APPENDIX D

AUDIT TRACKER UPDATE
NWSSP AUDIT & ASSURANCE
OVERDUE ACTIONS MEASURED AGAINST ORIGINAL AGEED DEADLINE DATES

Executive Lead - Chief Operating Officer						
ABM 1920-038		**Patient Environment**		**Report Issued October 2019**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no overarching Policy/Procedure in place to outline how external regulator / inspection reports are being managed across the Health Board. As a result, audit noted that the process for managing these reports varied. We would recommend an overarching policy/procedure for the management of all external regulator / inspection reports that will bring together the various processes currently operating for dealing with HIW, CHC, HSE and other, to ensure that any action required is appropriately managed and the HB is assured that all actions are complete and any lessons to be learned are disseminated in a timely and robust way.	**M**	An overarching policy/procedure will be developed for the management of all external regulator / inspection reports that will bring together the various processes currently operating for dealing with HIW, CHC, HSE and other, to ensure that any action required is appropriately managed and the HB is assured that all actions are complete and any lessons to be learned are disseminated in a timely and robust way.	31/01/2020	**June 2022:** Proposals are currently being discussed with Executive colleagues to centralise this work with the Assistant Head of Risk & Assurance and his team. Policy/Procedure will follow once the process detail has been agreed. Noting the above, deadline has been extended to 31/08/2022	31/08/2022
5	During our observation visit, we found areas that had recurring issues. Management should consider how they address issues of custom and practice that is resulting in repeat non-compliance with policies and procedures.	**M**	The policy (ref action 1 above) will set out a process for managing repeat non-compliance with policies and procedures to identify the issues and actions required by Units / specialist corporate staff / groups / committees.	31/01/2020	**June 2022:** Proposals are currently being discussed with Executive colleagues to centralise this work with the Assistant Head of Risk & Assurance and his team. Policy/Procedure will follow once the process detail has been agreed. Noting the above, deadline has been extended to 31/08/2022	31/08/2022

Executive Lead - Chief Operating Officer						
SBU 1920-025		**Discharge Planning (COO)**	**Report Issued February 2021**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	All patients we reviewed had some form of clinical plan in place promptly following admission, but the detail of plans varied from ward to ward, and the clear documentation of clinical management plans with content as expected by section 7.9 of the SAFER Policy was not common. Management should take steps to improve the consistency of practice in the documentation of clinical management plans and compliance with policy. Consideration should be given to progressing this as part of a quality audit & improvement initiative. Additionally, there may be merit in the implementation of standard template documentation to prompt key requirements.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of clinical management plans and include actions to provide assurance regarding implementation. Anticipated first draft for consultation end of February 2021.	01/05/2021	**Undated:** A revised SAFER policy is currently being written and this will be included as part of the revised policy **June 2022:** This recommendation was marked 'Complete' on 04/08/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
2	The methods used across wards for setting EDDs was inconsistent - on some wards, EDDs were set by Ward Managers, and some by Ward clerks, but there was little evidence within patient notes of medical input in determining the EDD. Management should take steps to ensure that the setting of the initial EDD is undertaken as part of the initial clinical management plan documentation within patient notes.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	01/05/2021	**Undated:** A revised SAFER policy is currently being written and this will be included as part of the revised policy **June 2022:** This recommendation was marked 'Complete' on 04/08/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered

3	Testing at Ward E, Neath Port Talbot Hospital, showed that EDDs are not always set within 24 hours having identified 9 patients that did not have an EDD after being admitted between 2 to 14 days earlier. Management should review the process for setting EDDs at Neath Port Talbot Hospital Ward E to ensure that they are set within 24 hours of admission in line with Policy	**M**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	01/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021 **June 2022:** This recommendation was marked 'Complete' on 04/08/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
4	Several observations identified divergence from policy requirements across wards: • Records did not demonstrate senior medical review occurring on a daily basis. Discussion with the Senior Corporate Matron has identified that a senior review might not always be required for some patients on some wards. • Patients at Gorseinon and Neath Port Talbot Hospitals did not receive a daily consultant review and there were also gaps between reviews by junior doctors too, but it was considered that patients on the wards visited here did not require daily medical input. The Policy does not indicate where variation from the daily requirement would be acceptable. • Often, the times of patient reviews recorded in notes fell after midday. • Reviews undertaken at weekends were very inconsistent across all wards with the majority of patients not receiving a senior or junior review. Management should consider these areas of divergence from policy. Where they are considered acceptable we would recommend policy be reviewed to accommodate them appropriately. Otherwise we would recommend action be taken to reinforce policy requirements and improve compliance.	**M**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the frequency, timing and recording of senior medical review, and include actions to provide assurance regarding implementation.	01/05/2021	**Undated:** A revised SAFER policy is currently being written and this will be included as part of the revised policy **June 2022:** This recommendation was marked 'Complete' on 18/07/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered

5	Ward 8 at Singleton used a Weekend Handover Sheet which outlined the criteria for patient discharge over the weekend to enable nurse-led discharge. Management should consider the implementation of weekend handover sheets across all wards	**L**	The standard for handover will be reflected within the revised policy version.	01/05/2021	**Undated:** A revised SAFER policy is currently being written and this will be included as part of the revised policy **June 2022:** This recommendation was marked 'Complete' on 18/07/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
6	There was non-compliance with policy in that the reason for changing the EDD was not always recorded within the Clinical Portal (or SIGNAL) which meant that it was not always possible to establish if all of the changes to the EDD were appropriate. Additionally, we noted differences between EDD dates recorded in the portal and those within SIGNAL (with one ward inputting only to SIGNAL). SIGNAL being a relatively new development is not currently covered by policy. Management should clarify what is expected of staff in respect of populating systems with the EDD data and reasons for changes, particularly where more than one system is in operation. Awareness of expectations should be reinforced and policy updated to reflect systems in place.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation	01/05/2021	**Undated:** Policy Completed **June 2022:** This recommendation was marked 'Complete' on 17/08/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered

7	Of the 55 patients tested there were ten patients where the EDD was updated beyond a patient being medically fit for discharge with the reason being related to Social Worker, Continuing Healthcare/Funded Nursing Care applications or repatriation. These do not fall under clinical reasons for change of EDD and therefore the EDD should not have been changed. Five patients at Singleton Hospital were identified as being medically fit for discharge within patient notes but this was not recorded as such within the Clinical Portal or Signal and so the EDD continued to be updated. Management should ensure all staff are trained and made aware of the appropriate reasons for updating the EDD. Consideration be given to a programme of improvement work across wards to coach staff in effective use and recording of the EDD to monitor better compliance & outcomes.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation.	01/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021. **Undated:** Policy completed. **June 2022:** This recommendation was marked 'Complete' on 17/08/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
8(i)	Whilst the ABMU Clinical Portal prompts for reasons, the field is not mandatory. Neither SIGNAL nor the Welsh Clinical Portal provide fields seeking reasons for EDD changes, so wards using them may not capture the same level of information. Furthermore, limitations within Signal and the Clinical Portals do not provide the functionality to support the display of '+days' when a patient is medically fit for discharge but remains in hospital beyond their EDD. Steps should be taken to ensure the systems chosen to facilitate the management of EDD promote the completeness of information required by policy. This may require working with NHS Wales partners to develop national products.	**M**	A paragraph on expectations, roles and responsibilities will be enhanced within the revised policy.	01/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021. **June 2022:** This recommendation was marked 'Complete' on 18/07/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
8 (ii)	Whilst the ABMU Clinical Portal prompts for reasons, the field is not mandatory. Neither SIGNAL nor the Welsh Clinical Portal provide fields seeking reasons for EDD changes, so wards using them may not capture the same level of information. Furthermore, limitations within Signal and the Clinical Portals do not provide the functionality to support the display of '+days' when a patient is medically fit for discharge but remains in hospital beyond their EDD. Steps should be taken to ensure the systems chosen to facilitate the management of EDD promote the completeness of information required by policy. This may require working with NHS Wales partners to develop national products.	**M**	The audit action findings will be presented to the Signal User Group to consider if further actions can be taken to improve the signal design in phase 3 to feature an improvement to assist clinical recording.	31/03/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021	31/05/2021

9	The review of 69 patients found that only one patient had an EDD recorded within patient notes and this did not provide any evidence of discussion with patient, family or carers. Through discussion at the MDT Board Round we attended at Gorseinon, there was evidence that EDDs were being discussed with patients but that this was not sufficiently recorded within patient's notes. Management should ensure that EDD is discussed with patients and families and the discussion is recorded in the patient notes. Consideration should be given to including this within a programme of improvement work across wards to coach staff in effective implementation of this aspect of discharge planning & documentation and to monitor improvements in practice.	**H**	Further engagement with Carers via Stakeholder reference group will be undertaken and a leaflet produced that outlines what communications and involvement patients and their families can expect to receive regarding the plans for their expected date of discharge.	30/05/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021	31/05/2021
		H	Comprehensive training and communication programme will be developed that includes communication with families and patients as part of the launch of the revised SAFER policy.	30/09/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this.	None Entered
10 (I)	Within Signal, the 'MDT d/c planning' column is utilised to record details and actions in relation to a patients discharge. There were wards at Morriston that had no comments this column in and very little detail recorded within patient's notes. We would recommend that the expected use of PSAG Boards (whether manual or electronic) be reinforced by management and direction be given to staff on expectations in respect of patient notes. Consideration should be given to including this within a programme of improvement work across wards to coach staff in effective implementation of this aspect of discharge planning & documentation and to monitor improvements in practice.	**H**	To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy.	01/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021. **June 2022:** This recommendation was marked 'Complete' on 14/10/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	31/05/2021

11	On ward 6 at Singleton there was evidence to suggest that arrangements for patients discharge would wait until after the patient is medically fit for discharge rather than this process being ongoing from admission. Management should ensure that discharge planning is undertaken by ward staff from the point of admission in line with policy.	**M**	The standards will be reflected in the rewording of the revised policy	01/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021. **Undated:** The draft Policy has been completed with this action included. **June 2022:** This recommendation was marked 'Complete' on 18/07/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
12	There was a low level of compliance with the Red / Green Day aspect of Policy. Two of the five wards tested at Morriston Hospital did not utilise the Red to Green columns on their PSAG Boards and the remaining three did not use them as intended, instead using them to show that a patient was Medically Fit and waiting for a process (e.g. Social Worker, CHC assessment). There was no evidence of use of Red to Green days at Singleton Hospital or NPTH. Management should ensure that the Red to Green Days element of the policy is understood and implemented at Ward level. Consideration should be given to progress this via a quality improvement programme approach.	**M**	To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy.	31/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021. **Undated:** The draft Policy has been completed with this action included. **June 2022:** This recommendation was marked 'Complete' on 18/07/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered

13	Staff at Singleton ward 8 highlighted that patient notes available at ward level were not comprehensive - interventions provided by staff from Therapies were held separately. We recommend that management take steps where necessary to ensure that ward-level patient records provide a comprehensive, up-to-date account of the patient's care and steps taken to ensure a safe discharge.	**M**	Revised policy will clarify how discharge planning will be recorded following the introduction of new systems.	01/05/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021. **Undated:** The draft Policy has been completed with this action included. **June 2022:** This recommendation was marked 'Complete' on 18/07/2021. However review has found insufficient evidence to close this action, as the revised SAFER policy is still a draft document which has yet to ratified/approved. An SBAR report has been produced and shared with relevant Executive colleagues, which makes recommendations for further action in this area. Feedback is awaited. As such, this recommendation has been reopened	None Entered
15	A review of Signal at Singleton in particular, has shown that staff are populating the system with detailed patient information which is not duplicated within patient notes. Staff report the system has had a positive impact at ward levels, reducing workloads and making patient information more accessible - However, once Signal is optimised across the Health Board, it will only have capacity to store information for a maximum of 30,000 patients which translates to storing information for approximately 6 months post patient discharge. After which, all of the detailed entries within Signal will be deleted. It is noted that the introduction of electronic nursing notes will overcome some of the above, however this system only includes entries from Nurses and assessments undertaken Management should review the arrangements for documenting patient records to ensure that a full patient history is maintained post discharge	**H**	This identified risk will be escalated to the Signal User Group and any unresolved risk assessed and added to the corporate risk register for monitoring until action is identified to resolve it.	31/03/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021 **Undated:** Work is progressing on this action but not yet complete.	31/05/2021
16	Discussion with management following issue of the draft version of this audit report has identified an additional action to improve the system design – the addition of an audit tool to provide management assurance regarding the implementation of revised policy. Earlier points have recommended consideration should be given to progressing as part of a quality audit & improvement initiative.	**M**	Development of a new Corporate Audit Management Tool, and standard operating procedure outlining the roles, responsibilities and expectations (including frequency) for service group audit of compliance, and to identify improvements and actions relating to the discharge policy.	31/03/2021	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021 **Undated:** Ongoing	31/05/2021

Executive Lead - Chief Operating Officer						
ABM 2122-013		**Planned Care Recovery Arrangements**		**Report Issued February 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.2	The Outpatient Redesign and Recovery group includes the review and discussion of advice and guidance tools which support pathway and referral management alongside receipt of service level recovery plans. We identified two forms of recovery plans submitted to the ORR group. Initial plans used Transformation format highlight reports and included a format of Goal Method and forecasted outcomes across the October 2021 – March 2022 period and overall projected outcome. The highlight report also included requirements to include the scoring and mitigating actions for key risks and an outline of current month and planned forecast actions. The completeness of returns and level of detail provided varied across services. To address Welsh Government urgent and long waiter targets further recovery plans were requested and received at the December 2021 ORR group meeting. Review of these plans again highlighted variation in levels of detail across returns. We note that Ear, nose & throat (ENT), oral and maxillofacial (OMFS), and urology contained a number of intended actions across validation, waiting list initiatives, additional clinics, use of consultant connect and alternative pathways but not necessarily projected trajectories. The return from trauma & orthopaedics indicated that the Service Manager had recently commenced in post and provided narrative rather than performance outcomes. Minutes of the January ORR Group did not highlight detailed discussions of the service plans. Additionally, we note that the January 2022 meeting minutes and the groups highlight report to PCPB indicate that Service Group engagement, particularly from clinical leads, could be improved. Morriston has provided no medical representation in the period April 2021 – January 2022, but has designated a lead Outpatients sister to attend, whilst Singleton Neath Port Talbot has had clinical representation at just two meetings. We recommend management review arrangements for receipt and monitoring of service/specialty recovery plans for appropriate approval and monitoring.	**M**	The governance within the service groups should be revisited and will be discussed with members of the outpatient's redesign & recovery group. Each service group have historically had their own outpatient's group, this provides the opportunity for a wider management review of service/ speciality plans, prior to submission to the Health Board wide group. Reassurance will be sought from service groups that these groups are still active and if they are not, they should be re-instated to provide an additional level of assurance at a speciality level. A review of the overall management structure of outpatients has been initiated to ensure that the correct reporting mechanisms are in place. In addition, steps are being taken to improve access to demand and capacity and performance information with a bespoke dashboard for outpatients.	30/04/2022	**June 2022:** Morriston and Singleton service groups have re-instated management meetings. Additionally, a monthly meeting with all service managers across the health board has been established with a focus on developing and delivering plans, providing data and shared learning opportunities. The Health Care Systems Engineering team are working closely with the services to develop demand and capacity modelling, alongside the development of data within the Outpatient Power BI Dashboard. Each Service Group has now established its own performance monitoring group with oversight of outpatient activity. The review of the outpatient management arrangements is ongoing with a recommendation that the function is centralised under once Service Group or within the Chief Operating Officer's team. Deadline moved to 31/07/2022.	31/07/2022

3.1	There is no formal group overseeing the Surgery and Theatres work streams which sit within the PCPB structure. The PCPB has received an outline structure which includes the establishment of a Surgery and Theatres sub-group however, this was only noted and no group has been introduced. We have noted the consistent submission of highlight reports providing updates against the progress of the modular theatre builds at Singleton and Neath Port Talbot sites. Information on other work stream developments has varied, and we note that information requested on the transfer of elective surgical services has been presented to the health board prior to presentation to the PCPB which could leave members unsighted and disengaged from potential changes. We recommend the structure and reporting requirements of the Surgical and Theatres work streams are considered and the group and reporting requirements related to those work streams supporting the PCPB be confirmed.	**M**	There are a number of groups already in existence to manage surgery and theatres, however there is a lack of join up across the Health Board. This has already been identified as an action, and plans are in place for the Deputy COO to set-up an overarching Health Board Group. This overarching group will provide oversight for the service changes planned for surgery and theatres across the Health Board geographical area and provide an escalation and assurance route directly to the Planned Care Board. A governance structure has been drafted and shared with the Planned Care Board. The structure will be discussed and agreed at the first meeting of the overarching group meeting	30/04/2022	None Entered	None Entered

Executive Lead – Director of Corporate Governance						
SBU 2122-001		**Risk Management & Board Assurance Framework**		**Report Issued February 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2.1	We noted that the HBRR, by comparison with other health boards in Wales, contains a relatively high count of risks, some of which may be operational in nature. Typically corporate level risk registers have 12 to 20 risks. A focus on only the health board's top risks would improve the process of risk management at health board level. We recommend that the health board explore separating: i. Strategic risks (those threatening the achievement of principal objectives) in a reduced and more focussed Corporate Risk Register and ii. High scoring operational risks with a corporate wide impact, and review these separately and thereby streamline and increase the effectiveness of the review of corporate level risks.	**M**	Agreed. A review of the Health Board Risk Register and underpinning high scoring operational risks will be carried out and the HBRR refreshed.	30/04/2022	**June 2022:** This remains open. Focus has been delivery of workshops in the recommendation above. Aiming to take forward during June/July. Noting the above, deadline extended to 31/07/2022	31/07/2022
3.1	We noted oversight of the principal risks in the BAF have been assigned to a relevant committee aligned to areas of responsibility but we observed that committee meeting agendas did not at the time of the audit include a review of these assigned BAF areas (committees do receive reports on the HBRR items assigned to them) and committee meeting minutes did not record any such reviews taking place. We were advised that the health board is in the process of addressing this and that committee coverage is to be extended accordingly We recommend that a review of BAF risks is built into the standing agenda of the committees assigned and that reviews are conducted at each of their meetings.	**M**	Agreed. A review of the BAF risks will be completed and assigning entries to sub Committees of the Board to enable deep dive reviews to be carried out and used for agenda setting together with the Health Board Risk Register.	30/04/2022	**June 2022:** Following a meeting with independent members, a process has now been agreed whereby the Board Assurance Framework will be received and discussed at monthly meetings of the Committee Chairs. This will facilitate its use on a regular basis as part of the agenda planning process by all Committees across the Health Board. The format and content of the BAF has been reviewed and revised in line with the findings of this report, and in order to better align it with the Health Board R&S Plan. The revised document has been distributed to Executive Directors for their review and input. It will be presented to the Management Board in June 2022, and the Audit Committee and Health Board in July 2022. It is envisaged that its use by the Committee Chairs will commence following those meetings. The deadline has been extended to 31/07/2022 in order to facilitate the above.	31/07/2022

4.1	The BAF tables contain a high volume of objective evaluation tables, in some cases covering the same themes, and correspondingly a significant number of actions designed to address assurance gaps. On examination, we noted that 30 of the 82 actions across these had passed their due date. We recommend the health board consider the following: • consolidating the level of detail at which enabling objectives are evaluated in the BAF structure is explored; and • addressing overdue actions as a matter of priority and that going forward, all actions are delivered by their due date	**M**	a. Agreed. A review of the BAF detail will be undertaken and a report submitted to the Audit Committee in May setting out the results of the review and any changes. b. Agreed. Process of updating the BAF to be reviewed and include a step for escalation.	30/05/2022	**June 2022:** The format and content of the BAF has been reviewed and revised in line with the findings of this report, and in order to better align it with the Health Board R&S Plan. The revised document has been distributed to Executive Directors for their review and input. It will be presented to the Management Board in June 2022, and the Audit Committee and Health Board in July 2022. As part of this revision process, a timetable for the ongoing review and update of the BAF by the Executive Directors and their teams has been drafted. It is based on a bi-monthly review process, with key dates linked to the Management Board, Audit Committee and Health Board reporting cycles. Noting this, the deadline has been extended to 31/07/2022 in order to facilitate Committee/Board review of the revised document.	31/07/2022

Executive Lead – Director of Digital						
SBU 2021-029		**Digital Technology Control & Risk Assessment**		**Report Issued January 2021**		**Assurance Rating – N/A**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
8	There has been no full assessment of what skills are held within digital services and the skills and resource needed to support the organisation and implement the Digital Strategy. Consequently, there has been no identification of the skills gap and no development of a structured staff development plan in order to close the gap. Without this development plan in place digital services may struggle to implement the strategy. A full assessment of the current skills within digital services, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	**L**	The PADR process is used to identify individual training requirements but it is recognised that there isn't a holistic overview of current/future gaps in expertise/knowledge. Digital Services will work with Workforce to identify and implement an approach to identify the skill gap within the directorate. Once identified a plan to upskill staff as required will be developed.	28/02/2022	**December 2021:** The health board are in the process of completing a National Digital Services skills assessment which is due for submission at the end of December. Once the outcomes of the assessment are shared a workforce plan will be drawn in 22/23. **February 2022 :** Set new timescale for December 2022	31/12/2022
12	Although there is a continuity plan in place, alongside DR plans and arrangements. There has been no testing of the plan. Without a process for testing the plans in conjunction with stakeholders the health board cannot be fully assured that they will work properly in a real world scenarios. The BCP and DR plans should be subject to testing in conjunction with stakeholders to ensure that the plans work and any issues are identified prior to need.	**L**	Agreed – Digital Services were working with the Head of Emergency Preparedness, Resilience and Response to test the BCP but this was impacted by COVID. (Which tested the plan in a real-life scenario). Digital services will look to test the plan on an annual basis.	31/01/2022	**February 2022 Update:** Testing of the BC Plans will be built into the Health Board Training Programme for 2022, and the schedule is currently being pulled together by the EPRR Team. A working group is being set up to facilitate the above. Timescales to be amended to August 2022. **April 2022:** The Cyber Security Team have held a couple of meetings to progress this. A Digital BC Planning Bronze group has been established and one Digital Services tide meeting has been held so far with another planned. The group are focusing on BC Plans in Digital Services specifically, and updating the BC Plans. We are also still awaiting a date for the BC Table Top Exercise with EPRR. **June 2022:** We have undertaken more BC Planning meetings with Morriston, NPT and Singleton, and the Cyber Security Manager held a Digital Service BC workshop for EPRR members. Dates have been scheduled for the Digital table top exercise from EPRR, in August, this is a half day event.	31/08/2022

Executive Lead – Director of Finance						
SBU 1920-016		**Procurement No PO – No Pay**		**Report Issued December 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	The Service Level Agreement between SBU and NWSSP for the provision of procurement services was inconsistent with those relating to other NWSSP function, and not as clear on the respective roles & responsibilities of each. We would recommend that the Health Board liaise with colleagues in the NWSSP to enhance the clarity of its SLA to ensure roles & responsibilities are clear.	**M**	It is noted that the SLA for the provision of Procurement Services by NWSSP to SBU requires more clarity with regard to respective roles and responsibilities of each organisation. The relationship between both parties has developed significantly since the introduction of a shared service model but this has not been reflected formally through the SLA. The SBU Head of Accounting and the NWSSP SBU Head of Procurement will meet in January 2020 to discuss and agree the respective roles and responsibilities for each organisation. This will be reviewed and approved by the SBU Director of Finance and the NWSSP Director of Procurement Services with an updated agreement in situ by the end of March 2020	31/03/2020	**April 2022:** A meeting has been arranged for the 13th May 2022 between the SBUHB Head of Procurement, the NWSSP Procurement Services Director and the NWSSP Head of Finance and Business Development to agree a timescale for the SLA review. Based on the foregoing, the deadline has been extended to 31/05/2022 for further update **June 2022 (Keir Warner):** The SBU Head of Procurement met with the NWSSP Procurement Services Director and the NWSSP Head of Finance and Business Development on the 13th May 2022. No firm timescale was agreed for the review of SLAs, with an agreement to revisit this in September 2022.	30/09/2022

Executive Lead – Director of Finance						
SBU–2021-043		**Integrated Care Fund Banker Role**	**Report Issued June 2021**		**Assurance Rating – N/A**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1(b)	The West Glamorgan Regional Partnership 'Integrated Care Fund Written Agreement 2019/20 - 2020/21' details the following: “11.3 Financial management of the ICF Fund will be subject to compliance with SBUHB Standing Order Schedule 6 Standing Financial Instructions.” Our sample testing identified three items, relating to a larger "data-load" for payment to care homes for which there was no recorded of authorisation by an approved health board officer prior to funds being released. The payment was processed on the basis of the approval of the expenditure amount received from the Transformation Office only. As such, the wider data-load did not receive approval within the health board by an authorised signatory to satisfy its Standing Financial Instructions (SFI’s). Additionally, we identified two payments for which the invoices that included them had been approved by a named authorised signatory, however, both invoices were over £25k in total and the authoriser only had an authorisation limit up to £25k for the GL code. As such, these invoices were not appropriately authorised in line with the health board’s SFIs. (These invoices comprised a number of schemes for reimbursement, including the two non-ICF funded schemes 4CAB and 5CA referred to earlier.) Management should consider producing an internal document detailing the process of managing the ICF fund to ensure that it complies with the written agreement.	**L**	The health board is reviewing how ICF funds are managed within the overall governance structure of the health board and the new process will be documented.	31/12/2022	**April 2022:** Initial meeting held on 30th March to look at re-designing the approval process covering ICF and Transformation. A follow up meeting is scheduled for April to look at the process in more detail. Likely there will be further meetings along with a revised and signed off process agreed before this action can be closed. Timescales for completion in Q1 of 22/23. Based on the foregoing, deadline extended to 30/06/2022 **June 2022:** We have had a number of meetings within the Finance Function in the last 2-3 months. At the last meeting in May it was noted that the wider RIF/ICF process was under review within RPB. Therefore, agreed we would await publication of this information to ensure any changes proposed are aligned to the wider work. Waiting outcome of response. SM chased for response 22/6/22. Therefore deadline for completed needs to be moved to end August 2022.	31/08/2022

Executive Lead – Director of Finance						
SBU 2122-015		**Procurement & Tendering STA & SQA**		**Report Issued October 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2.1	There is currently a lack of training available to employees who undertake procurement exercises. This was noted during the September 2021 Audit Committee meeting and the Head of Procurement has developed a draft training module which will reinforce the governance arrangements relating to the appropriateness of the SQA/STA process. We recommend that the draft training module developed is finalised and made available to all staff that require it. Completion of the training should be recorded, monitored and reported and follow up action taken for staff who have not been on the training.	**L**	Procurement training is being developed that will provide an overview of the STA/SQA process, including their appropriate use. The content of this training is complete. Materials and a training methodology will however need to be agreed. Procurement training has been delivered to executives (20/10/2021) which includes an overview of the STA/SQA process.	01/04/2022	**April 2022:** Training sessions have been planned for the 25th May and 15th June via MS Teams. These sessions will be promoted through the SBUHB intranet and via the senior leadership team. Procurement drop in clinics are being planned from September 2022 and will take place on a rotating basis at Singleton, Morriston, NPT, Cefn Coed and Corporate HQ. Based on the foregoing, deadline has been extended to 30/06/2022 in order to confirm training delivery. **June 2022:** Training slides have been developed but the delivery has been delayed due to resource issues within the procurement team. Two sessions will be delivered in early July 2022 and will be recorded so that all staff can access the sessions. Procurement drop in clinics are still being planned from September 2022 and will take place on a rotating basis at Singleton, Morriston, NPT, Cefn Coed and Corporate HQ. Deadline date extended to 30/09/2022 in order to confirm training delivery.	30/09/2022

Executive Lead – Director of Finance						
SBU 1920-009	**Control of Contractors**		**Report Issued March 2020**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	There was no evidence available to demonstrate that competency vetting had been undertaken, or details of insurances obtained, for eight out of 14 contractors reviewed, primarily those who: – Were engaged by NWSSP Procurement via Multiquote with Estates input – Regularly-used contractors appointed to delivery sub-£5K orders All contractors should be appropriately vetted for health and safety competency and insurance arrangements prior to appointment. Evidence should be retained of checks made	**H**	Agreed. The University Health Board, in conjunction with NWSSP: Procurement Services are looking at accreditation systems that will provide this level of assurance, for example CHAS (the Contractors Health & Safety Assessment Scheme).	31/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** Whilst it is recognised that the UHB is taking steps to introduce contractor assurance systems i.e. CHAS, this has not yet become 'live'. The implementation of the contractor assurance system should be finalised to enable a central repository of the required vetting arrangements for contractors, upon appointment. A cost-free solution was identified but this is taking longer to establish than expected. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022
3	The 2009 Managing Contractors policy specified insurance requirements for contractors, however it is noted that the 2019 policy no longer addresses the same. The UHB's insurance requirements for contractors should be included within the Managing Contractors Policy (or supporting procedures)	**M**	Agreed. The University Health Board, in conjunction with NWSSP: Procurement Services are looking at accreditation systems that will provide this level of assurance.	31/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** At the date of fieldwork, the available Managing Contractors Policy (dated December 2020) had not been updated in accordance with the agreed recommendation. The UHB's insurance requirements for contractors should be included within the Managing Contractors Policy (or supporting procedures). Agreed. The Policy will be updated accordingly by the Estates team. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022
5(a)	The UHB's last in-house audit of induction compliance undertaken at the time of audit fieldwork (dated March 2018) (see also finding 8), which identified that on average 36% of contractors/operatives (at the Morriston & Singleton sites), who had signed in to work on site during March 2018 had not received an induction. Whilst management advised that improvements had been made following those results, a follow-up audit had not been undertaken by the UHB at the time of this review, to determine current compliance rates. Subsequent to the conclusion of the audit fieldwork (January 2020), a new in-house audit of induction compliance rates was undertaken by the Estates team. This audit found reduced compliance from that previously reported. Contractors/operatives should not be allowed to commence work on site without having received an induction.	**H**	Agreed. Estates Managers will be reminded of the need to ensure all contractors have received appropriate induction.	21/04/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** Management confirmed that work remains ongoing as the UHB investigates the use of an electronic system which will enable monitoring of contractors which have/have not received inductions: and details of contractors who have signed in/out of site. The implementation of an automated system to record inductions and site attendance should be finalised; with appropriate manual controls implemented for the interim period. Agreed, however until such a system is implemented, the induction process was being managed by the department's Health & Safety Officer who has since retired. A recruitment process for their successor is ongoing. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022

8	The Estates department undertakes periodic in-house contractor compliance audits, as part of the ISO14001 environmental standard process (as opposed to being specifically for health and safety/contractor monitoring purposes). An in-house audit was last carried out in March 2018 (whilst scheduled annually, an audit had not yet been undertaken in 2019 at the time of audit fieldwork in September 2019). Upon review, it was found that these in-house exercises focused on only two areas in relation to contractor management: • Site induction compliance for the month preceding the date of the audit; and • Signing in/out compliance for the month preceding the date of the audit. In order to improve the information provided to Estates management, the Estates Board and the wider UHB (e.g. Health & Safety Committee), the audit process should be reviewed and enhanced, to encompass: • A specific focus on contractor compliance (as opposed to an indirect focus stemming from the ISO14001 work); • More frequent audit reviews, to provide ongoing assurance to management; and • Wider audit scope, to encompass other key areas of the Managing Contractors policy/HSE requirements. This may include appointment checks, RAMS processes etc. in addition to the existing checks of induction and signing in. In addition to retrospective document review, good practice observed at other health boards includes on-site checks of 'live' contractor practices, to ensure for e.g. that induction information has been understood, ID badges are worn, RAMS are held etc. by the operatives on site carrying out the work. We recognise however that current resources in Estates may not permit such wider monitoring at the present time. Estates in-house contractor management audit processes should be reviewed and enhanced to ensure: • The audit scope represents an appropriate range of HSE and UHB Policy requirements; • Audits are undertaken more frequently, to provide ongoing assurance of compliance throughout the year; • Results are reported to relevant forums/committees for scrutiny and action (e.g. Estates Board/H&S Committee).	**M**	Agreed. An audit was completed in December/January and will be repeated 6 monthly and reported to Senior Team. The reporting to the H&S Committee will be the responsibility of the Head of Health & Safety.	31/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The UHB internal audit recommendation Tracker reports this recommendation as complete. However, no supporting information was provided during the course of fieldwork in order to support this status. The in-house contractor management audit process should be reviewed, enhanced where appropriate and reported to an appropriate forum for endorsement. Plans were for contractor compliance to be audited bi-annually, however this has proved challenging due to staff vacancies. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review As such, this recommendation has been reopened	31/08/2022

Executive Lead – Director of Finance						
ABM 1920-007		**Capital Systems Financial Safeguarding**		**Report Issued November 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	Failure to comply with SO's/SFI's and Local Framework requirements in respect of: – Failure to use formal contracts (as opposed to simple orders) for procurements in excess of £25,000 [this is regardless of whether they are on a framework or not] – Failure to undertake financial vetting for new contracts/procurements in excess of £25,000 – Failure to apply Standards of Business Conduct requirements in respect of the completion of Declarations of Interest Local Framework Procedures and SFI/SOs should be reviewed, and updated where appropriate, to reflect the Estates Department's requirements.	**M**	Discussions will be initiated with the Director of Corporate Governance and the Assistant Director of Strategy – Capital to ensure that all procedural requirements are fit for purpose (e.g. SO/SFI and Local Framework Protocols).	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Partially Implemented** Whilst it is recognised that the UHB is taking steps to introduce contractor assurance systems i.e. CHAS, this has yet to become 'live'. Once the contractor assurance system is implemented, the Local Framework Procedures and SFI/SO should be reviewed and updated to reflect the changes to the governance procedures. A cost-free solution (assurance system) was identified but this is taking longer to establish than anticipated. Once complete, the required updates to the governance procedure will be processed. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022
3	Estates procurement activity was reviewed for the period April 2018 to July 2019, including an examination of all relevant Estates cost centres to determine patterns of unusual activity. This identified a significant number of individual orders below £5,000 in value placed with certain contractors. These were reviewed in more detail and discussed with Estates managers, and it was confirmed that: – The above relate primarily to maintenance/repairs – No formal competitive exercises had been undertaken to confirm that these contractors provided best value; – No competency vetting (including, e.g. appropriate industry accreditation checks, health and safety policies etc.) could be demonstrated – Mgmt. advised that the refrigeration contractor's qualifications should be held within an online portal, however evidence was not provided. – Declarations of interest proforma had not been completed (see also the Capital Systems report 2018/19). The Estates department utilises maintenance contracts to manage longer-term requirements for the provision of maintenance and inspection/testing services for estates infrastructure/ equipment, and in some instances the associated breakdown and repair works.	**H**	Agreed. Appropriate procurement controls will be developed for utilisation within the estates department. These will specifically consider repeat/multiple orders with key contractors/suppliers.	31/12/2019	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Partially Implemented:** Work has been undertaken to review the areas of highest spend. Of the areas identified, including water sampling, legionella testing, refrigeration, boiler maintenance and high voltage maintenance, at the date of fieldwork, contracts had only been awarded for two (legionella testing and high voltage). Contracts should be finalised for the identified maintenance areas. There have been issues experienced in the support being received to address. Two of the contracts have been with procurement since the end of last year to tender, however, due to staff shortages within procurement these have not been let. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022

	Effective from January 2018 the local NWSSP Procurement Services Maintenance team manages a number of these maintenance contracts. However, it was evident from the above, that not all maintenance areas are covered by appropriate contract arrangements. Note: see also Water Management, COSHH, Backlog Maintenance, Capital systems (2018/19) reports previously issued re: maintenance contracts etc. Appropriate procurement controls should be implemented for contractors employed below current quotation thresholds					
4(a)	Lack of appropriate procurement controls for cumulative spends in excess of £5,000 relating to maintenance contracts (see 3 above) An assessment of all current (and required) maintenance contract arrangements should be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee as appropriate; and associated maintenance contracts implemented.	**M**	Accepted. A review of all maintenance contract requirements across the estate will be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee for consideration and action as appropriate.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented** See previous matter arising 3. No evidence of the central reporting referred to in the recommendation was supplied during the follow-up review. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022
8	We sought to confirm that financial vetting had been undertaken where appropriate (i.e. for contractual arrangements over £25k in value). Financial vetting had not been undertaken at any of the 8 procurement exercises reviewed over the £25k threshold requirement. Financial vetting should be undertaken prior to entering into any contractual arrangement above £25k in value (in accordance with Standing Financial Instructions). Estates should liaise with Finance and Capital Planning to establish requirements for financial vetting at the Local Framework.	**M**	Agreed. Advice will be sought from UHB Finance and Capital Planning, together with NWSSP Procurement Services colleagues to determine an appropriate way forward.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Partially Implemented** See previous matter arising 2, noting that the proposed use of the CHAS system will address the requirement for vetting, risk assessment etc. A cost-free solution (assurance system) was identified but this is taking longer to establish than anticipated. Once complete, the required updates to the governance procedure will be processed. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022
9	In order to monitor and report any inadequate/ unusual procurement activity, it is considered sound practice to prepare periodic/ annual procurement activity reports, for consideration by the appropriate UHB forum / sub-committee. Such reports should consider key aspects of Estates procurement activity, with particular attention to areas that may signal fraud or failure to achieve value for money. Aspects should include, for example: • Compliance with SFIs in respect of quotation and tender exercises undertaken; • Analysis of the volume / pattern of single quotation / single tender actions; • High volume use of single contractors; • Analysis of use of contractors by individual Estates officers; • Status of maintenance contracts; • Use of frameworks. Management report all single tender / single quotation	**M**	Agreed. Procurement activity reports (for Estates activity), will be requested from NWSSP: Procurement Services. These will be used to inform reporting within the UHB.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The UHB internal audit tracker notes this recommendation as complete, stating that Procurement Services had provided the reports. However, no evidence was provided during the course of fieldwork to confirm the recommendation had been addressed. Periodic procurement activity reports should be prepared and reported to an appropriate UHB forum/sub-committee. The Procurement team is having issues supporting the process. Discussions with the Head of Procurement are to be scheduled to agree a way forward. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review As such, this recommendation has been reopened	30/11/2022

	actions to the Audit Committee for scrutiny. Financial procurement information is also provided to the Estates Department for budget monitoring purposes. However, the wider analysis / reporting of procurement activity was not identified. Good practice has been evidenced at other UHBs/Trusts involved NWSSP Procurement Services contributing to the same. Periodic procurement activity reports should be prepared and reported to an appropriate UHB forum/sub-committee.					
13	No documented procedures in place for the management of Estates Stores. Formal procedures should be developed and implemented for the management of Estates stores (in accordance with SFIs).	**H**	Agreed. Appropriate procedures will be implemented and management will undertake periodic checks/audits to ensure compliance.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The procedures have yet to be developed; and, at the date of the audit fieldwork, whilst requested, the stock count for the Estates stores had yet to be scheduled. Formal procedures should be developed and implemented for the management of Estates stores (in accordance with SFIs). The Department is looking to appoint a Procurement Officer whose role will include stores management. Permission has been given to proceed with the recruitment process. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022
14	Issues which reduced the effectiveness of intended controls, and SFI breaches were noted, including: • No annual stocktake at Morriston • Singleton stocktake not independently verified • 'Not stock' items on shelves at both stores, but not recorded on Planet FM Stores practices should be reviewed and enhanced in line with audit findings and SFI requirements.	**H**	Agreed. Appropriate procedures will be implemented and management will undertake periodic checks/audits to ensure compliance.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** **See previous matter arising 13.** The procedures have yet to be developed; and, at the date of the audit fieldwork, whilst requested, the stock count for the Estates stores had yet to be scheduled. Formal procedures should be developed and implemented for the management of Estates stores (in accordance with SFIs). The Department is looking to appoint a Procurement Officer whose role will include stores management. Permission has been given to proceed with the recruitment process. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022

Executive Lead – Director of Finance						
ABM 1617-009	**Backlog Maintenance**		**Report Issued October 2017**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no specific policy at the UHB relating to the management of backlog maintenance. The UHB is placing reliance on the WG PBC that has been approved yet there is no evidence to suggest that a strategic view is being taken of the longer-term requirements / projects that will need to be addressed vs. those which are bid upon. The overarching Service Strategy referred to in the PBC will 'expire' 31 March 2018. Management has stated that association with the ARCH collaboration is seen as a mechanism to address the longer strategy for Estates. However, there is no narrative information to support the detail of the longer term strategy / direction of the UHB; and is subject to the success of the collaboration which has yet to be tangibly demonstrated. Management will draft and issue an Estates Strategy which specifically identifies the longer term direction of the UHB, how it aligns with ARCH and the UHB's Service Strategy; and how backlog maintenance is to be managed i.e. targets for reducing significant backlog and how it is to be achieved in terms of capital delivery plans	**M**	The directorate, as part of the Arch project, is developing an overarching strategic plan for its estate. This will be based upon the six-facet survey that the Health Board is seeking to commission this financial year. The Health Board is developing specification for the completion of a six-facet survey, which will allow the Health Board to take an informed review of the estate under its control. The Health Board had approached Welsh Government for central funding for the provision of a six-facet survey as this had been centrally funded for another Health Board. However, the Health Board has not had confirmation of this funding and therefore is seeking to start the process utilising existing discretionary capital.	31/12/2018	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented:** Whilst and external party has been commissioned to assist with the development of the strategy; and the 6-facet survey work was successfully tendered; at the date of fieldwork, the work had not been completed and consolidated to further inform the wider Estates Strategy. The output of the 6-fact survey should be reviewed to assist in the development of an appropriate Estates Strategy to address the management of the backlog maintenance. The priority rating on this recommendation has been reduced from High to Medium, recognising the progress made. This will be undertaken once the 6-facet survey is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022
4	With regard to the maintaining of the detail on OAKLEAF, it has been observed that the updates are not appropriately delegated. The Assistant Director of Strategy (Estates) currently updates and maintains the system on an annual basis, rather than the system being updated from an operational basis with greater frequency. OAKLEAF categorises all assets by condition and risk, an exercise which will be performed on an annual basis. However, it was not evident that this information was extracted from the system to assist in the categorisation of work when bidding for capital funding; rather reliance placed on accumulated knowledge used to populate the departmental risk register The ownership of managing the OAKLEAF system will be reviewed to ensure timely, operational information is reflected	**M**	The Assistant Director of Strategy (Estates) formally coordinated the OAKLEAF return completion. In June 2017 he updated the database and advised each of the Estates Managers that they were now responsible for maintaining the information within the OAKLEAF system. Capital bids can only be made if the item is listed within the backlog maintenance system (excluding statutory work). Each estates department has a performance review every 6 to 8 weeks. It is now intended that this review will include backlog as an agenda item.	01/12/2018	**February 2022:** The department transferred its significant and high risks from the Oakleaf system into the DATIX system. The department met with the risk Governance group and were asked to revisit the format of the risk assessments to provide themes for the risk register. Working with the Assistant Director of Health & Safety this work has been completed in January 2022 and we are now arranging to review these revised risks with the Assistant Head of Risk & Assurance. Revised deadline date of 28/02/2022 for further update following the above meeting. **April 2022:** Meeting with the Assistant Head of Risk and Assurance has taken place, and a copy of the revised departmental risk register has been provided. This will be reviewed by the Assistant Head of Risk and Assurance, who will provide further feedback and comment - Estates strategy and 6 facet survey paper submitted to Space Utilisation Task and Finish Group on 21/4/2022. The deadline date has been extended to 30/06/2022 for further update.	30/06/2022

7	The last recognised date for the completion of a condition survey is circa 2005. Consequently, backlog maintenance costs are not properly stated. The UHB is in the process of developing a specification for the requirement of completion of a full condition survey on a room by room basis. The development of the specification will be finalised as soon as possible to facilitate the provision of a current 'market' backlog maintenance cost. This information will further assist in identifying the significant capital projects required to ensure the UHB sites are 'fit for purpose'	**M**	The Health Board is seeking to commission a six-facet survey this financial year. The Health Board is developing a specification for the completion of the survey, which will allow the Health Board to take an informed view of the estate under its control. The Health Board had approached the Welsh Government for central funding, for the provision of the survey, as it had been centrally funded for another Health Board. However, the Health Board has not had confirmation of this funding and, therefore, is seeking to start the process utilising existing discretionary capital.	01/10/2018	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented:** Whilst and external party has been commissioned to assist with the development of the strategy; and the 6-facet survey work was successfully tendered; at the date of fieldwork, the work had not been completed and consolidated to further inform the wider Estates Strategy. The output of the 6-fact survey should be reviewed to assist in the development of an appropriate Estates Strategy to address the management of the backlog maintenance. This will be undertaken once the 6-facet survey is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022

Executive Lead – Director of Finance						
ABM 14-15-003	**Disability Discrimination Estates Compliance**			**Report Issued March 2015**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	Costs to achieve compliance with DDA identified in Estates Facilities Performance Management System (EFPMS) data could not be reconciled to previously commissioned disabled persons access reports. Procedures will be established to demonstrate the derivation of EFPMS declared compliance costs (including reconciliation to surveys)	**M**	Agreed - However, the DDA act requires the Health Board to make services available to all patients, visitors and staff. Therefore in some cases there is no need to take action until a concern is raised over the accessibility to the service provided. Whilst it is important for the Health Board to address the fundamental accessibility issues such as disabled access through doors, hearing loops etc. More specific actions are only required if the Health Board cannot provide those services within its existing estate.	31/08/2018	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented:** Management advised that as part of the 6-facet survey work, it was requested that an equality review is also completed. At the date of fieldwork, the survey had yet to be completed. The output from the equality review undertaken should be reviewed to address the **requirements of the previously agreed recommendation.** **This will be undertaken once the 6-facet survey report is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review**	30/09/2022

Executive Lead – Director of Finance						
SBU 2021-008		**Water Safety**		**Report Issued June 2021**	**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
8(a)	The Water Safety Plan documents the training requirements for key officers, including the requirement for training to be refreshed at least every three years. Training was in date for the current Responsible Persons and Authorised Persons. However, training for Competent Persons (Estates Officers) was out of date with the last training recorded as February 2017. Management advised that the provision of the required face-to-face training had not been possible due to COVID restrictions. It is acknowledged that some Authorised Persons training has now been arranged (noting this takes place offsite); but securing on-site training (for Competent Persons) remains difficult. It was noted that whilst a training matrix for Estates officers was held for those working at the Singleton estate, the same was not evidenced for the Morriston estate. Training should be updated for relevant staff as soon as possible, COVID restrictions permitting	**M**	Agreed. Training will be updated as soon as possible.	31/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The Water Safety Plan includes two appendices relevant to training [1] Training Matrix and [2] Training Status. However there is no evidence of update reporting being provided to the Water Safety Management Committee or the Health & Safety Operational Sub Group; Water Safety Management to confirm the status of training provision for relevant staff, as per the recommendation. Training should be updated for relevant staff as soon as possible. Staff are being booked on courses, however, due to a lack of availability (owing to demand post-pandemic) there are gaps in compliance. Further, courses have increased in cost significantly – most Authorised Persons duties require a training course of either 1 or 2 weeks, which can vary in cost from £4k to £8k. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review	31/08/2022
8(b)	The Water Safety Plan documents the training requirements for key officers, including the requirement for training to be refreshed at least every three years. Training was in date for the current Responsible Persons and Authorised Persons. However, training for Competent Persons (Estates Officers) was out of date with the last training recorded as February 2017. Management advised that the provision of the required face-to-face training had not been possible due to COVID restrictions. It is acknowledged that some Authorised Persons training has now been arranged (noting this takes place offsite); but securing on-site training (for Competent Persons) remains difficult. It was noted that whilst a training matrix for Estates officers was held for those working at the Singleton estate, the same was not evidenced for the Morriston estate. Training requirements and compliance should be captured in a training matrix, for all staff with water safety responsibilities (including both Estates and departmental / ward staff) (O).	**M**	Agreed. The required detail will be incorporated into the Water Safety Plan.		**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The Water Safety Plan includes two appendices relevant to training [1] Training Matrix and [2] Training Status. However there is no evidence of update reporting being provided to the Water Safety Management Committee or the Health & Safety Operational Sub Group; Water Safety Management to confirm the status of training provision for relevant staff, as per the recommendation. Training requirements, and compliance, should be captured in a training matrix for all staff with water safety responsibilities (including both Estates and Departmental/Ward staff). Staff are being booked on courses, however, due to a lack of availability (owing to demand post-pandemic) there are gaps in compliance. Further, courses have increased in cost significantly – most Authorised Persons duties require a training course of either 1 or 2 weeks, which can vary in cost from £4k to £8k. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review As such, this recommendation has been reopened	31/08/2022

9(a)	Water-related risks are recorded by Estates management in the Datix risk management system in line with the wider corporate risk management procedure, escalating to the Corporate Risk Register should the score be sufficiently high. There were no corporate-level water risks reported at the time of the audit. The Water Safety Management Committee's terms of reference state that it should: – Provide a forum in which high level Water System monitoring outcomes and risks can be reported to, evaluated, so that appropriate reduction or elimination action is agreed; and – Consider identified risks, set priorities and produce action plans for each site. Whilst a number of appropriate risks were seen to be discussed at the Water Safety Management Committee, the risk register itself (as recorded in Datix) was not shared. On review of the current Datix recorded water-related risks, it was noted that some high-risk issues discussed at the Water Safety Management Committee had not been recorded (e.g. the absence of up to date risk assessments), whilst other risks, recorded in Datix, had not been discussed at the same (e.g. 'provision of resilience for the [Morriston] site'. Water safety risks captured in Datix should be routinely reported to and reviewed by the Water Safety Management Committee as a standing agenda item.	**M**	Agreed. Moving forward risks will be noted as an agenda item for the Water Management Sub Group for review.	31/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** Whilst this has been reported as completed on the UHB Internal Audit recommendation tracker (entry dated August 2021), at the date of the audit fieldwork, management confirmed that the water safety risks were still in the process of being updated. Once finalised, the details would be discussed with the Water Safety Group to ensure they are considered appropriately in the wider risk management of the UHB. The review of water safety should be completed and captured appropriately on DATIX to be effectively monitored and reported. Awaiting confirmation from the Assistant Head of Risk & Assurance on the completion/availability of the risk database that has been updated. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review As such, this recommendation has been reopened	30/09/2022
9(b)	Water-related risks are recorded by Estates management in the Datix risk management system in line with the wider corporate risk management procedure, escalating to the Corporate Risk Register should the score be sufficiently high. There were no corporate-level water risks reported at the time of the audit. The Water Safety Management Committee's terms of reference state that it should: – Provide a forum in which high level Water System monitoring outcomes and risks can be reported to, evaluated, so that appropriate reduction or elimination action is agreed; and – Consider identified risks, set priorities and produce action plans for each site. Whilst a number of appropriate risks were seen to be discussed at the Water Safety Management Committee, the risk register itself (as recorded in Datix) was not shared. On review of the current Datix recorded water-related risks, it was noted that some high-risk issues discussed at the Water Safety Management Committee had not been recorded (e.g. the absence of up to date risk assessments), whilst other risks, recorded in Datix, had not been discussed at the same (e.g. 'provision of resilience for the [Morriston] site'.	**M**	Agreed. As explained at the time of the Audit, the Estates element of DATIX has not yet gone "live". The Governance Department are arranging for a review of the Estates Risks and have also been working with the Department to allow us to put Health Board wide risks into the database. The reason that the risk assessment having just gone out of date is not entered, is because we were having to enter it for individual buildings. We are currently in discussions with Governance about giving us the capability to enter this information across the Estate rather than by building. The Health Board is in the process of awarding the risk assessment contract WATER SAFETY.	31/07/2021	**August 2021:** The Governance department are reviewing the estates risk register in September with the Estates team, which will also consider how the risks are allocated across the health board. This will then be presented to the October scrutiny panel suggested new date. First of November **February 2022:** The department met with the risk Governance group and were asked to revisit the format of the risk assessments to provide themes for the risk register. Working with the Assistant Director of Health & Safety this work has been completed in January 2022 and we are now arranging to review these revised risks with the Assistant Head of Risk & Assurance. Revised deadline date of 28/02/2022 for further update following the above meeting. **Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** See previous matter arising 9a above. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022

	Management should resolve the current Datix usability issues to ensure water-related Estates risks can be accurately captured, monitored and reported.					

Executive Lead – Director of Finance						
ABM 1819-009		**Safe Water Management (Including Legionella)**		**Report Issued May 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
12	WHTM 04-01 states: “Legionella monitoring should be carried out where there is doubt about the efficacy of the control regime or where the recommended temperatures, disinfectant concentrations or other precautions are not consistently achieved throughout the system. The WSG (Water Safety Group) should use risk assessments to determine when and where to test.” Whilst noting the same, the UHB’s Water Safety Plan (approved by the UHB Quality and Safety Committee in May 2018) states that: “The Health Board is seeking to commence a program of Legionella testing based on the table below (See Appendix B) for the area identified as requiring Legionella testing to take place the frequency of testing will be as follows: – Three samples will be taken within the area identified these being the system Sentinel outlets. These outlets will be tested for Legionella on a monthly basis. If there are three clear sets of readings sampling will reduce to bi monthly (retests that are negative will be treated as a clear result). If there are three sets of clear readings sampling will move to 3 monthly sampling. Sampling will never reduce further than three monthly.” Infrastructure risk assessments assess “water risks on all buildings owned or occupied by the Health Board and its equipment…in accordance with the guidance in ACoP L8 (2013), BS8580 (2010), and relevant HTMs in order to identify risks and assess water quality issues from work activities and water sources on the premises and to organise any necessary precautionary measures.” At the time of the current review, the infrastructure risk assessments were out of date and were not being referenced. However, a specialist water management company had recently provided revised risk assessments for all ABMU properties which were to be applied. Noting the above, whilst recognising that the WHTM recommends the use of risk assessments to determine when and where to test, at the time of the review, the same were not being applied. Additionally, noting lapse of the testing contract, the audit did not evidence legionella testing in accordance with the above. Legionella testing (in accordance with the agreed Water Safety Plan) remained to be formalised with the public health laboratory via a Service Level Agreement. A service level agreement / contract for water testing should be appropriately concluded.	**H**	Agreed. The Water Safety Plan states that we would routinely test for legionella, although under the WHTM guidance there is no requirement to test for legionella as it is based on an assessment of risk. Whilst the Health Board is aspiring to implement a programme, current practice is that we test for legionella where we have an adverse result or as part of a commissioning / decommissioning process. The water safety plan was not being adhered to at the time of audit.	31/07/2019	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** At the date of fieldwork, the contract for water testing had not been finalised. See also Financial Safeguarding previous matter 3. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022

Executive Lead – Director of Finance						
ABM 2021-009		**Fire Safety Management**		**Report Issued April 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	The Chief Executive of NHS Wales wrote to all NHS organisations on 13th February 2020 emphasising: "organisations assess and provide appropriate levels of investment in relation to fire safety measures." with direction to "discuss.. implications with organisations via the regular Capital review meetings" i.e. investment sources should be confirmed, including the need to submit capital business cases to Welsh Government. Site level reports undertaken by management in November 2020 detailed the following with regard the sampled sites: **Hospital Site** / **% compliance with Firecode** / **Projected compliance date** / **Cost to achieve compliance** Singleton / 70% / 2025 / £5m Morriston / 75% / 2021 / £5m Cefn Coed / 75% / 2022 / £0.3m There was no apparent strategy to achieve required compliance (particularly recognising the 2021 projected compliance date for Morriston Hospital). Management should develop an appropriate strategy targeting funding to address fire safety requirements.	**H**	Agreed. £37m has recently been made available across NHS Wales (as part of the National Capital Programmes in 2021-22 for Infrastructure, Fire Safety, Mental Health, and Decarbonisation, of which, £5.456m was allocated to SBUHB, with £0.261m being specific to Fire Safety). These monies were requested under general themes rather than specific investment projects, and allocations within this for items such as £84k for electric panels will also contribute to fire safety. A more detailed plan will be created with 5 – 10 year horizons, and the Health and Safety Fire sub-group will undertake detailed assessment of bids going forward.	30/06/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Outstanding** At the date of fieldwork, management confirmed that the 6-facet survey had been commissioned by the UHB and that it was due to be completed by the end of the financial year. The output of the survey will identify the scope of the works required to enable the UHB to develop the strategy accordingly. This will be undertaken once the 6-facet report is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022
12	In accordance with the Fire Safety Policy, there are enhanced fire responsibilities for key staff groups e.g. fire wardens, ward managers etc. Data for enhanced training, notably Fire Wardens was not identified across the UHB. However, management were able to evidence that the overall figure trained as of February 2021 was 75% (benchmarking below other health bodies that have recently been audited). However, there was also need to ensure adequate numbers of Fire Wardens / those with enhanced duties are trained (noting their key roles in outbreak and feedback). Noting the local and dynamic nature of training compliance, this is best monitored at a local level, with summaries to corporate management. This would also free limited central resource. Annual audits undertaken by central management (as required by WHTM 05), can focus on ensuring effective operation of such local controls. Fire safety training in the UHB should be prioritised for all staff.	**M**	Agreed. All face 2 face training was put on hold initially in wave 1 of the pandemic and has continued due to operational pressures to deal with COVID-19. All new starters have been provided fires safety training as part of the HB pathway for new and redeployed staff in response to the pandemic. Where staff have been able, they have undertaken on-line fire safety training with compliance of 75% at the end February 2021. As part of the transition to business as usual, there will be a focus on training (on-line) initially and then a combination of face 2 face and on-line learning.	31/05/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented** At the date of fieldwork, training had not returned to face-to-face, and the KPI data reported that delivery of training was not 100% compliant (77% of the workforce having completed fire training). It was evident that the UHB had developed training packs for be delivered, but completion of the agreed recommendation can't be concluded until there is evidence that full training has been delivered to staff. Fire training in the UHB should continue to be prioritised for all staff. The priority rating on this recommendation has been reduced from Medium to Low, recognising the progress made. The Welsh Government training target is 85% and whilst not achieved, are close to achieving. Service Groups have robust plans to increase the training performance noting that COVID-19 is still having an impact. Over the last 2-3 months, this has been noticeable with the number of staff off rather than the volume of patients being treated for COVID. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022

Executive Lead – Director of Finance						
ABM 2021-004		**Health & Safety Framework Follow Up**		**Report Issued January 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
6(i)	Review of the health boards health & safety intranet page confirmed that content and links had not been updated to be consistent with approved policies published on the health board main policies page (i.e. some out of date policies were accessible via this route e.g. lone working). Whilst this is the case updates policies can be found within the Corporate policy library. Management should undertake a review of all Health & Safety intranet pages to ensure they are refreshed to reflect the latest information and policies or links to the main corporate policy page so that alignment is ensured.	**M**	The health & safety webpage has been reviewed by the Assistant Director of Health & Safety, and a request has been made to update the webpage and remove the policy links and to insert: To access the latest versions of health and safety policies use this link: http://howis.wales.nhs.uk/sites3/documentmap.cfm?search=true&metatype=&filetype=&libraryid=14715&keywords=&orgid=743&go=FindJust Waiting for confirmation that this has been completed	31/01/2021	**August 2021:** Have contact IT to be able to gain access to the H&S page and not had any success, will continue to follow this up to either temporary take it off line or update as required. **February 2022:** The Health Board is in the process of launching a new intranet page and once launched H&S will develop a H&S section on the new platform. 16/02/22 Noting the foregoing, the deadline has been extended to 30/06/2022 for further update **April 2022:** The HB continue to develop the new intranet and once complete, the H&S Team will develop the H&S webpage.	30/06/2022
7(i)	Our previous report highlighted that of the 78 actions contained within the 2019/20 Improvement Plan only 17 were listed as complete, and that as part of closure of 2019/20 and as part of developing longer term strategies, the status of those actions remaining outstanding should be reported. The pandemic has had an impact both on the resource with which to address plans early in the year, and on the need to refresh the content of plans. It is apparent from our review of papers that there has been ongoing discussion on the development of the Strategic Action Plan for 2020/21 which has been received at HSC meetings in June, September and December 2020. Meeting notes of both the HSC and the Health & Safety Operational Group do not record effectively how the original 2019/20 improvement plan was closed. We note though that it is intended that an operational plan to support the strategic plan will be developed to support the SAP. We recognise that priorities have changed this year and new approaches and fresh plans may be appropriate. A plan has been presented to HSOG setting out how the health & safety function will support wider services. It has been too early to demonstrate the effectiveness of monitoring of progress against plans, noting that the development of the SAP has been ongoing during 2020/21 – so the principle of our previous recommendation remains to be addressed. We have none the less updated the recommendation as detailed below. Additionally, we would note that the term 'action plan' is often used interchangeably in papers and agendas making the distinction unclear and the content of minutes of discussions and decisions at the HSOG does not assist	**H**	Due to the on-going challenges with COVID-19 and priorities being focussed in other areas and the realisation of the SAP original dates being over optimistic, the SAP has been updated and presented to the HSC in December 2020, it was agreed that the plan will be for 2021/22 financial year. This will be relayed to the HSOG in the meeting scheduled 03/02/21. The SAP will be monitored through the HSOG and updates provided to the HSC for scrutiny	31/3/2021	**February 2022:** The H&S strategic action plan has been further reviewed due to challenges around COVID-19, the amended version is being submitted to the H&S committee in April 2022, this will cover 2022/23 & 23/24, this replaced the previous action plan. From the strategic action plan an operational action plan will be produced and provide a more detailed plan to be submitted through the HSOG. Based on the foregoing, the deadline has been extended to 30/04/2022 for further update April 2022: The updated plan was presented to the H&S Committee on 5th April 2022. Noting the foregoing, the deadline has been extended to 30/09/2022 in order to evidence progress reporting.	30/09/2022

	clarity. This has been reflected in the revised recommendation for point 7(ii). From December 2020, update reports to the HSC on the Health & Safety Strategic Action Plan should include a clear indication of progress against actions, with a summary position to aid oversight. The reports should include information on delay against original timescales and/or record where there are changes to original target dates clearly.					
7(ii)	Review of agendas and minutes confirmed that the Health & Safety Strategic Action Plan 2020/21 has been included within HSOG agendas at a number of meetings throughout 2020 as it was developed and timescales amended in light of the impact of the COVID-19 pandemic though it is too early to demonstrate review of progress. As noted at 7(i) above, discussion of the 2019/20 improvement plan was not clear. We note that whilst the Strategic Action Plan was not presented to the HSOG in November, the group received a 'Health and Safety Plan 2020-21' outlining the areas the corporate H&S team would prioritise for 2020-21. Consistent terminology should be used when referring to the Strategic Action Plan and any supporting plans for clarity, and that progress against each be reported clearly at HSOG meetings.	**M**	The HB take on board the points raised and the confusion this may cause and moving forward there will be the SAP that will outline the strategic view and the HSP (HSWP) that will have a more detailed operational plan to assist in implementing the SAP, both will be reviewed by the HSOG with updates provided to the HSC.	30/06/2021	**February 2022:** The H&S strategic action plan has been reviewed due to challenges around COVID-19, the amended version is being submitted to the H&S committee in April 2022, this will cover 2022/23 & 23/24, this replaced the previous action plan. Form the strategic action plan, From the strategic action plan an operational action plan will be produced with more consistent terminology. Based on the foregoing, the deadline has been extended to 30/04/2022 for further update **April 2022:** Following on from the presentation of the SAP to the H&S committee, it was agreed to develop a single action plan, this will now be developed in Q1 2022/23 and suggest this be extended to 30/06/2022	30/06/2022

Executive Lead – Director of Finance						
SBU 1819-007		**Systems: Declarations of Interest & Risk Management**		**Report Issued October 2018**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
14	Management were able to explain how the capital allocations from the 2018/19 discretionary programme were determined, based on risk, however no audit trail was available to verify the use of OAKLEAF to drive this process. It was also noted that the Estates Operating Procedures were out of date, and the funding allocation procedure described by management was not formally documented. Estates Operating Procedures should be updated, to set out the required processes associated with the recording of identified risks, and in the risk prioritised allocation of discretionary capital.	**M**	Agreed. The Department will review how this is achieved in light of the transfer of the Risk Register onto the DATIX system.	30/09/2019	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002): Outstanding** No evidence was provided by the UHB as to the action taken to address the agreed recommendation. Estates Operating Procedures should be updated, to set out the required process associated with the recording of identified risks, and in the risk-prioritised allocation of discretionary capital. The Department will review how this is achieved in light of the transfer of the risk register onto the DATIX system. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review	30/09/2022
16	A significant number of estate-related risks were captured on Unit risk registers across the Health Board. Unit risk registers (as held in the DATIX risk management system) were reviewed during the audit, and circa 100 risks were identified which had been categorised as relating to "Environment, Estates and Infrastructure." There is currently no formal process by which Estates were involved in the assessment or review of such risks held within the DATIX system. The only means by which the department would be aware of these risks, was if the Unit notified Estates of an issue which may require repair/resolution. There is a risk, therefore, that the OAKLEAF system may not adequately reflect the full range of estate risks identified across the UHB (particularly noting concerns that the OAKLEAF system may in general not be sufficiently up to date, given the lack of recent Health Board-wide estate survey: as highlighted at the 2016/17 Backlog Maintenance audit). Estates should review the estate-related risks captured at Unit risk registers, and ensure these are reflected in OAKLEAF, where appropriate.	**M**	Agreed. The Department are starting discussions on how to transfer its Risk Register onto DATIX. Once this is achieved, the Department will be able to capture all risk associated with the Estate from all of the Service Directorates. The OAKLEAF system will then be used only to hold its Condition Appraisal information, with DATIX being the Department's Risk Register.	30/09/2019	**February 2022:** The department met with the risk Governance group and were asked to revisit the format of the risk assessments to provide themes for the risk register. Working with the Assistant Director of Health & Safety this work has been completed in January 2022 and we are now arranging to review these revised risks with the Neil Thomas Head of Risk & Assurance. Revised deadline date of 28/02/2022 for further update following the above meeting **April 2022:** Meeting with the Assistant Head of Risk and Assurance has taken place, and a copy of the revised departmental risk register has been provided. This will be reviewed by the Assistant Head of Risk and Assurance, who will provide further feedback and comment. Based on the foregoing, the deadline date has been extended to 30/06/2022 for further update.	30/06/2022

17	It was observed that “assurance reports” provided by the Assistant Director of Operations (Estates) to the Director of Strategy and (verbally) to the Health & Safety Committee were somewhat disparate, and did not reference the Estates risk register, or the respective risk ranking of each of the compliance areas. Reporting of the key estates compliance issues to the responsible Director and elsewhere should include linkage to the risk register and the risk-ranked prioritisation of the issue/s being reported.	**M**	Agreed. Management will review the format of the report to include a risk rating for each of the issues being highlighted, with a view to prioritising these issues within the report.	31/05/2019	**July 20219:** A coordinated report without risks has been presented to H&S Group. Also presented a report to main H&S Committee on Estates Risks. A new report will be developed for September’s Committee using Risk ratings. It was agreed this format will be used going forward. **January 2020:** Reports have been presented at H&S Committee on Estates issues. The new WEB meeting will further enhance this operational H&S group. **April 2022:** The Estates risk register has been reviewed and presented to Management Board. Capital discretionary plan based on the updated Estates risk register signed off by board. Noting the foregoing, the deadline date has been extended to 30/06/2022 in order to obtain confirmation that Estates reporting has been updated in line with the agreed action.	30/06/2022

Executive Lead – Director of Finance						
SBU 1819-038		**Strategy & Planning Directorate**		**Report Issued October 2018**	**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2(i)	Most staff had objectives set for 2017/18. However, the objectives provided for Estates supporting managers related to delivery in 2015 & 2016. Additionally, whilst Capital Planning staff had objectives which included delivery in 2017/18, for some (including the Assistant Director) there were also objectives with delivery dates in preceding years - suggesting objectives had not been refreshed annually. We would recommend that Capital Planning & Estates refresh objectives annually, setting new targets for the year(s) ahead.	**M**	PADRs will be held with all staff to set objectives and targets	21/12/2018	**July 2019:** PADRs are reviewed via Estates Board, objectives have been set on a reactive basis to date. Moving forward objectives will be set at the start of financial year to align with budget allocations.	21/12/2018

Executive Lead – Director of Finance						
SSU-SBU 2122-005		**Waste Management**		**Report Issued February 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	Environmental awareness / recycling training had been removed from the UHB's Corporate Induction programme. Management recognises the need for wider awareness/recycling training provision within the UHB, and acknowledged they have sought support from the Learning & Development team to implement an online training module. However, progress has been slow, recognising COVID priorities. Support from the recently launched Sustainable Swansea Bay forum may be possible to take this forward, noting the potential benefits to improved waste reduction / recycling rates. Management should engage with the Sustainable Swansea Bay forum (or appropriate alternative) to present the benefits of wider awareness/recycling training across the UHB.	**M**	Agreed. We will engage with the forum to present the benefits of cross-UHB awareness / recycling training, to support the UHB's recycling targets	30/04/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 31/08/2022.	31/08/2022
3	The following issues were identified during the site visit to Morriston Hospital: • The hospital was not using the offensive (tiger stripe) waste stream for non-infectious PPE, as recommended by WHTM 07-01 and NWSSP:SES (see MA5); • The internal waste storage rooms observed had been left unlocked, despite being unattended. Noting these rooms contain clinical waste, and are located off public corridors, they should be locked when not in use; and • There was mis-segregation of general waste and recycling in the bins outside the Management Centre. Whilst recognising these bins were colour coded, there was an absence of signage to guide staff on required segregation. a) Relevant staff at all sites should be reminded of the importance of locking waste storage rooms when not in use. b) Staff should be reminded of correct waste segregation processes for general waste and recycling. Posters/signs should be displayed close to relevant bins to aid this process.	**M**	a) Agreed. The Assistant Director of Estates has written to the Service Directors on issues highlighted in the audit of waste management asking them to remind their teams on the importance of locking waste cupboards which was highlighted in the audit report. b) Agreed. We will obtain signage to attach to the walls by the bins to provide improved guidance to staff in this area.	30/04/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 31/08/2022.	31/08/2022

4	It was confirmed during the site visit to Morriston Hospital (see MA5), that the public / general staff areas observed (main entrances, visitor waiting rooms, staff rest areas, canteens) provided domestic waste bins for disposal of general waste, including masks. In the clinical areas observed, only orange (infectious waste) bins were provided. Management confirmed that the UHB does not currently use the offensive (tiger stripe) waste stream in its hospitals, therefore, is unable to comply with the current guidance. Management should report the costs/benefits of the introduction of the offensive (tiger stripe) waste stream to an appropriate forum/department (e.g. Infection Control), for onward consideration of the matter outside Estates.	**M**	Agreed. This will initially be reported to the Director of Finance & Performance, and then to the Operational Service Group Boards.	31/03/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022
5	Whilst some examples of good practice in waste minimisation were provided by management, it was not evident that a UHB-wide critical review has been undertaken in recent years. A critical review of waste volumes and types across the UHB should be presented to the Sustainable Swansea Bay forum (or appropriate alternative), to identify potential for waste minimisation in line with WHTM 07-01(5.3).	**L**	Agreed. We recognise the benefits of such an exercise, but the ability to facilitate the same sits outside Estates – recognising that key parties would include e.g. NWSSP Procurement Services and Infection Control. We will present the option (of e.g. a review of the largest consumable items within the UHB), and provide a critical review of 2021/22 data, to the Sustainable Swansea Bay forum for consideration by the relevant parties.	30/04/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022
6a	A process of action tracking and reporting was not evidenced for Pre-Acceptance audit non-conformities. a) Recommendations / non-conformities arising from Pre-Acceptance audits should be monitored via the central tracker.	**M**	a) Agreed, we will prepare a RAG-rated summary log of all audit findings.	31/01/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022
6b	A process of action tracking and reporting was not evidenced for Pre-Acceptance audit non-conformities. b) Pre-Acceptance audit non-conformities, and progress towards actioning the same, should be reported to a relevant forum/s (e.g. Estates Board / Hospital Management Boards).	**M**	b) Agreed. Recognising that Morriston has recently established a Management Board (with the same anticipated for Singleton), the presentation of relevant audit findings could be directed to these forums (rather than the Estates Board, which only has the ability to influence Estates issues), to enable appropriate oversight and action by the relevant responsible officers (i.e. ultimately the Service Directors). The Assistant Director of Operations (Estates) will liaise with the Service Directors to confirm how they wish for relevant issues to be reported. Where pre-acceptance audit findings relate to Estates, these will be incorporated into the existing Environmental Report. It is also noted that Estates are in the process of developing a Compliance Manager post, which would play a key role going forward in the monitoring of audit recommendations.	31/01/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022

7	There was minimal evidence of waste management issues being reported to the Health & Safety Committee during the period reviewed (April 2020 onwards), aside from a brief reference to waste risks within the Health & Safety Operational Group Key Highlights Report. There was no formal reporting evidenced from Estates. a) The Environmental Report (or alternative appropriate report) should be enhanced to widen the scope of reporting of waste management issues. (see also recommendation 6.1.b). b) The relevant Board-level Committee should receive periodic waste management updates. (see also recommendation 1.1.a).	**M**	a) Agreed. See also management comments above at 6.1.b regarding widening the scope of reporting outside the Estates Board to ensure Service Unit Directors are appropriately sighted on issues arising within their areas of responsibility. Further, from January 2022, waste is now included within the Estates update to the Health & Safety Operational Group. b) Agreed. We will incorporate a summary on waste management into the next Estates report to the H&S Committee, which is due before April 2022.	30/04/2022	**Undated:** Waste was included in the Estates paper submitted to the H&S Ops group on 02/02/2022	None Entered

Executive Lead – Director of Workforce & Organisational Development						
ABM 1718-046	**European Working Time Directive Portering Services**		**Report Issued May 2018**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no policy or procedure within the Health Board that supports the European Working Time Directive The Health Board should look into composing a Policy to ensure compliance with the Working Time Regulations 1998 across all staff disciplines.	**H**	Agreed. A policy/guidance will be composed.	01/09/2018	**February 2022** A guidance document has been drafted and will be circulated for comment (31/03/2022). Based on this date further extended to 31/03/2022. **June 2022:** Guidance needs to be approved by Staff Side. Staff Side will consider this at the next Sub Group meeting on 7th July 2022. Noting this, deadline extended to 31/07/2022 for further update	31/07/2022

Executive Lead – Director of Workforce & Organisational Development						
ABM 1819-042	**Junior Doctors Bandings Follow Up**		**Report Issued April 2019**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	On the recommendation of a previous audit review, Medical HR composed a draft document giving guidance on Junior Doctors Hours. The guidance outlined: - The requirements of junior doctors in terms of WTD compliance and Natural Breaks. - The need for operational service support for the monitoring process. The document was presented to the Local Negotiating Committee (LNC) where, we were informed, there was disagreement to some of the content (exception forms) by some attendees, so the guidance was not progressed any further at that time. It was also noted that a guidance document for handover procedures was also drafted, but also progressed no further. There was no progress on a policy/guidance on the use of hospital pager bleeps. We would recommend that the Medical Director, with the support of the Director of Workforce & OD, consider review of draft policies and procedures and progress their development and formal adoption.	**M**	This action is agreed by management. It should be noted there has been extensive resistance from the LNC to the adoption of the guidance and in particular the use of the exception form. We need to liaise with the newly constituted LNC for Swansea Bay UHB and junior doctors reps but after this, irrespective of views expressed, the documentation will be implemented.	30/06/2019	**November 2021:** Action yet to be progressed due to workforce pressures and other priorities. Aim is that matters progress Q1/2 2022/23. It should be noted Wales is currently exploring a new junior doctor contract and if adopted this will remove the need to monitor under the New Deal arrangements **June 2022:** Monitoring is limited at present. A more comprehensive programme will commence at the start of Q3. At this point simple guidance addressing Audit recommendations will be issued to support the exercise setting out the different roles and responsibilities which will satisfy audit recommendations. In 2023 it is likely that a new junior doctor contract may be implemented in Wales which will replace the New Deal arrangements. New deadline October 2022	31/10/2022

Executive Lead – Director of Workforce & Organisational Development						
SBU 1920-042	**Disclosure & Barring Service (DBS) Checks**		**Report Issued January 2020**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	The WODC action plan has an action to "Commence roll out of DBS plan" but no milestones or target date for its completion. There is a lack of quantitative detail in the high-level WODC action plan updates. Progress reported to WODC through the action plan does not include key information such as the number of DBS checks that have been completed against those required, the numbers in progress, or are yet to be started. We recommend that: i) Additional milestones and a target completion date be agreed for the completion of DBS clearance of staff currently employed but not previously checked. ii) Future reporting to WODC record progress against these milestones/targets including clear quantitative information such as: – the number of DBS checks that are required; – have been completed; – are in progress; – or are yet to be started.	**H**	i) Additional milestones and a target completion date has been agreed for the completion of DBS clearance of staff currently employed but not previously checked for end of March 2020. Documentation will be reviewed and amended in line with recommendations. ii) Future reporting to WODC will record progress against these milestones/targets including clear quantitative information such as the number of DBS checks that are required; have been completed; are in progress; or are yet to be started.	28/02/2020	**November 2021:** Action not yet progressed due to workforce pressures. To progress Q1/2 2022/23. Noting the above, deadline extended to 30/06/2022 for update. **June 2022:** Fresh scoping required due to the impact of the pandemic and identification of appropriate funding to support the completion of this work. Target deadline to complete scoping exercise and identification of funding end of September 2022. Noting this, deadline extended to 30/09/2022	30/09/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1920-020			**Falls**	**Report Issued September 2019**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
5	There are a number of "Gold Command" focus Groups active within the Health Board but there are no gold command policies or protocols in place that are linked to the performance management framework. Consideration should be given to establishing an operating protocol for "gold command" focus groups which is aligned to the performance management framework to ensure that these groups are effective and can demonstrate improvement.	**M**	Agreed. The policy provides details of management responsibility for key policy areas e.g. Security, asbestos, transport etc. however it will be reviewed for adequacy in light of the recommendation.	31/03/2020	**December 2021** The Interim Director of Corporate Governance is working with the Interim Executive Director of Nursing & Patient Experience, Executive Medical Director and Chief Operating Officer to review and update structural arrangements as part of the quality governance and strategy review work. Noting the above, date extended to 31/05/2022 to align with timescales within the Board Effectiveness Assessment Action Plan **June 2022:** The Acting Director of Corporate Governance is working with the Director of Finance to further review and explore alignment with the health board Performance Management Framework. The deadline has been extended to 31/08/2022 in order to facilitate the above (LJC)	31/08/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1920-025		**Discharge Planning (DoN)**		**Report Issued February 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
9 iii	The review of 69 patients found that only one patient had an EDD recorded within patient notes and this did not provide any evidence of discussion with patient, family or carers. Through discussion at the MDT Board Round we attended at Gorseinon, there was evidence that EDDs were being discussed with patients but that this was not sufficiently recorded within patient's notes. Management should ensure that EDD is discussed with patients and families and the discussion is recorded in the patient notes. Consideration should be given to including this within a programme of improvement work across wards to coach staff in effective implementation of this aspect of discharge planning & documentation and to monitor improvements in practice.	**H**	The all wales newly developed and piloted digital clinical risk assessments includes Expected date of discharge and will be rolled out across the health Board – this will improve recording of EDD and engagement with families and carers.	31/03/2022	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this.	None Entered
14	There were mixed findings in relation to Information Governance with different wards having different concepts relating to the amount of patient data permitted to be displayed within patient and visitors view. However, in general, full patient names were visible on most Signal PSAG Boards with some Wards displaying dates of birth, area of residence and detailed health information. These screens should be switched off when not in use for Board Rounds to limit the visibility to patients and visitors, however there were several instances when a Board was left unattended by staff and visible to passers-by. Clarity should be provided to staff across all sites on the detail permitted and required to be visible on the PSAG Boards in line with GDPR	**M**	The Quality & Safety Governance Group will develop a standard for inclusion of key requirements and management of PSAG "know how you are doing" boards.	31/05/2021	**February 2022** QSGG in March is to receive an update from the Head of Patient Flow on their work programme Deadline revised to 31/03/2022 based on the foregoing	31/03/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2021-027		**Safeguarding**		**Report Issued June 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3	We note that the health board has developed a Quality & Safety Dashboard, which provides a tool for corporate/service group triangulation & oversight of key incident levels at ward and hospital level. Management indicated that when the safeguarding module of Datix is implemented, safeguarding cases will also be included in the dashboard. The dashboard does not currently include workforce issues. Management should consider the development of monitoring information further to triangulate data on concerns with workforce matters such as grievances, suspensions, and sickness absence to provide broader indication of service areas with potential safety and safeguarding risks. Consideration should be given to how the review of this can be best implemented and demonstrated. This recommendation may require action outside the corporate safeguarding team.	**L**	• The Head of Nursing has emailed the Head of Patient Experience, Risk & Legal Services and the Head of Quality & Safety, Corporate Nursing to arrange to meet and discuss the recommendation • Safeguarding module on Datix work is progressing, there is no date as yet for the completion of this work	01/09/2021	**Undated:** The Safeguarding module on Datix work is progressing, led by NST, PHW and the NHS Wales Shared Services Partnership, there is no date as yet for the completion of this work. **August 2021:** This work is still ongoing with no completion date yet **December 2021:** The Safeguarding module is to be piloted by Hywel Dda UHB in the New year. Based on the above, deadline has been extended to 30/04/2022 for further update **February 2022:** The work is still ongoing, with no completion date. **April 2022:** Hywel Dda continue to pilot this work and no further update at this stage. Based on the foregoing, deadline has been extended to 30/06/2022 for further update	30/06/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2122-002		**Quality & Safety Framework**		**Report Issued January 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1	The health board has an agreed Quality and Safety Process Framework (QSPF). We note that whilst the QSPF was approved, it was shortly before the onset of the first wave of the COVID-19 pandemic. Whilst necessarily focussing on the operational pressures which followed, there is little evidence to support that there has been any further implementation of the framework beyond the establishment of the QSGG. A number of key steps included within an improvement plan were not progressed including: • Creation of an 'iHub' to support trend analysis and support quality improvement initiatives. • Mapping of reporting groups and subgroups to support the Quality and Safety Governance Group (QSGG). • Mapping of Executive Directors reporting portfolios. • Establishment of a QSGG business cycle/work programme. • QSGG Subgroups and Service Group quality and safety groups to amend terms of reference to reflect the QSPF process. Additionally, the QSPF will now need refreshing to consider the impact of Covid-19, the health board's new Quality Priorities, and the recently issued national Quality and Safety Framework. The health board should consider refreshing the Quality and Safety Process Framework to incorporate the impact of COVID-19, national guidance and its new quality priorities.	**H**	Health Board will run two externally facilitated Q&S workshops to review Q&S arrangements which will support a refresh of the Framework.	01/04/2022	**February 2022:** Worksop dates arranged for Feb and March 2022. Independent internal review of QSGG commenced. Outcome of workshop and findings of review will inform potential revision/relaunch of Quality and Safety Framework **April 2022:** Quality and Safety Patient Services Group Revised Framework proposals on the agenda to be discussed at the Management Board 20th April 2022. Based on the foregoing, deadline extended to 30/06/2022 to receive feedback from Management Board and take any further required action. **May 2022:** New Quality and Safety structures established. Quality and Safety Framework to be revised in line with WG duty of Quality Act. Please extend deadline to Sept 2022	30/09/2022
1.2	The health board has an agreed Quality and Safety Process Framework (QSPF). We note that whilst the QSPF was approved, it was shortly before the onset of the first wave of the COVID-19 pandemic. Whilst necessarily focussing on the operational pressures which followed, there is little evidence to support that there has been any further implementation of the framework beyond the establishment of the QSGG. A number of key steps included within an improvement plan were not progressed including: • Creation of an 'iHub' to support trend analysis and support quality improvement initiatives. • Mapping of reporting groups and subgroups to support the Quality and Safety Governance Group (QSGG). • Mapping of Executive Directors reporting portfolios. • Establishment of a QSGG business cycle/work programme.	**H**	The work programmes of the Q&SGG and Q&S Committee will be amended to include a review of the implementation of the framework (as a minimum three times a year)	01/05/2022	**February 2022:** A review of the role and function of QSGG is underway. This will be considered in line with the implications of the WG Duty of quality Act and an action plan developed and implemented to reflect this. **Undated:** Quality Strategy currently being developed. Please extend deadline to 30/9 in line with the development of the Framework **June 2022:** Welsh government draft Quality Framework due for publication Sept 22. This will inform our Framework development	30/09/2022

	• QSGG Subgroups and Service Group quality and safety groups to amend terms of reference to reflect the QSPF process. Additionally, the QSPF will now need refreshing to consider the impact of Covid-19, the health board's new Quality Priorities, and the recently issued national Quality and Safety Framework. In refreshing the QSPF, the health board should consider developing an action plan to support the implementation of a new framework, to be monitored at QSGG and QSC periodically					
2.2	Established just prior to the onset of the pandemic, the QSGG has modified its approach and agenda to compensate and support reporting and escalation to the QSC. The QSGG Terms of Reference include 42 objectives (including one duplicate objective). Our review identified that the group has not met all of these, with those related to monitoring the QSPF and receipt of terms of reference/annual plans from subgroups representing an ongoing gap. The supporting structure of the QSGG indicating reporting groups and subgroups remains outstanding. The Group otherwise had sufficient coverage of subject areas against its ToR, but we were informed that due to the large agenda there can be challenges in keeping the meeting within its timings whilst allowing contributors adequate scope to present reports and highlight key issues. A number of other objectives including monitoring of licensing standards, agreement of Patient Experience Plan and review implications of confidential enquiry reports could also be considered if still appropriate as objectives for the group. The QSPF includes that the QSGG 'acts as the first layer of corporate oversight, which exists to provide appropriate oversight to the devolved Service Delivery Units own quality and safety meetings, together with other formed groups and sub committees.' The current exception report in use provides coverage of performance but does not prompt information on the operation of service group quality and safety groups. We recommend that there is mapping of the QSGG sub-groups and reporting groups. Following this there should be a work programme/business cycle created to ensure all relevant information and reporting are addressed and distributed throughout the year.	**M**	Agreed	01/06/2022	**June 2022:** Mapping complete. Work programme being developed and to be presented at QSPGG 21st June 2022	30/06/2022

2.3	Established just prior to the onset of the pandemic, the QSGG has modified its approach and agenda to compensate and support reporting and escalation to the QSC. The QSGG Terms of Reference include 42 objectives (including one duplicate objective). Our review identified that the group has not met all of these, with those related to monitoring the QSPF and receipt of terms of reference/annual plans from subgroups representing an ongoing gap. The supporting structure of the QSGG indicating reporting groups and subgroups remains outstanding. The Group otherwise had sufficient coverage of subject areas against its ToR, but we were informed that due to the large agenda there can be challenges in keeping the meeting within its timings whilst allowing contributors adequate scope to present reports and highlight key issues. A number of other objectives including monitoring of licensing standards, agreement of Patient Experience Plan and review implications of confidential enquiry reports could also be considered if still appropriate as objectives for the group. The QSPF includes that the QSGG 'acts as the first layer of corporate oversight, which exists to provide appropriate oversight to the devolved Service Delivery Units own quality and safety meetings, together with other formed groups and sub committees.' The current exception report in use provides coverage of performance but does not prompt information on the operation of service group quality and safety groups. We recommend that the exception report include reporting on service group quality and safety group operation. The QSGG attendance tracker could be shared to support good practice in this area	**M**	Agreed - The exception report from Q&SGG to Q&S Committee will be reviewed following the Q&S workshops and a revised reporting template agreed by the Q&S Committee	01/06/2022	**June 2022:** Revised exception report being developed. Sub groups set up and inaugural meetings starting w/c 13/6 and reporting templates to be developed by these groups	30/06/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2122-023		**Mental Health Legislative Compliance**		**Report Issued February 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1	Reports presented to the MHL Committee provide a broad coverage of compliance against legislation. We recognise that some sections within legislation do not place statutory duties on health boards and that reporting is undertaken by exception, however assurance on the completeness of compliance cannot be demonstrated in the absence of a compliance map. We recommend that an exercise is undertaken to map the legislation and/or the Codes of Practice to the arrangements the health board has in place, in order to provide assurance on compliance against legislation, that arrangements are monitored and that there are no omissions.	**M**	An exercise will be undertaken to match the legislation and/or the Code of Practice to the regular reports made to the Mental Health Legislative Committee.	30/04/2022	**Undated:** Email sent out to leads for comments. Awaiting response.	None Entered
2.1	As reported to the MHL Committee, there have been 3 invalid detentions identified by the MHA Team in the first half of this financial year. We note that there is no formal MHA training provided to staff within the MHLD service group on a cyclical basis but that guidance in relation to form completion is available within patient dashboards. A review of service group performance reports taken to Safeguarding Committee has shown inconsistent levels of reporting of MCA and DoLS training and that in some instances, compliance is measured against all staff while some training is specific to certain staff levels. There was one report that did not record compliance against MCA and DoLS training. We recognise that this finding has wider implications across the health board and is not specific to MCA and DoLS Regular training on the Mental Health Act and Mental Health Measure is provided to relevant staff to ensure adequate provision.	**H**	A revised programme for MHA & MHM training will be put in place. A range of literature and guidance notes are also available for reference.	30/04/2022	**Undated:** Email sent out to leads for comments. Awaiting response.	None Entered
2.2	As reported to the MHL Committee, there have been 3 invalid detentions identified by the MHA Team in the first half of this financial year. We note that there is no formal MHA training provided to staff within the MHLD service group on a cyclical basis but that guidance in relation to form completion is available within patient dashboards. A review of service group performance reports taken to Safeguarding Committee has shown inconsistent levels of reporting of MCA and DoLS training and that in some instances, compliance is measured against all staff while some training is specific to certain staff levels. There was one report that did not record compliance against MCA and DoLS training. We recognise that this finding has wider	**H**	The Learning & Development team will put processes in place to ensure that the training available is targeted at the correct staff groups.	30/04/2022	**Undated:** Email sent out to leads for comments. Awaiting response.	None Entered

	implications across the health board and is not specific to MCA and DoLS Consideration should be given to undertake service group training needs analysis to establish which staff levels require which level of training, in order to effectively manage compliance across the health board.					

Executive Lead – Director of Public Health						
SBU 1819-012		**Vaccination & Immunisation**		**Report Issued August 2018**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4(b)	The May ChIG meeting discussed data quality issues in respect of immunisation records used for a GP cluster pilot. The Health Boards Primary Care Clinical member indicated in the preceding meeting that a review in her own practice had highlighted data cleansing issues. We would recommend cleansing of records within Primary Care be progressed via inclusion in the ChIG immunisation plan.	**M**	The process of data cleansing in primary care would impact on the child health department, as previous work undertaken has demonstrated that in many instances the information held on the child health system is also incorrect. Our plan is therefore to build a business case for resources to carry out data cleansing for the current back log of data, with a view of undertaking regular data cleansing to avoid discrepancies between Primary Care and Child Health records and ensure confidence that COVER data is an accurate reflection of our current performance. This business case will be presented to the Investment and Benefits group for consideration, following the next SIG meeting in September	04/09/2018	**February 2022** The development of an intended business case to undertake data cleansing across primary care and child health record systems has not progressed. Noting the time which has lapsed since this issue was originally raised, the Director of Public Health will now revisit this issue and establish the current situation and necessary action in terms of the accuracy of immunisation records (30/06/2022). Based on the above, date further extended to 30/06/2022	30/06/2022

Executive Lead – Director of Strategy						
SBU 2021-004	**Environmental Infrastructure Modernisation Programme (S2P2)**		**Report Issued August 2021**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) – states: "Risk registers for each individual project/programme must be completed, shared and monitored, with reference… to time, cost and quality". The risk register is intended to act as a key project management tool. Risks should progressively be managed down as the project progresses, and contingency is utilised to address issues i.e. enabling comparison of residual risk with residual contingency. The register itself was not costed, impeding its use for managing project costs and comparison with residual contingency. For the purposes of managing the risks, it may be prudent to differentiate risks between stage 3 and stage 4. In accordance with NHS Wales Infrastructure Investment Guidance, the risk register should be costed to allow it to be assessed against available contingencies.	**M**	Agreed. The monitoring of risk is undertaken during monthly CRL meetings between the Health Board and Cost Advisor and as part of the monthly reconciliation of forecast and actual expenditure. The Change Control Register also records the up-to-date contract value for the SCP. The Health Board will, with the Cost Advisor, review with the monitoring of the cumulative value of risks and contingency against the funding approval.	30/11/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Outstanding** Review of the latest version of the project risk register noted no costings. As a minimum, noting the current stage of the project, costs associated with the design, site/construction risks etc. to be included. As noted by the appointed Cost Adviser, a comprehensive Risk Register was developed for the project from completion of the RIBA Stage 2 report, which set out the scope of the project. The risk register reflected the anticipated risks thereon, has been reviewed by all parties and updated at regular intervals, and has been used in design development to mitigate risks and consequent costs. A financial evaluation of the risks will be included in the BJC submission, which will allocate the risks to the party best suited to manage them. The regular review of the risk register will continue throughout the construction period, assessing all risks not just those for which the Health Boards is responsible. The financial risks for which the Health Board is responsible will continue to be evaluated as construction work progresses. As a risk is partially or completely mitigated/closed out this will be reflected in the changing value included in the risk register. The value of a risk may increase as well as decrease and this will equally be shown. The residual risk values will be considered within each monthly cost report and will consider the out-turn cost for the project and not just the construction costs. The consideration of risk values within the cost report will ensure that the forecast out-turn cost is accurately reported, be it an under or over-spend. The risk contingency will not be used just to balance the forecast out-turn cost to the funding approval as this would potentially report a misleading financial position. A revised deadline date of 30/09/2022 has been agreed as part of the follow-up review.	30/09/2022

Executive Lead – Director of Strategy						
SBU 2122-003		**Elective Orthopaedic Unit**		**Report Issued October 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
7.1	The project risk management procedure was clearly defined in the Project Initiation Document, with a new risk register recently prepared to align with the refreshed governance arrangements and to reflect the current stage of the project. Whilst a range of risks had been appropriately identified and recorded at the time of review, the Project Manager recognised that further development was required, both through the involvement of the Steering Group and the supporting work streams (for example, recruitment and blood bank risks have been highlighted as areas requiring more detailed consideration). It is also noted that the revenue funding requirement for the project remained to be confirmed. This and other risks, such as procurement matters, were not captured on the risk register reviewed. The further development of the risk register will support existing reporting processes to the Steering Group and Planned Care Delivery Board, and ensure members can provide scrutiny and direction as to the management of the key risks affecting the project. The risk register should continue to be developed to ensure all relevant risks are captured.	**M**	Agreed. Going forward, the risk register will support existing reporting processes and will ensure that all relevant risks are captured so that members can provide scrutiny and direction as to the management of the key risks affecting the project.	30/11/2021	**June 2022: Update from NWSSP A&A** The project now has an external appointed Project Manager and the risk register is appended to the monthly PM report, but it is noted this is from the construction perspective rather than the project. Further project risks are maintained by the Transformation team and documented for regularity of review via the Teams channel that is maintained for the project. From review of information provided it is clear that risks are being added to at this register and reviewed and closed / maintained as open with narrative regarding mitigations [and any updates where required]. It is noted that the risk log includes total scores, not the impact / likelihood scores as would be expected. Would suggest that the internal project register is reviewed to ensure all elements are completed and, upon update, the recommendation can be closed. Responsibility for this would be with the Project Manager within Transformation. The deadline has been extended to 31/07/2022 in order to address these comments	31/07/2022
9.1	Once formal approval has been granted for the preferred way forward, any subsequent changes to the approved option need to be carefully managed, via a formal process of assessment and approval (in line with the UHB and project delegated authorities relevant to the quantum of the change in question). The ability to effectively control project changes will depend on the clarity with which the agreed project scope, design, objectives and benefits have been defined. However, the Project Initiation Document did not define a change management procedure to be applied. The Project Initiation Document should define the change management procedure to be applied at the project.	**L**	Agreed. The Project Initiation Document will be amended to define the change management procedure that will be applied at this project.	30/11/2021	**June 2022: Update from NWSSP A&A** Review of the PID notes that there is no reference to the change management procedure as per the agreed recommendation/management comment. It is noted that the latest PEP has been requested from the Project Manager, but has not yet been received. The deadline date has been extended to 31/07/2022 in order to progress this issue	31/07/2022

10.1 (a)	Advisers have been appointed from the UHB's Local Framework, to provide architectural, cost and mechanical and electrical advisory services to the project to date. Contracts were in place at the time of review, covering work on both the SOC and revenue solution, and had been appropriately completed and executed. However, the following issues were noted: • The Architect contract ('temporary bridging solution') was capped at £10,000, but payments to date totalled £23,584, exceeding the delegated authority provided by the contract signatories; and • All contracts had been executed after adviser duties commenced; with delays ranging from only one week to seven months (from the date first payment was made). Sufficient contractual cover should be in place to cover the value of works instructed.	**M**	Agreed. Within the Capital Planning Department, we strive to ensure that contracts are in place in a timely manner, as demonstrated within this instance. The contractors that we work with are selected from an existing framework which has already undergone competitive compliant procurement exercises that ensures that the Health Board is receiving Value for Money. We place a cap on the contracts to ensure that we are not financially exposed. We accept and agree with your comments. With regards to this particular instance as we have already iterated the project is evolving and progressing at pace and as a result the costs had escalated quickly. We are aware of it and will look to revise the contract to reflect these changes.	30/11/2021	**December 2021:** Capital and Revenue Monies have been received from Welsh Government therefore action can be closed **June 2022: Update from NWSSP A&A** Confirmed that two contracts were in place with this Architect – one for the temporary solution (£10,000) and one for the permanent solution (£25,000). Capital Business Nanager to confirm how the total spend (£23,584) has been apportioned between these contracts, and the governance processes involved in dealing with any potential spend in excess of the cap/contract value. A revised deadline of 31/07/2022 has been agreed in order to progress this issue As such, this recommendation has been reopened	31/07/2022

Executive Lead – Director of Strategy						
SSU–SBUHB–2122-01		**Singleton Hospital Replacement Cladding 21/22**		**Report Issued October 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
9.1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) – states: “All Welsh Government construction and infrastructure contracts valued at £2m or more which are delivered directly on behalf of Welsh Government Departments are required to apply a Project Bank Account unless there are compelling reasons not to do so. NHS Organisations should liaise with Welsh Government Officials and NWSSP-SES Framework Managers to determine whether individual projects are required to utilise Project Bank Accounts”. The June 2021 Project Board minutes noted that: "Whilst the Project Bank Account has not been set up on this scheme (works had already commenced and required payment). The Project Director noted that Welsh Government are expecting Health Boards to continue to progress their implementation on future schemes. However, it is acknowledged that contractors have been slow to engage with this process". These accounts are intended to provide greater control to the contractor and transparency in on-time payments, including facilitating timely payments to sub-contractors. At the Environmental Infrastructure project (sub-station 6), currently under design, provision has been made in the draft construction stage (Stage 4) contract for provision of a Project Bank Account (at Clause “Z” 27A). “Z” (bespoke) Clauses at the Singleton Cladding contract mirror this contract with the exception of this clause i.e. this requirement has not been specified at the agreed Cladding contract. It is noted therefore that non-provision of a Project Bank Account would not represent a breach of that contract. Both the July and August 2021 Project Reports stated that there was a requirement for "clarification” (from Welsh Government) “on whether the Project Bank Account will be required – the contract is progressing without a Project Bank Account and is waiting for further direction". Management should confirm treatment of a Project Bank Account in accordance with Welsh Government direction.	**L**	Agreed. The Health Board welcomes WG directive in the use of Project Bank Accounts as a means of addressing poor payment practices in public sector supply chains by facilitating fair and prompt payment. Project Bank Accounts (PBAs)will ensure best practice going forward and this is something that the Health Board is currently working towards with both the banks and contractors. The Head of Capital Finance is involved with meetings with regards to PBAs as within Wales we are aware that there have been issues with the Banks in establishing them as they are a still a relatively new concept. With regards to the Cladding Project – the sub-contractors had already been appointed with payments already commenced with the main contractor prior to audit undertaking their fieldwork. A PBA could not then be retrospectively put in place as it was deemed to have no benefit.	31/12/2021	**June 2022: Update from NWSSP A&A** Received copy of email sent by the HB to WG setting out why the HB is choosing not to pursue a PBA on this project. Discussion subsequently held with TJ, AD & BB [WG]. Additional work needs to be undertaken by WG regarding the stance being taken by the contractor regarding PBA; and following conclusion of this, FQ requested that WG provide confirmation of their acceptance for a PBA not to be in place at this project. Recommendation to remain open until the additional work / discussions required of WG are complete.	31/07/2022

Executive Lead – Director of Strategy						
SBU 2122-012		**Annual Planning Approach**		**Report Issued October 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3.1	The Executive Steering Groups terms of reference include clarity of purpose and detail is included relating to its role in plan development. However, it appears that it has not been refreshed for some time with a number of individuals listed within the membership having left the health board or taken on different roles. Membership also included the Director of Nursing & Patient Experience and Director of Public Health but we could not see evidence that this remained the case currently. Other aspects including key stakeholders would also benefit from refreshment. We recommend terms of reference for the Executive Steering Group be refreshed to reflect current membership and stakeholders. Consideration should be given to inclusion of senior quality & safety representation.	**L**	Executive Steering Group Terms of Reference will be refreshed.	04/10/2021	**April 2022:** To be discussed at the next meeting which is being held on 5th May 2022. Based on the foregoing, the deadline has been extended to 30/05/2022 for further update. **June 2022:** The Terms of Reference have been updated in line with the audit findings. The intended meeting of the Executive Steering Group in May 2022 was postponed. The updated TOR will now be considered at the next meeting of the Group. Deadline extended to 31/07/2022 for further update	31/07/2022

Executive Lead – Director of Strategy						
SBU–2122-018		**CAMHS Commissioning Arrangements**		**Report Issued December 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1	The health board commissions Child and Adolescent Mental Health Services (CAMHS) from Cwm Taf Morgannwg University Health Board (CTMUHB). There is no Service Level Agreement (SLA) / service specification in place detailing the CAMHS commissioning arrangement. The health board were unable to provide a definitive answer as to what CTMUHB's responsibilities are, and what remains the responsibility of the health board in respect of CAMHS. The health board should ensure that there is an appropriate SLA or service specification in place for the commissioning arrangement between the health board and CTMUHB that covers all key areas of the CAMHS commissioned.	**H**	As stated, the Health Board had already identified that developing a service specification for CAMHS would be included in the 2021-22 work programme. However the postholder supporting this work transferred to a new role in July 2021, and the backfill post was appointed to, but the candidate then withdrew, there has been no cover for this role since this time. This post is currently out to advert but it is unlikely that it will be filled until early 2022 which impacts on the target date for this. There will also need to be careful consideration for the Health Board of the financial implications of implementing a service specification to meet all national requirements which will need to be prioritised as part of the Annual Plan and resourcing requirements agreed for 2023-24 onwards.	30/04/2022	**April 2022:** A Project Group has been set-up to oversee the development of a Swansea Bay CAMHS Service Model and Specification. CTMUHB have agreed to provide initial baseline information to enable the development of a service specification.	30/06/2022
1.2	The health board commissions Child and Adolescent Mental Health Services (CAMHS) from Cwm Taf Morgannwg University Health Board (CTMUHB). There is no Service Level Agreement (SLA) / service specification in place detailing the CAMHS commissioning arrangement. The health board were unable to provide a definitive answer as to what CTMUHB's responsibilities are, and what remains the responsibility of the health board in respect of CAMHS. The SLA/service specification should include, but not be limited to, a description of the services to be provided and their expected service levels, metrics (both performance and quality) by which the service is measured, the duties and responsibilities of each party, the remedies or penalties for breach, and a protocol for adding and removing metrics.	**H**	These elements will be included in the service specification as it is developed.	30/04/2022	**April 2022:** A Project Group has been set-up to oversee the development of a Swansea Bay CAMHS Service Model and Specification. CTMUHB have agreed to provide initial baseline information to enable the development of a service specification.	30/06/2022
3.2	The health board has not identified any quality measures in respect of the service being provided to the CAMH patients or the outcomes for those patients. The health board's Mental Health Legislation Committee highlighted that the CAMHS governance report provided by CTMUHB as at August 2019 did not provide any assurance to the committee. We understand from discussion with key staff that the health board has not received a CAMHS governance report from CTMUHB since November 2019. The health board should ensure that it receives regular updates on quality that meets the expectation of the health board in order to provide the appropriate level of assurance to the board and its committees.	**H**	The information provided to the Mental Health Act Legislative Committee from CAMHS was developed and agreed with CTM based on the reports they produce for the CTM MHALC. Further information was requested from the Swansea Bay Committee regarding what further information was required to give assurance. This will be followed up and addressed as the reporting arrangements restart following the pandemic.	31/01/2022	**February 2022:** Issues around the content of reports provided to the Mental Health Legislative Committee will be followed up and addressed as the reporting arrangements restart following the pandemic. The deadline for this action will need to be extended to the end of March 2022. **April 2022:** The need for robust performance and governance reports has been made clear, with both now on the agenda of each monthly meeting of the CAMHS Commissioning Group. Further work is ongoing to improve the quality of the governance report, working with the Swansea Bay Mental Health Legislative Committee. Noting the foregoing, the deadline for this action has been extended to 30/06/2022 for further update.	30/06/2022

Executive Lead – Director of Strategy						
SBU–2021-006		**Capital Systems**	**Report Issued November 2020**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	The Capital Manual states: “Service Delivery Units and Corporate Directorates will need to approve all appropriate capital bids, considering the potential funding source and the overall scope and purpose of the funding bid prior to submission to the appropriate corporate forum for approval (Capital Management Group and Investments and Benefits Group)." At the five projects reviewed, excepting Ward G where the business case was still in development, formal business case submissions had not been made at any of the projects. Submissions had instead been via various other means and the WG had approved the project on the basis of the information provided in each case: • Perinatal - an expression of interest; and • CT Simulator and Anti-Ligature Phases 1 & 2 - cost forms. Evidence has also been provided to confirm Chief Executive and Board approval of the current year’s capital priorities (including the above projects, excepting Anti-Ligature Phase 1 which progressed during 2018/19). However, in respect of the earlier internal scrutiny process, prior to submission of the bid to WG, we have only received evidence for the Perinatal project (demonstrating scrutiny and approval at the IBG). Whilst recognising that formal business cases were not developed for these projects, the objectives, benefits and costs (including revenue implications) should still be subject to internal scrutiny and sign-off, before any bid is submitted to WG. A clear audit trail of internal scrutiny and approvals, and WG instructions/agreement, should be centrally retained in relation to each project.	**M**	Agreed. The Capital management team recognise that whilst the approvals had been received on the schemes too much time was spent locating this information as not all documentation is retained centrally. Time has been set aside in December to review the Capital Manual. The revised version will incorporate the recommendations within this report as suggested by Capital Audit, one being that in future all documentation will be centrally retained.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022
2	During the audit testing it was noted that a number of processes required by the Manual either no longer aligned with current operational practices or would benefit from review to bring enhanced efficiency to the project management process e.g.: • The requirement for a Statement of Need (SON) to be produced at the outset of a project, and approved by Finance, to facilitate the commencement of work. Whilst SONs had been produced at all the projects reviewed, only one (Ward G) had been approved by Finance in accordance with the Manual. Management advised SONs were issued to Finance to obtain a job number to enable a job to commence. However, this	**M**	Agreed. As already mentioned, this has already been acknowledged by the Capital management team and following the review of the manual it is anticipated that the manual will become more streamlined in order to ensure a more efficient project management process.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and	31/10/2022

	has previously resulted in multiple SONs being prepared as fees/costs progressed on projects; therefore is now seen as an onerous process and no longer consistently applied in line with the Manual; • Retention of the 'Brief Acceptance Certificate' from the appointed consultant. This certificate was not evidenced as completed for the Anti Ligature Phase 1 project; • Completion of the 'Request for Consultant Appointment from the Local Framework' proforma. This procedure was originally designed to ensure fair rotation of consultants from the Local Framework. However noting, under the new Framework arrangements, there is only one consultant per category, this procedure would appear redundant; and • The issuing of letters of appointment to consultants prior to entering into formal contract. The letters issued did not always contain the full information required by the Manual. Further discussions with management highlighted the question as to whether this step is still required noting a formal contract will follow. The Manual should be reviewed to ensure all procedures/proformas remain relevant to current operational practices, and facilitate the operation of an efficient project management process.				feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	
3	The Manual was last updated in 2018, and states its purpose as "… to provide a toolkit for managing all capital projects and must be read in conjunction with the Health Board's Standing Orders and Financial Control Procedures. However, it is not intended that all aspects of the manual will be implemented on all projects and each project will be assessed individually to ascertain the level of compliance required." The Manual applies to all capital projects, from minor discretionary schemes to major projects. It comprises the main narrative, and an associated project checklist. It was noted during the review of the Manual, and testing against its requirements, that there are some key areas lacking clarity of instruction and some degree of contradiction between the main narrative and the project checklist. These include: • The Manual does not provide sufficient definition of what constitutes a major / minor project. Whilst the main narrative references a £1m major project threshold above which full governance arrangements are required, the project checklist uses a £500k threshold for the major/minor distinction; • The Manual does not confirm whether these threshold values relate to works costs, or whole project costs. For the projects reviewed during this audit, the threshold had been applied to works costs only. Whilst recognising that the complexity/size of a project can often be determined from the works value alone (and	**M**	Agreed. The Capital Manual is to be reviewed over the forthcoming weeks and will be updated to reflect the recommendations within this report. The recommendations will be implemented in future working practices.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022

	will certainly dictate the complexity of Capital Planning department's involvement), other issues may impact from a Service perspective i.e. equipping, training, decanting and other associated costs which sit outside the works contract. The decision, therefore, as to whether to apply full governance arrangements may be more nuanced than currently detailed within the manual (and as such, should involve early sign-off by the Project Director); • Whilst the Manual states that Project Boards are required for major projects over £1m, it does not provide clarity as to whether the assignment of the key roles of Senior Responsible Owner and Project Director are similarly restricted to major projects. The project checklist indicates a Project Director appointment is not required for projects under £500k; and • Whilst the main narrative is clear that the roles of the Senior Responsible Owner, Project Director and Project Board are key from project initiation, to provide appropriate direction, ownership, oversight and scrutiny, the project checklist includes the initiation of these roles in Workstage 3 (i.e. post business case development, design and tender). a) The Capital Manual should be updated to provide clarity as to: • the threshold between major and minor projects; • whether this threshold relates to works costs or whole project costs; and • which governance arrangements are required for projects in each category. b) The Capital Manual should be updated to remove contradictory elements between the main narrative and the project checklist					
4	The Manual provides clear guidance (in line with best practice), that key project roles should be in place from project initiation to provide appropriate direction, ownership, oversight and scrutiny through each stage. Key roles are defined in the Manual as follows: • Senior Responsible Owner (SRO) • Project Director • Project Board For the projects reviewed, where they had been classified as major and therefore requiring full governance arrangements, the allocation of the Senior Responsible Owner and Project Director roles, and initiation of the Project Board, did not / was not planned to take place until after the project had progressed through the business case, design and approval stages. Whilst this aligns with the approach mapped out at the project checklist, it is non-compliant with the purposes of these key roles as set out above.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the	31/10/2022

	Key project roles, including SRO, Project Director and project boards should be initiated at the outset of a major project / programme, to provide overall direction through each stage				follow-up review.	
5	Noting that these key roles were not in place from the outset of the projects, the appropriate sign-off of key decisions in relation to the governance arrangements was not evidenced. This included the application of the 'minor project' classification at projects with wider cost implications: • The CT Simulator project: classed as a minor project with works costs of £540k, but a whole project value of circa £2m; and • The Anti-Ligature Phase 1 project: again determined as a minor project, with the initial works cost of circa £500k, but part of a wider circa £6m programme of works. Whilst recognising that full governance arrangements were being considered for Phase 2, these should have been in place from the outset to provide overall programme control. Where minor projects fall within larger programmes, formal governance arrangements (SRO, Project Director, Project Board, PEP etc.) should be put in place to oversee the overarching programme, from the outset.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022
6	Noting that these key roles were not in place from the outset of the projects, the appropriate sign-off of key decisions in relation to the governance arrangements was not evidenced. This included the application of the 'minor project' classification at projects with wider cost implications: • The CT Simulator project: classed as a minor project with works costs of £540k, but a whole project value of circa £2m; and • The Anti-Ligature Phase 1 project: again determined as a minor project, with the initial works cost of circa £500k, but part of a wider circa £6m programme of works. Whilst recognising that full governance arrangements were being considered for Phase 2, these should have been in place from the outset to provide overall programme control. Where the required governance arrangements lack clarity, such as at projects with large variances between works and whole project costs, the Project Director / Assistant Director of Strategy (Capital) should sign off the proposed governance structure/controls at the outset.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022

7	Project Teams had been formally defined within the project governance structure at applicable projects, with minutes provided for the Anti-Ligature Phase 1 project. However, recognising the current operational constraints (due to COVID-19), meetings have more recently been held via Teams, with minutes not always maintained due to the availability of support staff. Project Team meetings should be minuted wherever possible, even if taking place electronically.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** Where Project Team meetings take place via TEAMS, these are now recorded and retained in order to preserve the management trail. When staff availability permits, recordings are translated into narrative minutes. The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022
8	Other examples were also noted where the project control processes defined in the Manual were not being applied at the outset of a project. These included: • Preparation of the Project Execution Plan (PEP). Whilst PEPs were in place / in development for the major projects included in this review, they had not been developed until some way into the project; and • Completion of a Management Control Plan (MCP). MCPs were evidenced at three of the five projects reviewed, however, a MCP was not prepared for Anti-Ligature Phase 1, and had not yet been prepared at Ward G. PEPs and MCPs (where required by the Manual), should be developed at the outset of a project with further updates as required throughout the life of the project.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022

9	The Manual does not specify at which stage highlight reporting should commence. Whilst acknowledging management's advice that this is intended primarily for the construction phase, it does take place earlier at some larger schemes to monitor and report progress during the business case development phase. The Manual should provide clarity as to when Capital Highlight reporting is to commence.	**L**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Partially Implemented** Whilst the Capital Manual has been reviewed by the Capital Planning Team, discussions are required with Finance before presenting for endorsement by the Capital Management Group. Discussions with Finance should be finalised to ensure the revisions to the Capital Manual are appropriate, and address the recommendations included in the 2020/21 Capital Systems report. **June 2022:** The Draft Capital Manual went to CMG in January 2022, this information was shared and feedback received from Internal Capital Audit. Passed to Finance to finalise financial details. Next CMG is end of July 2022, whereby the Capital Manual is to be discussed. Subject to the outcome of the meeting, the Manual will be taken back to the CMG for approval in October. A revised deadline date of 31/10/2022 has been agreed as part of the follow-up review.	31/10/2022
10	The Manual requires that: "For all appointments for Consultants with a value over £5,000 a Professional Services Contract must be completed by both parties." At the projects reviewed, whilst contracts had been appropriately issued, it was noted that three contracts (related to two different projects: Ward G and CT Simulator) had not yet been returned by the consultant (the longest outstanding had been issued for signature in March 2020). Project Contract Date issued: • CT Simulator QS contract 20 August 2020 • Ward G QS contract 2 July 2020 • Ward G M&E contract 24 March 2020 Non-return of consultant contracts should be regularly chased, with performance considered as part of the Local Framework monitoring process	**M**	Agreed. This has been discussed within the Capital management team and the agreement has been that without a signed Consultant contract, work cannot begin on site. It is hoped that this approach will improve the speed at which the signed contracts are returned on future schemes.	01/04/2021	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Outstanding** Noting that the implementation of this recommendation was to be assessed at future projects, reference has been made to the projects reviewed as part of the 2021/22 Internal Audit plan (Singleton Cladding and Elective Orthopaedic Unit). At both reports, a recommendation was raised regarding timeliness of receipt/acceptance of contract documentation. June 2022: Consultant contracts are chased on a regular basis. It is primarily one M&E consultant that has caused the longest delays. Discussions are ongoing between the UHB and the Regional Director as to a resolution, noting the current reliance on head office rather than the local Cardiff office. A revised deadline date of 30/09/2022 has been agreed as part of the follow-up review.	30/09/2022

Executive Lead – Executive Medical Director						
SBU 1920-028		**Discharge Summary Communication: Improving Performance**		**Report Issued June 2020**		**Assurance Rating – N/A**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3	Early in the audit it was established that the original intent expressed in September 2019 to develop a recovery plan did not progress as it was decided to pause whilst an interface between the MTeD and TOMS systems was developed nationally. Following confirmation of implementation of an upgraded version of MTeD, we would recommend that the recovery plan be developed as originally conceived and arrangements be put in place to monitor and report on progress and outcomes	**M**	Update of recovery plan (including monitoring and reporting) to be developed to be agreed at next Exec MD/UMD meeting on 14th July 2020. The target date is the best estimate given the current trajectory of NWIS developments and it may require adjustment in line with any changes to NWIS timescales.	17/07/2020	**December 2021:** The focus on the recovery of services and return of operational functions has taken priority. Request extension to deadline. June 2022: The Executive Medical Director has tasked the Service Group Medical Directors to improve timely completion of discharge summaries by setting out the expectation that this be reinforced by Clinical Directors with their consultant groups. The Executive Medical Director has also written to all consultants highlighting the risk of poor communication and requesting that they reinforce the importance of this with their junior doctors. Progress will be monitored monthly at the joint meeting of the EMD with Service Group MDs. Noting this, the deadline has been extended to 31/08/2022 for further update	31/08/2022

Executive Lead – Executive Medical Director						
SBU 2021-026		**WHO Surgical Safety Checklist Follow Up**		**Report Issued April 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3	During the review, we were provided with an email sent from the Executive Medical Director to the Director of Digital requesting assistance in finding further ways to analyse the TOMS data and exploring the feasibility of providing further data to units. While there was no response recorded to this original request, the Director of Digital described to us the data currently available to units. This did not provide the further analysis required to investigate previous points raised. It was agreed that this action would be taken forward. Management should undertake further analysis and clinical scrutiny of TOMS data in relation to the timing of WHO Checklist completion. It may be useful to focus audits.	**M**	Discussion with Theatre management leads and IT have confirmed that the completion data held in TOMS is designed to be completed retrospectively rather than during the WHO checklist process to ensure staff are focussed on effective communication. This means that any timing data will not reflect actual data collection, making any analysis of this data unreliable. Discussed with Internal Audit and the limitations of TOMS data agreed. No further analysis of TOMS data planned. Compliance will be measured by in theatre audits of practice.	23/04/2021	**June 2022: A&A Follow Up Review (SBU-2122-028) – Not Implemented** Based on the management response, this recommendation was marked complete on 23/04/2021. However as a result of this follow-up review, A&A felt that there was insufficient evidence to support the closure of this recommendation, and requested that it be re-opened and subject to the appropriate level of scrutiny until it is fully completed (LJC) As such, this recommendation has been reopened	None Entered
6	On review of the letter issued by the Executive Medical Director to the Units it notes under action point 4: 'Please ensure that compliance data and observational audit outcomes are included as a standard item on your agenda for your Delivery Unit Quality and Safety meetings. It would also be appropriate for you to ensure that key Directorates within your Units also have audits of WHO Checklist compliance on their own Quality & Safety meeting agendas regularly.' As part of the follow up, we reviewed the Unit Quality & Safety minutes and papers for each of the units to ensure that regular updates on TOMs data and WHO Checklist compliance audits have been issued to the groups for assurance. The following was noted: **Singleton Delivery Unit -** The Unit's Quality & Safety Group papers from March 2020 to December 2020 were supplied for review. On review of the minutes and papers, no review data or WHO Checklist compliance audit outcomes were identified during this period. **Morriston Delivery Unit -** Quality & Safety Unit papers for 2019/20 and 2020/21 were supplied for review. No compliance data or observational audit outcomes were identified within notes of the meetings between October 2019 and November 2020. **Neath Port Talbot Delivery Unit -** As noted in objective 5b, the NPT Unit have issued regular updates on WHO Checklist compliance audits to the Quality, Safety & Improvement Group.	**M**	Unit medical directors have been reminded to ensure that the results of LocSSIPs (including the WHO) checks should be included in unit quality and safety meetings. (See recommendation 3 in relation to TOMS data)	30/06/2021	**June 2021:** All UMDs have been reminded of the need to review audits within their own Q&S meetings. **June 2022: A&A Follow Up Review (SBU-2122-028) – Not Implemented** Based on the June 2021 comment, this recommendation was marked complete on 25/06/2021. However as a result of this follow-up review, A&A felt that there was insufficient evidence to support the closure of this recommendation, and requested that it be re-opened and subject to the appropriate level of scrutiny until it is fully completed (LJC) As such, this recommendation has been reopened	None Entered

	As indicated in the Executive Medical Director's letter, assurance regarding TOMS compliance data and observational audit outcomes should be reported periodically to service group Quality & Safety groups and discussed at appropriate Directorate meetings.					
7	On completion of the previous review, the Executive Medical Director contacted the Director of Nursing & Patient Experience at the time suggesting that the checklist audit outcomes be issued to the Quality & Safety Forum (now the Quality & Safety Governance Group) on a bi-annual basis. No reports on this were evident in papers of the Quality & Safety Forum / Quality & Safety Governance Group from September 2019 – January 2021. A paper to the QSC in February 2020 set out intended improvements to governance arrangements. These included the establishment of a Clinical Outcomes and Effectiveness Group (COEG), which would be a sub-group of the corporate Quality and Safety Governance Group. The onset of the pandemic has delayed progress on actions intended. In particular, at the outset of the review the Assistant Medical Director informed us that the COEG was still forming and not yet operating fully, so the intended route for assurance to the Quality & Safety Governance Group was not yet in place. We would recommend that a reporting line for corporate assurance on WHO Checklist compliance be implemented.	**H**	Review of LocSSIPs audits will be undertaken at COEG and both Unit/Board Q&S groups. Both groups have been informed of this requirement and have agreed to require reports.	30/06/2021	**June 2021:** The need for COEG to review audits of checklists has been handed over in the legacy document. **June 2022: A&A Follow Up Review (SBU-2122-028) – Not Implemented** Based on the June 2021 comment, this recommendation was marked complete on 25/06/2021. However as a result of this follow-up review, A&A felt that there was insufficient evidence to support the closure of this recommendation, and requested that it be re-opened and subject to the appropriate level of scrutiny until it is fully completed (LJC) As such, this recommendation has been reopened	None Entered