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	**September 2022:** It has now been agreed that this work will be centralised with the Assistant Head of Risk & Assurance and his team. Production of the Policy/Procedure document has been delayed due to staff absence. **December 2022:** Ongoing staff absence has continued to impact on the production of the policy/procedure document. It is now anticipated that this work will be completed by the end of February 2023.	28/02/2023
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	**September 2022:** It has now been agreed that this work will be centralised with the Assistant Head of Risk & Assurance and his team. Production of the Policy/Procedure document has been delayed due to staff absence. **December 2022:** Ongoing staff absence has continued to impact on the production of the policy/procedure document. It is now anticipated that this work will be completed by the end of February 2023.	28/02/2023

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	**January 2023 (HJJ):** The “SAFER “ policy has been rolled out following the launch event from the Welsh Government via the Delivery Unit in December 2022 as an All Wales Policy, all Health Boards were involved in contributing to the policy from a multi-professional/agency perspective. All acute sites within ABMUHB are implementing their training plans over the next few weeks to ensure “SAFER” is rolled out and embedded into the ward culture. Discharge pathways 1-4 are in place following the launch of the “SAFER” policy. The guidance/policy provides the tools you need to reduce hospital delays and inefficiencies during a person’s care and treatment. It integrates the approaches taken within the D2RA, SAFER and Red 2 Green to support delivery of transformational care and safeguard against deconditioning ensuring better outcomes and experiences for people in hospital **A date of 31/03/2023 has been set for further update**	31/03/2023
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient’s hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new policy and re-audit against new policy	30/11/2022

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new policy and re-audit against new policy	30/11/2022
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new framework. Within this ABMU will need to incorporate that all acute clinical areas have a daily senior review, non-acute areas have bi-weekly reviews. Also to include Version 3 of SIGNAL in ABMU policy.	30/11/2022
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new framework and launch of SIGNAL V3 **January 2023:** SIGNAL 2 has been updated to capture the functionality. Version 3 of SIGNAL will be in place by the end of March 2023.	31/03/2023
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new framework. **January 2023:** EDDs are updated daily via the SIGNAL 2 system, also recorded on the ward PSAG boards on each Ward throughout the HB. **Date for 31/03/2023 set for further update.**	31/03/2023
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.	**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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. In line with new revised policy	30/11/2022
	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**	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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. In line with new revised policy	30/11/2022

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Is in place in V3 of SIGNAL. Rollout September 2022 with training programme in place.	30/11/2022
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. **January 2023:** All patients that are medically fit for discharge are discussed as a multi-professional team in the clinically optimised meetings on all sites and the EDD's are set via the signal system. All patients are also discussed each day on the daily Board Rounds. **A date of 31/03/2023 has been set for further update**	31/03/2023

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	**January 2023:** The "SAFER " policy has been rolled out following the launch event from the Welsh Government via the Delivery Unit in December 2022 as an All Wales Policy, all Health Boards were involved in contributing to the policy from a multi-professional/agency perspective. All acute sites within ABMUHB are implementing their training plans over the next few weeks to ensure "SAFER" is rolled out and embedded into the ward culture. Discharge pathways 1-4 are in place following the launch of the "SAFER" policy. The guidance/policy provides the tools you need to reduce hospital delays and inefficiencies during a person's care and treatment. It integrates the approaches taken within the D2RA, SAFER and Red 2 Green to support delivery of transformational care and safeguard against deconditioning ensuring better outcomes and experiences for people in hospital. Safer, D2RA and Red 2 Green posters along with deconditioning posters are printed and delivered to all clinical areas. **A date of 31/03/2023 has been set for further update (LJC)**	31/03/2023
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Version 3 of signal contains new icons and a standardise approach on all PSAG boards with a training programme in place (Sept 22).	30/11/2022

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. SharePoint in Place. V3 Signal	30/11/2022
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	**December 2022:** A proposal for the management of Outpatients was presented to Management Board on the 30 November. There was not a consensus opinion on the proposal and as a consequence a further meeting with the COO and Service Group Directors has taken place. An alternative proposal is due to be discussed with the CEO for sign off. In addition the current Outpatient Redesign and Recovery Group is to reconfigured to have a great focus on outpatient accommodation and transformation and a review of the membership of this group will be undertaken at the same time. **February 2023:** The Chief Executive has asked for a further paper to be presented in March 2023 which provides an update on the proposal for the future management of outpatients to enable a final decision to be made. The Outpatients Redesign and Recovery Group meetings have now ceased and a new Outpatient Transformation Group will be established with revised terms of reference and membership. **Date of 31/03/2023 set for further update**	31/03/2023

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**
1.1	We noted service groups work with bespoke versions of the Datix risk register reports to conduct their in-service group risk reviews. Practices vary between the service groups in the way in which they review their risks but we noted the following anomalies across the service group registers that we examined: • Risk scoring is not consistently applied and there is a wide range in the instance of high scoring risks (>=16) across the four service groups (116 max, 18 min). • There is a low level of evidence of the detailed regular review by service groups of all the high scoring risks in their registers; • Not all service group register risks consistently record mitigating actions, action owners and target dates; • There is a lack of clarity in the registers as to whether mitigating actions recorded have been carried out or remain outstanding; • In many cases, due dates of the actions recorded had expired. Our prior year report noted that Singleton and Mental Health & Learning Difficulties service groups had a high number of risks overdue. The Datix risk database has been the subject of a recent internal scrutiny review in which issues were raised over the completeness of actions related data fields but at the time of our audit these had not been rectified. This links to an RMG review of the health board risk management process in August 2021 in which was observed a need for further work on risk articulation and SMART actions to assist with completion of actions and help reduce scores. We recommend that improvements are made in service group risk registers to provide more consistency in the application of risk scores and better clarity over the documenting of risk mitigating actions.	**M**	Agreed. A series of risk workshops for clinicians and managers, in specialty-related sessions, was completed within Neath Port Talbot & Singleton Service Group in the late summer. The sessions provided training on risk management principles, health board arrangements and opportunity to apply this to local risk register entries. Arrangements are being made to roll the training out to the other service groups during the next two Quarters and progress will be reported to the Risk Management Group and Management Board. A review of Service Groups will also be undertaken and reported on. We anticipate completion by September 2022. A programme of service group risk register presentations for 2022 has been agreed at the December Risk Management Group meeting. Service Groups will be asked to report on processes in place to manage & scrutinise registers at a local level, and present their registers with a focus on their top risks. This will commence from March 2022 and the programme will complete by the end of the calendar year.	30/09/2022	**January 2023:** Service Group workshops have been completed in 3 of the 4 Service Groups (NPTS, PCT and MHLD). In respect of the final service group, Morriston: A risk workshop has been provided for Specialist Services and an awareness presentation given to Matrons. It has been difficult arranging sessions with other services during the period due to service pressures. Other options for delivery of training within Morriston are being considered to spread improvements. The possibility of using current meetings / drop ins, and focusing on the taught element in shorter sessions was shared at Risk Management Group in January 2023. In addition to this training, in December and January the Risk Management Group received and reviewed data on the use of some key fields within Datix Risk Register to support improved use - the analysis and areas for improvement were discussed. This will be repeated at a future meeting to review improvements. Revised Deadline: 31/03/2023 (Training element)	31/03/2023

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 **October 2022:** This remains open. Consideration has been given to operational risk reporting as part of development of enhanced approach to risk appetite articulation that is ongoing. Additional staff resource has been secured and will be taking forward work in November to review operational risks and their categorization recorded within registers for reporting through management groups and to Committee level. It is expected that this work will complete shortly following the completion of workshops. The approach to reporting of operational risk will be discussed at the Risk Management Group in November. Revised expected date of completion: End January 2023. **Jan 2023:** The Risk Appetite document was agreed in November by the Board. Work to develop an approach to reporting of operational risk in accordance with the agreed appetite is being worked though. Revised deadline 31/03/2023	31/03/2023

Executive Lead – Director of Corporate Governance						
SBU 2122-008		**Standards of Business Conduct Declarations**		**Report Issued July 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1	There is no set process which allows the Corporate Governance Team to be certain that all required declarations have been made, in so far as that is possible, and to identify missing declarations. We note that plans remain for the declarations form to be electronic, where the data can be held centrally. Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.	**M**	Quarterly reminders are sent to the corporate and service group leads to cascade within their teams to remind staff of their responsibilities to declare interests. In addition, declarations of interest and secondary employment are to be created as competencies within the statutory and mandatory training section of ESR with all employees required to complete these once a year and confirm that they have read the standards of business conduct policy.	30/11/2022	**September 2022:** Discussions have been undertaken with the learning and organisation development (OD) team which has confirmed that it is possible to add the statutory and mandatory competencies on ESR statements, which require staff to confirm they are aware of the standards of business conduct and if they have any declarations/secondary jobs to declare. While these could be added now to meet the original deadline of November 2022, it is proposed that the timescales be extended to March 2023, as this would tie-in with the roll-out of supervisor self-service and as such, managers would then receive a notification that the staff have completed the competencies and can discuss any concerns with them around declarations. This would also enable the process to commence at the start of the financial year, even if it was on a service group by service group basis.	31/03/2023
2.1	A previous version of the handbook was considered during the audit. A more recent version has since been published and does now reference the standards of business conduct. Declarations of interest and secondary employment are to be created as competencies within the statutory and mandatory training section of ESR with all employees required to complete these once a year as well as confirm that they have read the standards of business conduct policy. This will be part of the check-box on the checklist for completion of mandatory training. The revised staff handbook should be finalised and circulated to staff. The handbook should contain a checklist which requires completion by new starters and countersignature by the line manager, intended to ensure the initial declarations are received and submitted to the Corporate Governance Team within a specified time from the commencement of their employment.	**M**	A previous version of the handbook was considered during the audit. A more recent version has since been published and does now reference the standards of business conduct. Declarations of interest and secondary employment are to be created as competencies within the statutory and mandatory training section of ESR with all employees required to complete these once a year as well as confirm that they have read the standards of business conduct policy. This will be part of the check-box on the checklist for completion of mandatory training.	30/11/2022	**September 2022:** Discussions have been undertaken with the learning and organisation development (OD) team which has confirmed that it is possible to add the statutory and mandatory competencies on ESR statements, which require staff to confirm they are aware of the standards of business conduct and if they have any declarations/secondary jobs to declare. While these could be added now to meet the original deadline of November 2022, it is proposed that the timescales be extended to March 2023, as this would tie-in with the roll-out of supervisor self-service and as such, managers would then receive a notification that the staff have completed the competencies and can discuss any concerns with them around declarations. This would also enable the process to commence at the start of the financial year, even if it was on a service group by service group basis.	31/03/2023

Executive Lead – Director of Corporate Governance						
SBU 2122-017		**Safety Notices & Alerts**		**Report Issued June 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1a	Review of the process document highlighted that the required document review date has since passed (23rd November 2021). The current version of the document holds a number of blank areas, including author job title, approved by, and publication date. We were informed that the review commenced in January 2022 and remains ongoing at the time of fieldwork. The main SOP: Safety Notices and Important Documents Management Procedure should be reviewed updated, and contain standard elements such as author, approval and publication date. It should also be ensured that it is subject to an annual review going forward	**M**	The Safety Notices and Important Documents Management Procedure document will be reviewed and updated, and incorporate detail of the author and approval date. Once approved, the document will be subject to review in line with the Health Board's Policy on Policies.	30/09/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
1.1b	The latest version of the overarching SOP, Safety Notices and Important Documents Management Procedure was formally approved on 10th December 2020 by the 'Once for Wales Risk Management System Implementation Group / User Group'. There is no evidence that the SOP has been approved in line with the 'Policy for the management of health board wide policies procedures and other written control documents' requirements. The process document should be subject to formal governance approval at an appropriate group which contains Executive Director membership	**M**	The updated document will be submitted to the Management Board for approval.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
1.1c	The SOP does not include reference to an overall lead Executive for alerts and notices, this reflects a lack of single point of ownership within the health board for the process as a whole as responsibilities sit across a number of directorates and specialist areas. The health board should identify a lead Executive Director for notices and alerts, and this should be reflected within the SOP.	**M**	As part of the update process referred to above, discussions will be held to consider a lead Executive Director with overall responsibility for the safety notices and alerts process.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
1.1d	We found that in some places the main SOP used alerts and notices as synonyms rather than containing clear definitions, which may result in lack of clarity for readers. In addition, alerts and notices should be clearly defined and differentiated within the SOP	**M**	The various types of alerts and notices covered by the Procedure will be clearly identified, defined and differentiated as part of the update process.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023

<table>
<tr>
<td>1.1e</td>
<td>Review of the SOP content identified that it includes listing of 15 different types of alerts. Section 6 of the SOP requires that the ‘Responsible Persons’ for each alert develop local arrangements to be outlined in their own SOP. However, seven out of 15 alert types were not supported by any process documentation. We were informed that two of the SOPs, for Estates and Facilities alerts and notices, and CMOs, are currently under development.

We also note that the overarching SOP requires that each Service Group should have its own SOP, to reflect local arrangements to support distribution and management of alerts/notices. Our review of these Service Group SOPs found that three of them have not been reviewed for a number of years and varied in level of detail and content. In addition, we were informed that the combined SOP for Singleton Neath Port Talbot remains under development.

In line with the requirements of the overarching SOP, appropriate SOPs should be developed at the Service Group level and for each alert type where required. These SOPs should be subject to regular review and formal approval.</td>
<td>M</td>
<td>Service Group and/or Department level Procedures will be updated and/or developed as appropriate in tandem with the above.</td>
<td>31/10/2022</td>
<td>December 2022: Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process.
Date of 30/06/2023 set for further update</td>
<td>30/06/2023</td>
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<tr>
<td>2.1a</td>
<td>We selected a sample of 30 notices and alerts and found that, with the exception of one MDA, all were recorded in Datix. We found that alerts and notices have been entered within the Datix system in a timely manner, although our testing revealed that completion deadlines, in line with the timeframes required e.g. by WG, were not formally set within the system.

We recommend that formal deadlines are set, to complete the necessary actions in relation to safety notices and alerts. These deadlines must be in line with the specifications stated in the safety notices and alerts and, if there is no such specification, then the deadline should be formally set by the relevant Level 0 Responsible Person.</td>
<td>H</td>
<td>Deadlines for action will be set and communicated for each safety alert and notice received by the health board.</td>
<td>30/09/2022</td>
<td>December 2022: Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process.
Date of 30/06/2023 set for further update</td>
<td>30/06/2023</td>
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<tr>
<td>2.1b</td>
<td>Review of Datix identified that only 195 of the 964 alerts and notices between 1st April 2019 to 1st April 2022 were recorded as closed in the system. In addition, we selected a sample of 30 alerts and notices for confirmation that they had been distributed and actioned, and found the following:
<table>
<tr><th>Ref</th><th>Types of alerts / notices</th><th>Sample size</th><th>No deadline was set</th><th>Completed within the deadline</th><th>Completed after the deadline</th><th>Spectrum of delays (in months)</th><th>Overdue</th></tr>
<tr><td>1</td><td>Patient Safety Notices (PSNs)</td><td>12</td><td>0</td><td>1</td><td>5</td><td>within 1-7 months</td><td>6</td></tr>
<tr><td>2</td><td>Patient Safety Alerts (PSAs)</td><td>3</td><td>0</td><td>0</td><td>2</td><td>within 3-4 months</td><td>1</td></tr>
<tr><td>3</td><td>Medical Device Alerts (MDAs)</td><td>6</td><td>1</td><td>3</td><td>2</td><td>within 1-12 months</td><td>0</td></tr>
<tr><td>4</td><td>Estates & Facilities Alerts and Notifications (EFAs/EFNs)</td><td>5</td><td>2</td><td colspan="4">N/A - as no evidence was provided.</td></tr>
<tr><td>5</td><td>Chief Medical Officer letters (CMO)</td><td>4</td><td>0</td><td>4</td><td>0</td><td>N/A</td><td>0</td></tr>
<tr><td colspan="2">TOTAL
% as of total sample</td><td>30
100%</td><td>3
10%</td><td>8
27%</td><td>9
30%</td><td></td><td>7
23%</td></tr>
</table>
We also recommend that compliance with actions be proactively monitored, evidenced and the related audit trail is maintained to support the completion of actions.</td>
<td>H</td>
<td>Detail regarding monitoring and reporting requirements, together with the management trail to be maintained and retained in respect of compliance with required actions will be set out in the relevant Procedure document(s)</td>
<td>31/10/2022</td>
<td>December 2022: Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process.
Date of 30/06/2023 set for further update</td>
<td>30/06/2023</td>
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3.1	Distribution lists are in place to cascade alerts and notices through the health board. We tested two distribution lists in Datix and found that appropriate levels of representation were included. The main SOP requires that the distribution lists are subject to a review. However, we found no evidence that the distribution lists were circulated (as minimum annually) to the Service Group Directors for confirmation or amendment changes. The health board SOP does not require identification of any substitutes or alternative contacts for level 0 and 1. As such, there is a risk that safety notices and alerts may not get recorded in Datix or cascaded further within the health board. The distribution list should be subject to regular reviews, and these reviews should be formally evidenced. We also recommend that substitutes are formally identified for level 0 Responsible Person.	**M**	Distribution lists will be subject to regular review. Detail regarding timeframes, together with the management trail to be maintained and retained to evidence checks undertaken will be set out in the relevant Procedure document(s). All Level 0 Responsible Persons will be asked to nominate deputies to act in their absence.	30/09/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
3.2a	The health board's overarching SOP sets out the arrangements for communicating alerts and notices, cascading information from the Responsible Person (level 0) down to Ward and Departmental Managers (level 3), although the responsibilities for level 3 are not directly outlined. As would be expected, given the wide range of notice and alerts, the Responsible Persons are drawn from a number of directorates and specialist areas. Despite this, the SOP does not make a reference to individual Executive Director roles and responsibilities. We also recommend that roles and responsibilities are clearly defined in the main SOP, including for Executive Director and Level 3 (Service Group).	**M**	This will be actioned as part of the document review and update process.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
3.2b	We found other SOP (Morriston Service Group and the combined MDAs, Local Safety Notices (LSNs) and Local Security Alerts (LSAs) SOP) included references to level 4 cascading but the documents did not define roles and responsibilities to this level. Where additional levels are used in the Service Group SOPs, these should be clearly defined accordingly.	**M**	This will be actioned as part of the update and/or development of Service Group and/or Department level Procedures.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
4.1a	Overall, we note that no Key Performance Indicators (KPIs) had been set, monitored and reported across the various areas. As such, there is risk that the quality of the monitoring may not be sufficient and/or consistent across the different types of alerts/notices. A more robust monitoring and reporting process should be put in place, including setting up KPIs for each alert type, and monitoring them, especially in the compliance area.	**M**	Monitoring and reporting processes, including the setting of any relevant KPI, will be set out with the relevant procedure documents as part of the update and development process.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023

4.1b	The current main SOP does not explicitly state how issues related to safety notices and alerts should be escalated. A formal escalation route should be established and formally documented.	**M**	Details of escalation processes will be set out within the relevant procedure documents as part of the update and development process	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
5.1	While the current processes at the health board aim to reach compliance in relation to all safety notices and alerts, once the adequate status is achieved and compliance is established, no further check or reporting takes place. As a result, the health board does not actively monitor on-going compliance with the safety alerts and notices. Management should consider how on-going compliance related to safety notices and alerts can be assured, such as inclusion of alerts and notices within any internal quality assurance inspections.	**M**	Systems and processes capable of providing assurance in respect of compliance with safety notices and alerts at both a Service Group and Corporate level will be developed and documented as part of the Procedure review and update process.	31/10/2022	**December 2022:** Work is currently being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. As such, it is vital that any local systems and processes put in place dovetail effectively with the output from this exercise. Work to address this recommendation will therefore take place alongside, and in tandem with the development of the new all-Wales process. Date of 30/06/2023 set for further update	30/06/2023
SBU-2223-004		**Freedom of Information (FOI) Requests**		**Report Issued September 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2.1	The current training compliance rate for the mandatory IG module (as of June 2022 IGG meeting) is 82%, which is an increase from the 77% that was reported at the March 2022 IGG meeting. However, this is still short of the 95% compliance rate required. A review of the June IG compliance rate identified seven areas where compliance is below 75% and require staff to prioritise the completion of IG training. Staff should be reminded to prioritise the completion of IG training, with more focussed and targeted action being taken in the under-performing areas.	**M**	IG KPI's are a regular agenda item at IGG with IG training highlighted. Compliance is improving, however will continue to be driven forward and monitored closely with those 7 areas targeted, with leads to provide reports to IGG on improvement plans.	31/01/2023	None received.	

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	**February 2023:** The findings of the National Digital Skills Assessment are due to be reported to WG in March 23 and will not be released to Health Boards until this has happened. Following this Digital Services will use the findings to build a SBUHB Digital service workforce plan with appropriate support from SBU Workforce. This is now likely to be completed in Dec 2023.	31/12/2023

SBU 2122-021	ITIL Service Management Review	Report Issued October 2021	Assurance Rating – Reasonable

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
3.1	Currently the organisation has not fully implemented ITIL processes and Practices for Problem Management and recording and communicating Known Errors. Without these processes in place the Board is at risk of being: • a purely reactive support organisation; • an IT User organisation, confronted with recurring Incidents; and • an ineffective support organisation, since similar Incidents have to be resolved repeatedly and structural solutions are not provided. ITIL processes and Practices for Problem Management and recording and communicating known errors should be strengthened by implementing a more formal structure.	M	As highlighted in the report, the team do not adopt problem management processes, this will take time to implement and resource, it will be linked to the All-Wales Infrastructure Programme service desk replacement and associated process timescales. This requires a dedicated service management resource which will require a resource plan aligned to the IMTP digital resource plan for 2022/23 onwards. Subject to funding being made available a post will be recruited and a formal structure developed.	31/12/2022	**February 2023:** Due to funding, it has not been possible to recruit to a post to address this issue as intended. Date of 31/03/2023 set for further update.	31/03/2023

SBU-2122-005	Network & Information Systems (NIS) Directive	Report Issued April 2022	Assurance Rating – Reasonable

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
1	Our review highlighted that records of discussions and supporting information provided to the CRU have not been captured and maintained throughout the self-assessment process. Several instances of question marks were noted within the final CAF where clarification was sought from the CRU, however, the CAF was not then updated accordingly. Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	M	Agreed. This will be discussed at the next CRU assessment (tbc). Audit notes are normally recorded by the auditor and a suitable mechanism will be agreed with the CRU for example if via Teams then these will be recorded.	31/12/2023	**January 2023:** There hasn't been another audit to action this. A date of 30/06/2023 has been set for further update	30/06/2023

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. **December 2022:** Completion of this action has been further delayed due to ongoing absence within the department. The position will be reassessed in January 2023. **February 2023:** In correspondence with Procurement for assistance with the development of the standard operating procedures.	31/01/2023
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 31/12/2022 has been agreed as part of the follow-up review. **February 2023:** In correspondence with Procurement for assistance with addressing this recommendation. Date of 31/03/2023 set for further update.	31/03/2023
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 31/12/2022 has been agreed as part of the follow-up review **February 2023:** In correspondence with Procurement for assistance with addressing this recommendation. Date of 31/03/2023 set for further update.	31/03/2023

Executive Lead – Director of Finance						
SBU 2223-016			**Health & Safety**	**Report Issued September 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.2 (b)	The Policy includes that Service Directors will ensure there are 'appropriate arrangements within their areas of the organisation.' The health board is currently establishing arrangements in place for Service Groups operating across multiple community sites. Once site leads have been identified for all premises this information should be shared with the HSC and arrangements made for this information to be accessible to relevant staff.	**M**	Once the service group provides the information, this will be shared with the HSC, it is worth noting that the only area not covered to date is Primary Care, so this information is already available for three out of the four service groups.	30/11/2022	**December 2022:** Work is currently ongoing with Primary, Community & Therapies Service Group colleagues in order to progress this action. It is envisaged that this will be complete by March 2023.	31/03/2023
1.3	The Policy notes, under section 6.4 'Health and Safety Information', that copies of relevant policies and procedures will be available for employees. The current iteration of the intranet does not hold any health and safety guidance, although key policies are available in the corporate policy library. Health and safety policies held within the corporate library and on the external internet page should be updated to the latest approved version. The health board should also consider adding key health and safety guidance to the intranet ahead of the full roll out of detailed health and safety page.	**M**	The Health and Safety Policy as stated by audit is the old H&S policy, this has been superseded by the one approved by the HSC in 2022, this will be uploaded on to the intranet and internet websites.	31/10/2022	**November 2022:** This will now be completed by 31/12/2022.	31/12/2022
2.1	Review of the HSC terms of reference (ToR) and its work programme identified topics and subject areas listed within the ToR which do not explicitly feature within the work programme in their own right. We note for a number of these the intention is that assurance will be provided through deep dives undertaken at the Health and Safety Operational Group (HSOG) and reported through the subsequent 'Key Issues' Report. Whilst there is evidence to support this process in operation, we would note that the frequency of HSOG meetings does mean there could be substantial time gaps between reporting. Review of HSC agendas and papers also identified a gap where the HSC has received no information related to patient falls/patient manual handling. If there is continued use of the subject specific HSOG deep dives for assurance then consideration should be given to periodic updates on topics which the HSOG will not be addressing within a 12-month period. This could perhaps feature through an end of year deep dive reflection/assessment.	**M**	Deep dives are being carried out as outlined in the forward plan, there is also evidence that topics have been changed when specific areas have been raised. The group tested the option of undertaking two deep dives per meeting and it was agreed by the group that due to the amount of work to undertake the deep dives, that one is sufficient. The point raised by audit can be addressed by reviewing the exception reporting template to capture specific areas. This will be put to the next HSOG meeting in November 2022.	31/12/2022	**November 2022:** This has been addressed by the implementation of an updated exemption report template. This has been piloted in November H&S Ops Group, where initial feedback was positive. This will now be embedded across all service groups. Please extend deadline date to 28/02/2023	28/02/2023

4.1 (a)	Estates provide a report to each HSOG which provides updates against several areas such as medical gases, waste, electrical services, ventilation, and fire amongst others. The report is narrative and does not include reference to KPIs. We also note where action plans are referenced, copies are not included, which could make subsequent tracking difficult. Review of content did not identify reference to Estates & Facilities Alerts and Notifications received or compliance against these. The format of reporting provided from Estates services to HSOG should be reviewed and consideration given to modifying the format away from narrative updates to align with agreed Key Performance Indicators, group operation and progress against action plans, and alerts and notifications (where appropriate).	**M**	The exception reporting provided by estates is being reviewed and will be updated ready for the next HSOG meeting in November 2022.	30/11/2022	**November 2022:** Updated Estates report piloted at November H&S Ops Group meeting, where it was agreed that further revision was required. Please extend deadline date to 28/02/2023	28/02/2023
7.1	A business case has been developed as part of the review of the health board's health and safety resource and department structure. We were provided with the latest version, dated May 2021, which includes a number of new posts. Updates provided to the HSC in April and July 2022 included that resource was being appointed when available, with two fire safety officers appointed in early 2022 and the intention was to appoint to a number of other posts through 2022/23 and 2023/24. At the time of fieldwork, the previous Assistant Director of Health and Safety had taken up a new post within the health board as Assistant Director of Strategy (Capital), whilst continuing to fulfil health and safety responsibilities until arrangements regarding a replacement are confirmed. The health board should review and update the health and safety team resource business case to reflect the current and intended structure. This should include arrangements to support the long-term leadership of the health and safety function through the appointment of a substantive Assistant Director.	**M**	This has and is continually being reviewed, with some recruitment already taking place and/or in progress. Two fire safety advisers were appointed in Jan/Feb 2022, with interviews taken place in July/August for one health and safety advisor and one manual handling trainer/advisor, with expected commencement dates in September/October 2022. Further appointments will be phased in over the next 12 – 18 months to increase the level of resources.	31/12/2022	**February 2023:** Work to finalise the structure is currently ongoing. Date of 31/03/2023 set for further update	31/03/2023
8.1	Key Performance Indicators were approved by the HSC in July 2021 and shared at HSOG. We have been unable to identify any further KPI papers at HSC or HSOG. We reviewed papers submitted to HSOG by Service Groups, Estates and the Health and Safety Team, to identify if the KPIs featured within ongoing standard reporting noting the following: • Incident reporting – exception reports include information on numbers and themes but not the KPIs which is timeliness of entry onto Datix. • RIDDOR – report provided by Health and Safety Team to HSOG, but not by Service Group. • Induction – Service Groups provide training information, but not induction figures as outlined by KPIs. • Health and Safety training – Compliance reported in required areas. • Health and Safety audits – audit programme not in place. • Fire – Information from Fire Safety group includes risk	**H**	KPI report to be developed to provide a clear focal point for discussion with leads identified to provide routine monitoring. Incidents are reported by each of the service groups with an overall report submitted by the Head of Health & Safety. RIDDOR's are recorded by the service groups, with the main RIDDOR report produced by the health & safety team as outlined. All identified RIDDOR's are recorded and discussed at the HSOG. Health Board inductions have changed during the pandemic, with more concentration on the local induction and mandatory training and will work with service groups to see how this is captured. All service groups and support services provide training figures with the exception of estates. This is	31/12/2022	**February 2023:** Updated exemption reports now have a section specifically for KPIs for the Service Groups. Further review and update is being undertaken to ensure that appropriate information relating to estates KPI's in being captured.	31/05/2023

	assessments but not the other 7 KPIs. • Manual Handing – no information for KPIs. • Water Management/Asbestos/Fixed Wiring/Gas Safety – no related KPI performance information within Estate's reporting. Noting the varying sources required to populate the wide ranging KPIs and the gaps identified above, it is unclear at what levels they are to be reported and monitored.		being addressed as an overall review of the exception reporting template takes place and there will be a specific template for estates to capture information. Health & Safety audits have not commenced, this is due to resources and will be addressed once appropriate resources are in place as outlined on the plan. The HSOG and the HSC receive the minutes from the Fire Safety group, will review to see if an exception or key issues report would better address areas raised by audit. Manual handling training is reported in general, will look to include MH coaches and any audits/inspections that have taken place going forward. The reporting of estates KPI's is being reviewed and an updated version will be produced in time for the November HSOG meeting ahead of determining the final KPI model by 31st December 2022.			
9.1	Priority two within the Strategic Action Plan outlines steps towards the development of training to support managers within the health board. Milestones include: 1. Identify appropriate managers to undertake IOSH Managing Safely or equivalent. 2. Identify course provider or develop internally. 3. Schedule initial dates for pilot course completion. This potentially will be 10-year programme. During fieldwork we were informed that there has been consideration of the method of programme delivery, including review of training provided by neighbouring health boards. However, identification of managers remained outstanding outside of links to specific bandings and we note there is opportunity to link this to the identification of site leads currently being progressed by the health board The health board should undertake an assessment to ensure there is identification of managers, and those with health and safety responsibilities for specific sites, to ensure the rapid progression of training once the course and its delivery method are agreed.	**M**	The Health Board have commissioned a course for the Executive team and these are scheduled for 14th & 16th September 2022.	30/09/2022	**October 2022:** The IOSH for Executives took place on 14th and 16th September 2022. Managers within the HB will be covered initially by the pilot scheduled for December 2022. Through the all Wales H&S group CTMUHB have developed an on-line version of managing safely that will be on ESR, it is expected for this to be evaluated in Q4 2022/23 by all HB's/Trusts in Wales with the intention to adopt as an all Wales training system to ensure consistency throughout Wales. Hoping to adopt as an all Wales passport longer term.	31/01/2023
10.1	The HSC 2021-22 work programme included presentation of a health and safety annual report scheduled for October 2021. Review of papers and discussion with management confirmed that no annual report was prepared for the committee and so subsequently the Board has not received an overview of the issues and risks outside of the key issues reports which summarise HSC meetings. An annual health and safety report should be provided to the HSC which captures issues, risks, and actions for subsequent presentation to the board.	**M**	This point is noted and it is the aim of the team to produce an annual report for the November 2022 HSOG meeting ahead of presentation to the HSC and to the board.	30/11/2022	**December 2022:** The Draft Annual Report has been circulated to Health & Safety Ops Group members for comment during December 2022, with the intention that the final version be presented to the Health & Safety Committee in January 2023 for approval. Going forward, it is intended that the 2022/23 Annual Report will be presented to the Health & Safety Committee for approval in July 2023. Deadline of 31/01/2023 set for confirmation	31/01/2023

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. **October 2022 –** Development of the revised Health & Safety pages for the new Health Board intranet site continues, with Manual Handling pages now live. It is anticipated that this work will be completed by the end of the financial year.	31/03/2023
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 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	**September 2022:** Whilst progress has been made, overall performance in respect of the completion of PADR reviews has been adversely effected by staffing/resource issues within the Department (vacancies and sickness absence). Following appointment to key vacancies, it is anticipated that 100% compliance in respect of the completion of PADR reviews will be achieved by the end of the financial year.	31/03/2023

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.	31/12/2021	**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. Chased for response 22/6/22. Therefore deadline for completed needs to be moved to end August 2022. **Aug 2022** Governance work being undertaken by the RPB still not completed and shared with HB. Therefore item remains outstanding at the end of August. **October 2022: A** Financial Control Procedure (FCP) has been drafted, and is currently undergoing quality assurance review within the Finance Directorate. It is anticipated that this will be brought to the January 2023 meeting of the Audit Committee.	31/01/2023

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 **August 2022:** The cost-free solution was not delivered by the company who had initially presented it to the Health Board. The Assistant Director has written to all Estates staff involved in placing service contracts, and instructed them to seek CHAS accreditation as part of the procurement process. If they do not use a company with this accreditation, they must ensure that all appropriate insurance and competency checks are undertaken. **February 2023:** Recommendation remains overdue, however it is noted that the appointed Health & Safety Officer has now taken up their role, and that they have been charged with taking forward the expectations through the CHAS system. A date of 31/03/2023 has been set for further update	31/03/2023
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	31/03/2023

					December 2022: The team have provided induction via a seconded member of staff. A permanent appointment has now been made, who will take up post in January 2023. The secondment will continue until 31/03/2023, thus providing a period of parallel cover. Data on the number of inductions delivered since the commencement of the secondment to be provided to NWSSP A&A colleagues for review. Date of 31/01/2023 set for further update. February 2023: Recommendation remains overdue. As is noted from the compliance reviews undertaken by the Estate team, contractors continue to be allowed to work on HB premises without having received an induction. Date of 31/03/2023 set for further update.	
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. 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. 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 **September 2022 (DK):** Biannual audit undertaken in March 2022, with findings reported to the Estates Board. Further audit undertaken in September 2022, the findings of which will be reported to the next Estates Board meeting. Further work is required to review and widen the scope of the audit reviews. Following discussions with NWSSP Audit & Assurance colleagues, if has been agreed that the deadline will be extended to 31/03/2023 in order to facilitate and evidence the foregoing	31/03/2023

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. **August 2022:** The Assistant Director of Estates, Morriston Estates Manager, the Singleton Estates Manager and one of the Estates Officers at Singleton have all completed refresher training. The Health Board will now seek to commission training for CP as it becomes available. **September 2022:** On-site awareness training for Competent Persons has commenced and is ongoing. It is envisaged that all required water safety training will be delivered/refreshed by the end of December 2022. **February 2023:** Recommendation remains as overdue. Whilst the RP details have now been updated, details of training for Estates Managers / Officers was not evident as required at the last update of the tracker. A separate meeting will be held to determine a way in which to fully address the detail of the agreed recommendation. Date of 31/03/2023 set for further update	31/03/2023
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.	30/07/2021	**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 requirements, and compliance, should be captured in a training matrix for all staff with water safety responsibilities (including both Estates and Departmental/Ward staff). **October 2022:** Following discussions with NWSSP A&A colleagues, it has been agreed that further consideration will be given to what would be the most appropriate mechanism by which evidence of training can be captured and recorded. It has been agreed that the deadline date will be extended to 30/11/2022 in order to facilitate this. **December 2022:** The underlying recommendation was for the training matrix to reflect the current status of training (i.e. requirements/expectations). This has yet to be evidenced. Date set of 31/01/2023 for further update. **February 2023:** As per 8.1b, remains as overdue. More work is required on the detail of the matrix against the detail of the agreed recommendation. A separate meeting will be held to determine a way in which to fully address the detail of the agreed recommendation. Date of 31/03/2023 set for further update	31/01/2023

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	**June 2022:** 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. **August 2022:** The SBU Head of Procurement met with the Assistant Director of Procurement Services on the 18th August 2022 and SLAs will not be updated until the end of October 2022 at the earliest. **December 2022:** The review of all NWSSP SLA's with Health Boards and Trusts in Wales has been deferred to 2023/24. A date of 30/04/2023 has been set for further update	30/04/2023

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**
1	Whilst the waste policy was found to be generally comprehensive and in accordance with the guidance provided by WHTM 07-01 (6.4), it was noted that some areas had not been incorporated. The policy was supported by a series of procedural guides reflecting the current WHTM 07-01. Whilst comprehensive, these were last updated in 2015 and therefore required review to ensure information remains relevant to current UHB operations. It was further noted that the UHB's intranet site contained some out-of-date and superseded policy and procedural documents, which should be removed. a) At the date of the next review of the Waste Management Policy, it should be ensured that all key elements of WHTM 07-01 guidance, and enhanced information regarding governance and training arrangements, are incorporated. b) Waste management procedures (UHB-wide) should be reviewed and updated where necessary, via an appropriate forum(s). c) Out-of-date policy / procedural documents published online should be removed.	**M**	a) Agreed. We will incorporate the suggested elements at the date of the next review. b) Agreed. Work has now commenced on the review of the procedures. Initially, we are targeting those areas where issues in compliance have been identified. There needs to be a wider consolidation of all waste procedures across the UHB to ensure consistency in the approach. c) Agreed. We will ensure superseded documents are removed from the intranet. B and C to be completed by the end of June 2022	30/06/2022	**September 2022:** The Policy review is ongoing, but has been hampered by staffing/resource issues within the Department. The revised document will be presented to the H&S ops Group before going to the next meeting of the Health & Safety Committee for approval in January 2023. The process of reviewing and updating the supporting procedures has commenced and is ongoing, with anticipated completion by the end of November 2022. All out of date/superseded procedure documents have been removed from the intranet. **December 2022:** Revised Waste Management Procedure being worked on new simplified induction manual. 22 out of 29 procedures were submitted to November Estates Board for Ratification. **February 2023:** It is noted that the key officer leading on these recommendations has been absent for a number of weeks on bereavement leave therefore no further action has been taken since the date of the last tracker review. Date of 31/03/2023 set for further update	31/03/2023
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	**September 2022:** The ability to progress this action has been hindered by staffing/resource issues within the Department, and delays in the production of WG guidance. The Environmental Factsheet section of the staff handbook has been reviewed and updated. A meeting with Learning & OD colleagues and the Sustainable Swansea Bay Forum is planned for October to discuss further options, including the possibility for an ESR Module. **December 2022:** Meeting held with OD and Strategy Sustainability Planning Manager. Suggestions for amending both Sustainability and Environmental Portals (HB Intranet) and Staff Handbook submitted to OD and Strategy. Possible ESR module being considered by OD and Strategy. **February 2023:** See 1 above	31/03/2023

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	**October 2022:** A draft report has been prepared, and is currently with the Assistant Director of Estates. **December 2022:** The Assistant Director of Estates has discussed the draft report with the Director of Finance & Performance, however further work is required. A date of 31/01/2023 has been set for further update. **February 2023:** See 1 above	31/03/2023
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	**September 2022:** The ability to progress this action has been hindered by staffing/resource issues. A paper summarising waste volumes by type/category will be presented to the Forum by Dec. 2022. The Department are currently working with NWSSP Procurement colleagues to identify the most common consumable items purchased by the Health Board in order to further refine and focus this work/reporting going forward. **December 2022:** Critical review of common waste items with Strategy (Decarb Plan) and Procurement and Estates held in November 2022, following exercise by Procurement in identifying most purchased items. This will be an ongoing project. Proposed costings for improving recycling in line with Welsh Government provided to Decarb Action Plan Finance Group. **February 2023:** See 1 above	31/03/2023
6	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. 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**	a) Agreed, we will prepare a RAG-rated summary log of all audit findings. 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	**September 2022:** The ability to progress this action has been hindered by staffing/resource issues within the Department. Following the next Pre-Acceptance audits, which are due in November/December 2022, a dedicated Tracker will be put in place to deal with any recommendations/non-conformities highlighted. This will then be reported to the Estates Board, and periodically return for update and progress monitoring. It will also made available to the Sustainable Swansea Bay Forum. **October 2022:** It has now been confirmed that the Pre Accept Hazardous Waste audits will actually take place in January 2023. **December 2022:** Tracker developed. Monthly Estates Board paper now a standing agenda item – will include nonconformities from Pre-acceptance audits. **February 2023:** See 1 above	31/03/2023

Executive Lead – Director of Finance						
SBU 2122-003		**Financial Reporting & Monitoring**		**Report Issued May 2022**	**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	Budget delegation letters are issued to the four Service Group Directors. The Standing Financial Instructions states budget holders must sign the accountability letter formally delegating the budget. We note that of the four letters issued to Service Groups, the corporate Finance Team did not receive any responses. We also note that budget holders appear to be working to the budgets delegated to them, and the health board is on track to deliver the year end position. The importance of signing and returning delegation letters is re-iterated to budget holders to formally recognise budget accountability.	**H**	Accepted. Following the publication of the 2022/23 letters, which will include a deadline for replies, the Finance team will ensure there are regular checks on the receipt of responses and where necessary ensure reminders are issued. Where no responses are received within 4 weeks of the deadline this will be escalated to the DOF. Formal responses will be held on file by the Finance Team.	31/07/2022	**October 2022:** It has not yet been possible to issue final delegation/accountability letters, due to the need to clarify detail around certain elements of the overall HB allocation. **December 2022:** Work on finalising the allocation is near completion and final budgets with exception of specific items retained centrally will be issued to the areas for Mth 9 closedown. This will then drive the final allocations for 2022/23. This information will now be issued in an email to the Service Directors/Corporate Directors to provide total budget. Going forward the change in the management of Reserves aligned to the 2023/24 Accountability Framework will mean issuing of final budgets and responses will be done in Q1 of 23/24. Deadline of 30/06/2023 for further update	30/06/2023
3	Our review of Financial Control Procedure 6 - Budgetary Control Procedures noted that this document was last updated in November 2019 and was due for review in 2020/21. A paper taken to Audit Committee in November indicates review of these procedures was planned for quarter 4. We also recognise that the document is currently undergoing national review and recognise the impact of COVID-19 FCP 6 - Budgetary Control Procedures should be updated to reflect current working practices	**L**	Noted. Agreed the FCP6 needs to be updated and aim for completion during Q2	30/09/2022	**October 2022:** The review/rewrite has commenced, however it has not been possible to complete this by the originally agreed deadline due to the volume of work involved. It is anticipated that this will now be completed by the end of the calendar year.	31/12/2022
5	The manual non-pay listing has approximately 280 employees that are able to authorise payments without a purchase order. We recommend a wider review of this listing is undertaken, to assess the need for this number of authorisers given the NHS Wales 'No PO, No Pay' policy.	**L**	Noted. Agreed to be reviewed in Q3.	31/12/2022	**June 2022:** This is to be consider by the Group under point 4 – as to whether this action fits within the remit of the TOR. Update to be provided following first meeting in July. Agust 2022 (Sam Moss) - agreed this will be pick up as part of the Work stream outlined in the point above and will be part of the work programme. However timescales for completion may vary as the programme develops.	
6	Authorised signatory listings are maintained in relation to the Oracle system as well as for manual non-pay transactions. Monthly checks are undertaken against ESR records to ensure leavers are removed from the approval hierarchy. Periodic checks are also undertaken at a Service Group level, although the frequency and formality vary. As part of our review, we undertook a comparison of the arrangements in place at a sample of other health boards. This determined that annual confirmation checks are circulated to Service Groups to ensure that the authorised signatories listing is complete and that cost centres and approval limits are appropriate. We recommend that this good practice annual confirmation check is completed across all Service Groups and corporate delegates and that a central listing is maintained by the Finance Team.	**L**	Noted and agreed. A list per Service Group/Directorate will be issued annually for review by Service Group Directors and the tier below to include FBP.	31/07/2022	**October 2022:** Due to the ongoing organisational/structural changes resulting from implementation of AMSR, it has been agreed that it would be more beneficial to delay the introduction of this process until that implementation is complete, and a more stable structure is in place. As such, it is envisaged that the first of these annual checks will be completed by the end of the financial year.	31/03/2022

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	**August 2022:** Draft proposed guidance has been developed and shared with staff side. HB awaiting feedback. Aim to circulate agreed guidance internally in early September. **September 2022:** The EWTD Guide remains with staff side for comment. Clearance has not been possible, as no sub-group meeting has taken place since the draft document was shared. **December 2022:** The Policy has been shared with Staff-side and reaction is awaited. Staff-side have been told the guidance will be published on the intranet without comments. A date of 31/01/2023 has been set for further update	31/01/2023
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. **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 **September 2022:** Completion of this work has been impacted by capacity issues due to the AMSR project and other pressures. A scoping exercise is underway from the information available on ESR for all the employees who have no record of a DBS check and require once for their role within the HB. In relation to the frequency of DBS checks, this is being benchmarked on an all-Wales basis. It is anticipated that this work will be completed by the end of October. **December 2022:** A scoping exercise is being finalised and a benchmark on an all-Wales basis has been completed. A report will be prepared to share with the Executive team for further consideration by 31 January 2023.	31/01/2023

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. **January 2023:** Safer, D2RA and home first policy has now been circulated for each unit to implement via their own leads on all sites. The policy was sent out from WG following the launch event in December 2022. All acute sites are implementing their training plans over next few weeks to ensure SAFER is rolled out and embedded into the daily ward culture. Signal version 2 has been updated to capture all relevant information to include EDD's, Completion of all the information via signal has much improved since last audit was undertaken. Version 3 of signal will be launched March 2023. Date of 31/03/2023 set for further update	31/03/2023
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Version 3 of SIGNAL, new icons and a standardised approach on all PSAG boards with a training programme in place.	30/11/2022

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 **August 2022:** Hywel Dda UHB area are continuing with the pilot of the Safeguarding Datix module. Progress and feedback from this pilot will be reported to the all Wales Network meeting, chaired by the National Safeguarding Team, Public Health Wales. **December 2022:** There is still no date for the launch of the Safeguarding module in Datix. The date for the commencement of the pilot with the local authority is to be confirmed. Date set of 31/03/2023 for further update. **February 2023:** It is hoped that HDUHB will provide an update at the next Network meeting but the pilot with Local Authority has been delayed.	31/03/2023

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	**August 2022:** Re the compliance map - This is still work in train (scoping how this can be done), and is quite complex in terms of cross referencing, and understanding which parts of the legislation need to be reported against. The plan is for the compliance map to enable the code/legislation to provide the key headings under which future reports will be developed. This is complicated further by the developing work around LPS, and the future need for this to be incorporated into future reporting requirements. Suggest GH and HL meet up to scope where we are – esp. around the legal position and as such may also need input from Shared/Legal Services. MH Leg Committee updated of the plan and a progress update will be provided to the October 2022 Committee It is a medium priority, so would ask that the due date in the plan be changed to October 2022. **December 2022:** Assurance has been received from the Mental Health Act Department Manager, regarding compliance with the reporting requirements stipulated in the Code of Practice to the Mental Health Act. A date of 31/01/2023 has been set for further update	31/01/2023
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 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.	**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	**October 2022:** Work is currently being undertaken with L&D colleagues in order to develop and undertake training needs assessment. **December 2022:** The MHA Team have identified areas for staff training and are utilising the Service Groups 'Lunch & Learn' sessions to provide training on the MH Act. This is open to all professions across the Service Group. A date of 31/01/2023 has been set for further update	31/01/2023

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**
1.2	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. • 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	**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 **December 2023:** The Quality & Safety Performance Framework has been reviewed and updated, and was presented to the Patient Safety Group in September 2022 and Management Board in October 2022. The Framework was adopted with effect from 01/10/2022. A quality dashboard has been developed for measuring key metrics, this will go live in February 2023. The quality pages on the intranet have been revised and by April 2023 will contain the QI framework, Quality Strategy and any supporting tools and documents. The Director of Corporate Governance is undertaking a review of quality, safety and improvement resources across the HB, reporting to Management Board in March 2023 The draft Quality Strategy has been prepared, and is scheduled to be presented to the Management Board in December and the Health Board in January 2023. It is envisaged that the accompanying implementation plan will be agreed and in place by the end of May 2023.	30/5/2023
4.1	Review of service group terms of reference identified variation of content related to group's purposes. Only one contained a reference to the Quality & Safety Process Framework, with others referencing the health board's expired Quality Strategy 2014-18. Each contained a requirement for annual review of their terms of reference and self-assessment but the methodology and any further reporting of these are not outlined Following any review of the health board's Quality and Safety Process Framework and Quality and Safety	**M**	Agreed - These "golden threads" will be reviewed and confirmed following the Quality and Safety away sessions being held in Feb/March 2022. They will include a focus on the quality priorities, key requirements of the annual plan, service specific indicators, national quality frameworks, NICE compliance, as well as local risks, harms, outcomes.	01/07/2022	**December 2023:** Review/update for the terms of reference for Service Group quality & safety groups has been completed. These are now being centrally reviewed by the Quality & Safety Team. This process will be completed by the end of January 2023. **February 2023:** Service Groups given clear direction to mirror corporate structures in November 2022, new framework in place in NPTSSG, new structures in MDU and MHLD. PCCT finalising new structures. Terms of reference and structures to be presented to QSG in March	31/03/2023

	Governance Group terms of reference, there should be consideration of any key content to be adopted within quality and safety groups throughout the organisation to promote consistency and alignment of objectives.				23. Based on the foregoing, deadline of 31/03/2023 set for further update (LJC).	
4.2	Review of service group terms of reference identified variation of content related to group's purposes. Only one contained a reference to the Quality & Safety Process Framework, with others referencing the health board's expired Quality Strategy 2014-18. Each contained a requirement for annual review of their terms of reference and self-assessment but the methodology and any further reporting of these are not outlined In undertaking the above, the health board should consider if specific requirements are needed to support quality and safety group's self-assessments and if these should be periodically reviewed. The maturity matrix included within the health board's quality governance review may provide reference point for this.	**M**	Agreed – These will be considered, as well as the use of the maturity matrix, along with the outcomes of the Quality and Safety away sessions and the expectations contained within the Health and Social Care (Quality and Engagement) (Wales) Act 2020.	01/07/2022	**December 2023:** Review/update for the terms of reference for Service Group quality & safety groups has been completed. These are now being centrally reviewed by the Quality & Safety Team. Quality review and support and escalation processes will be developed as part of this. Work to be completed by the end of March 2023. **February 2023:** Service Groups given clear direction to mirror corporate structures in November 2022, new framework in place in NPTSSG, new structures in MDU and MHLD. PCCT finalising new structures. Terms of reference and structures to be presented to QSG in March	31/03/2023

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	**Vaccinations & Immunisation Follow Up (SBU-2021-014) – Partially Implemented** We note that additional resources were not secured immediately following the last audit to assist in clearing the data input backlog and additional on-going data cleansing. An SBAR paper had been completed but it is not clear following changes in key management positions that the paper progressed any further towards a decision. Discussions with the Service Group Manager, Children's Service Group and the ChIG Chair informed us that there had been some recent ad-hoc validation of GP and Child Health records to support data quality but that it was not yet and embedded process. We note that the draft ChIG 2020 Plan includes the intention to undertake quarterly data cleansing exercises between GP and Child Health records assisted by Health Visitors. The recommendation should remain open until the ChIG plan is approved and the routine data quality cleansing process is confirmed as implemented at SIG	30/06/2022

Executive Lead – Executive Medical Director						
SBU 2122-017			**NICE Guidance**	**Report Issued May 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2.2	During the audit, we selected a random sample of NICE Guidance publications to determine how they had been considered at service group level in line with the SOP. We requested evidence to demonstrate how each NICE Guidance publication had been reviewed for implementation and how the responses had been collated for reporting to COEG. However, we received limited responses and evidence to substantiate the process followed. Updates on NICE Guidance should be provided in a timely manner by Service Group Medical Directors or nominated responders.	**H**	The Internal Audit Report and required actions will be shared with the Group members at the next available meeting on 13th May 2022. Service Delivery Group MDs will be reminded of their responsibilities to the Group.	31/05/2022	**October 2022:** Process for receipt and distribution of NICE guidance; as well as process for self-assessment of compliance with guidance agreed. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023
2.3	Despite the lack of evidence provided, the Service Group Medical Director (SGMD) for Mental Health and Learning Disabilities advised that NICE Guidance should be added to the Quality and Safety Group agenda for action. Audits against NICE Guidance would be managed by the Clinical Audit subgroup and reported to the Mental Health and Learning Disabilities Quality and Safety Group. Similarly, the SGMD for Neath Port Talbot and Singleton Service Group advised that NICE Guidance and other technology appraisals are disseminated to the relevant divisions and are subject to departmental audits as appropriate. The SGMDs were unable to offer evidence that NICE guidance had been considered by the Service Group and that guidance had been adopted, or that there was a clear rationale for not adopting. However, they planned to have NICE Guidance as a standing agenda item at their Service Group Quality and Safety meeting to monitor going forward. Consideration should be given to include NICE Guidance, and other relevant standards, as a standard agenda item at Service Group Quality and Safety meetings.	**H**	The Internal Audit Report and required actions will be shared with the Group members at the next available meeting on 13th May 2022. Service Delivery Group MDs will be reminded of their responsibilities to the Group. Service Delivery Group MDs will be asked to progress the action point and report progress.	31/05/2022	Compliance with NICE guidance will be discussed at appropriate for a within service groups. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023
3.1	The health board has developed a Standard Operating Procedure (SOP) for the 'Development, Dissemination and Review of NICE Guidelines not Specifically Related to Medicines'. The SOP was approved by COEG in November 2020 and was due for review in November 2021. Review of the SOP has highlighted sections that appear incomplete, including examples where roles and responsibilities were not clearly stated or defined. We also noted several instances where question marks were still	**M**	The SOP for the Development, Dissemination and Review of NICE Guidelines not Specifically Related to Medicines will be reviewed and updated.	01/07/2022	Revised SOP to be completed by new Chair of COEG. October 2022 **December 2022:** The newly appointed Deputy Medical Director and Chair of COEG only took up the position on a full-time basis at the end of November 2022. As such, the revised target date for this work will need to be extended to 31/03/2023.	31/03/2023

	present in the text of the SOP demonstrating it was incomplete. The SOP for the Development, Dissemination and Review of NICE Guidelines not Specifically Related to Medicines should be reviewed and updated.					
5.1	The health board maintains a 'master spreadsheet' or tracker for monitoring and managing NICE Guidance publications. We consider that the inclusion of the following details at the master spreadsheet would enhance the monitoring arrangements at the health board: 1) Details of the lead individual(s) (nominated responder) responsible for 'championing' the NICE Guidance publication; 2) Confirmation of whether or not the NICE Guidance publication has been adopted and the date this was completed; 3) Justification is documented when it is determined that NICE Guidance will not be adopted; and 4) Measures that have been taken to ensure compliance with the guidance. The health board should consider enhancing the level of detail captured on the tracker to strengthen arrangements to manage and monitor compliance.	**M**	The Health Board will explore what options are available to capture additional detail within the digital AMaT software and will implement where this is possible; if there are constraints to the level of detail that it's possible to capture, these constraints will be reported through COEG and consideration given whether an alternative can be used.	01/10/2022	**October 2022:** Process established for self-assessment. Likely first round of self-assessment in December 2022 for review at COEG and monthly thereafter. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023
5.2	A separate tracker is presented and discussed at the COEG meetings. It is a dynamic document and only contains NICE Guidance that is currently under review and consideration. Once COEG is satisfied, based on responses provided from the Service Groups that guidance has been considered appropriately, the item is removed from the tracker. There is therefore an absence of a mechanism to demonstrate ongoing compliance with the guidance. Since July 2021, updates on NICE Guidance have been provided to the Quality Safety Governance Group, mainly via the 'COEG outstanding responses to national guidance' paper. At the July 2021 QSGG meeting, the percentage of responses received for newly published NICE Guidance was reported at 22.2%, with a small improvement to 27.3% noted in September 2021. This snapshot of 'responses received' is not evident at every COEG and QSGG meeting. However, whilst it is considered a useful tool to highlight the level of engagement within the health board, there is a lack of detail and clarity regarding the content of the responses in order to confirm that the NICE Guidance has been adopted by the health board and is being complied with. The tracker should be presented at COEG to allow senior management to seek assurances that NICE Guidance has been implemented as appropriate. Issues identified should be escalated to QSGG and the Quality and Safety Committee.	**M**	The data available on the AMaT system will be collated as a regular report for COEG.	01/10/2022	**October 2022:** Process established for self-assessment. Likely first round of self-assessment in December 2022 for review at COEG and monthly thereafter. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023

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	**August 2022:** Limitations of TOMS data are described in the original management response. EMD has written to Service Group MDs and Clinical Director for Theatres to establish monthly audits of practice to be shared with SGMDs and cascade to Directorates. Improvements to be addressed through SGMDs working directly with Clinical Directors/Clinical Leads for relevant services within their Service Group and progress monitored through Directorate and Service Group Q&S meetings. Deadline: October 2022. **December 2022:** Recent events have highlighted some issues to address in the current SOPs. The Clinical Director for Theatres has been asked to convene a group of clinicians to review and revise current processes. A date of 31/03/2023 has been set for further update.	31/03/2023
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	**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	**August 2022:** Executive Medical Director has written to all service groups requesting that TOMS compliance data are standing items on the agenda at Service Group Q&S meetings on a quarterly basis, beginning in September 2022 and that the discussions will be reflected. EMD has ask Service Group MDs to ensure that the same compliance data are discussed at monthly directorate meetings in relevant specialties (SGMDs to communicate to relevant directorates in their service group). Deadline: October 2022. **December 2022:** Recent events have highlighted some issues to address in the current SOPs. The Clinical Director for Theatres has been asked to convene a group of clinicians to review and revise current processes. A date of 31/03/2023 has been set for further update.	31/03/2023

	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. 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	**August 2022 (RE):** COEG to receive monthly exception reports on actions being taken and improvements in compliance. Deadline October 2022. **December 2022:** Recent events have highlighted some issues to address in the current SOPs. The Clinical Director for Theatres has been asked to convene a group of clinicians to review and revise current processes. A date of 31/03/2023 has been set for further update.	31/03/2023

Executive Lead – Executive Medical Director						
SBU-2223-019			**Controlled Drugs**	**Report Issued November 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1a	For a sample of CD orders, order and register documents were examined for compliance with requirements. This highlighted instances where: • the order had been raised and received by the same individual; • the ward signature in the 'Received by' section of the order slip was illegible or absent • the delivery bag seal number was absent from the orders' entry in the ward/theatre CD register; • the signature in the order entry section of the ward/theatre CD register was illegible; and • the second (witness) signature section on the CD register was illegible. Further testing identified instances where ward signatures in the register dispensing entries were illegible We recommend that these exceptions are addressed and that rules requiring double signatories for all CD register movements are applied without exception (signatures should always be accompanied by printed names in order that they may clearly identify the individual signing).	**M**	Where exceptions have been noted to Health Board policy/SOPs, the Service Group Controlled Drug Lead will direct the Service Group's response to this recommendation. This will include as a minimum: • Making all staff involved in the management of controlled drugs aware of these findings in order to help staff reflect on current practice. • Drawing staff attention to the Health Board's controlled drug policy and in particular the relevant sections relating to this recommendation, with the aim of improving adherence to policy requirements. • Ensuring performance relating to this recommendation is re-audited by the Service Group within 6 weeks to provide the Service Group, the Executive team and the Controlled Drug Accountable Officer with the necessary assurance that mitigating action has been successful and that practice is fully compliant with policy. • Ensuring that the findings and recommendation are discussed at the relevant Service Group controlled drug governance and quality & safety forums together with the outcome of mitigating actions.	06/01/2023	**February 2023:** Operational pressures mean that it has not been possible to implement this recommendation by the agreed deadline. The CDAO has reminded the Service Group Controlled Drugs Leads of the need to take forward the agreed action. **A deadline of 31/03/2023 has been set for further update**	31/03/2023
3.1	CDMAPS are not routinely reviewed and updated at CD management group / Quality & Safety meetings by all Service groups. • **Mental Health & Learning Difficulties:** actions were not dated and there were many of amber status denoting that they were not completed. • **Singleton / NPT:** the document has a narrative format without clear actions or target dates so it wasn't possible to determine status of the former. • **Morriston:** the latest revision of the CDMAP was dated April 2022 and we noted actions of the action plan largely completed, excepting three where revised target dates had expired (implementing a comprehensive training programme, structured review of the CD "Potential Diversion" Log, developing and implementing a comprehensive performance monitoring framework.) We recommend that all Service Groups review and update their CDMAP action plans to give clarity over those actions that are outstanding, their significance rating and target dates for completion and going forward, that these should be monitored and updated at each of the respective Service Group CD management group review meetings.	**M**	The Service Group Controlled Drug Lead will direct the Service Group's response to these recommendations. This will include as a minimum: • Ensuring that the Service Group reviews their Controlled Drug Management & Assurance Plan (CDMAP) in line with these recommendations. • Discussing the Service Group's updated CDMAP, or latest draft if ongoing, at the Service Group Controlled Drug Lead/Controlled Drug Accountable Officer biannual meeting in late November/early December 2022, to provide the Controlled Drug Accountable Officer with the necessary assurance that mitigating action has been successful. • Ensuring that these findings and recommendations are discussed at the relevant Service Group controlled drug governance and quality & safety forums, together with the outcome of mitigating actions.	06/01/2023	**February 2023:** Operational pressures mean that it has not been possible to implement this recommendation by the agreed deadline. The CDAO has reminded the Service Group Controlled Drugs Leads of the need to take forward the agreed action. **A deadline of 31/03/2023 has been set for further update**	31/03/2023

3.2	There is no evidence that CDMAP scopes have been reviewed against legislation to ensure all key aspects are covered (an action raised in our previous advisory review). CDMAPs scope should be reviewed against current legislation to ensure that all key aspects are covered, and against the findings reported in this audit and updated where necessary.	**H**	See 3.1 Above	06/01/2023	**February 2023:** Operational pressures mean that it has not been possible to implement this recommendation by the agreed deadline. The CDAO has reminded the Service Group Controlled Drugs Leads of the need to take forward the agreed action. **A deadline of 31/03/2023 has been set for further update**	31/03/2023