AUDIT COMMITTEE PUBLIC MEETING DRAFT
Minutes of the Meeting Held on 18.03.21
Via Microsoft Teams - the Health Board has determined that the public are excluded from attending the Committee's meeting in order to protect public health during the pandemic.

Present	
Richard Medwyn Hughes	Independent Member (Chair)
Eifion Jones	Independent Member
Jacqueline Hughes	Independent Member
Lyn Meadows	Independent Member

In Attendance	
Louise Brereton	Board Secretary
Mike Buckle	Assistant Director Of North Wales Dental Services (for Minute AC21.09)
Andrew Doughton	Performance Audit Lead, Audit Wales
Simon Evans-Evans	Interim Director of Governance
Dave Harries	Head of Internal Audit, NWSSP
Gill Harris	Deputy Chief Executive & Executive Director of Nursing
Sue Hill	Executive Director of Finance
Matthew Joyes	Acting Associate Director of Quality Assurance (for Minute AC21.08)
Simon Monkhouse	Finance Audit Lead, Audit Wales
Dawn Sharp	Deputy Board Secretary & Assistant Director
Mike Smith	Interim Director of Nursing, Mental Health & Learning Disabilities (for Minute AC21.06)
Chris Stockport	Executive Director for Primary and Community Care(for Minute (for Minute AC21.06)
David Thomas	Engagement Director, Audit Wales
Bethan Wassell	Statutory Compliance, Governance & Policy Manager
Jo Whitehead	Chief Executive
Iain Wilkie	Interim Director Mental Health & Learning Disabilities (for Minute AC21.06)
Dylan Williams	Chief Information Officer, Informatics (for Minute AC21.06)
Kamala Williams	Acting Assistant Director – Strategy & Planning (for Minute AC21.07)

Agenda Item	Action
AC21/01: Opening Business and Apologies for Absence. The Chair welcomed Members and attendees to the meeting. Members agreed that the meeting would be recorded for administrative/minuting purposes on the understanding that it would be deleted once the minutes were finalised No apologies were received.	
AC21/02: Declarations of Interest. No declarations of interest were made at the meeting.	
AC21/03: Procedural Matters. **AC21.03.01:** The Chair presented the items and Members noted the following points: **AC21.03.02:** Following a query raised at the Audit Committee pre-meeting, the Deputy Board Secretary provided additional information for the Standing Orders Details of Breaches (Appendix C) as follows: the Finance & Performance Committee breach was in relation to the 2021/24 Plan and the Planned Care Paper sign off. For the Strategy, Partnerships & Population Health Committee, the breach related to the Mass Vaccination Update Paper. Members noted that further details would be included in future iterations of the report. **AC21.03.03:** The Deputy Board Secretary drew Members' attention to Appendix D and the proposed Audit Committee Cycle of Business (CoB). Members noted that the Governance Review being undertaken by the Deputy Chief Executive was unlikely to impact the CoB of the Audit Committee and that the CoB would form part of the appendices to the Audit Committee's Annual Report due to be considered at the workshop in May. **RESOLVED:** That 1. the Minutes of the last meeting of the Committee held on 17/12/20 (Appendix A) be confirmed as a correct record; 2. the Public Summary Action Log (Appendix B) be received; 3. the Standing Orders - Details of Breaches (Appendix C) be noted; 4. the Audit Committee Cycle of Business (Appendix D) for the 2021/22 reporting year be approved; 5. the Joint Audit & Quality, Safety & Experience Committee (JAQS) minutes (Appendix E) be approved; and 6. the update on the draft Annual Report and draft Annual Governance Statement timelines for production be noted.	

Agenda Item	Action
AC21/04: Issues Discussed in Previous Private Committee Session. **RESOLVED:** That the report on issues discussed in the previous Private Committee session be noted.	
AC21/05: Chair's Assurance Report: Risk Management Group **AC21/05.01:** The Interim Director of Governance presented the item and provided Members with an update on the progress on the implementation of the strategy and the move away from the five-tier approach. There were 296 outstanding risks as of the 24/02/21. This was now down to 103 as of 18/03/21. Assurance had been provided by the Risk Management Team that these were being actively addressed and there was confidence that the target would be reached by the end of the month. The Chair stated that it was important to be clear and wanted to confirm that the commitment for all risks to be reviewed by the end of March 2021 was still on target. The Interim Director of Governance confirmed this to be the case. The Chair acknowledged the hard work undertaken behind the scenes though did note that the original deadline had been missed and that the Audit Committee had originally identified March as a more realistic timeframe. **AC21/05.02:** An Independent Member noted the reference to four absent Divisional Risk Reports and asked for further information in terms of detail and the impact/importance. The Interim Director of Governance advised that the omission was during the height of the pandemic. The process was that Divisional Leads were required to present their reports in person to enable a full discussion. At the meeting in January, some of the Divisional leads were understandably prioritising front line services. The Independent Member acknowledged this though pointed out that the paper indicated that it was the Corporate Risk Team who were responsible for completing the reports. The Interim Director of Governance confirmed that this was the case in order to reduce the administrative burden, though the Corporate team's input was limited to populating the data taken directly from the central database. The Independent Member expressed support for the approach though stressed the importance of divisional ownership and accountability. The Deputy Chief Executive & Executive Director of Nursing further added that any requests to escalate risks must be via the Risk Management Group (RMG). If there was inadequate representation, then the risk would not be discussed and would be referred back to the Divisional Lead. The Deputy Chief Executive & Executive Director of Nursing concluded by stating the importance of transparency in the organisation's ability to challenge.	

Agenda Item	Action
AC21/05.03: An Independent Member noted that the risk appetite was not detailed in the planned business for the next meeting and asked for assurance that it was being discussed, not only by the RMG and at an Executive level, but was also planned for Board discussions. The Deputy Chief Executive & Executive Director of Nursing advised that it had been discussed at the RMG and there were plans for a discussion as part of the April Board Workshop. The Board Secretary confirmed that the Risk Appetite was due to be reviewed at the Board Workshop in April. **AC21/05.04:** The Deputy Chief Executive & Executive Director of Nursing and the Interim Director of Governance provided Members with an update on the Risk Management Strategy & Policy review which came into effect in October 2020 and required an annual review. The Deputy Chief Executive & Executive Director of Nursing advised the Chair that the Strategy & Policy was ratified by the Board prior to October (July) so an extension was required. The Board Secretary advised that this had been taken this into account for the Audit Committee's cycle of Business. The provisional timeline was for review at the June Audit Committee meeting prior to ratification at July Board. **AC21/05.05:** The Chair concluded by acknowledging the amount of work that had been undertaken, particularly during a pandemic, and thanked the team for their efforts. **RESOLVED: That** 1. the report be noted; and 2. the Risk Management Strategy and Policy remain extant pending the annual review in June/July.	
AC21.06: Internal Audit Progress Report **AC21.06.01:** The Head of Internal Audit presented an overview of the Report. In particular, table four detailed all performance indicators as 'green', this was very positive and the Head of Internal Audit wished to expressly note thanks to the Board Secretary and Deputy Board Secretary - escalations were being addressed efficiently with the Executive Team to clear reviews within the specified timeframes. **AC21.06.02:** The Head of Internal Audit proceeded with an overview of the plan that was based on the Health Board's Board Assurance Framework, Corporate Risk Register and Committee papers as well as meetings undertaken by Internal Audit with the Executive Team, Audit Wales, Independent Members and Chairs. The plan had now been ratified by the Executive team. The Head of Internal Audit	

Agenda Item	Action
expressed further thanks to all those involved. Members noted that the plan had moved away from the domains this year due to the challenges associated with Covid on being able to provide a full opinion by domain. Members further noted that there were no Welsh Government mandated reviews. The Head of Internal Audit went on to describe the joint approach between Audit Wales and Internal Audit to ensure a comprehension audit plan without duplication. This ensured a maximum use of audit resources and provided a much broader audit opinion across the service. The Head of Internal Audit concluded by advising Members that the ability to deliver the plan depended on the audit team's ability to go out and test, which may be inhibited by pandemic restrictions. **AC21.06.03:** The Chair thanked both the Head of Internal Audit and Audit Wales for the work done to date and asked the Executives present whether they were content that the plan was comprehensive, or whether there were any potential omissions. The Executive Director of Finance confirmed that they felt all areas had been covered. However, it was important to note that it was difficult to foresee what risks may emerge over the next 12 months. This was addressed by the organisation's ability to review and amend the plan accordingly. **AC21.06.04:** An Independent Member raised a query with regard to the Roster Management review and whether it covered compliance with the Working Time Directive. The Head of Internal Audit advised that the scope of the review was a follow up to the previous Limited Assurance report in 2020. The review had focused on the correct payment for shifts undertaken and the signing off of rosters. Whilst compliance with the Directive was not within the scope, it could certainly be considered as a future review as it was a fundamental control from both a workforce and finance perspective. The Independent Member agreed and observed that it would also tie in with the On-Call Arrangements review. **AC21.06.05:** An Independent Member observed that the plan was a very comprehensive list of reviews with a significant amount of work planned. The Independent Member queried what tasks were undertaken prior to the field work to ensure efficiency and/or remove any potential hurdles in advance that may inhibit progress. The Head of Internal Audit provided Members with an overview of the preparatory work that included liaising with the relevant Executive and Senior Officer to agree a project brief based on the risks identified. The Head of Internal Audit acknowledged that there was room for improvement, noting that the Plan was not routinely shared wider than the Executive Team and the Audit Committee. The Head of Internal Audit queried whether this would be beneficial and agreed to discuss with the Board Secretary. The Independent Member added that it was also important that the relevant Director cascaded the information	LB/DH

Agenda Item	Action
down to service leads to ensure they were aware of their responsibilities. **AC21.06.06:** The Executive Director for Primary and Community Care and the Chief Information Officer joined the meeting to discuss the Business Continuity – Informatics limited assurance report. The Head of Internal Audit provided a summary of highlights noting that the review was based on a self-identified risk. Informatics, as a service, were proactive in identifying gaps and seeking assurances. Invariably, this would often result in a limited assurance report as management had already identified a potential issue. **AC21.06.07:** The Executive Director for Primary and Community Care concurred, noting that the Chief Information Office and the team had specifically identified the issue as an area for learning and an opportunity for Internal Audit input. The Executive Director for Primary and Community Care confirmed that discussions had been undertaken with the Chief Information Officer on how to address the recommendations and that they were confident with the plan in place. The Chief Information Officer provided Members with further details of the work undertaken to date and the future work required. The motivation behind the review was also in anticipation of a move towards an age of high digitalisation. It was vitally important that the Division was adequately prepared, A positive step had been the appointment of the Head of Informatics Programmes Assurance and Improvement who had a significant amount of experience and expertise in the area. The Chief Information Officer advised that Business Continuity testing within Informatics was complicated due to the variance of different services within the Division. Some departments were relatively straightforward whilst others were far more complex. This was reflected in the implementation dates and time scales. Informatics were working closely with the Corporate Business Continuity Team and the Chief Information Officer was confident that all of the recommendations would be fully implemented. **AC21.06.08:** The Chair queried when the last test had been undertaken. The Chief Information officer advised that this would not have been done within the last 18 months. However, real time implementation of plans had in fact been undertaken. For example the relocation of the Service Desk. The gap related to the documentation of the tests and was an area of governance that needed improvement to enable lessons to be learnt. The Chair affirmed that 'lessons learnt' was an extremely important requirement, more so during the pandemic. The Executive Director for Primary and Community Care and the Chief Information Officer left the meeting. **AC21.06.09:** The Interim Director Mental Health & Learning Disabilities (MH&LD) and the Interim Director of Nursing, MH&LD joined the meeting to discuss the MH&LD Governance Arrangements	

Agenda Item	Action
limited assurance report. The Head of Internal Audit provided a summary of highlights noting that the Audit Committee had formally requested the review. Whilst the pandemic had undoubtedly had a significant impact, the progress made in terms of improving governance since the last review, was disappointing. Though it was noted that the reporting into the Quality, Safety & Experience (QSE) Committee was robust and had meant the report remained as a limited assurance. There were two key issues aside from governance and the fragility of the senior leadership team. Firstly, the implementation of the Together 4 Mental Health (T4MH) Strategy and whether it remained fit for purpose for the people of North Wales. And secondly, concerns around the Psychological Therapies Service in terms of outward reporting and leadership. **AC21.06.10:** The Chair noted that in terms of the fragility of the senior leadership team, it may be difficult for the Interim Director Mental Health MH&LD and the Interim Director of Nursing MH&LD to address in too much detail as the issues predated their appointments. However, comments would be invited from the Chief Executive and Deputy Chief Executive. **AC21.06.11:** The Interim Director MH&LD advised the report had been considered by the Division and had found it useful. Covid had obviously had an impact on the Division with key governance meetings being stood down temporarily. The plan was to restart in April (the Business meeting, Finance and Performance, Clinical Strategy and the Quality, Safety & Effectiveness Group). In terms of management fragility and psychological services, wider Health Board discussions were required. The Interim Director MH&LD advised that they had been in post since the 1st of October and had been extended until the end of September 2021. The Interim Director of Nursing, MH&LD had been in post for a similar period and the contract had also been extended. The Executive Director of Public Health was currently holding Executive responsibility for MH&LD and this had also been extended. **AC21.06.12:** The Chief Executive acknowledged both the Interim Director MH&LD and the Interim Director of Nursing MH&LD's positive contribution to the service, which had been evident when liaising with the various services across MH&LD. Member's noted that one of the key areas of Targeted Intervention that had been identified for MH&LD, in partnership with Welsh Government, was the challenge and opportunity of creating consistent and credible leadership. Whilst there was a substantive Clinical Director of MH&LD in post, one of the key issues in moving forward across the maturity matrix was securing consistent leadership across the Division. However, there were complexities with regard to the management infrastructure and employment obligations that required consideration. This has meant	

Agenda Item	Action
that it has been appropriate to extend the interim positions to maintain stability and consistency. **AC21.06.13:** The Deputy Chief Executive & Executive Director of Nursing provided Members with a further update on psychological therapies. An internal advertisement for an Acting Head of Service post had been completed whilst work continued with the national and local team to pull together a substantive job description before proceeding to external advert. Applications for the post had been received and were being progressed. The Interim Director MH&LD confirmed that this would be a welcome addition to the senior leadership team. **AC21.06.14:** An Independent Member drew Member's attention to the Management Response within the report and queried the implementation dates – December 2021 and March 2022 were quite a way off considering the importance and gravity of the recommendations. The Interim Director MH&LD assured Members that meetings to address the T4MH recommendation were already underway. The Independent Member queried whether, given the importance of the recommendation, there could be interim milestones integrated. The Interim Director of Nursing MH&LD advised that the March 2022 date reflected the requirement for consultation and stakeholder participation but was happy to discuss and integrate interim milestones. The Independent Member advised that this was also applicable to the psychological therapies recommendation, noting that the psychological therapies report had been received 18 months previously. The Chief Executive advised that the Health Board had been reviewing its current processes of engagement and provided Members with an overview of the work undertaken. There was a view that if the Health Board were going to think about co-design engagement and consultation, then there would typically be an extended time frame required to review existing strategies. The Independent Member agreed that co-production was best practice and would generally take 12 months to complete. However, the Health Board had already undertaken a significant consultation three years ago, for which it had received accolades and awards. The Independent Member stated that there was still a significant amount of valuable data and information that could be utilised. The Health Board was not starting from a blank piece of paper and needed to be mindful that it was not asking the same questions for which they would receive the same answers. The Chief Executive agreed and advised that one of the first pieces of work undertaken would be an analysis of the existing data and responses. The Deputy Chief Executive & Executive Director of Nursing suggested that this could be incorporated as one of the intermediate milestones of the recommendation. However, it was also important to go back out and verify that responses remained the same post Covid. The Deputy Chief Executive & Executive Director of Nursing suggested that the intermediate milestones be	LB/IW/MS

Agenda Item	Action
monitored via the Targeted Intervention Framework. The Deputy Chief Executive & Executive Director of Nursing also concurred with the observation for the implementation of the psychological therapies recommendation and agreed it should be brought forward, particularly so, given the progression made to appoint a Head of Service. Members agreed that the Interim Director Mental Health & Learning Disabilities (MH&LD) and the Interim Director of Nursing would look to address the points raised. **AC21.06.15:** An Independent Member expressed support for the points made and additionally noted the importance of the Audit Committee being sufficiently reassured that progress would be made and adequately monitored by via the Targeted Intervention framework. It was important that any agreed interim milestones were completed within the specified time frames. **AC21.06.16:** An Independent Member advised that as a Trade Union Representative, they had observed a tangible change in the way the MH&LD Division engaged with the Trade Unions, working in partnership to make improvements in the service and staff well-being. Members agreed that this should be commended and noted. **AC21.06.17:** The Performance Lead, Audit Wales reminded Members of the Joint Review follow up that had been undertaken in 2016-17. As part of that review, the opinions of Local Authorities had been sought. Referring back to the point previously made about engagement and consultation, the Performance Lead, Audit Wales noted that some of the Local Authorities had not felt particularly engaged around Learning Disabilities. This would be an area for improvement within any subsequent consultations and something the Health Board may wish to concentrate slightly more on. **AC21.06.18:** The Interim Director Mental Health & Learning Disabilities (MH&LD) advised Members that all of the points made would be taken on board. The MH&LD Division had been working through, and continued to work through, some difficult legacy issues. However, progress was being made. The MH&LD Division were very conscious of the Maturity Matrix and the key deliverables within the Targeted Intervention Framework. The Chair thanked both the Interim Director Mental Health & Learning Disabilities (MH&LD) and the Interim Director of Nursing, MH&LD for their work, though acknowledged that frustrations and concerns remained as to the fragility of the management team. It was important that the momentum was maintained and that progress continued, defined target dates should not be permitted to slip. The Interim Director Mental Health & Learning Disabilities (MH&LD) and the Interim Director of Nursing, MH&LD left the meeting.	

Agenda Item	Action
AC21.06.19: Members agreed that the Internal Audit plan 2021/22 be formally approved. **RESOLVED:** That 1. the progress report be noted 2. the Internal Audit Plan 2021/22 be approved; 3. the Limited Assurance reports be received and discussions noted.	
AC21.07: Audit Wales Update Report **AC21.07.01:** The Finance Audit Lead, Audit Wales provided a brief update on the financial audit. Member's noted that good progress was being made on the planning and risk assessment and that Audit Wales were working closely with the Finance Team to iron out all of the complications caused by Covid. The Funds Held on Trust audit was planned to take place in August. **AC21.07.02:** The Performance Audit Lead, Audit Wales provided a brief overview of the performance audit update. Members noted that the update report reflected the pressures on the system and also Audit Wales beginning to introduce other elements relating to Covid, this included a report on Track, Trace and Protect, governance, Personal Protection Equipment (PPE) and ongoing work relating to vaccinations. Consequently, that had meant that some of the intended work planned for the next 12 months had been pushed back though the Care Home Commissioning review would be continued to progress. The review had been identified prior to the pandemic, though the pandemic had shone a light on the pressures within the system. The intention was for the report to be reported at a regional level. The report on ophthalmology had been paused, though there was significant recovery to be done around eye care services so it was important that the review recommenced. The Follow-up Outpatients was likely to be considered in part, as part of the Structured Assessment. The Performance Audit Lead, Audit Wales concluded by noting the planned work on the additional Welsh Government funding and the Health Board's plans for the financial allocation. The review would examine how the funding was being used to improve and deliver long-term sustainable services as opposed to just financial recovery. **AC21.07.03:** The Chair noted the comments on the additional funding and asked whether the Chief Executive could provide any further updates. The Chief Executive acknowledged that the strategic support had been provided to the Health Board to develop sustainable services. Part of the conversation as to finalising the Health Board's Plan was to be clear on the proposals to utilise the resources. Welsh	

Agenda Item	Action
Government had not quite finalised it's budgets though having said that, the Health Board were seized on the opportunity the resources afforded. The Chief Executive was clear, that any Business Plans needed to be seen as a 'loan' and were required to deliver fundamental benefits and improvements as a return on investment. Whilst there was certainly opportunity, Covid still represented a challenge for all Health Boards in delivering their in year savings target. Notwithstanding this, the Health Board were keen to use the resources to genuinely transform services and invest in new models of care. For example, the Health Board had 12 physician assistants who were about to graduate. In order to employee them safely, the Health Board needed to provide them with an internship / year of close supervision, which required investment. However, it was hoped that in the future the individuals would become part of a multi-disciplinary team that could reduce the reliance on locum rheumatologist consultants – a position that the health Board had been trying to recruit to for a number of years due to a national speciality shortage. Therefore, it was clear that persisting with an old model would not deliver a quality service. As a final point, the Chief Executive noted that North Wales covered a large area, there would be a requirement to have a conversation with Welsh Government about the extent to which the true cost of providing services is adequately reflected in the current funding formula. **AC21.07.04:** Members proceeded to review and discuss the Audit Wales plan. The Finance Audit Lead, Audit Wales drew Member's attention to some of the key points within the plan. The audit continued to be carried out remotely and the Audit members continued to remain independent to the Health Board, any threats to independence were managed via restricted access to information. Members noted that there were two generic risks included in the plan – management override of controls and revenue recognition. A watching brief was being kept upon the NHS 'scheme pays' initiative and its potential impact on the regularity of the opinion. Members also noted that the Health Board would not meet its first financial duty to break even over a three-year period. The Finance Audit Lead, Audit Wales concluded by providing members with an overview of the timings; the audit work will commence once the draft accounts were finalised on the 30th April, submitted to Audit Committee in June prior to being laid with Welsh Government 14th/15th of June. The Executive Director of Finance further noted that the Audit Wales team had been well integrated with the Finance Department; the challenges of remote collaboration had been dealt with efficiently and wished to thank both the team and the auditors. **AC21.07.05:** The Performance Audit Lead, Audit Wales provided a brief overview of the performance elements of the plan. The Structured Assessment would be split into two phases, the review of the effectiveness of operational planning arrangements to continue to	

Agenda Item	Action
respond to the challenges of the pandemic and to recover and restart services. Phase two would examine how well the Health Board was embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic. The second area the Performance Audit Lead, Audit Wales wished to draw Members attention to the All Wales Thematic Review. The planned work on unscheduled care would be delivered as part of the 2021 programme. There were still significant risks around unscheduled care, though consideration as to the timing of the review was required with regard to Covid pressures. **AC21.07.06:** The Engagement Director, Audit Wales provided Members with an update on the Audit fee, which was not included in the report due to not being approved by the Finance Committee of the Senedd in time. The fee had now been approved and Audit Wales would write out to the Health Board imminently after the meeting. Members noted that the fee would be as it was last year. An Independent Member noted that the fee had been frozen and queried whether remote working had delivered any savings with regard to there no longer being a requirement to travel to North Wales and, if so, would these savings be passed on to the Health Board. The Engagement Director, Audit Wales advised that in totality, the savings were balanced out by additional costs and complications of collaboration. The Engagement Director, Audit Wales assured Members that any identified savings would indeed be passed on to the Health Board. The Chief Executive noted an additional point on savings that the Health Board were beginning to consider was its carbon footprint. Whilst the Health Board would of course welcome a fee reduction, there were other benefits to be acknowledged. The Health Board was working collaboratively with Welsh Government to explore the future benefits and opportunities associated with agile working. **AC21.07.07** An Independent Member reiterated the Executive Director of Finance's appreciation for the work undertaken and went on to query whether the financial audit risks identified in the report were encapsulated within the divisional risk registers. The Executive Director of Finance advised that the majority of the risks were captured, though would review and confirm after the meeting. The second question for the Executive team was whether Members could be reassured that the Health Board were taking a proactive and parallel approach to ensure there were 'no surprises'. Given the breadth and importance of the area, It was important that the Health Board was not solely reliant on the outcomes of audit reports. The Executive Director of Finance confirmed that the Health Board were very much moving ahead on a number of different agendas; this was front and centre of the transformation programme. The Chief Executive confirmed that there was a significant amount of synergy between the work the Health Board wished to pursue, including the	SH

Agenda Item	Action
maturity matrices, performance management and the Board Assurance Framework. The Chief Executive was keen to engage with the Executive team and strengthen both individual and team performance reviews when objective setting. A discussion was planned for a future Board Workshop to provide clarity on the spend associated with the strategic support. This extended beyond clinical services and transformation to include capacity, which would enable the Health Board to focus on the task in hand. **AC21.07.08:** The Engagement Director, Audit Wales provided an overview of the other reports included for information. This included the Doing it Differently, Doing it Right report that detailed key themes, lessons and opportunities within NHS governance and the letter sent by the Auditor General updating on the findings from the work on Personal Protective Equipment (PPE). The full report was due for publication after Easter. **AC21.07.09:** The Acting Assistant Director – Strategy & Planning joined the meeting for the Well-being of Future Generations Wales report. The Acting Assistant Director – Strategy & Planning advised Members that the original report had been received in 2019 with the Management Response (MR) being delayed. Members noted that the nature of the report had necessitated the Health Board take a slightly different approach to the MR. The recommendations made were couched in terms of opportunities for improvement. The Acting Assistant Director – Strategy & Planning provided an overview of the highlights from the report. **AC21.07.10:** The Chair noted that the MR may require review in terms of key deliverables – it was important that tangible objectives could be drawn and measured against in terms of progress tracking. The Performance Audit Lead, Audit Wales concurred and observed that trying to track the MR as it stood, may become quite challenging to demonstrate evidence of progress. The Performance Audit Lead, Audit Wales noted that there were perhaps two ways to progress, one of those being the Audit Tracker, which would probably provide greater assurance, and the other being via the planning approach. The Well-being of Future Generations was not necessarily about compliance with the Act; rather, it was about embedding the spirit of the Act and the key principles into the Health Board's planning processes. The Chief Executive advised Members that the Health Board intended to further consider its planning processes. The Health Board needed to be clear about outcomes of activity and how this related to its strategic plan as well as both short and long-term objectives. The Performance Audit Lead, Audit Wales observed that the two options previously highlighted were not mutually exclusive, though if the Audit Committee did decide to specifically track individual items within the Tracker, the recommendations would need to be	

Agenda Item	Action
refined. The Chair noted the future planned workshop and queried whether this could be facilitated as part of the session. The Board Secretary confirmed this could be included in the May workshop. The Acting Assistant Director – Strategy & Planning left the meeting. **RESOLVED:** That 1. the programme update be received; 2. the Audit Wales Audit Plan be received and discussed 3. the BCUHB management response to the recommendations in the Well-being of Future Generations report was received and discussed and specific recommendations for tracking to be identified at the May Audit Workshop.	LB
AC21.08: Schedule of Financial Claims **AC21.08.01:** *The Chair advised Members that the agenda item was to be taken out of order to enable the public and private report to be presented consecutively by the Acting Associate Director of Quality Assurance.* **AC21.08.01:** The Acting Associate Director of Quality Assurance joined the meeting and provided an overview of the public section of the report. The Chair noted that the paper outlined the various levels of assurance and committees that had provided scrutiny.	

Agenda Item	Action
RESOLVED: That the claims and payments listed in the schedule be noted and reported to the Board as part of the Chair's assurance report.	
AC21.09: Dental Assurance Report **AC21.08.1:** The Assistant Director Of North Wales Dental Services joined the meeting and provided Members with an overview of the report. The Chair queried where the Health Board was in terms of take up and patient attendance – and how this compared with the last iteration of the report from September. The Assistant Director Of North Wales Dental Services provided Members with an update and advised that the Health Board were in an improved position in terms of service delivery. The NHS Business Services Authority had introduced a new clinical system called Eden, this had been adopted by the BCUHB Dental Contracting team and was being worked through so as to establish how best to utilise the new system and performance manage the practices. As to areas of non-compliance, it remained the case that contractors were being actively managed. With support from the Local Dental Committees, a Support and Assurance Forum had been created to provide additional support to performers and practices by facilitating discussions with the contracting team. To date, one contractor had been through the process and a successful resolution had been found. **AC21.08.2:** The Chair enquired as to what savings were required to be made and what the overarching current financial situation was. The Assistant Director Of North Wales Dental Services advised that Welsh Government had requested the service to implement contract reform which disbanded the traditional Units of Dental Activity (UDA) system. The focus moving forward would be to actively encourage contractors to join the contract reform programme as the previous clawback facility would not be available unless they did so. There was an expectation from the Chief Dental Officer and Welsh Government that contractors will participate in the new process. In the event that the Health Board found that a contractor was unwilling to participate, the Health Board would reserve the right to resort to the potentially identifiable UDA for accountability. With patient charge revenue being non-existent for the financial year, the budget for the service was a risk with a significant overspend. The service was working closely with finance colleagues to actively manage. **AC21.08.2:** The Chair asked the Executive Director of Finance for comments. The Executive Director of Finance confirmed that the Assistant Director of North Wales Dental Services was working closely with the Finance team to understand the specific implications of what contracts have been in place during Covid. Members were assured that the matter was fully addressed via other financial reports within the organisation. The Assistant Director Of North Wales Dental Services advised that there would need to be a requirement to revisit	

Agenda Item	Action
the budget. Of particular note, there would be significant additional costs associated with estate ventilation alterations necessary to deliver future services. This was being overseen by the Dental Clinical Director in conjunction with the Director of Estates and a business plan was being considered. The Chair and the Chief Executive noted the importance though considered that this was a more appropriate discussion to be had at the Quality, Safety & Experience Committee. The Chief Executive advised that they would reflect on the matter with the Board Secretary and the Executive Director of Primary Care & Community Services. The Assistant Director Of North Wales Dental Services left the meeting. **RESOLVED:** That 1. the Dental Assurance Report was received and discussed.	LB
AC21.10: Legislation Assurance Report **AC21.09.1:** The Statutory Compliance Governance & Policy Manager presented the report and drew Member's attention to the following points; The Legislation Assurance Framework (LAF) previously formed part of the Corporate Risk and Assurance Framework though was now a standalone product. The plan was to continue to report the LAF on a bi-annual basis. Members noted that appendix two (items of low or no assurance) was omitted from this iteration of the report. This was due to capacity issues within the Office of the Board Secretary and the requirement of operational leads to prioritise the Covid response. However, the Finance team had reviewed their allocated legislation and submitted a self-assessment. This was awaiting review/quality checks by the Statutory Compliance Governance & Policy Manager. The intention was that the appendix two would be reinstated for September Committee now that the substantive Board Secretary was in post and the Deputy Board Secretary had returned to their substantive post. **AC21.09.2:** The Statutory Compliance Governance & Policy Manager proceeded with highlights from appendix one which detailed legislation enacted since the previous report. A meeting had been held with the Chief Pharmacist and Deputy Director Medical Physics to discuss the implications of the Medicines and Medical Devices Act 2021 and ensure the information was disseminated throughout their respective governance arrangements/groups. The Statutory Compliance Governance & Policy Manager concluded by advising Members that the final item, the Equality Act 2010, s.1 as amended by the Wales Act 2017, s. 45, had been included specifically at the request of an Independent Member to acknowledge the imminent commencement of the Socio-Economic Duty for Wales though at the time of report writing, the Regulations were not in force. Since the report had been	

Agenda Item	Action
published, the Equality Act 2010 (Commencement No.15 (Wales)) Order 2021 had been enacted on the 12/03/21. **AC21.09.3:** An Independent Member queried whether this was just an administrative exercise for the Health Board. The Statutory Compliance Governance & Policy Manager advised that the report was presented to Audit Committee for information on newly enacted legislation and the measures the Health Board were undertaking to ensure awareness, implement and address any impacts. However, it was acknowledged that the assurance usually provided in appendix two was omitted so the report, in this instance, was of a more administrative nature. The self-assessment and review of assurance was a significant undertaking with over 600 pieces of legislation contained within the LAF. For example, the Estates department had in excess of 100 line items to review. The Independent Member queried whether the Health Board was clear on whether they were compliant with all legislation as the self-assessments had not been undertaken or quality checked and if so, what level of risk did this represent. The Statutory Compliance Governance & Policy Manager advised that the scale of legislation applicable to the Health Board meant that the impact of non-compliance varied from item to item. Though self-assessments had not been carried out for all items, the items that would be considered high risk were largely already managed. For example, Health & Safety was overseen by the Corporate Health & Safety team. The Independent Member acknowledged this and queried whether adequate resources were aligned to the LAF, it was important that those that were operationally responsible were well engaged. The Board Secretary observed that the LAF was a useful tool that they had not seen elsewhere before and it was an example of good practice from the Health Board. Acknowledging the Independent Member's point, the Board Secretary considered that there was more work to do now that capacity was back up within the team. The Board Secretary considered that given the scale, perhaps a risk-based approach could be considered. The Chair noted the work undertaken but observed that that this was again down to flux within the system. The Statutory Compliance Governance & Policy Manager advised Members that whilst a risk based approach to assessment was an option, i.e. identifying items that represented high liability - criminal prosecution or judicial review, it was often the unmanaged, under the radar items that could potentially trip the Health Board up. The Chief Executive noted the original point as to whether the exercise was mainly administrative in nature and observed that whilst this iteration of the report needed improvement, legislative compliance and assurance was an important aspect of the Health Board's corporate governance and agreed that a risk-based approach was preferable way forward. The Chief Executive further noted that legislative compliance was a very important aspect of governance in Australia so had been pleased to see the comparative work the Health Board had undertaken.	

Agenda Item	Action
RESOLVED: That the Legislation Assurance Framework report be noted;	
AC21/11: Issues of Significance for Reporting to Board **RESOLVED:** That the Chair prepare his assurance report for the Board.	
AC21/12: Date of Next Meeting: 10/06/21	
AC21/13: Exclusion of Press and Public Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960".	

Audit Committee Summary Action Log: Public Committee

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Louise Brereton / Dave Harries	AC21.06.05: Discussion re Internal Audit Plan awareness/dissemination to ensure operational leads are sighted.	June	Dissemination through EMG. Internal Audit Team will continue to notify operational teams of forthcoming audits in a timely way.	Close
Louise Brereton / Iain Wilkie / Mike Smith	AC21.06.14: MH&LD intermediate milestones to be identified and monitored via TIF	June	MHLD maturity matrices approved by the Board. Specific recommendations as identified within the Report will be tracked via Team Mate.	Close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Sue Hill	AC21.07.07: Confirmation as to whether the financial audit risks identified are encapsulated within divisional risk registers	June	On review of the six financial risks in the Audit Wales paper, two of them are already incorporated in the BCU risk register. However, there are four risks that need to be added to the Risk Register, as they do not currently feature. Two of these are specifically related to the COVID-19 pandemic; accounting for COVID-19 expenditure, and completing the accounts to the same high standard. These risks were mitigated to a significant level by the creation of the Financial governance working group, which had oversight of the accounts and included representatives from both Audit Wales and Internal Audit; and by the adoption of an agile working model for the finance team, which ensured that financial responsibilities were able to be completed to the same standard. The new risks will be submitted to the Risk Management Group for review and inclusion onto the Corporate Risk Register .	Close
Louise Brereton	AC21.07.10: Refinement of WBFG recommendations to be discussed at May Workshop then added to Tracker	June	Update provided to May Workshop. SB liaising with AD. Refined recommendations will then be shared with Members before the end of June.	Close
Louise Brereton	AC21.08.2: Discussion on Dental Assurance report (contents / appropriate committee)	June	Work will continue to refine the report and content to ensure appropriate material is presented to the Committee.	September 2021

Audit Committee

10.06.21

Record of Breaches of Publication of Committee Papers since last reported to Audit Committee, not in accordance with Standing Orders

Meeting Date	Body	Standard	Issue/Reason for Breach	Details of papers
25.3.21	Finance and Performance Committee	Publication of papers 7 days before meeting	4 x follow on papers	-Draft BCU Integrated Plan 2021/22 -Quality & Performance report -Quarterly plan monitoring report -Planned care update revision required
30.3.21	Health Board	Publication of papers 7 days before meeting	Late paper added to public session after publication day	Plan 2021-22
4.5.21	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	1 follow on paper for private session	Vascular

Dawn Sharp

Deputy Board Secretary

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

TIIF Steering Group

1. INTRODUCTION

1.1. The Board shall establish a short life group and associated governance arrangements, to be known as the **Targeted Intervention Steering Group (TIIF Steering Group)** to exist only while the Health Board is within the Targeted Intervention Improvement Framework as agreed with Welsh Government. The detailed terms of reference and operating arrangements in respect of these meetings are set out below.

2. PURPOSE

2.1. The purpose of the TIIF Steering Group is to advise and assure the Board on the effectiveness of the arrangements in place to respond to the Targeted Intervention Improvement Framework set by Welsh Government. The Group shall be responsible for gathering, assessing, assuring, and providing the Board with evidence of impact of the improvement actions taken and to make recommendations to the Board in relation to the self-assessment.

3. DELEGATED POWERS

3.1. The TIIF Steering Group is authorised by the Board to:

3.1.1. Ensure that the Health Board has a coordinated and effective approach to the TIIF;

3.1.2. Ensure the adequacy of key arrangements fundamental to assurance, including reporting, decision-making, and risk registers;

3.1.3. Seek assurance that lessons are being learnt and that, if appropriate, learning is being applied throughout the Health Board;

3.1.4. Oversee the effectiveness of communications with stakeholders including Welsh Government, patients, staff and partners, ensuring the avoidance of reputational harm as appropriate;

3.1.5. Make urgent decisions on behalf of the Board in relation to the operational management of change associated with the TIIF and to formally report progress and to each public Board meeting.

4. AUTHORITY

4.1. The TIIF Steering Group may investigate or have investigated any activity (clinical and non-clinical) to enable it to discharge its responsibilities. It may request from the Chief Executive, any information it deems necessary to maintain visibility of critical issues and transparency of the full Board.

4.2. The TIIF Steering Group may also obtain external legal or other independent professional advice if it considers this necessary, in accordance with the Board's procurement, budgetary and other requirements.

4.3. The TIIF Steering Group has the authority to consider and where appropriate, recommend Board approval of any TIIF related policy or strategy within the remit of its terms of reference.

4.4. The TIIF Steering Group has the authority to maintain and review the TIIF Risk Register and advise the full Board on the appropriateness of the scoring and mitigating actions in place.

5. MEMBERSHIP

5.1. **Members**

- Executive Director of Nursing and Midwifery and Deputy Chief Executive (Chair)
- Executive Director of Public Health
- Executive Director of Planning and Performance
- Executive Director or Workforce and Organisational Development
- Executive Director of Finance
- Executive Director of Primary and Community Care
- Board Secretary

In attendance

- Interim Director of Governance
- Assistant Director Corporate Governance

- Assistant Director of Communications and Engagement

5.1.1. Independent Members who are the link/buddy to an SRO in the program may attend any meeting of the steering group by giving due notice to the Chair.

5.1.2. Other Executives, Independent Members, officers and special advisers may join as required by the Chair, as well as any others from within or outside the organization whom the TIIF Steering Group considers should be invited, taking into account the matters under consideration at each meeting.

5.2. Member Appointments

5.2.1. The membership of the TIIF Steering Group shall be determined by the Chair, taking account of the balance of skills and expertise necessary to deliver the TIIF Steering Group's remit and subject to any specific requirements or directions made by the Welsh Government. The Chair may if required appoint a Vice-Chair.

5.3. Secretariat

The Secretariat will be determined by the Board Secretary.

5.4. Support to Group Members

The Board Secretary, on behalf of the Chair, shall arrange the provision of advice and support to TIIF Steering Group members on any aspect related to the conduct of their role.

6. TIIF STEERING GROUP MEETINGS

6.1. Quorum

At least three members must join a meeting to ensure a quorum of the Steering Group.

6.2. Frequency of Meetings

Meetings shall normally be held once per month, but may be convened at short notice if requested by the Chair.

6.3. Withdrawal of individuals in attendance

The TIIF Steering Group may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.4. Conduct of Meetings

Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology, to comply with social distancing requirements.

7. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. Although the Board has delegated authority to the TIIF Steering Group for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for delivering against the TIIF.

7.2. The TIIF Steering Group is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.3. The requirements of the conducts of business as set out in the Standing Orders are equally applicable to the operation of the Group with the exception of the quorum.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The TIIF Steering Group Chair shall:

8.1.1. Report formally, regularly and on a timely basis to the full Board on the TIIF Steering Group's activities;

8.1.2. Ensure appropriate escalation arrangements are in place to alert the full Board of any urgent/critical matters that may affect the operation and/or reputation of the Health Board;

9. REVIEW

9.1. These terms of reference and operating arrangements shall be reviewed by the TIIF Steering Group as required by the Chair, and at least every 6 month, with any changes recommended to the Board for approval.

Proposed date of approval: 20/05/2021

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 10/06/21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of Business Considered in Private Session to be Reported in Public
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Dawn Sharp, Assistant Director – Deputy Board Secretary
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Audit Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable							**N**

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Orders require the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

The issues listed below were considered by the Audit Committee at the private Committee meeting of 18/03/21:

- Minutes of the Private Session of Audit Committee held on 17/12/20
- Financial Conformance Report

- Post Payment Verification (PPV) Progress Report
- Counter Fraud Progress Report
- Schedule of Financial Claims
- Update on Internal/External Audit Actions (Tracker Tool).

Asesiad / Assessment & Analysis

Strategy Implications

This report is purely administrative. There are no associated strategic implications other than those that may be included in the individual reports.

Financial Implications

This report is purely administrative. There are no associated financial implications other than those that may be included in the individual reports.

Risk Analysis

This report is purely administrative. There are no associated risk implications other than those that may be included in the individual reports.

Legal and Compliance

Compliance with Standing Orders

Impact Assessment

This report is purely administrative. There are no associated impacts or specific assessments required.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee - 10th June 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	External Audit – Audit Wales Reports
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary, on behalf of the Executive Team
Awdur yr Adroddiad Report Author:	Andrew Doughton, Amanda Hughes and Dave Thomas
Craffu blaenorol: Prior Scrutiny:	All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director.
Atodiadau Appendices:	• Appendix 1 - Audit Wales programme update • Appendix 2 - Structured Assessment 2021 (Phase One) – Operational Planning Arrangements • Appendix 3 - Test, Trace, Protect in Wales: An Overview of Progress to Date • Appendix 4 - Welsh Health Specialised Services Committee Governance Arrangements • Appendix 5 - Procuring and Supplying PPE for the COVID-19 Pandemic • Review of Audited Accounts and Financial Statement (appended to agenda item AC21.29)

Argymhelliad / Recommendation:

The Audit Committee is requested to:

- Receive the report on the annual accounts.
- Receive and discuss the audit reports.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The documents for Audit Committee include the annual review of audited accounts and letter of representation. The documents also include the regular audit update alongside reports finalised since the last Audit Committee.

Cefndir / Background:

The documents include statutory work undertaken on the Health Board financial accounts and the result of that work. The update provides an overview of progress of the external audit programme The performance audit reviews provide assurance and opinion on the effectiveness of arrangements in key areas as are described within the reports.
Asesiad / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications
Opsiynau a ystyriwyd / Options considered
Goblygiadau Ariannol / Financial Implications The documents include statutory audit work undertaken on the Health Board 2020-21 financial accounts and the result of that work.
Dadansoddiad Risk / Risk Analysis
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Asesiad Effaith / Impact Assessment .

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: June 2021

Document reference: 2021A2020-21

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit Committee update

About this document 4

Accounts audit update 4

Performance audit update 5

Good Practice events and products 8

NHS-related national studies and related products 9

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2020-21 Financial Statements.	Audit work is largely complete, and our Report on the Financial Statements 2020-21 has been issued.
Opinion on Financial Statements	It is anticipated that the opinion will be issued on 15 June 2021 following the submission of the audited financial statements on 11 June 2021.
Audit of the 2020-21 Funds Held on Trust Accounts	The audit will take place in the autumn 2021 and our findings will be reported to the December 2021 Charitable Funds committee.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

4 In relation to the Welsh Health Specialist Services Commissioning Committee (WHSSC) review, the committee will receive the report only in June. The management responses from WHSSC and Welsh Government are currently being prepared and we will circulate to committee members once finalised and agreed in July.

Exhibit 2 – Work completed

Area of work	Audit Committee
Test, Trace and Protect	June 2021
Governance Review of Welsh Health Specialised Services Commissioning Committee	June 2021
Structured Assessment Phase 1	June 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
A cross-cutting review focussed on North Wales partnerships Executive Lead: Chris Stockport	Care home placements represent a significant area of expenditure. Our work seeks to determine whether regional partners are collaborating effectively to take account of demographic changes and other external pressures in the strategic commissioning of residential and nursing home care.	Fieldwork complete and drafting report.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Vaccination rollout Executive Lead Gill Harris	This fact-based review will provide a high-level overview on key aspects relating to the administration, planning and approach for the rollout of vaccinations in Wales. This review will not seek to investigate detailed arrangements within health bodies.	Factual accuracy checking of draft
Orthopaedic services – follow up Executive Lead – Chief Operating Officer	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges. Therefore, reporting has been moved to later in the Spring 2021 once the full year's position is known and Health Board's move to service recovery.	Drafting report to report to September Audit Committee
Quality Governance Executive Lead Gill Harris	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Fieldwork in progress September 2021

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead Gill Harris	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed Further work was postponed from 2020 to 2021. (Note this was replaced by work on Test, Track and Protect).
Ophthalmology services in Betsi Cadwaladr Health Board Executive Lead Gill Harris	We will recommence the review of eye care services, which we paused at the onset of the pandemic. This will consider both acute ophthalmology and community optometry service modernisation and action taken to reduce risk of harm resulting from delays in access to services.	Fieldwork started
Use of strategic support funding from Welsh Government Executive Lead Sue Hill	This work will provide an initial assessment of the Health Board's plans for the use of the additional Welsh Government financial allocation of up to £287m, which was agreed for a 3½ year period and commenced in 2020.	Fieldwork started

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment Executive Lead Jo Whitehead	This work will be undertaken in two phases. • Phase 1 will review the effectiveness of operational planning arrangements. • Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management.	Final report issued Set up meeting in June

Exhibit 4 – Planned work not yet started

Topic	Focus of the work	Current status
Follow-up outpatients Executive Lead To be confirmed	This work will provide a high-level commentary on the overall position of the Health Board, effectiveness of adoption of new technologies and ways of working, and to consider plans for recovering follow up outpatient performance. This work will also examine progress against any outstanding recommendations from our previous review of Follow up outpatients.	Not started

Good Practice events and products

5 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and

hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here. This includes the material from our COVID-19 Learning Week held in March 2021.

7 Details of future events are available on the GPX website.

NHS-related national studies and related products

8 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

9 **Exhibit 5** provides information on the NHS-related or relevant national studies published in the last 12 months. It also includes all-Wales summaries of work undertaken locally in the NHS.

10 The Auditor General has also published his Fee Scheme and Annual Plan for 2021-22.

Exhibit 5 – Recent NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Cwm Taf Morgannwg Joint Review follow up	May 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Doing it Differently, Doing it Right?	January 2021
Welsh Community Care Information System	October 2020
National Fraud Initiative 2018-20	October 2020

Title	Publication date
10 Opportunities for resetting and restarting NHS planned care	September 2020
Cracking the Code: Management of Clinical Coding Across Wales	September 2020
Raising Our Game; Tackling Fraud in Wales	July 2020

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Structured Assessment 2021 (Phase One) – Operational Planning Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2021

Date issued: May 2021

Document reference: 2386A2021-22

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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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.

This document is also available in Welsh.

Contents

Summary report

About this report 4

Key messages 5

Recommendations 5

Detailed report

Scope and coverage of the 2020-21 quarter three-four plan 6

Arrangements for developing the 2021-22 annual plan and opportunities for future strategy development 8

Arrangements for monitoring delivery of operational plans 9

Summary report

About this report

1 This report sets out the findings from phase one of the Auditor General's 2021 Structured Assessment on the operational planning arrangements at Betsi Cadwaladr University Health Board. Our Structured Assessment is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2014.

2 Health bodies are required to submit a three-year Integrated Medium-Term Plan (IMTP) to the Welsh Government on an annual basis. In January 2020, health bodies submitted IMTPs, covering the period 2020-2023, for approval. However, the Welsh Government suspended the process for approving IMTPs to allow health bodies to focus on responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic.

3 The Minister for Health, Social Services and Sport set out shorter planning cycles for health bodies covering 2020-21. Guidance set out key considerations for planning, with the requirement for health bodies to produce a quarter one plan by 18 May 2020, a quarter two plan by 3 July 2020, and a combined plan covering quarter three and four by 19 October 2020.

4 The planning framework for quarter three and four 2020-21 covers the maintenance of effective and efficient operational planning arrangements in health bodies to guide their continuing response to the pandemic as well as responding to winter pressures and the implications of EU transition. Health bodies also need to continue to lay the foundations for effective recovery beyond 2020-21.

5 In our 2020 Structured Assessment report we considered the Health Board's planning arrangements for developing the quarter one and two plans. This report considers the planning arrangements underpinning the development of the operational plan for quarter three and four of 2020-21 and the 2021-22 annual plan.

Key messages

7 Overall, **we found that the Health Board had improving short-term planning arrangements and is refreshing its strategy to help drive improvement, service recovery and sustainability**.

8 The Health Board's Quarter 3-4 plan broadly met the Welsh Government's guidance requirements. The plan focussed on the four COVID harms and included modelling and scenario planning to help inform the Health Board's capacity to respond to any surge in COVID-19 over the winter. The Quarter 3-4 plan provided a good link between previous plans, carrying over actions and projects not fully completed, and longer-term challenges such as restarting and recovering services. The Health Board also demonstrated that it learnt from previous short-term planning approaches, and prepared, engaged and approved the plan in a timelier way.

9 The Health Board set out a logical approach for developing its Annual Plan 2021-22. Their ambition was to pull together strategic intent (top down) and service planning (bottom up). This was a desirable but, in retrospect, challenging approach to take, because pandemic pressures on service delivery limited the capacity of key service management to engage in the planning process. There are significant challenges ahead, and the Health Board needs to ensure future service recovery and longer-term service sustainability. Current plans set out steps needed to increase service capacity with the aim of recovering performance. The Health Board is also planning to renew/refresh the existing strategy. There remain both risks and opportunities including engaging the public, staff and population as part of planning, building sufficient programme and planning capacity. Enablers such as workforce, digital and estates also need sufficient resource which is aligned to delivery of strategic objectives.

10 There are arrangements for scrutiny and assurance of plan delivery at Board level as well as regular reporting of progress to both the Strategy, Partnerships and Population Health and Finance and Performance committees. There is still a need to better describe the impact of delivery of programmes and initiatives set out in the plans. The Health Board is undertaking work to improve how it reports on the progress of delivering its plans. This is fundamental if the Board is to fully understand whether its investments and initiatives are leading to the desired improvement.

Recommendations

11 Previous structured assessment report recommendations remain in progress. In many areas the actions were paused because of the pandemic. As a result, we have made no additional recommendations arising from this audit. We will undertake phase 2 of the structured assessment later this year and this will include a follow-up of all outstanding structured assessment recommendations.

Detailed report

Scope and coverage of the 2020-21 quarter three-four plan

12 Our work considered the scope and coverage of the Health Board's 2020-21 quarter three-four plan (the Quarter 3-4 plan) in line with Welsh Government planning guidance. We found **the Health Board's Quarter 3-4 plan broadly met the Welsh Government's guidance requirements and was based around the four COVID-19 harms, risk, and ongoing improvement initiatives.**

13 The scale and nature of the pandemic significantly altered the planning landscape for the Health Board in 2020-21. In our 2020 Structured Assessment report, we highlighted some of the challenges that the Health Board experienced developing operational plans, such as the short timescales between preparation and Board approval. The Health Board learnt from earlier quarterly planning and improved the timeliness of Board level scrutiny of the Quarter 3-4 plan, prior to approval. The Strategy, Partnerships and Population Health Committee scrutinised the Quarter 3-4 plan on 1 October 2020. The Health Board submitted the Quarter 3-4 plan and a fully completed 'Minimum Dataset' to the Welsh Government by the required deadline, 19 October 2020. Formal Board approval occurred on 12 November 2020. Like other health bodies, the Board did not receive formal feedback from the Welsh Government.

14 The Quarter 3-4 plan broadly met the scope required by the Welsh Government and the plan aligned well with the seasonal winter plan which was produced at the same time. In general, there is good overall coverage in the Quarter 3-4 plan which is both a progression of the first two quarterly plans and provides some aspects of the future/longer-term direction of the Health Board. As such, there is a reasonable balance between short-term pressures and wider service change. We did note, however, very limited coverage on finances in the Quarter 3-4 plan itself. Because of this, it is not clear whether key aspects of the plan were affordable or whether other choices would have offered better value.

15 There is improving information supporting the development of plans. The Health Board undertook scenario planning and forecasting based on Swansea University data analytic models for surge demand. This led to scenario models which linked to the extent of COVID-19 infection over the winter. Capacity and demand information has also helped to shape initiatives such as the diagnostic and treatment centre proposals (see **paragraph 17**).

16 The Quarter 3-4 plan included analysis of core and surge capacity available within its normal sites and the temporary rainbow hospitals, supported by the completion of the Welsh Government's 'Annex D' dataset. The analysis indicated the potential to increase surge capacity and the timescale required to introduce it. The Health Board focussed on short-term workforce modelling if additional winter capacity was required or resources were impacted by infection/unavailability over the winter period. The plan recognised the toll of COVID-19 on the workforce, and the need to continue to focus on mental health, traumatic stress, and wellbeing of staff.

17 The Quarter 3-4 plan set the context of the four harms relating to COVID-19. This helped to balance focus between COVID-19 direct care, the need to maintain essential services and prioritise patients with the most urgent needs. Examples include:

- a health-board-wide risk stratification approach applied to patients waiting to access outpatients or inpatients/day cases to ensure that the highest priority patients are offered appointments at the soonest opportunity;
- delivery of 'essential services' supported by work to re-design and re-model services and, in some areas, additional investment;
- recognition of the growing backlog in delays and, as a result, developing a diagnostic and treatment centre model to help provide the capacity necessary to recover services in the medium-term; and
- ensuring continued access to primary care services, and communicating these, options for self-care and promoting COVID-19 vaccination.

18 The Quarter 3-4 plan sets out long-term outcomes, however, in many instances the measures defined are not good indicators of whether an outcome will be achieved. This is particularly notable in the domain of planned care. Actions are specific, have defined senior level owners, and are timebound, but in many instances 'outputs' are described in a way which will make it difficult to assess the impact achieved. We also note that the assessment of risks to delivery of actions could be strengthened. This would help the Board to understand not only the extent of ambition, but also where delivery of the plan may be hindered by risks within or outside the control of the Health Board.

19 While there are points for improvement, the plan provided a mechanism to focus improvement activity across the Health Board, is sufficiently comprehensive for a short-term plan. Its contents broadly align with our understanding of the key risks and challenges facing the Health Board at that point in time.

20 Health Board officers indicated that the process of quarterly planning has been helpful and commented on the ability to compare and contrast with other health boards over 2020-21. They also told us that while short-term plans help responsiveness and adaptability to the pandemic, there is a risk that very short planning cycles do not create the necessary space for creating meaningful change and improvement. This is an area that the Health Board continues to navigate as it balances short-term pandemic response, restarting core services and multi-year service recovery.

Arrangements for developing the annual plan and opportunities for future strategy development

21 Our work considered the Health Board's arrangements for developing the 2021-22 Annual Plan and wider strategy and programme capacity. We found that **there are reasonable arrangements for developing operational plans but significant challenges ahead that will require ambitious strategy and plans in the medium to long term**.

22 The Health Board has both a planning workstream and a planning group. The planning workstream includes senior management and service leads. The planning group includes representatives from informatics, workforce, finance and planning. When developing the 2021-22 Annual Plan (the Annual Plan), the Health Board's planning workstream considered the impact of COVID-19 during the autumn and adopted an initial annual planning approach based on a principle of collective internal engagement. The ambition was to pull together strategic intent (top down) and service planning (bottom up). This was a desirable but, in retrospect, challenging approach to take. The original intent of the Health Board was to prepare a board-approved Annual Plan by January 2021. However, growth of COVID-19 in December and January had a significant effect on key divisional/service management capacity to contribute to Annual Plan development. This in part contributed to the delay in the planning timetable.

23 We noted little evidence of external partner engagement as part of plan development, but within the plan, there are clear requirements for external engagement over the coming 12 months. New ways of working are incorporated in the Annual Plan. The Health Board is in the process of developing and agreeing a digital strategy and this has been shaped by engagement with staff, the public and partners. The engagement on the digital strategy has helped the Health Board recognise the opportunity to continue to develop digitally enabled clinical services, and the need to prevent digital exclusion for those who do not have access to or find it difficult to use new technology. It has resulted in a digital strategy approach which is shaped around patient choice.

24 The Strategy, Partnerships and Population Health Committee and wider board members had the opportunity to discuss and comment on the emerging Annual Plan in February 2021 and it was also later taken to the Finance and Performance Committee in March. The Board formally received the draft 2021-22 Annual Plan in its private session on 30 March 2021 and approved it for submission to the Welsh Government.

25 Strategy and planning are core domains within the Welsh Government's targeted intervention escalation framework[1]. The Health Board intends to refresh the Living Healthier Staying Well strategy during 2021. Strategy renewal provides the

[1] Welsh Government's targeted intervention framework for Betsi Cadwaladr University Health Board

opportunity to obtain a balance of focus across acute, community and primary care as well as meeting wider population level commissioning needs. Key risks and improvement areas for the Health Board are:

- the continued challenge to respond to the pandemic, the significant need to recover and develop sustainable services and wider contribution, in partnership, to population health and wellbeing.
- the need for clear objectives, which properly link to Wellbeing of Future Generations Act (Wales) 2015 requirements and set out ambitions and achievable goals.
- organisational plans that clearly align to the overall strategy, contributing to the delivery of its objectives. Clinical (and wider) engagement remains a pre-requisite of service change proposals.
- the need for a robust programme delivery structure and methodology supported by sufficient capacity and resource.
- sufficient internal planning capacity and expertise. The loss/churn of interim management which continues to occur may impact on the continuity of longer-term programmes.
- workforce, digital and estates all need to be sufficiently resourced to effectively enable service improvement and modernisation.

26 In our 2020 structured assessment report, we highlighted areas where the Health Board had responded well to the pandemic, setting up programme structures and aligning accountabilities around core workstreams. The effort was united around an urgent need to respond to the impact of COVID-19. The Health Board can draw on this experience and the capabilities it demonstrated as it tackles the challenges ahead, particularly in relation to the recovery of health services.

Arrangements for monitoring delivery of operational plans

27 Our work considered the Health Board's arrangements for monitoring and reporting on the delivery of the operational plans. **We found that there are appropriate arrangements for scrutiny and assurance of plan delivery and progress reports to committee are being refined to better help understand the business benefits.**

28 There are arrangements in place for Board scrutiny and assurance of delivery of operational plans at both the Finance and Performance Committee and the Strategy, Partnerships & Population Health Committee. Reporting progress on the delivery of the Quarter 3-4 plan continued at each committee meeting throughout the period November 2020 to March 2021. This scrutiny helped to ensure that undelivered aspects of the Quarter 2 plan continued to be monitored, where required. Officers have indicated that because of COVID-19 peaks over the winter, some aspects of the Quarter 3-4 Plan were not progressing as originally expected,

but the delivery of these aspects will continue to be monitored in 2021-22. We note there is often good scrutiny from independent members asking for more information on impact, reasons for non-achievement, recovery actions and the timescale required to complete these actions.

29 In our 2020 Structured Assessment report, we identified that the approach for monitoring plans was improving, but we identified a need to improve the focus on outcomes. Recommendation 3 of that report set out a requirement to 'Ensure that impacts and outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly and Annual Plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes.'

30 While there has been a slight improvement since previous iterations of monitoring reports, our review of more recent monitoring reports has found that against some actions it is still difficult to see the extent of delivery, and whether the intended outcome/impact has been achieved. We understand that the Health Board intends to strengthen the plan monitoring reports in spring 2021.

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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 4

About this report 6

Key messages 6

Main findings 9

How well are various agencies working together to deliver TTP in Wales? 10

How much is TTP costing? 12

How well is testing for COVID-19 working in Wales? 13

What factors are affecting testing? 18

How good is contact tracing? 20

What factors are affecting contact tracing? 23

What is being done to support people who need to self-isolate? 26

Looking ahead: key challenges and opportunities 29

Having better information to improve efficiency and evaluate the impact of TTP 30

Ensuring testing activities are fit for purpose and meet increasing demand 30

Creating a skilled, resilient workforce to deliver TTP 31

Influencing the public to follow public health protection guidance and requirements 32

Applying the learning from the TTP programme to other programmes and future ways of working 33

Appendices

1 Sampling and testing analysis pathway for Wales (as at December 2020) 35

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.

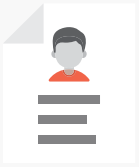
Exhibit 1 – how TTP works in Wales

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.

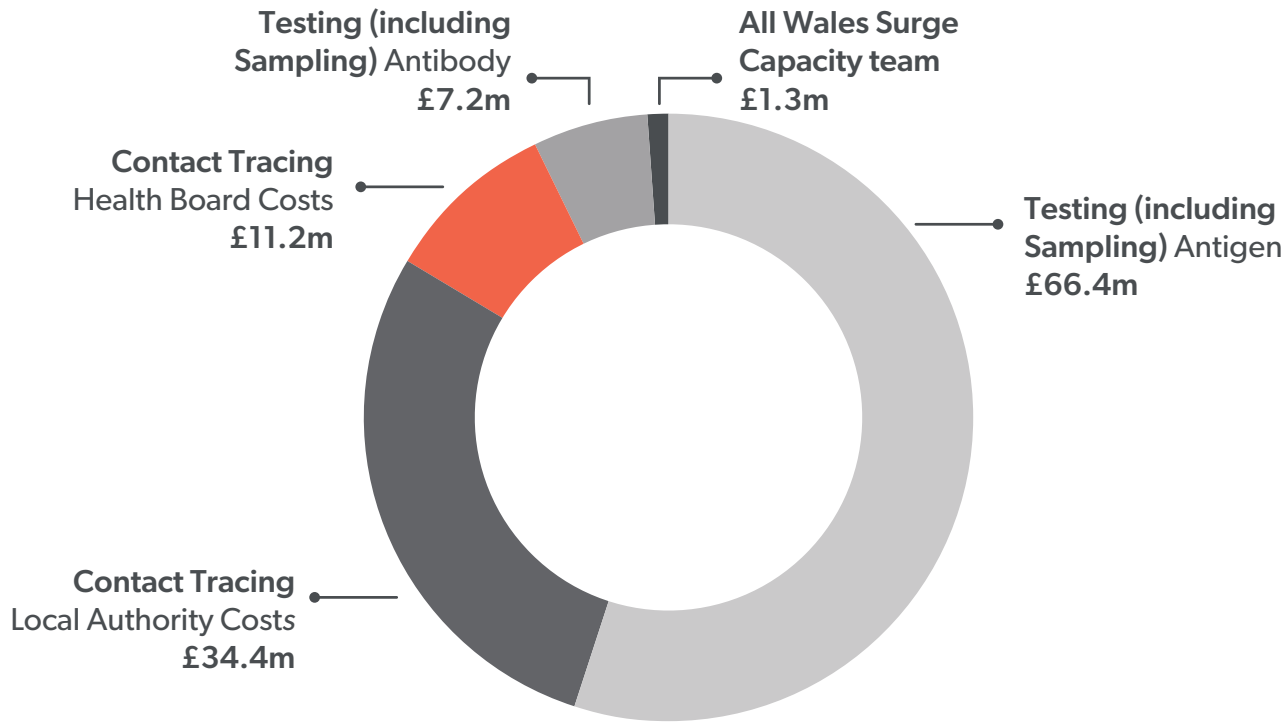
1.5 The programme has demonstrated that it can adapt and evolve quickly, learning lessons from the management of early outbreaks and trying to effectively marry Wales specific and UK-wide arrangements. However, this has, and continues to be, a challenge and officials we spoke to described it as trying 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.

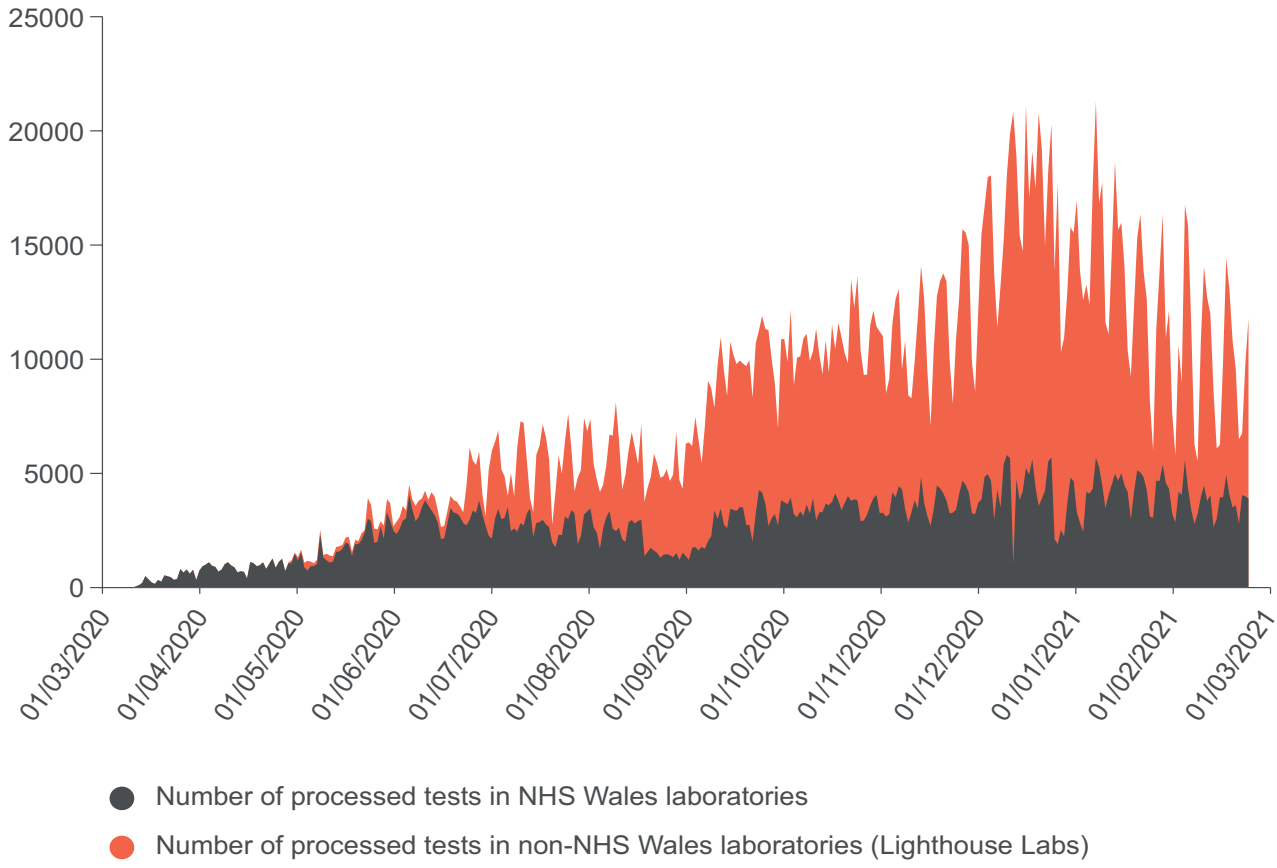
1.10 Significant sampling capacity has also been put in place since May. This continues to expand, including local testing sites and mobile testing units which can be moved to areas of need. A number of sampling facilities are run by private contractors as part of the UK testing programme. But health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

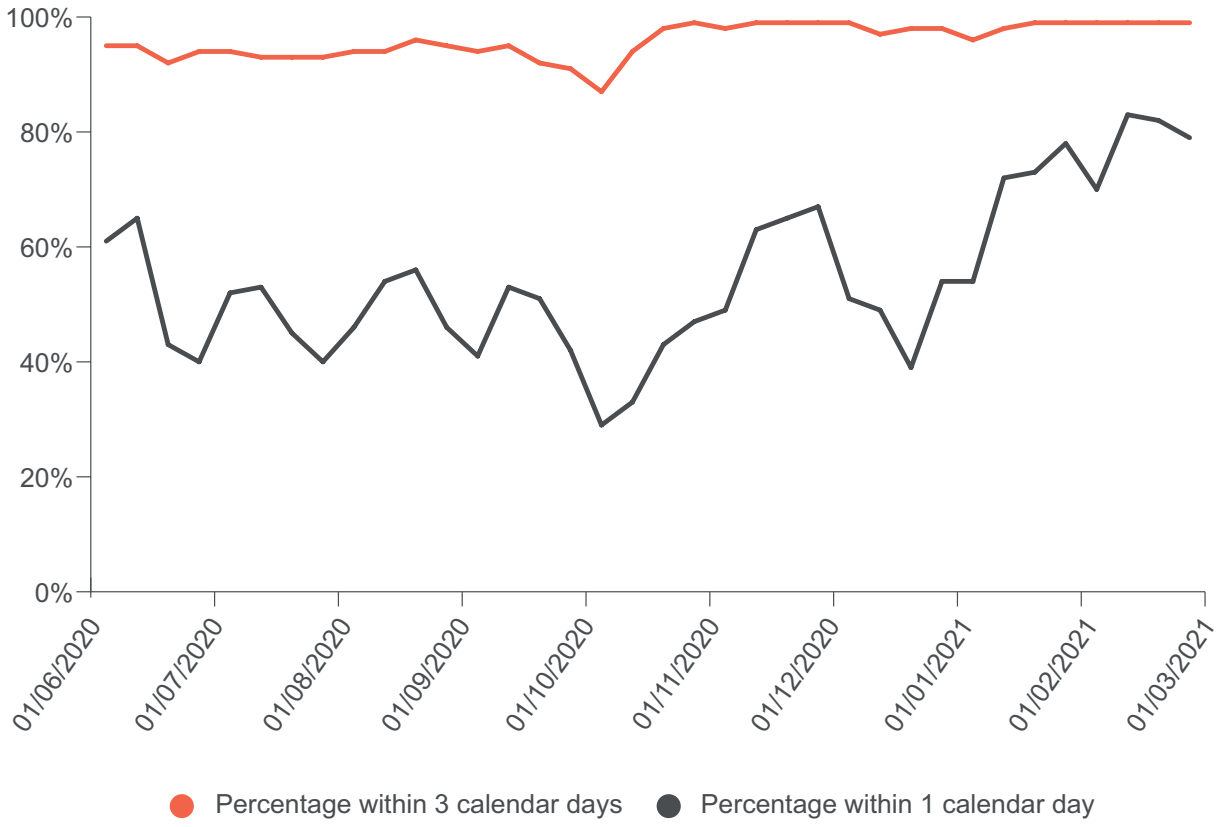


Source: Public Health Wales

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:

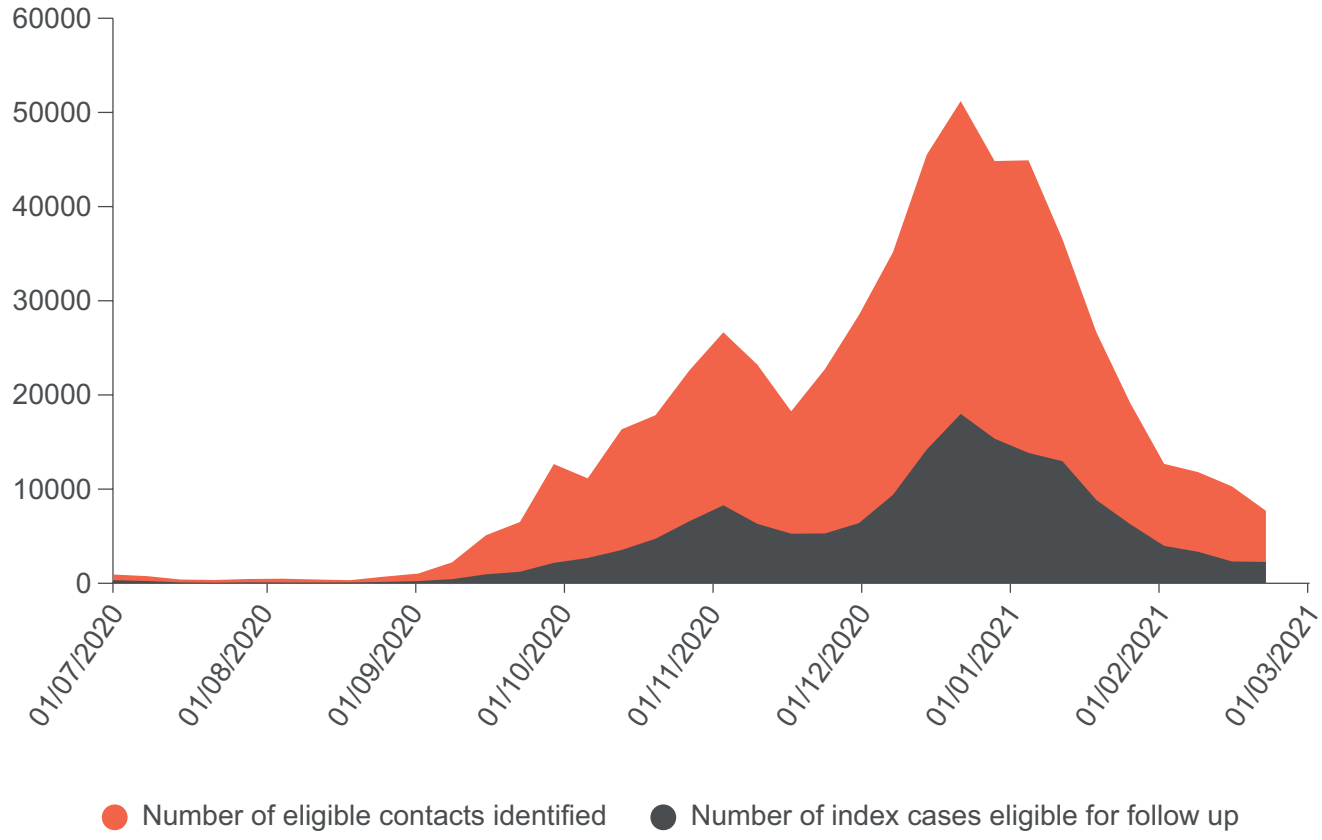
- development of all-Wales processes, guidance and scripts;
- the procurement, development and rollout of an IT system within a six-week period; and
- the local recruitment and training of a workforce which, by December 2020, was 2,400 strong.

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.

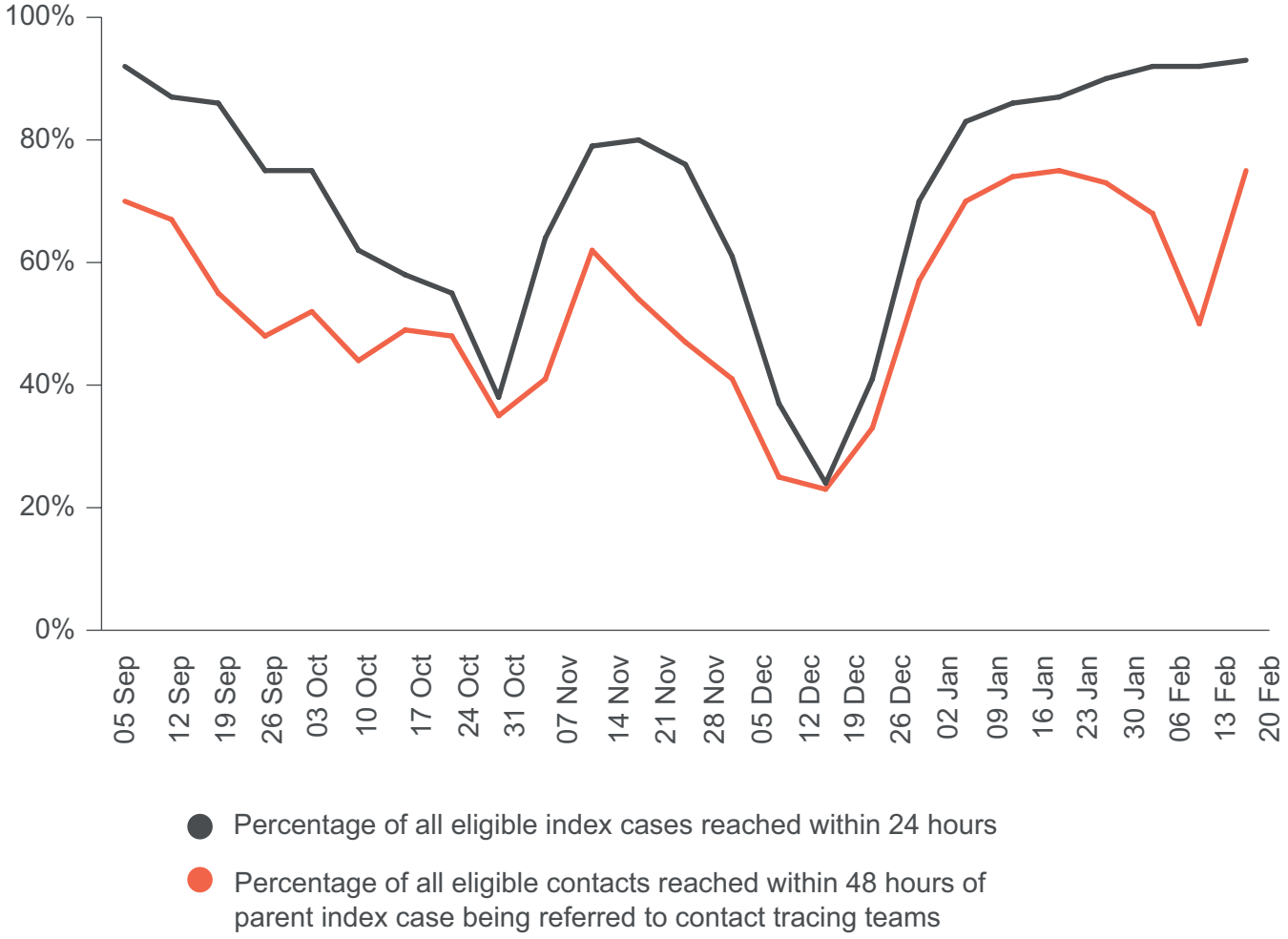
Exhibit 6 – all-Wales number of eligible cases needing to be contacted up to 21 February 2021



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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Welsh Health Specialised Services Committee Governance Arrangements

Report of the Auditor General for Wales

May 2021

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

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

Background 4

Key findings 6

Recommendations 10

Main report

Governance and assurance 14

Strategic planning 24

Future arrangements for commissioning specialised services 30

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

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.

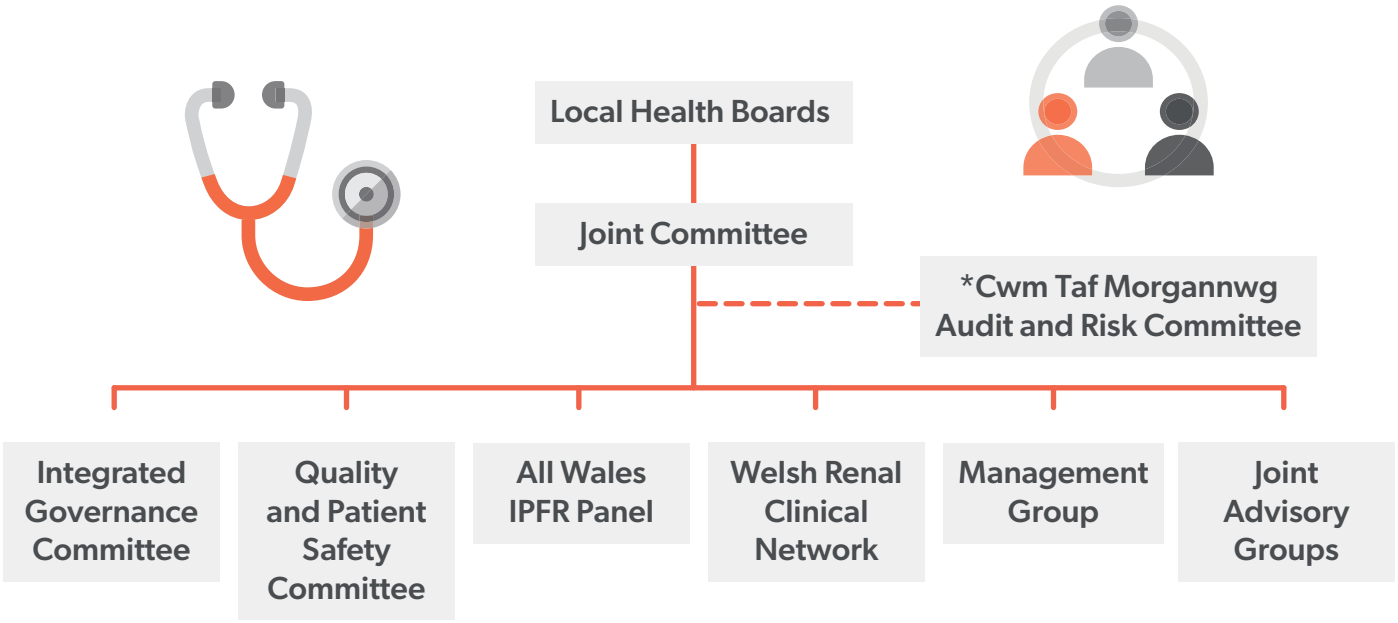
28 A hosting agreement exists between WHSSC and the seven Welsh health boards which includes provision for Cwm Taf Morgannwg University Health Board's Audit and Risk Committee to assist in the discharge of WHSSC's governance and assurance responsibilities. However, the existing hosting agreement has 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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Procuring and Supplying PPE for the COVID-19 Pandemic

Report of the Auditor General for Wales

April 2021

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Key messages 4

Key facts 7

Key roles and responsibilities 8

Recommendations 9

Main report 12

1 The supply of PPE 12

2 Procurement of PPE 34

Appendices 54

1 Audit approach and methods 55

2 Organisations and groups involved in the procurement and supply of PPE 58

3 Shared Services PPE stocks during the pandemic 60

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

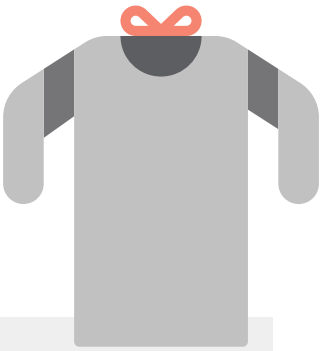
the number of items of PPE issued by Shared Services between 9 March 2020 and 7 February 2021

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

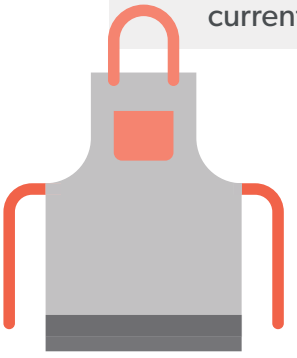
our estimate of how much the Welsh Government has received so far through the Barnett formula as a result of spending on PPE in England

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.

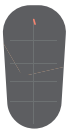
1.15 **Exhibit 1** sets out the PPE requirements at the time of drafting this report. Overall, there have been over 30 changes to the guidance since it was first issued in January 2020. One key change came on 10 April 2020 when the guidance was updated to reflect that non-symptomatic patients could be 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.

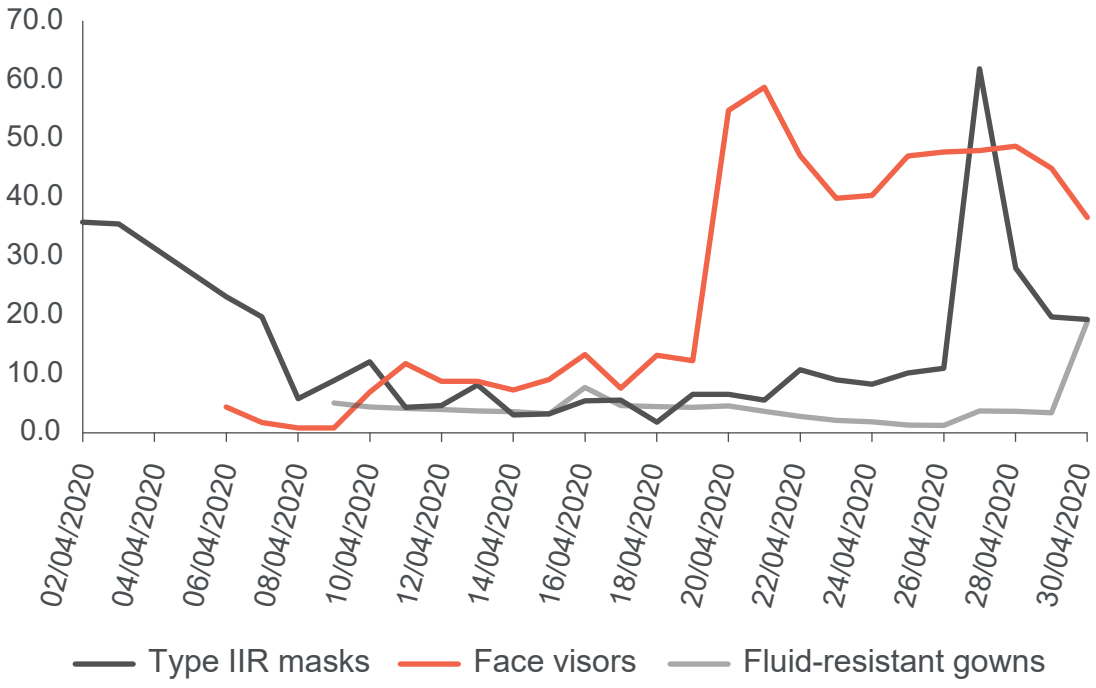
2 The PIPP stockpile included a type of safety glasses, procured by the UK Government, that were found by the Health and Safety Executive to not meet the required standards for splash protection. The Medicines and Healthcare products Regulatory Agency issued a safety alert for these products in May and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

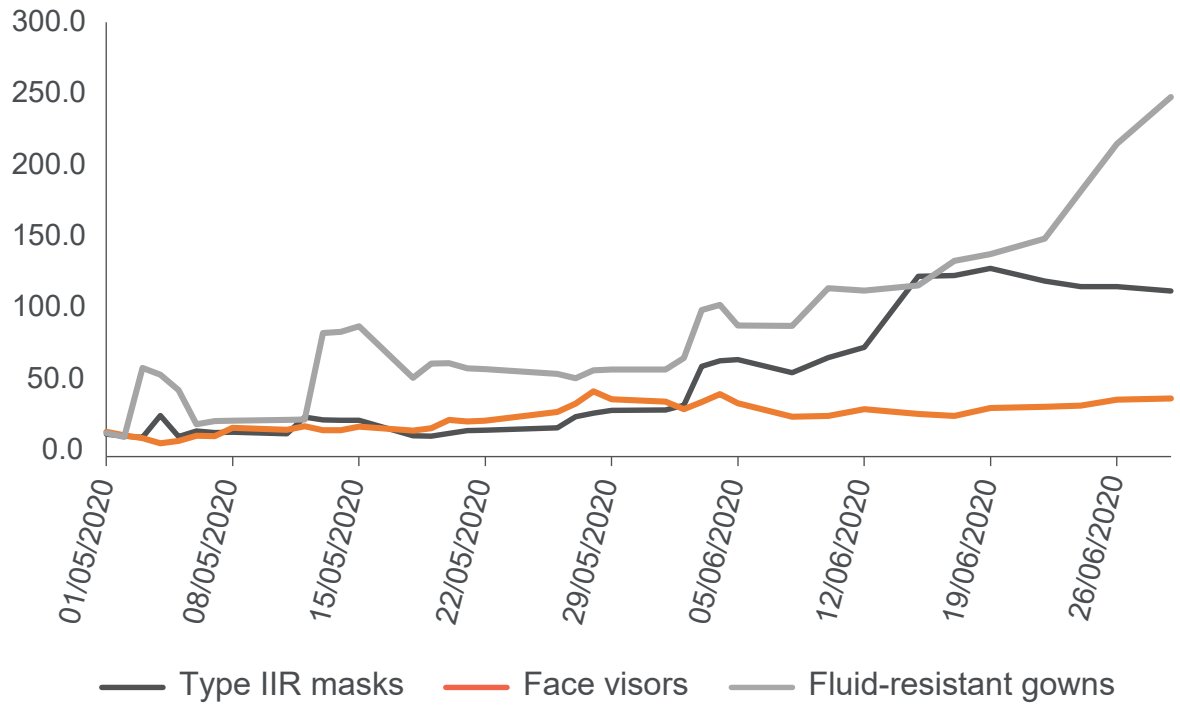


Note: days of Shared Services' stock remaining calculated using an average of previous 28-day issues. Lowest point for Type IIR Masks was 1.8 days on 18 April, for Face Visors was 0.8 days on 8 April, and for Fluid-Resistant Gowns was 1.2 on 26 April.

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.

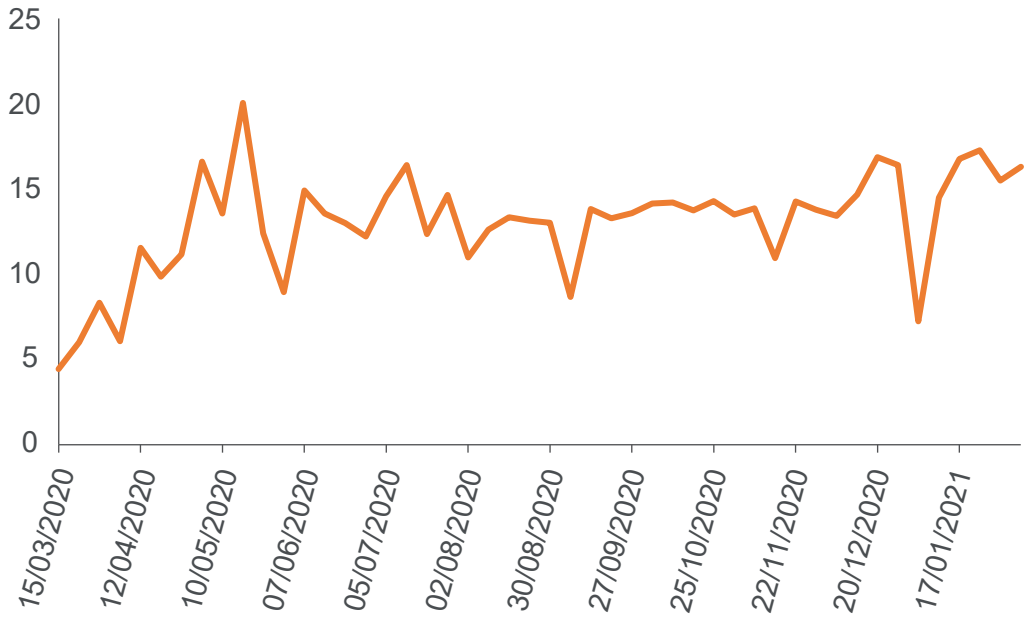
1.32 The Senedd Health, Social Care and Sport Committee highlighted the significant difficulties that the social care sector faced in meeting PPE requirements in the early stages. Notes from the local government working group on procurement (**paragraph 1.10**) confirm this picture. The group expressed 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).

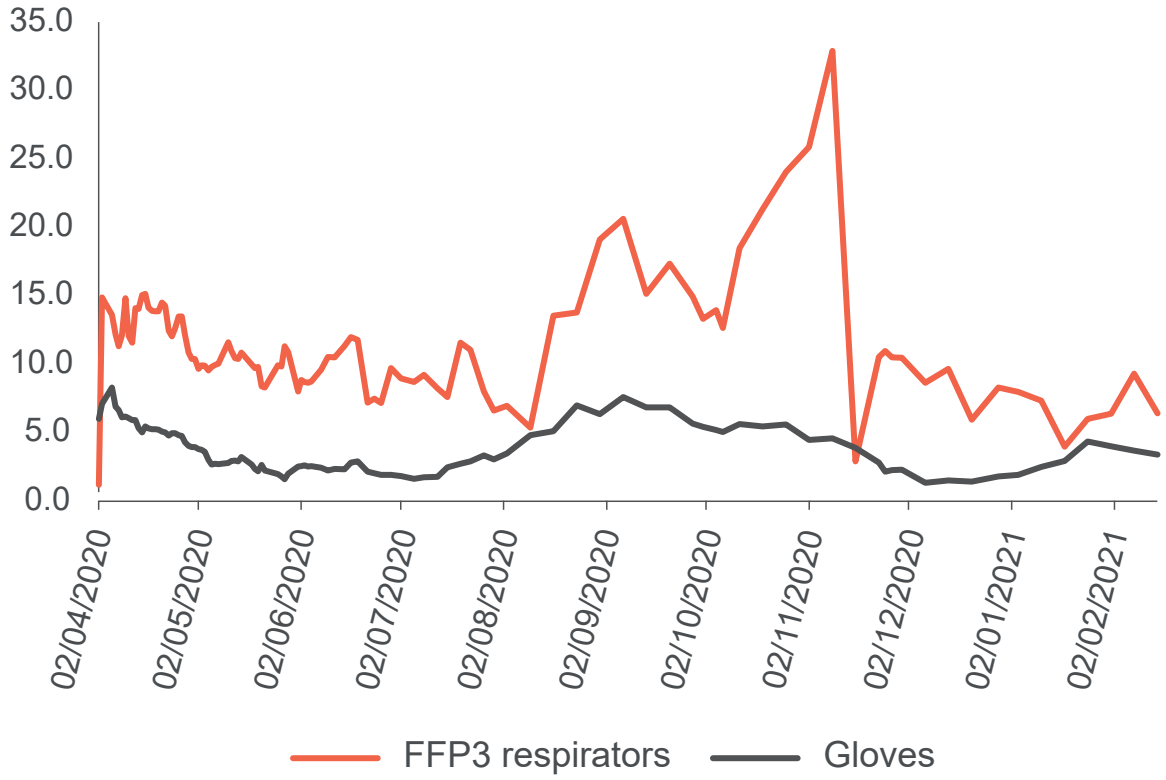
1.38 However, for some items there has never been a 24-week buffer. Through the second wave of the pandemic some stocks have declined significantly – in particular, FFP3 respirators and nitrile gloves (**Exhibit 6**). These two items have proved difficult to source.

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

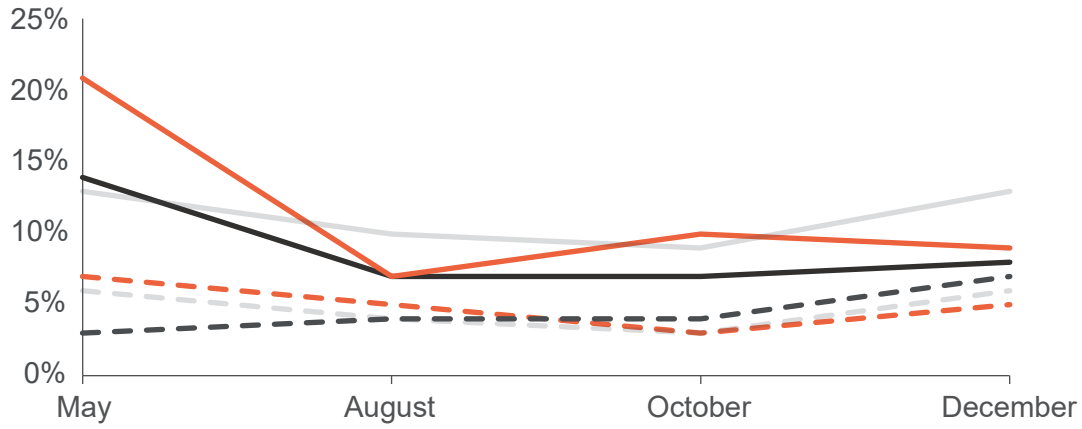
1.45 The BMA asked its survey respondents to identify areas of concern from a list of different issues. Those identifying PPE shortages as a concern dropped from 38% to 13% between May and December 2020[5]. However, when asked about specific types of PPE, BMA respondents' perceptions of PPE levels is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

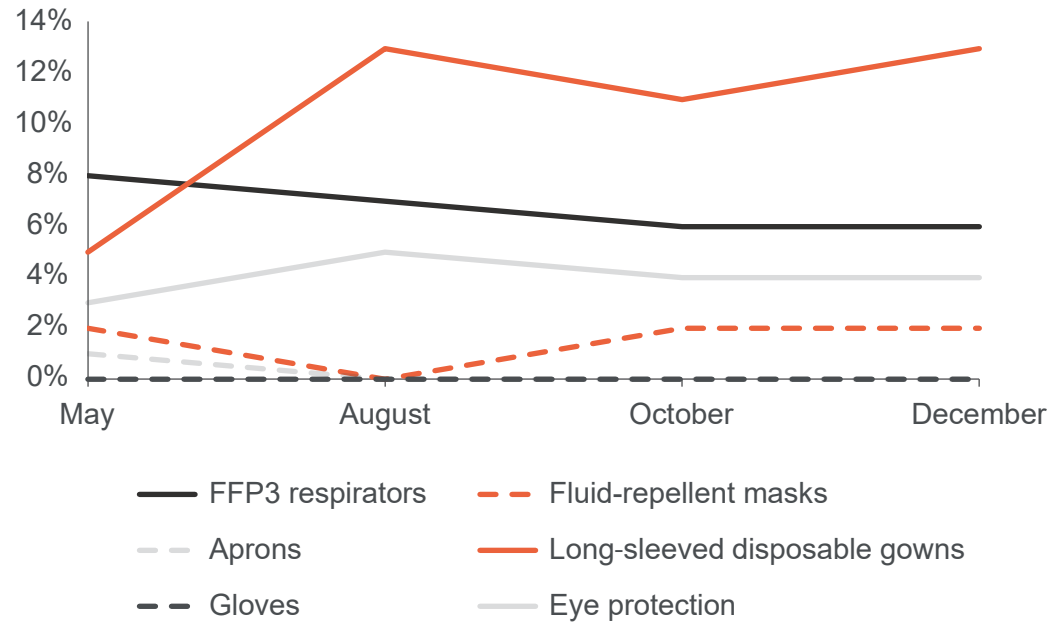
5 The question asked respondents to choose from a list of possible concerns over the next few months. They were able to choose as many options as they wanted, including 'PPE shortages'.

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.

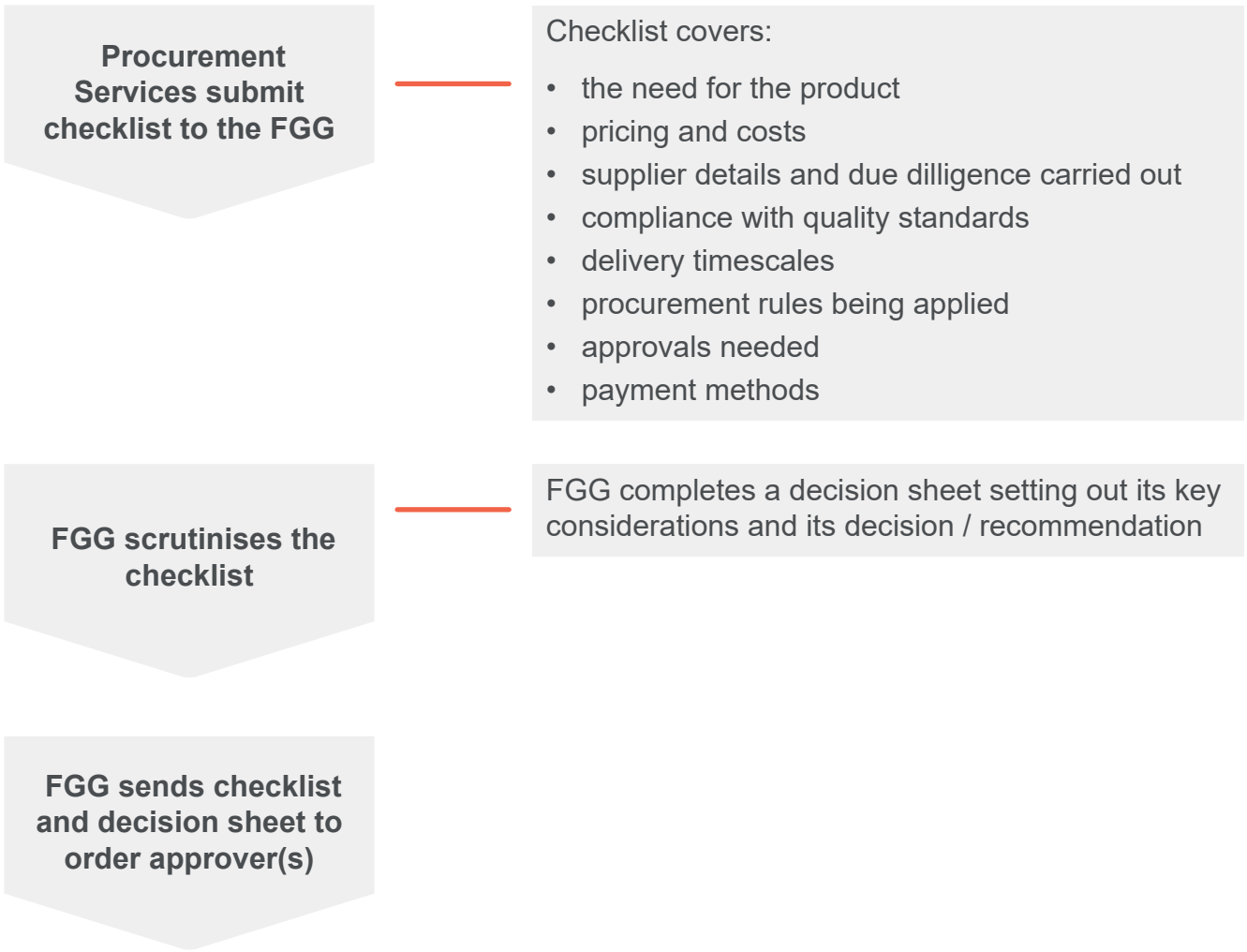
2.15 Shared Services set up a new cross-profession Finance Governance Group (FGG) in early April 2020 to manage risks while enabling rapid decision making related to COVID-19 procurement. **Appendix 2** sets out the membership of the FGG which also included members of the Board of Velindre University 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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