APPENDIX E

AUDIT TRACKER UPDATE
NWSSP AUDIT & ASSURANCE
AGREED ACTIONS COMPLETED SINCE LAST REPORT

Executive Lead – Director of Corporate Governance				
SBU-2122-007 **Welsh Language Standards Compliance** **Report Issued May 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2.1	Reviews of the arrangements in place at other NHS Wales bodies identified the roll out of self-assessment tools across Service Groups and Corporate Departments to capture compliance with the Standards. Action plans are then developed to address areas of non-compliance. This more robust process supports the embedding of the Standards throughout the organisation. Consideration should be given to the development and roll out of self-assessment tools across Service Groups and Corporate Departments to capture compliance against applicable standards. Action plans should be produced to address areas of non-compliance, the implementation of which should be formally monitored and reported on an ongoing basis.	Via the Welsh Language Standards Delivery Group, a programme of 'Deep Dives' will be put in place. These will require Service Groups and Corporate Departments to self-assess their performance/position in terms of compliance against specific groups of Standards and produce reports for the WLSDG, which will include an action plan to address any gaps in compliance identified by their self-assessment process. The Welsh Language Officer will liaise with his counterparts across Wales, and consider the adoption of self-assessment tools where it is felt that these will strengthen the Deep Dive process already in place.	**February 2023:** This process is in place. Service Group representatives provided feedback a the last meeting of the Group in respect of Standards relating to Correspondence
SBU-2122-028 **Follow Up Review** **Report Issued July 2022** **Assurance Rating Reasonable**	**1.1**	Our review of the audit recommendations tracker at other NHS bodies has identified good practice that the health board may wish to consider to further strengthen its arrangements, which includes the following: 1. Trackers typically capture internal and external recommendations, but there are examples of trackers which include recommendations from other assurance providers / inspection bodies, including Healthcare Inspectorate Wales, Counter Fraud and the Health and Safety Executive; 2. The tracker is reviewed by the Executive Management Team (the equivalent of the health board's Management Board) prior to Audit Committee. This includes revisiting timescales to ensure those that have been proposed remain realistic and a rationale is included to support extensions to completion dates; 3. Extracts of the audit tracker are submitted to Board Committees, to support oversight and scrutiny of recommendations relating to their remit; and 4. Actions taken to close a recommendation on the tracker is concise and references the audit evidence available to demonstrate completion. Management should consider the practices highlighted at other NHS Wales organisations to strengthen its arrangements to monitor progress with the implementation of actions.	The Health Board will review the areas identified by NWSSP Audit & Assurance colleagues, and implement those which are appropriate.	**February 2023:** Following consideration of the examples of practices highlighted at other health bodies contained within the report, a summary of the Audit Tracker is now being reported to both the Executive Team and Management Board. As such, this actions is considered complete.

Executive Lead – Director of Corporate Governance				
SBU-2122-007 **Freedom of Information Requests** **Report Issued September 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	3.1	During 2021/22, the health board failed to acheive the 90% target set by the ICO for responding to FOIA requests within 20 working days. Quarterly performance reports are produced by the FoIA manager and issued to the IGG, which focus on a range of key performance indicators (KPIs). However, these reports do not provide further detail, and therefore lack sufficient granularity to adequately explain the causes for under-performance and the actions required to improve compliance. The FOIA Team set a 10 working-day internal timescale for departments to provide the required information. Compliance with this target is lower and is likely to contribute to the health board's overall performance. Whilst the reports do highlight the number of complaints made in each quarter, no further detail is given or if there is any correlation between complaints and best practice identified. The health board should look to improve its FoI performance monitoring and reporting to adequately explain the causes for under-performance and the actions required to improve compliance.	Review performance monitoring to include key themes for non-compliance with the ICO 20-day target, the 10 working-day internal timescale for departments and complaints	**February 2023:** An updated IG report was submitted to IGG in December 2022, which included key themes around non-compliance. This action is considered to be complete.
	4.1	Quarterly performance reports are produced by the FoIA Manager and issued to the IGG. A review of the IGG minutes noted limited evidence of discussion, suggesting further review and scrutiny of the reports could be undertaken. A review of the IGG Chair's Assurance reports issued to the Audit Committee in 2021 and 2022 identified that they do not include the performance related to FoI. There should be a focus by the health board to improve its FoI performance monitoring and reporting, including more review and scrutiny of performance reports.	Quarterly performance reports to include detail around non-compliance with ICO targets and areas for improvement. Audit Committee reports to be reviewed and FOIA performance to be included going forward.	**February 2023:** An updated IG report was submitted to IGG in December 2022, which included ICO targets and areas for improvement. An updated Audit Committee report around IG included FOIA performance in November 2022. This action is considered to be complete.

Executive Lead – Director of Digital				
SBU-2223-023 **Information Governance** **Report Issued November 2022** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	3.1	A risk relating to GDPR compliance was included within the health board risk register (HBRR) when the regulations were being implemented. Whilst this was de-escalated from the HBRR, we note that the associated risks remain on the Digital Directorate risk register. However, the current risk associated with GDPR compliance in relation to SARs is not held within the corporate risk register. We observed attempts made by the Head of IG to escalate the risk relating to GDPR (SARs) compliance, due to the trend in volume and breaches, including to the IGG. However, further detail was requested to substantiate the need to include. We can confirm that the risks have been re-assessed and re-worded and will be presented to the Director of Digital Services and the Digital Services Business Meeting for further consideration. Management should ensure that the requirement to escalate an IG risk is appropriately supported to enable wider consideration, evaluation, and discussion within the health board.	Progress the escalation of the SAR risk to the Health Board risk register, highlighting the risk of non-compliance on SAR legal requirements and processes across the organisation, to include the risk associated with lack of robust clinical review of medical records prior to disclosure.	**February 2023:** The SAR risk has been submitted for consideration to be added to the HBRR as part of the January 2023 risk assessment process. This action is now considered complete.

Executive Lead – Director of Finance				
SBU-1920-009 **Control of Contractors** **Report Issued March 2020** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	3	The 2009 Managing Contractors policy specified insurance requirements for contractors, however it is noted that the 2019 policy no longer addresses the same. The UHB's insurance requirements for contractors should be included within the Managing Contractors Policy (or supporting procedures)	Agreed. The University Health Board, in conjunction with NWSSP: Procurement Services are looking at accreditation systems that will provide this level of assurance.	**September 2022:** Work on completion of the revision of the Managing Contractors Policy has been adversely effected by staffing/resource issues within the Estates Department. The revised Policy will be presented to the H&S Ops Group in November 2022, and subsequently to the January 2023 meeting of the H&S Committee for approval. **February 2023:** The policy was approved at the appropriate forum and had been updated for the matters agreed in the recommendation raised at the date of the Control of Contractors report. Complete.
ABM-1920-007 **Capital Systems Financial Safeguarding** **Report Issued November 2019** **Assurance Rating Limited**	**4a**	Lack of appropriate procurement controls for cumulative spends in excess of £5,000 relating to maintenance contracts (see 3 above) An assessment of all current (and required) maintenance contract arrangements should be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee as appropriate; and associated maintenance contracts implemented.	Accepted. A review of all maintenance contract requirements across the estate will be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee for consideration and action as appropriate.	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented** No evidence of the central reporting referred to in the recommendation was supplied during the follow-up review. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review. **December 2022:** A paper has been prepared for the Director of Finance & Performance, which is based on procurement activity reports. Whilst recognising the steps that have now been taken to review this, the recommendation has not been fully addressed as there was an agreement for the output to be reported to an appropriate forum. This has yet to be evidenced. A date of 31/01/2023 has been set to receive further update **February 2023:** The assessment has been completed and reported to the DoF [noting the explanation for not taking to the H&S Committee or Capital Management Group; with the mitigating risk being that has been reported to the DoF].
	9	In order to monitor and report any inadequate/ unusual procurement activity, it is considered sound practice to prepare periodic/ annual procurement activity reports, for consideration by the appropriate UHB forum / sub-committee. Such reports should consider key aspects of Estates procurement activity, with particular attention to areas that may signal fraud or failure to achieve value for money. Management report all single tender / single quotation actions to the Audit Committee for scrutiny. Financial procurement information is also provided to the Estates Department for budget monitoring purposes. However, the wider analysis / reporting of procurement activity was not identified. Good practice has been evidenced at other UHBs/Trusts involved NWSSP Procurement Services contributing to the same. Periodic procurement activity reports should be prepared and reported to an appropriate UHB forum/sub-committee.	Agreed. Procurement activity reports (for Estates activity), will be requested from NWSSP: Procurement Services. These will be used to inform reporting within the UHB.	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The UHB internal audit tracker notes this recommendation as complete, stating that Procurement Services had provided the reports. However, no evidence was provided during the course of fieldwork to confirm the recommendation had been addressed. Periodic procurement activity reports should be prepared and reported to an appropriate UHB forum/sub-committee. The Procurement team is having issues supporting the process. Discussions with the Head of Procurement are to be scheduled to agree a way forward. **December 2022:** Procurement activity reports have now started to be produced by the Procurement team on behalf of Estates. However it has been agreed that this action will remain open until the forum to receive these reports is clarified. Date for 31/01/2023 has been set for further update. **February 2023:** Activity procurement reports have been reported to the Estates Board.

Executive Lead – Director of Finance				
ABM-1617-009 **Backlog Maintenance** **Report Issued October 2017** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1	There is no specific policy at the UHB relating to the management of backlog maintenance. The UHB is placing reliance on the WG PBC that has been approved yet there is no evidence to suggest that a strategic view is being taken of the longer-term requirements / projects that will need to be addressed vs. those which are bid upon. The overarching Service Strategy referred to in the PBC will 'expire' 31 March 2018. Management will draft and issue an Estates Strategy which specifically identifies the longer term direction of the UHB, how it aligns with ARCH and the UHB's Service Strategy; and how backlog maintenance is to be managed i.e. targets for reducing significant backlog and how it is to be achieved in terms of capital delivery plans	The directorate, as part of the Arch project, is developing an overarching strategic plan for its estate. This will be based upon the six-facet survey that the Health Board is seeking to commission this financial year. The Health Board is developing specification for the completion of a six-facet survey, which will allow the Health Board to take an informed review of the estate under its control. The Health Board had approached Welsh Government for central funding for the provision of a six-facet survey as this had been centrally funded for another Health Board. However, the Health Board has not had confirmation of this funding and therefore is seeking to start the process utilising existing discretionary capital.	**October 2022:** The six fact survey is now complete, and production of the Estates Strategy is progressing. However this has been delayed by the need to confirm final Development Control Plans for Singleton and Morriston, and to share the same with the relevant site management teams. Request that deadline be extended to 31/12/2022 in order to facilitate this. **February 2023:** Whilst the Estates Strategy needs to be updated and presented back to Board in May 2023, the data needed to inform the content has been reviewed and included appropriately, therefore addressing the agreed recommendation at the 2021/22 Estates Assurance follow up report. Complete

Executive Lead – Director of Finance				
ABM-1819-009 **Safe Water Management (Including Legionella)** **Report Issued October 2017** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	12	WHTM 04-01 states: "Legionella monitoring should be carried out where there is doubt about the efficacy of the control regime or where the recommended temperatures, disinfectant concentrations or other precautions are not consistently achieved throughout the system. The WSG (Water Safety Group) should use risk assessments to determine when and where to test." Whilst noting the same, the UHB's Water Safety Plan (approved by the UHB Quality and Safety Committee in May 2018) states that: "The Health Board is seeking to commence a program of Legionella testing based on the table below (See Appendix B) for the area identified as requiring Legionella testing to take place the frequency of testing will be as follows: – Three samples will be taken within the area identified these being the system Sentinel outlets. These outlets will be tested for Legionella on a monthly basis. If there are three clear sets of readings sampling will reduce to bi monthly (retests that are negative will be treated as a clear result). If there are three sets of clear readings sampling will move to 3 monthly sampling. Sampling will never reduce further than three monthly." Infrastructure risk assessments assess "water risks on all buildings owned or occupied by the Health Board and its equipment…in accordance with the guidance in ACoP L8 (2013), BS8580 (2010), and relevant HTMs in order to identify risks and assess water quality issues from work activities and water sources on the premises and to organise any necessary precautionary measures." At the time of the current review, the infrastructure risk assessments were out of date and were not being referenced. However, a specialist water management company had recently provided revised risk assessments for all ABMU properties which were to be applied. Noting the above, whilst recognising that the WHTM recommends the use of risk assessments to determine when and where to test, at the time of the review, the same were not being applied. Additionally, noting lapse of the testing contract, the audit did not evidence legionella testing in accordance with the above. Legionella testing (in accordance with the agreed Water Safety Plan) remained to be formalised with the public health laboratory via a Service Level Agreement. A service level agreement / contract for water testing should be appropriately concluded.	Agreed. The Water Safety Plan states that we would routinely test for legionella, although under the WHTM guidance there is no requirement to test for legionella as it is based on an assessment of risk. Whilst the Health Board is aspiring to implement a programme, current practice is that we test for legionella where we have an adverse result or as part of a commissioning / decommissioning process. The water safety plan was not being adhered to at the time of audit.	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** At the date of fieldwork, the contract for water testing had not been finalised. See also Financial Safeguarding previous matter 3. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review **August 2022:** The tendering process for this service was completed and a preferred company selected, however the Health Board has received notification from the Minister that the outsourcing of services should be avoided. Therefore, the Health Board have approached Public Health Labs to provide this service, using the same specification used for the tender. The Health Board is awaiting confirmation of costs from PHLS. **December 2022:** (FQ): Legionella testing has been undertaken via provisions contained within an existing SLA. A new agreement has been negotiated with PHLS which will come into play from 01/04/2023; they are currently confirming costs/changes to the existing SLA. Previously, the company didn't have the capacity to do all that was wanted. But, upon review, and as per the new SLA, will be able to address all the needs. A copy of the previous/extant SLA will be made available to NWSSP A&A colleagues for review in order to ensure that all elements of the findings are addressed. A date of 31/01/2023 has been set for further update. **February 2023:** A SLA was in place for the period being reviewed; and a new one will be in effect from 01/04/2023 Complete.

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<tr><th colspan="4">Executive Lead – Director of Finance</th></tr>
<tr><th>ABM-2021-009

Fire Safety Management

Report Issued April 2021

Assurance Rating Limited</th><th>Rec Ref</th><th>Findings & Recommendation</th><th>Original Response / Agreed Action</th><th>Update/Comment</th></tr>
<tr><td></td><td>4</td><td>The Chief Executive of NHS Wales wrote to all NHS organisations on 13th February 2020 emphasising: “organisations assess and provide appropriate levels of investment in relation to fire safety measures.” with direction to “discuss... implications with organisations via the regular Capital review meetings” i.e. investment sources should be confirmed, including the need to submit capital business cases to Welsh Gov.

Site level reports undertaken by management in November 2020 detailed the following with regard the sampled sites:

<table><tr><th>Hospital Site</th><th>% compliance with Firecode</th><th>Projected compliance date</th><th>Cost to achieve compliance</th></tr><tr><td>Singleton</td><td>70%</td><td>2025</td><td>£5m</td></tr><tr><td>Morriston</td><td>75%</td><td>2021</td><td>£5m</td></tr><tr><td>Cefn Coed</td><td>75%</td><td>2022</td><td>£0.3m</td></tr></table>
There was no apparent strategy to achieve required compliance (particularly recognising the 2021 projected compliance date for Morriston Hospital).

Management should develop an appropriate strategy targeting funding to address fire safety requirements.</td><td>Agreed. £37m has recently been made available across NHS Wales (as part of the National Capital Programmes in 2021-22 for Infrastructure, Fire Safety, Mental Health, and Decarbonisation, of which, £5.456m was allocated to SBUHB, with £0.261m being specific to Fire Safety). These monies were requested under general themes rather than specific investment projects, and allocations within this for items such as £84k for electric panels will also contribute to fire safety.

A more detailed plan will be created with 5 – 10 year horizons, and the Health and Safety Fire sub-group will undertake detailed assessment of bids going forward.</td><td>Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Outstanding
At the date of fieldwork, management confirmed that the 6-facet survey had been commissioned by the UHB and that it was due to be completed by the end of the financial year. The output of the survey will identify the scope of the works required to enable the UHB to develop the strategy accordingly.

This will be undertaken once the 6-facet report is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review

September 2022: Consolidation of the output from the 6-facet survey and compartmentation surveys is required to assist in the development of an appropriate strategy to address the fire safety requirements. As such, a revised deadline of 31st December 2022 has been agreed with management.

February 2023: Whilst the Estates Strategy needs to be updated and presented back to Board in May 2023, the data needed to inform the content has been reviewed and included appropriately, therefore addressing the agreed recommendation at the 2021/22 Estates Assurance follow up report. Complete.</td></tr>
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Executive Lead – Director of Workforce & Organisational Development				
SBU-2223-013 **ESR Self-Service** **Report Issued November 2022** **Assurance Rating N/A**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1.2	Although we would not expect to see regular reporting of annual leave records within a formal report, there are opportunities to improve absence management and resource planning through provision of accurate and relevant information to managers. The health board should continue to monitor the uptake of ESR, to ensure that more reliable, accurate and timely information is available.	Accepted. A similar 'Usage and Maintenance Newsletter' will be produced for WF management to monitor uptake, along with other key issues worth highlighting. This will be in a format which can be shared with other interested parties e.g. Finance management, and produced monthly. The content is data driven, to enable objective measurement of progress.	**February 2023:** Recommendation accepted as completed and ongoing in the report, as we already monitor usage on a regular basis and continue to do so. Monthly data shared by email as opposed to a newsletter format, however, interested parties continue to have access to usage information. Noting the foregoing, management consider this action to be complete
	2.2	Formal training records captured on ESR within the health board include the core statutory and mandatory modules. Whilst we recognise that it is not practical to capture all staff training requirements on ESR, there are however many additional training modules accessible on the system (via the Online Learning Module) that other NHS Wales bodies typically require staff to complete. However, reporting of compliance figures within the health board is currently only available for statutory and mandatory training records. For example, there are several levels of safeguarding training available within ESR and we have noted that compliance levels are captured at other NHS Wales bodies. Our recent report following review of arrangements in place over compliance with mental health legislation at the health board, identified inconsistencies in the capturing and reporting of such training. The health board should consider updating reports to capture compliance of the additional training modules for ongoing monitoring purposes.	Accepted in part. As part of the project scoping, exploration would need to be included to establish capacity and limitations of the available reporting functionality, and to ensure that: a) the ability is present to include additional training in outputs, and b) that Stat and Mandatory training would remain distinguishable from other role specific training. SR will be raised by 1st January 2023 and following scoping work	**February 2023:** Recommendation accepted in part as it is not in scope of the Self Service Project which was the subject of the review, and would have to be undertaken as a separate project. Scoping has revealed that the scale of requirements are such that insufficient resource is currently available to carry out the preparation and implementation work required. NWSSP has withdrawn their interest in supporting a potential project, further reducing capacity that may have been available. Noting the foregoing, management consider this action to be closed

Executive Lead – Director of Strategy				
SBU-2122-018 **CAMHS Commissioning Arrangements** **Report Issued December 2021** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1.2	The health board commissions Child and Adolescent Mental Health Services (CAMHS) from Cwm Taf Morgannwg University Health Board (CTMUHB). There is no Service Level Agreement (SLA) / service specification in place detailing the CAMHS commissioning arrangement. The health board were unable to provide a definitive answer as to what CTMUHB's responsibilities are, and what remains the responsibility of the health board in respect of CAMHS. The SLA/service specification should include, but not be limited to, a description of the services to be provided and their expected service levels, metrics (both performance and quality) by which the service is measured, the duties and responsibilities of each party, the remedies or penalties for breach, and a protocol for adding and removing metrics.	These elements will be included in the service specification as it is developed.	**August 2022:** Service Specification now finalised, with update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting. A workshop has been held to develop further the outcome measures and additional measures will be reported from Q4. Detail in the specification enhanced in the short-term working towards more robust position in Q4. **January 2023:** Service specification agreed via the CTM/SB Commissioning arrangements. Decision has been made to repatriate CAMHS. Decision approved by Board. Repatriation ongoing.
	3.1	The health board has not identified any quality measures in respect of the service being provided to the CAMH patients or the outcomes for those patients. The health board should identify appropriate quality measures to assess the service and outcomes for its patients.	The Children's Commissioner's report and other sources of feedback from CYP have demonstrated that speed of access to the right support is the number one concern for young people. Therefore the focus for the Health Board has been on improving access times and improving the range of services available to meet individuals needs better, both of which clearly are key quality measures for this service. Beyond this, BaYouth have been involved in developing and agreeing the priorities for action within the multiagency Delivery Plan, to ensure these address the issues children and young people are facing. The Health Board will identify through the service specification work outlined in 1.1 above further quality measures and outcomes for patients. The Quality & Safety Committee receives regular reports on performance of CAMHS services, and has not sought any additional quality measures.	**August 2022:** Service Specification now finalised, with update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting. A workshop has been held to develop further the outcome measures and additional measures will be reported from Q4. Detail in the specification enhanced in the short-term working towards more robust position in Q4. **January 2023:** See action related to recommendation 1.2. Performance Dashboard now presented tat commissioning meetings. Trajectories and improvement plan received. Decision has been made to repatriate CAMHS. Decision approved by Board. Repatriation ongoing.

Executive Lead – Director of Strategy				
SBU-2122-007 **Singleton Hospital Replacement Cladding** **Report Issued August 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	4.1a & 4.1b	In May 2022, the UHB Board agreed that, on the basis of expert advice received, it was no longer beneficial to pursue legal action in respect of the original cladding installation. The supporting paper appropriately outlined the basis for the recommendation, and referenced circa £300k costs incurred at the project as a result of construction delays in accommodating the expert witness visits. These costs are currently being met from the project contingency budget. The paper did not, however, set out the wider costs incurred in pursuit of the legal claim, i.e. legal fees, expert witness costs etc., which total circa £70k, and have been met from revenue funding. Management should confirm whether the Board has previously been sighted on the legal & expert witness fees expended to date (e.g. via historic reports). If they have not, the Board should now be fully informed of all costs incurred in pursuit of the legal claim.	**4.1(a)** Agreed. We will confirm the position with the Executive Director of Finance. **4.1(b)** Agreed. We will ensure the Board receives an update at the next meeting if necessary. The Project Board will also be informed at the August meeting, that the Legal Claim is no longer being pursued. PB will be informed of the costs incurred and how these costs have been met.	**February 2023:** It is well documented in the PB meetings that the cost incurred through contracting the expert witnesses and associated costs due to delays, has been covered by the contingencies in the cladding scheme. It has also been noted that the overall scheme will possibly go over agreed budgets, including contingency sums and this will have to be picked up by the HB if the HB are not reimbursed to cover this by the end of the scheme. Noting the foregoing, management consider this action to be complete.
	6.1	Whilst the prior Cladding audit report (issued October 2021) noted that management had scheduled a lessons-learnt exercise after completion of the first ward, we are advised that this did not take place. With the project now at the half-way point, management agreed that this exercise would remain beneficial to inform delivery of the remaining programme. A mid-point lessons learnt review should be undertaken.	Agreed. A session has been scheduled with relevant internal and external parties in September 2022.	**October 2022:** Completion of this action to be deferred due to availability of personnel at Kier. Deadline extended to 31/01/2023 in line with the foregoing **February 2023:** The lessons learnt meeting was held on 11 January 2023 with representation from all appropriate parties including the health board, the SCP, Project Manager, Cost Adviser and NWSSP:SES. Recommendation can be closed
	6.2	Whilst recognising that quality issues have been clearly documented in e.g. project reports and Project Board / Team minutes, a lessons learnt log was not in operation to centrally capture the full range of issues identified (which may include both technical and operational matters). Lessons learnt (both technical and operational) should be captured in a central log.	Agreed. Follow up discussions to be had with the Project Manager to review lessons learned. Once these have been identified, they will be captured in a central log.	**October 2022:** Completion of this action to be deferred due to availability of personnel at Kier. Deadline extended to 31/01/2023 in line with the foregoing **February 2023:** Kier are to report on the management of the future challenges, as identified through the lessons learnt meeting. This will be included in their monthly report which is shared at Project Board. Reviewed the detail against those included from the notes of the lessons learnt meeting and confirmed that the coverage is the same, therefore addressing the requirements of a lessons learnt log. Recommendation can be closed.

Executive Lead – Executive Medical Director				
SBU-2122-017 **NICE Guidance** **Report Issued May 2022** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	3.2	Despite the lack of clarity in respect of some roles and responsibilities in the SOP, we gained an understanding of staff accountability for NICE Guidance during the course of the audit. Appendix 1 of the SOP is a flowchart that outlines the process and responsibilities in respect of NICE Guidance publications, whether in the development phase or newly published. However, as outlined at Matters Arising 2 above, we were not provided with any evidence to indicate that the process of evaluation of NICE Guidance is operating in practice. The SOP should be further updated with details of established practices for disseminating and reviewing NICE Guidance, including publications that provide updates to existing NICE Guidance, and to account for any changes to operational practices once the new AMaT system is implemented.	The AMaT system will be populated with Health Board information in order to support monitoring and reporting. A full review and any necessary re-organising of the support structures under the wider remit of the Executive Medical Directors Department will be undertaken in Q2/Q3 2022 to support inform many of the work-streams of COEG, including NICE.	**February 2023:** AMaT system is in use to issue requests for compliance statements supported by the CAE Department Digital Officer. This action is now considered complete.
	4.1	Library Services provided their 'NICE Distribution Process' document that they hold locally. It outlines the process for distribution of new NICE Guidelines, new NICE Interventional Procedures Guidance (IPGs), Quality Standards (QSs), updated NICE COVID-19 Rapid Guidelines, NICE Guidelines, IPGs and QSs in consultation and in development. We were advised that notifications of updates to NICE Guidance were not emailed out to the distribution lists in the same manner as newly published guidance. Instead, reliance is placed on individuals to keep up to date with these developments. We consider that this could expose the health board to unnecessary risk should any updates be missed by individual service groups; particularly as the health board has no tracking of NICE Guidance that was originally published prior to 2018. We recognise that the recent introduction of the AMaT system will enhance the health board's processes for disseminating, reviewing, monitoring and managing NICE Guidance. However, we are mindful that at the time of this audit, this system is in its infancy and has yet to be fully implemented and embedded. The Health Board should capture how it assesses newly published NICE Guidance to establish if this should be considered for adoption within the organisation.	See 3.2 above	**February 2023:** AMaT system is in use to issue requests for compliance statements supported by the CAE Department Digital Officer. This action is now considered complete.