickness levels in health boards, and staff not using PPE in accordance with guidance, as factors.

1.23 In social care, the WLGA told us that some providers continued to use their established PPE suppliers to maintain contractual relationships, even after PPE funded by the Welsh Government was available. It is also possible that demand is less than expected due to staff re-using PPE that was intended for single use or using items for longer than recommended. In addition, we are aware of differences in policy between local authority areas. Some go beyond the guidance, for example requiring social care staff to wear visors where the client is not a confirmed or suspected COVID-19 case. Such departures from guidance impact on the amount of PPE required.

Shared Services responded quickly to meet increased demand for PPE, though stocks of some items were very low at times before the position stabilised from late April 2020

1.24 From mid-March 2020, Shared Services took on new staff to meet the operational and logistical challenges. At the time of drafting, it had hired 94 new members of staff and expanded its vehicle fleet, hiring 44 extra vehicles, to support deliveries. It expanded its use of existing warehouses, including a large warehouse that it had procured in January 2019 to store equipment in the event of a no-deal Brexit. Shared Services also secured additional logistical capacity by contracting with Welsh hauliers and securing around 10,000 cubic metres of storage space from the private sector, paying only for the space actually used.

1.25 The military logistics team supporting the Welsh Government (**paragraph 1.19**) identified in its 2 April 2020 report that national and regional storage distribution capacity was fit for purpose and there was sufficient capacity to meet demand. The military would not need to replace existing supply chain provision but could usefully support local stores to manage supplies effectively and step in if workforce resilience failed. The military did subsequently assist local stores, but Shared Services were able to handle logistics nationally, with the military assisting on occasions with urgent requirements, such as unloading gowns from a plane at Cardiff Airport.

1.26 Shared Services initially distributed stock from the PIPP stockpile on a 'push' basis, issuing standard packs of available stock to providers based on a broad estimate of their needs. The PIPP stockpile made a substantial contribution to PPE provision during March and April 2020, but this varied by product (**Exhibit 2**). As noted in **paragraph 1.4** the PIPP stockpile did not contain all of the items needed for a coronavirus pandemic.

Exhibit 2: quantity of Items in the PIPP stockpile in March 2020 and how long it lasted

Product category	Units in stock at the outset (1 March 2020)	How long it lasted (weeks from 9 March 2020)[1]
Aprons	9,129,800	6.0
Eye protectors	3,144,000	10.0[2]
Type IIR masks	4,906,000	5.5
FFP3 respirators	870,000	10.9
Gloves (singles)	4,814,000	1.5
Hand sanitiser	37,326	4.3

Notes:

1 The length of time the stock lasted is based on actual distribution of stock by Shared Services to health and social care providers. Actual consumption by users may be different.

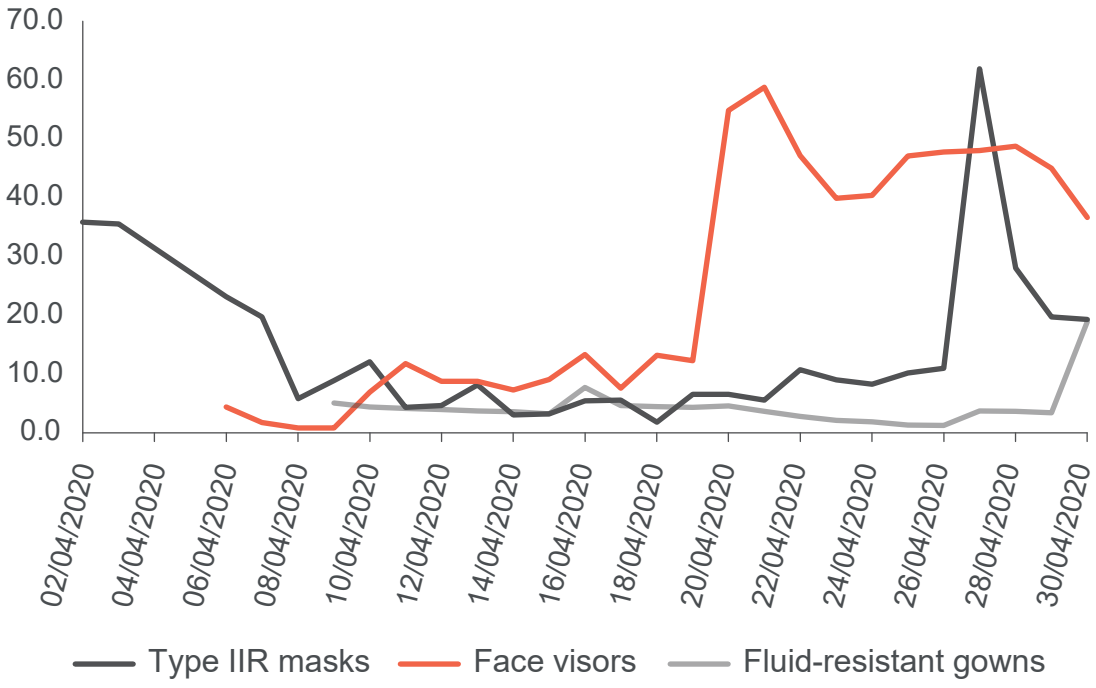
2 The PIPP stockpile included a type of safety glasses, procured by the UK Government, that were found by the Health and Safety Executive to not meet the required standards for splash protection. The Medicines and Healthcare products Regulatory Agency issued a safety alert for these products in May and around 25,000 glasses were subsequently destroyed by Shared Services.

Source: Audit Wales analysis of Shared Services data

1.27 PIPP stock levels declined as items were drawn down and deliveries from other sources were limited by supply shortages. Meanwhile, demand increased rapidly as Shared Services started to supply the independent primary health care and social care sectors as well as hospitals.

1.28 Pressures were particularly acute in April (**Exhibit 3**). There was less than a week's supply of Type IIR masks, face visors and fluid-resistant gowns in Shared Services' stock for much of the month. Type IIR masks almost ran out on 16 April, with stocks coming through on the day as part of mutual aid from Scotland and then as an order from China arrived. Supplies of fluid-resistant gowns were in perilously low supply, with less than two days of stock available at some points. Shared Services relied on an emergency delivery of fluid-resistant gowns around 20 April 2020 from England, and urgent action was taken to identify stocks held in local stores and hospitals. Shared Services did not have a comprehensive view of stocks held at local stores until the StockWatch system was established (**paragraph 1.41**).

Exhibit 3: days of Shared Services stock available for Type IIR Masks, face visors and fluid-resistant gowns, April 2020

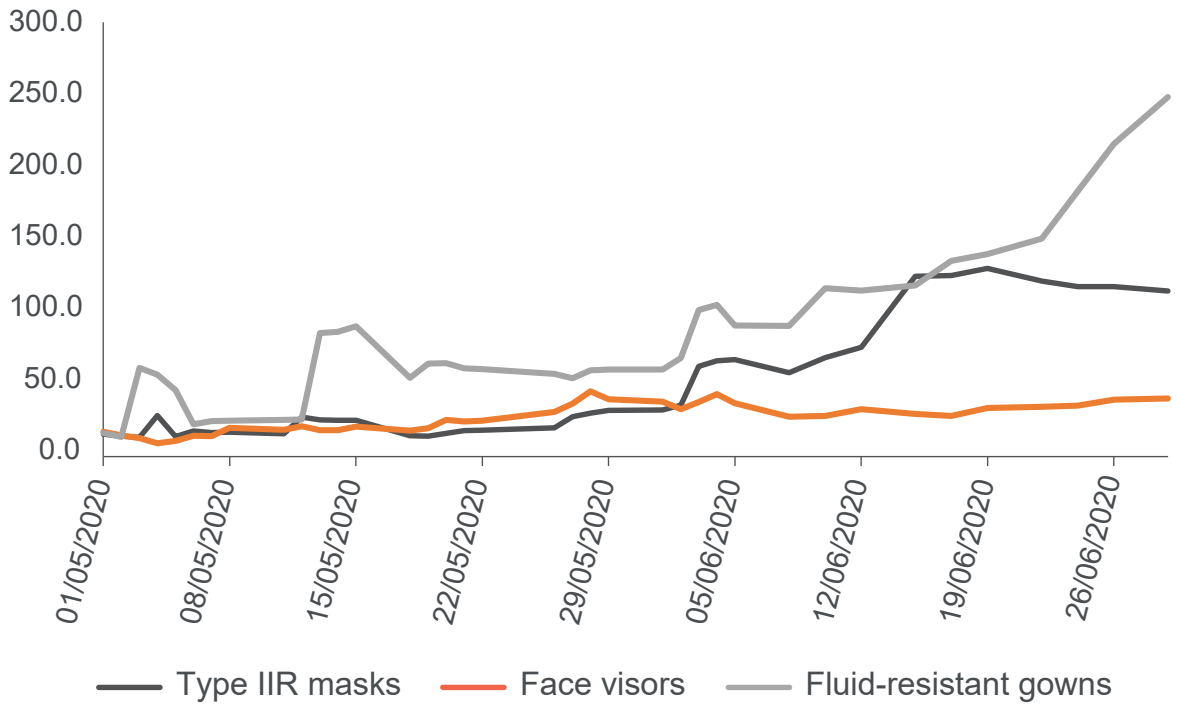


Note: days of Shared Services' stock remaining calculated using an average of previous 28-day issues. Lowest point for Type IIR Masks was 1.8 days on 18 April, for Face Visors was 0.8 days on 8 April, and for Fluid-Resistant Gowns was 1.2 on 26 April.

Source: Audit Wales analysis of Shared Services data

1.29 The situation gradually improved in late April 2020 and through May and June as stock from new suppliers started to be delivered (**Exhibit 4**). A delivery of 200,000 fluid-resistant gowns from Cambodia on 27 April (see case study in **Exhibit 10, page 39**), followed by larger deliveries from China in early May, enabled the Welsh Government to provide mutual aid to the other UK nations. Wales has ultimately provided more PPE items than it received[3]. The position on most items was stable by the end of May, with more than 14 days' worth of supply in central stocks for all items except gloves. By 20 July, following a delivery of gloves, there were more than 14 days' of supply for each item and all categories were classified as 'green' on Shared Services' risk rating system.

Exhibit 4: days of Shared Services stock available for Type IIR masks, face visors and fluid-resistant gowns, May to June 2020



Note: days of Shared Services stock remaining calculated using an average of previous 28-day issues.

Source: Audit Wales analysis of Shared Services data

3 Shared Services reports that, since the start of April 2020, it has issued 13.8 million items of mutual aid to other UK nations and received 1.4 million items on request from Scotland and Northern Ireland. In addition, it has received around 3.3 million items from the UK Government to replenish the PIPP stocks. Shared Services also entered into contracts to provide £37.5 million of PPE for other UK nations (**paragraph 2.42**).

1.30 Shared Services has gradually shifted to a ‘pull’ system of supply. Rather than standard packages or deliveries based on available stock, providers can specify what they need. This shift happened relatively quickly for NHS providers, in August for local government and in September for primary care. The ‘pull system’ means Shared Services has a better understanding of demand and providers are better able to get what they need and avoid having an oversupply that they need to store locally.

1.31 Shared Services’ stock data shows that it did not run out of stock for any item of PPE during the pandemic. We have not sought to check the levels of local stocks nor whether PPE was reused locally. Shared Services told us that NHS bodies were always kept supplied with sufficient stock to meet the requirements of the guidance. The minutes of the executive leads group (**paragraph 1.8**) showed that no NHS body reported that it had run out of PPE. The minutes reflect the concerns about low stocks detailed above and that at times there was mutual aid between health boards.

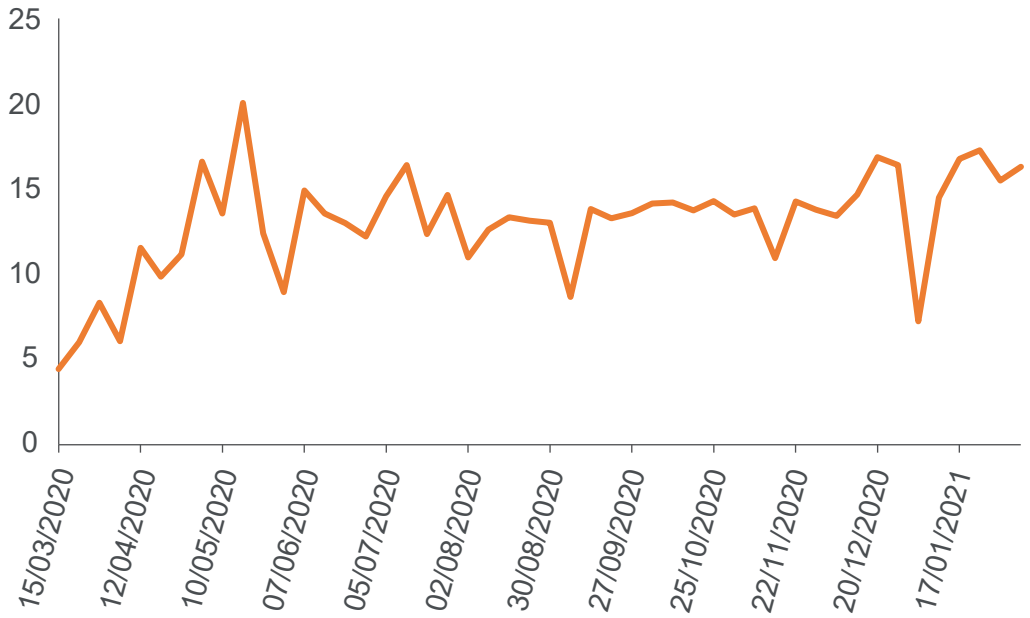
1.32 The Senedd Health, Social Care and Sport Committee highlighted the significant difficulties that the social care sector faced in meeting PPE requirements in the early stages. Notes from the local government working group on procurement (**paragraph 1.10**) confirm this picture. The group expressed serious concerns about the developing situation in late March 2020 and early April, including concerns about a lack of information on the availability of stock, the clarity of guidance and very low stocks of key items including hand sanitiser and masks.

1.33 By 6 April 2020, the group felt that the sector was in a crisis. At this stage, Shared Services was only responsible for supplying social care providers with PPE where they were unable to secure their own. Councils and private care homes were primarily securing PPE for themselves individually or as part of regional arrangements. However, the Welsh Government tasked Shared Services with supplying social care more widely and supplies started to increase. These were essential in maintaining a basic level of supply.

1.34 The situation improved, with the group reporting that by 7 May 2020 around two-thirds of the social care sector's needs were being met by Shared Services. The WLGA and Shared Services adopted a service level agreement on 1 September 2020 under which Shared Services would make weekly deliveries to local stores based on councils' estimated requirements. The change from Shared Services acting as a supplier of last resort to supplying most of social care's needs was not formally communicated to social care until 12 October. However, a shift in policy towards supplying social care providers' needs on demand occurred much earlier, in April 2020, and was communicated informally to providers through the WLGA and local authorities. While some independent providers preferred to maintain contracts with existing PPE suppliers, it appears that most needs are now being met by Shared Services.

1.35 Between 9 March 2020 and 2 February 2021, Shared Services distributed around 630 million items of PPE to health and social care. **Exhibit 5** shows that the amount distributed ramped up between March and June before becoming more stable. Over the period April 2020 to January 2021 around half of the PPE issued by Shared Services was for social care.

Exhibit 5: weekly distribution of PPE items by Shared Services, 9 March 2020 to 7 February 2021 (millions of items)



Source: Welsh Government, Weekly Personal Protective Equipment issues: up to 7 February 2021, released 11 February 2021

Shared Services has built up a buffer of PPE stock but the goal of 24-weeks' worth has not been met for all items

1.36 In July 2020, the Senedd Health, Social Care and Sport Committee recommended that the Welsh Government publish a strategy for securing a resilient PPE supply, including a plan for stockpiling. The Welsh Government accepted the recommendation. Shared Services' Winter Plan for PPE, agreed by the Welsh Government, involved building up a 24-week buffer of key items. Shared Services and the Welsh Government are in the process of reviewing the Plan and the 24-week target (**paragraph 2.46**).

1.37 For most items Shared Services was able to build up a 24-week buffer. For some items Shared Services' data shows several years of stock, although this may reflect the way that future demand is calculated[4]. **Appendix 3** sets out in detail the position on levels of stock issued and held nationally (excluding local stocks).

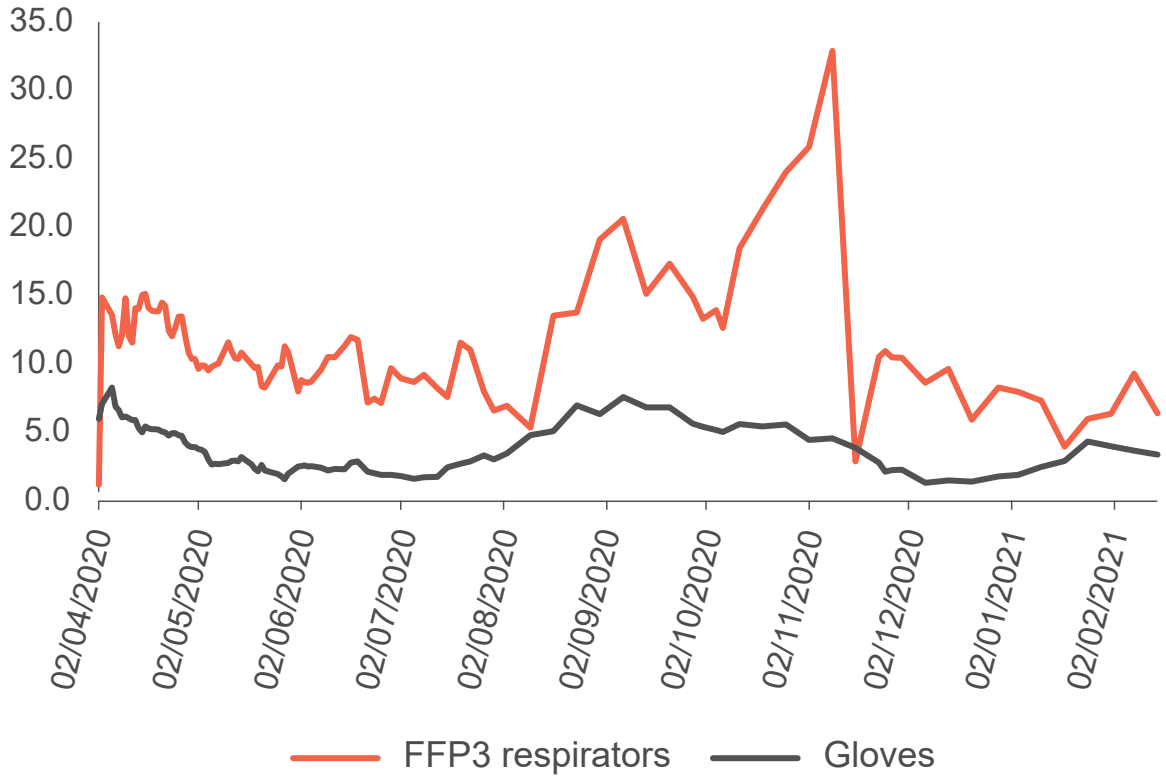
1.38 However, for some items there has never been a 24-week buffer. Through the second wave of the pandemic some stocks have declined significantly – in particular, FFP3 respirators and nitrile gloves (**Exhibit 6**). These two items have proved difficult to source.

1.39 In the case of nitrile gloves there are very few manufacturers, mostly located in Malaysia where the rubber needed to make them is grown. Shared Services reported that the state of emergency declared in Malaysia in January 2021 due to COVID-19 has hampered recent supplies. For FFP3 respirators, the issue is with a particular brand of mask which clinicians' favour. Shared Services told us that the manufacturer had refocused its efforts on FFP2 respirators, which had contributed to a global shortage and slippage in expected delivery dates.

1.40 At the time of drafting, Shared Services was awaiting delivery of large orders of FFP3 respirators and gloves. Shared Services calculates that these deliveries will take stock levels of these items to over 24 weeks. In the meantime, Shared Services has procured small amounts of these items to keep supply stable. However, the WLGA told us that while gloves are available, there is a shortage of specific sizes.

4 We have projected how long stock will last based on a combination of modelled and actual draw down over the previous 28 days. For some items, such as body bags, stock is sent out in a batch that lasts for several weeks. By basing the projections on recent supply, it can look like the stock will last longer than is the case and these projections then change when the next batch is sent out.

Exhibit 6: weeks of Shared Services' stocks of FFP3 respirators and nitrile gloves held, 2 April 2020 to 8 February 2021



Note: weeks of Shared Services' stock remaining calculated using an average of previous 28-day issues. The lowest point for FFP3 respirators was 1.2 weeks on 2 April and for gloves was 1.3 weeks on 7 December.

Source: Audit Wales analysis of Shared Services data

1.41 Systems for monitoring stock have improved over time. Shared Services' systems came under strain as stocks arrived from the PIPP stockpile, new purchases and as mutual aid, sometimes unexpectedly. The volume of stock and activity was far higher than before the pandemic. In response to the report of the military logistics team (**paragraph 1.25**), Shared Services introduced a StockWatch system for local stores to report weekly on their stock holdings for each item. However, Shared Services told us that local authorities do not always report information on a timely basis.

1.42 The WLGA told us that some councils question the value of StockWatch for social care. Local authorities' joint equipment stores hold minimal stocks of PPE, with most of it being sent to providers as soon as it arrives. StockWatch does not record stocks held by social care providers and is not integrated with local authorities' stock management systems. Notwithstanding these issues, Shared Services considers the information from StockWatch is valuable in helping it supply PPE to social care.

Confidence in the supply of PPE seemed to increase following the initial response but there remain concerns about specific items and some equality issues

Staff and social care providers' views

1.43 The Senedd Health, Social Care and Sport Committee heard evidence from representative groups and noted 'the fears and concerns of frontline staff about the availability of appropriate PPE' during the initial response. We invited organisations that gave evidence to the Committee to provide any updates for us to consider. We received further Wales-only survey evidence from the Royal College of Nursing (RCN), who surveyed nurses working in health and social care, and the British Medical Association (BMA). As the participants were self-selecting, rather than a random sample, we cannot know how representative these experiences are of the whole NHS and social care workforce.

1.44 While the overall number of respondents fell significantly, the RCN data suggested some improvement between April and May 2020 in the percentage who said they had sufficient supplies of different types of PPE. However, a significant minority of respondents still identified concerns, particularly in response to questions about FFP3 respirators and gowns in the context of high-risk procedures, such as aerosol generating procedures (**Exhibit 7**). Staff perceptions of PPE may have reflected their experiences of distribution within local sites rather than the national picture on stock levels.

Exhibit 7: RCN survey respondents who said they had sufficient supplies of each type of PPE, April and May 2020

PPE Type	April	May
Eye protection	52%	85%
Type IIR masks	46%	80%
Apron	90%	96%
Gloves	94%	96%
FFP3 respirators	63%	79%
Long-sleeved gowns	57%	67%

Note: the RCN received 875 and 292 responses from Wales in April and May respectively. The RCN only asked respondents about FFP3 respirators and gowns within the context of high-risk procedures, such as aerosol generating procedures.

Source: RCN member surveys

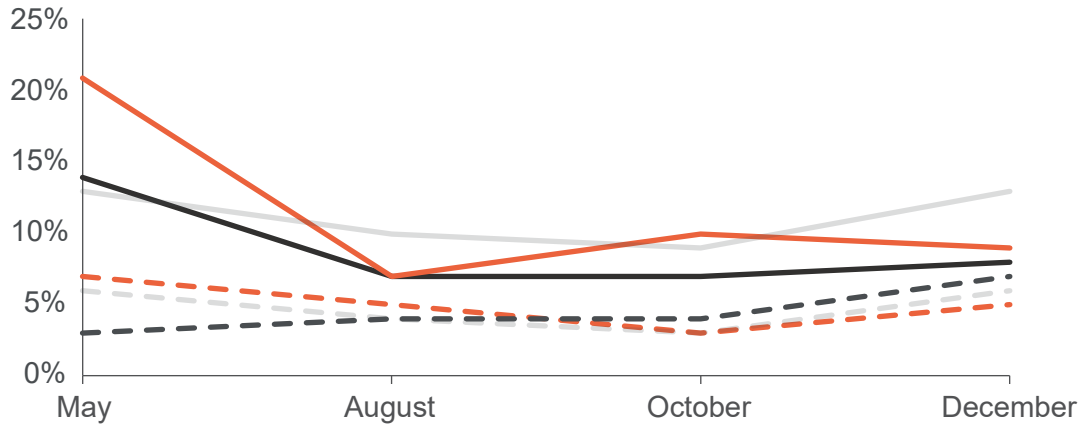
1.45 The BMA asked its survey respondents to identify areas of concern from a list of different issues. Those identifying PPE shortages as a concern dropped from 38% to 13% between May and December 2020[5]. However, when asked about specific types of PPE, BMA respondents' perceptions of PPE levels is mixed.

1.46 For several items, very few or no respondents said there was no supply at all (**Exhibit 8**). However, the proportion highlighting shortages increased for most items in December 2020. Concerns about shortages of gloves in December 2020 may reflect the fact that these have been challenging to source (**paragraph 1.38**). However, it is unclear why there would be an increase in concerns about supply of fluid-repellent (Type IIR) masks, eye protection and aprons given the levels of national stock of these items at the time. In its report (**paragraph 1.25**), the military said that some perceptions of supply could be due to a lack of sight of available stocks.

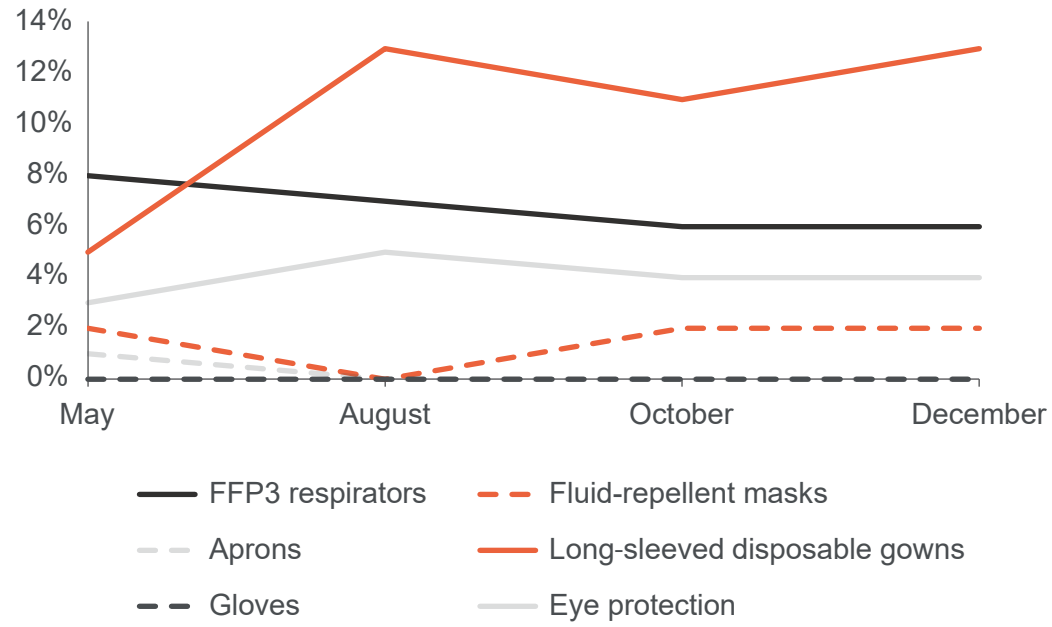
5 The question asked respondents to choose from a list of possible concerns over the next few months. They were able to choose as many options as they wanted, including 'PPE shortages'.

Exhibit 8: BMA survey respondents who said they had shortages or no supply of each type of PPE, May to December 2020

Shortages



No supply at all



Note: response numbers varied between 463 in May, 258 in August, 492 in October, and 505 in December. The survey asked: 'Over the last two weeks, have you had adequate NHS supplies or shortages of the following PPE?'. Respondents could answer 'adequate', 'shortages', 'no supply at all', 'don't know', or 'not relevant'. In some cases, the 'not relevant' response was as high as 27% and was consistently around 25% for those responding to the questions on FFP3 respirators and long-sleeved gowns.

Source: BMA COVID-19 PPE surveys

1.47 A key concern of staff reflected in the BMA survey has been the availability of FFP3 respirators and long-sleeved disposable gowns. These items are required by the guidance for higher risk aerosol generating procedures. It is hard to be sure to what extent staff concerns are about a lack of supply of required PPE or the guidance itself. The RCN and BMA survey findings in relation to FFP3 respirators and gowns also reflect wider concerns with the level of PPE required by the guidance. The BMA has expressed concern about revisions to guidance around gowns and FFP3 respirators when COVID-19 was downgraded from a High Consequence Infectious Disease in March 2020 (**paragraphs 1.12-1.13**).

1.48 In its February 2021 survey[6], the BMA found that just 37% (166 of 488) of respondents in Wales said they are currently provided with adequate PPE for non-aerosol generating procedures, while 44% said they did not feel it was adequate. In response to a question about what PPE would help them to feel safe in non-aerosol generating procedures, 88% said FFP3 respirators would help, while 45% said that long-sleeved disposable gowns would help. Neither of these items are required by guidance for non-aerosol generating procedures.

1.49 Evidence provided by the WLGA records some deep concerns that social care workers felt their PPE was inadequate. The contemporaneous notes of meetings of heads of procurement (**paragraph 1.10**) in the middle of May 2020 record that social care staff felt unprotected with ‘just a flimsy apron over street clothes’. Again, these concerns seem to reflect concerns with the nature of PPE required by guidance rather than the level of supply. Care Inspectorate Wales’ surveys show social care providers’ views improving during April 2020. In the first two weeks 11% of care home providers and 18% of domiciliary care providers said they had insufficient PPE. By the second half of April those figures fell to 5% and 8% respectively.

1.50 We are also aware that some health and care staff had concerns about the quality of some certified PPE. These were few in number relative to the overall volume of PPE supplied by Shared Services. The safety glasses that were held in the PIPP stockpile were unpopular, in part because they needed to be manually assembled, and were subsequently withdrawn for other reasons (see note to **Exhibit 2**). There were also complaints from staff about skin irritation caused by face masks, but these did not indicate non-compliance with product safety standards. There was also an isolated issue with a batch of nitrile gloves that were prone to tearing when putting on. These were mislabelled as nitrile gloves and were a vinyl mix that had not been ordered. Shared Services reported the issue to the Medical and Healthcare products Regulation Authority, and the contractor replaced the batch of 16 million gloves with the correct specification.

6 The BMA provided us with early sight of part of its February 2021 survey, but we had not seen the full dataset at the time of drafting.

Equality

1.51 Staff and representative groups have raised the issue of feeling inadequately protected due to PPE generally being designed for generic male physiques. This issue has been identified as a concern long before the start of the pandemic. Early in the pandemic, an issue was identified with the fit of a particular type of mask. Cardiff and Vale University Health Board identified a method to improve the fit and reduce fit-test failures. It shared a video across NHS Wales to help improve the fit of the masks for a wider range of healthcare staff. The use of fit test machines also lowered failure rates.

1.52 The Welsh Government and Shared Services are aware of these concerns about the fit of PPE for certain groups. They told us that there are several manufacturers, including a manufacturer in Wales, developing products with potential to offer a more bespoke fit for different face and body types. However, as far as they are aware these items are yet to secure full certification.

1.53 Equality concerns have also been raised by groups who have identified that being unable to see a carer's face is to the detriment of some care. The use of clear face masks has been suggested. However, the leading design purchased by the UK Government, on behalf of all UK nations, is not yet certified as PPE so can only be used where a user has undertaken a risk assessment and in line with Health Safety Executive guidance.

Cases and deaths

1.54 There have been several COVID-19 outbreaks in Welsh hospitals[7], but we do not have evidence to establish a casual link between these outbreaks and PPE. Some health boards have reviewed the factors contributing to individual outbreaks, including potential links to staff compliance with PPE. Further work would be needed to fully understand any role that PPE, as part of overall infection prevention and control measures, may have played.

7 Public Health Wales publishes data on the number of 'probably' and 'definite' cases of hospital transmission on its COVID-19 data website.

1.55 Many health and care staff have contracted COVID-19, and sadly some of those people have died. There is published Office for National Statistics data[8] on cases and deaths generally and the Health and Safety Executive has provided us with data on notifications it has received[9]. However, there are various limitations noted with the data in both cases and care needs to be taken when interpreting the findings. We do not have hard evidence that any of these cases or deaths were caused by occupational exposure, or more specifically by a shortage of suitable PPE.

1.56 We did not examine these issues and any possible root causes in more detail as part of our work. The Welsh Government has emphasised to us that NHS Wales has well-established processes to ensure that staff and patient deaths are appropriately reported, fully investigated and where appropriate referred to the coroner. It is from these processes that it and NHS Wales will gain evidence on any potential systemic failures, including in the supply or use of PPE, that have resulted in work-related deaths from COVID-19. In its February 2021 report, the UK Public Accounts Committee recommended that the UK Government carry out a review into whether there are any links between PPE shortages and staff infections and deaths.

8 Office for National Statistics data shows that 23 social care workers and 34 NHS workers died of COVID-19 in Wales between 9 March and 28 December 2020. The analysis does not prove conclusively that rates of death involving COVID-19 are necessarily caused by differences in occupational exposure. Office for National Statistics, Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 28 December 2020, released 28 January 2021.

9 Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), employers have a duty to report to the Health and Safety Executive (HSE) cases where a worker has been diagnosed as having COVID-19 and there is reasonable evidence to suggest that it was caused by occupational exposure for whatever reason. Of 1,696 notifications for Wales between 10 April 2020 and 9 January 2021, 1,156 related to human health and social work activities. Among the 1,696 were 11 fatal notifications, of which seven related to human health and social work. The HSE has made clear in its Technical summary of data on Coronavirus (COVID-19) disease reports that there are a number of limitations that should be kept in mind when considering this data and its accuracy.

Procurement of PPE

02

2.1 This part of the report examines the work led by Shared Services to procure PPE. In March 2020, the Welsh Government chose to adopt the UK Cabinet Office's Procurement Policy Note 01/20[10]. The Policy Note permits, under regulation 32(2)(c) of the Public Contract Regulations 2015, procurement of goods, services and works without competition or advertising so long as there are genuine reasons for extreme urgency. This meant Welsh public services were able to procure PPE without going through the usual competitive processes. The Welsh Government also adopted Procurement Policy Note 02/20[11], allowing advance payments where a value for money case is made. Any payments up front exceeding 25% of the contract value require Welsh Government approval.

2.2 During March 2020 and through April, Shared Services undertook its own procurement of PPE as did local government bodies for social care. At this point, the procurement was 'at risk' with no guarantee of any UK Government funding cover. In mid-June 2020, the UK Government confirmed to the Welsh Government that it would get funding to procure PPE via the Barnett formula[12].

Public services worked together in an increasingly collaborative way to identify and respond to potential PPE suppliers

2.3 In the early days of the pandemic, many local organisations came forwards with offers to supply PPE. The Welsh Government appointed Life Sciences Hub Wales (LSHW) in a facilitation role to collate all offers of support to health and social care and identify appropriate businesses who could potentially supply items on NHS Wales' critical products list.

2.4 LSHW established an online portal for industry to upload offers of support. Using guidance provided by Shared Services' Surgical Materials Testing Laboratory (SMTL) and the National Procurement Service (NPS), LSHW reviewed submissions from suppliers wanting to sell PPE and other products and services. These reviews included ensuring conformity with quality requirements and some standard business checks. Qualified offers of products were forwarded to Shared Services to progress offers into the procurement process.

2.5 LSHW also received, and directed to NHS Wales organisations, enquiries relating to donations of other products and services. Enquiries relating to field hospitals, the production of wearable products, and volunteering by healthcare workers and the general public were referred by LSHW to the appropriate bodies.

10 UK Government Cabinet Office, Procurement Policy Note - Responding to COVID-19, Information Note PPN 01/20, March 2020

11 UK Government Cabinet Office, Procurement Policy Note - Supplier relief due to coronavirus (COVID-19), Action Note PPN 02/20, March 2020

12 The Barnett Formula determines how decisions to increase or reduce spending in England result in changes to the budgets of the devolved administrations.

2.6 As at 26 October 2020, LSHW had managed 2,285 enquiries, referring 556 to the NHS, Welsh Government and other relevant organisations (**Exhibit 9**). Three-quarters of enquiries triaged but not progressed by LSHW were for reasons such as incomplete documentation received, failure to pass initial due diligence, and products and processes falling out of scope and not on the critical products list.

Exhibit 9: offers of products and services in response to COVID-19 referred by Life Sciences Hub Wales

Product type	Organisation receiving referral	Number of referrals
Infection control (including PPE) and medical devices	Shared Services	226
Digital solutions	Welsh Government Digital Health Cell	165
Point of care and testing	Public Health Wales	22
Other	Industry Wales, Welsh Government and others	143
Total		**556**

Source: Life Sciences Hub Wales

2.7 The Critical Equipment Requirement Engineering Team (CERET), established by the Welsh Government in March 2020, works closely with Welsh manufacturers who indicated that they could potentially expand into manufacturing PPE with some support. CERET worked with Business Wales to invite expressions of interest, with Business Wales reporting the following results:

- over 30 companies have repurposed their production lines to provide hand sanitiser
- 25 companies have repurposed their production lines to make face visors
- there are now 9 companies who have invested in machinery to produce clinical grade face masks and face coverings, five of these companies can now mass produce although they are yet to win contracts to supply the NHS (**paragraph 2.48**)

2.8 Shared Services faced the challenge of fragmented global supply chains, due to countries imposing export restrictions and huge demand as the pandemic took hold across the world. Many existing suppliers were unable to supply PPE in the volume and at the pace required. Shared Services therefore had to source PPE using their network of contacts, through suppliers getting in touch themselves and through other referrals. In some cases, Shared Services told us they had to work with agents who had the right contacts with the key manufacturers. In at least one case, this meant sourcing products directly from a factory that was supplying the global companies that Shared Services had been unable to source PPE from.

2.9 Shared Services and the Welsh Government report that they have never had an equivalent to the twin-track ‘high priority lane’ approach to identifying potential suppliers described by the NAO in its report on government procurement in England during the COVID-19 pandemic. In our review of procurement documentation, we found no evidence of such an approach or of suppliers getting preferential treatment because of the person referring them.

2.10 Shared Services and LSHW told us that referrals from politicians were subject to the same process, scrutiny and prioritisation as any other contacts. In our sample testing we did not see reference to any referrals being from politicians. We found one example where one of the directors of a supplier was known to a member of the group set up by Shared Services to scrutinise requests for orders to be raised. This was appropriately declared in the advice for decision makers.

Overall, the Welsh Government and Shared Services developed good arrangements to manage the risks involved in procuring PPE in a fragmented market but did not publish details of all contracts on time

Timeliness risks

2.11 The challenging situation with stocks, especially in the early weeks of the pandemic (**paragraphs 1.27 to 1.29**), meant that Shared Services was under significant pressure to procure PPE very quickly. While recognising the importance of timely decision making, the Welsh Government set out in a 30 March 2020 letter to NHS bodies that it still expected good governance around spending decisions. The letter recognised the need to adapt arrangements on an interim basis and included guidance on financial management and reporting, including expectations related to being clear on delegating authority for decision making and recording decisions and the supporting rationale.

2.12 To speed up decision making, the Board of Velindre University NHS Trust agreed changes to its own and Shared Services' schemes of delegation. On 18 March 2020, these were amended to allow the Chair and Managing Director of Shared Services to authorise expenditure up-to £2 million (up from £100,000), with the limit increased to £5 million on 30 March 2020. All approvals over these limits needed to go through the Board of Velindre University NHS Trust. In addition, the requirement for Welsh Government approval for expenditure over £1 million has stayed in place throughout.

2.13 Overall, the arrangements enabled Shared Services to make swift decisions and supply PPE quickly. We understand this was achieved within the pre-existing staff capacity. We recognise that this placed significant pressure on individuals involved, who have been working late at night and in the early hours of the morning to deal with suppliers overseas and to take calls from worried frontline staff. We saw evidence of the Board of Velindre University NHS Trust and the Welsh Government responding promptly to turn around approvals and avoid delays. **Exhibit 10** provides a case study showing the rapid timescales and collaboration involved in procuring PPE.

Exhibit 10: timeline of procurement and supply of surgical gowns from Cambodia, April 2020

April 21

Minister for Health and Social Services tells press conference Wales has just days of full PPE.

April 22

19:50 lead comes into Shared Services from a company in Northern Ireland on potential supply of gowns from Cambodia. Within an hour, Shared Services has sought in principle approval from the Welsh Government, subject to due diligence which was underway.

April 23

Before 08:00 Welsh Government gives in-principal approval.

11:30 FGG meets to scrutinise documentation and requests further checks on company and to negotiate on advance payment and price.

13:30 Shared Services meets virtually with the company directors to discuss issues, including price, and understand company structure and background.

15:00 FGG provided with updated position, including reduced price and advance payment.

16:00 Surgical Materials Testing Laboratory confirms the products have the correct certification.

April 24

Shared Services charters a plane from Cambodia to Cardiff Airport.

April 25

Shared Services receives confirmation that the gowns have been manufactured and are on trucks in Cambodia.
Shared Services becomes aware that freight-handling staff at Cardiff Airport are on furlough.

April 26

Shared Services agrees with Cardiff Airport a payment mechanism for freight handling staff to come off furlough and requests military support to unload the plane.

April 27

Gowns arrive at Cardiff Airport. The military, Shared Services and Cardiff Airport staff and others are involved in unloading. Some go to the central stores; some are distributed directly to Welsh hospitals and some are sent as mutual aid to other parts of the UK.

Source: Audit Wales review

Financial risks

2.14 Seeking to urgently procure scarce PPE in a fragmented and highly competitive global market posed significant financial risks. Many of the companies offering PPE were either new or had recently expanded into PPE and had limited track records. There were significant risks of fraudulent activity. And there were novel financial requirements, most notably a requirement from many companies for payment in advance.

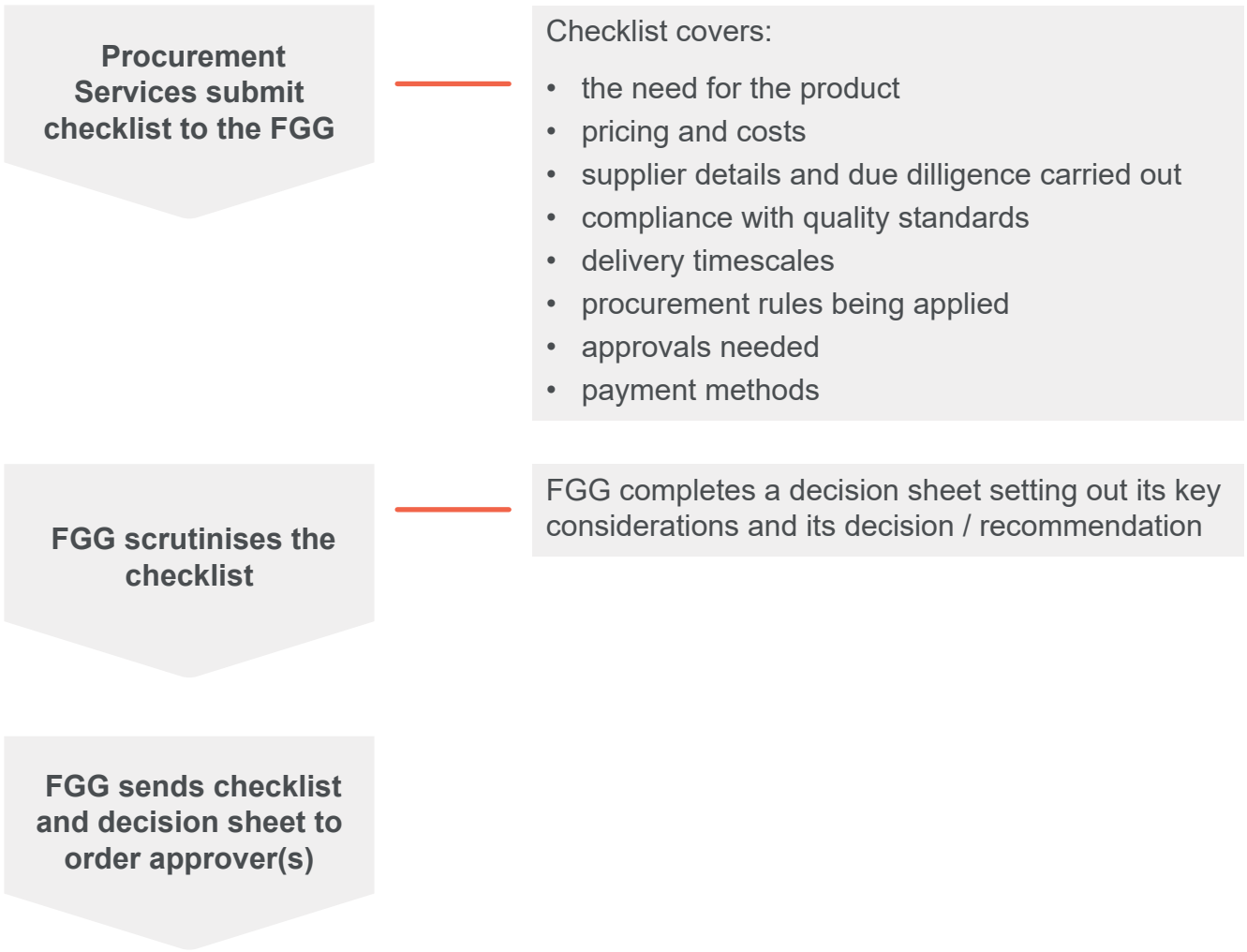
2.15 Shared Services set up a new cross-profession Finance Governance Group (FGG) in early April 2020 to manage risks while enabling rapid decision making related to COVID-19 procurement. **Appendix 2** sets out the membership of the FGG which also included members of the Board of Velindre University NHS Trust. FGG meetings consider potential contracts for PPE that either or both:

a need Welsh Government support for the advance payment because it is 25% or more of the value of the contract (**paragraph 2.1**).

b need formal approval from the Board of Velindre University NHS Trust.

The group's role is to ensure appropriate scrutiny and checks before requests for orders to be raised are sent for approval (**Exhibit 11**).

Exhibit 11: role of the Finance Governance Group in the contract approval process



Source: Audit Wales review

2.16 We reviewed the checks put in place on a sample of 16 contracts let by Shared Services. Our sample included the larger/more risky contracts reviewed by the FGG as well as some smaller contracts not covered (**Appendix 1**). We found that in all cases there was a documented evidence trail, picking out the key issues and risks and how they would be managed. All the decisions we reviewed had been made in line with the required processes, and the subsequent approvals of the orders were in line with Shared Services' scheme of delegation and Welsh Government requirements.

2.17 The pressure of securing PPE meant due diligence could not always be carried out to the level it would outside of a pandemic in a normal competitive tendering process. However, for each contract we reviewed, we found evidence of key due diligence checks being carried out. These included background checks on the companies involved. In some cases, the companies looked like they were entirely new to the PPE market. However, further exploration showed that they had a sister company or were part of a group with experience in the PPE market. In other cases, the companies were new, but the Directors involved had credible direct access to PPE manufacturers.

2.18 Our findings on approvals confirm those of an internal audit review of Shared Services' financial governance, including PPE and other COVID-19 related expenditure, reported in October 2020. It found that the procedures around background checks, approvals and recording of decisions that the Welsh Government and NHS had put in place were complied with in all cases. It also noted that there were improvements to the financial governance arrangements and quality of documentation over the period.

2.19 The FGG monitors orders that involve advance payments to ensure the products are received. Nine orders reviewed by the FGG had advance payments made through an 'escrow' account. Shared Services and Welsh Government told us that this approach was used for large volume contracts or with new higher risk suppliers. The arrangements meant that the suppliers could see that the funding was in place but could not draw down the money until the goods were received and checked.

2.20 Shared Services cancelled four orders involving advance payments that had been reviewed by the FGG. Two of these advance payments had been made through an 'escrow' account. Refunds were received in full for three orders and for one order the advance payment was transferred to another order with the same supplier.

2.21 Despite the urgency, there was not a blanket approach of buying PPE whatever the cost. Inevitably, in what was in effect a seller's market, prices were higher (**paragraph 2.44**). We saw an example where Shared Services recorded that it had prioritised a slightly more expensive provider over a cheaper one, because it could supply more quickly. Nonetheless, we saw examples where Shared Services negotiated down the price. For one order, a unit glove cost negotiated to two-thirds of a unit cost offered by a different supplier avoided expenditure of £6.5 million. Shared Services also avoided costs by negotiating transport of PPE freight by sea and not air for some orders.

2.22 Benchmarking data presented to the FGG, including historic data and data from other parts of the UK, set parameters for what Shared Services was willing to pay. Shared Services did not proceed with one contract where it had later been able to source the same PPE at a lower price.

2.23 As at the end of December 2020 the FGG had reviewed 43 proposed contracts, nearly all of which related to PPE. There were a further four contracts which were entered into in late March and very early April 2020 before the FGG was established. There were also a further four contracts that should have been, but were not, subject to review by the FGG. Shared Services Internal Audit reported that appropriate authorisation was in place for each contract order. Some of the contracts considered did not proceed or were subsequently cancelled.

2.24 As of January 2021, a total of 37 orders related to PPE that had either been through FGG or should have been[13], had been delivered, or were expected to be delivered. Of those 37 orders, 16 were with existing suppliers and 21 with companies new to Shared Services. Around half of the orders with new suppliers came from companies new to the PPE market, six of which were with the same new supplier.

Quality risks

2.25 There were widespread concerns, particularly at the start of the pandemic, that there were unscrupulous traders offering bogus PPE. PPE must meet strict certification standards. Shared Services Procurement Services worked closely with the SMTL, based in Bridgend, to test the quality of PPE. For some orders, this meant verifying that the certification provided was authentic. We understand that SMTL identified 37 fraudulent certificates being offered by potential suppliers. In some cases, SMTL carried out tests on a sample of the product. SMTL also worked closely with domestic manufacturers to help them secure certification.

2.26 As noted in **paragraph 2.19,** Shared Services had protection from losing advance payment where the PPE was not certified as described. There were two examples where proposed orders presented to the FGG were not proceeded with because the PPE did not meet the quality requirements. Other than the isolated example of mislabelled gloves (**paragraph 1.50**), we saw no evidence of examples, like those described by the NAO in England, where PPE was purchased centrally that was not deemed fit for purpose.

13 These 37 include the four orders let before the FGG started to meet. We chose to analyse this sub-set of 37 orders rather than all orders as they comprise most of the expenditure on PPE and exclude many smaller, lower risk contracts.

2.27 Contemporaneous notes kept by the WLGA record that local government bodies had purchased some PPE with fraudulent certificates in the early stages of the pandemic and that some of this had probably been used by frontline staff. These purchases were outside of the quality checking process put in place by Shared Services. We have not sought to verify the volume and nature of these purchases nor how local government bodies managed the risks.

Transparency risks

2.28 In the absence of transparent competition, public bodies can maintain public confidence by openly reporting details of contracts let under emergency powers. The Cabinet Office's Procurement Policy Note (**paragraph 2.1**) sets out that a contract award notice should be published within 30 days of a direct contract being awarded. In Wales, contract awards above the relevant thresholds set out in the UK Public Contracts Regulations 2015 are published on the Welsh Government's Sell2Wales website. Before the end of the Brexit Transition Period, Sell2Wales automatically published award notices to the online version of the Official Journal of the European Union (Tenders Electronic Daily). Sell2Wales now publishes them on the Find a Tender Service, the new UK e-notification service.

2.29 All 16 of the contracts covered in our sample testing of expenditure were direct awards due to extreme urgency. Shared Services has published full contract award notices for nine. Of the remaining seven:

- five contracts involved the same intermediary. For four of these, Shared Services published contract award notices covering the fees of the agents for a range of services but not the separate contract for the PPE items. Shared Services told us the contracts were with non-EU manufacturers and therefore it did not need to publish a contract award notice. We could find no such exemption in the relevant regulations or guidance. For one of the contracts, Shared Services published a contract award notice, but it was drafted as though the intermediary had provided the PPE and did not refer to the separate contract Shared Services had agreed with the manufacturer.
- for one contract, Shared Services published a different type of notification - a Voluntary Ex-Ante Transparency Notice (VEAT)[14] - but not a full contract award notification. Shared Services told us that because it published a VEAT, it did not need to publish a full contract award notice. We could find no such exemption in the relevant regulations or guidance.
- the final contract involved air travel sourced through the military and English NHS. Shared Services told us it did not need to publish a notification for this contract.

2.30 Of the nine full contract award notices published in our sample, none were published within 30 days of awarding the contract. On reviewing them, we found several had incorrect dates for the date the contract was awarded. Shared Services is rectifying these errors. For two contracts in our sample, Shared Services published VEATs within 30-days of letting the contract, although this is not a requirement for VEATs which are normally published in advance of letting a contract.

2.31 Shared Services told us that its staff have been stretched and needed to focus on the priority of securing PPE for frontline staff. Shared Services told us it was therefore not able to prioritise publishing contract award notices. Shared Services also told us that publication of contract award notices was delayed for some orders because of difficulties getting suppliers to register on Sell2Wales.

14 This was a Voluntary Ex-Ante Transparency Notice (VEAT), which is used to give advance notice of the intention to let a contract. However, the VEAT in this case was published after the contract was let.

2.32 There has been regular reporting and scrutiny of COVID-19 expenditure within Shared Services' governance framework. Shared Services published the Internal Audit report on its website as part of audit committee papers. However, in our view it could build public trust in the procurement process in Wales by making the details of its contracts for PPE easy to access. We think there is merit in maximum transparency and collating information that is not commercially confidential into a single place. It would be very difficult for the public or those interested to get an overview of PPE contracts from the Sell2Wales website without already having in-depth knowledge.

Ethical risks

2.33 All public bodies are expected to observe Welsh Government guidance on ethical supply chains in procurement. The guidance includes reference to ensuring that supply chains do not involve modern human slavery. No change was made to this guidance during the pandemic. The Welsh Government told us that the expectation remained, while recognising that the context of a pandemic may limit what was practically possible.

2.34 The WLGA's notes of the meetings with Welsh Government and Shared Services show that on multiple occasions, local government representatives raised concerns and queries about how to manage the risks of there being slavery and unethical employment practices in the manufacturing of PPE for Wales.

2.35 In our review of Shared Services documentation for PPE to the NHS, we saw no specific references to ethical employment practices in the consideration of risks. The Internal Audit review of Shared Services' financial governance arrangements (**paragraph 2.18**) considered ethical supply. It found that 'there were no issues/ concerns identified with the companies at the time of purchasing, but due to the urgency of the pandemic and the need to secure equipment; this was not a primary consideration when determining which supplier to use'.

The Welsh Government expects to spend over £300 million on PPE for health and social care in 2020-21

2.36 Normally, NHS Wales would expect to spend around £8 million a year on PPE. We do not have figures for social care as much of the spend would have been by private care homes. The arrangements for funding PPE expenditure, especially in social care, have changed during the pandemic (**Box 1**).

Box 1: arrangements for funding PPE

The Welsh Government currently funds the provision of COVID-related PPE required by national guidance for healthcare and social care settings. This commitment extends to all secondary care and primary care settings including GP surgeries, dentists, optometrists and pharmacies. NHS bodies continue to fund their 'business-as-usual' PPE requirements on the basis that these are broadly in line with previous expenditure.

Initially, Shared Services would only supply social care for staff working with suspected or confirmed cases of COVID-19. Local authorities could claim the additional costs of PPE back from the Welsh Government through the Hardship Fund, set up to support local government during the COVID-19 pandemic. Since mid-April 2020, Shared Services has increasingly been meeting the needs of social care (residential care and domiciliary care) in both the public and independent sectors. Shared Services agreed a service level agreement with the WLGA, which runs from September 2020 to August 2021.

2.37 Shared Services expects to spend an additional £286 million on PPE, primarily for health and social care, in 2020-21. Shared Services placed orders of PPE with 18 suppliers in 2019. During the period March 2020 to February 2021, Shared Services has bought PPE from 67 suppliers, of which 51 are new suppliers. The £286 million projected spend on PPE by Shared Services, which is funded by the Welsh Government, includes:

- £186 million for PPE distributed to health and social care bodies; and
- £99 million for PPE which is held in stock or expected for delivery by the end of March 2021.

2.38 At the end of January 2021, Shared Services was expecting to spend an additional £7.8 million on COVID-related operational expenditure in the 2020-21 financial year, with £5.6 million (72%) of this related to PPE. **Exhibit 12** shows that almost £3.2 million of the additional PPE-related spend is on staff costs, and £1.6 million is on transportation costs.

Exhibit 12: forecast additional PPE-related operational costs being incurred by Shared Services in 2020-21

	£ million
Staff costs	3.2
Transportation costs	1.6
Storage and security costs	0.6
Other PPE related costs	0.2
Total	**5.6**

Source: Shared Services

2.39 The Welsh Government agreed initially to fund local government expenditure on PPE as part of the wider Hardship Fund, set up to support local government through the pandemic. It is difficult to identify exactly how much PPE the Welsh Government has funded through this mechanism. The Welsh Government has provided data for Hardship Fund claims submitted up to October 2020.

2.40 Councils have received around £10 million for PPE claims although that may include some non-PPE items such as cleaning product, and around £0.5 million for associated costs such as transporting and storing PPE. The Welsh Government has also provided around £39 million[15] to cover the general increased costs of social care for providers, including the costs of PPE. The Welsh Government is unable to separate out the PPE elements of the general cost pressure expenditure.

2.41 Combining the Shared Services spending on PPE for health and care, operational costs and the funding for social care through the Hardship Fund takes the total funded by Welsh Government to over £300 million. We estimate that the Welsh Government has received around £880 million so far through the Barnett formula due to spending on PPE in England, although the Welsh Government is yet to confirm the final figure with HM Treasury.

2.42 In addition to the spend on PPE for Wales set out above, as of the end of January 2021 Shared Services had spent £37.5 million on PPE procured on behalf of other parts of the UK (**Exhibit 13**). Shared Services recoup the expenditure by invoicing the relevant administration.

15 This is in addition to other Hardship Fund support for social care, such as funding additional staff costs.

Exhibit 13: procurement of PPE on behalf of other UK nations for which expenditure is recouped, to the end of January 2021

	£ million
England	28.3
Scotland	4.8
Northern Ireland	4.4
Total	**37.5**

Note: this expenditure is separate from mutual aid that was provided on request to other UK nations to meet urgent requirements (**paragraph 1.29**).

Source: Shared Services

The cost of PPE items has been significantly higher than before the pandemic but has fallen since the first wave

2.43 Intense global competition for scare PPE resources drove up prices significantly, to a peak in April 2020. As the market adjusted, the prices paid by Shared Services fell over time. Procurement Services have shared an analysis of prices they paid for Type IIR masks, FFP3 respirators and nitrile gloves at the start of the pandemic and how they fell over time.

2.44 **Exhibit 14** shows how the unit cost of Type IIR masks, FFP3 respirators, nitrile gloves and fluid-resistant gowns rose sharply at the beginning of the pandemic before falling back to more normal levels towards the end of 2020. The largest increase was for gloves, which cost 800% of the average pre-pandemic price at the peak. Generally, across the period of the pandemic, Shared Services has procured higher volumes of PPE items at the lower prices. In the case of Type IIR masks, Shared Services' most recent contracts are for a cheaper unit price than before the pandemic.

Exhibit 14: examples of unit costs paid by Shared Services for Type IIR masks, FFP3 respirators, nitrile gloves and fluid-resistant gowns in November 2019 and during the pandemic in 2020

Type of PPE	Date	Unit price, £[1]	Volume purchased (for orders during the pandemic)[2]
Type IIR masks	Nov 2019	Range: 0.14 – 0.24 Average: 0.24	-
	Apr 2020	0.73	1,200,000
	Apr 2020	0.60	750,000
	Apr 2020	0.47	40,000,000
	Apr 2020	0.40	44,000,000
	May 2020	0.35	65,000,000
	June 2020	0.20	65,000,000
	Oct 2020	0.05	76,000,000
FFP3 respirators	Nov 2019	Range: 2.42 – 5.38 Average: 4.80	-
	Apr 2020	6.49	500,000
	June 2020	4.76	1,800,000
	Oct 2020	5.50	2,000,000
Nitrile gloves	Nov 2019	Range: 0.02 – 0.19 Average: 0.03	-
	Apr 2020	0.25	100,000,000
	Apr 2020	0.15	10,000,000
	May 2020	0.135	144,000,000
	Oct 2020	0.095	100,000,000
	Nov 2020	0.08	182,000,000

Type of PPE	Date	Unit price, £[1]	Volume purchased (for orders during the pandemic)[2]
Fluid-resistant gowns	Nov 2019	Range: 0.42 – 2.23 Average: 1.41	-
	Apr 2020	4.50	400,000
	May 2020	2.50	3,000,000

Notes:

1 Pre-pandemic prices are a weighted average of multiple different types of products which fall under the category. For example, there were 17 different lines under 'nitrile gloves' in November 2019. It is likely that the mix of products purchased during the pandemic differs from the position pre-pandemic.

2 The volume of items procured may not reconcile to the data on stocks and issues because some items were due to be delivered in batches, with some batches yet to be received. Also, for some orders, Shared Services was procuring additional items for other UK governments.

3 The unit prices and volumes of nitrile gloves are per individual glove.

Source: Shared Services

2.45 There has been significant media attention on the fees associated with intermediaries and agents involved in the procurement of PPE in England. We understand that where Shared Services engaged with agents, the agent's fee was absorbed into the unit price for the items, under an arrangement between the agent and the manufacturer. As such Shared Services does not know how much profit was made by the agent. In one case, the fees for the agents were capped at a specific percentage of the unit price. These fees covered overheads, administration, staffing costs, land transport, due diligence checks, in-country inspections, escrow account fees and profit.

There are some key decisions to make as part of the future procurement strategy for PPE, including on the involvement of domestic manufacturers

2.46 Shared Services' Winter Plan for PPE ran to the end of March 2021. There are some significant issues for the Welsh Government to consider for future procurement, including the size and nature of any future stockpile and the involvement of Welsh manufacturers. Shared Services is working with the Welsh Government to extend the key principles of the Winter PPE Plan (**paragraph 1.36**) into 2021-22. An interim position is being developed which is likely to reduce the 24-week target stock holding for most PPE items to reflect the reducing risk from the end of the EU transition period. A longer-term strategic plan will be developed during summer 2021.

2.47 Of the 67 suppliers that we referred to in **paragraph 2.37**, 13 were Welsh manufacturers and there were also several Welsh-based distributors involved in securing PPE. Other Welsh manufacturers have supplied local bodies with donations of PPE, for example of hand sanitiser and visors.

2.48 Welsh Government officials involved in the CERET worked closely with manufacturers to help them build capacity and get certification for some of the more complex PPE items. However, the time taken in preparations meant that the potential suppliers could not capitalise on relatively high prices in spring and summer 2020 when Shared Services was ramping up orders for its Winter Plan, and when the Welsh suppliers would have been reasonably price-competitive. In its report, the NAO highlighted the challenge of developing the domestic PPE market given the large amount of PPE stockpiled in England, which limits the potential size of the market for some items.

2.49 The Senedd Health, Social Care and Sport Committee's report encouraged the Welsh Government to consider the options for supporting local businesses that wish to continue making PPE. The Welsh Government is re-shaping its overall approach to procurement, with a view to having a greater focus on the local economic benefits and the foundational economy. In our view, the Welsh Government now needs to give a clear steer to public services and manufacturers as to its intentions for the domestic PPE market.

2.50 Under the normal approach to procurement, public services can compare the merits of different bidders using a range of criteria to demonstrate 'value' in the round. The more expensive option may offer additional benefits in terms of innovation or and wider policy goals, such as sustainable development in line with the Well-being of Future Generations (Wales) Act 2015. The issues highlighted in **paragraphs 2.33 to 2.35** around ethical supply chains are also relevant in this context.

2.51 There are also some decisions to make about the size and nature of the stockpile that will be held in case of a future pandemic. The current goal of a 24-week buffer is significantly larger than the stockpile previously held for a flu pandemic. Holding a stockpile involves costs in warehousing, staff to manage the stock and possible waste as some items may go past their useable date. If there is to be a significant stockpile, there will be questions to resolve about the timing of procurement and whether it can be built up when prices are back to normal rather than at a time of still high international demand.

Appendices

1 Audit approach and methods

2 Organisations and groups involved in the procurement and supply of PPE

3 Shared Services PPE stocks during the pandemic

1 Audit approach and methods

Audit approach

The scope of our work took in the procurement and supply of PPE for all public services. However, in practice, our primary focus was on the NHS and social care and the national procurement led by the Welsh Government and NHS Wales Shared Services Partnership (Shared Services). While recognising that there has been local procurement and distribution of PPE, this was not a significant focus of our work.

To inform our work, we reviewed evidence submitted to the Senedd Health, Social Care and Sport Committee in spring/summer 2020. The Committee covered PPE in its July 2020 report, Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales: Report 1.

We also reviewed two reports by the NAO that covered the procurement and supply of PPE in England.

- Investigation into government procurement during the COVID-19 pandemic, November 2020,
- The supply of personal protective equipment (PPE) during the COVID-19 pandemic, November 2020.

Building on these reports, the UK Parliament's Public Accounts Committee published its own report in February 2021, COVID-19: Government procurement and supply of Personal Protective Equipment.

We have explored similar issues in our work. We have discussed PPE procurement and supply with the NAO and with counterparts at Audit Scotland and the Northern Ireland Audit Office.

Audit methods

We used a range of methods:

- **Document review:** we reviewed pre-pandemic planning documents, strategic plans, papers considered by NHS boards and committees, guidance documents including on PPE use in different settings and on procurement, and relevant Internal Audit reports including:
    - in October 2020, the NHS Wales Audit and Assurance Services (part of Shared Services) reported on Shared Services' financial governance arrangements during the COVID-19 pandemic. The review covered COVID-19 related expenditure, including but not limited to PPE, between March and July 2020. Part 2 of our report covers some similar issues for PPE specifically.
    - in December 2020, the Welsh Government's Internal Audit Services reported on Welsh Government strategy and governance arrangements for PPE. The auditors recorded a 'reasonable assurance' rating, noting their view that the arrangements were operating effectively for oversight of PPE. The report recommended that officials conduct a 'lessons learned' exercise, collate a timeline of key events and make some minor administrative changes.
- **Semi-structured interviews:** we interviewed officials involved in the planning and procurement of PPE across Shared Services, the Welsh Government, and the Welsh Local Government Association.
- **Data analysis:** we reviewed available data on the distribution of PPE items in Wales, NHS Wales expenditure, the price of items of PPE and the levels of stock held and distributed. The more centralised approach to monitoring and reporting for the NHS means data on healthcare has been more readily available than data on social care.
- **Staff surveys:** we analysed survey data provided by bodies representing medical, and nursing staff (Royal College of Nursing and British Medical Association). As the participants were self-selecting, rather than a random sample, we cannot know how representative these experiences are of the whole NHS and social care workforce.
- **Procurement testing:** we reviewed a sample of 16 PPE-related contracts, checking for compliance against expected procedures and looking for broader consideration of risks to value for money. We selected a mix of larger value and smaller value contracts that were not part of the normal supply chain (**Exhibit 15**). Our sample covered 71% of the value of these contracts let at the end of November 2020, which included purchases on behalf of other UK countries.

- **Site visit:** in November 2020, we visited the warehouse where a significant proportion of the PPE buffer stock is held. We carried out a health and safety risk assessment in advance. Audit Wales and NHS Wales staff wore face coverings and maintained social distancing.
- **Wider engagement:** we wrote to organisations that supplied evidence related to PPE as part of the Senedd Health, Social Care and Sport Committee inquiry in spring/summer 2020. We invited them to share any new evidence or issues of concern. We wrote to 21 organisations and received 6 responses. In some cases, we followed up those responses through further dialogue.

Exhibit 15: details of contracts covered in our procurement sample testing

Sample number	PPE item procured	Anticipated contract value at end of November 2020
1	Type IIR masks	£23,400,000
2	Type IIR masks	£21,150,000
3	Nitrile gloves	£19,440,000
4	Type IIR masks	£18,000,000
5	Nitrile gloves	£14,497,960
6	Type IIR masks	£14,483,220
7	Type IIR masks	£12,432,205
8	FFP3 respirators	£11,143,934
9	FFP3 respirators	£9,500,000
10	FFP3 respirators	£12,100,000
11	Fluid-resistant gowns	£6,019,355
12	Fluid-resistant gowns	£1,720,000
13	Fluid-resistant gowns	£1,008,000
14	Type IIR masks	£890,000
15	Air freight charges	£655,000
16	Air freight charges	£248,259

2 Organisations and groups involved in the procurement and supply of PPE

Beyond the Welsh Government as a whole, we refer in this report to various organisations or groups involved in the national procurement and supply of PPE. **Exhibit 16** provides an overview but is not exhaustive. Other organisations or groups have had input at different times for specific purposes.

Exhibit 16: organisations and other key groups involved in the national procurement and supply of PPE for health and social care

Organisation	Description
NHS Wales Shared Services Partnership (Shared Services)	Shared Services provides professional, technical and administrative services on behalf of other NHS bodies, which include procurement services and the Surgical Materials Testing Laboratory. The Shared Services Partnership Committee sets the Shared Services policy for NHS Wales, monitors the performance and supports the strategic development of Shared Services and its services.
Public Health Wales	Public Health Wales NHS Trust aims to protect and improve health and well-being and reduce health inequalities. It has worked alongside the public health agencies of the other UK nations to develop and issue infection prevention and control guidance, which includes the use of PPE.
Velindre University NHS Trust	Shared Services is hosted by Velindre University NHS Trust via a formal agreement, signed by each statutory organisation in NHS Wales. As a hosted organisation, Shared Services operates under the legal framework of Velindre University NHS Trust.
Finance Governance Group (FGG)	Shared Services set up the FGG to scrutinise and manage risks related to COVID-19 procurement. The FGG involves different parts of Shared Services along with members of the Velindre University NHS Trust Board. Shared Services representatives are from procurement, audit and assurance, finance and corporate services, legal and risk services and counter fraud.

Organisation	Description
Surgical Materials Testing Laboratory (SMTL)	The Surgical Materials Testing Laboratory is part of Shared Services and provides testing and technical services in support of NHS Wales procurement.
Life Sciences Hub Wales (LSHW)	An organisation formed in 2014 that brings together members in the Life Sciences sector to collaborate on solutions. A framework document between the Welsh Government and LSHW sets out the governance and accountability arrangements, and LSHW receive an annual remit from the Welsh Government.
National Procurement Service (NPS)	Part of the Welsh Government, promoting Welsh public sector procurement collaboration and managing a number of collaborative procurement frameworks for a range of goods and services.
Critical Equipment Requirement Engineering Team (CERET)	Established by the Welsh Government in March 2020, bringing together colleagues from across Welsh Government, the NHS, SMTL, LSHW and Industry Wales to support the procurement of PPE for healthcare settings.
Welsh Local Government Association (WLGA)	The WLGA coordinated social care responses and procurement between the 22 local authorities and liaised with Shared Services, the National Procurement Service and the wider Welsh Government.

3 Shared Services PPE stocks during the pandemic

Exhibit 17: volume and number of weeks of items held in stock at 7 February 2021, highest and lowest points

PPE item		Weeks of stock at 7 February 2021	Highest number of weeks	Lowest number of weeks
Aprons	Weeks	37.8	47.8	2.4
	Date		30 Nov 2020	5 May 2020
Body bags	Weeks	384.8	5,733.8	2.2
	Date		30 Jul 2020	14 Apr 2020
Eye protector	Weeks	601.9	205.557.3	0.1
	Date		9 Jul 2020	11 May 2020
Face visor	Weeks	19.3	55.6	0.1
	Date		7 Sept 2020	8 Apr 2020
FFP2 respirator	Weeks	97.0	1,496.6	12.3
	Date		12 May 2020	27 Jul 2020
FFP3 respirator	Weeks	9.3	32.9	1.4
	Date		9 Nov 2020	2 Apr 2020
Fit test kits & spares	Weeks	667.6	2,729.4	0.2
	Date		4 Jan 2021	6 Apr 2020
Gloves	Weeks	3.7	7.6	1.3
	Date		7 Sept 2020	7 Dec 2020
Gloves (cuffed)	Weeks	26.8	71.5	0.8
	Date		18 Jan 2021	7 Apr 2020
Gowns (fluid-resistant)	Weeks	116.3	145.9	0.2
	Date		17 Aug 2020	25 Apr 2020

PPE item		Weeks of stock at 7 February 2021	Highest number of weeks	Lowest number of weeks
Gowns (other)	Weeks	3.3	44.8	0.6
	Date		22 Jun 2020	26 Apr 2020
Hand sanitiser	Weeks	79.1	127.1	1.6
	Date		18 Jan 2021	15 Apr 2020
Hand wipes	Weeks	11.4	83.2	5.7
	Date		4 Jan 2021	31 Aug 2020
Type I & type II masks	Weeks	85.3	147.2	0.3
	Date		30 Nov 2020	7 Apr 2020
Type IIR masks	Weeks	50.5	116.0	0.2
	Date		18 Jan 2021	7 Apr 2020
Respirator hoods	Weeks	Analysis not possible due to limited issuing		
	Date			
Respirator filters	Weeks	Analysis not possible due to limited issuing		
	Date			

Note: one unit of gloves are reported as pack, which vary in size, and hand sanitiser as a bottle, varying in volume.

Source: Audit Wales analysis of Shared Services data

Exhibit 18: total units of PPE issued up to 7 February 2021

PPE Item	Units
Aprons	113,770,625
Body bags	11,316
Eye protector	1,627,000
Face visor	5,167,736
FFP2 respirator	126,036
FFP3 respirator	2,823,373
Fit test kits and spares	5,965
Gloves	337,469,340
Gloves (cuffed)	1,306,900
Gowns (fluid-resistant)	2,000,584
Gowns (other)	643,990
Hand sanitiser	391,514
Hand wipes	20,135,400
Type I & type II masks	1,174,150
Type IIR masks	143,238,551
Respirator hoods	102
Respirator filters	22,176
Total	**629,914,758**

Note: one unit of gloves are reported as pack, which vary in size, and hand sanitiser as a bottle, varying in volume.

Source: Welsh Government, Weekly Personal Protective Equipment issues: up to 7 February 2021, released 11 February 2021

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Mr Adrian Crompton
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8 June 2021

Dear Adrian

Procuring and Supplying PPE for the Covid-19 Pandemic

The Welsh Government (WG) and NHS Wales Shared Service Partnership (NWSSP) welcome the findings of the Audit Wales report on *Procuring and Supplying PPE for the Covid-19 Pandemic* and offer the following joint response to the recommendations. A table summarising the action plan and delivery progress is included at Annex A.

Recommendation 1 *– As part of a wider lessons learnt approach, the Welsh Government should work with other UK countries where possible to update plans for a pandemic stockpile to ensure that it is sufficiently flexible to meet the demands of a pandemic from different types of viruses.*

WG accept Recommendation 1 and agree the importance of continuing to work with other UK countries to update our plans for an appropriate and flexible pandemic stockpile. WG has recently attended the first meeting of the UK Review of Emergency Preparedness Advisory Board, chaired by Department for Health and Social Care. The remit of the group includes a PPE workstream which will provide advice on the types of PPE required for each case setting for infectious disease risk and will support procurement planning and Covid-19 PPE management. The workstream is dependent on epidemiological advice on likely pathogens and scenarios but is intended to be initiated early in 2021/22. WG will draw on the advice of this group along with the expertise within WG and NHS Wales Shared Services Partnership (NWSSP) to update pandemic preparedness plans, including on PPE. Whilst dependent on UK wide activity we expect to have updated our plans by December 2021.

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In the interim, WG have advised NWSSP to continue to hold a stockpile of key PPE items and maintain a minimum stockpile holding of 24 weeks until 1st July 2021 and a 16 week minimum thereafter. The reduction from 24 weeks to 16 weeks reflects the reducing need to hold contingency for the end of the EU transition period (previously 8 weeks contingency). The 16 weeks stockpile includes contingency for BAU PPE requirements (4 weeks), Covid-19 requirements (8 weeks) and pandemic preparedness stock (4 weeks).

Recommendation 2 - *In updating its own plans for responding to a future pandemic, the Welsh Government should collaborate with other public bodies to articulate a set of pan-public sector governance arrangements for planning, procuring and supplying PPE so that these do not need to be developed from scratch.*

WG accept Recommendation 2 and will work with other public bodies to develop a clear framework for PPE governance arrangements based on the best practice and lessons learned during the Covid-19 pandemic.

As reflected in the AGW's report, working collaboratively with stakeholders has been at the heart of the WG and NWSSP's response on PPE procurement and supply. Best practice and lessons learnt on PPE have been collated throughout the pandemic and these included a recognition that, in some cases, governance and finance frameworks were designed as the pandemic progressed resulting in some duplication of effort. To address this WG will:

1) Review all the governance arrangements on PPE.
2) Ensure the decision-making and controls framework for PPE are agreed in advance as part of contingency planning.
3) The ToR will ensure there is clarity on accountability between governance groups and teams.
4) These arrangements will be kept under review, for example to ensure alignment with the broader Four Nations and Emergency Preparedness approach.

WG anticipate completing this work by 30th September 2021.

Recommendation 3 *- Shared Services should work with NHS and social care bodies to maintain an up-to date stock management information system that provides timely data on local and national stocks of PPE that can be quickly drawn upon in a future pandemic to support projections of demand and availability as well as providing a robust source of information for briefing stakeholders.*

NWSSP accept recommendation 3. Lesson learnt activity has already identified that two-way data and information sharing between policy, planners and frontline teams has been critical in ensuring procurement is aligned with demand and that there is confidence in the system. NWSSP will:

1) Continue to invest in and embed the Stockwatch system and roll-out to Social Care where possible.
2) Maintain the accuracy and timeliness of stock information within the NHS Oracle Finance & Procurement System.
3) Maintain the PPE supply and demand model so that this can be used again in future if need arises.
4) Enhance integrity of the NHS Oracle stock information through proposed rollout of Scan4Safety in health organisations.

NWSSP consider elements 1 to 3 above to represent on-going activity and element 4 is subject to the approval of the Scan4Safety business case.

Recommendation 4 *- In updating the strategic approach to PPE, Shared Services and the Welsh Government should work together to develop a clear direction in terms of:*

- *A return to competitive procurement and an end to emergency exemptions.*
- *Fuller consideration of the wider criteria usually applied to procurement, such as sustainable development and policies on modern slavery.*
- *The intentions and aspirations in relation to the domestic PPE market, including the balance between the potential benefits of resilience through local production capacity against the potentially increased costs compared to international manufacturers.*
- *The size and nature of the pandemic stockpile it intends to hold, considering the benefits and costs of holding and maintaining stock and the timing of purchases given the ongoing disruptions to the PPE market.*

NWSSP and WG accept Recommendation 4 and have started work to develop a longer-term, strategic approach to PPE procurement and supply. NWSSP will:

1) Develop a plan that provides a strategic approach to the procurement of PPE.
2) Go out to tender for a compliant framework contract for the future competitive procurement of PPE.
3) Ensure that the new framework covers supply chain resilience, foundation economy, modern slavery, the Wellbeing of Future Generations Act and Decarbonisation.
4) Build on the work already undertaken by CERET to review the respective merits of local production against international purchases.
5) Ensure that the longer-term plan for PPE analysis the optimum stock holdings and timings of purchases.

NWSSP anticipate completing these actions by 30th September 2021.

Recommendation 5 *- To increase confidence in stocks and supplies at the national level, Shared Services should work with the Welsh Government to publish details of the amount of stock it holds of each item alongside the regular publication of data on the numbers of items issued.*

WG accept that ensuring confidence in PPE stocks and supplies is a critical part of ensuring confidence in the Government's pandemic response and **accept Recommendation 5.**

WG currently publish a fortnightly statistical release on PPE items issued based on management information provide to the Welsh Government by NWSSP.

WG will work with NWSSP to consider what further management information can be provided on National stock levels to provide greater transparency. The information provided will show how WG and NWSSP are performing against the commitment to hold a minimum stockpile on PPE and will need to take into consideration the fluid nature of PPE supply and demand. It is also important to note that the information will be based on the National stock levels of PPE held by NWSSP and will not take into consideration the often large volumes of PPE items held locally by Health Boards and Local Government.

WG anticipate completing these actions by 30th September 2021

Recommendation 6 *- Shared Services should: check that it has published contract award notices for all contracts where it is required to do so; review those that it has published to ensure they are accurate; and ensure that it publishes contract award notices within the required timeframe for future contracts.*

NWSSP accept Recommendation 6 and have already completed reviewing existing contract awards and have taken corrective action where necessary to ensure contracts have been published as appropriate.

In addition NWSSP are reviewing and refreshing their internal operating procedures to ensure compliance with the requirements to publish notices for future contracts. NWSSP anticipate completing this work by 31st May 2021.

Recommendation 7 *- The Welsh Government should review whether the Sell2Wales site needs updating to allow bodies to publish retrospective contract award notices more efficiently without relying on suppliers to sign-up.*

WG accept Recommendation 7 to review whether the Sell2Wales site needs updating to allow bodies to publish retrospective contract award notices more efficiently without relying on suppliers to sign-up. WG anticipate completing the review by 30th June 2021.

Recommendation 8 *Given public interest in the awarding of PPE contracts and to promote confidence in the procurement system, the Welsh Government and Shared Services should publish details of the contracts awarded under emergency exemptions in a single place that is easy to access*

NWSSP and WG accept Recommendation 8 to publish a one-off list of the contracts awarded under emergency exceptions, the information will be held on NWSSP's website and will be completed by 30th June 2021. Future purchases will be managed through the new framework agreement.

I hope this information is helpful. Should further information be needed please contact Lisa Wise, lisa.wise@gov.wales.

Yours sincerely

Dr Andrew Goodall CBE

Annex A - Summary of Actions and Progress

Recommendation	Who?	Agreed Action	Date for Completion	Progress
R1 As part of a wider lessons learnt approach, the Welsh Government should work with other UK countries where possible to update plans for a pandemic stockpile to ensure that it is sufficiently flexible to meet the demands of a pandemic from different types of viruses.	WG	The Welsh Government accept Recommendation 1 and agree the importance of continuing to work with other UK countries to update plans for an appropriate and flexible pandemic stockpile. 1. WG will ensure appropriate representation on the DHSC led UK Review of Emergency Preparedness Advisory Board and PPE workstream. Please note the PPE workstream is dependent on epidemiological advice on likely pathogens and scenarios but DHSC have advised it is intended to be initiated early in 2021/22 to consider overlaps with Covid-19 and pandemic influenza PPE. 2. WG will draw on the advice of these groups along with the expertise within WG and NHS Wales Shared Services Partnership (NWSSP) to update pandemic preparedness plans, including on PPE.	We anticipate completing work against this action by 31st December 2021 although this is dependent on UK Government progress.	1. WG representatives recently attended the first meeting of the UK Review of Emergency Preparedness Advisory Board (chaired by DHSC). The PPE workstream has yet to be established. 2. WG have advised NWSSP to continue to hold a stockpile of key PPE items and maintain a minimum stockpile holding of 24 weeks until 1st July 2021 and a 16 week minimum thereafter. The reduction from 24 weeks to 16 weeks reflects the reducing need to hold contingency for the end of the EU transition period (8 weeks contingency). The 16 weeks stockpile includes contingency for BAU PPE requirements (4 weeks), Covid-19 requirements (8 weeks) and pandemic preparedness stock (4 weeks).
R2 In updating its own plans for responding to a future pandemic, the Welsh	WG	The Welsh Government accept Recommendation 2 and will work with other public bodies to develop	We anticipate completing this work by	1. Best practice and lessons learnt on PPE have been collated and shared with the

Recommendation	Who?	Agreed Action	Date for Completion	Progress
Government should collaborate with other public bodies to articulate a set of pan-public sector governance arrangements for planning, procuring and supplying PPE so that these do not need to be developed from scratch.		a clear framework for PPE governance arrangements based on the best practice and lessons learned during the Covid-19 pandemic. WG will: 5) Review all the governance arrangements on PPE. 6) Ensure the decision-making and controls framework for PPE are agreed in advance as part of contingency planning. 7) Ensure the ToR provide a clear RACI between governance groups and teams. 8) These arrangements will be kept under review, for example to ensure alignment with the broader 4N approach.	[30th September 2021].	PPE Procurement and Supply Group – these include a recognition that governance and finance frameworks were designed as the pandemic progressed resulting in some duplication of effort across groups. 2. WG have collated ToR for all PPE-related governance groups that were stood up during the Covid-19 pandemic.
R3 Shared Services should work with NHS and social care bodies to maintain an up-to date stock management information system that provides timely data on local and national stocks of PPE that can be quickly drawn upon in a future pandemic to support projections of demand and availability as well as providing a robust source of information for briefing stakeholders.	NWSSP/ WG	NWSSP and WG accept this recommendation and lesson learnt activity has already identified that two-way data and information sharing between policy, planners and frontline team has been critical in ensuring procurement meets demand and that there is confidence in the system. 1. Continue to invest in and embed the Stockwatch system and roll-out to Social Care where possible.	On-going.	1. NWSSP have purchased and embedded the Stockwatch system across Covid stores in the NHS and Social Care. 2. As we return to BAU NWSSP stock information is captured within Oracle Inventory plus the additional rollout of Scan 4 Safety will capture stockholdings within the health organisations. 3. As above. 4. The Deloitte demand model will be maintained for future

Recommendation	Who?	Agreed Action	Date for Completion	Progress
		2. Ensure accuracy and timeliness of stock information within Oracle. 3. Enhance integrity of Oracle stock information through rollout of Scan4Safety. 4. Maintain Deloitte demand model so that this can be used again in future if need arises.		use if required.
R4 In updating the strategic approach to PPE, Shared Services and the Welsh Government should work together to develop a clear direction in terms of: • a return to competitive procurement and an end to emergency exemptions. • fuller consideration of the wider criteria usually applied to procurement, such as sustainable development and policies on modern slavery. • the intentions and aspirations in relation to the domestic PPE market, including the balance between the potential benefits of resilience through local production capacity against the potentially increased costs compared to international manufacturers. • the size and nature of the	NWSSP	1. Develop a plan that provides a strategic approach to the procurement of PPE. 2. Go out to tender for a compliant framework contract for the future competitive procurement of PPE. 3. Ensure that the new framework covers supply chain resilience, foundation economy, modern slavery, the Wellbeing of Future Generations Act and decarbonisation. 4. Build on the work already undertaken by CERET and prospective ESNR PPE pilots to review the respective merits of local production against more economic international purchases. 5. Ensure that the longer-term plan for PPE analyses the optimum stock holdings and timings of purchases.	1. 31/08/2021 2. 01/07/2021 3. 01/07/2021 4. 30/09/2021 5. 31/08/2021	1. An interim plan is in place but a longer-term strategy is being developed with a planned implementation date of 1 September 2021. 2. Fully compliant framework contract for future competitive procurement currently out to tender and will be in place by 1st July 2021 3. The new framework contract fully considers the points raised including supply chain resilience, foundation economy, modern slavery, wellbeing of future generations act and decarbonisation. 4. Work is on-going to further develop the work already undertaken by CERET and any ESNR PPE Pilot. 5. The plan will include this analysis with WG providing

Recommendation	Who?	Agreed Action	Date for Completion	Progress
pandemic stockpile it intends to hold, considering the benefits and costs of holding and maintaining stock and the timing of purchases given the ongoing disruptions to the PPE market.				policy steer and NWSSP providing expertise on improving resilience.
R5 To increase confidence in stocks and supplies at the national level, Shared Services should work with the Welsh Government to publish details of the amount of stock it holds of each item alongside the regular publication of data on the numbers of items issued.	WG/ NWSSP	WG accept that ensuring confidence in PPE stocks and supplies is a critical part of ensuring confidence in the Government's pandemic response and accept Recommendation 5. WG currently publish a fortnightly statistical release on PPE items issued based on management information provide to the Welsh Government by NWSSP. In addition: 1. WG will consider what further management information can be provided on National stock levels to provide even greater transparency. 2. The information provided will show how WG and NWSSP are performing against the commitment to hold a minimum stockpile on PPE and will need to take into consideration the fluid nature of PPE supply and	30/09/2021	1. Initial view is to provide a RAG rating rather than detailed stock levels based on issues during the 16 highest weeks in the pandemic. NWSSP will provide this data weekly to WG subject to agreement with WG around parameters. 2. An initial draft of the data table is being shared with the PPE Procurement and Supply Group for comment 19 May 2021.

Recommendation	Who?	Agreed Action	Date for Completion	Progress
		demand. It is also important to note that the information will be based on the National stock levels of PPE held by NWSSP and will not take into consideration the often large volumes of PPE items held locally by Health Boards and Local Government. 3. WG will liaise with NWSSP on provision of data on weekly basis.		
R6 Shared Services should: check that it has published contract award notices for all contracts where it is required to do so; review those that it has published to ensure they are accurate; and ensure that it publishes contract award notices within the required timeframe for future contracts.	NWSSP	1. Review existing contract awards and take corrective action where necessary in terms of publication. 2. Review and refresh internal operating procedures to ensure compliance with the requirements to publish notices for future contracts.	1.Complete 2.31/05/2021	1. NWSSP have undertaken checks and corrective action has been taken for contracts awarded. 2. Review of internal operating procedures is underway to ensure that any future contract awards are compliant with publishing requirements.
R7 The Welsh Government should review whether the Sell2Wales site needs updating to allow bodies to publish retrospective contract award notices more efficiently without relying on suppliers to sign-up.	WG	WG accept the recommendation to review the Sell2Wales site to publish retrospective contract award notices without relying on suppliers to sign-up.	30/06/2021	1. Initial conversations have been held with the WG Sell2Wales team who have set out that there are a number of reasons why it isn't possible or desirable to implement the recommendation:

Recommendation	Who?	Agreed Action	Date for Completion	Progress
				• There are numerous fields which need adding in order to complete the contract award notice in line with FTS schema requirements (individual name, business name, address, contact details etc) and by allowing a buyer to add these manually introduces data quality issues and it's also an onerous task for the buyer. • Risk regarding GDPR consent, as the manual approach would not record PN consent on Sell2Wales for audit purposes and provides an issue in relation to future challenge. • Diminished Sell2Wales reporting, S2W would be unable to properly report on Suppliers being awarded contracts as this is driven by the full supplier registration profile. • It sets a precedence and could impact on the number of suppliers

Recommendation	Who?	Agreed Action	Date for Completion	Progress
				registered which is a key selling point to encouraging buying org's to utilise Sell2Wales. 3. The Sell2Wales team have suggested that an alternative approach could involve the buyer (NWSSP) inviting the supplier to register through the Sell2Wales site. Once the supplier has registered the buyer can make the award at a later date. This functionality already exists in Sell2Wales but requires administrative effort from both the buyer and supplier. 4. Sell2Wales has also suggested that the Sell2Wales site could publish the listing created by NWSSP under recommendation 8.
R8 Given public interest in the awarding of PPE contracts and to promote confidence in the procurement system, the Welsh Government and Shared Services should publish details of the contracts awarded under emergency exemptions in a single place that is easy to access.	NWSSP	Ensure that all current and future PPE contract awards are appropriately publicised.	30/06/2021	1. For already awarded PPE contracts a full listing will be provided on NWSSP's website. 2. Future purchases will be managed through the new framework agreement.

Agenda Item 6

Document is Restricted

Archwilio Cymru
Audit Wales

Welsh Health Specialised Services Committee Governance Arrangements

Report of the Auditor General for Wales

May 2021

This report has been prepared for presentation to the Senedd under the Public Audit (Wales) Act 2004 and the Government of Wales Act 1998

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within **A Healthier Wales**.

Summary report

Main report

Summary report

Background

1 The Welsh Health Specialised Services Committee (WHSSC) is a joint committee of each local health board in Wales, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The remit of the Joint Committee is to enable the seven health boards in Wales to make collective decisions on the review, planning, procurement, and performance monitoring of agreed specialised and tertiary services.

2 The Joint Committee is hosted by Cwm Taf Morgannwg University Health Board and is responsible for the joint planning and commissioning of specialised services on behalf of local health boards in Wales. WHSSC is made up of, and funded by, the seven local health boards with an overall annual budget of £680 million with the financial contributions determined by population need. Some health boards in Wales provide specialised services. In particular, Cardiff and Vale and Swansea Bay University Health Boards receive significant funding for the services that they provide.

3 On a day-to-day basis, the Joint Committee delegates operational responsibility for commissioning to Welsh Health Specialised Services (WHSS) Officers, through the management team (**Exhibit 1**) and supported by six multidisciplinary commissioning teams. These teams commission specialised services, including:

- Cancer and Blood
- Cardiac
- Mental Health and Vulnerable Groups
- Neurosciences and long-term conditions
- Renal
- Women's and children's

Exhibit 1: WHSS management structure

Source: Welsh Health Specialised Services Standing Orders

4 In 2015, two separate reviews highlighted issues with WHSSC's governance arrangements. The Good Governance Institute highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. In the same year, Healthcare Inspectorate Wales (HIW) conducted a review of clinical governance at WHSSC. That review found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

5 Time has now passed since these reviews. Considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in A Healthier Wales, the Auditor General felt it was timely to review WHSSC's governance arrangements. This report considers the extent to which there are effective governance arrangements and whether the planning approach effectively supports the commissioning of specialised services for the population of Wales. Given the impact of COVID-19 on the capacity and productivity of services, we have also highlighted some specific challenges which relate to recovery.

6 Much of our review was carried out between March and June 2020, but as a result of the pandemic, we paused aspects of the review, restarting in July with a survey to all health boards and concluding the fieldwork in October. The delivery of our work included interviews with WHSS officers and WHSSC independent members, observations of Joint Committee and sub-committee meetings, questionnaires of health board chief executives and chairs and a review of documentation.

Key findings

7 Overall, we found **since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within A Healthier Wales**.

Governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19

8 Our work has found improvements in the overall governance arrangements in WHSSC since 2015. WHSSC is formed of a mix of independent members, health board chief executives, and WHSS officers who work in collaboration to lead specialised services commissioning on behalf of the population of Wales. There are benefits to this system of governance which provides partners with the opportunity to collaborate on service developments. In general, we found that the Joint Committee operates well and there is normally a healthy working relationship between Joint Committee members. There are, however, occasions when this has become more challenging, such as discussions around new service models for major trauma and thoracic surgery. This tends to occur when new services are commissioned from providers who are Joint Committee members. This can present a risk of conflict of interest but the negative impact of this has been reduced through the introduction of a new majority voting system. These conflict-of-interest issues will remain a live risk, particularly when considering post-pandemic service recovery.

9 The agenda of the Joint Committee meetings appears appropriate and proportionate. However, our observations highlighted opportunities to increase the attention given to finance, performance, and quality reporting at Joint Committee. We also identified a need to review the independent member recruitment arrangements and the level of remuneration that they receive to help deal with the challenges of independent member turnover.

10 The Joint Committee's sub-committees and groups are well-chaired and administered, although there is a need to strengthen the Integrated Governance Committee to ensure it discharges its terms of reference. WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities, and Communications. WHSSC also forms part of the governance and accountability framework of the Health Board via the Audit and Risk Committee and requirement for financial disclosure in annual reports and accounts. Work is ongoing to strengthen the role and function of the Health Board's Audit and Risk Committee in respect of its hosted statutory joint committees.

11 WHSSC has developed good risk management processes using a corporate risk assurance framework. The risks are regularly scrutinised at corporate and Joint Committee levels with a specific arrangement to capture COVID-19 risks since the onset of the pandemic. Likewise, performance management arrangements provide a good foundation, adopting a tiered model for service escalation and appropriate operational monitoring. WHSSC has adapted these arrangements as a result of the pandemic but may need to become more robust in future to ensure specialised services minimise the risk of harm as a result of delays in treatment.

12 After an initially slow response, WHSSC has responded to the recommendations made in 2015 relating to the need to strengthen quality assurance arrangements. In 2019, WHSSC established a Quality Assurance Team, which is embedding well and is now taking steps to update its quality assurance framework.

Planning arrangements provide a good foundation but there is a need for a clear strategy to respond to the challenges presented by COVID-19

13 Annual planning arrangements are generally effective. Year on year, development and approval of the Integrated Commissioning Plan has become timelier and there are clear formal arrangements for the identification and prioritisation of emerging specialised care services and treatments. Welsh Government officials told us of the additional capacity and capability they received from WHSSC planning officers to help drive through review of health board and trust quarterly plans during the first wave of the pandemic. This provides a good indication of the expertise within the team. Information to support planning and commissioning is improving and this is supported by a performance information system which continues to develop. Delivery of existing commissioned service plans is well managed, but elapsed time for the introduction of new services such as new service models for major trauma and thoracic surgery in South Wales has been slow. This is not within the sole remit of WHSSC but indicates the need for wider 'end to end' programme management at regional levels.

14 Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan. COVID-19 has significantly reduced access to some specialised services, and recovery will have some significant financial consequences. There is a need to understand the financial consequences resulting from the pandemic in terms of service recovery. Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs to become more ambitious and more strongly linked to patient outcomes, prioritisation, and decommissioning (where there isn't good evidence that services/interventions are leading to improved outcomes).

15 COVID-19 has delayed specialised services strategy development and will no doubt continue to impact on the timeline for the development of the strategy. Specialised service officers can start to shape a strategy that focusses on the impacts of COVID-19 alongside advances in technological, therapeutic and policy developments. Strategy renewal is more crucial than ever and will need to be shaped around the changing risks and opportunities for specialised services taking consideration of the issues and opportunities identified in this report.

Future arrangements for commissioning specialised services

16 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales, signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability. Whilst the governance arrangements for WHSSC have continued to evolve positively in the main, there would still be benefits in the Welsh Government including WHSSC in the planned review of national hosted functions. In looking at potential future governance and accountability arrangements for specialised services, it should be recognised that the current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that see individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

> The Welsh Health Specialised Services Committee (WHSSC) commissions around £680 million of specialised services on behalf of the population of Wales and is a vital component of the Welsh healthcare system. Given this level of responsibility and investment, I'm encouraged by the progress WHSCC has made to improve its governance, management, and planning arrangements over recent years.
>
> An immediate challenge for WHSSC is to develop a clear strategy to address the challenges associated with recovering specialised services following the Covid-19 pandemic. My report also shows that there is still a need to take a more fundamental look at the model for commissioning specialised services, in line with the commitment set out in the Welsh Government's NHS Plan 'A Healthier Wales'. It is important that this commitment is taken forward and I hope that the findings set out in this report can helpfully inform that debate.
>
> **Adrian Crompton**
> Auditor General for Wales

4 Recommendations

17 Recommendations arising from this audit are detailed in **Exhibits 2 and 3**.

Exhibit 2: recommendations for the Welsh Health Specialised Services Committee

Recommendations

Quality governance and management

R1 **Increase the focus on quality at the Joint Committee.** This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.

Programme management

R2 **Implement clear programme management arrangements for the introduction of new commissioned services.** This should include clear and explicit milestones which are set from concept through to completion (ie early in the development through to post-implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the joint committee.

Recommendations

Recovery planning

R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on:

a the backlog of waits for specialised services, how these will be managed whilst reducing patient harm.

b potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening.

c the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.

Recommendations

Specialised services strategy

R4 The current specialised services strategy was approved in 2012. WHSSC should **develop and approve a new strategy during 2021**. This should:

a embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post-pandemic recovery.

b be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services:

- which do not demonstrate clinical efficacy or patient outcome (stop);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer);
- where alternative interventions provide better outcome for the investment (change);
- currently commissioned, which should continue (continue).

Exhibit 3: Recommendations for the Welsh Government

Recommendations

Independent member recruitment

R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role.

Sub-regional and regional programme management

R6 This is linked to **Recommendation 2** made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi-partner programme management arrangements are in place from concept through to completion (ie early in the development through to post-implementation benefits analysis).

Future governance and accountability arrangements for specialised services

R7 **A Healthier Wales** included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.

Main report

Governance and assurance

18 Our review has examined WHSSC's governance and assurance arrangements, such as the way the Joint Committee and its sub-committees conduct business, systems for managing performance and risk, and arrangements to ensure probity and propriety. We found that **governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19**.

Conducting business effectively

19 We looked at the clarity of governance structures, decision-making arrangements and conduct at the Joint Committee and its sub-committees. We found that **committee arrangements have improved, although challenges around conflicts of interest remain and there is a need for stronger focus on quality, finance, and performance at Joint Committee meetings**.

The Joint Committee is well administered with a healthy relationship between members. However, there is scope for greater scrutiny of service quality and routine finance and performance reports, and an opportunity to look afresh at independent member recruitment arrangements

20 The Joint Committee is made up of 15 voting members and three associate members. The voting members include the chief executives of the seven health boards, four independent members (three of whom are drawn from health boards), including the Chair (a Ministerial appointment) and Vice Chair, and four WHSS officers. In October 2020, a new Chair was appointed, taking over from the Interim Chair who had been in post for a little over three years. WHSSC is expecting turnover of independent members in the coming months which will present both capacity and recruitment challenges. It was reported that recruiting independent members is difficult, especially since the pool from which they can be recruited is limited to health boards only. Consideration should be given to widening the recruitment pool to include all NHS Wales organisations, not just health boards. In addition, there is no additional remuneration for independent members of WHSSC, which makes the position less attractive. Thought, therefore, should be given to whether the current remuneration arrangements reflect the commitment expected of independent members of WHSSC.

21 We observed the Joint Committee both before and during the pandemic. Meetings were well attended and the relationship between members was respectful with a healthy level of challenge. Due to the pandemic, WHSSC moved to holding virtual meetings from March 2020. At this time, the Joint Committee's agenda had a COVID-19 focus with updates on commissioning independent hospitals, which the WHSS team was responsible for, risk management and delivering specialised services during the pandemic. WHSS officers fed back that the revised arrangements improved meeting efficiency and engagement and created better approaches for responding to questions. Moving forward, we would encourage WHSSC to review and consider the advantages of retaining these arrangements.

22 Those we interviewed were positive about the Joint Committee, indicating that it had matured in the past one to two years. Generally, it was felt the Joint Committee works effectively, is open and transparent, that chief executives are supportive of each other, and that roles and responsibilities are clear. Our observations at Joint Committee indicated a tendency to focus on new service modelling which resulted in a south Wales focus in meetings. We also saw limited discussion about the performance of commissioned services. Despite good systems for quality assurance at an operational level within WHSSC, there is a lack of sufficient oversight at Joint Committee. These need to be strengthened as part of a focus on service recovery.

Decision making arrangements have improved, but conflicts of interest remain a risk

23 WHSSC commissions specialised health services for Wales as a whole. Whilst membership of the Joint Committee is drawn from existing health boards, the members are supposed to be independent. However, decision-making for some members poses a potential conflict of interest. This is because the larger Welsh health boards are substantial providers of specialised services, especially in south Wales. Those we spoke to reported that there can be some tensions around negotiations, citing the major trauma centre and thoracic surgery, and potential to draw attention on these specific issues at committee meetings at the expense of wider aspects of the agenda.

24 As a result of previous challenges in decision making, WHSSC's voting arrangements changed from 100% agreement required to a two-thirds majority vote in accordance with a Ministerial direction dated 12 November 2018. This was subsequently reflected in an amendment to WHSSC's standing orders. The new voting system is more pragmatic and ensures quicker decision-making, but this was introduced relatively recently, so WHSSC should keep this new arrangement under review. The governance arrangements mean that chief executives and independent members take part in votes on commissioning services from their own health board. As a result, the previous interim Chair of WHSSC reinforced the need to act on behalf of the all-Wales position when making decisions. Moving forward, the difficulties presented by the pandemic are likely to be challenging. When acting on behalf of 'all-Wales' and to minimise patient harm as a result of delays in receiving specialised care, shifts in investment may be necessary. This again may increase the risk of conflicts of interest if chief executive members are required to vote on diverting investments from their own health boards.

Flows of assurance between the Joint Committee and individual health boards are variable

25 As the Joint Committee commissions specialised services on behalf of the seven health boards, we would expect to see clear lines of assurance from the Joint Committee to individual Boards. On reviewing health board papers[1] we found that as a minimum all seven health boards had approved their own standing orders, which set out their responsibilities regarding WHSSC, and WHSSC's standing orders. All health boards report WHSSC's assurance reports and minutes of the Joint Committee meetings (or provide a link to the minutes).

26 However, health board minutes show some variability in the extent of discussions of WHSSC services. For example, the programme business case approval for major trauma and thoracic surgery prompted extensive papers and good discussion at health boards. But at other times WHSSC papers were just noted with limited discussion. We found that Board level oversight of quality and escalated specialised services appears limited, but we note that this is something WHSS officers are working to improve through their engagement work with health boards across Wales.

1 For each health board, we reviewed its Board papers and papers for its quality and safety, finance and performance meetings.

WHSSC's hosting arrangements function largely as intended, albeit there are occasional operational challenges and an opportunity to strengthen the governance role of the host health board's Audit and Risk Committee

27 WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities and Communications. WHSSC employees have a contract of employment with Cwm Taf Morgannwg University Health Board and WHSSC's Managing Director has a line of accountability to its Chief Executive. Interviewees indicated that in general these arrangements operated sufficiently, but there were some concerns expressed about Cwm Taf Morgannwg University Health Board's capacity to support WHSSC, particularly in relation to HR and ICT support services. In addition, it was noted that Cwm Taf Morgannwg University Health Board is a provider of specialised services commissioned by WHSSC, which could provide further conflicts of interest over and above the inherent provider/commissioner tension at Joint Committee.

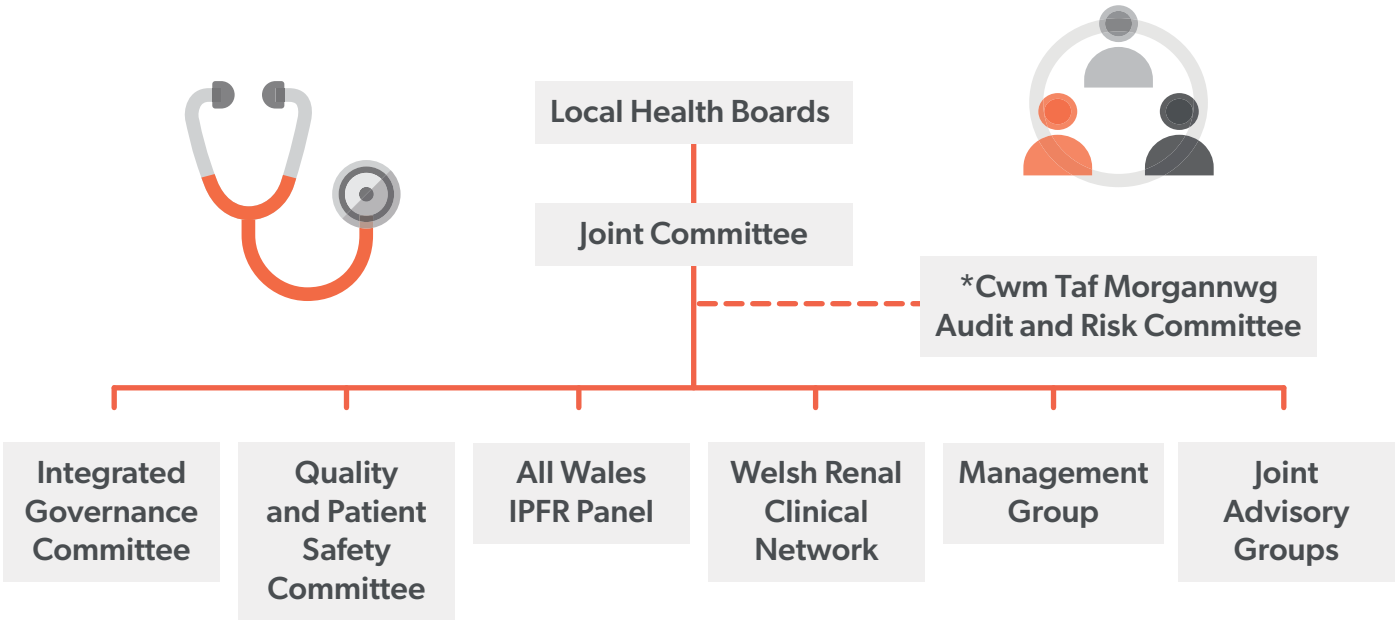
28 A hosting agreement exists between WHSSC and the seven Welsh health boards which includes provision for Cwm Taf Morgannwg University Health Board's Audit and Risk Committee to assist in the discharge of WHSSC's governance and assurance responsibilities. However, the existing hosting agreement has limited detail on how these arrangements should work, and the degree of scrutiny of WHSSC business at the committee can be fairly limited. Hosted organisations are considered at Part 2 of Audit and Risk Committee meetings. Cwm Taf Morgannwg University Health Board is working to clarify the assurance requirements of the hosted bodies[2] through developing an assurance framework. The new framework aims to define the role, function, responsibilities and accountabilities of the Audit and Risk Committee, the host, the all-Wales statutory joint committees and the directors involved. We understand that this work is ongoing and will require further engagement across all bodies affected.

2 Cwm Taf Morgannwg University Health Board is also the host for the Emergency Ambulance Services Committee (EASC) and the NHS National Imaging Academy.

WHSSC's sub-committees and groups generally operate well, although there is a need to ensure that all aspects within terms of reference are appropriately covered

29 WHSSC is required through its standing orders to have committees responsible for quality and safety, and audit. As identified earlier, the Audit and Risk Committee is facilitated through hosting arrangements. However, the Joint Committee is also supported by a range of its own sub-committees and groups (**Exhibit 4**). Some provide scrutiny and receive assurances, while others are more focussed on delivery and decision making. The Quality and Patient Safety Committee, forms part of WHSSC's own committee and group structure. The Joint Committee also has three advisory groups, which at the time of our fieldwork were under review.

Exhibit 4: WHSSC Governance Structure[3]



* Functions as both the Health Board's Audit and Risk Committee and WHSSC's Audit Committee.

Source: WHSSC

3 See section 2.3 of the 2019/20 WHSSC Annual Governance Statement for more information on the arrangements for Cwm Taf Morgannwg's Audit and Risk Committee and Quality and Patient Safety Committee in relation to WHSCC governance.

30 Most of our observations took place prior to the pandemic. Generally, we found that the meetings had a clear agenda, were well administered with formal procedures observed as expected, such as declarations of interest and review of previous minutes. Meeting papers were clearly written with a templated cover report detailing the purpose of the paper such as for approval, noting and assurance. The sub-committees have an up-to-date work programme and terms of reference.

31 WHSSC's Quality and Patient Safety Committee effectively scrutinises assurance reports from all of its commissioning teams on escalated services, service risks, quality visits, inspections and any incidents or concerns. The committee also receives reports on concerns, serious incidents, ombudsman reports, clinical policy review and COVID-19. WHSS officers are also aiming to improve the flow of information between WHSSC and the quality and safety committees of health boards.

32 During 2019-20, the Integrated Governance Committee met infrequently, leaving a six-month gap between the October 2019 and April 2020 meetings. However, the number of meetings was still in line with the committee's terms of reference and, since April 2020, the frequency of meetings has increased. Our work indicates that there needs to be greater clarity on the role and function of this committee. At present, part of the Integrated Governance Committee's remit is to maintain oversight of the work of the Quality and Patient Safety Committee, Audit and Risk Committee, and the Welsh Renal Network. The Integrated Governance Committee is also responsible for scrutinising delivery and performance of the Integrated Commissioning Plan. Whilst there was good oversight of the plan's development by the committee, we found that with the exception of a routine report on escalated services, there was no evidence of wider scrutiny of delivery against the plan.

33 Our observations found that Management Group, an officer-level group which makes recommendations to the Joint Committee, is well chaired, and in general papers are well discussed. But, as with Joint Committee, we saw a need for better discussion of performance, finance, and service quality and patient safety.

Systems of assurance

34 We examined whether the Joint Committee has an effective system of internal controls to support assurance systems. We found that **in recent years there has been notable strengthening of systems of assurance, but there is scope to strengthen them further**.

Arrangements to promote probity and propriety are in place

35 WHSSC's governance and accountability framework was last fully reviewed in September 2019. This version reflects the amended voting arrangements and includes:

- Standing Orders
- Memorandum of Agreement
- Hosting Agreement
- Joint Committee Business Framework

36 To help ensure probity and propriety, WHSSC maintains registers for declarations of interest and gifts, hospitality, and sponsorship. The registers are appropriately updated, with records available on the WHSSC website and declared within the Annual Governance Statement.

37 WHSSC keeps an internal audit recommendation tracker, which is clearly formatted and reviewed at each Audit and Risk Committee meeting. There were no external audit recommendations on the tracker when we conducted our review, but we are told that historically recommendations have been listed on the tracker and they were scrutinised in the same way as they were for the host. We would particularly expect the recommendations made in this review to appear on the tracker and be subjected to scrutiny.

38 WHSSC also monitored progress against the 2015 Good Governance Institute and HIW reviews. WHSSC developed a governance action plan and most actions are closed. The Integrated Governance Committee received six-monthly updates on the outstanding actions, the last of which was in March 2019.

Good risk management processes are in place, with risks regularly scrutinised at corporate and Joint Committee level, and systems in place to capture risks arising from COVID-19

39 WHSSC has a Corporate Risk Assurance Framework (CRAF) which identifies high-level risks to commissioned services. Each of the commissioning teams has a risk register. Risks rated 15 or above after controls are put in place are escalated to the CRAF. The Joint Committee has sight of the CRAF twice a year and it is reviewed regularly by the sub-committees and the Corporate Directors Group Board. The CRAF is clearly presented and includes the information we would expect to see on a corporate risk register including a lead director and assuring committee for each risk.

40 WHSSC has recently updated its integrated risk management framework including reviewing existing risk registers, developing a new risk register template, and training staff. The framework sets out accountabilities, responsibilities, and the organisation's risk appetite. WHSSC is seeking further improvements to tighten escalation and de-escalation processes and by introducing an electronic risk management system. It hopes to roll out new risk processes in spring 2021.

41 During the pandemic, a separate risk assessment and register was completed to assess how essential specialised services were impacted by COVID-19. The assessment is a live document which is updated as providers supplied more information. The Joint Committee continues to review both the COVID-19 risk register and the CRAF.

WHSSC is taking necessary action to strengthen its performance management arrangements but will need to consider how these are adapted to monitor and manage the post-pandemic recovery of services

42 WHSSC predominantly monitors a service's performance through national key performance indicators. The measures are set out in contracts and service specifications. Underperformance is managed through WHSSC's escalation framework, which has four levels of escalation, with level four being the highest. The WHSS team holds regular Service Level Agreement (SLA) meetings with Welsh providers, and at least an annual contract meeting with English providers. Escalated services are subject to enhanced performance management arrangements until significant improvement can be demonstrated to allow de-escalation.

43 During the height of the pandemic, WHSSC stood down SLA monitoring in line with the Welsh Government's practice. At this point only essential specialised services were being delivered. During this time, the WHSS team found it difficult to engage with both Welsh and English providers who were heavily focussed on the pandemic. Pragmatically, to overcome this they adopted a direct monitoring system, reviewing available performance data and challenging providers on the findings. WHSSC is still 'direct monitoring' services and is sharing information with the Welsh Government. Where the WHSS team has been able to proactively engage with providers they have been able to negotiate the continuation of some services. WHSSC reported that despite the pandemic, escalation arrangements continued to work well, and it has helped to highlight differences in activity and productivity between different providers.

44 The pandemic has also highlighted the need to review performance management arrangements and metrics. For example, performance against referral to treatment (RTT) waiting times was often used to determine escalation levels[4]. But in the current climate where RTT waiting times have risen across the NHS, it is difficult to differentiate risk of harm or patient outcome when so many patients are delayed and waiting. As a result, WHSSC is currently in the process of reviewing each service in escalation to see if it is still relevant. WHSSC does not currently have an overarching Performance Management Framework, although it has developed a performance analysis system called 'MAIR' (My Analytics and Information Reports). However, the team is developing a Commissioning Assurance Framework. The framework will set out a new performance assurance process alongside more outcome focussed performance measures. It also proposes an annual meeting between WHSSC executives and health board executives to understand commissioner priorities to feed into the Integrated Commissioning Plan development process. It is hoped the new framework will be launched alongside the refreshed Integrated Commissioning Plan. This is a positive development as monitoring services as they recover from the pandemic will need a different approach. Reviewing data on patient outcomes and harm will need to be an important part of these developing arrangements.

45 WHSSC's integrated performance dashboard is presented to the Corporate Directors Group Board and Management Group monthly, and to the Joint Committee bi-monthly. While there is discussion and challenge at commissioning team meetings, as stated earlier, we observed little scrutiny of this report at Joint Committee. The existing reports do not have a breadth of measures, reporting mainly on waiting times and RTT performance and there is opportunity to refresh these as part of post-pandemic recovery and the new Commissioner Performance Assurance Framework.

4 The escalation framework works on a four-tier basis with level four being the highest level of escalation. Services can be escalated for performance and/or quality issues.

WHSSC is driving quality improvement through its Quality Assurance Team and quality assurance framework

46 In 2015, the Good Governance Institute and HIW made several recommendations related to quality governance. Since these reviews, WHSSC has made good progress in improving quality governance. The Joint Committee has senior clinical representation, the Director of Nursing and Quality Assurance is a member of the Joint Committee and the Medical Director attends the meeting. At an operational level, each of the six multidisciplinary commissioning teams has an associate medical director for clinical advice and guidance.

47 A Quality Assurance team, led by the Director of Nursing and Quality Assurance, was established in 2019. The team is responsible for monitoring and learning from quality and patient experience to help improve commissioned services. Specifically, this includes managing and responding to complaints, near misses, serious incidents and never events. The team is also part of the multidisciplinary commissioning teams and is involved in planning and quality assuring commissioned services. In addition, WHSSC has updated its Quality Assurance Framework which was agreed in 2014 and will form part of the new Commissioning Assurance Framework.

48 To share intelligence and reduce duplication, the Quality Assurance team maintains good relationships with providers and regulators. For example, the team holds quarterly meetings with the quality leads at provider health boards to review a range of quality measures and information. They also use intelligence from regulators, clinical audit, and the National Collaborative Commissioning Unit (mental health services) to feed into planning and monitoring of services. There is a different system for English providers. NHS England has a quality assurance portal, which WHSSC accesses. Information on the portal is detailed and benchmarked against similar NHS England providers. WHSSC plans to replicate this approach for Swansea and Cardiff and Vale University Health Boards.

Strategic planning

49 Our work examined whether WHSSC has a clear and robust approach to strategic and financial planning. As a result of the pandemic, the specialised services environment has changed, with some services, particularly surgical, stopping or significantly curtailed. Our review found that **planning arrangements provide a good foundation but there is need for a clear strategy to respond to the challenges presented by COVID-19**.

Annual planning arrangements are generally effective, but recovery of services will be challenging

50 WHSSC currently undertakes planning each year culminating in a rolling three-year Integrated Commissioning Plan. This plan is agreed annually and has become increasingly timely and mature in recent years. There are clear stages of development and engagement with health boards as part of the approval process, prior to formal ratification/approval at the WHSSC Joint Committee. There is also a clear process and accountability for different stages of preparation and approval and, if necessary, consultation with relevant stakeholders.

51 WHSSC consults key stakeholders and the public on new commissioning policies, service specifications and revised commissioning policies where there are material changes to the service. There are good examples of this in relation to major trauma and thoracic surgery with the relevant community health councils actively engaging in stakeholder feedback and analysis. Community health council feedback informs both WHSSC planning and the relevant health boards whose population may be affected by proposed service changes.

52 The extent that health boards incorporate specialised services within their own integrated medium-term plans is variable across Wales. For example, Powys Teaching Health Board and Hywel Dda University Health Board rely more significantly on externally commissioned specialised services and we see these featuring in their plans more so than in the plans of the health boards that are specialised service providers.

53 Our work indicates that WHSSC has sufficient capacity and capability to support planning. That capacity and capability was drawn upon in 2020 to help support the Welsh Government's NHS Planning Team's review of health boards' quarterly plans, using their knowledge and experience of complex service planning. WHSSC's planning arrangements include significant contribution from each of the specialised services commissioning teams, clinical impact advisory group and WHSSC Management Group. Clinical advice helps to shape specialised services and WHSSC intends to increase the level of internal 'consultant-level' expertise further.

54 WHSSC has adopted a continuous approach for identifying and evaluating new research, treatments and using NICE[5] guidance to shape commissioned services. This 'horizon scanning' is supported by a consistent and transparent prioritisation process (**Exhibit 5**) to help ensure that investment decisions are affordable, offer value for money and are supported by convincing evidence of safety and effectiveness. The robustness of the approach helps to secure agreement of new proposals at the Joint Committee.

Exhibit 5 – key principles of the prioritisation process adopted by WHSSC

- Scoring and ranking of interventions by the WHSSC Prioritisation Panel is carried out using formal and agreed methodology
- The prioritisation process is intended not to duplicate work already completed (for example by NICE)
- There must be appropriate and timely engagement with NHS Wales as part of the process
- There are clear and agreed scoring criteria and voting technology is utilised during assessment. The criteria include:
  - Strength of clinical evidence
  - Patient benefit
  - Economic assessment
  - Burden of disease (severity of condition and also impact on the population)
  - Reducing inequalities of access

Source: Audit Wales fieldwork

5 National Institute for Health and Care Excellence https://www.nice.org.uk/

55 COVID-19 has significantly affected the delivery of specialised services across Wales and England. After the first wave of the pandemic, we understand that variation in service productivity between providers was increasing, with some providers able to restart specialised services earlier and with greater degrees of success than others. This creates a commissioning challenge as WHSSC looks to develop post-pandemic recovery plans on behalf of the population of Wales.

Information to support planning and commissioning is improving and will need to adapt to the challenges brought about by the pandemic

56 WHSSC's development of My Analytics and Information Reports (MAIR) in 2018-19 was a notable improvement on previous arrangements. WHSSC has worked closely with health board teams to ensure that health boards now have access to the comprehensive information sets now available. Reports can be tailored by health board or provider, by specialty and point of delivery. Results can also be made available using a variety of visualisation tools including maps, charts, tables, and pathways. This has enabled health boards to gain a deeper understanding of their demand patterns for specialised services and compare their own access rates to other health boards and inform areas for targeted review.

57 Plans for further development of MAIR include:

- Producing performance management dashboards and heat mapping
- Improving the timeliness of performance reporting
- Exploring how quality and outcomes data can be incorporated
- Improving the familiarisation of health boards with the variety of WHSSC's contracts by the production of deep dive reports.

58 Commissioning and contracting services can only be effective if there is robust information to inform operational and strategic decisions. Our work has identified that prior to the COVID-19 pandemic, there was a good track record of analysis of demand and capacity of services both in Wales and England. This will become even more important post-pandemic, to help provide options for recovering service performance and reducing risk of harm as a result of delays in access to care.

Delivery of Integrated Commissioning Plans is effective, but development and implementation of new services can be slow

59 For services that are already commissioned and being delivered, the necessary arrangements are in place to ensure they are resourced and being delivered as intended, with arrangements to escalate matters should there be any concerns.

60 Commissioning of new services from first consideration through to the launch of new services can, however, be a lengthy process, particularly for services provided in Wales. For example, the major trauma network in south Wales was launched in September 2020, after having been originally identified as necessary back in 2013, although WHSSC's involvement only commenced in 2018-19. Similarly, the improvements to thoracic surgery services, identified as necessary by the Royal College of Surgeon's report in 2016, are not expected to go live until 2024, and this is subject to a capital business case requiring Welsh Government funding.

61 Whilst introduction of new services is by no means simple, there has been protracted debate on where the new developments mentioned above should be housed, although the statutory engagement and consultation process, which is integral to this, can consume considerable time. The roll out of such schemes is not the sole domain of WHSSC and depends upon the wider architecture that supports regional service development within the NHS in Wales. There is scope, however, to strengthen end-to-end programme management of such schemes to improve timeliness of service development. The pandemic has created a common sense of urgency amongst providers. This momentum needs to be maintained to identify and rapidly develop or reshape services to accelerate recovery.

Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan but will need to ensure value for money as services restart and aim to recover

62 Financial planning is an integral element of the Integrated Commissioning Plan. Health boards are fully engaged in discussions on costs and projected cost growth for the coming financial year during planning and agreement stages, prior to ratification of the plan. Cost growth is explicitly defined in the plan and justified through the agreed process for horizon scanning and prioritisation. Financial planning has two distinct elements:

- determining overall specialised services costs and the apportionment of these costs to health boards; and
- contracting and commissioning health boards and trusts in relation to provision of specialised services.

63 These are managed through financial risk-sharing agreements. These agreements set out who pays for what in relation to the provision and receipt of services. The risk sharing agreements are based on a financial formula and this is used both as part of planning and at the year-end to look at variance in activity against plan and determine distribution of under and overspends. There are different models for risk sharing designed to suit different types of commissioned services. For most services, planning is based on actual utilisation and a two-year average of activity. This is designed to smooth some peaks and troughs but also create incentive for efficiency. Highly specialised services which are not utilised often are funded using a population-based formula which is designed to provide continuity of income. This is to ensure services are sustainable, but also to protect against peaks of extreme costs when services are required.

64 Our review of health board expenditure on specialised services for the period 2014-15 to 2020-21[6] indicates the overall costs have increased above inflation. We understand that this is typical when new specialised therapies and treatments are developed and adopted into commissioning agreements.

65 In the short to medium term, however, the impact of COVID-19 on finances presents a number of challenges, including:

- payments to providers have continued in Wales and England albeit recent negotiations have resulted in rebates/reductions where there is under-delivery by providers;
- lack of service delivery during the pandemic has created a backlog of waits for some specialised services; and
- lack of patients presenting to primary and secondary care with symptoms during the pandemic may mean that there is greater hidden demand, and that conditions may have exacerbated, requiring more costly intervention downstream.

66 The Joint Committee should seek to understand the short and medium term financial impacts of COVID-19 to determine what this means for service recovery plans.

6 2019-20 data is taken from the Month 12 Health Board expenditure on Welsh Health Specialised Services. 2020-21 costs are based on forecast expenditure budgeted within the 2020-21 integrated commissioning plan. We acknowledge that 2019-20 data is currently unaudited, and 2020-21 data is subject to significant variation as a result of the COVID-19 outbreak.

Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs more strongly to link to patient outcomes, prioritisation, and de-commissioning

67 Prudent and value-based care is a core aspect of the 2020-2023 Integrated Commissioning Plan. This focussed on increasing the value achieved through improvement, innovation, use of best practice and eliminating waste. The value-based commissioning approach adopted by WHSSC is logical and methodical. This includes identifying commissioning opportunities, refining these, and engaging the WHSSC Management Group members and wider teams. WHSSC has developed thematic areas for value-based commissioning. Some of these will be easier to achieve than others and some may need to be pursued over a multi-year period. The areas include procurement, efficiency, service rationalisation, disinvestment, and assessing access criteria.

68 While COVID-19 has changed the position significantly, the extent of the original value-based commissioning savings for 2020-21 was around £2.75 million. Overall, our review has identified that WHSSC's value-based approach is developing and there is opportunity to exploit this further. In doing so, we expect there will need to be a clear and strong focus on collecting patient outcome information to inform the development of opportunities to reduce waste and maximise the benefit of investment in specialised care. For example, there remains greater opportunity to assess services:

- which do not demonstrate clinical efficacy or patient outcome (**stop**);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (**transfer**);
- where alternative interventions provide better outcome for the investment (**change**);
- currently commissioned, which should continue (**continue**).

COVID-19 has delayed the development of a new specialised services strategy, but this now provides the opportunity to shape the direction to focus on recovery, value and to exploit new technology and ways of working

69 A key function of commissioning relates to planning of services to meet population need. The specialised services strategy provides a framework for commissioning services, but the current version is dated 2012. Senior specialised services officers had intended to refresh the strategy in 2020, but this has been delayed by the pandemic. However, this gives specialised service officers the opportunity to shape the strategy to focus on COVID-19 recovery arrangements alongside routine technological, therapeutic and policy developments.

Future arrangements for commissioning specialised services

70 Our review, in examining both WHSSC's governance and planning arrangements indicates that **there would still be merit in reviewing the future arrangements for commissioning specialised services in line with the commitments of A Healthier Wales.**

71 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales signalled an intention to create a national executive to strengthen national leadership and strategic direction across a range of areas. Linked to this, **A Healthier Wales** signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability.

72 Whilst the findings in this report show that the governance arrangements for WHSSC have continued to evolve positively in the main, they do also point to a need still to undertake the wider review signalled within **A Healthier Wales**. The current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that sees individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

73 The Good Governance Institute's report in 2015 questioned the hosting arrangements for WHSSC, suggesting that a more national model might be appropriate. WHSSC's hosting arrangements have remained unchanged since that report and our work has shown that in respect of WHSSC's governance, the use of the hosting health board's Audit and Risk Committee needs to be reviewed to ensure there is sufficient depth of debate and scrutiny (see **paragraphs 27** and **28 above**).

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Mr Adrian Crompton
Auditor General for Wales
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2 June 2021

Dear Adrian

Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements: Report of the Auditor General for Wales, May 2021

Thank you for the above Audit Wales report, published on 12 May.

I welcome your conclusion that governance arrangements and decision making at WHSSC have improved since previous reviews. The WHSSC team has worked hard to make these changes and I will expect them to make further progress by addressing your recommendations in relation to an increased focus on quality, programme management, COVID-19 recovery and the specialised services strategy. My officials will be following up on these areas at their regular meetings with WHSSC.

In terms of your recommendations to the Welsh Government, I set out my initial response below, although these may well be subject to any views from the new Minister in light of her priorities.

Recommendation 5: Independent Member recruitment – accepted and action in train

I am aware there have been challenges in securing nominations from health boards to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.

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Recommendation 6: Sub-regional and regional programme management (linked to recommendation 2 directed to WHSSC) – accepted

As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.

Recommendation 7: Future governance and accountability arrangements for specialised services – accepted in principle

A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate.

In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.

Yours sincerely

Dr Andrew Goodall CBE

cc: Chair of the Senedd Public Accounts Committee.

Document is Restricted

Archwilio Cymru
Audit Wales

Rollout of the COVID-19 vaccination programme in Wales

Report of the Auditor General for Wales

June 2021

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

4 Key messages

Context

1 The COVID-19 pandemic has affected everyone. The vaccination programme is a key strategic tool to fight the virus and help reopen the economy and wider society.

2 The purchase and supply of the vaccines is the responsibility of the UK Government. The vaccination programme in Wales is the responsibility of the Welsh Government and NHS Wales.

3 This report considers the rollout of the vaccination programme in Wales. In it, we discuss the shape of the programme, how it is performing, the factors that have affected rollout to date, and future challenges and opportunities. **Appendix 1** describes our audit approach and methods.

4 There are many vaccines in development globally, and the UK government has signed contracts for vaccine supply with eight major pharmaceutical providers (**Appendix 2**). At the time of our fieldwork, three vaccines were approved by the Medicines and Healthcare products Regulatory Agency (MHRA): Pfizer-BioNTech, Oxford-AstraZeneca and Moderna. All three vaccines require two doses to maximise effectiveness.

Key findings

5 Overall, the programme has delivered at significant pace, with local, national and UK partners working together to vaccinate a considerable proportion of the population who are at greatest risk. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy have provided a strong impetus to drive the programme. To date, the Welsh Government's milestones have been met.

6 The Welsh Government has adopted UK prioritisation guidance from the Joint Committee on Vaccination and Immunisation (JCVI). A national group in Wales provides additional guidance where further clarity on prioritisation is required. The guidance has generally been followed, but the process of identifying people within some of the nine priority groups (**Appendix 3**) has been complex.

7 The organisations involved in the rollout have worked well to set up a range of vaccination models which make best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

8 Overall vaccine uptake to date is high, but there is lower uptake for some ethnic groups and in the most deprived communities. There are also increasing concerns about non-attendance at booked appointments, although health boards to date have been able to minimise vaccine waste.

9 The dependency on the international supply chain is the most significant factor affecting the rollout. Limited stock is held in Wales, primarily to allow for second doses and short-term supply to sites. This means that shortfalls in supply can seriously impact the pace of rollout. However, increasing awareness of future supply levels is allowing health boards to manage the calling of individuals effectively.

10 In the short-term, the workforce supporting the vaccination programme has been meeting the demands placed on it and many staff have been working ‘above and beyond’. The current programme is unlikely to complete all second doses until September 2021, and an autumn booster programme is being discussed. This will offer little respite for key vaccination staff in an environment where workforce resilience is vital.

11 Early observations from military partners identified some sites were more efficient than others. Some vaccination sites may become unavailable in coming months as partner organisations look to reopen venues over the summer.

12 As Wales maintains its focus on delivering against existing milestones, there is a need now for the Welsh Government and NHS Wales to develop a longer-term plan for vaccine rollout. This needs to include sustainable workforce models which can respond to supply, whilst also responding to demands as other services are restarted.

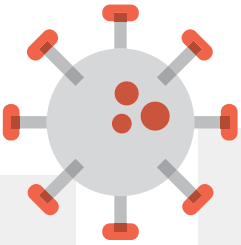
13 Consideration also needs to be given to the longer-term estate requirements to support autumn boosters, with a focus on ensuring that vaccination models are cost effective. Strategies to minimise waste need to be maintained and increased action taken to encourage uptake as the programme moves to the remaining population.

14 More broadly, there is much to be learnt from the positive way in which the vaccine programme has been rolled out to date. The Welsh Government and NHS Wales should be looking to apply that learning to wider immunisation strategies and the delivery of other programmes.

> Wales has made great strides with its COVID-19 vaccination programme. Key milestones for priority groups have been met and the programme is continuing at pace with a significant proportion of the Welsh population now vaccinated. This is a phenomenal achievement and testament to the hard work and commitment of all the individuals and organisations that have been involved in the vaccine rollout to date.
>
> However, the job is far from over. A longer-term plan is needed that moves beyond the existing milestones and considers key issues such as resilience of the vaccine workforce, evolving knowledge of vaccine safety, the need for booster doses, and maintaining good uptake rates - especially in those groups that have shown some hesitancy in coming forward for their vaccinations.

Adrian Crompton
Auditor General for Wales

Key facts



3.3 million

Vaccinations given in Wales

0.4%

Percentage of all vaccines considered unsuitable for use

91.5%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a first dose

£29.4 million

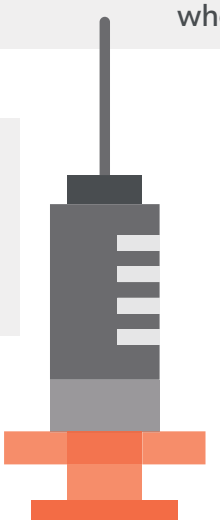
Costs for 2020-21 (excludes redeployed staff and the cost of vaccines)

84.4%

Percentage of the 2.52 million eligible adults who have received a first dose

66.1%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a second dose



Vaccinations being delivered in:

54 mass vaccination centres

346 general practice locations

30 hospital locations

11 pharmacies

18 mobile team units

As of the end of May 2021

Source: Public Health Wales and the Welsh Government

Main report

How the programme is set up

15 Public sector partners across the UK have worked together since the beginning of the pandemic to explore the potential for a COVID-19 vaccination. The programme in Wales was first established in June 2020 to enable an appropriate infrastructure to be put in place before any vaccinations came online.

16 The programme is based around the principle of local autonomy for vaccine deployment through health boards. Supply policy and guidance is nationally coordinated:

a the UK government's Department for Business, Energy & Industrial Strategy (BEIS) led on UK-wide arrangements for research, purchase, and coordination of the national vaccine supply[1] working with the UK Vaccine Taskforce. Responsibility for the Vaccine Taskforce is now shared between BEIS and the UK Department of Health and Social Care. Welsh Government officials engage with the Vaccine Taskforce to streamline vaccine supply and anticipate upcoming issues.

b the Welsh Government is leading on vaccine deployment in Wales. It developed the national Vaccination Strategy for Wales[2] and formed a national programme structure (including Stakeholder and Deployment Boards, and an operational delivery group). The Vaccine Clinical Advisory and Prioritising Group (VCAP) considers clinical developments in vaccination against COVID-19 infection. The group advises the programme and partners on the implementation of the national vaccination programme, interpreting the priorities as outlined by the JCVI for the Welsh context. Collectively, these national groups provide policy and guidance, support financial resourcing, and have facilitated the Primary Care COVID-19 Immunisation Scheme[3] for commissioning primary care.

1 The UK Government Vaccine Taskforce (VTF): 2020 achievements and future strategy report provides an overview of UK level progress

2 The Vaccination Strategy for Wales was first published in January 2021 and formally updated in February, March and June 2021.

3 The Primary Care COVID-19 Immunisation Scheme sets out requirements and reimbursement for Primary Care providers that have signed up to the scheme.

c health boards are responsible for local vaccination plans, set up of mass-vaccination sites through collaborative working with local partners, and aspects of training and staffing. They are also responsible for securing vaccination centres in primary care and outreach/mobile services, with the Welsh Immunisation System (WIS) working to identify those in the priority groups using information on GP and hospital-based IT systems.

d Public Health Wales provides expert advice, surveillance data, vaccine effectiveness and safety monitoring, and public and patient information and reporting. It also assists in the development of training policy, patient group directions (PGDs) and tools.

e other partners are responsible for logistics:

- NHS Wales Shared Services Partnership and the Welsh Blood Service are responsible for supporting the pharmaceutical co-ordination team for consumable and storage logistics.
- Digital Health and Care Wales has led the design, test and rollout of the WIS that enables identification and coordination of priority groups and related appointment booking, vaccination recording and clinical quality assurance such as vaccine batch control. The system also provides performance data.

17 The Vaccination Strategy for Wales provides a high-level framework setting out the expectations for prioritisation and delivery of the COVID-19 vaccine. The Welsh Government has adopted the Joint Committee on Vaccination and Immunisation: advice on priority groups (**Appendix 3**). The national strategy focusses on developing the infrastructure for vaccine deployment, and communication about progress.

18 The first version of the strategy provided a clear milestone for the first four priority groups. In February 2021, the updated strategy provided target dates for the remaining milestones (**Exhibit 1**), with the aim of achieving 75% uptake for priority groups 5-9. This approach has continued to focus all partners on the time-critical aims of the vaccination programme as it continues to roll out.

Exhibit 1: Current key milestones for the vaccination programme

Milestone 1	**By mid-February 2021**: Priority groups 1 – 4 Subject to supply, the aim is to offer first dose vaccination to all care home residents and staff; frontline health and social care staff; those 70 years of age and over; and clinically extremely vulnerable individuals.
Milestone 2	**By mid-April 2021:** Priority groups 5 – 9 Subject to supply, the Welsh Government's aim is to offer first dose vaccination to all remaining priority groups.
Milestone 3	**By July 2021:** Offer first dose vaccination to the rest of the eligible adult population according to the JCVI guidance.

Source: Welsh Government

19 Programme oversight and monitoring take place at national and local levels receiving significant and regular officer level scrutiny as well as ministerial oversight. Public Health Wales and the Welsh Government publish regular updates[4]. Public Health Wales also undertakes enhanced surveillance, including analysis on vaccination uptake by deprivation, age, ethnic background and gender.

20 Vaccination delivery models vary by health board, predominantly based on geography and population density. Mass vaccination sites are being used in areas of higher population density, but in rural and hard to reach areas some health boards have adopted smaller local site models which enable vaccines to be delivered closer to the communities that they serve. Some health boards also depend more on primary care than others. Irrespective of geography, health boards are using outreach models to vaccinate in care homes and have set up temporary and mobile hubs (such as the Swansea Bay UHB Immbulance service).

21 Workforce planning is largely a delegated responsibility for health boards. A national workforce group has created policy and guidance providing high-level productivity modelling and has developed role descriptors for recruitment.

4 Public Health Wales vaccination updates are available on their interactive dashboard. Welsh Government updates are published each week.

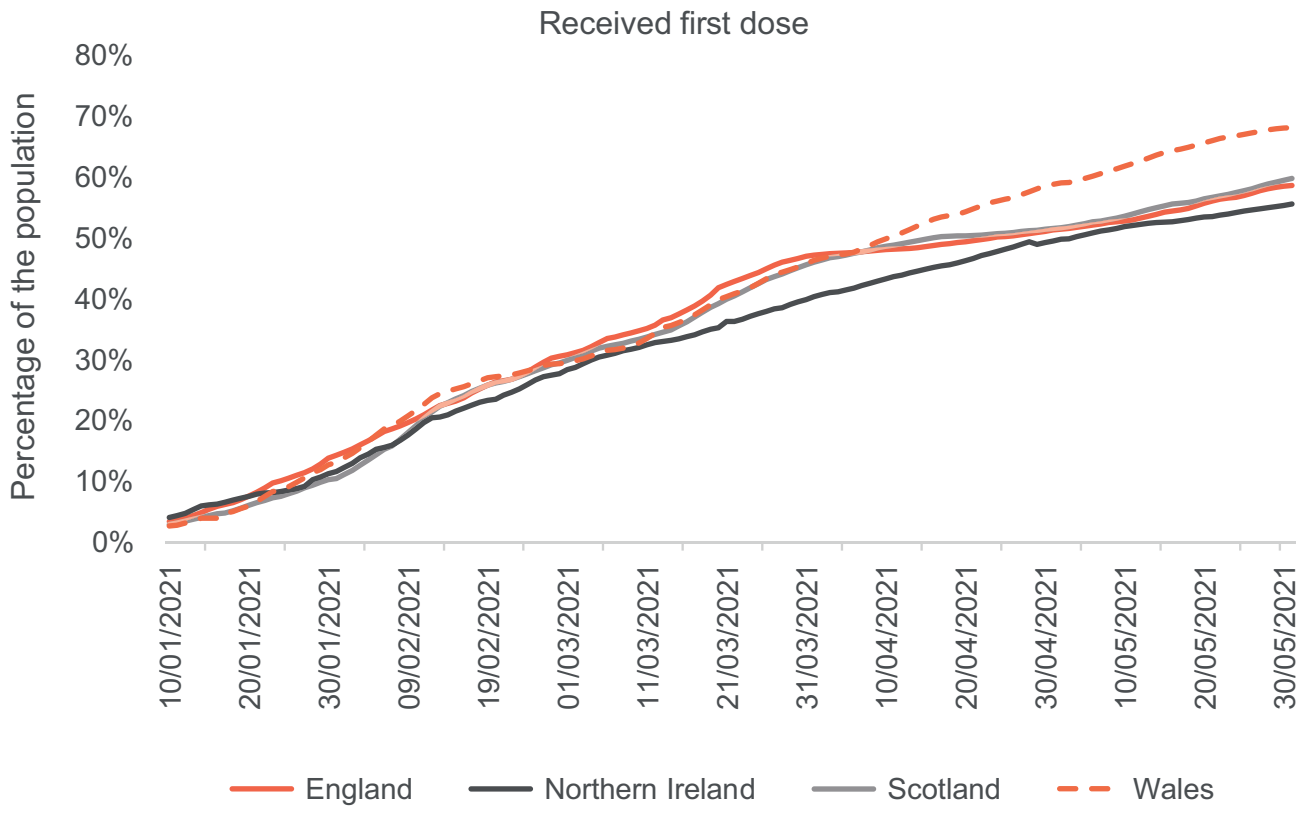
22 To date, vaccine procurement costs have been met by the UK Government in full. The Welsh Government funds the transport, storage, and additional local deployment costs in Wales. It provisionally estimated these costs at £34.9 million for 2020-21, including an estimated cost of £7.8 million for personal protective equipment (PPE). At the end of March, the actual costs for 2020-21 were reported as £29.4 million, as a result of costs associated with PPE largely being funded through existing PPE budget allocation. . Of the £29.4 million, £10.8 million has been spent on additional staffing, £9.54 million on the Primary Care COVID-19 Immunisation Scheme and £0.2 million on capital costs. Some staff are redeployed from within their organisations at no additional cost, although this has potential workforce implications for the part of the business where they originally worked.

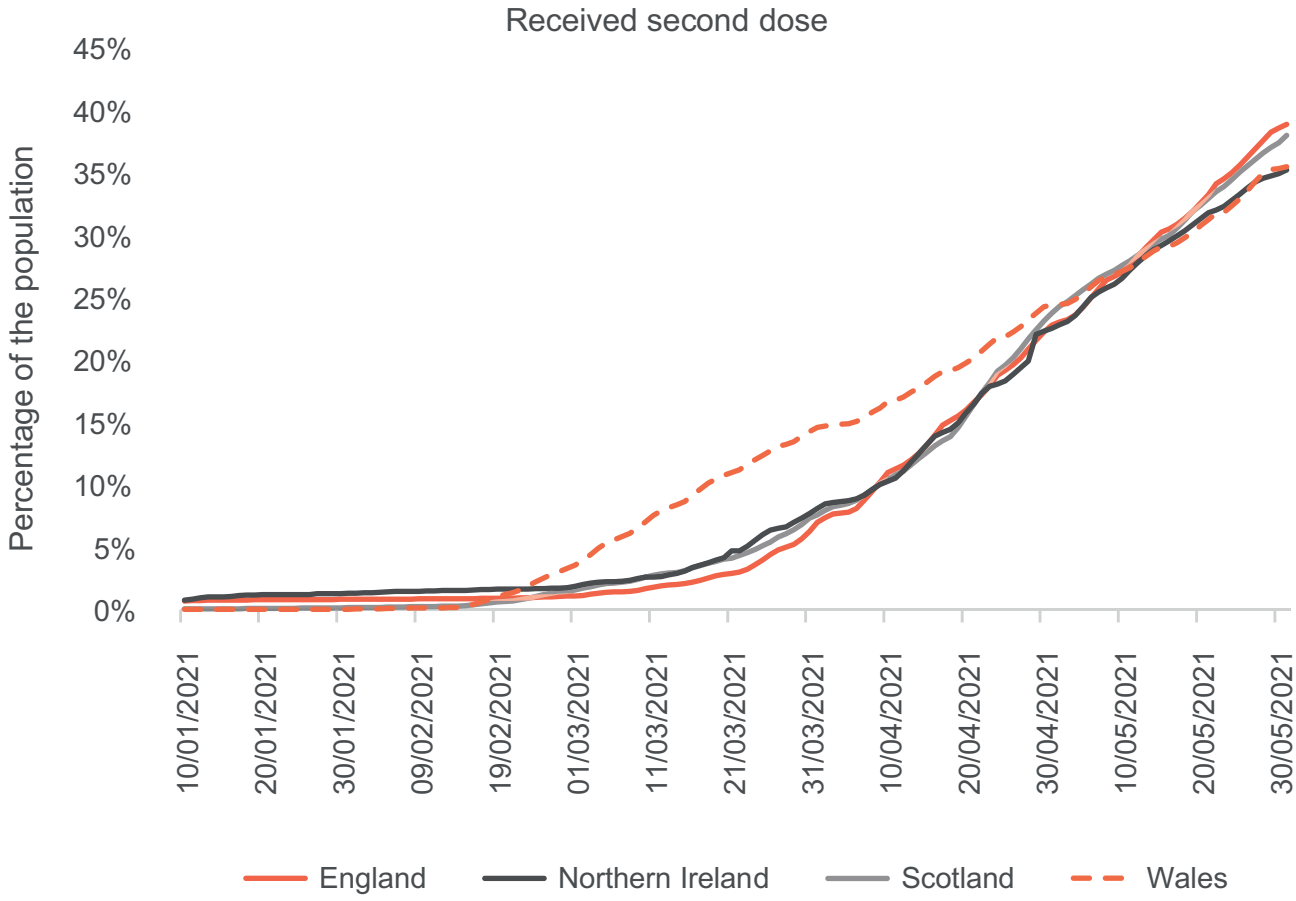
23 Other non-pay costs include transportation, site venue hire, personal protective equipment and syringe packs, security, and communications material. We understand that some vaccination sites are provided to the programme at no additional revenue cost. This is likely to change if local authority or other partners require the return of their facilities and health boards need to relocate to alternative accommodation which may come at a cost. The forecast costs of the programme for the first three months of 2021-22 (April to June 2021) are £31.5 million.

How is the programme performing?

24 Overall, as of 31 May 2021, the percentage of the adult population to have received the vaccine in Wales is higher than in the other UK nations (**Exhibit 2**). Wales made particularly good progress delivering second doses in March, although England and Scotland have now accelerated the delivery of second doses.

Exhibit 2: Percentage of the adult population to have received first and second doses of COVID-19 vaccination by country, as at 31 May 2021

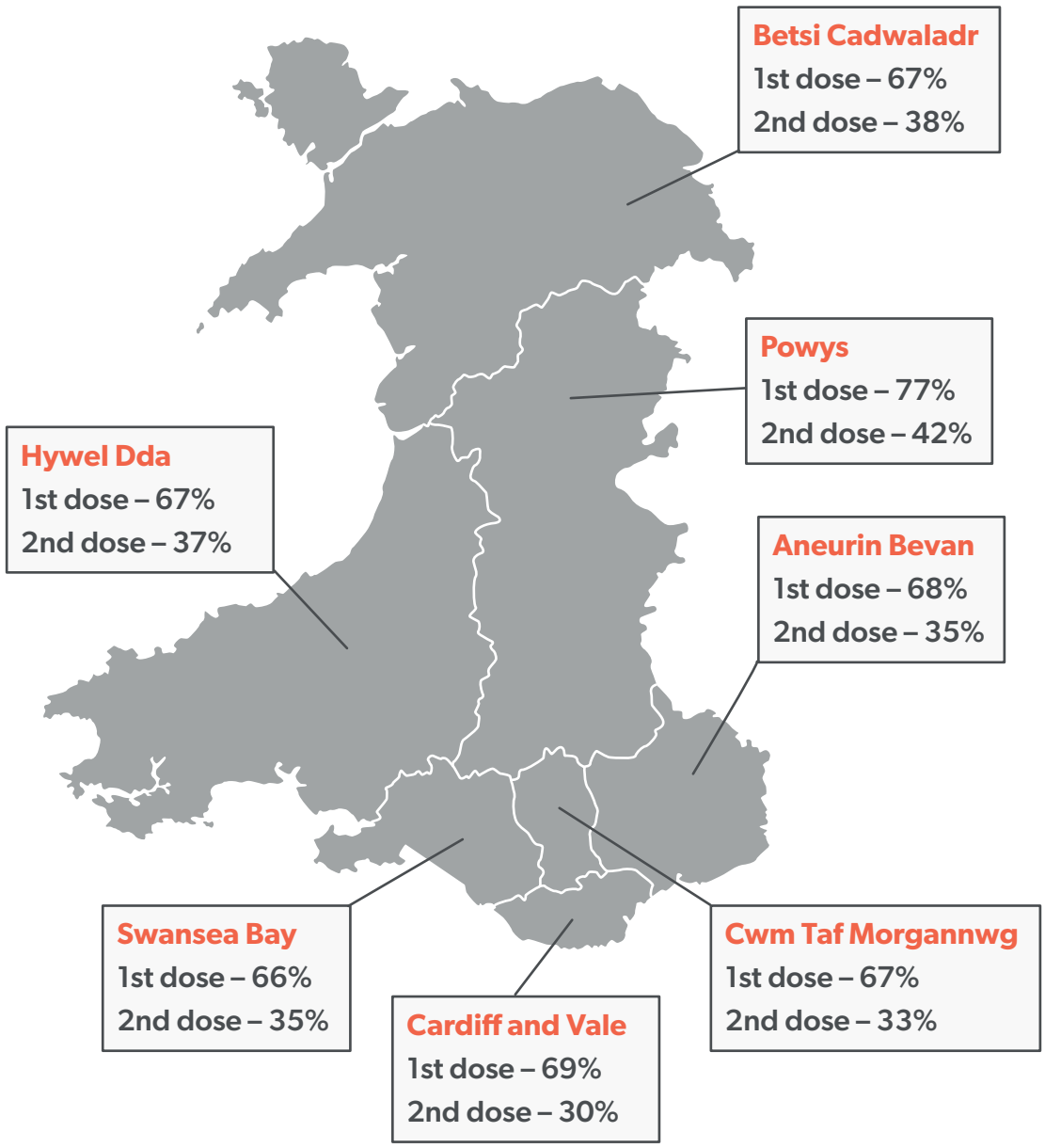




Source: UK Coronavirus Dashboard

25 There is some variation in the progress across health boards, most notably for Powys Teaching Health Board which is making the greatest progress (**Exhibit 3**). This is due to a combination of factors in Powys including a greater proportion of an older population and a higher level of supply per population as a result of batch sizes.

Exhibit 3: Vaccine doses given by health board as a percentage of the adult population as at 31 May 2021



Source: COVID-19 Vaccination Enhanced Surveillance Report, Public Health Wales

26 On 12 February 2021, the Minister for Health and Social Services announced that Milestone 1 of the vaccination strategy had been met. The Minister also announced on 4 April, that Milestone 2 had been met. Both milestones focus on the offering of an appointment for a vaccine. It is not possible to know if everyone eligible within the priority groups 1-9 were identified in the booking process. However, Welsh Government and health board officials took steps to help verify the position, such as contacting care homes to ensure all staff and residents had been offered a vaccination. At 31 May, around 95.5% of those in Milestone 1, and 87.9% of those in Milestone 2 had received their first dose.

27 While the programme has moved ahead to focus on Milestone 3, the Welsh Government and health boards are operating a ‘no one left behind’ policy. This means that anyone eligible in previous groups who has not yet had a vaccine for any reason can inform the relevant health board and make an appointment.

28 Public Health Wales surveillance reports show that influenza vaccine uptake is typically around 70% for those aged 65 and older. So far, the overall COVID-19 vaccine uptake for priority groups 1-9 is 91.5% which reflects positively in comparison. Reasons for not achieving 100% uptake include for example, people that are too unwell to receive the vaccine and the minority, to date, that have chosen not to have the vaccine. At the time of reporting, 66.1% of the priority groups 1-9 had received their second dose, and good progress was being made with vaccine rollout to younger age groups.

29 **Exhibit 4** shows some variation on uptake of first doses against the prioritisation groups by health board, particularly for priority group 6. We have observed extensive national-level discussion to respond to the challenges of identifying relevant population datasets. This included identifying all those aged 16-64 years clinically at risk where definitions of clinical conditions have needed to be clarified, and information about individuals is contained on different systems. There have also been challenges identifying unpaid carers who have previously not been recorded on any system. This indicates some of the difficulty in using a complex vaccination prioritisation model in the environment where no single centrally maintained population dataset exists for this purpose.

Exhibit 4: Percentage of first doses given by priority (P) group, at 30 May 2021

Priority Group		Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
P1.	Residents of care homes	97.5	98.6	98.0	96.4	98.2	96.8	98.8
P2.	80 years +	96.3	96.0	94.3	95.9	96.1	97.2	96.2
P3.	75-79 years	97.0	96.5	95.9	97.1	96.6	97.2	97.3
P4.	16-69 years clinically extremely vulnerable	94.2	93.8	93.2	94.7	93.9	95.7	94.4
P4.	70 – 74 years	96.6	95.6	95.4	96.5	95.7	96.2	96.6
P5.	65-69 years	94.9	94.5	93.5	95.4	94.3	95.0	95.5
P6.	16-64 years clinically at risk	88.6	86.5	88.1	88.2	86.7	90.4	87.8
P7.	60-64 years	93.6	91.6	91.5	93.7	92.2	91.6	93.3
P8.	55-59 years	91.6	89.4	89.3	91.9	90.0	89.4	91.1
P9.	50-54 years	89.7	87.7	86.5	90.1	87.5	88.1	89.0

Note: P2, P3 and P4 also includes data for those in the respective age groups who are also residents of care homes. Frontline health and care staff, as well as unpaid carers are not explicitly identified at health board level but instead included within the relevant age groups.

Source: Weekly COVID-19 coverage report, Public Health Wales

30 Equality considerations are a growing concern. Public Health Wales data shows clear variation in uptake among different ethnic groups with uptake lower particularly within the Black community (**Exhibit 5**).

Exhibit 5: Percentage uptake of first dose of COVID-19 vaccine by age and ethnic group as at 5 May 2021

Ethnic group	White	Black	Asian	Mixed	Other
80+ years	97.2	80.7	87.3	93.1	82.5
70-79 years	96.6	79.9	87.3	88.0	83.4
60-69 years	94.4	76.8	86.6	84.5	78.9
50-59 years	91.3	71.9	84.3	79.4	71.7

Source: Monthly enhanced surveillance report, including analysis on equality of coverage, Public Health Wales

31 As part of their analysis, Public Health Wales also found lower uptake in deprived communities. Although the differences are not as great as for ethnic groups, uptake between the least and most deprived areas for some age groups varies by up to 5.3%. Analysis of COVID-19 positive cases over the last 12 months has indicated that case prevalence and severity have been higher in Black, Asian and Minority Ethnic groups as well as in some of Wales' most deprived areas, with Merthyr Tydfil experiencing the highest number of cases per head of population. In March 2021, the Welsh Government published its Vaccination Equity Strategy for Wales. The Vaccine Equity Committee met for the first time in April 2021 and is preparing a vaccine equity plan.

32 Vaccine wastage (known as vaccines unsuitable for use) to date is around 0.4% of all vaccines supplied. As of 31 May, this equated to around 14,400 doses. Wastage is more prevalent for Pfizer-BioNTech with 0.8% of doses unsuitable for use. Only 0.2% of Oxford-AstraZeneca doses have been deemed unsuitable, with 0.04% reported for Moderna. In comparison, NHS Scotland has estimated that around 1.8% of COVID-19 vaccines are wasted[5]. The other UK nations do not publicly report vaccine wastage.

5 Scotland's COVID-19 Vaccine Deployment Plan – Update March 2021

33 Reasons for vaccines being unsuitable for use include doses that fail quality assurance on initial inspection, doses that fail quality assurance following preparation and vials/doses which expire during the vaccination session. Specific requirements for storage, transportation, and shelf-life of Pfizer-BioNTech once thawed have presented challenges.

34 Arrangements to minimise wastage include:

a systematic recording of temperatures during the different stages of transportation to ensure storage requirements are met from source to site storage, and then on to vaccine centres.

b using reserve lists so that people can attend at short notice at the end of the day to use any vaccine left because of people not attending booked appointments. Approaches to reserve lists vary across health boards with some making reserve lists open to all priority groups while others are targeted to specific priority groups.

c allocation of the Pfizer-BioNTech vaccine mainly to mass vaccination sites. Pfizer-BioNTech shelf-life once defrosted is shorter than the Oxford-AstraZeneca, so the allocation to mass vaccination sites helps to ensure that it is used rather than reaching the end of its shelf-life.

What have been the factors affecting rollout to date?

35 Vaccine supply is the most significant factor affecting the pace of the rollout. UK-wide supply, while agreed through formal contractual obligations, is constrained by commercial pharmaceutical supply and international demand. In general, the Welsh Government and NHS Wales are informed of the expected notional supply around one month ahead. But this can change at short notice both upward and downwards, so reliable projections are difficult beyond two weeks and are in a range, with best, realistic, and worse case scenarios from BEIS.

36 Supply challenges to date include:

a the temporary withholding of a batch of Pfizer-BioNTech vaccines, equating to 25,000 vials, because of quality control issues in January. The MHRA quality control process ensures that vaccines are safe to administer.

b a reduction in February resulting from the refurbishment of both Oxford-AstraZeneca and Pfizer-BioNTech facilities in Europe to accommodate increased production levels.

c a reduction in April owing to the reprioritisation of Indian-produced Oxford-AstraZeneca vaccine resulting in an expected four-week delay.

37 Workforce models have evolved since the beginning of the vaccination programme, with a need to remain flexible to expand or reduce services at relatively short notice in response to supply. All health boards initially used registered health staff immunisers. This was then supplemented through GP practices, which has enabled vaccination activity to be scaled up and offered close to home. Changes to UK legislation has also enabled non-registered staff to be trained to vaccinate under supervision, and over time other partners, such as the military and more recently fire and rescue service personnel, have assisted in the rollout. Plans are also in place to use community pharmacies, with the first pharmacy offering of the COVID-19 vaccine launched in April 2021 in Cardiff.

38 Support staff, clinical staff who have either previously left or retired, and volunteers are also helping at vaccination sites in a variety of roles. The Welsh Government and health boards recognise the goodwill of retired staff who have agreed to come back and assist, as well as volunteers, but we heard mixed views on how easy and beneficial making use of these groups has been in practice. We heard of cumbersome processes to bring back retired or returning staff, some volunteers were only offering to help for short periods, and there were differing views about the need to undertake mandatory training.

39 Prioritisation in line with the Welsh Government policy and guidance has been an essential element of the programme to date. Almost all (99%) of the population at most risk from COVID-19 are in priority groups 1-9. All health boards have adopted prioritisation principles set out within the national vaccination strategy. However, there have been concerns about how the prioritisation approach has varied across Wales and the risk that some (including NHS staff) may have received their vaccine ahead of their allotted priority group. This has arisen because of the desire not to waste unused vaccine and the differing approaches to manage reserve lists. Welsh Government officials have written to health boards in an attempt to standardise the approach for reserve lists. There have also been challenges defining ‘frontline’ for health and social care staff, which may have also resulted in some staff receiving the vaccine earlier than intended.

40 We found that communications relating to prioritisation for the COVID-19 vaccination at a UK, Welsh Government and health board level have been generally consistent, reducing the risk of mixed messaging. In addition, work undertaken by Community Health Councils has found that the public have generally been happy with the communication that they have received from health boards. However, there appeared to be greater concern at earlier stages of the programme from people:

a wanting to know where and when they will be vaccinated;

b not understanding why, for example, a couple could not go to the same vaccination centre on the same day; and

c feeling that some with lower priority had been vaccinated before them.

41 As the programme has gathered pace, many of those initial concerns have eased. A longer lasting issue related to the format of invite letters. These letters are produced automatically by the Welsh Immunisation System for individuals invited to attend a mass vaccination centre, and for the first three months of the programme there was little that could be done to tailor them. We heard of concerns around:

a identical letters being used for first dose and second doses. An example was given to us where an individual was called back for a second dose at the initial recommended four-week period[6], but they thought they had received a first dose letter again in error and ignored it.

b the format of the letters, with interchangeable use of English and Welsh language over several pages, affecting the clarity of the letter and how to raise a concern or rearrange the booking.

42 The format of invite letters has since been addressed in relation to the use of English and Welsh language although the need to make clearer that the invitation is for second doses remains.

6 Initial guidance from the JCVI recommended that the second dose of the COVID-19 vaccine should be administered at four weeks after the first dose. This was subsequently changed to up to 12 weeks in January 2021.

What are the future challenges and opportunities?

43 The vaccine programme in Wales has progressed extremely well but there is still some way to go. Around 4.5 million doses are needed to protect 90% of the adult population in Wales with two doses. At the current rate, and with 3.3 million doses completed as at 31 May, this could mean that second doses for the remaining adult population are not completed until September. Alongside this, there is increasing discussion of an autumn booster programme. It is likely that there will be little respite between finishing vaccinating the remaining adult population and planning a possible next phase of the programme. This all points to a need to develop a longer-term plan for vaccine rollout that looks further ahead and moves beyond the here and now.

44 Vaccine supply is likely to remain a significant challenge. While new vaccines are also becoming available, the more that are in use, the greater the challenge to coordinate their deployment. Storage, transportation, preparation, shelf-life, and training requirements differ depending on the vaccine. Changes to JCVI guidance may also present challenges. For example, the recent guidance to offer under 40s an alternative to the Oxford-AstraZeneca vaccine[7] could result in slower rollout if alternative vaccines are not available. As more vaccines come on stream in Wales, complexity will increase further as may waste and operational efficiency. The Welsh Government are aware of this risk and are working to mitigate it.

45 The current workforce model is meeting the needs of the vaccination programme. However, as other services are restarted and as the wider economy reopens, a sustainable and still flexible workforce solution will be needed for the medium to longer term. Key issues include:

a some health board staff supporting the vaccination programme have been redeployed from their normal role. As other services are restarted, there will be competing workforce pressures as staff are called back to their core roles.

b we have heard that the workforce is fatigued, with many having worked above and beyond at many stages of the pandemic. This will not be sustainable in the longer term. We also heard that as the economy reopens and COVID restrictions are eased, the supply of volunteers is reducing.

c consideration is being given to the potential to combine a COVID-19 booster programme with the routine flu immunisation programme, or whether there is a clinical need to keep them separate. Either way, there are implications for the development of the workforce to meet demand.

7 JCVI statement on Use of the AstraZeneca COVID-19 vaccine: 7 May 2021

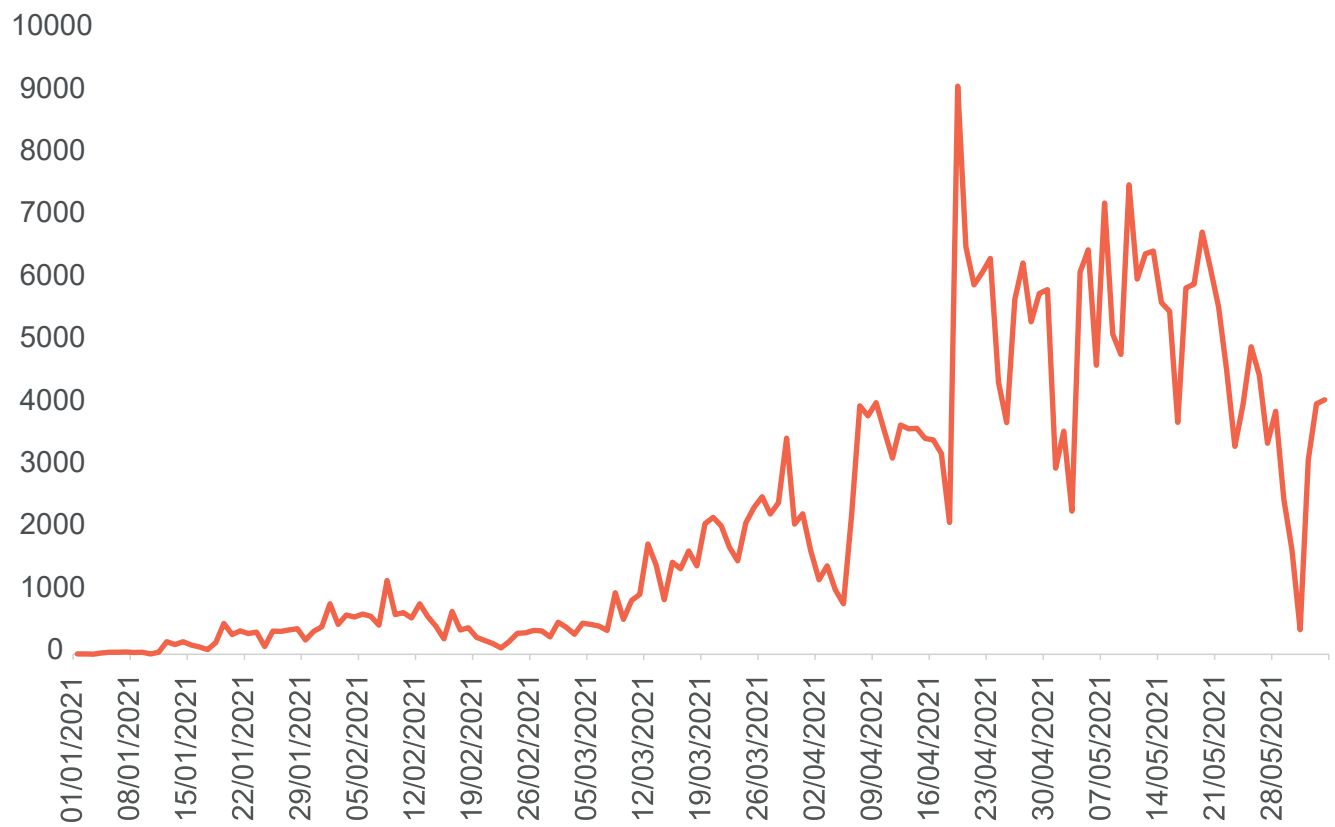
46 Sites used as mass vaccination centres have largely been made available to health boards through the goodwill of partners. Many of these venues were closed due to COVID-19 restrictions. With restrictions easing, organisations will now be looking at the potential to reopen these venues before the anticipated end of the current programme as a way of remaining commercially viable, for example, Venue Cymru in Llandudno. Health boards are likely to need to consider alternative cost-effective options for vaccination centres at relatively short notice to deliver the remainder of the current programme. They will also need to look at how to accommodate the longer-term COVID-19 vaccination programme alongside the wider immunisation programme.

47 There will always be differences in vaccination models to respond to local population needs and geography. Nevertheless, some models will be delivering greater efficiency than others. Early observations from the military partners involved in the vaccination programme identified vaccination sites were not always making the most efficient use of qualified staff and that rates of vaccination per hour per staff varied between 2.6 and 10.2. This variation in vaccination rates merits further investigation by operational officials, but the local variations will be, in part, due to supply and vaccine type. Health boards and the Welsh Government need to maintain a focus on ensuring that service models provide value for money. This will also help inform the shape of future models and programme design.

48 As the programme moves forward, there is a growing concern that the younger population are less likely to accept the offer of a vaccination. Health boards are continually assessing and adapting vaccination models to ensure they are accessible to all and working in partnership with other agencies to understand the reasons for vaccine hesitancy and to put actions in place. This has included some positive actions being taken to engage community leaders in particular ethnic communities, and members of the travelling community. Health boards and partners need to maintain this focus to build trusted relationships and improve the confidence in the vaccine programme. This is likely to be resource intensive if the Welsh Government and NHS wants to maintain its overall positive uptake rate for the remainder of the population and to ensure uptake of second doses is as high as is being achieved for first doses.

49 Having dropped at the end of March and early April, the number of individuals who do not attend for their appointment has since increased again (**Exhibit 6**). It is understood that non-attendance is greater for first dose vaccines, than second dose vaccines. Non-attendance impacts the pace of the programme and represents a cost-inefficiency as staff can end up underutilised. Arrangements to call those on reserve lists in at short notice are helping to fill empty slots, but as the percentage of the population yet to have a vaccine reduces, filling these slots will become more challenging. Non-attendance rates do vary by health board with Aneurin Bevan, Cardiff and Vale, and Swansea Bay University Health Boards experiencing some of the highest levels.

Exhibit 6: Numbers of people invited for vaccination but did not attend by day up to the end of May 2021



Source: Welsh Government

Note: the data used is intended for internal management information purposes and has therefore not been validated

50 Some of the reasons for non-attendance have included delays in invite letters being received, and problems getting through to contact numbers to rearrange appointments, as well as people not turning up because of vaccine safety concerns. Difficulties in getting time off work to attend appointment slots and clashes with holidays as society opens are increasingly likely to result in further non-attendance over the coming months. There is opportunity to reflect on the current approach for booking, with consideration to web-based systems to support self-booking of appointments. This will help provide flexibility and minimise the resource intensive process when people have to re-book or staff must find people to fit in the slots. The programme is actively working on establishing this with Digital Health and Care Wales.

51 Following a recent 'Programme Assessment Review' in March, the Welsh Government has considered future challenges and how it strengthens national programme management arrangements. To date, there has been limited additional central capacity to drive the programme at a national level, and reliance has been placed on a relatively small number of officials both within the Welsh Government and across the NHS to lead the rollout programme. Programme management arrangements during the early part of the vaccine rollout were rather unwieldy, with early oversubscribed Stakeholder Boards due to intense interest. In excess of 60 people from different professional backgrounds attended. Changes have been made to tighten up these arrangements and we understand that more changes are planned to further streamline programme management and governance.

52 Whilst the challenges outlined here need to be carefully considered as the vaccine rollout moves to its next stage, it should be recognised that the programme has moved at a scale and pace not previously seen in Wales. There is much to celebrate in that and there are many positive lessons to learn for the delivery of other programmes and the wider immunisation agenda.

Appendices

1 Audit approach and methods

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

1 Audit approach and methods

Our primary focus was on the national vaccination programme and the deployment of vaccines in Wales. We drew on the vaccination deployment of three health boards to obtain an understanding of rural and urban settings. We considered the set-up of the national programme, performance of the programme, and the factors or issues that have affected rollout.

Our work excluded vaccination arrangements administered by the UK government. The National Audit Office has examined the UK government's preparations for potential COVID-19 vaccines[8]. We reviewed that report to help inform our wider understanding of procurement, contracting and vaccine costs, which are administered UK-wide.

Audit methods

We used a range of methods:

- **document review**: we reviewed national strategy, guidance, Welsh Government announcements and update reports, health board vaccination plans, local and national performance reporting. We also reviewed national vaccination stakeholder and deployment board papers and minutes.
- **observations**: we attended several national vaccination stakeholder board and deployment board meetings as observers.
- **semi-structured interviews**: we interviewed Welsh Government officials involved in the vaccination programme, selected members of the national vaccination deployment board, and senior managers from three health boards involved in the set-up of vaccination sites and the deployment of vaccines.
- **data analysis**: we reviewed available data on first and second dose vaccination progress in Wales and the other UK nations. We considered vaccine wastage and deployment costs, in relation to pay costs, non-pay costs and the extent of costs associated with vaccination in primary care settings.

It is not possible for us to present data for the same period throughout this report. Data in this report are taken from differing sources and are published at differing intervals. Detailed information on vaccine availability, stock, and utilisation by manufacturer is not publicly available for reasons of commercial confidentiality.

We completed our fieldwork between February and April 2021.

8 Investigation into preparations for potential COVID-19 vaccines, National Audit Office, December 2020

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

Vaccine	No of doses	Status
Oxford-AstraZeneca	100 million	Approved 30 December 2020 and in deployment across Wales from January 2021
Janssen	20 million	Approved 28 May 2021
Pfizer-BioNTech	100 million	Approved 2 December 2020 and in deployment across Wales from January 2021
Moderna	17 million	Approved 8 January 2021 and in deployment from April 2021 in Aneurin Bevan and Hywel Dda University Health Boards
GlaxoSmithKline/ Sanofi Pasteur	60 million	Phase 3 trials
Novavax	60 million	Encouraging phase 3 safety and efficacy data
Valneva	100 million	Phase 3 trials
CureVac	50 million (initial order)	Phase 3 trials
Total	**507 million**	

Source: Recent GOV.UK announcement, updated based on information from the London School of Hygiene and Tropical Medicine and recent GOV.UK announcement

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

Vaccine prioritisation groups	
1	People living in a care home for older adults and their staff carers
2	All those 80 years of age and older and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and people who are extremely clinically vulnerable (also known as the "shielding" group) – people in this group will previously have received a letter from the Chief Medical Officer advising them to shield
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions*, which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Source: Welsh Government

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Agenda Item 8

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Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

An overview of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board: A summary of progress made against recommendations

May 2021

The Auditor General has prepared this report under section 61 of the Public Audit (Wales) Act 2004, and in accordance with section 145 of the Government of Wales Act 1998. The work has been undertaken jointly with Healthcare Inspectorate Wales.

Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales. We inspect NHS services, and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

Contents

Introduction and background

1 Cwm Taf Morgannwg University Health Board (the Health Board) provides primary, community, and hospital services to the populations of Merthyr Tydfil, Rhondda Cynon Taf and Bridgend.

2 In November 2019, Healthcare Inspectorate Wales (HIW) and Audit Wales (AW) undertook a joint review of quality governance and risk management arrangements within the Health Board. This work followed a report by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives which identified a number of serious concerns and service failings with maternity services. The Royal Colleges' report threw into sharp focus the concerns we had previously articulated about the Health Board's quality governance and risk management arrangements. As a result of the Royal Colleges' report, in April 2019 the Health Board's maternity services were placed into special measures and the organisation was escalated to the status of 'targeted intervention' within the NHS Wales escalation and intervention framework[1].

3 Our November 2019 Joint Review[2] found a number of fundamental weaknesses in the Health Board's governance arrangements in respect of quality of care and patient safety. We made 14 recommendations for improving risk management, the handling of incidents claims and complaints (concerns), patient safety and organisational culture. The Health Board fully accepted the findings and began to respond to the report's recommendations.

4 Since our review there have been changes to the senior leadership team within the Health Board. This includes a new Health Board Chief Executive who was appointed in September 2020, taking over from the interim appointment made in June 2019, following the departure of the previous Chief Executive. There have also been some changes to other key executive roles including the appointment of a substantive Director for People, Interim Executive Director of Therapies and Health Sciences, Interim Director of Planning and Performance and Interim Chief Operating Officer.

1 The NHS Escalation and Intervention Arrangements

2 A joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board

5 In addition, the Health Board has implemented a new operating model, creating three Integrated Locality Groups (ILGs) based around the geographical areas of Merthyr Tydfil and Cynon Valley, Rhondda, Taff Ely and Bridgend. The ILGs are clinically led and managerially supported to strengthen clinical leadership and to ensure a focus on quality and safety. ILGs and their Clinical Service Groups (CSGs) are responsible for delivering acute, primary, community and mental health services to meet the needs of their local communities.

6 This report provides a progress update against the original 14 recommendations made in our report. We have been mindful of the impact that the COVID-19 pandemic (the pandemic) has had on the ability of the Health Board to respond to the recommendations, however, given the fundamental deficiencies identified in 2019 we felt it was important to establish and assess what progress the Health Board has made. We undertook similar evidence gathering activities as in our previous review. The pandemic meant that our work was undertaken remotely given the ongoing requirements for social distancing and the suspension of our onsite audit and inspection work at the time of fieldwork.

Main conclusions

7 The Health Board is making good progress to address the recommendations that we made in 2019, particularly when taking account of the challenges it has faced in responding to the pandemic. This has impeded progress on improvements in some areas, meaning some actions haven't progressed as quickly as the Health Board originally intended.

8 The Health Board has made progress at a strategic level, ensuring a greater focus on quality, patient safety and risk. Through its Quality and Patient Safety Governance Framework it has defined what high-quality care is, aligning this framework to its new operating model. However, the pandemic has impacted on the development of the Health Board's Quality Strategy and further work is needed in this area. Since completing our fieldwork, the Health Board has indicated its intention to integrate the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is being developed. The Health Board has also indicated its intent to align the Patient Experience Strategy to the overall Health Boards Engagement strategy. These strategies are due for completion by Autumn 2021.

9 Accountability and responsibility for quality and safety is now clearer. Leadership of quality and patient safety has been strengthened with collective responsibility being shared amongst the four clinical executive directors. The Quality and Patient Safety Governance Framework defines responsibilities at an operational level through to the executive level. In addition, resources have been strengthened through the introduction of new roles to support quality and patient safety, within both the nursing management team as well as the office of the Medical Director.

10 The Health Board has improved its organisational scrutiny of quality and patient safety. Work has been undertaken to improve flows of assurance from service to Board which are now clearer and supported by improvements in the quality of information presented to the Quality and Safety committee. Independent members are now more supported in their scrutiny role through ongoing development and induction, and there is more focus on gathering and learning from patient experience.

11 Quality and safety are now a key focus of regular day to day business in terms of meetings at an operational and executive level. However, the suspension of some of the governance frameworks due to the pandemic means that more work is needed to fully embed these arrangements across the Health Board and ensure they are operating effectively.

12 Arrangements for the identification and management of risk have been strengthened. There has been significant work undertaken throughout the Health Board to implement the new risk management strategy, and this is now in place and operating. Processes for managing, identifying, and mitigating risk have improved. Operationally, ILGs have made an effective contribution to this by reviewing risks in their areas to ensure that an accurate and up to date picture of risks is now being presented. Despite early progress, further work is needed to ensure that the highest rated CSG risks are appropriately escalated to the ILG risk registers.

13 The management of incidents, concerns and complaints has been improved. Oversight and governance of Datix[3] is improving, with evidence that the information within the system is now being used more effectively both at an executive and operational level. Some challenges remain with the interrogation of data within the current system, but this should be assisted by the planned implementation of the new Once for Wales system in July 2021. Work to improve the management of complaints and incidents continues with additional resources now in place to support the concerns and complaints teams, and investment in ILG resources. While these resources are helping to address the significant backlog in responding to complaints and incidents, progress on this has slowed as a result of the Health Board's response to the pandemic and there is more for the Health Board to do to ensure it fully captures the learning from complaints and incidents.

14 Positive steps have been taken by the Health Board to improve organisational culture and learning. The Health Board launched its Values and Behaviours Framework in October 2020. Whilst it is too early to assess the impact of this framework, there are encouraging signs from its implementation and roll out. The framework was co-produced with a range of stakeholders including staff, stakeholders, and the local community. Whilst plans are in place to strengthen the Health Board's processes for organisational learning e.g., the establishment of the Shared Listening and Learning forum, this is an area that will require continued focus and attention to ensure that improvement is sustained.

3 Datix is a web-based system that is used to manage incident reporting, risk registers, complaints and safety alerts.

15 In conclusion, against the backdrop of the pandemic, much work has been done by the Health Board to address the issues we raised in 2019. We noted considerable commitment, drive, and enthusiasm from the staff we interviewed, and a clear desire to get things right. This energy needs to be sustained to ensure that the work completed so far is built upon and embedded.

16 Notwithstanding the good progress we have recognised through our follow up, there is still work to do in each of the areas where we made recommendations in 2019. As such, each of the recommendations should remain open. We will continue to monitor the Health Board's actions against the issues identified in this report and agree the timing of any further follow up work as part of our routine engagement with the Health Board.

17 More detailed information about progress against the individual recommendations made in 2019 is set out in the following sections of the report.

Recommendations

Recommendations to improve the strategic focus on quality, patient safety and risk

Recommendation made in November 2019	A summary of progress made by April 2021
R1 The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy.	**The Health Board has defined what high-quality care means but its ambition to agree quality priorities, set out in a quality strategy, has been significantly delayed due to the pressures of the pandemic.** In 2019, we found that the Health Board had not articulated organisational quality priorities. The Health Board's Quality and Patient Safety Governance Framework (Quality Governance Framework) implemented in June 2020 defines high quality care as care that is safe, timely, effective, efficient, equitable and patient-centred. These domains provide the framework against which organisational quality priorities can be identified, and their success measured. During 2020, the Health Board planned to develop a Three-year Quality Priority Strategy in partnership with the local community, staff, and other key stakeholders. The Health Board appointed an Associate Medical Director with responsibility for quality improvement to take forward development of the strategy with engagement and coproduction with the three ILGs. However, progress has been delayed significantly given the availability of locality teams and re-deployment of staff to respond to the pandemic. Nonetheless, it is important that progress is now made on developing the Quality Priority Strategy. Since completing our fieldwork, the Health Board has indicated its intention to integrate the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is due to be published by Autumn 2021.

Recommendation made in November 2019	A summary of progress made by April 2021
R2 The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically; a The Board Assurance Framework (BAF) reflects the objectives set out in the current IMTP and the Health Board's quality priorities. b The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board.	**The Health Board has made good progress in this area through the introduction of the new risk management strategy which reflects the new operating model and has good alignment with the Quality Governance Framework.** **The Board Assurance Framework (BAF) used by the Health Board is continuing to evolve to reflect the new operating model and strategic objectives.** In January 2020, the Board approved the new Board Assurance Framework. This was seen as an interim step prior to undertaking the significant work needed on the Health Board's processes for managing and identifying risk, agreeing the Health Boards risk appetite, and agreeing the principal risks. During 2020, the Health Board took the first step towards updating the current BAF by undertaking a comprehensive review of its risk management approach. In September 2020, the Health Board agreed the key threats and principal risks that would affect the achievement of their strategic objectives and gained formal agreement from the Board of its current risk appetite. In November 2020, the Board received the new organisational risk register following a large-scale review of risks by the ILGs and the corporate departments. Work to define the mitigating actions and to identify the controls and sources of assurance is ongoing. Once complete, the Health Board intends to produce a more detailed Board Assurance Framework. The Health Board has also articulated its intention, by the end of 2021, to develop a Board Assurance Report (BAR), which will detail the principal risks rather than the operational risks as currently defined in the risk register.

Recommendation made in November 2019	A summary of progress made by April 2021
c The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework.	**There has been a comprehensive review of the Health Board's risk management approach since our 2019 review.** The revised risk management strategy and Risk Management policy were agreed by the Board in January 2021, after significant work by the Health Board to fundamentally review its approach and reflect the new locality based operational model. The new strategy clearly sets out the risk management process from service to board as described in the Quality, Patient Safety and Governance Framework, as well as articulating the intended plans for the Board Assurance Report process. The risk assessment Procedure was also reviewed and approved by the Management Board in January 2021 which further supports the risk approach and process within the Health Board.
d Terms of reference for the relevant committees, including the Audit Committee, QSRC[4] and CBM[5], reflect the latest governance arrangements cited within the relevant strategies and frameworks.	**Significant progress has been made on developing and implementing the Quality Governance Framework, however, more work remains to fully embed it within the organisation.** Since our review there have been many iterations of the framework with the latest version setting out the structures and processes that need to be in place operationally and strategically within the Health Board. The framework clearly defines high quality care (see progress against recommendation 1) and aligns to the organisation's Values and Behaviours. During the pandemic it has been easier to operationalise the Quality Governance Framework at an organisation and ILG level, but work to embed the governance structures within the CSGs which sit beneath the ILGs is ongoing. **Terms of references for relevant committees have all been updated to reflect the new scheme of delegation and operating framework.** In January 2021, the terms of reference and Health Board scheme of delegation were revised to reflect the updated risk management arrangements. The Health Board took the opportunity to update and revise the terms of reference for each committee following changes to the governance framework after our 2019 review. These will now be subject to an annual review as part of the ongoing governance processes and is captured in the cycles of business for Board Committees.

4 In December 2019 the Quality, Safety and Risk Committee became the Quality and Safety Committee, and the Audit Committee became the Audit and Risk Committee.

5 Clinical Business Meetings were stood down following the introduction of the new operating mode introduced in April 2020.

Recommendations for leadership of quality and patient safety

Recommendation made in November 2019	A summary of progress made by April 2021
R3 Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety. b Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates. c Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.	**The Health Board has taken steps to strengthen responsibilities in relation to quality and patient safety both across the executive team and within its ILGs.** **Collective responsibility for Quality and Safety is now shared by the four clinical executive directors.** The Medical Director, the Executive Nurse Director, the Executive Director of Therapies and Health Sciences and the Director of Public Health have specific responsibilities for quality and safety, as well as professional leadership across their respective disciplines, with the Executive Director of Nursing acting as executive lead. This is clearly set out in the Health Board's Quality Governance Framework. The capacity of the clinical executive directors has been reduced for a number of years because of the challenge of recruiting a substantive Director of Therapies and Health Sciences. Since our last review, the Health Board did recruit substantively, however, this post became vacant once more. This post is now filled on an interim basis by the Executive Director of Therapies and Heath Sciences from Cardiff and Vale University Health Board who works across both Health Boards, the Health Board is also recruiting a full time Clinical Director for Allied Health Professionals (AHPs) to ensure professional leadership and capacity. **The Health Board has clarified the roles and responsibilities for quality and patient safety within the new ILGs and CSGs.** The Quality Governance Framework aligns to the operating model that was introduced in April 2020. Responsibilities at an operational level for quality and patient safety are defined by the Quality governance Framework, which sets out the process and structure for the ILGs and their respective CSGs. The new operating model is helping to improve the focus on quality. For instance, ILGs are held to account by the Director of Operations, Nurse Director, Medical Director and Chief Executive for the delivery of high-quality patient centred care in line with the Quality Governance Framework.

Recommendation made in November 2019	A summary of progress made by April 2021
	The Health Board has invested in additional capacity to support quality and patient safety at a corporate and ILG level. The Health Board has invested in new roles to support quality and patient safety. Within the nursing management team, new posts include an Assistant Director for Nursing and Peoples Experience, Deputy Executive Director of Nursing, a Head of Corporate Nursing, and a Senior Nurse for Professional Standards and Quality Assurance. The Medical Director has also established several new roles for Associate Medical Directors to lead on development of the quality strategy and clinical audit. The Health Board has also recently established a Quality Improvement team and appointed an Associate Medical Director for Quality Improvement and the Director of Improvement started in post in April 2021. The Health Board is also in the process of establishing the systems and infrastructure to support the Health Board's improvement work. Newly appointed Nurse Directors are in place for each of the three ILGs, and they are responsible for supporting quality governance, which is a shared responsibility across the three ILG senior leaders. In addition, each ILG also has a Head of Quality and Safety in place to support the quality governance agenda. Their role is to support the work of quality and patient safety within the ILGs, linking with the central Patient Care and Safety Team and the Assistant Director for Quality, Safety and Safeguarding. Over the past few months ILGs locally have also started to recruit additional governance staff to address their capacity issues as there are differences in the team sizes across the ILGs. The Bridgend and Merthyr Cynon ILG also have a new appointed Head of Midwifery for their respective obstetric units under the leadership of our Director of Midwifery who commenced in post in Jan 2020.

Recommendations for organisational scrutiny of quality and patient safety

Recommendation made in November 2019	A summary of progress made by April 2021
R4 The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following: a Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively. b Improvements to the content, analysis, clarity, and transparency of information presented to QSRC.	**Although some aspects of this recommendation have been superseded, there has been good progress with establishing the new governance framework and reporting.** **Plans for implementing subgroups to support the Quality, Safety and Risk Committee[6] were stood down following a revision to the Patient and Safety Governance Framework, therefore this element of the recommendation is superseded.** The Quality and Patient Safety Governance Framework has evolved in response to the new operating model introduced in April 2020. Quality governance arrangements have been established within each ILG and each ILG reports on quality and patient safety matters directly to the Quality and Safety Committee. **The quality of information presented to the Quality and Safety Committee for assurance and scrutiny is improving.** The Committee routinely receives quality and patient safety reports from each ILG and an organisation wide Patient Safety Quality report. These reports cover all service settings including acute, primary and community and mental health services. They also include a set of overarching Health Board wide quality metrics. The reports contain information across a wide range of quality indicators and enable scrutiny of patient experience across all three ILGs in a standard template which enables comparisons. The content covers all service areas, and ILGs are encouraged to flag areas of incidents, claims and complaints (concerns), and risks, and there is appropriate narrative to provide assurance. Reports are delivered by the ILG

6 This committee was replaced in December 2019 with the Quality and Safety Committee.

Recommendation made in November 2019	A summary of progress made by April 2021
c Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications, and training.	teams themselves, which enables oversight and scrutiny from independent members. Our observations of Board and Quality and Safety committee meetings found appropriate levels of scrutiny and challenge with candid responses from officers. The improvements to the quality reports are positive and include the use of trend information but fall short of setting targets or thresholds where further work or escalation may occur, for instance if pressure ulcer occurrence in one ILG area goes higher than expected. There is an ambition to move to live dashboards to improve analysis and data interrogation and discussions have started to move this forward by the end of 2021. Plans have also been developed by the Nursing Directorate to introduce a 'focus on' section in the Health Board Quality and Safety report to address issues requiring greater interrogation and triangulation, and this will be presented to the next Q&S Committee in July 2021.
R5 Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.	**Independent Members receive appropriate support through the provision of an induction programme and ongoing development to support them in their scrutiny role.** Our 2019 review identified opportunities to improve induction and development programmes for Independent Members (IMs) to support their work and effectiveness. Since then, the Health Board has introduced a more structured induction programme for IMs, which compliments the Welsh Government's all Wales induction process. Local support for IMs is provided by the corporate governance team. During 2020, all IMs received an appraisal with the Chair of the Health Board and the Director of Governance. Training needs were identified, and Personal Development Plans (PDPs) recorded. A programme of external evaluation and observations of Independent Members (IMs) has taken place with feedback given on their performance. There has also been work on engagement and relationships, team building, coaching, direction-setting, scrutiny and the relationship between the Board and its committees. The initial external evaluation of this work has shown positive improvements in areas such as scrutiny of information, and improved relationships between board members.

Recommendation made in November 2019	A summary of progress made by April 2021
R6 There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	**The Health Board has instigated several improvements related to this recommendation, to improve how it learns from patient experience. However, the pandemic response has impeded its ability to further progress and embed these improvements.** In response to our review in 2019, the Health Board began the development of a comprehensive three-year Patient Experience Strategy, however, its completion and implementation has been impeded by the pandemic response, and we have not received an update on its progress and a completion date from the Health Board in this regard. Attention will be needed to complete this strategy which underpins the Health Board's approach to patient experience. The Health Board has implemented a Shared Listening and Learning Forum, and its inaugural meeting was held on 17 February 2021. The forum has been established as part of the Health Board's framework for listening to and learning from incidents and patient or staff concerns and experiences, and to promote and support a learning culture. We reviewed the forum's draft Terms of Reference, which appear appropriate. It is chaired by the Executive Director of Nursing and will meet quarterly, reporting directly to the Management Board. It is, however, too early for us to judge the forum's effectiveness, and the impact it has made on patient experience and learning. Patient stories now form a regular part of the Board and sub-committee meetings, which was not always the case previously. The patient stories provide an opportunity for Board members to gain an insight into the experiences of individuals using the Health Board's services. A consequence of the pandemic has been the curtailment of executive and independent board member's patient safety walkabouts, which includes visiting ward and patient areas. However, there are plans to resume the programme of visits in due course when safe to do so.

Recommendation made in November 2019	A summary of progress made by April 2021
	The ILGs have introduced dedicated leads to manage patient feedback, concerns, and incidents. This has improved reporting to the Quality and Safety committee, as well as the local ILG Quality, Safety and Patient Experience meetings. We saw evidence that themes and trends are identified, but there is recognition more could be done to share and embed learning across the ILGs. The Health Board implemented a Friends and Family Test (FFT) tool across the organisation to collect and report real-time patient feedback. It was piloted in early 2020 and subsequently rolled out across the Health Board. However, this was halted due to the pandemic and in April 2021 the Health Board are implementing the new national 'Civica' patient experience feedback monitoring system. There is a commitment to ensuring patient feedback is captured, and the impact of this should be seen soon.

Recommendation made in November 2019	A summary of progress made by April 2021
R7 There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	**Good progress has been made by the Health Board in addressing visibility and oversight of clinical audit, but it could be better targeted to areas of organisational risk.** In December 2019, the Health Board approved additional funding to strengthen the Clinical Audit and Quality Informatics Department's ability to monitor compliance with participation, and to improve the quality of data used for all national audits. The additional funding has increased staffing with the appointment of a Deputy Assistant Medical Director for Clinical Audit, a dedicated clinical audit manager to lead on compliance with the national audit programme, a Quality Informatics Manager with responsibility for improving clinical data in Health Board systems and a Deputy Head and Lead Nurse for Clinical Effectiveness. The additional resources are helping the Health Board to utilise the audit findings to inform quality improvement initiatives and service redesign, such as establishing major trauma centres at the Princess of Wales and Prince Charles Hospitals in partnership with the ILGs. Oversight of the clinical audit programme is improving at a strategic level. The Audit and Risk Committee has received the clinical audit forward plan, and in February 2021 it also received, for the first time, a quarterly update report outlining progress of the plan. As part of its forward work plan the Quality and Safety committee plans to receive quarterly updates on the clinical audit plan. We would expect these updates to identify outcomes from the audit, actions being taken to share learning and to provide the committee with a source of assurance on the quality and safety of care being delivered. There is also the opportunity for clinical audit to be targeted to areas of organisational risk such as the impact on patients of Emergency Department overcrowding.

Recommendations to improve the arrangements for quality and patient safety at directorate level

Recommendation made in November 2019	A summary of progress made by April 2021
R8 The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	**The Health Board has made progress in clarifying the accountabilities and responsibilities for quality and patient safety across ILGs and within the CSGs, but more work is needed to ensure these improvements are embedded.** Accountability and responsibility for quality and patient safety has been strengthened across the ILGs with the introduction of appropriate directives within accountability letters issued by the Chief Executive to the Director of Operations. The letters emphasise the need for quality and patient centred care, and appropriately highlight that ILGs and CSGs are accountable for delivering high quality services in line with the quality framework, and that high-quality clinical leadership, supported by strong service management is critical. The Health Board has taken steps to strengthen clinical leadership across the organisation with a greater emphasis on quality and safety. This includes reviewing the accountability and responsibility of the Heads of Nursing roles within each ILG in relation to site management and quality and safety. In 2019 we found that the Head of Nursing was assuming responsibility for several non-clinical and estates related issues. In addition, because of taking over responsibility for the Bridgend County Borough Council, only two of three acute sites had a substantive Head of Nursing in post (Merthyr and Cynon and Rhondda and Taff Ely) and there were disparities in their responsibilities. However, since the implementation of three ILGs, a Head of Nursing role is now in place for the Bridgend locality. Accountabilities and responsibilities for this role are now clearly defined and are consistent across each ILG. In addition, there has been further recruitment to support quality and safety with the appointment of a Head of Nursing, a deputy Head of Nursing and a dedicated Head of Quality and Safety for each ILG.

Recommendation made in November 2019	A summary of progress made by April 2021
	Each ILG holds Patient Safety and Experience meetings, chaired by the ILG Nurse Director to provide assurance. This is a positive development albeit one that is continuing to develop, and our observations found that more coverage is needed in certain areas such as Infection, Prevention and Control. However, the Quality Governance Framework does not clearly articulate the quality governance arrangements for the CSGs that sit below each ILG. It has not been possible for some governance meetings to take place at CSG level due to the demand on clinical resources during the pandemic. Internal Audit's recent audit of Community and Adult Mental Health Services also found that the governance arrangements within the CSG were not clear with a lack of clarity about how they operate and function. This is an area that requires strengthening. In addition, whilst accountability and responsibility of the Heads of Nursing is clearly articulated, there appears to be an over-reliance on the Heads of Nursing to represent an overall clinical perspective during key quality and safety meetings, with limited input from medical teams. Due to the pandemic, the Health Board has had to delay its work on the clinical leadership and management development programme.This has impeded progress in terms of further embedding the quality and safety agenda within CSGs. This issue requires attention to ensure that responsibilities in relation to quality and safety are jointly demonstrated by both nursing and medical staff. Some of the formal quality and governance mechanisms established by the Quality Governance Framework were temporarily stood down during recent pandemic outbreaks and have recently been re-established, it therefore has been difficult to fully review the processes. Whilst the Health Board has taken steps to address this recommendation, these improvements remain at an early stage and still need attention to ensure they are being embedded across the organisation.

Recommendation made in November 2019	A summary of progress made by April 2021
R9 The form and function of the directorate governance committees and CBMs must be reviewed to ensure there is: a Clear remit, appropriate membership, and frequency of these meetings. b Sufficient focus, analysis, and scrutiny of information in relation to quality and patient safety issues and actions. c Clarity of the role and decision-making powers of the CBMs.	**Governance arrangements at an operational level have been strengthened. Since our 2019 review CBMs have been removed following the introduction of the new operating model. This recommendation is therefore superseded.** As stated previously, in April 2020 the Health Board made significant changes to the way it organises and manages its business, most notably establishing the three clinically led ILGs. The CBM process has been replaced. Routine executive oversight of the ILGs is now maintained through the Integrated Locality Group performance reviews between the ILG triumvirate and the Executive Director of Operations. The Medical Director, Director of Planning & Performance, Director of Finance and Executive Director of Nursing also attend depending on their availability. These meetings are supported by the ILG business partners for quality and safety, workforce, planning and finance. Consistency of these meetings is ensured with a template slide pack covering information on quality, complaints and incidents, risks, finance, sickness absence and performance. These meetings are an improvement on the CBMs with a clear remit and sufficient focus on information across quality and safety issues. The Group ILG Directors are also formal members of the Management Board[7] (MB) enabling them to escalate issues and concerns. At the time of our follow-up work, minutes and actions from Integrated Locality Group Performance reviews were not formally shared within the MB meetings, and there is a need to strengthen arrangements for MB oversight of issues raised at ILG level, and action taken in response as this would improve the clarity of decision making. However due to the pandemic several of the planned Integrated Locality Group Performance review meetings were stood down and were restarted in March 2021 following the Health Board moving out of the emergency pandemic response phase. Therefore, more time is needed to fully realise the benefits of this process.

7 The Management Board is the executive team responsible for service delivery, which meets bimonthly to discuss operational delivery across the Health Board.

Recommendations to improve the identification and management of risk

Recommendation made in November 2019	A summary of progress made by April 2021
R10 The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	**The Health Board has made good progress in addressing the serious concerns we identified in relation to risk management arrangements and has invested in dedicated support for governance and risk.** Since our 2019 review, the Health Board has reviewed its risk management systems and aligned them to the new operating model. This has been a root and branch review looking at arrangements from service to board. To ensure clarity, the Health Board has implemented a new Risk Management Strategy approved at Board in January 2021. Corporate support for Risk Management has been improved through the appointment of an Assistant Director of Governance and Risk. This post supports the executive directors, ILGs and the Heads of Quality and Patient Safety to ensure a consistent approach to describing and scoring risks, compiling risk registers, and identifying mitigation actions. This has facilitated an increased focus on risk and driven the improvements that have been delivered. There has been a Health Board wide review of risks at a corporate, ILG and CSG level. This was a large piece of work undertaken at a time of considerable service pressures and is to be commended. The product of this work was the revised organisational risk register, which was presented to the Board in November 2020. This is a significant improvement since the previous risk register, however there is recognition within the Health Board that more work is needed to improve the mitigations and actions as described. Also, some aspects of the CSG risk registers are still being updated to ensure they are accurately reflected within the Integrated Locality Group registers.

Recommendation made in November 2019	A summary of progress made by April 2021
	The Risk Management Strategy sets out a clear route from service to board, showing the process for escalating risks through the ILG management tiers within the new operating model based upon risk score. Whilst there is evidence that risks are de-escalated where appropriate to do so, there is still more work to do in relation to where risks scoring less than eight are captured. At the time of our follow-up work, the Health Board had prioritised the capture of risks scoring nine and above on the Datix system given the ongoing response to the pandemic. However, where ILGs, CSGs or corporate teams identify risks that score 1-8, these are captured on local risk registers and not the Datix system. The Health Board acknowledges the risks of maintaining parallel systems and of the need to ensure clarity regarding the process for de-escalation. Internal Audit's recent assessment[8] of one CSG found evidence that not all risks are escalated appropriately, again demonstrating the need to ensure that the improvements made at ILG level are still to be embedded across the CSGs.

8 Internal Audit Report

Recommendations to improve the management of incidents, concerns, and complaints

Recommendation made in November 2019	A summary of progress made by April 2021
R11 The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.	**Oversight and governance of DATIX is improving with more use made of information at corporate and ILG levels within the organisation. Further work is needed on strengthening organisational learning from incidents, claims and complaints (concerns).** There is now clarity as to where the ILG Datix teams sits within the Health Board's structure, reporting through the Health and Safety team to the executive Director for People. The Health Board has indicated that these new accountability arrangements will be reviewed over the next three to six months. There is now a renewed focus on ensuring that quality and patient safety is a priority. Mechanisms to improve oversight and scrutiny at an executive team level are in place. The Executive Director of Nursing and the Assistant Director of Quality, Safety and Safeguarding chair a short weekly meeting to review the previous week's complaints and incidents in conjunction with the quality metrics for nurse staffing levels. At the beginning of December 2020, a report to the weekly executive Director-led Patient Safety weekly meeting identified that more than 600 incidents had occurred within the prior six months that were yet to be allocated for investigation. The Health Board is working to address this backlog of investigations and completion of the appropriate fields within the Datix system, prioritising these based on the severity of harm. Whilst the Health Board has informed us that since our work it has developed investigation and serious incident trackers to enhance monitoring in relation to incident management, more work is required to ensure that opportunities are taken for identifying early learning following incidents. Use of Datix has improved, although there are some issues with the access to information at the Integrated Locality Level which is affecting their ability to produce localised reports. This is being addressed by the Datix team but does required a considerable amount of work. The Health Board will be implementing the Once for Wales system In July 2021.

Recommendation made in November 2019	A summary of progress made by April 2021
	Information provided by the Health Board indicated that it was not able to accurately identify staff who could investigate incidents and undertake root cause analysis. Additionally, the Welsh Risk Pool (WRP) recently expressed concerns over the time being taken by the Health Board to complete timely Learning from Events Reports (LFER) in line with WRP reimbursement procedures. This has been a challenging area for the Health Board due to the high numbers of legacy and maternity cases and the WRP has expressed concerns around the quality and timeliness of information submitted by the Health Board. In response, further work and progress has been made, and a task force established with weekly progress meetings with a commitment made by the Health Board to submit all LFER by the 31 March 2021. We have also been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module, which has enabled accurate tracking and monitoring of attendance. The Assistant Director of Quality, Safety and Safeguarding holds biweekly meetings with the ILG Heads of Quality and Patient Safety with the aim of ensuring that appropriate actions are taken in response to complaints and incidents. Within the ILGs the monthly Quality and Patient Experience Meetings also scrutinises information from Datix to look at trends and analysis. All three ILGS have identified that analytical capacity is a barrier to using this data effectively and are recruiting to analytical support posts as a consequence. The ILGs have also identified that there is further work to do in addressing training needs for staff in relation to DATIX and ensuring that the right people have access to the system. The January 2021 report to the Quality and Safety committee provided reassurance that feedback from incident reporting through DATIX was improving, however there is further work required to improve the quality of feedback provided to the reporter.

Recommendation made in November 2019	A summary of progress made by April 2021
	As noted earlier in the report, the Health Board has also established a Shared Listening and Learning forum which reports to the management board. Part of the forum's remit is to oversee the Health Board's framework for listening and learning from quality and patient/staff related concerns and experiences. In addition, it champions a patient and staff safety culture and facilitates learning and sharing good practice. The forum's inaugural meeting was held in February 2021 with all ILGs presenting themes, issues and learning from incidents, claims and complaints (concerns). Whilst this is a positive development, it is too early to assess the effectiveness of this forum.

Recommendation made in November 2019	A summary of progress made by April 2021
R12 The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate staff need to be empowered to take ownership of concerns and take forward improvement actions and learning.	**Whilst the Health Board has made progress with addressing this recommendation, oversight of training corporately, and within each ILG, requires further attention.** Our 2019 review identified the need to improve the oversight and management of concerns. This included the operational processes for investigating and learning from concerns. Training on concerns management has been prioritised and has been provided across the Health Board for relevant individuals delegated with the responsibility for managing the concerns process. In addition, the Health Board's concerns policy was also reviewed and approved by the Board in August 2020. Training requirements for managing concerns are identified within the policy. Whilst at the time of our work ILGs were not able to accurately report on the proportion of their staff who have received training to investigate concerns, incidents or undertake root cause analysis, we have been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module enabling it to track who has received this training. There now appears to be consistency of approach and clearer accountability in relation to concerns management across each ILG, with concerns managed within the relevant CSG before gaining ILG approval, and subsequent submission to the corporate concerns team for final response approval. We saw examples of this within quality and safety and experience groups across the ILGs, where there was evidence that staff at local level are taking greater ownership and responsibility for a concern, and for implementation of improvements where required. To further strengthen concerns management processes, recent recruitment has increased the size of locality and corporate concerns teams.

Recommendations for organisational culture and learning

Recommendation made in November 2019	A summary of progress made by April 2021
R13 The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation.	**The Health Board has made good progress in developing and rolling out its Values and Behaviours Framework, although it has needed to adjust the implementation timescales because of the pandemic.** At the time of our 2019 report, the Health Board was launching a programme of work to develop a Values and Behaviours framework for the organisation. Listening events were held with staff, patients, and service users between November 2019 and February 2020 to help identify the issues that such a framework would need to address. The outbreak of the pandemic meant further work on the Values and Behaviours Framework was delayed until June 2020. However, when the work resumed the Health Board was able to take account of staff experiences of responding to the pandemic and gather baseline information about staff well-being. In total the Health Board collected around 6,445 pieces of feedback from staff, stakeholders and the local community which informed the framework. To inform the development of its Values and Behaviours Framework, the Health Board undertook a series of listening events, engaging with approximately 8,000 people, including patients and staff. External consultants were appointed to support this work and to develop the engagement methodology. The work appears to have had a positive impact on the development of the framework and in planning for the Patient Experience Strategy. The Health Board formally launched the Framework on World Values Day, 15 October 2020. There was a live interactive session with a keynote presentation from Professor Michael West on compassionate leadership in the NHS. More than 2,000 staff participated in the event. The framework was also publicised on the Health Board's intranet and social media channels.

Recommendation made in November 2019	A summary of progress made by April 2021
	A detailed implementation plan is in place to embed the Values and Behaviours, and this is monitored by the People and Culture Committee. Staff whom we interviewed were generally positive about the Values and Behaviours Framework. The Health Board recognises that it will take time to fully embed the Values and Behaviours across the organisation and to enhance employee experience. To help embed them, the Health Board is revising its leadership programmes to incorporate the values and behaviours. The Values and Behaviours are reflected in key Health Board documents, and they are visible on its website. They are also reflected in the Terms of Reference for the ILGs.
R14 The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	**The Health Board has started to develop a stronger approach to organisational learning, although the pandemic has impeded progress against this recommendation.** In 2019, we found a lack of formal processes to identify and share learning for improvement across the organisation to support the delivery of safe and effective care. Additionally, in 2019, the NHS Wales Delivery Unit also raised concerns about the management and learning from serious incidents and never events. We have highlighted the Health Board's current position regarding learning and improvement in response to concerns and patient and staff feedback (R12). Progress has been made in strengthening the overall responsibility and management of clinical and serious incidents across the Health Board. A clinically-led Serious Incident team has been established, alongside a more robust process for the management of incidents, and learning resulting from them. Supporting this, the Health Board has implemented a Serious Incident Tool kit. This tool has reportedly assisted with consistency in managing incidents and supported sharing learning. The Serious Incident team undertakes a monthly clinical audit and super audit (quarterly) in collaboration with the Patient Care and Safety Team. The findings and actions for learning from these audits are reported through the locality Quality, Safety and Executive groups, and into the Quality and Safety Committee.

Recommendation made in November 2019	A summary of progress made by April 2021
	The Health Board is also establishing an improvement function called 'Improvement CTM', which will bring together learning from audit activity and concerns. Improvement CTM is expected to empower the Health Board's workforce to take responsibility for implementing continuous improvement through organisational learning. This is still early in its implementation and therefore too early to assess its effectiveness. It was widely reflected to us that tackling the issue of improving organisational learning has been a challenge for the Health Board because of the pandemic response. Whilst there is some evidence of a stronger approach being taken to organisational learning, we have limited evidence at this time to be assured that learning is being effectively disseminated to all areas of the organisation and frontline staff. Minutes and observations found evidence of learning being shared within CSG and ILG quality and safety meetings. However, there is a need to strengthen overall arrangements for sharing learning across the ILGs. The Health Board is aware of this and hopes this will improve, particularly with the Heads of Quality and safety now in post across all ILGs. Our observations of CSG and ILG quality and safety meetings found that external activity such as HIW inspections are being regularly discussed to ensure that action is taken to address recommendations, and learning is disseminated across CSGs and the Health Board. The previously mentioned Shared Listening and Learning forum will also focus on the learning and dissemination of findings and recommendations from external reviews, audits, and inspections. However, there is limited evidence to demonstrate that wider learning beyond the clinical area being inspected is shared effectively across all other clinical areas and with staff, particularly with those on the front line who are responsible for day-to-day care of patients.

Recommendation made in November 2019	A summary of progress made by April 2021
	Assurances are given to the Quality and Safety Committee about learning from incidents, but the reports do not provide examples of the learning and how it is being applied or shared more widely across the organisation. This is an aspect that needs to be strengthened. Our previous review found that opportunities for learning following the Bridgend transfer in relation to undertaking FFTs had not been taken. In 2019, staff within Princess of Wales Hospital felt there had been little consideration of the benefits for patients and staff through the use of FFT, and its use for real-time patient feedback. However, since our review, the Health Board has embraced this learning and implemented the FFT throughout each site.

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WRITTEN STATEMENT
BY
THE WELSH GOVERNMENT

TITLE	**Cwm Taf Morgannwg University Health Board – Interim findings from the Independent Maternity Services Oversight Panel's deep-dive review of neonatal care**
DATE	**07 September 2021**
BY	**Eluned Morgan MS, Minister for Health and Social Services**

In recent months, the Independent Maternity Services Oversight Panel (IMSOP), which was set up to oversee improvements in maternity and neonatal care at Cwm Taf Morgannwg University Health Board, has increased its focus on neonatal care.

In March, Dr Alan Fenton, a consultant neonatologist and Ms Kelly Harvey, a neonatal nurse, joined the panel. In May, supported by a small team of clinical reviewers, it began a deep dive review into the neonatal service at Prince Charles Hospital, in Merthyr Tydfil. The terms of reference were agreed with the health board, which welcomed this development. The aim was to take stock of the current neonatal service and the existing improvement plan to seek assurance that services are safe, effective, well led and importantly, integrated with maternity to provide a seamless service for women and babies.

This comprehensive exercise is being informed by evidence gathered from a range of sources including:

- Feedback from families who have experienced neonatal care, with more than 100 families responding to a listening exercise the panel undertook during July.
- Conversations with staff and wider stakeholders.
- Case reviews of the sickest infants presenting to the neonatal unit during 2020.
- A review of a wide range of documentation relating to clinical outcomes, safety and effectiveness data as well as clinical governance and assurance.

From the evidence reviewed to date, the panel has identified some areas, which it determined were impacting on the consistent provision of safe and effective care that would be expected of such a unit in the UK.

It took the decision to advise the health board of its interim findings and escalate a range of issues for immediate and short-term action. It has worked closely with the health board and my officials over the past week to ensure appropriate steps are taken at pace. This includes:

- Immediate improvements to medicines prescribing and administration with pharmacy support and daily checking of prescriptions. Further work will be carried out over the next month to develop a standard operating procedure, checklists and audits.
- An audit has been initiated to ensure the timely transfer of babies needing referral to a tertiary unit and reducing inappropriate admissions to the Prince Charles Hospital unit.
- Increasing the intensity of consultants overseeing the unit and increased time allocated to the unit. Closer working with and support from the specialist neonatal unit in Cardiff. The recruitment of an additional two consultant posts is already underway, with one taking up post in November.
- Establishing a specialist centre support programme for neonatal nursing staff.
- Improving specific aspects of clinical practice, including urgent review of the approach to therapeutic cooling of babies and for those requiring intubation.
- Improvements to the standard of documentation, including the introduction of a revised observation chart.

Securing closer working with the Wales maternity and neonatal network and support from neighbouring units, will be key in helping to embed these improvements.

I am mindful of the pressures currently facing staff and neonatal services are no exception - these findings will be difficult and upsetting. However, the openness of the unit's staff and their ideas about what needs to change have been welcomed by the panel.

It is important staff are supported to make these improvements and their wellbeing is a key consideration in the health board's improvement plan.

Equally, while these findings will be concerning for families using the service, I hope they will see that their voices and involvement really do matter and can effect change. Many of the improvements in train have been informed by their feedback and I am assured that the health board want to work with families to ensure that communication and support is improved and that parents have greater involvement in decisions about their baby's care.

The panel and my officials will be working closely with the health board to support and monitor the improvements. The panel will be producing a report when this part of their work is concluded and I will make this available to Members when I receive it later this year.

I will continue to keep Members updated and will make a further statement after I receive the next progress report from IMSOP on all aspects of its work and its assessment of the health board's overall progress.
The panel is finalising its analysis and findings from the second element of the clinical review look back programme, involving babies who sadly were stillborn. I will also make this report available.

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

Agenda Item 9

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