Agenda – Public Accounts Committee

Meeting Venue:
Committee Room 5 – Tŷ Hywel
Meeting date: 26 November 2018
Meeting time: 13.30

For further information contact:
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(The Committee agreed on 12 November 2018, a motion under Standing Order 17.42 to resolve to exclude the public from this meeting)

1 Introductions, apologies, substitutions and declarations of interest

(13.30)

2 Paper(s) to note

(13.30 – 13.35) (Pages 1 – 2)

2.1 Local Government Services to Rural Communities: Auditor General for Wales Report

(Pages 3 – 76)

2.2 Scrutiny of Accounts 2017-18: Correspondence from the Assembly Commission (20 November 2018)

(Pages 77 – 78)

3 Management of follow up outpatients across Wales: Auditor General for Wales Report

(13.35 – 13.50) (Pages 79 – 102)

Research Briefing

PAC(5)-31-18 Paper 1 – Auditor General for Wales Report

PAC(5)-31-18 Paper 2 – Welsh Government Response

4 Radiology services – national summary report: Auditor General for Wales Report

(13.50 – 14.05) (Pages 103 – 160)

Research Briefing

PAC(5)-31-18 Paper 3 – Auditor General for Wales Report

5 Forward Work Programme – Spring 2019

(14.05 – 15.00) (Pages 161 – 179)

PAC(5)-31-18 Paper 4 – Forward work programme

PAC(5)-31-18 Paper 5 – Correspondence from Darren Millar AM on Tawel Fan Ward at Ysbyty Glan Clwyd (6 November 2018)

PAC(5)-31-18 Paper 6 – Cabinet Secretary for Health and Social Services Statement on Betsi Cadwaladr University Health Board Special Measures Update (6 November 2018)

Concise Minutes – Public Accounts Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: Monday, 12 November 2018

Meeting time: 13.15 – 16.04

This meeting can be viewed on Senedd TV at:

http://senedd.tv/en/5039/

Attendance

Category	Names
Assembly Members:	Nick Ramsay AM (Chair) Mohammad Asghar (Oscar) AM Rhianon Passmore AM Adam Price AM Jenny Rathbone AM
Witnesses:	Reg Kilpatrick, Welsh Government Alun Michael, South Wales Police and Crime Commissioner Mark Price, Welsh Government Stephen Carr, Welsh Local Government Association
Wales Audit Office:	Adrian Crompton – Auditor General for Wales Matthew Mortlock Dave Rees
Committee Staff:	Meriel Singleton (Second Clerk) Claire Griffiths (Deputy Clerk) Katie Wyatt (Legal Adviser)

1 Community Safety in Wales: Technical Briefing

1.1 Members received a technical briefing on Community Safety in Wales from Reg Kilpatrick, Director for Local Government, Welsh Government; Alun Michael, South Wales Police & Crime Commissioner; Stephan Carr, Safer Communities Programme Manager, Welsh Local Government Association; and Mark Price, Welsh Government Safer Communities Programme Co-Ordinator.

2 Auditor General for Wales Report: National Fraud Initiative 2016-18

2.1 Members received a briefing from the Auditor General on his report and agreed to give further consideration to the issues raised, possibly as part of a wider look at public sector counter fraud arrangements.

3 Introductions, apologies, substitutions and declarations of interest

3.1 The Chair welcomed Members to the Committee

3.2 Apologies were received from Neil Hamilton AM and Jack Sargeant AM.

4 Paper(s) to note

4.1 The papers were noted.

5 Implementation of the NHS Finance (Wales) Act 2014: Letter from the Welsh Government (31 October 2018)

5.1 The Committee considered the response from the Welsh Government and agreed that the Chair would write to the Welsh Government seeking clarification on a number of issues.

Closing Remarks

The Committee agreed a motion to meet in private on 26 November 2018.

November 2018

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Local Government Services to Rural Communities

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared and published this report in accordance with the Public Audit (Wales) Act 2004.

The Wales Audit Office study team was managed by Nick Selwyn and comprised Steve Frank, Gareth Jones, Euros Lake, Sara Leahy, Martin Gibson, Philippa Dixon and Matt Brushett under the direction of Jane Holownia

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The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Councils are not yet finding sustainable ways to help rural communities overcome the challenges they face and need to think and act differently

1 Delivering fair and equitable public services and maintaining specialist provision in rural areas is challenging due to geography, distance, cost and scalability. A tradition of strong community resilience and a culture of self-reliance in rural areas, can often mask significant problems. The loss of the ‘cornerstones’ of village life such as banks, schools, and post offices and poor access to key infrastructure like public transport and superfast broadband can compound the challenge of sustaining public services in rural communities.

What we mean by 'Rural Wales':

There is no single agreed definition of a rural Wales. The classification used by Welsh Government defines roughly 20% of the overall Welsh population as living in rural areas. For the purpose of this study, and in line with the Welsh Local Government Association's rural policy forum, we classify nine authorities as rural, 11 authorities as semi-rural and two authorities as non-rural and urban.

PRIMARILY RURAL

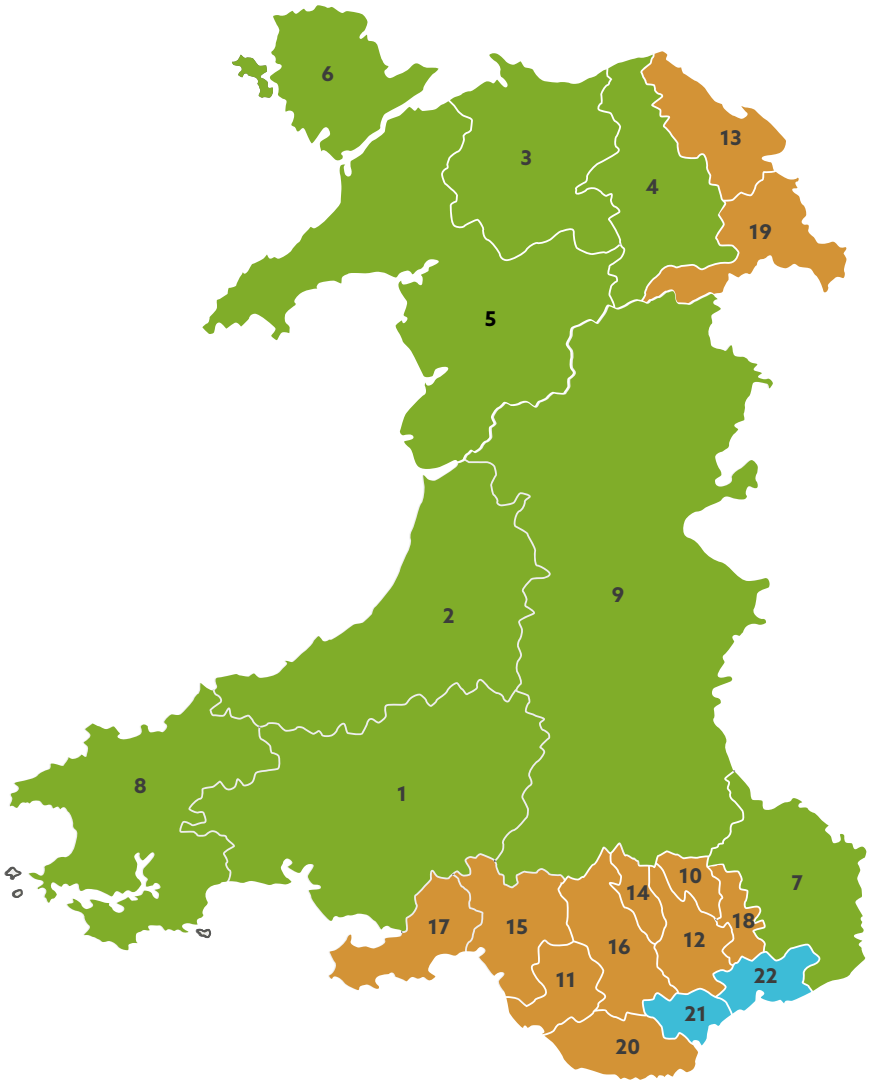
1 Carmarthenshire
2 Ceredigion
3 Conwy
4 Denbighshire
5 Gwynedd
6 Isle of Anglesey
7 Monmouthshire
8 Pembrokeshire
9 Powys

SEMI-RURAL/URBAN

10 Blaenau Gwent
11 Bridgend
12 Caerphilly
13 Flintshire
14 Merthyr Tydfil
15 Neath Port Talbot
16 Rhondda Cynon Taf
17 Swansea
18 Torfaen
19 Wrexham
20 Vale of Glamorgan

FULLY URBAN

21 Cardiff
22 Newport



2 Since 2010-11, councils have faced significant financial constraints. Net revenues from Welsh Government grants, business rates and collected council tax fell by 7.5% between 2009-10 and 2016-17 (excluding fees and charges), which is the equivalent to £529 million[1]. The Welsh Local Government Association estimates that austerity has resulted in councils cutting spending by over £1 billion in real terms and 25,000 jobs being lost in councils since 2010-11[2]. The impact of austerity on provision of services is resulting in councils facing tough choices and requires them to identify alternative service models and new ways of working to maintain and protect services.

3 Under its Programme for Government 2016-2021, the Welsh Government has set an outcome of 'Successful, Sustainable Rural Communities'. Under this outcome, there are specific targets and actions for public bodies, including local government[3]. This review assesses how local government directly provides services to rural communities, and how councils work with others, and considers whether they:

a have clear priorities for services to rural communities based on an understanding of needs and demands;

b are making best use of resources by, for example, developing new joint models of service delivery such as gateway services or joint service and community hubs;

c are making best use of facilities, co-location and/or transfer and use of assets;

d are supporting citizens to become more resilient and self-reliant; and

e are taking a longer-term place based view on how best to deliver services.

4 Our review methods are set out in Appendix 1. Based on the findings of this audit, the Auditor General has concluded that **councils are not yet finding sustainable ways to help rural communities overcome the challenges they face and need to think and act differently.**

1 www.walespublicservices2025.org.uk/files/2017/11/Austerity-and-Local-Government.pdf
2 www.wlga.wales/local-government-settlement-the-war-of-attrition-continues-says-wlga
3 Priority 4 relates to public bodies supporting community-led projects, promote skills development, job creation, entrepreneurship, community energy, rural transport and broadband access. Priority five focuses on safeguarding social housing in rural communities by ending 'Right to Buy' and continuing to support the work of Rural Housing Enablers.

Our findings

5 For many people in rural Wales, it is a great place to live and work. However, reductions in public spending coupled with socio-economic change, poor infrastructure and ongoing public service delivery challenges are resulting in services being less accessible and effective compared to urban areas.

6 **Part 1** of this report examines the shifting face of rural Wales, looking at demographic challenges in providing services to dispersed communities in rural areas. The loss of the cornerstones of village life – banks and post offices for example – and poor infrastructure have adversely affected rural communities.

7 **Part 2** examines how public bodies are currently responding to the challenge of planning and delivering services in rural Wales. We find that public bodies who cover both rural and urban areas too often create and deliver services shaped by their urban context. Whilst there are significant variations in the local environment, policy choices and councils' operational structures, there is also a steady drift towards standardisation and centralisation based on a perception of being able to manage costs and increase efficiency. Public bodies continue to deliver a 'one size fits all approach' which is creating and reinforcing 'rural inequality'[4].

8 Finally, **Part 3** concludes that with fewer resources, rising demand and complex delivery challenges, public bodies need to work together in deciding how they set priorities and deliver frontline services if they are to meet the long-term needs of citizens. From our review we have identified there are opportunities to do things differently and to provide solutions that can better meet the future needs of rural Wales. Key to addressing this challenge is to make a reality of co-ordinated and integrated services to maximise both the use of resources and the quality of service delivery. This requires liaison and co-operation between public, private and voluntary sector providers, including the development of multi-purpose, cross-sector hubs. Public bodies also need to do more to equip citizens and communities to become more resilient and self-reliant as public finances continue to reduce.

4 By rural inequality, we mean the real and perceived imbalance and difference in the quality, accessibility, and affordability of service provision in rural areas compared to urban ones. Not only can a 'one size fits all' approach' stifle innovation, it can work against current policy shifts towards personalisation of services, particularly in social care. An over generalised view of service demand and people's needs can hinder the targeting of increasingly scarce resources and impede prevention activity. It can restrict people's personal choices. A 'one size fits all' approach is not a solution to policy variance and inconsistencies in services.

Recommendations

9 We have made recommendations for improvement and these are set out below.

Recommendations	
R1	Socio economic change, poor infrastructure and shifts in provision of key services and facilities has resulted in the residualisation of communities in rural Wales. (See paragraphs 1.2 – 1.16) **We recommend that Welsh Government support public bodies to deliver a more integrated approach to service delivery in rural areas by:** • **refreshing rural grant programmes to create sustainable financial structures, with multi-year allocations; and** • **helping people and businesses make the most of digital connectivity through targeted and more effective business and adult education support programmes.**
R2	The role of Public Service Boards is evolving but there are opportunities to articulate a clearer and more ambitious shared vision for rural Wales (see paragraphs 2.2 to 2.9 and 2.28 to 2.31). **We recommend that PSB public services partners respond more effectively to the challenges faced by rural communities by:** • **assessing the strengths and weaknesses of their different rural communities using the Welsh Governments Rural Proofing Tool and identify and agree the local and strategic actions needed to support community sustainability; and** • **ensuring the Local Well-Being Plan sets out a more optimistic and ambitious vision for 'place' with joint priorities co-produced by partners and with citizens to address agreed challenges.**
R3	To help sustain rural communities, public services need to think differently in the future (see paragraphs 3.1 to 3.12). **We recommend councils provide a more effective response to the challenges faced by rural communities by:** • **ensuring service commissioners have cost data and qualitative information on the full range of service options available; and** • **using citizens' views on the availability, affordability, accessibility, adequacy and acceptability of council services to shape the delivery and integration of services.**

Recommendations

R4 To help sustain rural communities, public services need to act differently in the future (see paragraphs 3.1 to 3.12). **We recommend councils do more to develop community resilience and self-help by:**

- **working with relevant bodies such as the Wales Co-operative Centre to support social enterprise and more collaborative business models;**
- **providing tailored community outreach for those who face multiple barriers to accessing public services and work;**
- **enhancing and recognising the role of town and community councils by capitalising on their local knowledge and supporting them to do more;**
- **encouraging a more integrated approach to service delivery in rural areas by establishing pan-public service community hubs, networks of expertise, and clusters of advice and prevention services;**
- **enabling local action by supporting community asset transfer identifying which assets are suitable to transfer, and having the right systems in place to make things happen; and**
- **improving community-based leadership by developing networks of interest, training and coaching, and encouraging volunteering.**

Part 1 – Socio economic change, poor infrastructure and shifts in how key services and facilities are provided has resulted in the residualisation of communities in rural Wales

1.1 Public services are key to helping and protecting citizens, and traditionally focus on solving problems. However, there are a host of challenges that face the Welsh public sector in the 21st century. In this part of the report, we consider the implications of the shifting face of rural Wales looking at the impact of population, employment and housing changes in the recent past. We also consider the infrastructure challenge of providing public and other services to dispersed communities in rural Wales – the quality of roads, access to broadband and the provision of key services such as banks and post offices. We also consider citizens views on local public service provision and recent changes. These challenges are often interconnected, defining the operating environment in which public bodies deliver services.

Demographic change and challenges in encouraging employment has impacted on the sustainability of communities and services

Rural communities are ageing more quickly and the rate of new household formation slowing than other parts of Wales

1.2 Demographic changes are increasing pressure on already stretched public services such as social care as demand for services increase. Depopulation and an ageing society in remoter rural areas is also resulting in local services becoming less viable. The demography of rural Wales and, in particular, the growing number of older people, has implications for the future of public service provision – for example increasing demand on social care and housing services. Between 2012 and 2016 all nine primarily rural councils have seen a reduction in the number of people aged under 18 and an increase in the number of people aged over 65. Whilst all rural areas will see the number of households in their area increase by 2035, eight of the nine primarily rural authorities will see new household formation at levels lower than the Welsh average. Daffodil[5] forecasts that this trend will continue for the next 20 years.

5 Daffodil is a web-based system developed by the Institute of Public Care for the Welsh Government, which pulls together in one place the information needed to plan care, support and housing services in the future.

The lack of well paid jobs and difficulties creating and maintaining employment has encouraged younger people to move away

1.3 Our analysis highlights that, in some aspects, the economy of rural Wales is performing well. The employment rate in primarily rural authorities has seen a greater increase since 2007-08 than other parts of Wales, and all rural areas (with the exception of Ceredigion) at levels above the Welsh average. Overall, fewer people in rural Wales are economically inactive, unemployed or in receipt of welfare benefits than other parts of the country[6].

1.4 Despite these changes, rural Wales faces some significant economic challenges. Developing and sustaining a high skills economy can be difficult because the labour market is relatively small and there can often be a mismatch between having a workforce with the right skills to attract inward investment. New businesses are less prevalent in rural than urban areas. Whilst six of the nine primarily rural authorities have seen more businesses created than closed in 2016, the rate of growth has been gradually reducing since 2013 and the number of active business enterprises per 10,000 population fell in eight of the nine primarily rural authorities between 2008 and 2016.

1.5 Most communities in Wales have seen average (mean) gross weekly earnings increase since 2012, but seven of the nine primarily rural authorities have average weekly wages below the overall Welsh average and in Pembrokeshire, wages have fallen[7]. Comparatively, rural Wales has lower wages and the gap between the counties with the lowest and highest average earnings is widening.

1.6 The economy of rural Wales is heavily geared towards self-employment and smaller businesses. In 2016-17, self-employment levels in the nine primarily rural authorities were above the Welsh average. Only one other authority (Torfaen) is above the Welsh average[8]. Data published by the Office of National Statistics show that a greater proportion of the workforce are employed in micro (between 1 and 9 employees) and small (between 10 and 49 employees) businesses in rural Wales than other parts of the country[9]. For example in 2017, 40.1% of the workforce in Powys worked in micro businesses compared to 13.8% in Cardiff.

6 www.nomisweb.co.uk/articles/1048.aspx
7 https://statswales.gov.wales/Catalogue/Business-Economy-and-Labour-Market/People-and-Work/Earnings/averageweeklyearnings-by-welshlocalareas-year
8 https://statswales.gov.wales/Catalogue/Business-Economy-and-Labour-Market/Businesses/Business-Demography
9 www.ons.gov.uk/businessindustryandtrade/business/activitysizeandlocation/bulletins/ukbusinessactivitysizeandlocation/2017

1.7 Research shows that young people in rural areas are more likely to be in low paid work, insecure employment or working within smaller firms than their urban counterparts. A particular challenge for young people is the difficulty in progressing in work due to the concentration of small firms, which offer limited opportunities for young people to upgrade their skills and progress. Consequently, this results in young people feeling that they are being 'pushed' away from rural areas because of the lack of opportunities and lower wages, and 'pulled' to urban areas because they have better job opportunities, progression prospects and higher salaries[10].

Poor infrastructure and changes in how key services and facilities are delivered has adversely affected rural communities

1.8 A well-connected and good quality road network, regular and inexpensive public transport, affordable housing, accessible public and private services and excellent broadband coverage are key pre-requisites of creating sustainable rural communities. These building blocks connect people to the services they need so they can thrive and grow. But citizens we surveyed raised concerns that the foundations of rural life, the things that contribute to making their community a great place to live and work, coupled with the impact of public funding cuts and continuing economic uncertainty, have changed their communities in recent years, and not always for the better.

Poor transport infrastructure has affected citizens ability to access facilities, services and work

1.9 Whilst the quality of roads are improving across Wales, authorities in rural Wales have the poorest quality roads[11]. Rural authorities also disproportionately cover the bulk of the Welsh road network with 66.3% of roads in the nine primarily rural authorities. Some 56% of Town and Community Councils responding to our survey rated the condition of roads as in poor condition, a finding echoed by 31% of citizens who replied to our survey.

10 www.dera.ioe.ac.uk/15199/1/Barriers-to-education-employment-and-training-for-young-people-in-rural-areas.pdf
11 https://statswales.gov.wales/Catalogue/Transport/Roads/Lengths-and-Conditions

1.10 Research by the Campaign for Better Transport shows that whilst most councils in Wales maintained or increased investment between 2010-11 and 2016-17, they still reduced their expenditure on local bus routes by £5.1 million (24%). The largest increase was in Powys, where the budget increased by roughly £690,000 and the largest cut in Gwynedd, where the budget reduced by over £1 million[12]. Respondents to both our public and Town and Community Council surveys noted that public transport is less available than in the past and fear this decline is set to continue. Citizens cited Powys, Monmouthshire and Ceredigion as the areas with the least accessible public transport. Town and Community Councils across Wales similarly highlighted a decline in the availability of public transport with 50% of respondents stating services had decreased in their community.

Citizens are being prevented from accessing and using public services because of poor broadband coverage

1.11 Superfast broadband is essential for consumers and businesses. It can help improve access to information, advice and help for citizens, and support public bodies to channel shift services to make it easier for citizens to access and use them but also to increase efficiency and create savings. Digital services also allow businesses to provide flexible working for employees so that they can work from home and access company systems remotely, saving costs and reducing carbon footprints.

1.12 The UK has poor broadband infrastructure, Wales has the poorest broadband links in the UK and rural areas in Wales the poorest access to services. An analysis of over 63 million broadband speed tests worldwide revealed that the UK sits in 31st place, with an average speed of 16.51 Mbps[13]. Seven of the ten wards in Great Britain with the lowest average download speed are in Wales and located in Gwynedd, Powys, Monmouthshire, Carmarthenshire and Pembrokeshire[14].

1.13 The findings of our Town and Community Council survey echo these conclusions. A number of respondents commented on poor superfast broadband speed and ongoing difficulties accessing online information, completing forms and applications. The result is that rather than improving access to services, poor broadband coverage is resulting in services becoming less available and accessible especially as councils are increasing their provision of online services.

12 www.bettertransport.org.uk/sites/default/files/research-files/2010_final_buscuts.pdf
13 The data rates of modern residential high-speed Internet connections are commonly expressed in megabits per second (Mbps). www.docs.google.com/spreadsheets/d/1A8LDcCLY3HN5Oqys6VxB0ug8xgroDADVIA2BeAF_tSM/edit#gid=0
14 www.researchbriefings.files.parliament.uk/documents/SN06643/SN06643.pdf

Bank and post office closures have adversely affected many Welsh communities

1.14 The growth in online and mobile services have seen a reduction in banks and post offices. Research by Which estimates that 93 banks have closed since 2015[15]. Of these, 50 banks closed in the nine rural authority areas, 36 in mixed urban/rural and six in urban authority areas. Powys has seen the largest number of closures in Wales with the loss of 11 banks since 2015. Post office provision has similarly fallen across all Welsh communities since 2007[16]. Research by Deloitte[17] and by Move your money[18] highlight that the majority of closures happen in areas that are more dependent on bank and post office branches and most likely to be adversely affected by their shutting. For example, Deloitte classifies many areas of rural Wales as 'declining rural communities' who will experience further closures because of 'shrinking footfall and reduced demand for financial products and services'.

There have been difficulties in developing and accessing housing in some rural areas

1.15 More people own their home than rent in rural areas. The nine primarily rural authorities have levels of owner occupation equal to or greater than the Welsh average but levels of social housing – rented from a housing association or council – are, overall, below the Welsh average[19]. House prices are also generally higher in rural areas than in urban communities. For example, in May 2018 six of the nine primarily rural counties recorded average sale prices in excess of the Welsh average of £148,894[20]. In recent years, new house building in rural Wales has mostly remained static but in four of the nine primarily rural authorities – Isle of Anglesey, Denbighshire, Monmouthshire and Powys – new dwelling construction has fallen[21].

15 www.which.co.uk/news/2017/04/mapped-the-482-bank-branches-closing-in-2017/
16 Post Office Limited Network Report 2017; and www.researchbriefings.files.parliament.uk/documents/SN02585/SN02585.pdf
17 www2.deloitte.com/content/dam/Deloitte/uk/Documents/financial-services/deloitte-uk-bricks-and-clicks.pdf
18 www.drive.google.com/file/d/0BxHxIVSxtvx2YVRtLTZDdkI0a0E/view
19 https://statswales.gov.wales/Catalogue/Housing/Dwelling-Stock-Estimates/dwellingstockestimates-by-localauthority-tenure
20 https://www.gov.uk/government/publications/uk-house-price-index-wales-may-2018/uk-house-price-index-wales-may-2018
21 http://gov.wales/statistics-and-research/new-house-building/?lang=en

1.16 Citizens responding to our survey highlighted the availability of housing, especially for younger people, the lack of affordable housing and rising house prices as growing problems. Welsh Government has supported authorities to create Rural Housing Enabler[22] (RHE) posts to assist development of housing in rural communities. Despite investing in this important role, the supply of new affordable housing has not significantly increased and a recent report highlighted that 'the dilemma facing all those involved in the RHE project is that delivery of rural affordable housing remains low'[23].

Citizens generally feel that key council services are not as available, affordable, accessible, adequate and acceptable as they used to be

1.17 Citizens we surveyed believe there has been a decline in council services in the last five years. According to 43% of citizen survey respondents, council services have got worse over the past five years, compared to 39% who state there is no change. Only 10% say services have improved. 24% note that council services they use have been stopped and 10% that services are now restricted. Just under half of citizens responding to our survey said that the council services they use are unaffordable to them.

1.18 Despite recognising that things need to change, citizens' reaction to alternative service delivery models is mixed. Just under half are open to the idea of encouraging communities to run services themselves, particularly those in younger age groups. However, whilst residents accept the need to deliver future services differently, roughly seven in ten survey respondents still want council services delivered as they are now.

1.19 With increasingly constrained budgets, citizens are less positive about the future of public services. Only 29% agree that their local council will be able to deliver high quality services in the future but most citizens responding to our survey are unwilling to pay more council tax. Town and Community Councils responding to our survey support these conclusions, in particular, that the cost of council services have increased and become less accessible and available.

22 Rural Housing Enablers work with rural communities to identify local need for affordable homes and then work with the local community to find a suitable opportunity to develop housing.

23 http://rhewales.co.uk/images/user/Evaluation%20Rural%20Housing%20Enablers%20Wales%20Final%20Report%202014.pdf

Exhibit 1: the impact of service change on citizens and communities in rural Wales

Citizens and town and community councillors have seen a reduction in public services in rural Wales.

Comments from Citizens on changes to public services

Comments from Town and Community Councils on changes to public services.

'Low percentage of people are internet users and there is limited public transport.'

'Elderly people and young people are disadvantaged by lack of locally available facilities and the reliability of public transport, which is both inefficient and infrequent.'

'Closing of library services has made it more difficult for people to pay council tax and council house rent.'

'People without their own transport cannot get to work using public transport on time. School buses often late. Young people looking for work whose parents do not drive do not find work easy. They cannot afford or are unable to travel far for work. Lack of bus service no chemist no local doctor no library living rural now means being cut off more especially for the sick or elderly.'

'No public transport and no services in the area other than what is put on my community in the village hall. So anyone who can't drive is not able to access services.'

Community Asset Transfers have increasingly been used by councils to save money but have not always resulted in sustainable solutions

1.20 With less money available to maintain key assets – for example, community halls, playing fields and changing rooms – councils are closing or selling off community assets to balance the books. In rural areas, these facilities are often key components of village life, the things that help communities to thrive and survive. Rather than closing amenities, one option for councils is to pursue a Community Asset Transfer (CAT)[24]. Consequently, the approach to CAT is indicative of how well public bodies support and encourage communities to do more for themselves and protect services.

1.21 We found that more community asset transfers are happening. Twenty five percent of those responding to our Town and Community Council survey stated they have been involved in the transfer of open spaces, 19% the transfer of a village or community hall, 9% of bus shelters and 2% of streetlights. In Neath Port Talbot, the council has transferred 55 assets including eight community centres and nine libraries into community control and is supporting the development of social enterprises. Research by Locality[25] concluded that the public bodies who are good at transferring assets have some common features. Namely, good quality and supportive guidance with short end-to-end processes for overseeing and approving cases. Critically, the success of transfers is founded on shared responsibility; both from the council transferring the asset, but also the community group and the body taking on responsibility.

24 CAT involves the transfer of ownership or management of land and buildings and represents an opportunity for public bodies to sustain services, and help rural communities develop greater self-resilience.

25 http://locality.org.uk/services-tools/support-for-community-organisations/ownership-and-management-of-land-and-buildings

1.22 We are concerned that councils are not always doing all they can to ensure a smooth handover and create a sustainable legacy. For instance, councils could do more to build capacity in their communities to be able to take on and successfully sustain assets. Only seven councils, of which four are primarily rural, provide capacity building, training, mentoring, and financial support to community groups and potential transferees. Only 15% of those Town and Community Councils responding to our survey who have taken on responsibility for an asset, received some form of financial assistance from their council, and only 10% ongoing support after transfer. For the bulk of assets transferred, Town and Community Councils take the asset in good faith and often feel they have to take on the transfer even when they do not have the skills, capacity or resources to maintain the asset.

1.23 CAT policies and business case templates often lack detail on the criteria used to decide on transfers, in particular demonstrating financial health and proven record of accomplishment is often overlooked or not detailed. Only five councils signpost expert guidance on CATs aimed at community groups produced by Welsh Government[26] and others. Applicants are often not required to set out how service provision will change or the impact of the transfer on protecting and promoting the Welsh language. Too often councils operate a 'one size fits all' approach and do not differentiate between the size of asset to be transferred. Generally, councils initiate and encourage the transfer but the risks associated with taking on an asset are not always transparently set out. Councils often do not require a business case nor do they have an equality impact assessment to support the disposal.

1.24 See our more detailed report on Community Asset Transfers.

26 The Welsh Governments Best Practice Guide provides good information and helpful resources to encourage councils to collaborate with community groups to both build capacity and enable successful transfers: http://gov.wales/docs/dsjlg/publications/comm/160310-community-asset-transfer-env2.pdf.

Part 2 – Councils and their partners are not always responding effectively to the challenges faced by rural communities

2.1 In the preceding section, we have highlighted the difficulties that councils and their partners face, and need to overcome, in providing services to rural communities. The infrastructure gap facing our villages and rural communities is not only physical or digital; it is social and public. The renewal of rural Wales depends on public bodies working strategically and smartly together to understand and address these gaps. Individual agencies alone cannot solve problems. In this part of the report, we review how councils and their partners plan to support and sustain their rural communities in the future, through the work of Public Service Boards (PSBs). We review the quality of needs assessments, the effectiveness of partnership arrangements, the impact of consultation and engagement with citizens in setting priorities and actions, and the approach to collaboration and service integration. The section concludes with an assessment of how public bodies evaluate impact in deciding future choices.

The role of Public Service Boards is evolving but there are opportunities to articulate a clearer and more ambitious shared vision for rural Wales

2.2 Under the Well-being of Future Generations Act 2015 (the 'Act'), partnership arrangements in Wales are changing. The creation of PSBs helps to strengthen joint working across all public services. PSBs are required to complete assessments of local wellbeing and identify areas where the PSB can have the biggest collective impact (towards the well-being goals) by working together. PSBs therefore offer the opportunity to move from multiple organisation planning and silo working to the creation of single place based strategies.

2.3 We identified some positive approaches that are creating a well-articulated vision for the future. For example, Monmouthshire's People Place Prosperity Strategy[27] recognises the different communities within the county and how meeting needs, and demand varies, is specific to local communities and requires different responses. In comparison however, some PSBs continue to deliver a one size fits all approach based on universal eligibility and centralised delivery models. Wellbeing Assessments and Plans have a number of shortcomings when considering rural areas. Too often, they act as a plan to make a plan and have not moved from analysing the current situation to actually setting out a shared vision underpinned by actions to make things better. Actions in the Wellbeing Plans we examined are very broad and it is often not clear who will do what or how services in rural areas will become more adequate, accessible, available, affordable, or acceptable.

2.4 Opportunities to collaborate and integrate services to maximise impact and make best use of resources are under developed or not pursued. Despite working together in recent years, key PSB partners have not clarified what they have learnt so far by looking at what works well and why. Wellbeing Assessments we reviewed did not consider future spending and the opportunities to pool budgets. In addition, service capabilities, impacts of prevention work, options for improvement, and information on spending and budgets are often lacking in Assessments.

2.5 PSBs do not always assess the capabilities of current services nor identify the contribution the private and third sectors can make. Social enterprises, which offer a community led response to the challenge of residualisation, are a particularly important option that PSBs should support, but their role is mostly overlooked. The establishment or involvement of social enterprises is not without challenge or risk – there is a mixed record of accomplishment of success and councils have examples of lost time and money trying to support them.

2.6 Nonetheless, with increasing pressures on the public purse and a commitment by policy makers to design services around the needs of citizens, it is clear that the private, third and social enterprise sectors have an important and growing role to play. They offer flexibility to harness and improve quality and achieve innovation, but PSBs need to integrate services at the point of delivery to identify and support the most appropriate response, be it from the public, private, or third sector, including social enterprises.

27 https://democracy.monmouthshire.gov.uk/documents/s13975/180418%20Draft%20Social%20Justice%20Strategy%20V5%20Appendix%20A%20180502.pdf

2.7 PSBs have much to do in order to improve relations with Town and Community Councils. Only 11% of Town and Community Councils responding to our survey indicated that they had a good working relationship with their PSB, compared to the 66% of respondents who felt that they had a good working relationship with their council. Almost a third of Town and Community Council respondents indicated they did not understand the role of PSBs.

Analysis of data to understand problems and agree appropriate solutions is poor

2.8 PSBs are using data to understand the challenges they need to address and to review past performance. Some PSBs – Pembrokeshire, Ceredigion, and Carmarthenshire PSBs – are also collaborating and have joint wellbeing guidance, a Joint Methodology Framework, and actively share reports, data and information. Several PSBs are planning to map all service and community assets – for example, Pembrokeshire, Ceredigion, Neath Port Talbot, Swansea, and the Vale of Glamorgan – to identify how best to collectively optimise asset use and delivery of services. Pembrokeshire, Powys and Conwy and Denbighshire PSBs also have information strategies to improve how they collect and analyse data.

2.9 However, we also identified some common weaknesses in current approaches. The root cause of problems in different communities are not identified because data is often collected, managed and analysed in silos and/or at a county level only. This can result in organisations overlooking the different challenges in diverse rural areas. Councils recognise that their data is not robust and has limitations, and that they do not have the right skills nor capacity to make the best use of data.

2.10 There is little demonstration of how public bodies understand the diverse nature of their rural communities. For example, in those Wellbeing Assessments and Plans that mention rural matters, infrastructure is a common area for improvement, but Plans contain few specific actions or steps to improve infrastructure, such as actions to improve roads and cycle ways, integrate public transport and extend broadband networks.

Councils are not always tapping into their communities to help them prioritise and deliver services

2.11 Involving partners and the public in developing and shaping the services they provide and receive can have a wide range of benefits: for public bodies, the public involved and society more widely. Engaging key groups at an early stage can help shape delivery choices so the services provided are more meaningful and useful to the people who use them, and will consequently make a more positive impact. Good communication and engagement can also stimulate interest and encourage people to become more involved in shaping and delivering services.

2.12 Several Wellbeing Assessments identify the potential for social capital[28] and volunteering. Powys PSB recognises that many people are willing to volunteer, and the focus on encouraging social capital in Monmouthshire's Wellbeing Plan is a particular strength that can be built on. The findings of our citizen's survey highlight the potential benefit of social capital with roughly half of the people we surveyed open to the idea of encouraging communities to run services themselves, particularly those in younger age groups (61% of 16-34 year olds).

2.13 Engagement work is often via established channels. For example, in tackling loneliness and isolation in rural areas, community involvement has involved traditional 'set piece' events, online consultation, and some basic social media shout outs. Where engagement happens, it is mostly focused on one-off issues rather than driving a fundamental shift in approach. Other ways of engaging and involving the public are not regularly pursued; for instance using a programme of targeted surveys of a representative cross section of the community, annually posting surveys with council tax bills or other correspondence, and examining common themes from correspondence and community contact over the last few years.

28 Social capital is the economic resources obtained from interactions between businesses or public bodies and individuals or networks of individuals.

2.14 A number of public bodies have sought to improve public engagement by developing corporate standards and approaches. These include:

a Gwynedd County Council's central engagement team's internal guidance and toolkit to support services in engaging with service users and communities, and its citizen-focused approach under the Ffordd Gwynedd principle.

b Dyfed Powys Police and Pembrokeshire Coast National Park Authority have established 'customer service excellence standards' and monitor service provision against these, which enables the service to address problems as they are identified.

c the Isle of Anglesey County Council in collaboration with Medrwn Mon's Community Voices project (a third sector initiative) engages with people with protected characteristics in reviewing services. In addition, the council's Engagement and Consultation Board is also mapping approaches to engagement to determine what works and why to provide further resources that support relevant engagement activities.

d the Vale of Glamorgan Council's approach to community engagement using a community mapping tool, although at them time of our review this had only been undertaken in four communities and not rolled out to all communities in the rural areas.

e the Welsh Government funded LEADER programme that encourages empowerment through local strategy development and resource allocation. Currently there are 18 Local Action Groups in Wales covering eligible wards in 21 Local Authority areas[29].

2.15 A strong and clear message from citizens is that councils are not good at communicating their vision of future services to communities so that people know what will be available, and what role the community itself can play. Most residents have not been given the chance to voice their opinions. Our citizen survey finds the majority of respondents' (83%) had not completed a survey or been asked for their views on the services they have used in the last 12 months.

2.16 Our findings suggest that Town and Community Councils are not being utilised to understand need, which is concerning given their strong links to village life in many remote and very rural areas of Wales. Very few indicate that their local authority or PSBs consult them in order to understand residents' needs. Only 30% of Town and Community Councils responding to our survey contributed to consultation activity to identify local needs in their area and only 7% in setting the priorities of their PSB. Similarly, a number of stakeholders we interviewed commented that engagement with the private sector and business community is not always effective.

29 https://gov.wales/topics/environmentcountryside/farmingandcountryside/cap/ruraldevelopment/wales-rural-development-programme-2014-2020/leader/?lang=en

Whilst partnership working and collaboration is long established and can be effective, integration of services is limited

2.17 We found that most public bodies acknowledge that they do not have the capacity, resources or skills to respond to the needs of rural communities and know that they need to work differently and with others. With dispersed communities across much of Rural Wales and the new focus of the Act on combined service delivery options to address needs, there is an expectation that colocation, partnership working, and collaboration will increasingly become the standard model for delivering services, and a catalyst for integration of services.

2.18 Whilst councils recognise the value of joint and integrated working, they are not always organising and coordinating their work to make the best use of their expertise or realise the benefits that integration can bring. Rather, public bodies continue to focus on their own responsibilities, not the wider challenge of how public services collectively work together in an area.

2.19 For example, public bodies continue to operate out of separate buildings and run their own websites with their own information about their services and activities. Mapping provision is taking place but has not extended to reviewing current service delivery to identify options for co-location and integration. Collaboration is often based on opportunity or one-off relationships and not driven by place-based change or design.

2.20 Emergency services (Police and Fire) generally find working with other emergency services easier, but are less able to influence partnership working with other public bodies. Similarly, councils find it easier to engage with some bodies and agree joint priorities for action, for example housing associations, than others such as health boards. Regional arrangements have the potential to manage the effects of changing patterns of demand for services by sharing and integrating increasingly scarce resources and expertise. Our findings are consistent with the recent Parliamentary Review of Health and Social Care in Wales that found that the current pattern of health and social care provision is not fit for the future and emphasises the need for change[30].

30 https://gov.wales/docs/dhss/publications/180116reviewen.pdf

2.21 We did identify some good joint initiatives in rural areas such as the Rural North Flintshire Family Centre, integrated health and social care in the rural community of Llanrwst in Conwy County Borough, and the Health Challenge in Denbighshire. However, these are largely one-off initiatives rather than a fundamental shift in delivery with shared budgets, joint resourcing, integrated posts and delivery bases.

Managing and preventing demand is acknowledged as essential in maintaining services but progress is mixed

2.22 Preventing unnecessary and avoidable demand for services represents good value for money. Demand management can be a starting point for public service providers as they balance delivery of services that meet the needs of citizens with fewer resources at their disposal. To work, it requires collaboration, longer-term thinking, and an insight into how best to deliver services embracing new ways of working[31].

2.23 Currently, too much prevention activity in rural areas centres on 'one off' approaches to reduce demand or prevent service requests. For instance, services are often located in main urban areas or larger towns, which can result in people living in more remote rural areas not using them because of their location and poor transport links. On paper, services appear accessible and configured to address need, but in reality, more dispersed rural communities do not use them.

2.24 Another common limitation in prevention activity we reviewed is its short-term nature, partly a reflection of funding cycles and annual grants. Likewise, weak evaluation of the wide variety of initiatives and limited sharing of project learning means there are risks to the sustainability of prevention projects by replicating problems and potentially duplicating efforts. In line with a public body's statutory responsibility, services are often designed to reduce risk, but focusing on this rarely leads to demand being addressed. Professionals can label service users and define their needs but this can overlook underlying problems. Consequently, demand escalates before there is an intervention because public bodies pass responsibility for addressing issues back and fore.

31 Appendix 10 of our report on **managing demand – homelessness** sets out some clear principles to help shape management of demand that can be applied to provision of services to rural areas.

2.25 The other part of the demand equation is supply, and the availability of qualified staff is one area where services are increasingly overstretched. National organisations we spoke to told us about recruitment problems in qualified primary school teachers, family doctors, planners and Welsh-speaking carers. A shortage of on-call retained fire fighters is leaving some stations in rural areas potentially under-resourced. Currently there are more than 400 on-call retained fire fighter vacancies across the three Welsh Fire and Rescue Authorities.

2.26 We found some positive approaches where organisations are preventing demand and increasing access to services. These include Mid and West Fire and Rescue Authority who use their Safe and Well Home safety checks, and risk based commercial inspections, to help people in rural communities. Similarly, Dyfed Powys Police Farmwatch project, a neighbourhood-policing project with a rural focus, which we highlight as good practice in Appendix 3.

2.27 Other approaches to prevention and managing demand look to develop greater self-reliance in citizens, with public bodies looking to equip people to address their own problems. Self-sufficiency is often highlighted as central to rural life and there is a perception that rural communities are more resilient and need less support than urban areas. This is important because prevailing images of rural areas are often polarized as both declining and stagnant or alternatively that rural areas are picturesque and self-sufficient.

2.28 A few authorities actively test this perception highlighting community resilience, volunteering, and developing social capital as key strands of work. For example, the Future Monmouthshire programme includes a high-level vision of shifting the focus from direct provision to enabling communities and empowering citizens to do more for themselves. However, as noted in Part 1 of this report, the ageing profile of the rural population and the continuing outward migration of young people, and inward migration of older people,[32] as well as volunteers' longer-term engagement or 'enthusiasm' can be lost through burn-out or competing commitments, raises challenges in creating greater self-sufficiency.

32 See http://www.wales.nhs.uk/healthtopics/populations/ruralhealth

Councils and their partners need to improve their understanding of the impact their decisions have on people from different communities

2.29 There is variable practice in how councils seek to understand and demonstrate the impact, or potential impact, of their decisions and services on citizens. Most councils undertake, for example, Human Rights Act, Legal, Equality and Welsh language risk/impact assessments when implementing new policies and plans or revising existing documentation. However, these tend to consider services at a council-wide level and do not look at the different needs of different communities. In addition, we also found very few examples of public bodies using the Welsh Governments Rural Proofing Tool in revising or developing services (see Appendix 4). Too often, this results in a single broad-brush analysis that can overlook and ignore differences.

2.30 Generally, councils often lack the data and evidence to judge the impact of their work on different rural communities, or to identify what works and how they can improve. Councils with larger urban areas and dispersed rural communities are particularly challenged by the one-size fits all approach to evidence and evaluation. Focusing on county level data to identify need and scrutinise performance does not provide the detail needed to shape services to the different rural communities.

2.31 Many organisations do not see rural issues as a distinct policy area. This is particularly applicable to those we have classed as mixed urban/rural councils. The impact of service change follows a one-size fits all approach centred on the ease of delivering services from larger centres. Moreover, because councils with a mix of larger urban centres and dispersed rural communities have not used the Welsh Governments Rural Proofing Tool to help shape context, this can result in an over emphasis on urban need and urban solutions.

2.32 Consequently, some councils are not focusing on rurality as a policy or delivery strand despite containing significant rural areas and rural communities. For instance, whilst public bodies like Neath Port Talbot understand the challenges facing people across their different communities, public service partners have mostly prioritised future work in the main urban areas of Neath, Aberavon and Port Talbot. Officers and members recognise that priorities for these areas may not be suitable for more rural and valleys communities.

Part 3 – To help sustain rural communities, councils and their partners need to think and act differently in the future

3.1 The way services are provided to communities, villages and towns in rural Wales needs to change. With significant cuts in public funding, councils have focused on to 'salami slicing' budgets and reducing non-statutory services. However, increasingly councils are reflecting that 'more of the same' is not a sustainable long-term response.

3.2 The policy direction of the Welsh Government is encouraging a rethink of the local public service model. Regional partnerships such as the Growing Mid Wales partnership covering Ceredigion and Powys County Councils, draw together local businesses, academic leaders and national and local government to create a vision for future growth. Shifting delivery to regional bodies is based on the view that a more systematic integrated response to problems is both possible and desirable. It also supports the integration of some local services, shifting investment away from a reactive service model towards more community-based and preventative solutions.

3.3 The evidence from our review highlights that councils alone cannot effectively solve the problems of rural Wales. A collaborative approach between public services working together with their communities and doing things differently is required. To achieve this, councils and their partners need to think and act differently, working together to build capacity, social capital and encourage communities and citizens to do more for themselves. Co-location and integration also needs to become the standard operating model going forward.

3.4 A place-based approach is therefore a good starting point in thinking about how best to reshape delivery of public services. Such an approach moves the debate from lots of separate and distinct front doors into individual services to a single front door, or gateway, to access public services. Taking such an approach places the citizen and community at the centre of service design because it allows public bodies to focus on the individual and their needs rather than organisational or professional boundaries.

3.5 This model sits well with provision in rural areas in a time of austerity because the cost of sharing offices is less and the prospect of retaining services enhanced. Working as a single place-based public system also provides the opportunity to focus more clearly on outcomes, because a broad range of factors influences outcomes and require an integrated response to resolve them[33].

33 The work of the Canadian Centre for Community Renewal is a good starting point for public bodies pursuing a place-based approach. Their detailed **Community Resilience Toolkit: A Resource for Rural Renewal and Recovery** provides a systematic guide to strengthening community resilience. The Toolkit focuses on helping organisations – community, statutory and private – to understand the concept of resilience, complete an

3.6 A whole system approach also recognises that very often citizens and service users have multiple needs, which require inputs from many public services to address them. Research by the Greater Manchester Public Service Reform Team[34] found that 48 individual citizens who sought help and assistance from public bodies had collectively made 1,235 requests or demands for assistance, an average of 26 per client. Under a traditional model of service delivery, where each agency operates independently, and often-different services within the same agency act in silos, the onus is on the citizen to seek a solution and it is down to them to work their way through the public service system. This can result in demand escalating and problems becoming more critical and costly to deal with because citizens may not know who to contact for assistance, and may not get the help they need at a time when problems can be resolved.

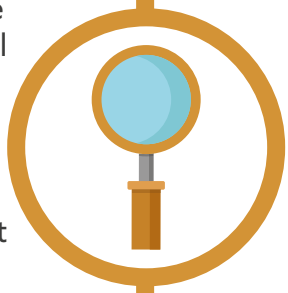
3.7 Councils and their partners should explore different system perspectives, including citizens, and ask what we need to support public bodies and people to contribute to improving outcomes[35]. Research also suggests that to do this you need to understand the key perspectives within a local system (people and organisations); the role they can play in achieving positive change; and the collaborative local infrastructure needed to enable them to work towards shared objectives in the context of place[36]. Our review has identified that there is potential to support a more sustainable future if councils and their partners shift to a place-based approach and think differently in designing services to respond to the needs of rural Wales. To make place based working a reality we have identified four key strands of work and these are set out below:

34 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/588237/Integrated_place_based_services_Academy_seminar_slidepack_310117.pdf

35 Collaborate CIC, February 2017.

36 https://www.jrf.org.uk/why-we-need-build-social-capital-cities

3.8. **A STRATEGIC PLACE BASED APPROACH** – councils and their partners recognise the scale of the problem they face in delivering services in rural Wales but are less clear on what they are going to do to overcome these. PSBs need to therefore develop a more ambitious and optimistic vision for the future, highlighting the good things about rural communities and pinpointing practical opportunities to improve people's wellbeing. One way to achieve this is for PSBs to work with local partners and citizens to create a place-based vision and set out how local partners will integrate and collectively deliver services. The approach should build on the Local Well-being Plan setting out an agreed collective understanding of long-term community needs; the social and economic vision for place with joint priorities to address agreed challenges; and map the services, networks and facilities that are potentially available to co-locate and integrate services.



3.9. **WORKING COLLABORATIVELY AND INTEGRATING SERVICE DELIVERY** – even if under pressure, councils still need to be provided in rural Wales and it is the responsibility of public bodies to find the most efficient and effective (for the citizens) way to achieve this. A change in mind-set and an acceptance that acting alone is no longer viable is required. This will need a shift to co-financing and potentially compromise on service models delivery points, and a move to creating integrated public service and community hubs.

3.10. From the customer perspective multi-service hubs are a good option as they are convenient 'one-stop shop' and can become community focal points thereby enhancing social capital. They need to be multi-purpose, cross-sector and reflect local needs in terms of what they provide, hosting a range of partners and public services. Hubs can also extend the use of local assets and offer the potential to act as gateways to public services operating either as:

a) Service hubs with a public sector focus – run by a council, housing association or other public sector organisation, bringing together different services under one roof.

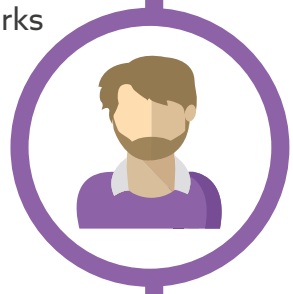
b) Community hubs run by community organisations – with different projects, activities and services, often run with a high level of involvement from the local community to fill gaps where public services have disappeared – for example supporting the work of credit unions.

3.11. **ADDRESSING INFRASTRUCTURE GAPS** – rural Wales has some significant infrastructure challenges. We recognise that addressing these are not always the primary responsibility of local government, cannot be dealt with by councils alone and requires support and assistance from others. However, councils and partners can pursue some steps. For instance:

a) supporting an integrated public transport network aligning bus and cycling networks with rail services;
b) help people and businesses make the most of digital connectivity by investing in infrastructure and digital skills (see the good practice example of Carmarthenshire County Council Boosting Wi-Fi connectivity rural areas in Appendix 3);
c) proactively promoting and raising awareness of infrastructure rollout e.g. Gwynedd Council increasing awareness and engagement with local communities and enhancing skills through their Digital Gwynedd project[37]; and
d) supporting community asset transfer by identifying which assets are suitable to transfer, and clarifying what needs to be done.

3.12. **SUPPORTING SELF-HELP IN RURAL COMMUNITIES** – provide the full range of services traditionally made available, councils and partners need to not only change how they work but they also need to encourage communities and citizens to do more for themselves by:

a) improving community based leadership by developing networks of interest, supporting volunteering and encouraging people to step up;
b) supporting social enterprise and more collaborative business models by identifying options for existing and new organisations;
c) developing guidance, toolkits and networks that support the development of place based town/village planning and place plans created within and led by communities;
d) providing tailored, community outreach to encourage and support communities to do more for themselves; and
e) enhancing and recognise the role of town and community councils and working with and supporting them to do more.



37 www.citizensonline.org.uk/digitalgwynedd

Appendices

Appendix 1 – Study Methodology

Our review methodology covered the following:

- A review of accumulated audit knowledge and practice.
- Communication and engagement with rural communities via attendance at the Royal Welsh Show and a range of local county fayres in Monmouthshire, the Vale of Glamorgan and the Isle of Anglesey.
- A detailed analysis of data drawn from StatsWales, the Local Government Data Unit Benchmarking Hub, the Office of National Statistics, NOMIS, the Institute of Public Care and HM Land Registry.
- A review of published literature including reports and primary research by the Wales Rural Observatory, the Commission for Rural Communities, Move your Money, Better Transport, Deloitte, Post Office Counters LTD, the Welsh Government, One Voice Wales, BDRC Continental, DCLG and DEFRA.
- An analysis of a sample of Public Service Board Well-being Assessment and Plans.
- A survey of 711 Town and Community Councils to identify the challenges they face in managing, maintaining and developing services to rural communities and how well they engage with and work in partnership with local authorities in respect of community asset transfers. We received responses from 355 bodies.
- A qualitative survey of 750 citizens to ascertain how well local government engage with and understand public perceptions in shaping services to rural communities. The survey question framework was framed to link with past research on services to rural communities, in particular the 2007 Wales Rural Observatory report 'Coping with Access to Services'[38] which identifies five important dimensions of delivering services in rural settings: adequate, accessible, available, affordable and acceptable.
- Interviews with key national stakeholders including Welsh Government, One Voice Wales, Society of Community Council Clerks, Welsh Local Government Association, third sector bodies, Community Housing Cymru, the Big Lottery, the Princes Trust, the National Farmers Union, academic institutions, private businesses and government agencies.
- Detailed fieldwork in Carmarthenshire, Isle of Anglesey, Gwynedd, Monmouthshire, Neath Port Talbot and the Vale of Glamorgan, the three National Park Authorities, Dyfed Powys Police and Mid and West Fire and Rescue Authority. Our fieldwork included interviews and focus groups with officers, members, and engagement with local partners.

38 www.walesruralobservatory.org.uk/sites/default/files/12_CopingAccessServices.pdf

Appendix 2 – Defining 'Rural' Wales

A key difficulty in looking at this area of work is that there is no single agreed definition of a rural area in Wales. The Welsh Government differentiates between two categories - less sparse context and sparsest context - and between three settlement types.

Within the Less Sparse context there are:

- **Large Towns:** with populations of at least 10,000 people including Cardiff, Newport and Swansea along the North Wales coast, Deeside and Wrexham;
- **Small Towns:** settlements of less than 10,000 people in the more densely populated areas for example Denbigh and Monmouth – and also areas of urban fringe around the major settlements; and
- **Others:** villages, hamlets and dispersed dwellings in the less sparse areas

In the Sparsest context there are:

- **Large Towns:** settlements with a population of at least 10,000 people – Holyhead, Newtown, Aberystwyth and Carmarthen;
- **Small Towns:** in the less densely populated areas with less than 10,000 people; and
- **Others:** villages, hamlets and dispersed dwellings in the sparsest areas of Wales

According to the Welsh Government's classification, nearly 20% of the overall Welsh population lives in areas that are broadly classified as rural. Of these rural residents, only 30 percent live in the sparsest large or small towns; the majority (70%) live in either 'other' less sparse or sparsest areas (Welsh Government, 2015).

According to the Welsh Index of Multiple Deprivation in 2014, these areas are ranked as some of the least deprived areas based on income, which would appear to indicate that rural areas suffer less poverty and deprivation than urban areas in Wales. The Welsh Index of Multiple Deprivation (WIMD) takes account of a range of factors when measuring deprivation. It identifies Isle of Anglesey, Powys, Ceredigion, Carmarthenshire, Neath Port Talbot, Bridgend and Caerphilly as the counties with the highest incidence of rural deprivation in Wales.

The WLGA's rural policy forum consists of nine councils (Anglesey, Carmarthenshire, Ceredigion, Conwy, Denbighshire, Gwynedd, Monmouthshire, Pembrokeshire and Powys with representation from National Parks Wales.) In late 2015, the forum published a new series of priorities[39], which focus on three key areas - Future Generations; Our networks; and Our places.

39 WLGA Rural Forum - A Manifesto of the WLGA Rural Forum for 2015-2020 http://www.wlga.gov.uk/download.php?id=6257&l=1

Appendix 3 – Good practice case studies

A strategic place based approach

Powys – the PSB has a sound process of reviewing data and the format of the wellbeing assessment reports are very accessible and cross-referenced with up-to-date data sources. Independent advice has been sought to give reassurance on data quality. Some comparison of data is made with councils outside Wales such as fly tipping, and with other regions in Wales including sustainable energy generation. A research library has been established which holds research papers and information on rural issues and this is referenced when deciding potential responses in its first Wellbeing Plan. The PSB's Well-Being Assessment rates the impact of each key finding against the seven well-being goals and whether they have a positive or negative affect on well-being. The Assessment uses a wide range of local and national data to make a considered analysis of domestic violence and abuse, public health issues, educational attainment in rural schools, locations and provision of suitable accommodation for older people, broadband connectivity, and the impact of cybercrime on local rural businesses. As a result, the PSB is in a better position to co-ordinate action more effectively.

Vale of Glamorgan – the Creative Rural Communities Team was established in 2004 in the Vale of Glamorgan and the work is undertaken in partnership with communities to develop innovative projects and ideas that will create long-term social and economic benefits for the area. The aim is to empower individuals to become actively involved in the future of their communities. The Creative Rural Communities Mapping project built upon findings of a tackling poverty analysis commissioned by the former Vale Local Service Board, which found that it is generally the St Athan area of the Vale of Glamorgan that experiences the most poverty and deprivation when compared to other rural parts of the Vale. The approach seeks to work with communities to identify both the Social Assets, for example, community groups, organisations and individuals as well as Physical Assets including Community centres, open spaces and businesses in a community. The council piloted the use of the mapping approach in three communities in the Rural Vale in St Athan, Wenvoe and Rhoose. The mapping process has brought people together across those communities and has led to the identification of what matters in those communities. In St Athan one of the main priorities that the community identified was better play areas for children. A local group of residents have formed a community group to tackle this need and are working with the council's play development officer to increase their knowledge around the delivery of play activities and the volunteers are receiving informal mentoring to assist them with developing play provision in the area.

Dyfed Powys Police – the Force's rural policing strategy 2017-20 sets out what work is being planned to improve access to services in rural areas. The police are developing and supporting rural watch schemes, and increasing the number of Special Constables and volunteers working in rural communities. PCs and PSCOs are more accessible by being stationed in rural communities using shared facilities with Mid and West Wales Fire and Rescue Service, the use of the pop up tents and marquees at the summer shows and events and the introduction of a number of twitter accounts with local police teams. Police officers and support staff are receiving enhanced levels of training to ensure they have the correct expertise to deal with rural crime; this is necessary due to the complex nature of certain rural crimes. Supporting these officers is a Rural Crime Coordinator.

The Force has also created county-based Rural Crime Forums, which bring together farming union representatives, Farmwatch coordinators, rural based community groups and local authorities. These forums help build confidence in reporting crime, find shared solutions and improve the exchange of information and intelligence to enable focused targeting of criminals and criminality. Dyfed Powys Police Rural Crime Strategy 2017 also outlines the specific rural challenges the force faces, and the resources it will put in place to implement the rural strategy. These include actions to improve prevention activity, detection and enforcement actions, intelligence sharing, and public reassurance work.

Working collaboratively and integrating service delivery

North Wales Fire and Rescue Authority – the Authority's Community Assistance Team teamed up with Welsh Government, the three emergency services, Denbighshire County Council, Conwy County Borough Council, Betsi Cadwaladr University Health Board, Galw Gofal Care Connect, and North Wales Regional Call Monitoring Service to offer integrated safety and health advice and respond to vulnerable people who experience a fall in their home. Referrals were made from hospitals, GPs, from family members, carers, or from the people themselves. As a result, demand for the services of the specialised Community Assistance Team continued to grow since the initiative aimed at protecting people in their homes began in August 2016. The Community Assistance Team benefited over a thousand people since the launch of the pilot in Denbighshire and Conwy. The scheme helped to reduce the number of people who needed to attend hospital, reducing the pressure and demands on ambulance and medical services. Funding for the project has now ended and it is no longer operating.

Addressing infrastructure gaps

Carmarthenshire County Council – a Wi-Fi initiative is boosting connectivity and economic regeneration in the rural towns and villages of Ammanford, Burry Port, Carmarthen, Llandovery, St Clears and Whitland. The project is backed by Carmarthenshire County Council, who have given grant funding and made a successful funding bid on behalf of the Grŵp Cefn Gwlad Local Action Group, which has secured funding of £120,000 from the national LEADER scheme. Town councils, businesses, organisations and individuals are now able to access digital on-line training resources to support digital skills development. The initiative also incorporates free local Wi-Fi. As a result, new opportunities for jobs, apprenticeships, work placements and digital volunteers are being created.

Community Asset Transfer – we identified the following authorities as having developed good approaches to community asset transfer:

- Rhondda Cynon Taf who have declared a number of assets as surplus to their needs (referred to as 'Assets of Community Value'). The Council's website includes guidance, online templates, a detailed building description and a single point of contact for information, all aimed at helping to ensure the smooth transfer of assets.
- Powys County Council advertises land and building assets that have the potential to be transferred. Online expressions of interest forms and a business case template is available that encourages a detailed and shared understanding of project risks.
- the Vale of Glamorgan Council has a comprehensive toolkit with guidance and templates and signposts applicants to further information and including potential financing.

Ceredigion – the responsibility for running the services at Tregaron Leisure Centre have been transferred by Ceredigion County Council to a local community group. The process was established following work undertaken by the Council's Leisure Reconfiguration Board who identified Tregaron as suitable for transfer to the community – a process known as Community Asset Transfer. The Council then sought expressions of interest for the delivery of community sports activities from the leisure centre. Hamdden Caron Leisure are a group of volunteers from Tregaron and the surrounding area and gave an expression of interest to run the leisure centre after detailed consultation with users, non-users, and sports clubs in the area. A 30-year lease has now been signed between Ceredigion County Council and Hamdden Caron Leisure. The Leisure Centre now operates as a community hub for leisure and sporting activity with new sports clubs joining. The Council will continue to operate some services from the leisure centre and plans to develop more outreach services and drop in sessions in the future.

Supporting self-help in rural communities

Devon County Council is using its data to build community resilience in rural areas. Understanding the resilience of a local community is important so councils can target help and support where needed most, and people in rural communities can help themselves. Devon County Council provides an online view of community resilience for each Devon community using a range of national and local data, which has been mixed with information from the #WeAreDevon Survey 2016, and Community Insight Survey 2017. The resulting community resilience score integrates various national and local measures to indicate the resilience of communities in Devon. This is creating a dialogue between public bodies, and is mobilising action to plan for and recover from big events such as extreme weather and economic changes.

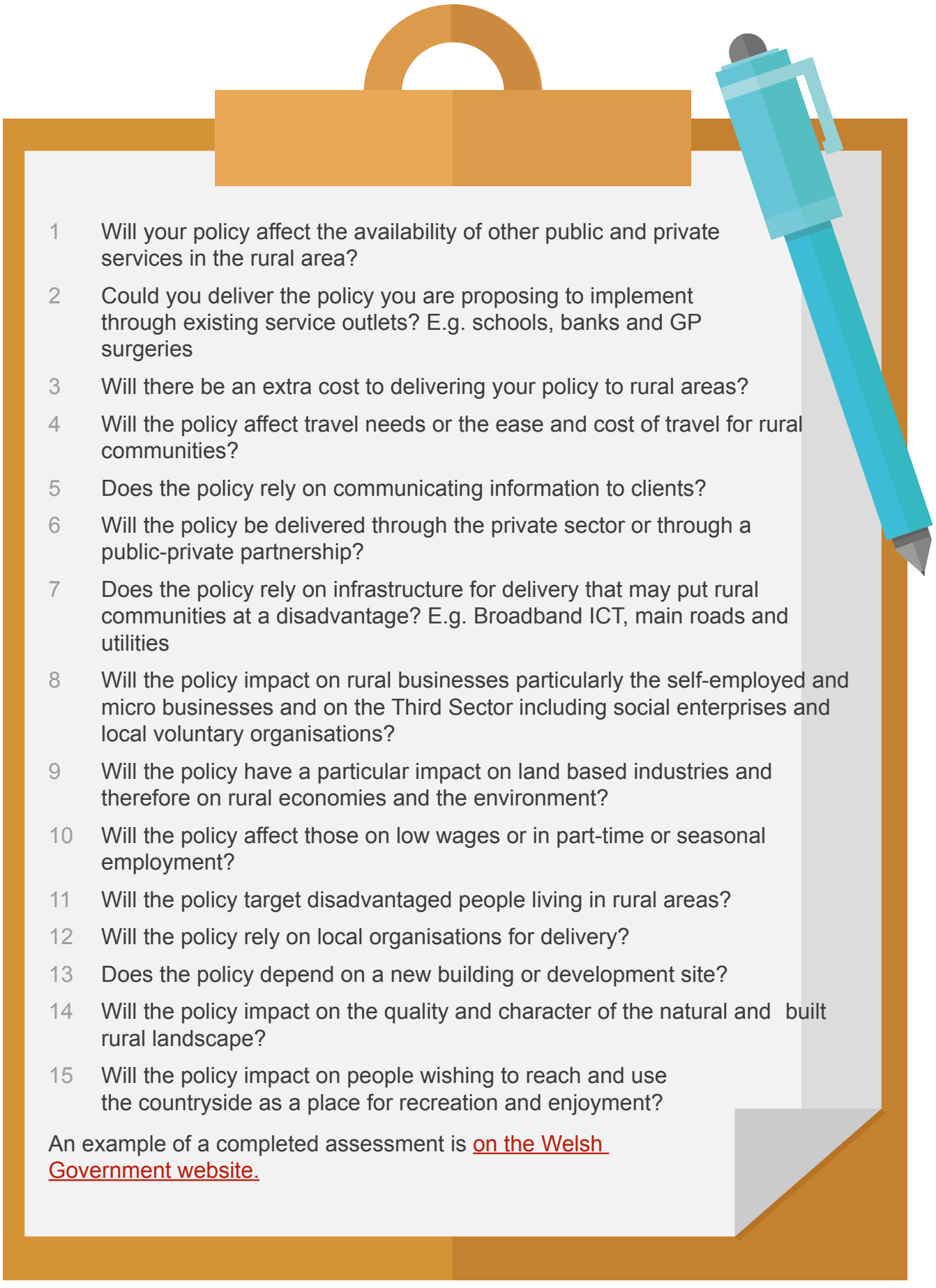
Devon Voluntary Action (DeVA) estimates there are 31,255 active volunteers. The Council is linking people and volunteers with those organisations who can help. The Council efforts are supported by an online independent advice centre known as Pinpoint that signposts thousands of services and community groups across Devon www.pinpointdevon.co.uk Over 500 community groups are registered and people can find a range of help and advice on how to maintain independent lives, find work, volunteer, improve personal wellbeing and build self-reliance.

Caffi Cletwr, Tre'r Ddôl, Ceredigion - With the support of Ceredigion County Council, Caffi Cletwr is developing a community-based approach to provide key services and tackle a number of issues facing the rural community in the village of Tre'r Ddôl and its surrounding areas. Tre'r Ddôl is a small community of roughly 600 residents and over the years has seen its local shop, church and primary school close. When faced with the local café also closing in 2009, a local community group gained grant funding from Ceredigion County Council, the Big Lottery Fund, European Union and businesses such as Santander and the Laura Ashely Foundation to purchase the business and develop a new café and shop in the heart of the village.

Caffi Cletwr is continuously evolving and the direction of its development is entirely dependent on the needs of the local community. It is continuously mapping the needs of the community in order to align their provision as closely as possible to residents' wishes. This has led to developing initiatives, which tackle issues that are synonymous with those faced by rural communities across Wales.

- Caffi Cletwr is much more than a café. In the wake of other community assets closing, this vibrant community centre provides a focal point where people can meet or pop in. Events are held and specific discounts on teas and coffees are aimed at elderly residents in order to encourage those who may otherwise not see or speak to anyone all day long to get out of the house.
- limited face-to-face interaction with public service providers. Ceredigion County Council makes use of Caffi Cletwr as a pick-up point for waste and recycling bags for citizens and its mobile library visits the café on a monthly basis, maximising its role as a community hub. Dyfed Powys Police has also made use of Caffi Cletwr by holding drop-in sessions with Police Community Support Officers at the café.
- fuel poverty: Caffi Cletwr arranges and facilitates a community syndicate for citizens to buy fuel for their oil-heated homes. Whereas citizens may otherwise have to purchase fuel in larger quantities from companies on an annual basis, by working on a syndicate basis citizens are able to purchase in smaller and more affordable quantities three or four times a year via the Caffi's fuel club. Buying 'in bulk' has also led to discounts for residents.
- lack of jobs for local people: Between the café and shop, Caffi Cletwr employs eight members of staff as full time equivalent. This includes a manager and assistant manager in the shop and three cooks in the café's kitchen. In addition, 50 volunteers are associated with the enterprise and regularly undertake jobs that need doing or help with organising community events held at the café.

Appendix 4 – Welsh Government Rural Proofing Tool questions



1. Will your policy affect the availability of other public and private services in the rural area?
2. Could you deliver the policy you are proposing to implement through existing service outlets? E.g. schools, banks and GP surgeries
3. Will there be an extra cost to delivering your policy to rural areas?
4. Will the policy affect travel needs or the ease and cost of travel for rural communities?
5. Does the policy rely on communicating information to clients?
6. Will the policy be delivered through the private sector or through a public-private partnership?
7. Does the policy rely on infrastructure for delivery that may put rural communities at a disadvantage? E.g. Broadband ICT, main roads and utilities
8. Will the policy impact on rural businesses particularly the self-employed and micro businesses and on the Third Sector including social enterprises and local voluntary organisations?
9. Will the policy have a particular impact on land based industries and therefore on rural economies and the environment?
10. Will the policy affect those on low wages or in part-time or seasonal employment?
11. Will the policy target disadvantaged people living in rural areas?
12. Will the policy rely on local organisations for delivery?
13. Does the policy depend on a new building or development site?
14. Will the policy impact on the quality and character of the natural and built rural landscape?
15. Will the policy impact on people wishing to reach and use the countryside as a place for recreation and enjoyment?

An example of a completed assessment is on the Welsh Government website.

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Archwilydd Cyffredinol Cymru
Auditor General for Wales

Provision of Local Government Services to Rural Communities: Community Asset Transfer

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared and published this report in accordance with the Public Audit (Wales) Act 2004.

The Wales Audit Office study team was managed by Nick Selwyn and comprised Steve Frank, Gareth Jones, Euros Lake, Sara Leahy, Martin Gibson, Philippa Dixon and Matt Brushett under the direction of Jane Holownia.

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The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

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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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Community Asset Transfers have increasingly been used by local authorities to save money but must result in sustainable solutions

1 This document complements the Auditor General's report on the Provision of Services to Rural Communities, published in November 2018.[1] It highlights and summarises the study findings specifically relating to Community Asset Transfers (CATs).

2 This document is a learning resource for local authorities to help them improve their approach to CATs in rural areas, although the approaches we highlight also have relevance for authorities in urban areas. Equally, some of the 'urban' good practice case studies highlighted throughout the report have relevance to 'rural' areas.

Community Asset Transfers can play an important role in helping to sustain rural communities

3 Community ownership of local land or buildings can help create long-term resilience and support communities to thrive. For rural communities, many social, economic and environmental well-being benefits flow from using local spaces and buildings to meet people's needs. There are benefits for local authorities too as continued and long-term financial constraints mean that authorities cannot deliver services in the same way they have done in the past. A collaborative, well-managed and long-term approach to transferring assets to community organisations can create efficiencies for authorities whilst ensuring that service provision is maintained in communities.

4 The loss of the community 'cornerstones' such as banks and post offices compound the challenge of sustaining public services in rural communities, especially as local authorities have less money available to maintain key assets such as community halls, leisure centres and libraries, and are closing or selling off these assets to balance the books. These public assets are often key components in the makeup of a rural community and their role as active community focal points is often equally important as their purpose as buildings from which to provide authority services. Consequently, local authorities' approach to CATs is often indicative of how they are supporting and encouraging rural communities to survive and thrive as viable places for future generations to live and work.

1 Weblink to published report.

The Welsh Government has adopted effective policies to support transfer but unlike England, the number of assets transferred by authorities is not known

5 The legal basis for CATs in Wales is highlighted in the **National Assets Working Group** (NAWG) publication Community Asset Transfers in Wales – A Best Practice Guide dated March 2016[2]. Local Authorities have the power to dispose of land in various ways. There are circumstances where local authority can dispose of an asset at below full market value under the 'General Disposal Consent' (Wales) December 2003 provisions under the Local Government Act 1972.

6 Estimates by Rural England show the by 2018 the total numbers of transfers in urban areas of England numbered 1,222 and in rural areas roughly 500 assets have been transferred. The total value of assets transferred was estimated to be £1.2 billion. There is no comparable data collated in Wales showing either the number or the financial value of CATs.

2 See gov.wales/community-asset-transfer/best-practice-guide

Our findings

7 Each section of this resource sets out the challenges associated with CATs and considers some options and solutions to overcome these challenges.

- **Part 1** identifies the key aspects of a strategic approach to CAT and the policies and systems authorities need to support asset transfers.
- **Part 2** considers the operational challenges in supporting communities to take on assets. We examine how local authorities can build capacity in their communities so recipients can best take on and successfully sustain assets in the future.
- **Part 3** examines support offered by local authorites after the transfer. Some of the common challenges and pitfalls when managing the asset are also considered.

8 The most successful local authorities use a whole systems approach to CAT where communities' long-term needs and capacity are considered in parallel with a clear end-to-end transfer pathway, culminating in a community asset being used sustainably for the benefit of the community. Exhibit 1 sets out some of the key steps for local authorities to achieve this and move away from their role as 'doers' to 'enablers'.

Exhibit 1 – a whole systems approach to Community Asset Transfer

Recommendations

9 Our recommendations for improvement are set out below.

Recommendations	
R1	Local authorities need to do more to make CATs simpler and more appealing, help build the capacity of community and town councils, give them more guidance in raising finance, and look to support other community development models such as social enterprises that support social value and citizen involvement. **In addition, we recommend that local authorities monitor and publish CAT numbers and measure the social impact of CATs.**
R2	Local authorities have significant scope to provide better and more visible help and support before, during, and after the community asset transfer process. We conclude that there is considerable scope to improve the business planning, preparation, and aftercare for community asset transfer. **We recommend that local authorities:** • **identify community assets transfer's role in establishing community hubs, networks of expertise and clusters of advice and prevention services;** • **work with town and community councils to develop their ability to take on more CATs;** • **identify which assets are suitable to transfer, and clarify what the authority needs to do to enable their transfer;** • **ensure their CAT policy adequately covers aftercare, long term support, post transfer support, signposting access to finance, and sharing the learning about works well; and** • **support community-based leadership by developing networks of interest, training and coaching, and encouraging volunteering.**

Part 1 – The most effective authorities take a strategic approach working collaboratively with partners to enable asset transfers

1.1 In this section, we consider how local authorities are strategically using CATs to think and act differently to sustain and protect services. Demographic change and challenges in encouraging employment has impacted on the sustainability of communities and services

Challenges

1.2 Developing strategic approaches to support CATs can be difficult given the variety of ways that authorities can transfer an asset and the wide variation in the types of assets being transferred. Exhibit 2 summarises the key obstacles to overcome in promoting transfers.

Exhibit 2 – blockages that need to be tackled to ensure a smooth transition towards effective Community Asset Transfer

We cannot transfer assets to communities effectively because....

It's giving away 'the family silver'
Authorities may be reluctant to give up control of assets because of:

1. Political choice or long-standing policy;
2. Capital values can help offset authorities' financial balance sheets; **and**
3. The authority may think the public has mixed feelings about the transfer of assets out of authority control. This fear is often untested.

We need to find savings immediately
CAT is not a quick route to finding savings from the disposal of unwanted assets. CAT should be an opportunity to help develop communities sustain services in rural communities across Wales. This needs a well planned approach.
A panicked approach can lead to problems and unsustainable transfers that may result in community groups having to sell or hand assets back.

Community groups don't have the capacity to take on assets
Authorities need to help build the appetite, capabilities, and confidence of community groups to become more self-reliant and take on assets. This means a change in authorities' role from being 'doers' to 'enablers'. A positive reciprocal attitude, grants, training, and good quality guidance can help.

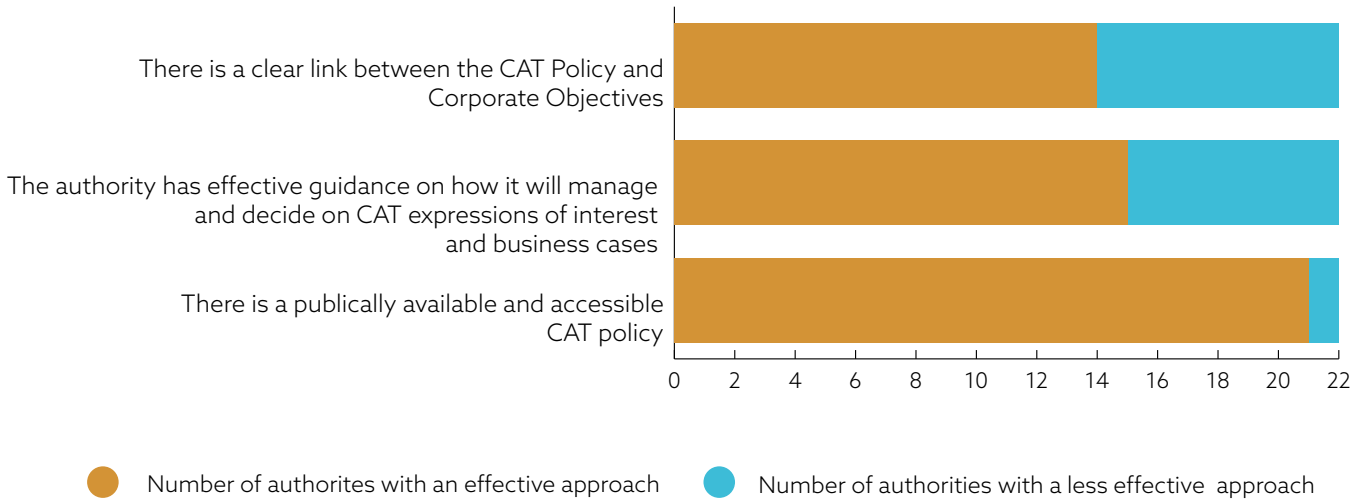
Community groups don't have a sufficient track record to run assets
The application process for CAT and business case approval must be relevant and proportionate to the nature/size of the opportunity. Terms of transfer should support both parties and be robust but fair.
Authorities can do more to help get community groups ready for investment.

Source: Wales Audit Office

1.3 Our review of CAT policies found that all but one local authority in Wales has a policy on CATs available on their website. Most authorities have adopted appropriate guidance on how they will oversee CATs and have clearly identified how their approach to CATs supports them to deliver corporate objectives and strategic priorities – Exhibit 4. Our review of local authority CAT policies finds some common strengths including growing links between CAT policies and corporate policies. Local authorities are giving greater consideration of the longer-term use of the asset, and provision of templates of business cases for applicants to complete. We found good examples of authorities evaluating the potential impact of CAT business cases on future generations, equalities and sustainability issues in Monmouthshire and Rhondda Cynon Taf.

Exhibit 3 – Wales Audit Office review of CAT Policies and online Guidance

Most authorities have an adopted and publically available policy for CAT with appropriate guidance to support transfer decisions that are linked to corporate priorities.



Source: Wales Audit Office

1.4 Despite this, there remains scope to provide better and more visible help and support before, during, and after the 'community asset transfer' process. For instance, we found that CAT policies often lack detail on the criteria used to decide on transfers, in particular demonstrating financial health and proven record of accomplishment. Only five authorities signpost expert guidance on CATs aimed at community groups. Too often authorities do not differentiate between the size of asset to be transferred and operate a 'one size fits all' policy.

1.5 Local authorities need to do more to make CATs simpler and more appealing, help build the capacity of Town and Community Councils, give them more guidance in raising finance, and look to support other community development models such as social enterprises that add social value and widen citizen involvement.

1.6 Our survey of Town and Community Councils found that in almost 60% of cases the local authority initiates and encourages the transfer. However, whilst it is felt there is a clear rationale for the transfer to take place, the risks associated with the transfer are not always set out. We received many comments from Town and Community Councils who felt that the notification time provided by the local authority was inadequate. In addition, a number of Town and Community Councils stated that from their experience, authorities often do not require a business case to support the disposal of an asset and neither do they provide the receiving body with the rationale for the disposal.

Local authorities' inability to continue delivering services and maintaining assets as they have done in the past are leading them to consider alternative ways of working. Disposing those assets traditionally maintained by local authorities is one way of saving money and we are seeing more CATs happening as a result.

25% of those responding to our Town and Community Council survey stated they have been involved in the transfer of open spaces; 19% the transfer of a village or community hall; 9% of bus shelters and 2% of streetlights.

Options and solutions

1.7 Our survey of citizens living across rural Wales conducted in 2017-18 found that the reaction to potential alternative service delivery models is mixed but that half of citizens are open to the idea of encouraging communities to run services themselves, particularly those in younger age groups (61% of 16-34 year olds). Similarly, almost 40% of those who responded to our survey of Town and Community Councils felt their organisation has the capacity to deliver more services or amenities than it currently does.

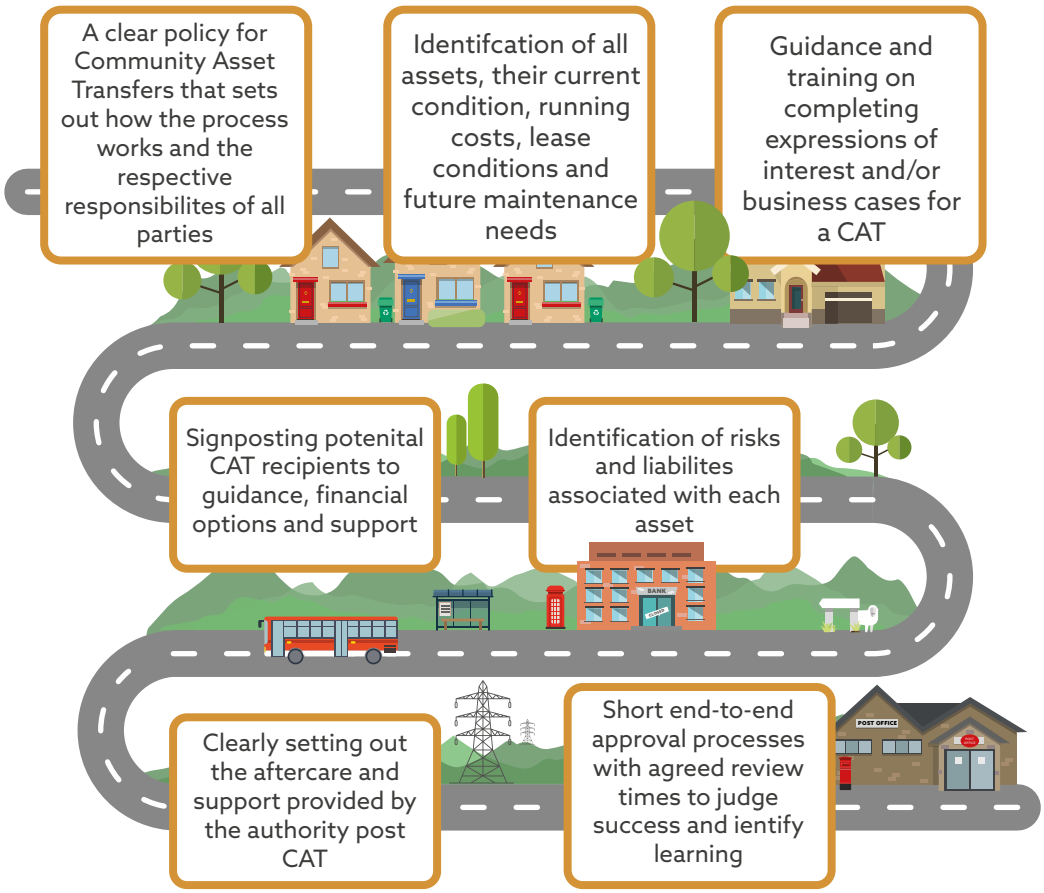
1.8 Research by Locality[3] finds that public bodies that are good at transferring assets have some common features. Namely, good quality and supportive guidance with short end-to-end processes for overseeing and approving cases. Critically, the success of a transfer is founded on shared responsibility; both from the local authority transferring the asset, but also the community group and body taking on responsibility.

1.9 The successful transfer of assets and the securing of a sustainable future is often dependent on an authority having good quality guidance and responsive approval processes. The availability of relevant information, advice and support has a big impact on the effectiveness of the CAT process[4]. Exhibit 4 summarises what we consider the key components of a good strategic approach to CAT.

3 http://locality.org.uk/services-tools/support-for-community-organisations/ownership-and-management-of-land-and-buildings/

4 See locality.org.uk/resources-for-councils-service-providers

Exhibit 4 – features of an effective strategic approach to community asset transfer



Source: Wales Audit Office

1.10 Local authorities with a strategic approach to CATs proactively map what assets they own or control against corporate priorities and projected budgets to identify their strategic relevance, the potential financial impact and consequently the opportunities for CATs. Authorities are increasingly doing this with Public Services Boards (PSB) to gain a full picture of who owns what. For instance, the approach adopted by Flintshire County Council and its PSB partners who have identified all of their assets and those that are suitable for transfer[5]. Elsewhere, some local authorities, such as Devon County Council, are taking this a step further mapping all community assets such as church halls, scout huts, and theatres to gain an understanding of all the key facilities within communities.

5 See flintshire.gov.uk/Community-Asset-Transfer-(CAT)/AssetsForConsideration

A review of Heritage Lottery funding by Locality in September 2017 found that the value of grants in 2016-17 totalled £74.4m for community groups in England (91% of all funding), £4.1m for Scotland (5% of all funds) and £3.3m in Wales (4% of funds covering 4 projects). This suggests community groups in Wales are not accessing key sources of funding that support CAT.

Good practice examples of a strategic approach to Community Asset Transfers

Case study – A community run leisure centre in Ceredigion

The responsibility for running the services at Tregaron Leisure Centre have been transferred by Ceredigion County Council to a local community group. The process was established following work undertaken by the Council's Leisure Reconfiguration Board who identified Tregaron as suitable for transfer to the community. The Council then sought expressions of interest for the delivery of community sports activities from the leisure centre. Hamdden Caron Leisure are a group of volunteers from Tregaron and the surrounding area and gave an expression of interest to run the leisure centre after detailed consultation with users, non-users, and sports clubs in the area. A 25-year lease has now been signed between Ceredigion County Council and Hamdden Caron Leisure. The Leisure Centre now operates as a community hub for leisure and sporting activity with new sports clubs joining and overall participation up by 20%..

Case study – Effective approaches to Community Asset Transfer

We identified the following authorities as having developed good approaches to community asset transfer:

- **Rhondda Cynon Taf County Borough Council** has declared a number of assets as surplus to its needs (referred to as 'Assets of Community Value'). The Council's website includes guidance, online templates, a detailed building description and a single point of contact for information, all aimed at helping to ensure smooth transfer.
- **Powys County Council** advertises land and building assets that have the potential to be transferred. Online expressions of interest forms and a business case template is available that encourages a detailed and shared understanding of project risks.
- **The Vale of Glamorgan Council** has a comprehensive toolkit with guidance and templates and signposts applicants to further information and potential financing.

Case study – A proactive asset transfer programme in Cornwall

In 2011, Cornwall Council gathered detailed information on all existing assets and published criteria on suitability for community asset transfer. From a long list, 25 were selected for the first phase from 2011-14 based on their suitability for transfer based on their score against Cornwall's joint community needs analysis and fit with corporate objective. The top ten were then identified for detailed feasibility studies. These projects were designated and championed by local councillors, and supported with professional and legal costs to undertake the transfer into the recipient community organisation. Once the projects were transferred, they were independently evaluated and the learning points were integrated into a suite of policy documents, community capacity building workshops, financial packages, and guidance.

Case study – Whole systems approach to Community Asset Transfer in Norwich

Norwich Council provides an online timeline and set of service standards that community groups can expect. This gives a realistic overview of how long it takes and they key stages along the way. The timeline includes an annual review of the service agreement targets and benefits to community wellbeing. The local authority's CAT policy sets out its Assessment criteria and how it expects community benefit to be maximised. Norwich also provides a specific online newsfeed to community groups and citizens informing them about opportunities ad progress with transfers.

Case study – sustainability and wellbeing considerations in Community Asset Transfer

East Dunbartonshire Council in Scotland recognises that the community and voluntary sector make a significant contribution to the quality of life in its communities. The East Dunbartonshire Asset Register includes details of all local authority and publically owned assets and includes criteria showing if it is available for asset transfer. Application guidance includes equality impact assessment and an environmental screening process to highlight ways to conserve natural resource. Applicants are asked to demonstrate how the transfer will improve economic, environmental, and social wellbeing. Ongoing support, community involvement, language considerations including promotion of the use of British Sign Language, and long term outcome monitoring are particularly strong features of the new Community Asset Transfer Policy 2018.

Part 2 – Local authorities need to work with communities to develop their capacity and skills to be able to take on and manage assets in the future

2.1 In Part 1 we consider what constitutes a good strategic approach to support the successful transfer of assets to communities. Local authorities also need to ensure there are sufficient skills and capacity in their communities to make a transfer successful. In this section, we examine the challenge of building capacity in communities to support them to successfully take on assets. This includes helping community groups develop financial and property management, marketing, and commercial skills. We also explore how and why local authorities need to have efficient and effective systems in place to support and enable transfers to succeed.

Challenges

2.2 Community organisations who bid for and take on the management of a local authority asset will need to ensure that they have the necessary skills to manage finances, undertake fundraising, meet health and safety, safeguarding and insurance obligations and liabilities, and work within the law. This can be daunting and requires help and support. A review of CATs by the Joseph Rowntree Foundation[6] highlighted that different types of skills and knowledge are needed to effectively deliver asset transfers, in particular, financial skills and working knowledge of charity regulations, including liabilities.

2.3 Ultimately, local authorities have to satisfy themselves that the recipient of an asset is the right body and has the necessary skills to take on the asset. Consequently, local authorities have an important role to play to support recipients of CATs. For instance, providing guidance on fundraising, charity regulations and alternative community development models such as social enterprises.

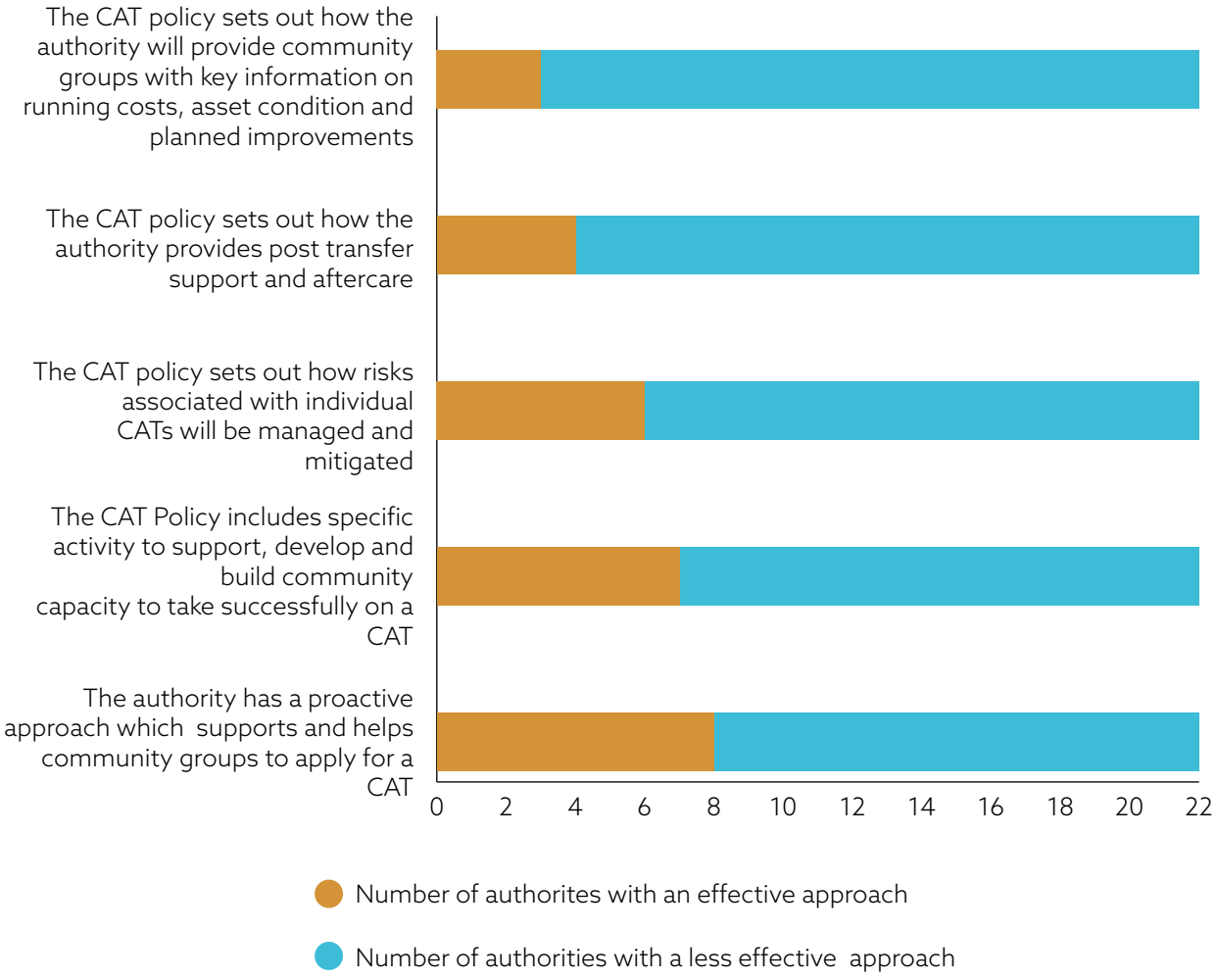
2.4 Our review of local authority websites and guidance is set out in Exhibit 5 below. Overall, we conclude that there is more that local authorities could do to help community bodies. For instance, our review of policies and guidance materials found that only seven authorities provide specific and active capacity building to community groups and potential transferees such as mentoring, financial support, training and workshops to promote good practice and learning from successful CATs. For example, Flintshire County Council provide guidance on business modelling to help community groups bid for and secure external funding to support the initial stages of the asset transfer[7].

6 See jrf.org.uk/report/community-asset-transfer-northern-ireland
7 See flintshire.gov.uk/en/Community-Asset-Transfer-(CAT)

2.5 In addition, only six authorities outline how they will manage and mitigate risks associated with individual CATs and only three identify the importance of providing good information on running costs and asset condition to transferring bodies. This suggests that authorities are not doing all they can to ensure a smooth handover and create a sustainable legacy. A number of Town and Community Councils responding to our survey noted that they felt they had to take on the transfer even when they acknowledged they did not have the skills or resources to maintain the asset.

Exhibit 5 – Wales Audit Office review of CAT Policies and online Guidance

Most authorities have significant gaps in their CAT policies and are not doing all they can to support community groups to take on and sustain assets



Source: Wales Audit Office

Options and solutions

2.6 Community groups can find it difficult to bid for and secure early investment to enable a transfer to happen but there is a lot of material available to support them and local authorities. These include:

- **Welsh Government guidance** encourages local authorities to collaborate with community groups to build capabilities and provide them with the confidence and skills to take on the management of assets and have produced some helpful materials including resource toolkits, checklists and signposts to a range of finance options[8].
- **The Big Lottery Fund**[9] provides a wealth of information to help groups to develop the necessary skills and capabilities to bid for and secure grants[10].

2.7 Short-term management agreements are one way to offer community groups a taste of running a community asset before full transfer takes place. Both Neath Port Talbot County Borough Council and Shropshire County Council offer twelve-month management agreements which help community groups to build, experience and skills. Short-term arrangements are a good stepping stone to see if a longer-term transfer with a more substantial agreement in the future is possible[11]. Most local authorities choose to transfer on a leasehold rather than a freehold basis, so that the property remains in public ownership. A long leasehold (over 25 years) will be acceptable to most funders, though some loan funders expect a longer lease

A community group told us: “the county council transferred the liabilities rather than an asset”

A local authority told us: “the council has sought to undertake some immediate Health and Safety works for some assets to ease the asset transfer. All properties have full surveys and accurate position statement on the “warts and all” of an asset.”

One local authority told us: “we wanted to avoid the community groups feeling as if they had to take on an asset and were not supported to continue to provide services”.

8 See gov.wales/c-a-t-checklist
9 See biglotteryfund/making-the-most-of-funding/building-capacity
10 See gov.wales/topics/community-asset-transfer/community-banks-and-finance
11 See shropshire.gov.uk/community-asset-transfer

2.8 Likewise, up front investments in assets before they are transferred can also ensure the assets are more attractive for recipients, reduce uncertainty and reduce transfer risks. This investment can vary from repairing components, removing any hazardous material, or cleaning the building. Likewise, the provision of high quality broadband in an asset helps to encourage a CAT. Broadband enables the community organisation to be better connected,encourages businesses to locate within the asset or to deliver services from within the asset. Negotiating access to broadband before, during or after the asset transfer is an important consideration together with ensuring all other utility services are fit for purpose.

2.9 Exhibit 6 highlights the features of effective community capacity building to support successful transfers. A variety of options are available to local authorities to proactively build capacity in communities to grow the skills and capabilities needed to take on and develop assets and the services they host.

Exhibit 6 – Helping to build community capacity

Source: Wales Audit Office

Good practice examples of working with community groups to support and enable a Community Asset Transfers

Case study - Strong community involvement during transfer of former Splott Library, Cardiff

This property served as a purpose built Council managed library from early 1900s until it closed in 1994. With no alternative operational uses identified by the council, it was declared surplus to requirements in 2012. At that time, the concept of Community Asset Transfer (CAT) was new to the Council, but this approach was adopted as a number of local community organisations had expressed an interest in taking the building over and using it for community related purposes. The project is now well established and the building has been extensively refurbished, and the success of this is largely due to strong political and local community interest and support. The key factors influencing this success is secure occupancy of the building, support from councillors, committed community leadership, strong public support and social media presence, access to external finance, and attracting regular users.

Case study - Building community capacity in Cardiff

Stepping Up is an initiative supported by Cardiff Public Services Board. The initiative is an online toolkit, which has been developed to support residents, and communities in developing and managing services and assets (e.g. community facilities) The toolkit has been written for people and community organisations and sets out the stages involved in taking over the management of services and assets; checklists to guide people through the process; sources of further information and advice; and useful templates to support the development of business planning, recruitment of volunteers and stakeholder engagement etc.

Case study - Community organisation health check in Manchester

Manchester Community Central's Capacity Building Team provides information and support to build the capacity and sustainability of voluntary, community and social enterprises in Manchester. The service works closely with other local organisations to offer a co-ordinated approach in the development of skills and capabilities to support Community Asset Transfer and other initiatives. Coaching, mentoring and tailored training is offered on project management, governance, raising finance, marketing, and risk management.

Cast study – collaboration with Voluntary Action Groups to build capacity

Many organisations have the potential to manage premises effectively, but do not meet the full criteria for asset transfer. Croydon Voluntary Action[12] provides capacity building for these organisations, including: a skills audit; a capacity building plan agreed on point of transfer; visible standards (or equivalent good practice standards); and access to expert advice on finance and resources such as commercial loans, lottery funding, Future Builders and community anchor funding. In addition, Croydon Council may be able to provide interest free loans of up to £100,000, subject to funds being available.

12 See croydon.gov.uk/community capacity/advice/transfers

Part 3 – Community groups often require ongoing support from local authorities following transfer but this is variable

3.1 CATs can be a long and complex process and the transfer of the asset is not the end. A successful CAT requires commitment and support from local authorities and ambition and dedication from communities. A whole systems approach is required with support throughout the transfer pathway as well as ongoing and post transfer help and advice from the local authority.

Challenges

3.2 What happens after a CAT is just as important as the lead up activity. Authorities should not leave the success of an initiative to chance. A constructive and ongoing dialogue with transferees not only helps to ensure that the original aims of the CAT are achieved, but it also increases the likelihood that any ongoing investment is more secure and that future opportunities are maximised.

3.3 Failed CATs can result in local authorities having to spend money to take back ownership of an asset or having to dispose or sell the asset, which can have an adverse impact on both the community where the asset is located. This can damage public confidence in the CAT process and discourage community groups from coming forward to take on and manage other community assets.

3.4 Our review of online guidance and CAT policies found that only three authority's had policies to specifically identify and manage the risks associated with the post transfer of an asset and its sustainability and only Cardiff Council gives adequate consideration of post transfer assistance, support, and learning. This is important because authorities will want to see a CAT succeed and need to recognise that they have an important role to play in making this happen.

3.5 Too many local authorities have a 'one size fits all' approach to managing and mitigating the risks of asset transfer. For example, transferring the responsibility for street lighting will not need the same level of risks management as transferring a leisure centre. There are a number of approaches to managing risks in asset transfer. For instance, the purpose for which the asset is sought, the size of asset, and also the capacity of the receiving organisation to manage the asset.

3.6 Our survey of Town and Community Councils finds considerable scope to improve the business planning, preparation, and aftercare for community asset transfer. For example, only a 10% of those Town and Community Councils who have taken on responsibility for an asset in their area received ongoing support after the transfer.

A community group told us "after transfer the electrics were found to be non-compliant on first day, and the upgrade cost £70,000 which the charity is finding funds for overtime"

A town and community council told us: "the local authority could improve its communication and support around asset transfers, particularly after the transfer has happened"

Options and solutions

3.7 Elected members have an important role in supporting CATs and may need support in understanding all the risks involved.[13] Case studies in Appendix 3 highlight how important leadership is in ensuring smooth asset transfers. Welsh Government is seeking to develop a Welsh approach to CATs and has held conferences with a particular focus on building capacity and supporting elected Member's skills development.

Case study – Bradford Council handover arrangements

The Council sees CATs as a long-term partnership with the community group. The Council has a dedicated CAT Team that offers ongoing help and support, including bi-annual visits to each property transferred to identify further assistance that recipient bodies or groups may require. A support visit is also an opportunity to discuss such things as statutory compliance, health etc. and make sure that the property is adequately insured. Bradford Council's Handover Pack[14] contains all legal documents, the latest building condition survey, inventory of equipment, health and safety guidance, all certificates for compliances, and insurance documents.

13 See locality.org.uk/COMMUNITY-ASSETS-COUNCILLOR-GUIDE.pdf
14 See bradford.gov.uk/your community-asset-transfer

3.8 Some projects take some time to achieve sustainable finances and may require ongoing revenue support via grants, loans or other sources of finance such as Crowdfunding[15] to enable them to develop so that they generate a profit. Ongoing support from local authorities includes signposting external grants and presenting community groups with financial options. The Big Lottery is a popular source of finance for community groups undergoing CATs However, applying for a Big Lottery grant can take up to two years and interim support may be needed. The Welsh Government provides some excellent information to support and signpost organisations taking on transfers to useful resources.[16]

3.9 Local authorities are finding it difficult to monitor and measure the impact of CATs, in particular the wellbeing and social impact of a transfer. This is important because sharing what works well helps demonstrate and encourage community groups to take on and manage an asset because they feel supported. The Social Return on Investment (SROI) model[17] is widely used by the third sector and can help to illustrate the social value of CATs. Some local authorities have made their own attempt to measure social value: Devon County Council, and Birmingham City Council, for example, with the think tank Rich Regeneration, have created a social value toolkit specifically for CATs[18].

3.10 Exhibit 7 below summarises some of the key issues authorities need to consider in providing ongoing support to address common challenges and risks in transferring assets. Appendix 3 sets out a more detailed self-evaluation and risk matrix aimed at decision makers in transferring authorities.

15 Crowdfunding is a method of generating funding for a service or project from a number of people, normally through social media. See Welsh Government guidance community-asset-transfer/crowdfunding and Crowdfunding and Civic Assets - learning from the USA

16 See https://gov.wales/topics/people-and-communities/communities/community-asset-transfer/resources/?lang=en

17 Social return on investment is a principles-based method for measuring extra-financial value (i.e., environmental and social value not currently reflected in conventional financial accounts) relative to resources invested.

18 See communityassettransfer.com/valuing-worth

Exhibit 7 – Providing ongoing support

Source: Wales Audit Office

Appendices

Appendix 1 – Study Methodology

- A detailed analysis of data drawn from StatsWales, the Local Government Data Unit Benchmarking Hub, the Office of National Statistics, NOMIS, the Institute of Public Care and HM Land Registry.
- A review of published literature including reports and primary research by the Wales Rural Observatory, the Commission for Rural Communities, Move your Money, Better Transport, Deloittes, Post Office Counters LTD, the Welsh Government, One Voice Wales, BDRC Continental, DCLG and DEFRA.
- An analysis of a sample of Public Service Board Well-being Assessment and Plans.
- A survey of 711 Town and Community Councils to identify the challenges they face in managing, maintaining and developing services to rural communities and how well they engage with and work in partnership with local authorities in respect of community asset transfers. We received responses from 355 bodies.
- A qualitative survey of 750 citizens to ascertain how well local government engage with and understand public perceptions in shaping services to rural communities. The survey question framework was framed to link with past research on services to rural communities, in particular the 2007 Wales Rural Observatory report 'Coping with Access to Services'[19] which identifies five important dimensions of delivering services in rural settings: adequate, accessible, available, affordable and acceptable.
- Interviews with key national stakeholders including Welsh Government, One Voice Wales, Society of Community Council Clerks, Welsh Local Government Association, third sector bodies, Community Housing Cymru, the Big Lottery, the Princes Trust, the National Farmers Union, academic institutions, private businesses and government agencies.
- Detailed fieldwork in Carmarthenshire, Isle of Anglesey, Gwynedd, Monmouthshire, Neath Port Talbot and the Vale of Glamorgan, the three National Park Authorities, Dyfed Powys Police and Mid and West Fire and Rescue Authority. Our fieldwork included interviews and focus groups with officers, members, and engagement with local partners.
- Engagement with rural communities via attendance at the Royal Welsh Show and a range of local county fayres in Monmouthshire, the Vale of Glamorgan and the Isle of Anglesey.

19 http://www.walesruralobservatory.org.uk/sites/default/files/12_CopingAccessServices.pdf

Appendix 2 – Defining ‘Rural’ Wales

What we mean by ‘Rural Wales’:

There is no single agreed definition of a rural Wales. The classification used by Welsh Government defines roughly 20% of the overall Welsh population as living in rural areas. For the purpose of this study, and in line with the Welsh Local Government Association’s rural policy forum, we classify nine authorities as rural, 11 authorities as semi-rural and two authorities as non-rural and urban.

PRIMARILY RURAL

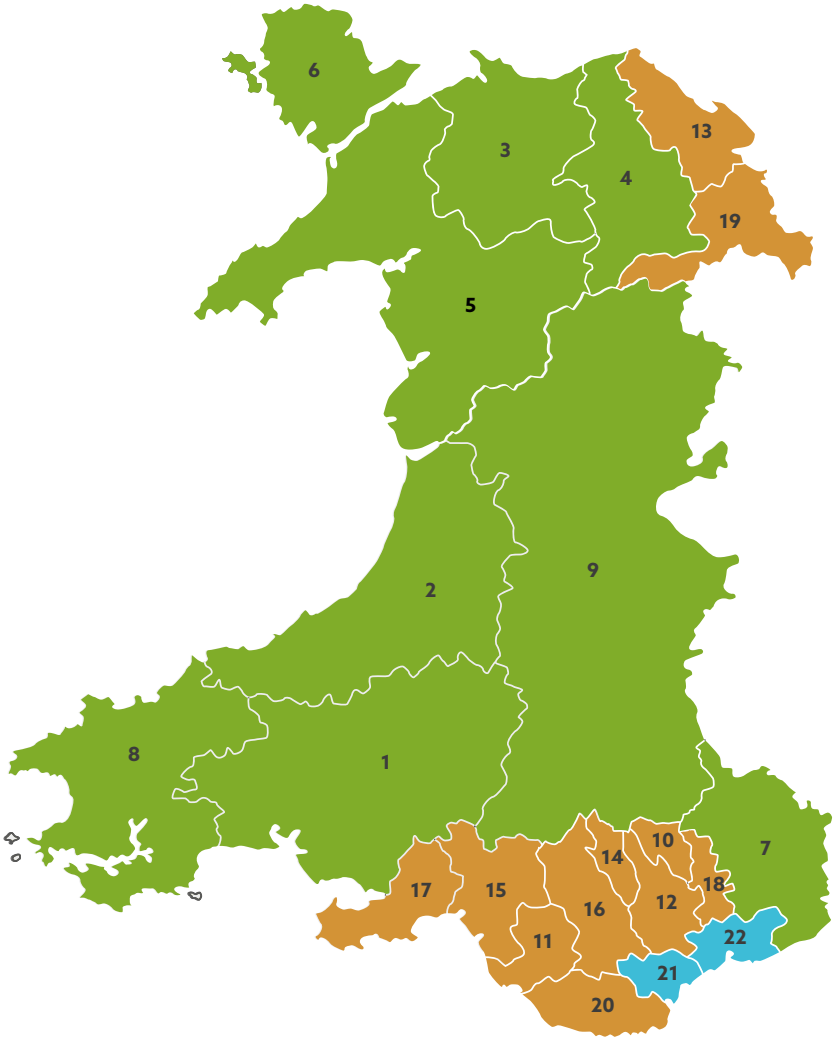
1 Carmarthenshire
2 Ceredigion
3 Conwy
4 Denbighshire
5 Gwynedd
6 Isle of Anglesey
7 Monmouthshire
8 Pembrokeshire
9 Powys

SEMI-RURAL/URBAN

10 Blaenau Gwent
11 Bridgend
12 Caerphilly
13 Flintshire
14 Merthyr Tydfil
15 Neath Port Talbot
16 Rhondda Cynon Taf
17 Swansea
18 Torfaen
19 Wrexham
20 Vale of Glamorgan

FULLY URBAN

21 Cardiff
22 Newport



Appendix 3 – Managing Community Asset Transfer risks - self evaluation

The following self-evaluation and risk matrix is aimed at decision makers in transferring authorities.

Risk	Risk rating High; Medium; Low	Your mitigating action
The local authority knows where all of its community assets are located in rural areas		
The local authority has capacity to support community asset transfer		
The local authority has identified which rural areas have the highest risk of social isolation		
The local authority has mapped community capacity, capabilities, skills and resources in rural areas		
The local authority matches the transferring asset with local need, future demand and community capabilities		
The objectives proposed by the community organisation for the asset are clear and aligned to those of the transferring local authority		
The local authority makes its full knowledge of the asset freely available – e.g. condition, running costs, rights of way, historic interest, value, accessibility, and boundaries		
The local authority has invested in the asset so it can be transferred quickly		
The receiving community organisation has the capacity, skills and capabilities to manage the asset		
The receiving community organisation is not over reliant on a small number of volunteers		
Community organisations have access to external funds to purchase, refurbish and maintain the asset		

Risk	Risk rating High; Medium; Low	Your mitigating action
Staff transfer arrangements such as TUPE have been addressed and the outcome of the assessment communicated to all parties		
The local authority has assured itself that the community organisation receiving an asset has appropriate and effective legal and governance arrangements		
Roles and responsibilities for the asset transfer are clear and known		
Community organisations know what to do to maintain the asset in the future		
The community asset has good utilities and broadband access (where applicable)		
Community organisations taking on the asset are financially stable		
Agreements, including suitable conflict resolution arrangements, are in place to deal with any problems that may arise in respect of the asset		

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Prif Weithredwr a Chlerc y Cynulliad
Chief Executive and Clerk of the Assembly

Y Pwyllgor Cyfrifon Cyhoeddus / Public Accounts Committee
PAC(5)-31-18 PTN3

Nick Ramsay AM
Chair of Public Accounts Committee
National Assembly for Wales
BY EMAIL

20 November 2018

Assembly Commission 2018 Voluntary Exit Scheme (VES)

Dear Nick

At the Commission's recent appearances before the Finance Committee and Public Accounts Committee, I was asked about the possibility of a Voluntary Exit Scheme (VES). I am now writing to confirm that, at its 5 November meeting, the Commission agreed to offer a Voluntary Exit Scheme to all staff.

The VES will help to ensure that the Commission can continue to provide the necessary skills, expertise and capacity to support the Assembly through the particular challenges brought by Brexit and Constitutional Change, whilst continuing to work, for as long as possible, within the overall establishment cap of 491 posts.

In summary the aims of the VES will be to:

- allow the Commission to respond to changes in skill and expertise requirements;
- facilitate organisational change, including within particular teams;
- improve workforce efficiency; and
- where possible, deliver long-term savings and avoid an establishment increase in meeting resource needs.

We intend to launch the VES on 22 November 2018, with the window for applications open until early January 2019. The scheme will be run in accordance with Cabinet Office/Treasury rules and will have robust and tested assessment criteria and decision processes. We will take full account of the recommendations arising from the internal audit

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review of our previous schemes and from the wider WAO review of severance schemes. The Trade Union Side (TUS) has been informed of our intention to offer a VES and will be invited to observe the work of the selection panel.

The financial implications have been carefully considered and we have identified a budget of up to £800K. I can confirm that this budget can be funded from underspends from the Commission's operational staffing budget, largely resulting from higher than normal levels of staff turnover. This budget is similar to the budget of £850K set for the 2015 VES, of which £650K was committed. The Welsh Government, in its most recent VES, set a budget of £5.5M.

Finally, the costs of the scheme will be published as part of the 2018-19 Annual Report and Accounts in July 2019.

Please do not hesitate to contact me if you have any queries or would like any further information.

Manon Antoniazzi

Prif Weithredwr a Chlerc/Chief Executive and Clerk

Cynulliad Cenedlaethol Cymru/National Assembly for Wales

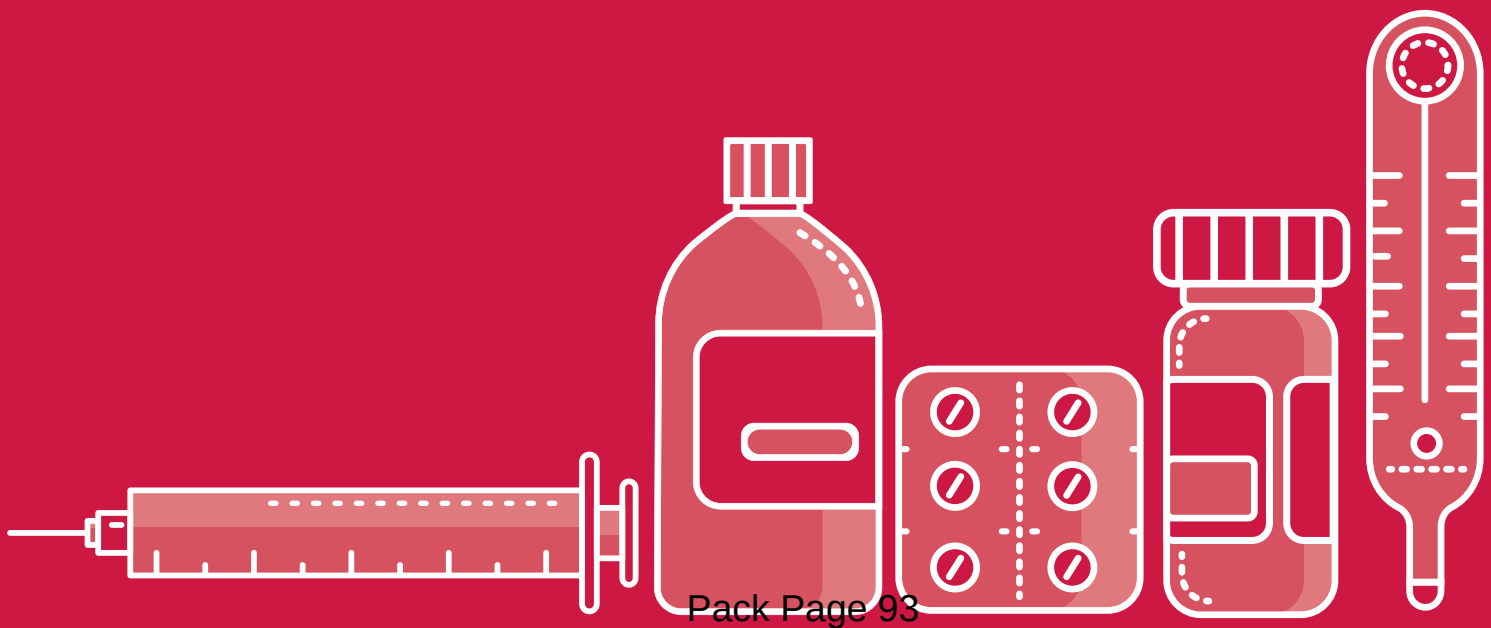
Agenda Item 3

Document is Restricted

MANAGEMENT OF FOLLOW UP OUTPATIENTS ACROSS WALES

OCTOBER 2018

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



CONTENTS

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

The Wales Audit Office study team comprised Anne Beegan, Andrew Doughton, Emily Howell, Katrina Febry, Matthew Brushett, Delyth Lewis and Sara Utley under the direction of David Thomas.

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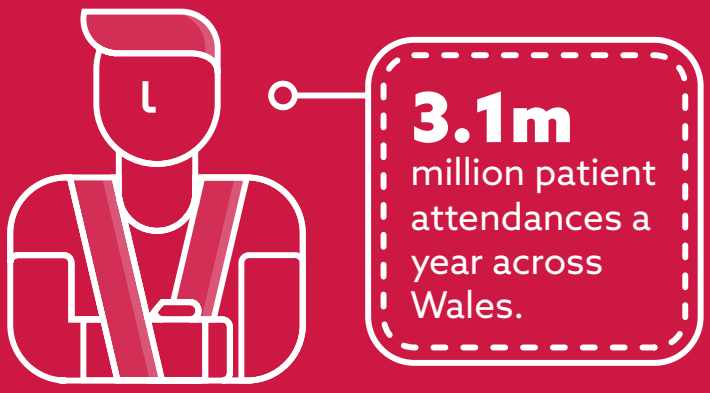
SUMMARY

Outpatient services play a crucial role in the majority of NHS care pathways...

Outpatient departments see more patients each year than any other hospital department, with approximately 3.1 million patient attendances a year across Wales.

The performance of outpatient services has a major impact on the public's perception of the overall quality, responsiveness and efficiency of health services.



Follow-up outpatient appointments make up a large proportion of outpatient activity but there have been concerns about the management of these appointments in recent years...

- A follow-up appointment is one that follows an initial attendance to outpatients.
- Over two-thirds of all outpatient appointments are follow-up appointments.
- In 2014, the Royal National Institute for the Blind Cymru (RNIB) issued a report called **Real patients coming to real harm.** This report highlighted the risks of ophthalmology patients losing their sight because of a delayed follow-up.
- The concerns raised by the RNIB were the stimulus for improving the management of ophthalmology follow-ups, led by the Chief Medical Officer, and the subsequent need for health boards to report their follow-up positions on a monthly basis to the Welsh Government.

The Auditor General examined health boards' arrangements for managing follow-up outpatient appointments in 2015-16. This work found...

- Large numbers of patients were on waiting lists for follow-up appointments, and many patients were experiencing delays in receiving appointments.
- The potential risks of delays in follow-up appointments were not being effectively assessed.
- Health boards' arrangements for reviewing outpatient follow-up performance were generally underdeveloped.
- While all health boards were working to improve the accuracy of their follow-up waiting lists, the majority were not meeting Welsh Government reporting requirements.
- Actions to improve outpatient services were mostly delivering short-term solutions.

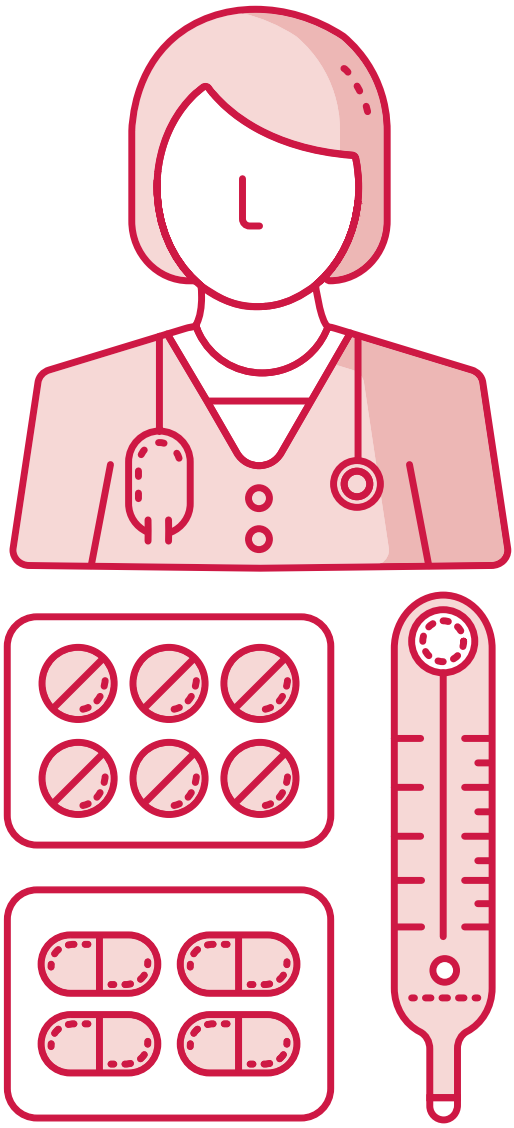
Findings from the Auditor General's 2015-16 work were reported locally and nationally...

All health boards received a report with recommendations for securing improvements.

We shared a summary of the findings from local audit work at health boards, and key areas for action, with the national Planned Care Programme Board in May 2016.

In 2017-18, the Auditor General did further work to assess the local and national level progress in response to the challenges and issues he identified in his 2015 work. This found that...

- Health boards have made some progress but the pace and impact of improvements are limited, and delays in follow-up appointments vary significantly across Wales.
- National improvement arrangements are starting to focus on follow-up outpatients, but so far they have led to few tangible improvements.
- Since 2015, the number of patients on outpatient follow-up waiting lists and those whose appointment has been delayed has increased substantially.



The worsening situation since our original work in 2015-16 is of significant concern and action is needed in a number of areas ....

- Health boards need to get better at assessing and managing the clinical risks to patients from delays in follow-up appointments.
- The unexplained variation in delayed follow-up appointments across health boards needs to be addressed as a matter of urgency.
- There needs to be greater focus on the management of outpatient follow-up appointments within national and local performance management arrangements.
- National working group arrangements need to be more effective at driving change and improvements locally.
- Work to modernise and improve the outpatient system needs to pick up pace, supported by strong and engaged clinical leadership.
- There needs to be a clearer strategy for supporting new outpatient service models using technology, underpinned with costed and resourced plans.

DETAILED FINDINGS

1 Outpatient services are complex and multi-faceted, and perform a critical role in patient pathways. The performance of outpatient services has a major impact on the public's perception of the overall quality, responsiveness and efficiency of health boards.

2 Follow-up outpatient services are a core part of a continued treatment approach for a large and growing proportion of the population. Patients will have a broad variety of needs including (but not limited to) a review after surgery, management or maintenance of chronic conditions, or monitoring for signs of deterioration, prior to intervention.

3 Health boards manage follow-up appointments that form part of the referral to treatment pathway and these are subject to the Welsh Government target of 26 weeks. However, follow-up appointments for many patients falls outside the referral to treatment pathway. These follow-up appointments are managed within clinical guidelines where available and clinically set target follow-up outpatient dates. These dates will be different dependent on the specialty, condition and clinician's opinion. Delays are measured based on the extent of the delay beyond the clinically set target date, as a percentage. Data is collected on patients experiencing 100% delays ie patients waiting as, a minimum, twice as long as they should be.

4 There are known clinical risks associated with delays in follow-up appointments, and patients can come to irreversible harm while on the waiting list. The RNIB report highlighted the risks of ophthalmology patients losing their sight because of delayed follow-up, but there are also a number of other high-risk specialties were patients could equally come to harm because of delays in receiving follow-up care.

5 Good management of follow-up outpatient services is needed to ensure efficient, effective and economical use of resources by:

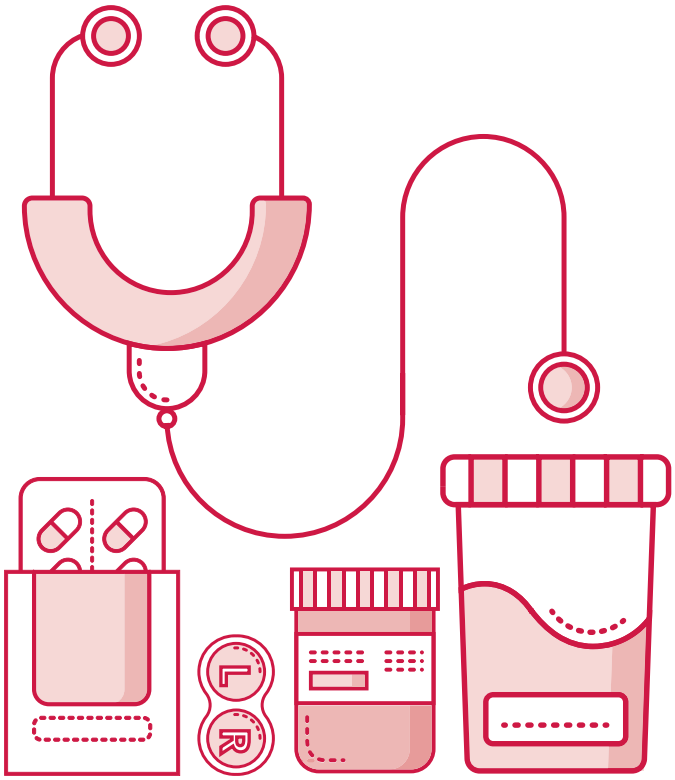
- ensuring only those with a clinical need to see an acute specialist are booked for a follow-up appointment;
- adopting see-on-symptom[1] and virtual clinic[2] approaches;
- exploiting opportunities to use technology[3] for example by allowing patients to self-manage their condition, avoid unnecessary travel, and to record and track outcomes;
- transforming the service model and pathway, by developing community and primary care based services, which reduces reliance on traditional hospital-based care models.

FOOTNOTES

1 A 'see on symptom' approach results in patients being discharged when clinically safe to do so, and then relies on the patient to self-refer if there are any issues with their condition.

2 There is no single definition for the scope and function of a virtual clinic. However, these may be clinics that result in a clinical decision being made without the need for the patient to attend. These may include reviewing case notes, reviewing diagnostic test results or making telephone or video contact with the patient.

3 Includes the use of email and/or text to upload test results or blood pressure readings to minimise the need to attend an outpatient appointment.



Wales Audit Office work on follow-up outpatients

6 As a result of growing national concerns relating to the management of follow-up outpatients, the Auditor General has undertaken initial and follow-up reviews at each health board in Wales over recent years to help define the extent of the challenges being faced and the progress that has been made in addressing them.

7 This report summarises:

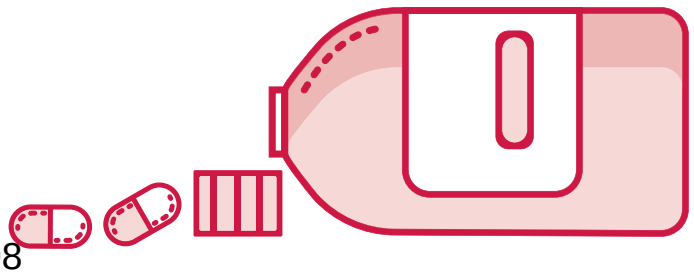
- progress made by health boards since the Auditor General's initial 2015-16 review, which focussed on data reporting and validation, arrangements to determine patient risks, and the extent of operational improvement and longer-term service modernisation;
- national arrangements to improve the management and performance of follow-up outpatients; and
- changes in the waiting list, including the volume of patients waiting on the follow-up outpatient waiting list, and those experiencing a delay.

Health Boards have made some progress in response to recommendations made in 2015-16, but the pace and impact of those improvements are limited, and the extent to which patients experience delays in follow-up appointments varies significantly across Wales

8 In 2015-16, auditors found:

- waiting lists for follow-up appointments were large, and delays remained a significant concern across Wales;
- most health boards were not consistently meeting Welsh Government reporting requirements;
- all health boards were working to improve the accuracy of follow-up waiting lists;
- health boards were not effectively assessing clinical risks associated with delays;
- reporting and scrutiny of follow-up outpatient performance within health boards was insufficient; and
- health boards were taking several short-term actions to improve outpatient services, but longer-term plans to develop new service models were less developed.

9 In each health board, auditors made a number of recommendations aimed at improving the management of follow-up outpatient appointments. Our 2017-18 follow-on reviews at health boards demonstrated that some progress had been achieved in response to our original recommendations, but, in key areas, progress had been slow.



10 Some health boards have a better understanding of clinical risk associated with harm because of a delay but more work is required. We found:

- health boards have taken different approaches to determining the clinical risk of harm associated with a delay.
- Cardiff and Vale University Health Board has developed a more systematic approach for identifying specialties and conditions presenting the greatest risk of harm and similar work is ongoing in Cwm Taf University Health Board. Other health boards have been slower to respond.
- systems to identify the incidence of harm associated with delays are not yet effective.

CASE STUDY

Cardiff and Vale University Health Board has developed a clinical risk assessment to identify the specialties or clinical conditions that are of higher clinical risk associated with follow-up delays. Their analysis identifies the specialty, specific clinical condition and the potential harm that may be caused because of a delay. The assessment is being used to inform how resources are directed to the areas with the greatest risk of harm.

11 All health boards are working to improve the overall operational effectiveness of outpatient services. We found:

- health boards were introducing text reminder services to minimise the number of patients who 'do not attend';
- an improving picture in relation to utilisation of clinic time through the revision of clinic templates to ensure an appropriate balance of available new and follow-up appointment slots;
- better analysis of demand and capacity for outpatient treatment; and
- improving use of clinical 'validation' of follow-up waiting lists to ensure only those patients with a clinical need are receiving a follow-up appointment.

12 These initiatives have yet to make a significant impact on the growth in demand. Auditors found that:

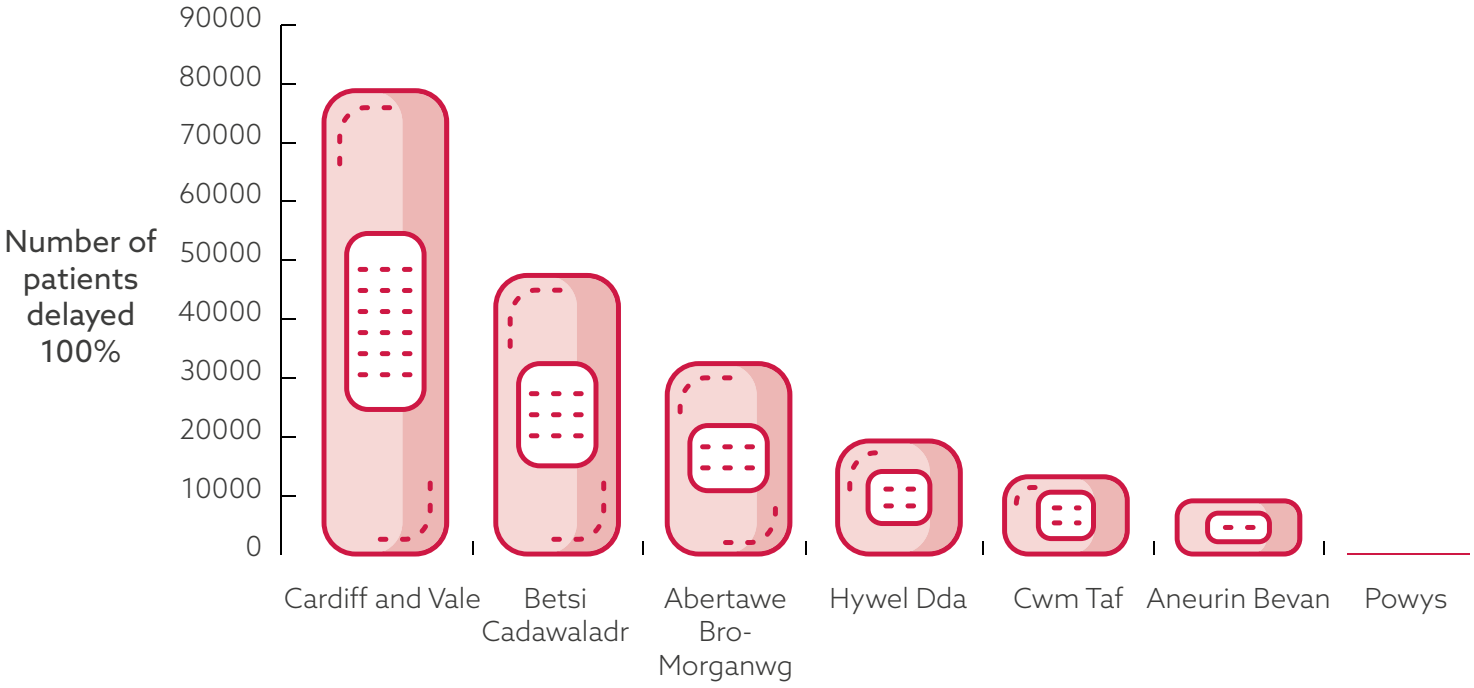
- some aspects of the operational improvement of outpatients need further development, such as reduction of clinically inappropriate referrals, development of efficient clinical pathways, and the system-wide introduction of 'see on symptom' pathways;
- none of the recommendations that the auditors made in 2015-16 in relation to outpatient modernisation were completed and progress remains slow and challenging; and
- there was an awareness that more needed to be done to address variations in clinical practice such as the consistent application of the cataract pathway across Wales.

13 Health boards are making some improvements to the quality and reliability of follow-up outpatient data and information. We found:

- Betsi Cadwaladr and Aneurin Bevan University Health Boards have resolved the issues relating to the under-reporting of patients on the follow-up outpatient waiting list with a booked appointment, although this remained an issue for Hywel Dda University Health Board until 2018; and
- there are now improving levels and quality of information used internally by health boards to actively manage operational improvement activity and performance

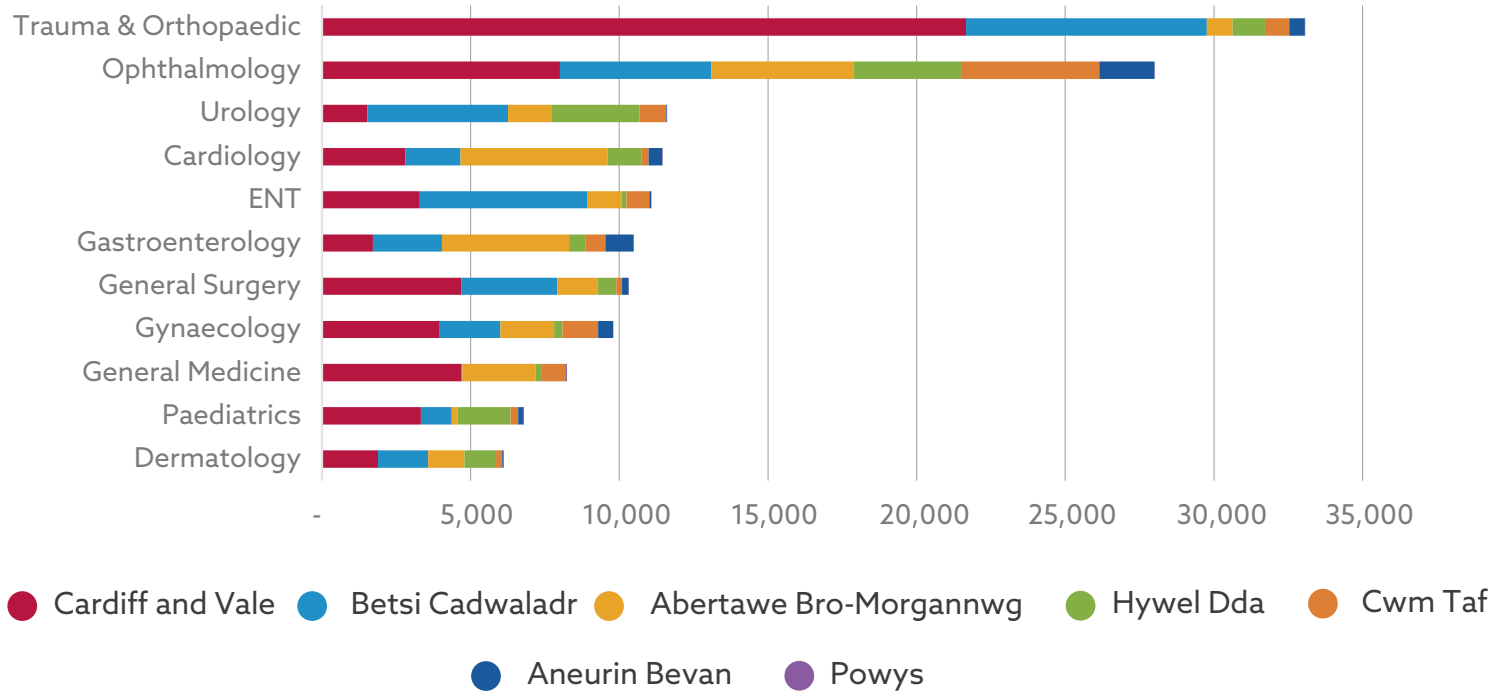
14 There is variation across health boards and specialties in the number of patients delayed more than twice as long as they should be (**Exhibits 1 and 2**). Whilst some of this variation reflects the overall volume of activity in larger health boards, this alone does not explain the variation observed within and between health boards. The data indicates a clear need for targeted remedial action alongside planning future-proof sustainable services.

Exhibit 1: number of follow-up outpatients delayed more than twice as long as they should be, by health board, as at April 2018



Source: Health Board submissions to the Welsh Government

Exhibit 2: number of follow-up outpatients delayed more than twice as long as they should be, by specialty and health board, as at April 2018



Source: Health Board submissions to the Welsh Government

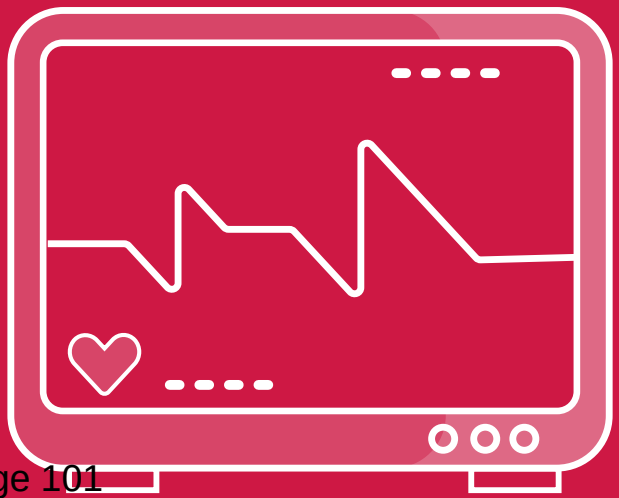
National improvement arrangements are starting to focus on follow-up outpatients, but so far these have failed to translate into tangible improvements

15 There is improving recognition of the extent of the problem, and a growing ambition to resolve it at a national level:

- since 2016, there has been a notable increase in the focus on follow-up outpatients by the Planned Care Programme Board, through creation of the Outpatient Steering Group.
- the Cabinet Secretary for Health and Social Services has set out a requirement to take action to tackle follow-up outpatient improvement challenges across four specialties. These are orthopaedics, ophthalmology, ENT and urology. Supporting groups have been established under the Planned Care Programme Board to reflect these four specialties.
- there has been ongoing work since 2016 to develop a good practice compendium, a good practice guide and national learning events, but the extent of adoption of these at a clinical level in health boards appears highly variable.
- there is a developing high-level vision for outpatients, but there is also lack of clarity about agreement and adoption by health boards as well as plans to deliver it.
- there is a commitment to utilise value-based healthcare principles and patient-reported outcome measures to improve efficiency, but actions in these areas are not yet being taken forward with sufficient scale and pace.

16 Performance arrangements to date have predominantly focussed on the 26-week referral to treatment time target:

- the focus on improving referral to treatment time performance, particularly at the year-end, drives an increase in new appointments but also has the effect of increasing demand for follow-up work, as the majority of new patients will require a follow-up appointment. Additional funding made available to improve waiting time performance does not include funding for subsequent additional follow-up outpatient demand. This exacerbates a gap between demand and resourced capacity for follow-up outpatient waiting lists.
- follow-up outpatients have not been a key performance target within national and local performance management arrangements. Although more recently, quality and safety aspects of follow-ups are starting to be discussed at national Quality and Delivery meetings with health boards.
- a new performance management target for ophthalmology, which integrates the referral to treatment pathway with follow-up outpatient care, is in the process of being introduced. This may help enable a better focus on patient outcome and preventable harm.



17 The availability of data is improving, but it is not yet fully reliable and informatics are not yet sufficiently enabling outpatient pathway improvement:

- opportunities available through improved use of informatics are not yet being taken to enable 'quick to introduce' solutions to improve outpatient management.
- the separate primary and secondary care clinical systems appear to be reinforcing silo working. This is not yet enabling integrated management of pathways across primary and secondary care, which are particularly important for the management of patients with chronic conditions.
- there is a lack of informatics involvement or sufficient resource in some of the planned care group structures.
- from a low baseline in 2014, follow-up outpatient data quality is improving. However, information is not always recorded in the same way (such as 'see on symptom' and virtual clinics), and assessment of patients' clinical risk while on the waiting list is hampered by a lack of clinical condition coding. The outpatient steering group is currently working on standardising a definition for a virtual clinic.

18 Although there is clinical willingness to change, more needs to be done to set the clinical direction across Wales:

- there is a lack of clinical leadership at the national Outpatient Steering Group. The group is focussing on operational improvements such as reducing 'did not attend' rates but there are opportunities to focus more on required changes in clinical practice and pathways.
- obstacles get in the way of rapid progress to improve outpatient efficiency, with a resistance to change clinical practice amongst some clinicians and a lack of systematic adoption of nationally agreed lean clinical pathways, for example, knee and cataract pathways.
- there is opportunity to engage medical directors more, as a conduit to lead clinical change and adoption of nationally agreed pathways within health boards.

19 The national Planned Care Programme arrangements are not conducive to drive timely change or performance improvement:

- there is varied understanding by key stakeholders on the role and function of the national planned care specialty groups. Some view them as providing a diagnostic overview, while others view the groups as responsible for delivering change across Wales.
- given the extent of the challenge for nationally-led service improvement and modernisation, the groups do not have the necessary capacity and authority to drive changes between meetings. The groups also do not meet frequently enough, and although have large memberships, significant numbers of apologies are given.
- until recently, there has been a lack of holding health boards to account for delivery of service improvements and change identified through the Planned Care Programme Board and its supporting specialty groups. Delivery against Planned Care Programme priorities, however, is now featuring more prominently in the regular Joint Executive Team meetings with health boards.
- the lack of capacity at a national level does not necessarily mean additional revenue funding is required, but the existing capacity across the national infrastructure could be better co-ordinated.
- the Outpatient Steering Group has recently strengthened its membership and focus but still lacks clinical leadership and needs to demonstrate it is positively influencing service performance improvements and transformation within health boards.

20 The issues identified above appear to be tempering the extent of ambition to 'what is potentially achievable' rather than 'what needs to be done'.

Since 2015, the number of patients on outpatient follow-up waiting lists, and the number of patients whose appointment has been delayed have substantially increased

21 Analysis of the health boards' data submissions to the Welsh Government paints a worrying picture with an upward trend in patients waiting, growth in delayed follow-up appointments, and in particular a growth in those waiting twice as long as they should have.

22 There has been a growth overall in the numbers of patients waiting for a follow-up outpatient appointment between April 2015 and April 2018. This growth is reflected across many high volume specialties (**Exhibit 3**).

12% GROWTH

Average number of patients on the follow-up waiting list has increased from 941,000 to 1,059,000 from April 2015 to April 2018

Exhibit 3: number of patients waiting for a follow-up outpatient appointment in April 2015 and April 2018, by specialty

Specialty	Patients waiting for a follow-up outpatient appointment **April 2015**	Patients waiting for a follow-up outpatient appointment **April 2018**
 ORTHOPAEDICS	131,105	150,283
 OPHTHAMOLOGY	97,784	116,758
 GENERAL SURGERY	63,564	69,706
 CARDIOLOGY	54,578	65,064
 ENT	53,194	66,299
 UROLOGY	44,731	51,592
 PAEDIATRICS	34,047	46,131
 GYNAECOLOGY	40,481	42,636
 DERMATOLOGY	38,104	38,996
 GASTROENTEROLOGY	27,678	34,208

Source: Health Board submissions to the Welsh Government.

23 The number of patients waiting for a follow-up appointment that is delayed has grown substantially between 2015 and 2018 (**Exhibit 4**):

- in April 2015, there were 240,108 patients waiting for a delayed follow-up outpatient appointment. This has increased to 376,229 by April 2018.
- in April 2015, there were 128,000 patients waiting twice as long as they should be. By April 2018, this has increased to just under 200,000 patients.

55% GROWTH
Patients waiting twice as long as they should be (100% delayed)

24 In comparison to the referral to treatment waiting list, there are substantially more patients experiencing delayed follow-up outpatients:

- overall, the number of patients on the referral to treatment waiting list has increased by 0.7% to 431,872, and the number of patients on the follow-up outpatient waiting list has increased by 12% to 1,059,610 between April 2015 and April 2018; and
- in April 2018, 88% of patients were waiting within 26 weeks on the referral to treatment waiting list, whereas only 65% of follow-up outpatients are within their target appointment date.

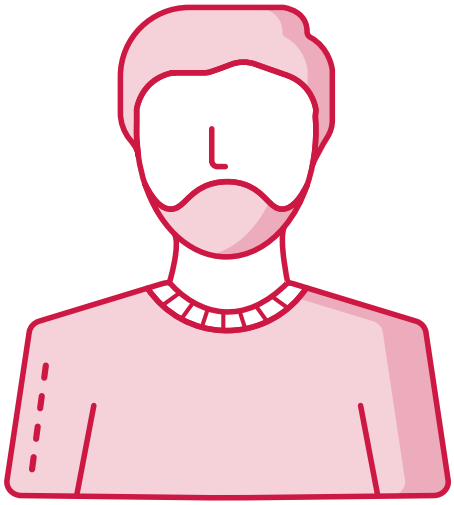
Exhibit 4: number of patients delayed twice as long as they should be between April 2015 and April 2018, by specialty

Specialty	Number of patients delayed twice as long as they should be			
	April 2015	April 2016	April 2017	April 2018
Orthopaedics	17,294	19,723	23,881	33,063
Ophthalmology	16,412	17,143	21,438	28,009
Urology	11,056	11,019	9,938	11,593
Cardiology	7,529	6,954	9,231	11,464
ENT	7,939	8,491	8,322	11,089
Gastroenterology	5,819	7,229	9,171	10,488
General surgery	9,273	7,552	8,688	10,331
Gynaecology	6,057	6,528	7,744	9,794
Paediatrics	2,939	4,991	5,805	6,710
Dermatology	3,973	3,877	4,047	6,112

Source: Health Board submissions to the Welsh Government.

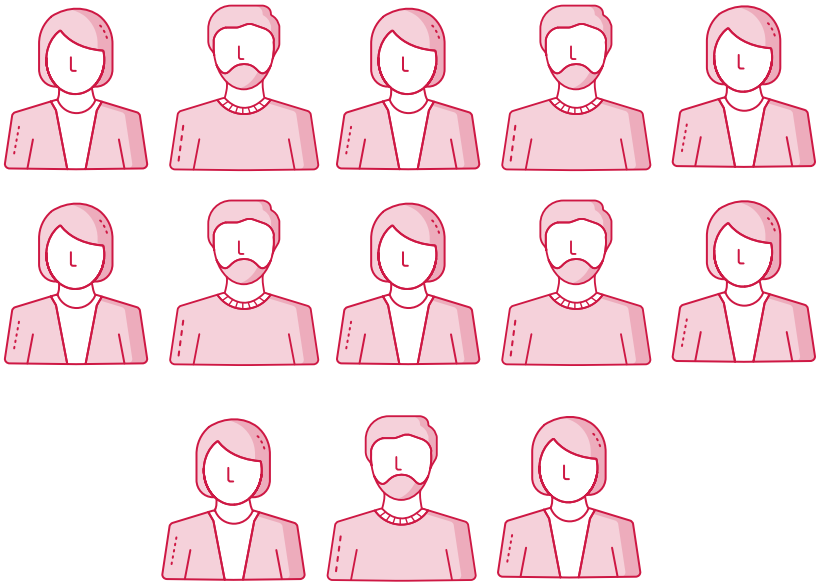
At April 2018, there were over 13 times as many people waiting twice as long as they should be on the follow-up list compared to the number of patients waiting on the referral to treatment list over 36 weeks.

REFERRAL TO TREATMENT >36 WEEKS



(14,797)

FOLLOW-UP OUTPATIENTS 100% DELAYED



(199,968)

RECOMMENDATIONS

25 In preparing and discussing this report with stakeholders, numerous references were made to some good examples of work emerging that will have a positive impact on the management of follow-up appointments. This is encouraging, although it will be important to ensure that any such emerging good practice is shared, spread and scaled up to leverage the change which is required.

26 The continuing growth in follow-up outpatient waiting lists and patients waiting beyond their target date for a follow-up review points to the need for further concerted action to curb and reverse this trend. In addition to the recommendations that we have already made to health boards through our local audit reports, we make the following recommendations to Welsh Government.

R1 **Set a clear ambition –** set a clear target and timeframe to reduce the number of patients delayed twice as long as they should be waiting (ie 100% delays).

R2 **Strengthen the national delivery structure** – adapt the Planned Care Programme Board and its underpinning structure to ensure it is delivering improvements that materially improve follow-up outpatient performance and drive the development of transformed service models and pathways that are efficient and meet expected growth in demand. In doing so, the Welsh Government should ensure:

- membership of the Planned Care Programme Board and its supporting groups is appropriate.
- the lines of accountability for delivery of improvement actions at national and health board level are clear and work as required.
- there is sufficient capacity to lead change between meetings of the various groups, which should include consideration of the frequency of meetings, the use of task and finish groups between meetings, and the capacity of members to lead improvements between meetings.
- ensure informatics is integral to the solution. NWIS needs to be a key stakeholder in procuring, developing and project managing solutions to improve outpatient services and new models of care. The service should be a key member of the Planned Care Programme Board. Where technological solutions are required, procurement rather than development may achieve better scalability and pace of delivery.

R3 **Develop a clear plan to support national level service developments** – set out a clear plan of action needed at a national level to accelerate the scale and pace of outpatient transformation through the Planned Care Programme Board structure, which is costed and resourced, and makes maximum use of available technologies.

R4 **Plan sustainable services** – ensure there are clear plans to improve follow-up performance and modernise outpatient services within health board Integrated Medium Term Plans (IMTP) and annual plans.

R5 **Align the priorities of the national resource**s – to maximise the impact of the national resources available to support improvement, such as the Delivery Unit, ensure that their programmes of work are aligned to support the transformation of outpatient services and reductions in follow-up delays. The national resources will include but not be limited to NWIS, the Delivery Unit, and the 1,000 lives team.

R6 **Strengthen and focus performance accountability** – build on the developing focus at Quality and Delivery meetings with health boards, by strengthening the focus on holding health boards to account for delivering improvements to reduce follow-up outpatient waiting lists in the short, medium and long term.

R7 **Strengthen clinical accountability** – raise awareness amongst health board Medical Directors of their professional roles and responsibilities in driving through the required clinical changes and adherence to national follow-up outpatient guidance.

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Welsh Government

Adrian Crompton
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20 November 2018

Dear Adrian

Auditor General for Wales Report – Follow Up Outpatients

I am writing in response to the report on Follow up Outpatients Appointments. I acknowledge the recommendations and areas highlighted for action and will work in partnership with the NHS to address them. While the report acknowledges that the Planned Care programme is working to support the reduction of follow-up delays, I do recognise that further work to transform outpatients and improve waiting times for outpatients is required. We will work with the Outpatients Steering Group (OPSG) to ensure that the OPSG challenges and drives delivery against the recommendations in your report and those already made to health boards through local audit reports.

I also acknowledge that despite significant past additional investment in this area a greater focus on service redesign is needed to deliver a sustainable service model for the future. This redesign requirement is strengthened through “A Healthier Wales” to care for patients in the most appropriate setting. There are many opportunities for different pathways and innovative multi disciplinary services, in appropriate settings outside the traditional secondary care model.

Following a presentation from the WAO on their report, the national OPSG group has developed a national outpatient performance dashboard. This dashboard will be used to monitor and challenge the progress health boards are making in achieving improvements. The dashboard will support the formal performance management process within Welsh Government which monitors progress against agreed targets, such as to reduce the numbers of patients delayed more than twice as long as their stated target review date.

The introduction of the new eye care measure highlights the impact that national work led by clinicians can have on the service. In this instance it is driving the management and redesign of eye care services.

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I can confirm that we accept all the recommendations in the report, and I will now respond to each one in turn.

Recommendation 1 **Set a clear ambition** – set a clear target and timeframe to reduce the number of patients delayed twice as long as they should be waiting (i.e. 100% delays).
Recommendation – accepted I have asked the OPSG to make recommendations to Welsh Government for a national target and timeframe for the reduction of the number of patients delayed twice as long as they should. Welsh Government will consider their advice before deciding on the actual target.
Recommendation 2 **Strengthen the national delivery structure** – adapt the Planned Care Programme Board and its underpinning structure to ensure it is delivering improvements that materially improve follow-up outpatient performance and drive the development of transformed service models and pathways that are efficient and meet expected growth in demand. In doing so, the Welsh Government should ensure: • Membership of the Planned Care Programme Board and its supporting groups is appropriate; • The lines of accountability for delivery of improvement actions at national and health board level are clear and work as required; • There is sufficient capacity to lead change between meetings of the various groups, which should include consideration of the frequency of meetings, the use of task and finish groups between meetings, and the capacity of members to lead improvements between meetings; • Ensure informatics is integral to the solution. NWIS needs to be a key stakeholder in procuring, developing and project managing solutions to improve outpatient services and new models of care. The service should be a key member of the Planned Care Programme Board. Where technological solutions are required, procurement rather than development may achieve better scalability and pace of delivery.
Recommendation - accepted Membership and accountability of the programme is regularly reviewed. The next review of the programme role and function will form part of the "A Healthier Wales" recommendation looking at the role of programme boards and networks. The review (due in early 2019) will also consider other aspects of this recommendation around resources and the role of digital support which is another key area of focus in the A Healthier Wales.
Recommendation 3 **Develop a clear plan to support national level service developments** – set out a clear plan of action needed at a national level to accelerate the scale and pace of outpatient transformation through the Planned Care Programme Board structure, which is costed and resourced, and makes maximum use of available technologies.
Recommendation - accepted This will form part of the review of the role of national programmes and the linkage with the national transformation programme and fund, as covered in the response to recommendation two. The OPSG are also in the process of developing an action plan that will accelerate a number of key actions to support the transformation required.

Recommendation 4 **Plan sustainable services** – ensure there are clear plans to improve follow-up performance and modernise outpatient services within health board Integrated Medium Term Plans (IMTP) and annual plans and we will revisit the detail of each organisations plans and commitments.
Recommendation – accepted The need to improve follow-up performance and modernise outpatient services has been identified as a priority within the planning framework. I expect this to be fully addressed within health board Integrated Medium Term Plans (IMTP) and annual plans.
Recommendation 5 **Align the priorities of the national resources** – to maximise the impact of the national resources available to support improvement, such as the Delivery Unit, ensure that their programmes of work are aligned to support the transformation of outpatient services and reductions in follow-up delays. The national resources will include but not be limited to NHS Wales Informatics Services, the Delivery Unit, and the 1,000 lives team.
Recommendation – accepted As part of the A Healthier Wales plan, work is in train to create a National Executive Function which will strengthen the national approach in key areas, including the transformation of the outpatient service. Whilst this is underway, my officials are aligning priorities across the support functions to ensure better alignment of the work of the Delivery Unit, NWIS and 1,000 Lives.
Recommendation 6 **Strengthen and focus performance accountability** – build on the developing focus at Quality and Delivery meetings with health boards, by strengthening the focus on holding health boards to account for delivering improvements to reduce follow-up outpatient waiting lists in the short, medium and long-term.
Recommendation – accepted The outpatient dashboard described in our response to recommendation one will be formally used as part of the Welsh Government's accountability arrangements with health boards to ensure they achieve the required improvements and the appropriate redesign of services. The national OPSG will be used to add additional challenge but and to support the sharing of good practice and national adoption where possible of evidence service redesign.
Recommendation 7 **Strengthen clinical accountability** – raise awareness amongst health board Medical Directors of their professional roles and responsibilities in driving through the required clinical changes and adherence to national follow-up outpatient guidance.
Recommendation – accepted Through the Chief Medical Officers national group, NHS medical directors will be tasked with ensuring that local clinical leadership is fully engaged in the national OPSG as well as local outpatient improvement arrangements. This will accelerate and support the required drive in system changes. The clinical leads within the national planned care groups and the national planned care clinical lead will play an important role in providing visible clinical leadership.

Yours sincerely

Dr Andrew Goodall

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The PAC Chair via the PAC mailbox – SeneddPAC@Assembly.Wales
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Olivia Shorrocks
Frank Atherton
Chris Jones
Andrew Sallows

Agenda Item 4

Document is Restricted

Y Pwyllgor Cyfrifon Cyhoeddus / Public Accounts Committee
PAC(5)-31-18 P3

November 2018

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Radiology Services in Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998 and 2006.

The Wales Audit Office study team comprised Anne Beegan, Elaine Matthews, Fflur Jones, Katrina Febry, Phillip Jones, Rachel Harries, Tracey Davies and Urvisha Perez under the direction of David Thomas

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Contents

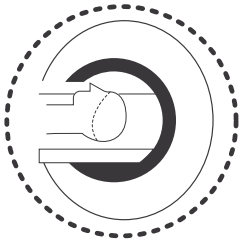
Summary report

Background

1 Radiology is a key diagnostic and interventional service used to help diagnose, monitor and treat disease and injuries.

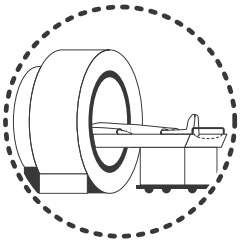
2 Hospital-based clinicians and general practitioners refer patients to radiology departments to undergo radiological examinations or to have images taken. Radiographers use sophisticated radiology equipment to produce differing types of images, depending on the issue being investigated. Exhibit 1 provides a summary of the key radiology techniques commonly used across the NHS.

Exhibit 1: key radiology imaging techniques



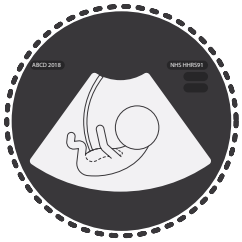
Computerised tomography (CT):

Uses X-rays and a computer to create detailed images of structures inside the body, including internal organs, blood vessels and bones. Patients lie on a bed that passes into a doughnut shaped scanner



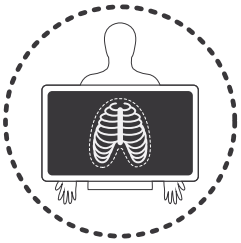
Magnetic resonance imaging (MRI):

Uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Can be used to examine almost any part of the body, including bones and joints, the heart and blood vessels, and internal organs, such as the liver. An MRI scanner is a large tube in which patients lie during the scan.



Ultrasound (US):

Uses high-frequency sound waves to create an image of a part of the inside of the body. Ultrasound probes gives off high-frequency sound waves. The sound waves bounce off different parts of the body, creating an "echo" that is picked up by the probe and turned into a moving image. This image is displayed on a monitor while the scan is carried out.



X-ray:

Uses radiation to pass through the body, the energy from X-rays is absorbed at different rates by parts of the body. X-rays are mainly used to look at bones and joints, but can also be used to detect problems affecting soft tissue, such as heart problems and tumours.

Source: NHS Choices

3 Following an examination, a clinical radiologist[1] will view the resulting image or images, and produce a report, which provides an interpretation. Radiologists play a key role in the clinical management of a patient's condition, advising on, and selecting the best imaging technique to enable diagnosis and minimise radiation exposure. Interventional radiologists have a more direct role in treating patients, using minimally invasive procedures, aided by radiology imaging, to diagnose and treat various diseases.

4 Many clinical decisions about the management of a patient cannot be made without a radiologist's input into the diagnosis. Where rapid diagnostic testing is in place, this enables clinical decisions to be made quickly.

5 **The Future Delivery of Diagnostic Imaging Services in Wales** (2009)[2] report set out that demand for some types of radiology examinations was increasing by between 10% and 15% per year.

6 In 2010, the National Imaging Programme Board was created at the request of NHS Chief Executives, as the primary source of advice, knowledge and expertise for the planning of diagnostic radiology services in Wales. The National Imaging Programme Board, through NHS Chief Executives was given delegated authority for developing and implementing a programme of strategic work for radiology, and for adopting all-Wales standards and protocols for radiology services across Wales. Since then, although progress has been made at a national level, a number of significant challenges are yet to be fully addressed.

7 It is widely accepted that there are ongoing difficulties in recruiting general and specialist radiology staff. There are also concerns about the capability of radiology information systems to support the delivery of services. In addition, radiology equipment is expensive to purchase and maintain. Waiting time performance in the past five years suggests that the current capacity of radiology services is not sustainable.

8 The Wales Audit Office report on **NHS Waiting Times for Elective Care in Wales** (January 2015)[3] showed that waiting time targets for diagnostic tests were not being met. Similarly, the Wales Audit Office report **A Review of Orthopaedic Services** (June 2015)[4], showed that the long waiting times for radiology examinations was contributing to long waits for overall orthopaedic treatment.

1 In this report, reference made to radiologists, includes consultant radiologists, middle-grade doctors, specialist registrars and junior doctors. Where there is any variation from this, the report content will specify what the variation is, for example, 'consultant radiologists'.

2 Welsh Assembly Government, The Future of Diagnostic Imaging Services in Wales, 2009

3 Wales Audit Office, NHS Waiting Times for Elective Care in Wales, January 2015

4 Wales Audit Office, Orthopaedic Services, June 2015

9 Given the challenges, the Auditor General commenced a review of radiology services at all health boards in Wales in late 2016. The work examined each health board's arrangements to meet demand for radiology examinations and made recommendations for service improvements. We excluded therapeutic radiology from the review. Appendix 1 provides the audit approach and methodology used for this work.

10 During 2016-17, the Wales Audit Office conducted a value-for-money examination of the NHS Wales Informatics Service[5]. The review considered the implementation of key NHS information systems, including the implementation of RADIS[6] across Wales. The report highlighted that frontline staff are dissatisfied with the functionality of RADIS.

11 This report summarises the key messages from the Auditor General's local work on radiology services, and refers to the findings set out in the Auditor General's separate report on the NHS Wales Informatics Service where relevant.

Key findings

12 Waiting time targets for radiology examinations are currently being met and our work has shown that radiology services are generally well managed. However, rising demand, difficulties with recruitment and retention of staff, outdated and insufficient scanning equipment, along with IT weaknesses are putting services under pressure and point to the need for clear and targeted action to ensure that radiology services are able to cope with future demand.

13 Our key findings are set out further in the paragraphs below.

Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results

14 Demand for radiology examinations is increasing each year, in particular for the most complex scanning techniques. The reasons for the increase in demand are numerous.

15 Where a GP or consultant decides that a patient is in need of a radiology examination, those referred as outpatients are added to a waiting list. Our review found that waiting lists are prioritised according to need, and all health boards review the appropriateness of the referral priority.

5 Wales Audit Office, Informatics systems in NHS Wales, January 2018

6 RADIS – Wales Radiology Information System

16 Hospital inpatients with emergency health needs may need prompt access to radiology examinations. In normal working hours, hospitals set aside a small number of appointments to accommodate urgent inpatient cases. However, we found that out of hours access to radiology examinations for patients with urgent needs is variable. Whilst CT and X-ray examinations are available out of hours in most hospitals, MRI and US examinations are not.

17 There has been improvement in waiting time performance over the last five years, with a reduction in the number of patients waiting more than eight weeks for a radiology examination, supported by additional funding from the Welsh Government. Health boards have secured improvements in waiting times by outsourcing examinations to private sector mobile units and making use of unused capacity in other health boards.

18 Following a radiology examination, a report of the image is produced. Generally, reporting turnaround targets are met, however, some patients wait a long time for their results, and not all examinations are reported.

19 Whilst radiologists report most examinations, specially trained radiographers are able to report on less complex images. However, staff shortages were limiting health boards' ability to make greater use of radiographer reporting. As a result, health boards have relied on outsourcing reporting to help ensure timely turnaround of radiology reports.

Recruitment, retention and an ageing workforce are threatening the sustainability of the service and limiting health boards' ability to train staff

20 We found that all but one health board was struggling to recruit and retain radiologists and radiographers. Health boards have been increasingly reliant on using locum staff to bridge the gap caused by unfilled vacancies. At the same time, the radiology workforce is aging and at the time of our review, more than one third of radiologists and radiographers were aged 50 or over, and therefore, vacancy levels could increase without appropriate action.

21 To help address the reporting capacity shortfall, a National Academy has been set up to provide a training facility for trainee radiologists. The first cohort of trainees are due to commence training in September 2018.

22 We found that staffing shortages were limiting health boards' ability to train their staff, and all health boards were struggling to keep staff compliant with statutory and mandatory training modules.

Ageing and underutilised equipment are making it harder for health boards to meet demand and health boards do not have the staffing resources to extend opening hours

23 Comprehensive arrangements are required to ensure the maintenance and replacement of radiology equipment. Older imaging equipment is more expensive to maintain and has a greater risk of failure. At the time of our review, all health boards had equipment nearing the end of their lifespan. A capital replacement programme for radiology equipment requires significant funding, and as such, capital funding is provided on an all-Wales basis but not necessarily to the level needed to replace all out of date equipment. Since our review, the Welsh Government provided funding for additional radiology imaging equipment in 2016-2017 and 2017-18, and is working with health bodies to identify and prioritise further additional imaging investment over the period 2018-19 to 2020-21.

24 We found there was scope to increase the utilisation of scanning equipment in all health boards. However, additional radiology staffing would be required to achieve this. A further complication is that increasing operating hours would also lead to higher maintenance costs, and reduce equipment lifespans.

Wales-wide radiology IT system challenges and weaknesses in local IT infrastructures inhibit radiology services' efficiency

25 Our review found that the core radiology system, RADIS, was not fulfilling health boards' needs. Inadequacies in the system were causing difficulties for some health boards in planning and delivering radiology services and leading to inefficiencies. We also found that inadequacies in local IT infrastructures were also compounding inefficiencies.

26 At the time of our review, the absence of an e-referral system and weaknesses in Picture Archiving and Communications Systems (PACS) and voice recognition systems were creating inefficiencies in the planning and delivery of radiology services. However, since our review there has been phased implementation of electronic referrals as part of the wider rollout of the Welsh Clinical Portal.

Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services

27 We found that strategic and operational planning of radiology services need strengthening in most health boards. Only three health boards undertook demand and capacity modelling. At the time of our review, only one health board had a specific, detailed financial plan for radiology.

28 Performance data and audit results help health boards to monitor and evaluate the performance of radiology services. However, we found that most health boards had opportunities to widen the range of radiology performance measures reported to their Boards and Committees. In addition, currently there is no standard radiology activity measurement. Health boards do not record radiology activity consistently across Wales. This makes it difficult to provide true comparisons of activity and performance between health boards.

29 Our review found that the operational management and accountability arrangements for radiology services were clear and appropriate. We found that nearly all health boards are taking positive steps to reduce inappropriate referrals, but signposting to local referral guidance could be improved. However, since our review, access to national referral guidance has improved.

30 Our review also found that not all health boards had an executive lead for radiology that was a member of the Board. The absence of an executive lead for radiology attending board meetings at some health boards may mean the opportunity to highlight and monitor emerging issues is missed.

31 Given the nature of some of the issues facing radiology services, action taken alone by health boards will not be enough to ensure the future sustainability of radiology services. National strategic planning is required to address the challenges facing radiology services. Since we reviewed radiology services across Wales, the Welsh Government established an Imaging Taskforce to develop and deliver a high-level **Imaging Statement of Intent**[7]. The aim of the Imaging Statement of Intent (the Statement of Intent) is to address the challenges facing diagnostic radiology services in Wales. In developing the Statement of Intent, the Imaging Taskforce took account of the findings from our local work. The Statement of Intent was published in March 2018. It contains a number of actions for NHS Wales to address.

7 Welsh Government, Imaging Statement of Intent, March 2018.

Key challenges and recommendations

32 The findings from our work identify a number of key challenges that face health boards, and require action both locally and nationally by NHS Wales, or locally by some or all health boards. These are set out in Exhibit 2.

Exhibit 2: key challenges that need to be addressed nationally and locally

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Workforce		
• Ensure that the level of trainee radiologists and radiographers is sufficient to address recruitment challenges and increasing demand.	✓	
• Ensure that opportunities to maximise the contributions that support staff and other professions can make to radiology services are identified and secured.		✓
• Ensure that health boards have radiology workforce plans, which identify the capacity and skill mix required to sustainably meet current and future radiology demand in a timely and safe way.		✓
Equipment		
• Ensure that there is a national coordinated approach to address equipment needs, with sufficient funding for the replacement of equipment and purchase of new technology to meet increasing demand and technology advances.	✓	
• Ensure that health boards have equipment replacement programmes, which set out priorities, requirements and associated costs.		✓

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Demand		
• Ensure that regional levels of current and future demand are known, to enable planning for additional capacity to be coordinated across regions.	✓	
• Ensure that health boards know the current and future demand for each referring specialties that takes account of changes, such as to patient pathways.		✓
• Ensure that health boards have action plans that detail how waiting times and reporting targets will be achieved in the short-term, and sustained in the future.		✓
• Ensure that health boards can demonstrate a value-based approach to radiology services by making better use of benchmarking information across Wales and the UK.		✓
ICT		
• Ensure that information systems are efficient and enable reliable management and performance information to be produced, and facilitate the appropriate sharing of patient information and images within and between health boards.	✓	
Management of services		
• Ensure that management accountability and strategic oversight is appropriate to drive service improvements.		✓
• Ensure that referral guidance provides sufficient information and is accessible to referring clinicians.		✓

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Quality		
• Ensure that common procedure codes are in place and used to ensure that workload is measured consistently with and between health boards.	✓	✓
• Ensure that common performance indicators are in place to drive the consistency of benchmarking and improvement of services.	✓	✓
• Ensure that appropriate and robust performance quality measures are in place, which includes the review of patient experiences and service quality reviews.		✓
• Ensure that appropriate monitoring arrangements are in place at board and committee level.		✓

Source: Wales Audit Office

33 Our local audit reports set out specific recommendations for health boards. All health boards have prepared management responses setting out the actions they are taking to address audit recommendations. Our local reports and the associated management responses are available on the Wales Audit Office website (www.audit.wales).

34 The challenges that require a national response align closely to the actions set out in the Statement of Intent. Consequently, we do not see value in repeating those actions in the form of recommendations here.

35 The Imaging Taskforce, in consultation with the public and stakeholders, is developing a national imaging implementation plan for NHS Wales to address the actions set out in the Statement of Intent. We therefore base our recommendations around ensuring that national implementation adequately addresses the challenges identified through our work and the Statement of Intent.

Recommendations

The national challenges facing radiology services across Wales are reflected in the Imaging Statement of Intent and appropriate action has been identified. However, delivery against these actions is reliant on a timely national imaging implementation plan being developed and acted upon.

R1 The Welsh Government, through the Imaging Taskforce, should ensure that the national imaging implementation plan addresses each of the actions set out in the Imaging Statement of Intent, and the key challenges highlighted in this report.

R2 The national implementation plan should include clear implementation dates to deliver action in the short to medium term, with clearly identified accountabilities for delivery.

R3 The Welsh Government should properly cost the implementation plan and ensure that the necessary resources are in place to support delivery.

R4 The Welsh Government should ensure the necessary arrangements are put in place to monitor delivery of the national implementation plan.

Part 1

Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results

Demand for radiology imaging is increasing annually, and in particular for the most complex scans

1.1 The growing role of radiology in clinical care has led to increasing demand for radiological examinations. A number of factors drives the increase in demand. This includes demographic changes, new clinical guidelines, lower thresholds for referral, and advances in technology and understanding about how the features of disease present themselves on diagnostic images.

1.2 In Wales, the total number of diagnostic radiology examinations undertaken per year increased by 9% between 2013-14 and 2016-17[8] (Exhibit 3). In addition, scans are becoming more complex. The biggest percentage rise in volume for radiological examinations has been for CT and MRI imaging due to an increase in their role in the early diagnosis of many diseases. Between 2013-14 and 2016-17, the number of CT scans undertaken per year increased by 33% and the number of MRI scans increased by 28% (Exhibit 3). MRI and CT examinations are complex and can include multiple images, and therefore, per patient examination, are more labour-intensive for radiologists interpreting images than other examinations, such as X-rays.

Exhibit 3: increase in demand for CT, MRI, US and X-ray imaging between 2013-14 and 2016-17

	2013-14	2014-15	2015-16	2016-17	Percentage increase 2013-14 to 2016-17
CT	235,861	256,935	284,672	313,947	33%
MRI	97,929	109,506	119,066	126,335	29%
Plain film X-ray	1,291,395	1,279,348	1,299,609	1,281,067	-1%
Total ultrasound	409,363	419,378	444,540	468,361	14%
All others	120,532	143,956	144,203	153,941	28%
Total examinations	2,155,080	2,209,123	2,292,090	2,343,651	9%

Source: NHS Benchmarking Network

8 These figures are based on data provided by five health boards who participated in the NHS Benchmarking Network review of radiology services. Hywel Dda University Health Board and Powys Teaching Health Board did not participate.

1.3 The increase in demand for radiology examinations is not unique to Wales. In England between 2013 and 2016 the number of CT examinations increased by 33% and MRI examinations by 31%, equating to a mean annual growth of just over 10%[9].

Patients on waiting lists are prioritised according to clinical urgency, and emergency access for radiology examinations in normal working hours is good, but emergency access out of hours is variable

1.4 While most radiology departments offer some form of open access to patients referred to the department as outpatients, the extent of access varies and typically is limited to X-rays only. Where open access is not available, patients are placed on a waiting list. The referral should specify the degree of urgency. This ensures that the patients with the most critical needs are seen first. The referrer assigns the urgency.

1.5 All health boards operate three priority levels for outpatients: urgent, urgent suspected cancer and routine. Urgent referrals are prioritised and seen as soon as they can be accommodated.

1.6 In all health boards, radiologists or appropriately trained advanced practice radiographers review the priority of the referral using the clinical information provided by referrers. The priority of the referral may be amended following review. This system ensures waiting lists are based on clinical priority.

1.7 However, only two health boards operate a centralised waiting list within the health board. Five health boards have separate radiology waiting lists in different parts of the organisation. By maintaining more than one waiting list, health boards are failing to manage demand on an organisation-wide basis, with the result that some patients may wait longer than they would have if they had been on a single waiting list.

1.8 Inpatients with emergency health needs may need prompt access to a radiology examination both within and outside of normal working hours. During normal working hours, all health boards told us they set aside a small number of appointments to accommodate emergency inpatient referrals, based on historic demand. However, the unpredictable nature of emergency demand means that sometimes, too much or too little time is allowed in the appointment timetable.

9 NHS England, Diagnostic Imaging Dataset (accessed 24 August 2017).

1.9 Out of hours provision is based on staff working on call rotas. At the time of our review, access to out of hours examinations for inpatients with urgent healthcare needs was variable across health boards. CT scans and X-rays were available out of hours at the majority of hospital sites, and at least one hospital site at each health board provided cover. However, out of hours MRI scans and US scans were not available in three health boards.

The percentage of patients waiting more than eight weeks for an examination has fallen in the last five years, waiting time performance has been helped by securing additional scanning capacity from the private sector

1.10 All NHS bodies in Wales are required to comply with the Welsh Government diagnostic waiting times target which states that no patients should wait more than eight weeks to receive their diagnostic test[10].

1.11 Since 2009, waiting times for radiology examinations have also formed part of the referral to treatment target[11], where the referral for radiology has been made as part of the patient pathway. Health boards in Wales are required to ensure that 95% of all patients waiting for elective treatment receive their treatment within 26 weeks from the point at which the referral was received. For many of these patients, diagnostic tests help decide which treatment is the best option.

1.12 In March 2018, there were no patients waiting more than eight weeks for a diagnostic radiology examination at three health boards. However, there were patients waiting more than eight weeks for a radiology examination at Aneurin Bevan, Betsi Cadwaladr and Cardiff and Vale University Health Boards, and Powys Teaching Health Board[12]. Exhibit 4 provides the number of patients that had been waiting more than eight weeks at the time of our review, and in March 2013 and March 2018.

10 The diagnostic waiting time target applies to all radiology examinations including MRI, CT, and non-obstetric US, fluoroscopy, barium enema, and nuclear medicine. The Welsh Government target does not include X-rays.

11 Welsh Health Circular (2007) 014 – Access 2009 – Referral to Treatment Time Measurement, Welsh Health Circular (2007) 051 – 2009 Access – Delivering a 26 Week Patient Pathway – Integrated Delivery and Implementation Plan and Welsh Health Circular (2007) 075 – 2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways.

12 Abertawe Bro Morgannwg, Betsi Cadwaladr, Hywel Dda University Health Boards and Powys Teaching Health Board. Powys Teaching Health Board provides plain X-ray and US examinations only, other imaging and interventional procedures are commissioned from a range of providers in neighbouring health boards in Wales and NHS trusts in England.

Exhibit 4: all-Wales waiting times for CT, MRI and non-obstetric US scans[1]

		Total number of patients waiting for an examination					
		Up to 8 weeks	Over 8 weeks and up to 14 weeks	Over 14 weeks and up to 24 weeks	Over 24 weeks	Total waiting	Percentage of patients waiting more than 8 weeks
CT scan	March 2013	6,777	159	61	5	7,002	3%
	August 2016[2]	7,301	63	51	11	7,426	2%
	March 2018	8,054	9	1	1	8,065	0%
MRI scan	March 2013	11,087	2,520	2,241	278	16,126	31%
	August 2016[2]	11,662	913	66	163	12,804	9%
	March 2018	10,662	121	59	62	10,904	2%
Non-obstetric US scan	March 2013	19,454	3,110	867	7	23,438	17%
	August 2016[2]	18,944	1,999	626	133	21,702	13%
	March 2018	20,097	13	0	0	20,110	0%

Notes:

1 Waiting time targets do not apply to X-rays as most health boards provide open access for X-ray examinations.

2 Waiting time data reported in our local reports.

Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

1.13 Exhibit 4 shows that waiting time performance has improved over the last five years, although there have been fluctuations in performance (Appendix 2). Generally, the month 12 performance has shown an improvement compared to the full year's performance in general. The improvement is a result of a concerted effort by health boards to meet waiting time targets, often funded with additional Welsh Government monies. Whilst the waiting time target applies all year around, performance monitoring tends to focus on the year-end performance as opposed to performance during the year.

1.14 Health boards have achieved reductions in waiting times for radiology examinations over the last five years by securing additional scanning capacity by outsourcing imaging to private sector mobile CT and MRI units, and utilising unused capacity in other health boards. In 2014, the Welsh Government provided £840,000 to radiology services across Wales to reduce the backlog of patients waiting more than eight weeks for an MRI examination[13]. Since then, health boards have funded initiatives to keep waiting times within the eight-week target by outsourcing examinations and increasing radiology opening hours.

Whilst average reporting turnaround targets were largely being met, some patients waited more than six months for results, and health boards were unable to make full use of their reporting capacity

1.15 A report outlining the interpretation of the image must be produced following a radiology examination. This report is then used to make further decisions about the ongoing care of the patient.

1.16 All examinations must be reported and provided to the referring clinician within a timeframe appropriate to the patient's clinical condition. The Welsh Reporting Standards for Radiology Services 2011 were produced in order to clarify previous guidance and regulations[14]. The Standards range from same-day to ten working days.

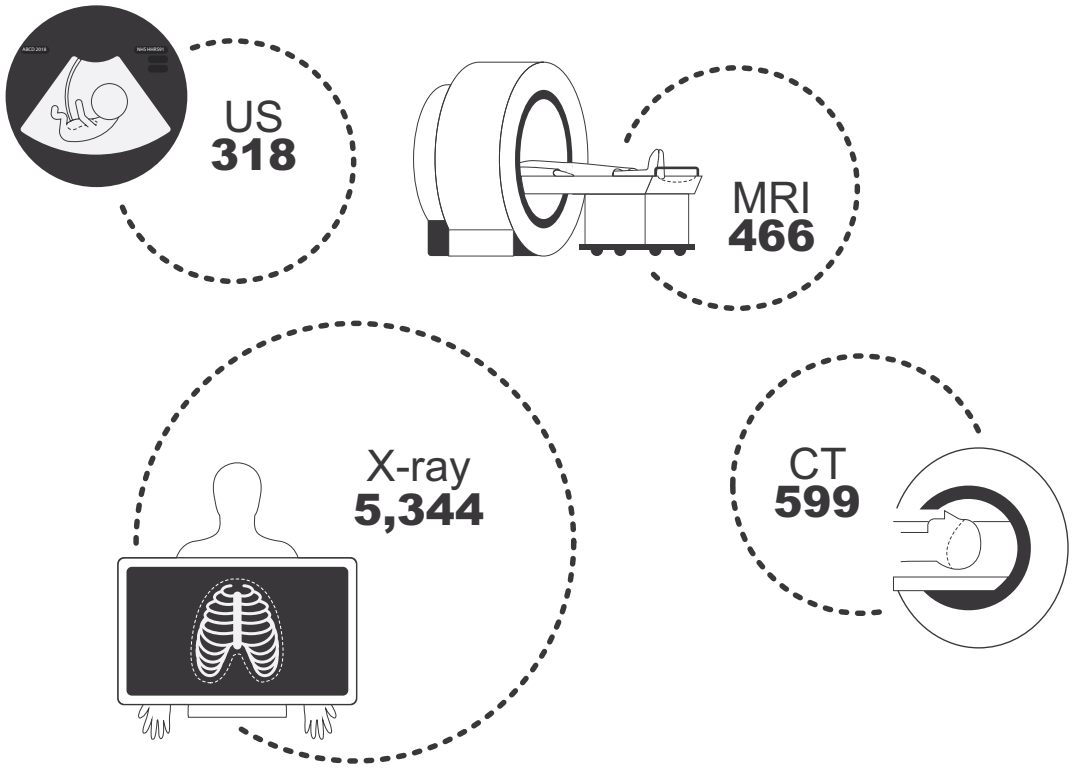
13 In January 2014, 41% (7,179) of patients waiting for an MRI had been waiting more than eight weeks, 1,463 patients had waited more than 24 weeks.

14 Produced by the Medical Imaging Sub-committee (a sub-group of the Welsh Scientific Advisory Committee). The Reporting Standards for Radiology Services 2011 set out that radiology should aim to provide reporting turnaround times appropriate to the type of referral as follows: urgent – immediately/same working day; inpatient – within one working day; accident and emergency – within one working day; GP – within three working days; and outpatient – within ten working days.

1.17 We asked health boards to provide the average and longest reporting times and the number of unreported examinations for CT, MRI, US and X-ray imaging by hospital. The type of referral (for example urgent, inpatient, GP) is not routinely available. The average reporting time between 1 April 2015 and 31 March 2016 for each type of scan was 10 days or less at all but one of the hospitals participating in the review[15]. However, local audit work found that some patients wait a long time for their scan to be reported. At the time of the audit, the longest report turnaround time was over six months. Exhibit 5 shows the number of unreported examinations at the end of March 2016. Whilst these represent less than 1% of the total examinations undertaken, they nonetheless show that a notable number of examinations have delayed reporting or are not reported at all, with associated quality of care risks to patients from delayed diagnosis and treatment.

Exhibit 5: number of examinations not reported as at 31 March 2016 across Wales[1]

Total for hospitals participating in the review



Note:

1 Unreported examinations include those examinations that remain unreported more than 10 days since the examination date. The figures exclude Cardiff and Vale University Health Board and Powys Teaching Health Board.

Source: Wales Audit Office, Hospital Site Survey

15 One hospital told us that the average reporting time for X-rays was 16 days.

1.18 Whilst radiologists report most images, specially trained radiographers provide additional reporting capacity. Extended practice radiographers (EPRs) receive training to interpret and report some types of images, typically less complex scans, such as X-rays, and sonographers report US scans.

1.19 Whilst all health boards, with the exception of Powys Teaching Health Board, have invested in EPRs, at the time of our review shortages in the radiology workforce across Wales was making it difficult for health boards to utilise EPR reporting skills. Our review found that resourcing constraints in the radiologist workforce meant that opportunities to train and support EPRs were limited. Similarly, radiographer shortages has resulted in health boards being unable to release EPRs from undertaking examinations, to enable them to report images, resulting in reduced reporting capacity within health boards.

1.20 Radiologist staffing shortages and the resulting reduction in EPR reporting capacity led to the introduction in November 2014 of a national contract to provide additional, outsourced reporting capacity from the private sector. Radiology Reporting Online Limited was awarded a contract to provide reporting capacity across Wales. The contract was initially for a two-year period, with an option to extend the contract for an additional year. The contract value was £1.5 million (excluding VAT) for the initial two-year period. However, increasing demand, particularly for CT and MRI reporting, resulted in the service being used significantly more than predicted with the actual spend across the initial two-year contract being £3.5 million excluding VAT. The contract was subsequently extended until November 2019, at a cost of £11 million over the three-year extension. At the time of our review, outsourced reporting capacity bridged the gap created by staff shortages, but is not a sustainable solution for the long-term.

Part 2

Workforce challenges are threatening the sustainability of the service and limiting health boards' ability to train and appraise staff

All but one health board is struggling to recruit and retain radiology staff, resulting in a reliance on locums

2.1 Radiologist, radiographer and sonographer vacancy levels compound the ability to meet increasing demand for radiology examinations. On 31 March 2016, there were 112 full time equivalent (FTE) vacancies within radiology departments across four health boards in Wales (Exhibit 6).

Exhibit 6: number of radiology staff vacancies in Wales as at 31 March 2016[1]

	Radiologists	Radiographers/ sonographers	Other radiology staff[3]
Number of FTE vacancies	22	58	32
FTE vacancies as a percentage of the FTE establishment[2]	15%	9%	6%

Notes:

1 The figures are based on four health boards. Cardiff and Vale, Cwm Taf University Health Boards and Powys Teaching Health Board did not provide their vacancy levels.

2 The FTE staffing establishment is the level of staff that the Health Board has determined it needs to provide services and for which funding has been made available.

3 Other radiology staff includes staff such as nurses, scientific and technical staff, healthcare support workers and administrative staff.

Source: Wales Audit Office, Hospital Site Survey

2.2 Whilst vacancy levels were reasonably consistent across the health boards providing data, there were particularly high radiologist vacancy levels at Hywel Dda University Health Board with 42% of FTE establishment posts vacant. The relatively high vacancy rate for radiologists shown in Exhibit 6 creates particular challenges. Many radiologists specialise in a particular area, meaning that the loss of a single radiologist can have a big impact on a radiology department. For instance, at the time of our review there were two interventional radiologist posts in Cwm Taf University Health Board, however, only one was filled. The vacancy put the interventional radiology service under considerable pressure and resulted in restricted out of hours interventional radiology cover. Across Wales, there is a shortfall of consultant radiologists in interventional, breast, paediatric and nuclear radiology specialties. The level of radiologist vacancies is not unique to Wales. Across the UK, the number of unfilled consultant radiologist posts in 2016 was 9%, compared with 13% in Wales[16].

2.3 Whilst vacancy levels were high at the time of the audit, the age profile of staff working in radiology services creates further challenges in terms of retirement and succession planning. As at June 2018, 38% of consultant radiologists and 34% of radiographers and sonographers in Wales were aged 50 or over (Exhibit 7).

Exhibit 7: number and percentage of consultant radiologists and radiographers in Wales by age group as at June 2018

	Age					
	Under 39	**40–44**	**45–49**	**50–54**	**55–59**	**60+**
Consultant radiologists[1]	27	36	41	23	15	26
	(16%)	(21%)	(24%)	(14%)	(9%)	(15%)
Radiographers[2]	535	98	84	147	133	86
	(49%)	(9%)	(8%)	(14%)	(12%)	(8%)

Notes:

1 NHS workforce definition: staff with consultant grade code or job role working in radiology – note this includes both diagnostic and therapeutic radiologists.

2 NHS workforce definition: Staff bands 5–9 with a diagnostic radiography occupation code (S*F).

Source: NHS Wales Workforce, Education and Development Services, NHS workforce census data for June 2018

16 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2016 Report, 2017.

2.4 For the period 2016-2021, consultant workforce attrition due to retirement is likely to be higher in Wales than in any other part of the UK. Around 30% of consultants in Wales are expected to retire, compared to 22% for the UK as a whole (based on an assumed retirement age of 60)[16].

2.5 At the time of our review, all health boards, other than Cardiff & Vale University Health Board, told us that they found recruiting both radiologists and radiographers challenging. More than one health board told us that some adverts for radiology posts had received no suitably qualified applicants.

2.6 Our review found that health boards across Wales were making use of locum staff to bridge staffing gaps, although this was not successful in covering all the vacant posts with 35 FTE locums recruited compared to 112 FTE vacancies[17].

2.7 NHS Wales has experienced particular challenges in securing sufficient trainee radiologists and then retaining those staff in Wales. In 2015, compared to other parts of the UK, Wales had the lowest proportion of trainees to consultant radiologists; 25% in Wales compared to 38% across the UK[16], and NHS Wales has previously lost two out of every five trainees to England or countries outside of the UK[18].

2.8 In response to the challenges facing the radiology workforce, the National Imaging Programme Board developed a business case for a National Imaging Academy for Wales (the Academy) to be based in Bridgend. The Academy is a collaboration between health boards to provide a bespoke training facility for at least 20 trainee radiologists a year, with trainees splitting their time between the Academy and clinical placements in hospitals across South Wales. The Welsh Government has funded initial set up costs, and the health boards will meet the annual running costs. Initially, the Academy will train radiologists; however, later will also train enhanced practice radiographers, sonographers and other imaging professionals to report images.

16 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2016 Report, 2017.

17 The FTE of locums is based on the average FTE of locum use between 1 Oct 2015 and 31 March 2016, and FTE vacancy levels at 31 March 2016. Includes all staff groups, and is based on five health boards, Wales Audit Office, Hospital Site Survey.

18 NHS Wales, NHS Wales Health Collaborative Diagnostic Services Modernisation Programme, December 2015.

2.9 The Academy combines training and provides a reporting facility across Wales. The Academy is intended to address the recruitment challenges experienced across Wales, and may help to reduce the reliance on outsourced reporting in future years. However, whilst the Academy opened in 2018, it will take a number of years before the first trainees have completed their training. The first cohort of trainees have been recruited, and the full cohort of 22 trainers have been appointed to the Academy.

2.10 Whilst in the long-term the Academy should increase the number of trained radiologists in Wales, our local work found that radiology services were also planning to amend their staffing models to increase their reporting capacity. Health boards were planning to train more radiographers and other appropriate staff groups, such as cardiologists, to report examinations. Using a different staff mix to report examinations will help to reduce health boards' reliance on radiologists. In addition, we found that health boards were reviewing the skill mix of their staff to explore opportunities to make more use of non-professional grades, such as assistant practitioners, to help provide additional capacity for imaging (whilst working under supervision) to help bridge radiographer staffing shortages.

Operational pressures and staffing constraints are limiting health boards' ability to train staff

2.11 Annual staff appraisals and continuing professional development (CPD) reviews are an important part of ensuring that the quality of radiology services is maintained and that staff training needs are properly addressed. We asked health boards to provide us with the percentage of staff that had received an appraisal and a CPD review. Across Wales, at least 75% of radiologists, radiographers and other radiology staff had received an appraisal or a CPD in 2015-2016.

2.12 However, not all staff are compliant with statutory and training modules[19]. In 2015-2016, there was variation in the percentage compliance rates between staff groups and modules across health boards. One health board told us that only 48% of radiographers were compliant with Moving and Handling Training, and another health board told us that only 33% of radiographers were up to date with Information Compliance Training. Some health boards told us that they had been unable to maintain compliance with mandatory training and were struggling to achieve higher rates of annual appraisals and CPD reviews due to staffing constraints. Non-compliance with statutory and mandatory training could present a risk to staff members, patients and ultimately health boards.

19 The statutory and mandatory training modules are set out in the UK Core Skills and Training Framework. They are: Equality, Diversity and Human Rights; Health, Safety and Welfare; Fire Safety; Infection Prevention and Control; Moving and Handling; Safeguarding Adults; Safeguarding Children; Resuscitation; and Information Governance.

Part 3

Ageing and underutilised equipment is making it harder for health boards to meet demand, and health boards do not have the staffing resources to extend opening hours

3.1 Health boards must ensure their radiology equipment capacity and specifications meet increasing demand and advances in both clinical practice and technical sophistication.

All health boards have equipment nearing the end of their lifespan

3.2 Comprehensive arrangements are required for the maintenance and replacement of radiology imaging equipment. Older imaging equipment has a higher risk of failure and maintenance costs increase. Image quality also declines with age. Radiology equipment more than ten years old is typically considered to no longer be state of the art and technical advances render the equipment obsolete[20]. In addition, the lifespan of radiology imaging equipment shortens with increased use.

3.3 In November 2015, NHS Wales estimated that 87% of imaging department scanners would require replacement by 2017[21]. We asked health boards to provide us with the age of their CT, MRI and US scanners as at September 2016 (Exhibit 8).

Exhibit 8: age of CT, MRI and US imaging equipment across Wales as at September 2016[1]

		CT	MRI	US
Median scanner age (years):		5	7	4
Number of scanners:	aged up to 6 years	17	9	105
	aged between 6 and 10 years	6	7	9
	aged over 10 years	1	2	1
	total	**24**	**18**	**115**

Note:

1 Based on equipment in five health boards for CT and MRI scanners, and six for US scanners. Aneurin Bevan University Health Board did not provide data. Powys Teaching Health Board has US scanners, but no CT or MRI scanners.

Source: Wales Audit Office, Radiology Equipment Age Survey; and European Society of Radiology

20 The European Society of Radiology advocates that equipment aged: up to five years old reflects the current state of technology, and can be upgraded; between six and ten years old is fit to use if properly maintained, but require replacement strategies to be in place; and 11 or more years old requires replacement.

21 Diagnostic Service Programme NHS Wales, All Wales Gantry (MRI, CT, Gamma Camera and Ultrasound) Usage/Capacity, November 2015.

3.4 In September 2016, 17% of US scanners in Wales were six or more years old. However, 29% of CT scanners and 50% of MRI scanners were six or more years old. Our review identified two 13 year-old MRI scanners, and one 11 year-old CT scanner. Staff at all health boards identified ageing radiology equipment in need of replacement. One health board told us about an ageing CT scanner which regularly broke down (approximately every eight weeks). As the only CT scanner in that hospital, the regular disruption was affecting the care of critically ill patients and resulting in the cancellation of outpatient appointments. Since our local work, the CT scanner has been replaced.

3.5 It is essential that health boards have equipment replacement plans to identify how and when imaging equipment will be replaced. Our review found that whilst six health boards has a radiology equipment plan, all health boards were struggling to identify finances to replace and purchase additional radiology equipment.

3.6 MRI and CT scanners cost upwards of £800,000. Historically, health boards have relied on capital funding from the Welsh Government to buy replacement and additional radiology imaging equipment. In 2014, the Welsh Government provided funding for £8.5 million between five health boards to purchase new and replacement CT, MRI and mammography equipment.

3.7 At the end of 2016, the Welsh Government announced £16 million of funding to provide additional and replace out of date radiology imaging equipment. The funding was allocated across all health boards and Velindre NHS Trust for CT, MRI, mammography, US and X-ray equipment.

3.8 Since our review, the Welsh Government has provided a further £9 million for imaging equipment in health bodies, and to support the development of the Imaging Academy. The Welsh Government is working with NHS organisations to identify and prioritise further additional imaging investment over the period 2018-19 to 2020-21.

3.9 When replacing aging equipment, it is essential that health boards adequately plan for the installation of the new equipment. CT and MRI scanners are large, and the cost of installation can be as much as the cost of the scanner. Where a new scanner is required to replace existing equipment, the downtime can be considerable. In addition, where the new scanner is in addition to existing scanners, an extra room may be required to house the scanner, and this can cause considerable disruption and be costly. In 2016, two of the CT scanners financed by the Welsh Government in 2014 remained in storage because the health boards who were receiving them had struggled to identify finances to modify their buildings to install the equipment. Since our review, the two CT scanners have been put to use.

3.10 The Statement of Intent recognises that a national coordinated approach is needed to plan, identify and address imaging equipment needs. The Statement of Intent sets out that planning is required on a regional level with additional scanners providing extra capacity for regions, rather than a single health board. In 2016, the Welsh Government announced an additional £6 million for a Diagnostic Hub at the Royal Glamorgan Hospital (Cwm Taf University Health Board) which included funding for a replacement CT scanner and an additional MRI and CT scanner, to serve the needs of the South Wales area. The Diagnostic Hub opened in February 2018, and Cwm Taf University Health Board have reported that it provides additional capacity of approximately 7,200 MRI scans and 6,600 CT scans a year. A Regional Planning and Delivery Group established in October 2017, is overseeing the Diagnostic Hub and rollout of wider regional solutions across the South Central and East Wales region.

Whilst there are opportunities to increase imaging capacity with existing equipment by increasing the operating hours, this would have a significant impact on resourcing

3.11 One way for health boards to shorten waiting times for radiological examinations, particularly diagnostic radiography scans is to maximise the opening hours, and thus increase the number of available appointments. The longer the operating hours, the more patients can be seen; however, there are additional costs associated with this.

3.12 In 2014, NHS Wales undertook a review of the operating hours of CT, MRI and US scanners in Wales (Exhibit 9).

Exhibit 9: percentage usage of CT, MRI and US scanners in 2014, averaged across Wales, 2014

Type of scanner	Average number of operating hours per scanner per day		Percentage usage of equipment[1]
	Monday to Friday	Saturday to Sunday	
CT	8.7	0.7	52%
MRI	10.6	2.1	67%
US	7.7	0.0	46%

Note:

1 Based on the planned operating hours as a percentage of potential operating hours (seven days a week and 12 hours a day).

Source: NHS Wales, All-Wales Gantry Usage/Capacity Report, November 2015. Data based on the operating hours in 2014

3.13 In 2014, if all CT, MRI and US scanners across Wales had operated 12 hours a day and seven days a week, we estimate that it may have been possible to undertake at least an extra 1,340 CT examinations, 1,110 MRI examinations and 4,630 US examinations a week[22].

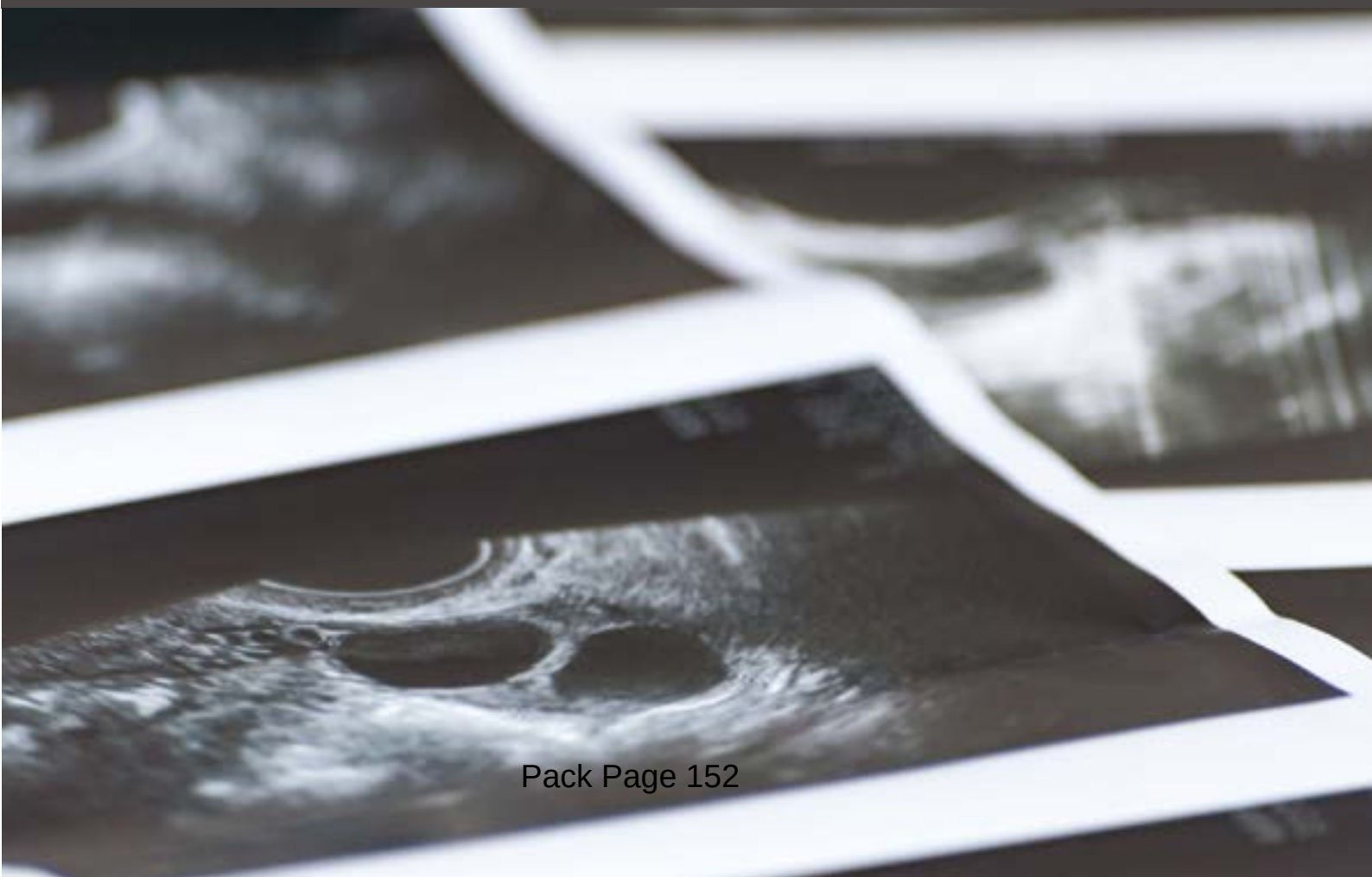
3.14 Since then, health boards have increased the number of operating hours of CT and MRI examinations on weekdays and weekends. Health boards have achieved the increase in operating hours largely by staff undertaking shift work. However, at the time of our review, only one health board was providing CT and MRI examinations for at least 12 hours a day over seven days a week at each hospital site. The standard operating hours across the other health boards varied. Out of 17 hospital sites surveyed, on weekdays, only seven provided CT examinations for 12 or more hours a day, and 10 provided MRI examinations for 12 or more hours a day. On weekends, only two hospital sites provided CT examinations for 12 hours a day and the same number provided MRI examinations for 12 hours a day (the same two hospitals). None of the hospitals provided US services 12 hours a day on weekdays or weekends, and only one hospital provided US examinations as standard on weekends.

22 The time an examination takes depends on the nature of the examination required. CT examinations can take between 10 and 45 minutes, MRI examinations between 15 and 90 minutes, and US examinations between 15 and 30 minutes. Therefore, our estimation is based on a CT examination length of 45 minutes, 90 minutes for MRIs and 30 minutes for a US examination.

3.15 However, extending operating hours is not a simple option for increasing capacity. Extending operating hours would require additional staff, meaning additional cost, and at a time when health boards are already finding it challenging to fill existing vacancies (paragraph 2.2). In addition, higher rates of equipment use results in shortened equipment lifespans, and potentially higher maintenance costs (paragraph 3.2).

Part 4

Wales-wide radiology IT system challenges and weaknesses in local IT infrastructure inhibit radiology services' efficiency



The core radiology management system is not serving health boards' needs, and this is further impeded by weaknesses in local IT infrastructures

4.1 Having effective ICT systems plays a central role in delivering efficient radiology services. In Wales, the Radiology Information System (RADIS) is a national system developed and run by NHS Wales Informatics Service. All health boards use RADIS. RADIS supports the scheduling of radiology investigations, provides a clinical record of scans received by patients and allows health boards to generate reports and statistics on performance. Other systems link to RADIS to provide additional functionality; these different systems must integrate with each other to ensure that information easily transfers and updates between systems.

4.2 Our review found that across Wales, health boards had mixed views on RADIS. Despite RADIS 2 being rolled out in 2005, at the time of our review three health boards were running separate instances[23] of RADIS, and a further two health boards were using a mixture of RADIS and alternative core radiology systems. Having numerous instances of RADIS or alternative systems, is a consequence of NHS reorganisation during the latter half of the 2000s. Hospitals that were part of separate organisations are now part of the same health board, but the separate infrastructure remains in place in some areas. Work is ongoing to provide a single instance of RADIS in all health boards.

4.3 Having separate instances of RADIS is time consuming for clinicians and makes it difficult to plan and deliver services across the whole health board. For example, if a patient has a scan in one hospital, another hospital in the same health board will not have a record of it. Having multiple instances of RADIS also makes it difficult to retrieve management information, as this has to be done separately for each instance and then consolidated into one report manually.

23 An 'instance' refers to a separate database that is specific to a particular location. It is used in order to differentiate from 'versions', which refer to updates and upgrades. For example, two hospitals could have the same version of RADIS, ie they are both equally up to date, but they would still have separate instances because staff in one hospital would not be able to access the records held in the other. Separate instances mean that clinicians cannot access patient information across administrative or geographical boundaries.

4.4 Whilst, some health boards told us they felt that RADIS is adequate in terms of patient scheduling, clinical reporting and management reporting, other health boards expressed doubts in the reliability of the reports produced, and said that they were unable to create bespoke reports in-house. In addition, health boards expressed concerns that RADIS does not integrate with other systems in use by health boards, meaning that changes to information in RADIS had to be updated manually in other systems.

The current absence of a fully functional e-referral system and weaknesses in picture archiving systems and voice recognition systems are creating inefficiencies in the service

4.5 In addition to the core radiology system, other systems are required for each stage of the patient journey, including electronic referrals, archiving of images and providing a record of the report.

4.6 Electronic requesting systems can enable clinicians referring patients for diagnostic imaging to request and receive updates and the outcomes of radiology requests quickly. At the time of our review, the functionality of request software was generally limited to providing a template for a request, which then has to be emailed to the radiology service. The absence of an e-referral system across Wales means that the vast majority of referrals are paper based. Paper based referrals can be problematic, creating more administration because all referral forms have to be scanned and there is the risk that sections are not fully completed or legible.

4.7 Once the examination has been undertaken, radiologists create a report to record their interpretation of the image. When reporting on images, radiologists can choose to use voice-activated dictation systems to record their report. Across Wales, health boards were generally dissatisfied with voice-activation dictation systems. Whilst some health boards used the dictation software built into RADIS, others were using alternative systems. Staff in some health boards indicated that IT network weaknesses meant that dictation systems were prone to freezing and timing out. The consequence of dictation software timing out is that all reports dictated in a session are lost and need to be repeated, leading to frustration and inefficient working.

4.8 All images must be archived. Picture Archiving and Communications Systems (PACS) acquire and archive radiology images, and enables the safe distribution of the image to other health professionals[24]. The report of the image (stored on RADIS) and the scan image (stored on PACS) together comprise the clinical record of the image. Whilst we found that health boards were generally satisfied with their PACS, there was variation in accessibility to PACS images. All health boards told us that radiologists and other hospital staff working within the health board could access images. However, not all radiologists can access PACS images remotely out of hours, and access for GPs and other NHS staff working in other locations was limited.

4.9 Work is ongoing to roll out the full functionality of the Welsh Clinical Portal across Wales. The Welsh Clinical Portal is a digital workspace, which allows the sharing of medical information between professionals securely. When fully functional, the system will provide an electronic platform for sharing information across Wales, including test results and allow electronic patient referrals. The system is being rolled out in a phased approach, with health boards implementing the different elements of the system in a timeframe that is manageable for the individual organisation. The Welsh Government has formed a Welsh Technical Standards Board to support the creation and maintenance of a catalogue of standards and requirements to enable integration and interoperability across all health and care systems in a consistent and secure manner.

4.10 The Statement of Intent has set out a vision for high quality radiology informatics systems to be developed with a secure IT infrastructure that operates across Wales. The vision is for systems that allow electronic referrals, review, processing and reporting through standardised software and that are interoperable, to allow the safe transfer of care between hospitals and allow imaging sharing across Wales.

24 A third party, Fujifilm, provides PACS. Fujifilm supplies hardware and software to health boards for the provision of PACS services, including voice recognition and full disaster recovery solutions. Each health board provides the necessary infrastructure to run those services, including networks and server space.

Part 5

Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services

Most health boards need to strengthen strategic and operational planning

5.1 Health boards should clearly set out their strategy for meeting current and future demand for radiology services. Service changes and developments in the wider organisation should inform radiology operational plans. Almost all clinical specialties rely heavily on radiology to help diagnose, treat or monitor disease or injury. When health boards are planning service changes that may lead to an increase to the number of patients referred for radiology imaging, they must ensure that they adequately consider the impact on radiology departments.

5.2 At the time of our review, only three health boards undertook demand and capacity modelling. Across Wales, our review found that there was variation in the degree to which radiology teams were involved in decisions about service changes that affected radiology services.

5.3 Each radiology service should have an agreed documented annual operational delivery plan. The operational plan(s) should clearly identify service demand, the workforce and equipment capacity required to meet this demand as well as the finances available and required to deliver the service safely, efficiently and effectively. Our review found that whilst one health board had a five-year strategic plan, four health boards did not. Four health boards did not have operational plans, and two health boards had neither a strategic nor an operational plan. Not all health boards had clearly set out their workforce needs. Only one health board had a specific, detailed financial plan for radiology, with other health boards financial planning being informed by the previous year's expenditure. Our local work found financial expenditure in four health boards exceeded the budgeted expenditure, which may be a symptom of the absence of adequate financial planning.

Nearly all health boards are taking positive steps to reduce inappropriate referrals, however, signposting to local referral guidance could be improved

5.4 GPs and consultants refer patients to radiology. Ensuring that patients are referred for the most appropriate diagnostic investigation depends on clear guidance and standards. Each inappropriate investigative image performed is, in effect, an example of valuable NHS resources being wasted. Encouragingly, all health boards told us that they return inappropriate referrals to consultants with an explanation for the refusal. In addition, six health boards regularly undertake audits to highlight patterns of inappropriate referrals.

5.5 All health boards use the Royal College of Radiologists' iRefer[25] guidance although at the time of our review, some consultants told us they found it difficult to access iRefer guidance. Since our review, iRefer has been made available via the NHS Wales e-library, providing access to all Welsh NHS professionals.

5.6 Most health boards had also developed supplementary local guidance. Although in the sample of consultants we interviewed many said that they were unaware of local guidance highlighting a need for better signposting and awareness raising in respect of these documents.

All health boards review the clinical performance of their radiology service, although there are opportunities to increase the range of reviews undertaken

5.7 Radiology services must ensure that clinical performance always meets the appropriate standards for patient treatment and care. They need to comply with the **National Diagnostic Imaging Framework**[26] and monitor clinical performance to ensure compliance. Radiology services must ensure that their practices are safe and comply with the Ionising Radiation Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017.

5.8 At the time of our review, all health boards had good arrangements in place to learn from incidents, errors and complaints, and the reporting of incidents is encouraged. All health boards had a regular programme of audits to assess service quality, however, there were opportunities for all health boards to increase the range of audits they undertook (Exhibit 10).

25 iRefer is a radiological investigation guidelines tool from The Royal College of Radiologists.

26 Welsh Government, National Diagnostic Imaging Framework, 2009

Exhibit 10: number of health boards undertaking regular audits of quality and clinical performance

	Number of health boards undertaking regular audits[1]
Appropriateness of referrals	6
Appropriateness or urgent and/or out of hours referrals	5
Quality of written requests	5
Demand levels by time of day/day of week	4
Demand levels by GPs/hospitals	6
Accuracy of reporting	7
Reporting turnaround times	6
Lost and late reports	3

Note:

1. Health boards were asked to indicate whether they undertake the audits listed in the review.

Source: Wales Audit Office, Health Board Survey

5.9 Whilst five health boards regularly undertook patient experience surveys, the other two health boards did not and should review arrangements to learn from patient experiences.

5.10 The Imaging Services Accreditation Scheme (ISAS) is a patient-focused accreditation scheme that helps imaging services to manage the quality of their services and make continuous improvements. In Wales, the National Imaging Programme Board is overseeing the introduction of ISAS. However, progress at individual health bodies has been limited by a lack of staff resources to enable coordination of the work associated with the accreditation process. Since our review, Betsi Cadwaladr University Health Board commenced a two-year pilot exercise to attain ISAS accreditation. The exercise will be used to identify how best to roll out ISAS across Wales.

In most health boards we identified opportunities to widen the range of operational performance measures reported

5.11 Effective monitoring and scrutiny of radiology service performance is important in assessing if the service is delivering its organisational goals and objectives, and identifying the need for remedial action. Health boards should use performance data and audit results to monitor and evaluate the performance of their radiology departments. Performance monitoring and review should take place at all levels within the organisation, from operational level to board level.

5.12 Our review found that whilst all health boards regularly review performance information about their radiology services, there was variation in the range of performance information reported. All health boards regularly viewed radiology waiting times data and incidents data. Most health boards regularly reviewed a range of workforce performance measures on appraisal and compliance with training rates, sickness levels, and planned versus actual staffing levels. However, not all health boards reported key information such as capacity versus demand and reporting turnaround times. All heath boards had scope to further develop the range of performance measures to support business reports by reviewing existing measures and identifying gaps.

5.13 Five[27] health boards in Wales are members of the radiology NHS Benchmarking Network (NHSBN). The NHSBN undertakes an annual radiology survey of approximately 85 radiology departments across the UK. The survey collects data and allows participants to compare a range of measures relating to staffing and activity levels. Despite the range of information available, the use of benchmarking comparative data in business reports was limited across health boards.

5.14 One of the challenges for health boards when comparing their performance with other health boards is the absence of a standardised radiology activity measurement. When measuring radiology activity, care is needed to ensure that comparisons are like for like. A single image may count as one unit of activity. However, where a patient receives complex or multiple images this may count as one or more units of activities depending on a health board's view.

27 Hywel Dda University Health Board told us it does not participate in the network because it does not have the administrative capacity to complete data collection returns. Powys Teaching Health Board does not participate because comparative data for the health board is limited due to the differences in the radiology service.

5.15 In the absence of standard activity count, the medical classification system, the Systematised Nomenclature of Medicine Clinical Terms (SNOMEDCT), has enabled some activity measurement. SNOMEDCT in an international classification system that allows clinical data to be recorded in a consistent way, as it uses a standardised set of clinical terminology and codes. NHS England is adopting SNOMEDCT as the universal classification and terminology for all health organisations and for all aspects of health. In Wales, SNOMEDCT has only been adopted in radiology and a small number of other specialties. SNOMEDCT automatically applies multiplication for some activities depending on the coding applied. However, comparisons of activity between radiology departments has to be treated with caution as any count of activity is reliant on organisations recording activity using SNOMEDCT consistently. At the time of the audit that was not the case in Wales, meaning that even with SNOMEDCT in place, there were still difficulties in obtaining meaningful comparisons of activity.

5.16 The Statement of Intent indicated that improving radiology informatics systems must incorporate common international procedure codes to improve benchmarking of radiology services. In addition, the Statement of Intent has set out that a common set of performance indicators will be developed to broaden the range of information collated to drive the improvement of quality and consistency of radiology services.

In most health boards, operational management and accountability arrangements are clear

5.17 Effective leadership and clear lines of accountability are vital components of any healthcare service. Radiology is a complex service, which comprises radiologists, radiographers and nursing staff working together to produce and interpret images. For a health board to deliver effective radiology services, it needs leadership, and an operational and professional management structure with clear lines of accountability.

5.18 Radiology team structures and lines of accountability differ in each health board. Generally, our review found that the operational management and accountability arrangements were clear.

Health boards could do more to proactively make their boards aware of the issues effecting radiology services

5.19 Our review found that there was variation across health boards in the degree to which radiology services are represented at board level. Not all health boards had an executive lead for radiology that was a member of the Board. However, our local work found that service managers were invited to provide updates on radiology issues and risks at board committees (and board meetings where appropriate). Whilst this ensures that risks and challenges are highlighted to Boards and Committees when required, the absence of an executive lead for radiology attending board meetings at some health boards may mean the opportunity to highlight and monitor emerging issues is missed.

5.20 The Welsh Government has published a Statement of Intent in response to challenges being faced by radiology services.

5.21 The Welsh Government's Future Delivery of Diagnostic Imaging Services in Wales and the National Diagnostic Imaging Framework provided a set of measures to be taken forward at local, regional and national level to improve radiology services. The National Imaging Programme Board was established in 2010 to take action at an all-Wales level, and comprises clinical and management representatives from organisations involved in the delivery of imaging services in NHS Wales.

5.22 The National Imaging Programme Board was given delegated authority for developing and implementing a programme of strategic work for radiology through to 2016, and for adopting all-Wales standards and protocols for imaging services in NHS Wales. Although the National Imaging Programme Board has made progress, most notably the progress made in setting up the Academy, there remain significant challenges that require strategic input from the Welsh Government.

5.23 In March 2018, the Cabinet Secretary for Health and Social Services published a high-level Imaging Statement of Intent for radiology services. The Imaging Taskforce is developing a national implementation plan to address the actions set out in the Statement of Intent, and the Taskforce is due to report back to the Cabinet Secretary in summer 2018.

5.24 The Statement of Intent addresses many of the challenges identified through our local audit work and summarised in this report, including:

a Workforce (paragraphs 2.8 to 2.10)

b Equipment (paragraph 3.9)

c Information systems (paragraph 4.10)

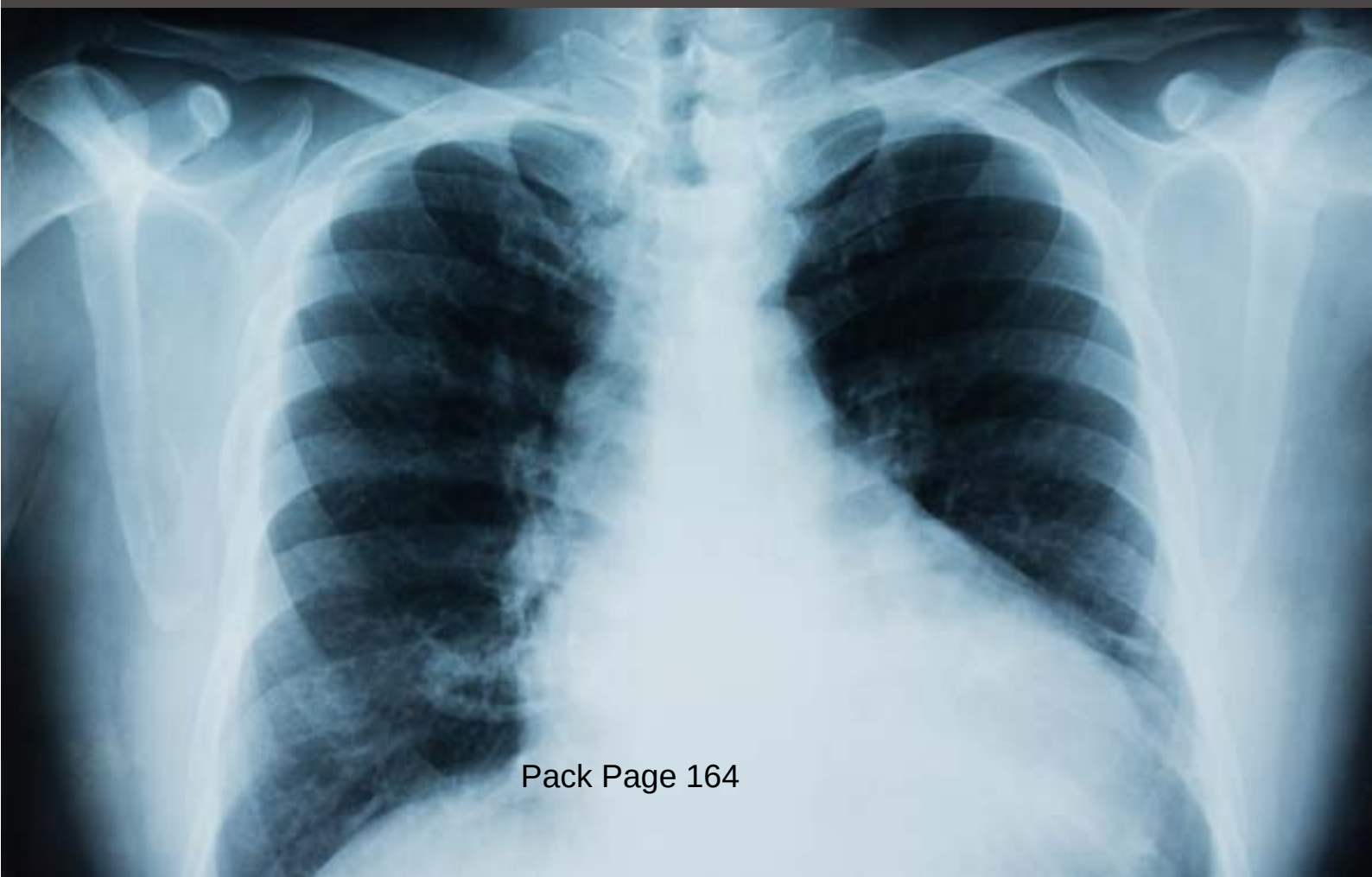
d Consistent activity recording (paragraph 5.16)

e Performance indicators (paragraph 5.16)

Appendices

Appendix 1 – Methodology

Appendix 2 – Five-year waiting times trends



Appendix 1 – Methodology

We undertook our review of radiology services at all major hospital sites that provide a range of radiology imaging, including CT and MRI examinations. In Powys Teaching Health Board, we undertook the review at the six hospitals providing X-ray and US examinations[28]. Exhibit 11 provides the hospital sites included in the review.

Exhibit 11: hospital sites that were included in our review

Health Board	Hospital sites included in the review
Abertawe Bro Morgannwg University Health Board	• Morriston Hospital • Neath Port Talbot Hospital • Princess of Wales Hospital • Singleton Hospital
Aneurin Bevan University Health Board	• Nevill Hall Hospital • Royal Gwent Hospital
Betsi Cadwaladr University Health Board	• Glan Clwyd Hospital • Wrexham Maelor Hospital • Ysbyty Gwynedd
Cardiff and Vale University Health Board	• University Hospital Llandough • University Hospital of Wales
Cwm Taf University Health Board	• Prince Charles Hospital • Royal Glamorgan Hospital
Hywel Dda University Health Board	• Bronglais General Hospital • Glangwili General Hospital • Prince Philip Hospital • Withybush General Hospital

28 Powys Teaching Health Board commissions other imaging and interventional procedures, such as MRI and CT scans as well as X-ray and US reporting from a range of providers in neighbouring health boards in Wales and NHS trusts in England. Commissioning arrangements are through service level agreements which cover a range of services including professional support for the radiographers, radiation protection and IT services to archive and share images with health professionals.

Health Board	Hospital sites included in the review
Powys Teaching Health Board	• Brecon War Memorial Hospital • Llandrindod Wells County War Memorial Hospital • Machynlleth Community Hospital • Montgomery County Infirmary • Victoria Memorial Hospital • Ystradgynlais Community Hospital

Our methodology is provided in Exhibit 12.

Exhibit 12: audit approach

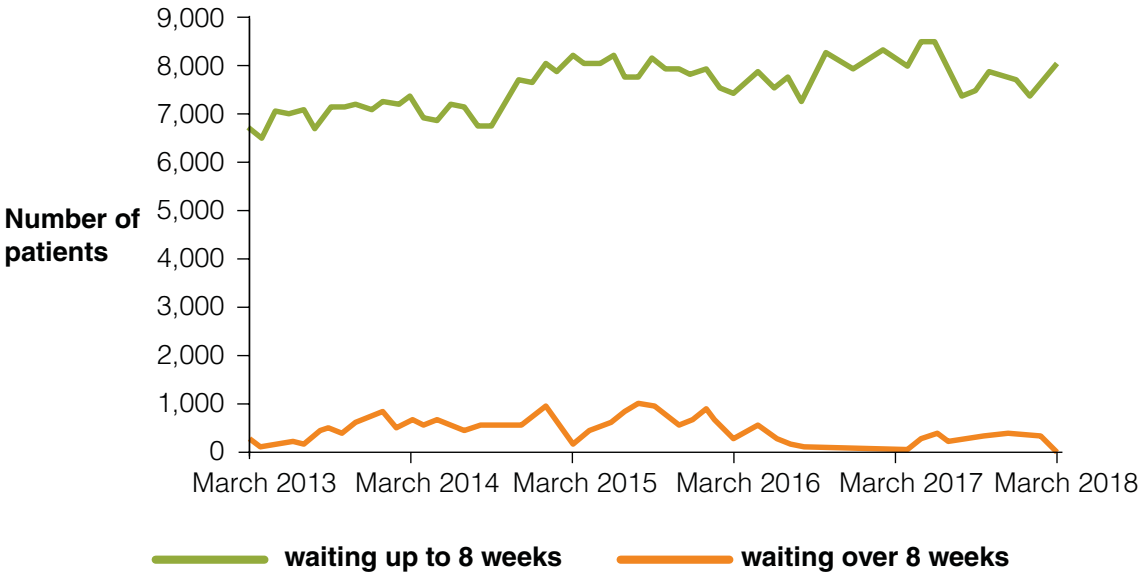
Method	Detail
Information and data collection	We used health board and hospital-site level data collection forms to capture data and information on radiology services. We also utilised data and information from a number of other sources, including: • NHS Benchmarking Network radiology 2015 and 2016 data collection (data collection period 2 May to 8 July 2016); • The All Wales Equipment Capacity Report, NHS Wales Health Collaborative (December 2015); • Stats Wales: Radiology Diagnostic Waiting Times; and • National Reporting and Learning System (NRLS) data: Patient safety incidents.

Method	Detail
Document request	We requested and reviewed documents from each health board, including: • terms of reference and membership of health boards' main radiology groups, together with a sample of minutes from the previous meetings; • examples of condition pathway documents (for stroke, cancer or heart disease) illustrating radiology service provision requirements; • relevant radiology papers to board and committees along with operational papers including safety reports; • examples of each health boards' main radiology service performance reports or performance scorecards from the past six months; • the most recent financial reports showing progress towards the savings/cost improvement plan; • health boards' radiology equipment replacement plans; • health boards' radiology risk registers; • guidance provided to hospital referrers and GPs on expectations when referring patients to the service; and • examples of any work carried out by health boards over the past two years to measure radiology patient experience.
Interviews	We interviewed staff at each health board including: • the Radiology Directorate Manager; • the Radiology Clinical Director; and • a sample of consultants selected by health boards from Surgery, Medicine, Accident and Emergency and Anaesthetics specialties.
Focus groups	We carried out focus groups at each health board of: • Radiographer Senior Leads at each main hospital site; and • GP Locality Leads.

Appendix 2 – Five-year waiting times trends

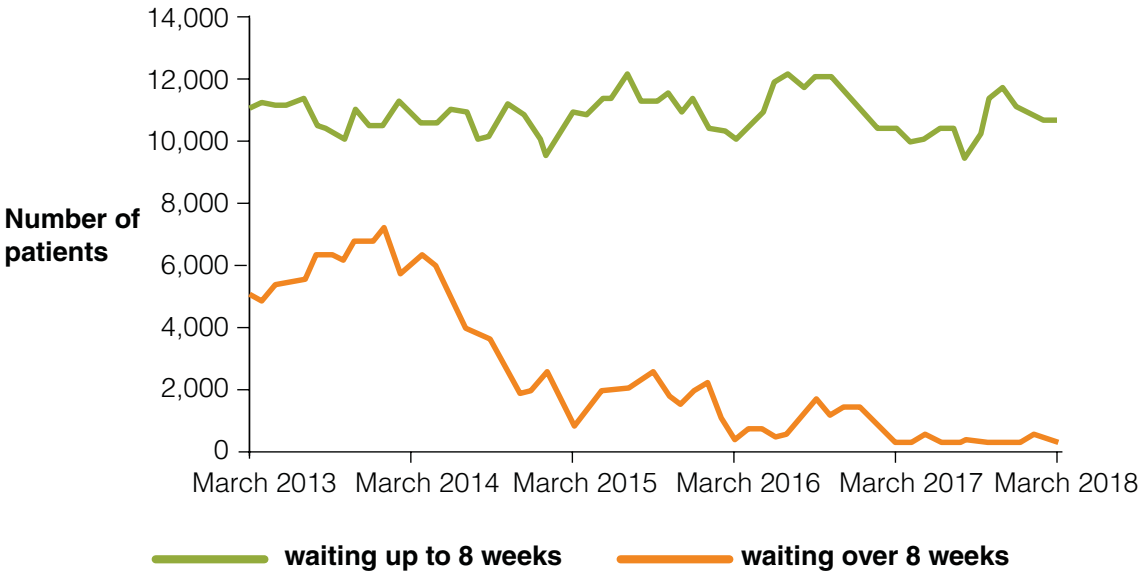
Exhibits 13, 14 and 15 provide the numbers of patients waiting up to eight weeks and more than eight weeks for CT, MRI and US examinations between March 2013 and March 2018.

Exhibit 13: all-Wales CT waiting times trend March 2013 to March 2018



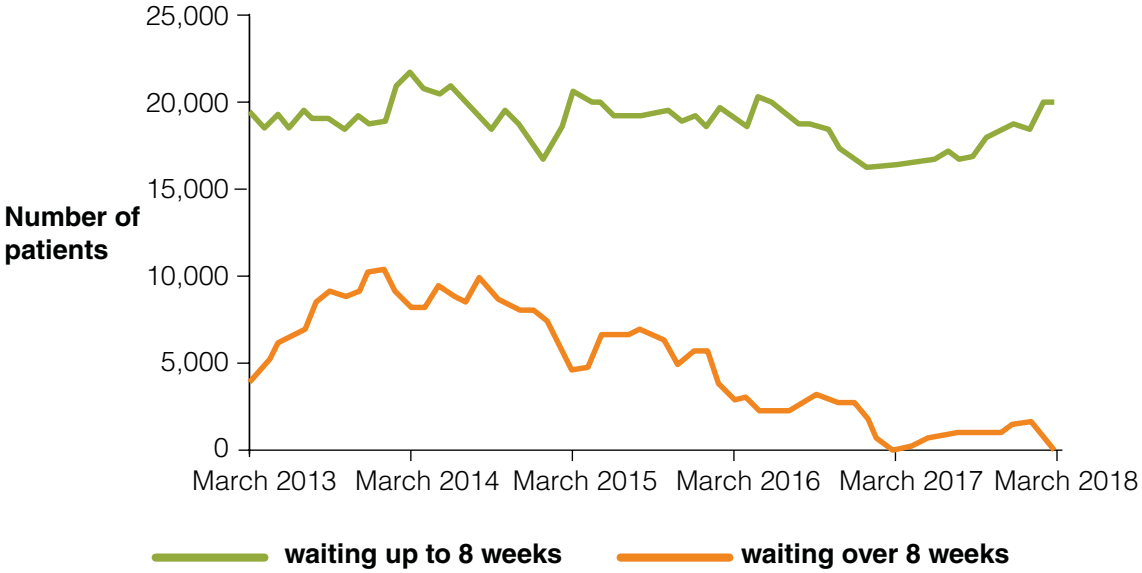
Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

Exhibit 14: all-Wales MRI waiting times trend March 2013 to March 2018



Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

Exhibit 15: all-Wales non-obstetric US waiting times trend March 2013 to March 2018



Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

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Public Accounts Committee

PAC(5)-31-18 Paper 6

26 November 2018

STATEMENT BY THE WELSH GOVERNMENT

TITLE: Betsi Cadwaladr University Health Board Special Measures Update

DATE: 6 November 2018

BY: Vaughan Gething, Cabinet Secretary for Health and Social Services

I made a statement on 5 June on the progress made in some key areas during the time the Health Board has been in special measures, the significant challenges that remained and plans to work with the Health Board during the next phase of improvement.

My statement today will focus on progress against the expectations I set out to the Health Board in May in the special measure improvement framework. The framework sets out milestones for 18 months in four key areas – leadership & governance, strategic and service planning, mental health and primary care including out-of-hours. The Health Board is required to report on progress every 6 months and the first report was discussed and agreed at its Board meeting held last week.

I met with the new Chair and the Chief Executive for my regular accountability last Tuesday to discuss the progress made and plans to deliver on the challenges and difficulties that remain.

On leadership and governance there has been a strong focus on improving Board capability. During May to September 2018 all Board vacancies were addressed. Mark Polin was appointed as the new Chair and a new Vice Chair and independent members' appointments made. In line with my expectations, an Executive Director of Primary and Community Care has been appointed to drive the required improvements in this area. A new

Executive Director of Planning and Performance has also been recruited and will start in post in November.

More robust appraisal and reporting/ assurance systems are now being introduced by the new Chair to further drive improved good governance. There has also been increased commitment and impetus to partnership working from the Board to support delivery of 'A Healthier Wales' and the transformation agenda. I was pleased to announce last week support from the 'Transformation Fund' for a North Wales project to help people with learning disabilities live more independent lives and get the care they need closer to home. This will involve sharing resources, skills and expertise across health, social care and the third sector.

In relation to finances, the Health Board remains in a challenging position. However, if the control total set for this year is met, it will represent an improvement on the previous year. The Board are in no doubt that achieving this will require focused action over the latter part of this financial year to deliver on the turnaround needed to secure stability and drive the shift to transformation in its future plan. I announced in July additional funding of £1.7million under the special measures arrangements to strengthen the management capacity and analysis capability in the turnaround team.

A key expectation of the improvement framework was that the Board responded promptly and appropriately to the Health and Social Care Advisory Service (HASCAS) investigation findings and the Ockenden Review recommendations. I am content that the plans the Health Board has put in place to implement the recommendations, both with mental health and more widely, are comprehensive and robust – with operational leads identified and being held to account. My focus now is on ensuring there is rapid progress on implementing these plans. We are already verifying the progress so far reported by BCU in their regular reports is recognised by the frontline staff in mental health – this is in addition to the HIW inspection programme which is also reporting progress. Improvements so far include the confirmation of a new and visible senior management team, appointment of a new mental health nursing director, creation of listening leads across front line staff and the launch of the 'Today I Can' approach.

Furthermore, a stakeholder group has been created to further test the improvements being made. I am pleased that some members of the Tawel Fan families have agreed to be part of this group, along with the CHC and other stakeholders.

I met with a number of Tawel Fan Families again last week. Understandably a small number of families are not entirely content with either the process or outcome of the investigation, there was consensus though of the need to ensure the Health Board reports and action plans prepared result in sustainable and meaningful improvements in both mental health services and care of those with dementia across services. My officials have been very clear with the Health Board of the need to ensure it communicates plans and actions effectively to all staff.

The focus of developments in mental health to date has been around immediate improvements to in-patient services, including environmental works. The Health Board is also working to assess and improve community services by implementing its mental health strategy, working closely with local authorities, third sector, services users and the police to deliver local implementation plans. A key focus for the next 6 months will be to improve and maintain performance against the mental Health Measure and CAMHS targets.

To support this work the Delivery Unit is reviewing demand and capacity and my officials are discussing what further support might be needed in this area to rebalance service capacity and demand.

Improvement to engage and involve staff is on-going and the results of the NHS Staff Survey 2018 show positive changes since 2013 and 2016 most notably in staff engagement. This includes an increase of 18% from the 2013 survey to 65% of staff proud to say they worked at BCU.

The strategic and service planning area including performance requires acceleration and more focussed effort. There has been progress in individual specialities strategies with the Sub-Regional Neonatal Intensive Care Centre and primary percutaneous intervention plans implemented and the vascular surgery plan underway. These plans increase success in recruitment and in delivering specialist services in the region for the North Wales population.

Work on other areas including orthopaedics need to be further progressed on a whole system basis and described more clearly in its plans for service transformation and improvement.

In primary care the new Executive Director will provide increased focus to deliver further improvements working in partnership with clusters. Work is continuing to improve GP out of hours services and the Health Board performance is now more in line with the rest of Wales. The ambition of the Health Board is now to transform the service model so that it becomes more fit for purpose and sustainable.

In this statement I have noted areas of progress but also outlined the significant difficulties that remain. I am determined that special measures is not a sticking plaster and delivers sustainable improvements that puts in place the capacity and capability required for the medium and long term. During the next 6 months the Health Board will need to focus on finance, strategic and service planning especially unscheduled care and RTT and delivering on the recommendations from HASCAS and Ockenden. The Chair and the Board is clear on the work needed and committed to making progress. Welsh Government will be working alongside to provide the necessary support and I hope regional partners and key stakeholders will also pay a key role in ensuring improved and sustainable health and care services for the North Wales population.