GP Out of Hours

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

Contents

Executive Summary 1

Findings & Agreed Action Plan 2

Appendix A 7

Review Reference	HDU-2526-13
Fieldwork	May 2026
Executive Sign Off	15 June 2026
Audit Committee	23 June 2026
Executive Lead	Andrew Carruthers, Chief Operating Officer
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

To assess the controls in place for the management of key systems and risk areas within GP Out of Hours – specifically controlled stationary and controlled drugs.

Overview

We have concluded **Limited** assurance on this area. The matters requiring management attention include:

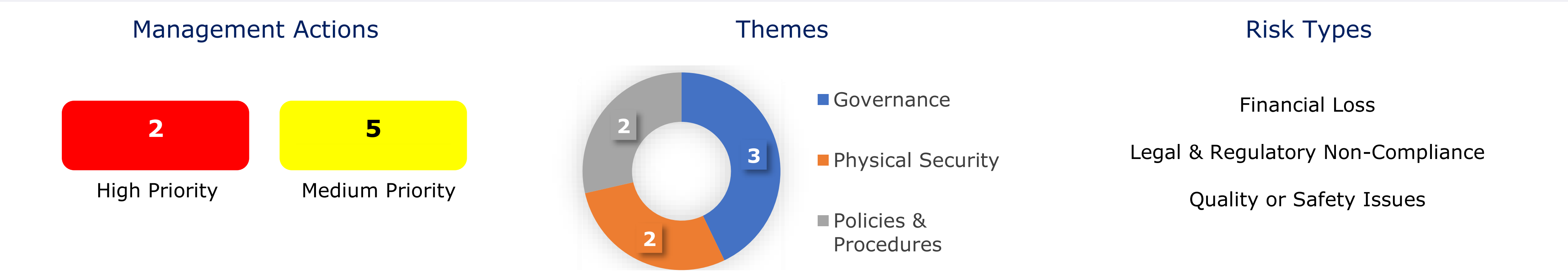
- Procedures relating to controlled stationery require updating to comprehensively reflect current practice
- Physical security of prescription pad stock during transportation between sites requires strengthening
- Lack of segregation of duties between prescription pad access/management and stock check arrangements
- Absence of policies/procedures relating to the management and administration of controlled drugs in GP OOH
- Access to controlled drugs at GGH OOH is not restricted to clinicians
- Inconsistent CD registers, and in one case entries in the register suggest that only issues to patients are captured, rather than all stock movements
- Optimum CD stock levels have not been determined and whilst stock checks are undertaken, they are inconsistent and not undertaken at defined intervals

Full details of matters arising are detailed within the Findings & Agreed Action Plan on page 2.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	Mechanisms are in place to safeguard controlled stationary including prescription pads	1, 2, 3	**Reasonable**
2	Mechanisms are in place to safeguard medicine stock including controlled drugs	4, 5	**Limited**



Findings & Agreed Action Plan

Objective 1: Mechanisms are in place to safeguard controlled stationary including prescription pads	Reasonable

The *Guidance for Prescription Safety in Out of Hours, Primary Care* document sets out the high-level process for ordering, storing and distributing prescription pads. Walkthrough of the process with the OOH Administrator for Carmarthenshire identified elements of the process are omitted from, are not clear within the procedure document, or do not reflect current practice. **[Finding 1]**

Prescription pads are ordered centrally by the OOH Administrator for Pembrokeshire. Stock is recorded on the Script Management Database using the serial numbers of the first and last script on each pad. A stock of pads for GGH and PPH OOH is held in the OOH Administrators office at GGH, securely stored in a locked safe with access restricted. Stock is replenished as and when required from the main stock in Pembrokeshire.

GPs request new prescription pads using a standardised paper form. While requests may occasionally be submitted by OOH administrative staff on behalf of GPs, a control is in place whereby the OOH Administrator emails the GP directly to confirm that a pad has been issued to them. All issued pads are recorded on the Script Management Database providing a comprehensive audit trail, and all paper documentation relating to each issue includes the serial numbers of the first and last prescription, enabling GPs to verify completeness of the pad upon receipt. GPs are required to sign and return a confirmation form to acknowledge receipt of the prescription pad. There is scope to improve process efficiency through the adoption of electronic solutions in place of existing paper-based processes.

Stock transferred between OOH administrative offices and departments is transported by administrative staff and in some instances, this involves the OOH Administrator meeting a driver off site to facilitate onward transport. The physical handover of prescription pads is not formally documented, resulting in a lack of audit trail in the event of loss. **[Finding 2]**

Weekly stock checks are performed, although segregation of duties is not possible due to staffing arrangements. **[Finding 3]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Policies & Procedures** The *Guidance for Prescription Safety in Out of Hours, Primary Care* document sets out the high-level process for ordering, storing and distributing prescription pads. Walkthrough of the process with the OOH Administrator for Carmarthenshire identified elements of the process are omitted from, or are not clear within the procedure document, or do not reflect current practice including: • The process for ordering new stocks of pads from the supplier is not clear. • Arrangements for access to stocks of prescription pads. • Process and controls for the transportation of pads between the OOH administration offices and OOH departments. • Responsibilities for completing weekly stock checks. The procedure lacks basic document controls including author/owner, approval/implementation date and review dates.	Inconsistent and/or non-compliant practices. **Medium Priority**	**Agreed Action:** The *Guidance for Prescription Safety in Out of Hours, Primary Care* document will be updated to comprehensively document the end-to-end process and controls for the ordering, storage, distribution and stock management of prescription pads. **Expected Evidence of Implementation:** Updated procedure document signed off by the relevant meeting **Officer:** Richard Archer, Clinical Director

	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 30 September 2026
2	**Transportation/Handover of Pad Stock** Stock transferred between Pembrokeshire and Carmarthenshire OOH administrative offices, as well as prescription pads distributed to OOH departments at GGH and PPH, are transported by administrative staff. In some instances, this involves the OOH Administrator meeting a driver off site to facilitate onward transport. Although stock movements are recorded on the database, the physical handover of prescription pads is not formally documented, resulting in a lack of audit trail in the event of loss.	Errors or irregularities in prescription pad stock may not be identified, potentially resulting in missing and/or inappropriate use of prescriptions. Risk of harm to staff.	**Agreed Action:** Individuals transporting script pads will be required to sign as confirmation of receipt and acceptance of responsibility for the pads. Use of tamper-proof bags for transportation of script pads will be considered. Changes in process will be reflected in the procedure document *(see Finding 1)*.
			Expected Evidence of Implementation: Use of tamper proof bags confirmed. Electronic confirmation of prescription transfer
		Medium Priority	**Officer:** David Richards, Service Delivery Manager **Target Implementation Date:** 30 September 2026
	Theme: Physical Security	Control Design	
3	**Weekly Stock Checks** There is no segregation of duties in the weekly stock checks undertaken at the Carmarthenshire OOH Administration Office. The checks are undertaken by the OOH Administrator, who is also solely responsible for managing the pads and the only person with access to them. Given the infrequency of prescription pad distributions from stocks, less frequent, independent checks would be more appropriate and beneficial.	Errors or irregularities in prescription pad stock may not be identified, potentially resulting in missing and/or inappropriate use of prescriptions.	**Agreed Action:** Monthly/quarterly stock checks will be performed by the Service Delivery Manager. This will be reflected within the Procedure *(see Finding 1).*
			Expected Evidence of Implementation: Evidence of quarterly stock checks undertaken by the Service Delivery Manager and Clinical Director
		Medium Priority	**Officer:** David Richards, Service Delivery Manager **Target Implementation Date:** 30 September 2026
	Theme: Governance	Control Design	

Objective 2: Mechanisms are in place to safeguard medicine stock including controlled drugs — Limited

Policies & Procedures

The Health Board has a *Ward/Department Procedures for the Handling and Storage of Controlled Drugs (CDs) Standard Operating Procedure (SOP)* however this does not reflect the operating arrangements within GP OOH. The findings of our review set out below demonstrate the need for a policy/procedure setting out the specific arrangements for the management and administration of controlled drugs within GP OOH. **[Finding 4]**

Physical Security

Visits to GGH and PPH GP OOH departments confirmed that controlled drugs are securely stored within locked cabinets which are fixed within the locked general drugs cabinets. Keys for the outer and inner cabinets are stored separately within key safes. Access should be restricted to clinicians, although at GGH we observed the OOH Administrator entering the key safe code. **[Finding 5]**

CD Records

The *Ward/Department Procedure for the Administration of Controlled Drugs to Patients* (part of the SOP referred to above) states that the administration of CDs is a two-person procedure and both must witness the entire procedure from preparation to actual administration. The first person should be a registered doctor or nurse, the second person checking may be a doctor, nurse or other health care professional (pharmacist, registered ODP, HCSW with relevant training etc). In GP OOH controlled drugs are rarely (if ever) administered to patients in the department – they are predominantly administered to palliative care patients in their own homes. In the CD register, the first signatory is always the GP, the second signatory is typically an OOH administrator or a driver and does not witness the entire procedure. **[Finding 6]** In the absence of procedural guidance for GP OOH **[Finding 4]**, there is lack of clarity regarding (i) whether it is appropriate for the second signatory to be a non-clinical staff member; and (ii) the specific actions or assurances the second signatory is attesting to.

There was inconsistency in the CD registers in use at GGH and PPH. Both had been issued by Pharmacy and included the same core requirements so there was no fundamental impact on the information recorded, but there was no apparent rationale for the variation. This has been highlighted to management for consideration. **[Finding 6]**

Noting that CDs are administered to patients outside of the GP OOH department, GPs routinely withdraw CDs from stock in advance of patient visits based on anticipated clinical need. Any unused CDs should subsequently be returned to the CD cabinet and recorded accordingly in the CD register. At GGH, the CD register provided evidence that this process is being followed, with unused CDs clearly recorded as returned to stock. The same was not evidence at PPH, indicating that entries in the CD register are being completed retrospectively, capturing only those CDs administered to patients rather than reflecting the full movement of stock. **[Finding 4 & 6]**

CD Stock Checks

Optimal stock balances based on usage history/demand have not been determined. **[Finding 7]**

The Procedure for the Balance Checking of Controlled Drugs on Wards/Departments (part of the SOP referred to above) states that the balance of CDs is to be checked at least every 24 hours. In the absence of procedural guidance for GP OOH, the required frequency of CD stock checks has not been determined. The CD registers at GGH and PPH evidence that stock checks are undertaken by both GP OOH and Pharmacy, but the frequency is inconsistent. **[Finding 7]**

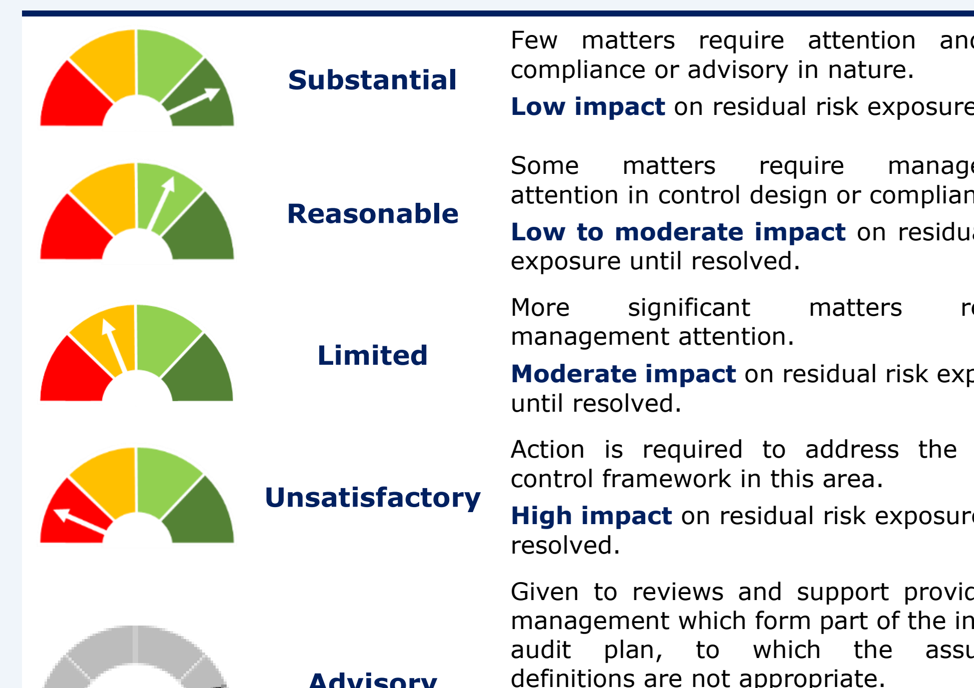
CD stock checks were undertaken at both GGH and PPH OOH departments by the Service Delivery Manager and Clinical Director, in the presence of Internal Audit. A single discrepancy was identified in GGH, attributable to an error in the unit of measure recorded in the CD register by one clinician. This was addressed with the clinician at the time of the stock check. No further actions are required.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Policies & Procedures** The findings of our review demonstrate the need for a policy/procedure setting out the specific arrangements for the management and administration of controlled drugs within GP OOH, including (but not limited to): • Physical security – both on site at GP OOH departments and transportation to/from patient visits; access to key safes and CD cabinets. • Issuing CD stock – including clarity as to whether the second signatory must be a clinical staff member and the specific actions or assurances they are attesting to. • Record keeping – use of consistent CD registers, and the requirement to record all stock movements (not just stock administered) • Optimum CD stock levels – requirement to determine and periodically review these • CD stock checks – including the frequency of checks by GP OOH, whether these must be undertaken under dual control, by clinical/non-clinical staff; and the frequency of independent checks by Pharmacy.	Weak or poorly understood processes and controls relating to the management of controlled drugs increase the risk of misuse, potentially resulting in patient or staff harm and financial loss.	**Agreed Action:** A formal policy/procedure for the management and administration of controlled drugs in GP OOH will be developed, with appropriate input from Pharmacy colleagues, addressing all findings identified within this review.
			Expected Evidence of Implementation: Approved policy/procedure document.
		High Priority	**Officer:** Richard Archer, Clinical Director **Target Implementation Date:** 30 September 2026
	Theme: Policies & Procedures	Control Design	
5	**CD Security** The Clinical Director and Service Delivery Manager advised that key safe codes are restricted to clinicians only and shared securely via the Adastra system. Codes are not routinely changed at defined intervals. During a visit to GGH OOH department we observed an OOH Administrator accessing the key safe at the request of a clinician.	Unauthorised access to controlled drugs potentially resulting in inappropriate use, compromising staff or patient safety; and/or financial loss through theft.	**Agreed Action:** Key safe codes will be changed with immediate effect. All GP OOH staff will be reminded that access to controlled drugs including the key safes must be restricted to clinicians only. The requirement to routinely change the codes, responsibilities for doing so and the defined interval will be documented within the GP OOH controlled drugs policy/procedure (Finding 5).
			Expected Evidence of Implementation: Correspondence (e.g. email) to GP OOH staff. Approved policy/procedure document (Finding 5).
		Medium Priority	**Officer:** David Richards, Service Delivery Manager

	Theme: Physical Security	Control Design	**Target Implementation Date:** 30 September 2026
6	**CD Registers** In a ward setting, CDs must be prepared and administered to the patient under dual control by two clinicians and recorded as such within the CD register. This is not feasible in GP OOH as CDs are administered to the patient off site with only one GP present. Two signatures are still captured in the CD register, but the second signatory is often a OOH Administrator of driver as the GP may be the only clinician on duty, and the purpose of the second signature is not clear as the signatory does not witness the entire process from preparation to administration. There was inconsistency in CD registers in use at PPH and GGH. Entries in the CD register at PPH indicate that the register is being completed retrospectively to record only those CDs administered to patients rather than reflecting the full movement of stock.	Weak or poorly understood processes and controls relating to the management of controlled drugs increase the risk of misuse, potentially resulting in patient or staff harm and financial loss.	**Agreed Action:** The requirement for a second signatory and purpose of this signatory will be reviewed and clarified within policy/procedure (see Finding 4). The CD registers in use at all sites will be reviewed and replaced where necessary to ensure consistency. This will be done in consultation with Pharmacy colleagues. The requirement to capture the full movement of CD stock within the CD registers will be emphasised within the policy/procedure (see Finding 4) and reinforced with GP OOH clinicians.
			Expected Evidence of Implementation: Approved policy/procedure document. Evidence of correspondence with clinicians (e.g. email) reinforcing the requirement to capture the full movement of CD stock within CD registers.
		High Priority	**Officer:** Richard Archer, Clinical Director **Target Implementation Date:** 30 September 2026
	Theme: Governance	Control Design	
7	**CD Stock Levels & Checks** Optimum CD stock holding levels have not been determined, to ensure stock availability whilst minimising the risk of wastage through obsolescence. CD registers evidence that stock checks are undertaken by both GP OOH and Pharmacy, but they are not undertaken at defined intervals and frequency is inconsistent.	Weak or poorly understood processes and controls relating to the management of controlled drugs increase the risk of misuse, potentially resulting in patient or staff harm and financial loss.	**Agreed Action:** Optimum CD stock levels will be determined for each site – this will include additional stock levels required for peak periods such as bank holidays. The process for and frequency of stock checks will be defined within policy / procedure (see Finding 4).
			Expected Evidence of Implementation: Defined stock levels for each site. Approved policy/procedure document.
		Medium Priority	**Officer:** Richard Archer, Clinical Director **Target Implementation Date:** 30 September 2026
	Theme: Governance	Control Design	

Appendix A

Assurance Opinion



Rating	Description
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Hywel Dda University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.