BOARD ASSURANCE FRAMEWORK (BAF)

Levels of Assurance

VISION AND STRATGEIC PRIORITIES

First Line
Operational

- Management Board and substructures – evidence of delegation of responsibility through line Management arrangements
- Compliance with appraisal process
- Compliance with Policies and Procedures
- Incident reporting and thematic reviews
- Compliance with Risk Management processes and systems
- Performance Reports, Complaints and Patient Experience Reports, Workforce Reports, Staff Nursing Report, Finance Reports

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

- Audit Committee
- Finance Committee
- Quality and Safety Committee
- Remuneration Committee
- Risk Management Group, Health and Safety Groups etc.

Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification

Third Line
Independent Assurance

- Internal Audit Plan
- Wales Audit Office (WAO) (Structured Assessment)
- External Audits (e.g. Annual Accounts and Annual Report)
- Health Inspectorate Wales (HIW) Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews
- Patient/Staff/Public surveys, feedback etc.

REGULATORS

EXTERNAL AUDIT

Approach to Risk Assessment - Risk scoring = consequence x likelihood

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 4	Low risk
5 - 9	Moderate risk
10 -15	High risk
16 - 25	Very High risk

The current scores for principal risks are summarised in the following heat map.

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Board Assurance Framework Summary Against Key Areas – February 2023

	Nov 2022	Feb 2023
Quality Services		
Workforce		
Sustainable Clinical Services		
• **Primary & Community Care**		
• **Mental Health & Learning Disabilities**		
• **Urgent & Emergency Care**		
• **Planned Care**		
• **Cancer Care**		
• **Children, Young People & Maternity Services**		
Population Health & Partnerships		
Digitally Enabled Health Care & Wellbeing		
Finance		
Estates Infrastructure		

Key	Improvement	Deterioration	No Change
			

BAF 1: Quality Services		
Principle Risk: If we are unable to implement a Quality Management System then patients may not have the experience we would wish and or they may suffer harm.	**Trend:** **No Change**	
	Assurance Rating: **Reasonable**	
Executive Lead(s): Executive Director of Nursing Executive Medical Director Director of Therapies & Health Science	**Assuring Committee:** Quality & Safety Committee	
Associated HBRR Entries: **HBRR 4 – Infection Prevention Control & Decontamination (20)** **HBRR 51 – Non Compliance with Nurse Staffing Levels Act 2016 (20)**	**HBRR 57 – Controlled Drugs: HO Licenses (16)** **HBRR 78 – Nosocomial Transmission (12)** **HBRR 84 – Cardiac Surgery – Getting It Right First Time Review (16)**	

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Clinical Audit & Effectiveness Policy, which sets out the hierarchy of audit reviews
- Clinical Audit & Effectiveness Team in place
- Clinical Outcomes & Effectiveness Group (COEG) established
- Audit Management and Tracking (AMaT) system in place to support Service Delivery Groups and departments with improved monitoring and reporting on clinical audit progress.
- Review of LocSSIP and WHO Surgical Checklist audits form standing agenda items at meetings of the Clinical Outcomes and Effectiveness Group (COEG)
- Approved local SBUHB Mortality Review Framework document and SOP in place.
- Health Board Policy to Determine the Requirements for Home Office CD Licenses in place
- National Infection Control Manual supplemented by local policies, procedures, protocols and guidelines.
- We have IPC action plans in place for all service groups with clear accountability lines for improvement
- Infection Prevention Control Committee in place, which includes oversight of decontamination
- BI support for quality improvements and quality outcomes supported with data required down to ward level with early warning of infection risks..
- Infection prevention and control related training programmes
- Documented Cleaning Strategy/Policy in place. Enhanced ward cleaning by domestic staff being considered to free nursing time for direct patient care
- Quality & Safety Committee in place with approved Terms of Reference, supported by a **Quality & Safety Group.**
- Quality & Safety Process Framework in place, Approved by Q&SC and Executive Board
- Established Quality & Safety forums in place at Service Group level.

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
All levels of clinical audit activity will be monitored by COEG and reported to the **Quality & Safety Group**, who in turn report to the Quality & Safety Committee.	x			Improvement required in governance arrangements in order to allow the CD Accountable Officer to fully discharge their accountability as outlined in the Welsh Government Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008	In progress. The Controlled Drug Accountable Officer will continue to work closely with Service Group Controlled Drug Leads to strengthen controlled drug governance and improve assurance across the Health Board. A key part of this work will be the timely implementation of remedial action required following the recent Controlled Drug Compliance Internal Audit Report. **31/03/23**
Clinical Audit midyear and annual reports received and scrutinised by the Audit Committee		x			
Quarterly mortality review reports to the Quality & Safety Committee (commenced August 2021)		x		Scope identified to enhance format/content of Service Group Controlled Drugs Management and Assurance Plans (CDMAPS), and the systems and processes around their review and update.	Enhancements to content, system and process to be taken forward by Service Group Controlled Drugs Leads. **31/03/2023**
A&A Report ABM-1819-022 – April 2019 Clinical Audit & Assurance – Limited Assurance			x		

A&A Report ABM-1819-025 – October 2018 Mortality Reviews (Follow Up) – Limited Assurance			x	Quality & Safety Process Framework requires review/refresh in light of the impact of COVID, and development of an action plan to support its implementation.	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. **Complete**
A&A Report SBU-2021-028 – April 2021 Mortality Reviews – Limited Assurance			x		
A&A Report SBU-1920-021 – July 2019 WHO Checklist – Limited Assurance			x	Operational managers' approach to risk management is inconsistent, with risk registers often incomplete and missing mitigating actions.	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: Training has been provided to the most senior management tier, Clinical Cabinet, Matrons and Specialist Services. 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. **Amended deadline: 31/03/2023**
A&A Report SBU-2021-026 – April 2021 WHO Surgical Safety Checklist (F/UP) – Limited Assurance			x		
A&A Briefing Paper SBU-2122-006 – December 2021 Controlled Drugs Governance – No Assurance Rating Given			x		
Clear corporate and Service Group IPC assurance framework in place, which reflects the HCAI quality priority actions.		x			
Infection Control Committee monitors infection rates, receives assurance reports from Service Groups and sub-groups to the Infection Control Committee, and identifies key actions to drive improvements. Reports regularly to Quality & Safety Committee		x			A programme of service group risk register presentations for 2022 was agreed. Two Service Groups presented registers and discussed local arrangements in December and a trial approach to register review undertaken – it proved useful but difficult to balance coverage and depth in the time. The remaining two service groups discussed their management arrangements in January without the detailed review, but at both December and January meetings, analyses of the field usage within registers was received and discussed identifying areas for improvement. While services will continue to present at future meetings, register analysis reports will continue to be received and developed as a means for monitoring improvements. **Complete**
Decontamination Subgroup reporting bi-monthly to the IPC	x				
A&A Report SBU-1920-019 – July 2019 Infection Prevention Control – Reasonable Assurance			x		
A&A Report SBU-2021-025 – January 2021 Infection Control (Cleaning) – Reasonable Assurance			x		
A&A Report SBU-2122-002 – January 2022 Quality & Safety Framework – Limited Assurance			x		
Audit Wales 2714A2021-22 Review of Quality Governance Arrangements (SBUHB)			x	Staff are not always aware of the HB's values and behaviours, and do not always recognise a culture that promotes learning from errors.	Our Big Conversation staff engagement programme has been developed as culture audit tool. It will act as a vehicle to inform and shape the 'Swansea Bay Way' culture– a values driven, quality focused organisation. Phase 1 is now complete, with a report being presented to Workforce & OD Committee in February 2023. Launching phase 2 to run during January and February 2023, which will aim to: • feedback what you told us and what we have heard from across the organisation • share a proposed vision for the organisation • engage on how we take this vision forward together **Review in March 2023**
A&A Report SBU-2122-001 – February 2022 Risk Mgmt & Board Assurance Framework – Reasonable Assurance			x		
A&A Report SBU-2122-017 – June 2022 Safety Notices & Alerts – Limited Assurance			x		
A&A Report SBU-1920-020 – September 2019 Falls – Reasonable Assurance			x		
A&A Report SBU-2021-027 – June 2021 Safeguarding – Reasonable Assurance			x		
A&A Report SBU-2122-017 – May 2022 NICE Guidance – Limited Assurance			x	Compliance with Personal Appraisal and Development (PADR) reviews is low. A performance improvement plan should be put in place which sets out when full compliance can be achieved.	The data as of 31st of December shows a steady increase in the Health Board overall compliance figure, to 68.42%. Managers are provided with detailed reports on their PADR & Training compliance figures monthly, highlighting trends and areas of concern, with targeted support provided. Impact of operational changes on staffing and structure may result in a temporary reduction
A&A Report SBU-2021-024 – May 2021 Concerns: Serious Incidents – Reasonable Assurance			x		
A&A Report SBU-2223-019 – November 2022 Controlled Drugs – Reasonable Assurance			x		

					in compliance figures. Progress will be monitored via local service group meetings and Management Board, and reported to Workforce & OD Committee. **Ongoing**
				Systems and processes for dealing with and reporting on safety notices and alerts in need of view and update, together with the associated policy/procedures	Task and finish group established to review and update systems, processes, reporting and supporting documentation in respect of the handing of safety notices and alerts. Deadline extended due to the need to synchronise with work on all-Wales alerts module. **30/06/2023**
				Identified scope to improve oversite and reporting on the completion of WHO/LocSSIP checklists at both a Service Group and Corporate Level.	The Clinical Director for Theatres has been asked to convene a group of clinicians to review and revise current processes. **31/03/2023**

BAF 2: Workforce			
Principle Risk:	If the Health Board fails to identify and plan for its future workforce requirements, and to promote THE Health Board as an attractive place to work then we may fail to recruit and retain staff with the right skills and experience Resulting in Loss of skills and talent, staffing shortages which adversely affect the quality of care and employee experience. If the Health Board fails to put the values of the organisation into practice Then we will not have a culture that embraces inclusion, openness, innovation and teamwork Resulting in poor experience for staff and patients alike, diminishing the trust and confidence of our population	**Trend:** **No Change**	
		Assurance Rating: **Reasonable**	
Executive Lead(s): Director of Workforce & OD		**Assuring Committee:** Workforce & OD Committee	
Associated HBRR Entries: **HBRR 3 – Recruitment of Medical & Dental Staff (20)**			

Key Controls:

- Established Workforce & Organisational Development Committee in place
- Multi-disciplinary Occupational Health Service in place providing timely advice for managers and staff regarding management of health in the workplace
- Multi-disciplinary Staff Wellbeing Service in place providing staff with support for mild-moderate musculoskeletal and mental health problems, which also continues to support the needs of COVID-related health impacts
- The Health board has invested in the TRiM programme (Trauma Risk Management)
- Wellbeing Champions in place, supporting teams and services
- Post-COVID Staff Wellbeing Strategy has been developed to outline additional support available for staff
- Local bank/Agency booking processes have been reviewed, and revised management controls introduced (Feb 2022)
- Regular periodic review of block booked bank staff taking place (Feb 2022)
- KPI's for nurse roster management have been reviewed, and form part of the regular nurse staffing meetings (Feb 2022) – this includes EWTD controls
- Our Big Conversation and Cultural OD Programme Plan
- All areas have been allocated L&OD support for development of local staff action plans to improve the staff experience
- Clearly articulated organisational values
- Chief Executive and other Executive Directors attend HB Partnership Forum on a regular basis.
- Speciality based local workforce boards established
- Established partnership working and engagement initiatives with key stakeholders.
- Workforce Planning function in place which facilitates the design, redesign and development of workforce plans for all staff groups
- HB Home working and flexible working policies have been revised and reissued

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Reporting to and oversight by the Workforce and Organisational Development Committee on the following: – Workforce Metrics (every meeting) – Medical Workforce efficiencies (quarterly) – Recruitment & Retention (every Meeting) – Attendance, Wellbeing & Occ. Health (3 x per year) – Workforce Risk Register (3 x per year) – Nurse Staffing (Wales) Act 2016 (5 x per year) – Guardian Service (bi-annual update) – Update on PADR Compliance (2 x per year) – Statutory & Mandatory Training Compliance (2 x per year) – Medical Revalidation (2 x per year) – Equality Report (Annually) – Nursing & Midwifery Board Update (every meeting) – Medical Workforce Board Update (every meeting) – Therapies & Health Science Group Update (every meeting)		x		Lack of timely sickness absence data Need for bank and agency staff continues. Lack of Health Board-wide policy or procedure which supports EWTD PADR completion performance is below the Welsh Government target of 85%. Gaps in assurance around recording of PADR due to delay in implementation of roll out of supervisor self-service.	Project to review workforce informatics **31/08/2023** Local bank/Agency booking processes have been reviewed, and revised management controls introduced. The position will be reviewed with the COO and DoN to address the post-COVID position. **Completed** EWTD guidance has been drafted and sent to staff side, staff side have provided no comment so the guidance will now be issued. **Complete** The transfer of the ESR team to the WOD Directorate is now complete and the Service Improvement plan is in progress. The detail of the SSS roll out is currently being considered and worked through. Target date for the roll out to be confirmed at a later date. **TBC**

Both Staff Health & Wellbeing Service and Occupational Health Service have won national awards October 2020, and again in January 2022 from Case-UK Limited Employers positive contribution to their workforce well-being Award.			x	Need to enhance clarity and detail of reports to the W&OD committee in respect of Disclosure and Barring Service (DBS) checks undertaken	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 one for their role within the HB. In relation to the frequency of DBS checks, this is being benchmarked on an all-Wales basis. **31/03/2023**
Monthly management data for Occupational Health and Staff wellbeing services regularly reviewed by Senior Occupational Health Management Team regarding capacity/demand and waiting times. This information is used to manage capacity and demand	x			Lack of Workforce and OD Delivery Group to oversee operational delivery of workforce priorities	Workforce and OD Delivery Group in place. Schedule of meetings established and aligned to Workforce & OD Committee. **Completed**
A&A Report SBU-2122-024 – September 2021 Staff Wellbeing & Occ Health - Reasonable Assurance			x	Recruitment and retention plan(s) to be produced in support of the Workforce and Organisational Development Framework.	In conjunction with professional heads, develop and implement a recruitment strategy to support the development of a sustainable workforce. **(30/09/2022) - Development** **(31/03/2022) – Implementation.**
Weekly reporting of Bank and Agency usage to service groups as well as monthly Corporate Nurse staffing meetings	x				
SGs have local reporting mechanisms for bank and agency spend	x				In conjunction with professional heads, develop and implement a retention strategy to address retention issues. **31/03/2023**
Monthly Roster scrutiny meetings held across all service groups and Corporate Nurse staffing meetings	x				
KPI reports are sent to service groups weekly	x				Contract in place with external company to develop branding and attraction campaign for HB. To be launched April 2023 **30/04/2023**
A&A Report SBU-1718-046 – May 2018 EWTD - Limited Assurance			x		
A&A Report SBU-1819-043 – April 2019 Staff Performance Mgmt. & Appraisal - Limited Assurance			x	Progress the adoption of draft guidance documents in respect of junior doctors' hours and handover procedures.	Guidance has now been adopted. **Completed**
Service Groups are invited to Workforce & OD Committee to present local actions plans to improve the staff experience.		x		Delay of national staff survey which is commissioned by Welsh Government with no fixed role out date.	Our Big Conversation staff engagement programme has been developed as culture audit tool. It will act as a vehicle to inform and shape the 'Swansea Bay Way' culture– a values driven, quality focused organisation. Phase 1 is now complete, with a report being presented to Workforce & OD Committee in February 2023. Launching phase 2 to run during January and February 2023, which will aim to: • feedback what you told us and what we have heard from across the organisation • share a proposed vision for the organisation • engage on how we take this vision forward together The National Staff Survey has been delayed, and is now expected in August 2023. **August 2023**
Results from NHS Wales and LHB Staff Surveys			x		
Workforce planning and recruitment issues and updates are reported through various committee fora and to the board via a number of service-specific update reports.		x			
Permanently funded central resourcing team from 2022/23 fin. year	x				
Overseas nursing campaign for 200 Nurses funded for 2022/23	x				
Streamlined recruitment for medical staff. Retrospective VCP and anticipatory recruitment for medical posts linked to major rotations.	x				
Working with head hunter agencies to recruit hard to fill medical posts	x				
A&A Report SBU-1920-039 – February 2020 WOD Framework - Substantial Assurance			x	National Strike Action	
A&A Report SBU-1920-042 – January 2020 DBS Checks - Reasonable Assurance			x		
A&A Report SBU-1819-042 – April 2019 Junior Doctor Bandings (Follow-Up) - Reasonable Assurance			x		
A&A Report SBU-2223-013 ESR Self Service – No Rating Given (Advisory Report)			x		

BAF 3: Sustainable Clinical Services	
Principle Risk:	If we fail to change then we will not be able to deliver a sustainable clinical model which may result in: • The health board not able to provide consistent levels of care, 24 hours a day, and seven days a week at our three main hospital sites; • Not achieving acceptable waiting times for urgent and emergency care; • Not reducing our over-lengthy hospital stays, and consequently delays in patients being discharged; • Not improving access for routine medical and surgical treatments; and • Staff not feeling supported at work.

3.1	**Primary & Community Care**	**Associated HBRR Entries:** **None**	**Trend:** **No Change**	
Executive Lead (s): Chief Operating Officer		**Assuring Committee:** Performance & Finance Committee	**Assurance Rating:** **Reasonable**	

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Monthly PCT Board Meeting – oversight of performance and strategic development – with focussed sub meetings to manage specific areas of focus
  - PCT Forum
  - PCT Business meeting (Performance and Finance focussed)
  - PCT Quality and Safety
  - PCT Health and Safety
- Partnership governance arrangements within Regional Partnership Board (RPB) structure.
- HMP Prison Partnership Board

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Monthly reporting of clinical and financial performance via Business meeting and PCT Board for scrutiny and assurance	x			Identified need to reviewed PCT Group Quality & Safety structures to mirror SBUHB structures	Complete and implement the revised Q&S structures **Commenced & Ongoing**
Monthly reporting of Q&S issues via Q&S and PCT Board for scrutiny and assurance	x				
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x			
Monitoring of the implementation of the Home First project and management of Integrated Community Services within the RPB Transformation Board governance framework		x			
Quarterly performance reviews		x			
Monthly finance reviews.		x			
A&A Report SBU-2122-023 – October 2021 General Dental Services (GDS) – Substantial Assurance			x		
A&A Report SBU-2021-013 – January 2021 Primary Care Cluster Plans & Delivery – Reasonable Assurance			x		

3.2	Mental Health & Learning Disabilities	Associated HBRR Entries: HBRR 43 – Deprivation of Liberties/Liberty Protection Safeguards (15)	Trend:	
Executive Lead (s): Chief Operating Officer		**Assuring Committee:** Performance & Finance Committee	**Assurance Rating:**	

Key Controls:

- Established Mental Health Legislation Committee in place
- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Liberty Protection Safeguards task-and-finish group to meet from December 2022

Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1st	2nd	3rd		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Scope identified to enhance reporting to the Mental Health Legislation Committee in respect of assurance on legislative compliance.	An exercise to be undertaken to 'map' legislation and codes of practice to Mental Health Legislation Committee reports. **31/10/2022**
A&A Report SBU-2122-023 – May 2022 Mental Health Legislative Compliance – Reasonable Assurance			x	Inconsistencies in reporting noted in respect of Mental Capacity Act and Deprivation of Liberty Safeguards training.	A revised programme of training will be put in place.

3.3	**Networked Hospitals – A Systems Approach** **Urgent & Emergency Care**	**Trend:**	
Associated HBRR Entries: **HBRR 1 – Access to Unscheduled Care Services (25)**	**HBRR 80 – Unable to Discharge Clinically Optimised Patients (20)** **HBRR 82 – Risk of Closure of Burns Service (16)**	**Assurance Rating:**	
Executive Lead (s): Chief Operating Officer	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, to offer leadership and support in addressing risks and issues within systems, and to create an enabling framework to allow care to be delivered appropriately.
- Performance & Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Unscheduled Care reports received from the COO
- An integrated Unscheduled Care Plan has been developed with partners, based around the WG Six Goals for Urgent & Emergency Care, and approved by the West Glamorgan Regional Partnership Board.
- An Urgent and Emergency Care Network Board has been established to oversee the Health Board's Unscheduled Care Plan.
- Programme Management Office (PMO) in place to improve Unscheduled Care
- Health Board Representation on the National Unscheduled Care Board.
- Development of a 'Phone First for ED' model in conjunction with 111 to reduce demand
- Implementation of Consultant Connect for major referring specialties
- H2H implemented, developed into Rapid Discharge to Assess pathway in line with WG directive.
- SAFER – Patient Flow and Discharge Policy in place
- 24/7 Ambulance triage nurse in place.
- Patient level dashboard in place, which allows breakdown of clinically optimised patient numbers by delay type
- Direct Pathway to Older Person's Assessment Service (OPAS) implemented and operational hours extended.
- Establishment of virtual wards aligned to GP clusters.

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Need for clear definitions for MFFD patients and SOP for MFFD meetings	Establish a group to work with the Local Authority on reducing numbers of Medically Fit For Discharge (MFFD) Patients with clear Terms of Reference for the Service Group Meetings.
Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board,		x		Failure to adhere to, as well as inconsistent application of, elements of the SAFER Patient Flow and Discharge Policy. Scope to enhance the content of the policy, as well as systems and processes in respect of the setting of EDD and arrangements for patient discharge, were also highlighted as part of the NWSSP A&A review.	The Health Board's 'SAFER Patient Flow and Discharge Policy' is to be reviewed and updated. This will be followed by a comprehensive training and communication programme for staff. **30/11/2022**
Monitoring of the implementation of the integrated Unscheduled Care Plan via the Unscheduled Care Board and Community Silver Command (Regional Partnership Board), and Quality & Safety Committee		x			Development of new audit tools and SOP to accompany the revised SAFER Policy. **30/11/2022**
Rapid Discharge to Assess pathway performance monitored via H2H implementation group and reported to Community Silver.	x				SIGNAL User Group to consider further enhancements in phase 3 around clinical recording, including reasons for changes to EDD, a standardised approach to Board Rounds, and risks around limitations of storage capacity. **30/11/2022**
A&A Report (SBU-1920-025) – February 2021 Discharge Planning - Limited Assurance			x		Following engagement with Carers via Stakeholder Reference Group, produce leaflet outlining patient and family communication and involvement in EDD planning. **30/11/2022**
WAO Report 255A2017-18 Discharge Planning - No Assurance Rating Given			x		

3.4	**Networked Hospitals – A Systems Approach** **Planned Care**	**Trend:** **Improvement**	
Associated HBRR Entries: **HBRR 16 – Access and Planned Care (20)**	**HBRR 58 – Ophthalmology F-Up Clinic Capacity (16)** **HBRR 61 – Dental Paediatric GA Services (16)**	**Assurance Rating:** **Reasonable**	
Executive Lead (s): Chief Operating Officer	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, to offer leadership and support in addressing risks and issues within systems, and to create an enabling framework to allow care to be delivered appropriately.
- Performance & Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Planned Care reports received from the
- The Planned Care Recovery Programme Board has been established
- Plans based on specialty level capacity and demand models which set out baseline capacity and solutions to bridge the gap.
- Appropriate utilisation of the Independent Sector
- Focussed intervention to support the 10 specialties with the longest waits. Fortnightly performance reviews to track progress against delivery
- Quality Impact Assessment process set-up to manage the re-start of essential services
- Outpatients Clinical Redesign and Recovery Group established in June 2020.
- Use of Doctor Dr and Consultant Connect to prevent unnecessary referral and attendance
- Increased use of virtual appointments
- DNA monitoring and management
- Opthalmology Gold Command established and meeting on a monthly basis, chaired by Deputy COO, reporting to Q&S Committee
- Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on the follow-up list.
- Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow-up backlog.
- Outsourcing of cataract activity to reduce overall service pressure.
- Redesign of approaches to improve waiting list management. Rollout of See-On-Symptom and Patient Initiated Follow-Up principles and processes where clinically appropriate have been implemented.
- Following Royal College of Surgeons guidance for all surgical procedures; patients on waiting lists have been categorised and clinically prioritised accordingly.
- A live dashboard for all surgical demand has been developed, supplemented by a scheduling tool to ensure that available capacity can be used to maximum benefit.
- Developed monitoring tools using data from TOMS to improve monitoring and efficiency of theatre capacity utilisation and benchmark performance
- Implementation of WPAS update in order to enable reporting of planned care wait times using new deferred target dates based on clinical assessment.
- New care pathway implemented with Parkway Clinic for the provision of Paediatric DA dental Services, including revised SLA/Service Specification - no direct referrals to provider for GA

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		There is currently a gap in assurance around our ability to deliver >52 and >104 day waits by the revised target date of June 23, and elimination of diagnostic waits of over 8 weeks by the end of March 24.	Weekly meeting with specialties with the most significant challenges taking place. Demand and capacity plans currently in development for each specialty (finalised March 23). Monthly reports provided to Planned Care Board and P&F Committee. Regional plan to address endoscopy waiting times submitted to WG – awaiting feedback.
Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board		x			
A&A Report SBU-2021-015 – April 2021 Adjusting Services: QIA - Reasonable Assurance			x		
A&A Report SBU 2122-013: Planned Care Recovery Arrangements Reasonable Assurance (February 2022)			x		
Regular reports from Ophthalmic Gold Command received by Q&S Committee		x			
Paediatric Dental GA referral and treatment outcome data collated and reviewed by Paediatric Specialist.		x			

Assurance documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients Parkway Clinic HIW Inspection Visit Documentation provided to HB The risk register has been updated to reflect the reduction in the waiting times for both new and follow up ophthalmic patients. There have been no significant incidents regarding loss of lines of sight due to delay in follow up during 2022 (October 2022)	x x		x		

3.5	**Networked Hospital – A Systems Approach** **Cancer Care**	**Trend:** **No Change**	
Associated HBRR Entries: **HBRR 50 – Access to Cancer Services (25)**	**HBRR 66 – Access to Cancer Treatment SACT (15)** **HBRR 67 – Access to Radiotherapy Treatment (15)**	**Assurance Rating:** **Reasonable**	
Executive Lead (s): Executive Medical Director	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Performance & Finance Committee in place, with Terms of Reference which detail a responsibility to provide advice on aligning service, workforce and financial performance matters into an integrated whole systems approach, as well as scrutinise and monitor the performance of the organisation and individual delivery units in respect of cancer services, to ensure the trajectories and plans set out in the annual plan are achieved.
- Establishment of Health Board Cancer Performance Group, which will support execution of service delivery plans for improvements and report to the Cancer Performance Board
- Prioritised pathway in place to fast track Urgent Suspected Cancer patients. Process developed to manage each individual case on the USC pathway.
- Enhanced/weekly monitoring of action/improvement plans for top 6 tumour sites.
- Weekly cancer performance meetings for both NPTS and Morriston Service Groups.
- Weekly Clinical Lead Recovery Planning meetings being held in Endoscopy.
- National Endoscopy Programme (NEP) deferred patient spreadsheet utilised to track deferred procedures, surveillance, screening and USC patients.
- Faecal Immunochemical Testing (FIT) implemented for low risk groups. Primary care roll-out commenced (February 2022)
- Redesigned endoscopy Straight To Test (STT) pathway implemented (December 2021)
- Increased service provision in respect of Capsule Endoscopy, PH Manometry and hydrogen breath test procedures
- Review of Chemotherapy Day Unit scheduling by staff to ensure that all chairs are used appropriately. Daily scrutinising process in place to micro-manage individual cases, deferrals etc.
- Chemotherapy option appraisal completed by Service Group. Business case for shift of capacity to home produced and endorsed by CEO and agreed at Business Case Advisory Group and Management Board.
- Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place.
- Requests for radiotherapy treatment and treatment dates monitored by senior management team.
- Hypo Fractioning for prostate RT (where appropriate) commenced November 2022.
- SACT bi-monthly reports now in place demonstrating oncology SACT waiting times performance to support ongoing improvements in the pathway

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Further work required to ensure that all patients referred for USC radiology investigations are registered for monitoring and reporting purposes in support of the implementation of the Single Cancer Pathway (SCP)	Capacity increased within CT/MRI via recruitment and extended working hours. Further increase to 6 day working planned for 22/23, subject to funding. **31/03/2023 (Subject to Funding)**
Cancer performance update reports are received and considered by the Performance & Finance Committee.		x		Performance and activity data monitored, but delays in treatment continue while sustainable solutions found. The current trajectories do not effectively link with D&C, and practical actions being undertaken at tumour site level.	Business case for delivery of Acute Oncology Services (AOS) from Morriston Hospital approved by Business Case Advisory Group. SOP in place to support changes needed within AOS service following AMSR implementation. **Ongoing**
Operational Plan performance tracker reports.		x			
Backlog trajectory to be monitored in weekly enhanced monitoring meetings.	x			Capital and revenue assumptions and resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.	10-Year regional transformation and development plan for SWWCC in conjunction with Hywel Dda. Strategic Programme Business case approved for onward submission to Welsh Government by Management Board in January 2023. **Ongoing**
Radiotherapy performance and activity data monitored and shared with radiotherapy management team and cancer board.		x			Increase capacity within Radiotherapy pathway by looking at weekend working for CT and Pre-Treat. Developing case to look at piloting this extended working **30/09/2023**
					Move of Chemotherapy Day Unit onto main hospital site following closure of COP wards in Singleton **30/09/2023**

3.6	**Children, Young People & Maternity Services**	**Trend:** **No Change**	
Associated HBRR Entries: **HBRR 48 – CAMHS Sustainability (12)** **HBRR 63 – Screening for Fetal Growth Assessment in line with Gap-Grow (16)** **HBRR 65 – Misrepresentation of Abnormal Cardiotocography Readings (20)**	**HBRR 69 – Adolescent Pats. On Adult Mental Health Wards (20)** **HBRR 74 – Delays in Induction/Augmentation of Labour (20)** **HBRR 81 - Critical Midwifery Staffing Levels (25)** **HBRR 85 – Non-Compliance with ALNET Act (20)**	**Assurance Rating:** **Reasonable**	
Executive Lead (s): Executive Director of Nursing		**Assuring Committee:** Performance & Finance Committee	

Key Controls:

- Established Nursing & Midwifery Board in place
- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Project Board established to oversee installation of central cardiotocograph monitoring system, and necessary training
- Health Board Maternity Ultrasound Group convened to develop future ultrasound services
- CAMHS Commissioning Group in Place
- Children & Young People's Emotional and Mental Health Planning Group 3-Year plan 2021-2023 in place.

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Lack of SLA/Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS	Service specification now finalised, with update paper presented to Management Board. Final specification will be approved between SBUHB and CTMUHB at the September Commissioning meeting. **Complete**
A&A Report SBU-2122-018 – December 2021 CAMHS Commissioning Arrangements – Limited Assurance			x		
CAMHS performance against local and WG targets included in Integrated Performance Reports		x			A review of Swansea Bay CAMHS has been undertaken with a preferred option identified to repatriate the service from CTM – Board agreed to the preferred option at their September meeting. The SLA with CTM will cease from the 1st April 23, and CAMHS will be hosted by Swansea Bay – Mental Health & LD Service Group. A Project Board has been established ensuring a smooth transition of the service from Cwm Taf Morgannwg UHB to Swansea Bay University HB. The project Board meets fortnightly with a detailed Project Plan. Agency staff arrangements to continue to ensure service continuity. **Ongoing**
Monthly monitoring of progress against waiting list improvement plan via the CAMHS Commissioning Group, with quarterly updates to the Management Board, and to Performance & Finance Committee when required.	x			The HB has not identified quality measures in respect of CAMHS being provided to the patients or the outcomes for those patients.	A workshop has been held to develop further outcome measures and additional measures will be reported from Q4.
External review of Swansea Bay University Health Board Maternity Services Governance Process conducted by the Wales Maternity & Neonatal Network			x	The Mental Health Legislative Committee felt the CAMHS governance report provided by CTMUHB did not provide sufficient assurance.	Governance reporting has now been re-established with a governance report provided monthly. **Complete**

BAF 4: Population Health & Partnerships

Principle Risk:	If the Health Board does not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints, then we will fail to prioritise our efforts and resources appropriately and to achieve a consensus for change in implementing a Population Health Strategy, resulting in continuing health inequalities and poor population health outcomes.	**Trend: Improvement**	
		Assurance Rating: Limited	

Executive Lead(s): Director of Public Health

Assuring Committee: TBC

Associated HBRR Entries: None

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Public Health strategy and work plan
- Strategic Immunisation Group (SIG) and immunisation action plan in place
- Childhood Immunisation Programme
- Primary Care Influenza Group and Vaccination Programme
- Support from Public Health Wales Health Protection Team
- Local Smoking Cessation Services
- Joint working with Regional Area Planning Board

Forms of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Lines of reporting assurance in respect of vaccination & immunisation systems, processes and performance are not clear.	The publication of the National Immunisation Framework on 25 October has provided some additional clarity over Welsh Government intentions for the immunisation model. Some detailed elements, including resource allocation, are not yet in place, however.
Key Population Health measures included in integrated performance reports (P&F Committee): • Childhood Vaccinations • Flu Vaccinations • Alcohol attributed hospital admissions • Hospital admission rates which mention intentional self-harm		x		Scope identified to enhance governance arrangements and oversight around the work of vaccination & immunisation subgroups.	The Welsh Framework will guide the reconfiguration of arrangements to provide strategic direction to and operational oversight of vaccination activity within SBUHB. There will be a need for a SBUHB programme group to be established to support the migration to compliance with the NIF arrangements.
A&A Report ABM-1819-012 – August 2018 Vaccination & Immunisation - Limited Assurance			x		A whole system Immunisation Group will be established within SBUHB during Q4 of this year (FY22-23). Reporting would then be via the Management Board. The NHS Delivery Unit will be performance-managing vaccination from April 2023 onwards.
A&A Report ABM-2021-014 Vaccination & Immunisation (F/Up) - Reasonable Assurance			x	Due to COVID-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.	A proposal for local implementation of the National immunisation Framework has been drafted with the intention of submitting to Management Board for approval during March 2023. This will create a position of Immunisation Lead to co-ordinate vaccination activity across the health sector (directly delivered and contracted programmes) and with an information team as part of a central resource. The new immunisation team will operate from within the Corporate Directorate and report to the Director for Public Health. Governance arrangements for Population Health programmes have been proposed that will create a direct reporting line for immunisation

				Previously identified resource issues in respect of maintaining vaccination & immunisation records for those aged 17-19	performance via a revised Management Board structure to a new Partnerships, Population Health and Planning Committee (a sub-committee of the Board). These new arrangements will allow for greater visibility of performance and consideration of vaccination issues at a whole system level. However, there will remain issues over operational oversight, which require to be worked through as the new arrangements are implemented. There remains no definitive solution to this issue. Workarounds are in place using Welsh Immunisation System in relation to COVID vaccination for individuals in these age groups. There is ongoing liaison between the COVID vaccination team and Child Health. The underlying issue is failure to invest in Child Health records team. Additional input from the central immunisation records team will mitigate the current risk pending development of a definitive solution during Quarter 2 2023-24.

BAF 5: Digitally Enabled Health Care and Wellbeing		
Principle Risk: If our digital infrastructure and systems are not sufficient or adequately protected, then this could compromise connectivity and access to key/critical systems, resulting in compromised patient care (including patient delays, cancellation of services), reputational damage and potential fines.	**Trend:** **No Change**	
	Assurance Rating: **Reasonable**	
Executive Lead(s): Director of Digital	**Assuring Committee:** Performance & Finance Committee	
Associated HBRR Entries: **HBRR 27 – Digital Transformation (16)** **HBRR 36 – Paper Record Storage (16)**	**HBRR 37 – Data Informed Decisions (12)** **HBRR 60 – Cyber Security (20)** **HBRR 90 – Non Compliance with GDPR (SARs) (16)**	

Key Controls:

- Digital Strategy and Strategic Outline Plan
- Digital Leadership Group (DLG) in place, supported by a Digital Service Management Group and Digital Transformation Programme/Project Boards. The DLG provides governance and assurance for the delivery of the HB's Digital Strategic Plan, and has oversight of the Digital Transformation Programmes and their delivery plans.
- Information Governance Group (IGG) and Digital Service Management Group (DSMG) in place.
- Digital Risk Management Group and Risk Register in place.
- HB Capital Prioritisation Group considers digital risks for replacement technology, which is fed into the annual discretionary capital plan.
- HB Business Case Assurance Group process provides scrutiny to ensure digital resources are considered for all projects.
- Digital Services prioritisation process introduced to ensure that requests for digital solutions are considered in terms of alignment to the strategic objective, technical solutions and financial implications.
- Project Boards established for all significant projects.
- Clinical Reference Group established, providing a forum for engagement with and feedback from clinicians in respect of digital solutions and enhancements, and the strategic direction of digital services. Meetings recommenced in June 2021.
- Digital meetings with Service Delivery Groups to identify and prioritise requirements, monitor progress with implementation, and address issues with business-as-usual activities.
- Receipt, approval and recording of changes/updates made to all existing digital solutions via the Digital Services Change Advisory Board.
- Internal Digital Business meetings monitor performance of business-as-usual activities and achievement of internal objectives Joint Executive Team for Boundary Change provides oversight of the disaggregation process in respect of Digital Services (CTMUHB boundary change process).
- Business Intelligence Modelling Cell established to prioritise the delivery of BI requirements. Approved Business Intelligence Strategy in Place.
- The Health Board has representation on national groups such as Advanced Analytics Group (AAG), all Wales Business Intelligence & Data Warehousing Group and Welsh Modelling Collaborative.
- Records managed by medical records libraries are Radio Frequency Identification (RFID) tagged and location tracked.
- Medical records libraries are regularly risk assessed for fire by Health & Safety.
- Alternative offsite storage arrangements for paper records have been identified
- Requirement for all records to be documented on the Information Asset Register
- Creation of a Health Board Cyber Security Team. Firewalls in place at a local and national level, with national security tools in place to highlight vulnerabilities and provide warnings when potential attacks are occurring.
- Patching regime in place which ensures desktops, laptops and servers are protected against known security vulnerabilities.
- Digital Services Management Group ensures systems are compliant with security standards.
- Cyber Security training and phishing simulation in place to increase staff awareness.

Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1st	2nd	3rd		
The DLG is accountable to the Executive Board and reports to the Senior Leadership Team		x		Issues identified in respect of the operation and functionality of the Theatre Operational Management System (TOMS)	Previously approved WG DPIF funding for TOMs development was not provided for 2022/23. Work has progressed with support of discretionary capital and extensive planning and ways of working assessments undertaken. TOMs redevelopment completion revised to March 2024. **31/03/2024**
The SLT receive update reports on progress against digital transformation programmes	x				
Update reports also provided to the Board and Audit Committee.		x		Rapid deployment of digital solutions and hardware has resulted in increased pressures on the Digital Services Team and Digital Operations Team, with an average increase of 45% in calls logged.	SBUHB has contributed to a national workforce review and are awaiting outcomes. Digital Services will use the findings to build a SBUHB Digital Services workforce plan with appropriate support from Workforce & OD. **31/12/2023**
Operational Plan performance tracker reports.		x			
Annual Cyber Security progress reports to Senior Leadership Team, Audit Committee and Board		x			
Monitoring of complaints and incident reporting in respect of paper records		x		Despite the rollout of digital solutions (e.g. Radio Frequency Identification (RFID)), significant volumes of paper records remain, exacerbated by the enforced halt of record destruction as part of the infected blood enquiry.	Continued rollout of digital solutions to reduce the volume of paper being used/added. Multi-faceted to include: • HEPMA (Singleton initially) • WNCR (NPTH initially) • SIGNAL V3 **31/03/2026**
Quarterly reports to the Performance & Finance Committee		x			
A&A Report SBU-2021-029 – February 2021 Digital Technology Control & Risk Assessment. No Assurance Rating Given			x	Cyber security training is not currently mandatory within the Health Board.	Work is ongoing at a national level to put a joint mandatory Cyber and IG training solution in place across Wales. **TBC (all-Wales)**
A&A Report SBU-2122-020 – May 2022 Digital Project Management - Substantial Assurance			x	Lack of a holistic review of current/future gaps in digital services staff expertise/knowledge	The National Digital Services skills assessment has yet to be published. Revised timeline for completion is therefore to be confirmed. **TBC**
A&A Report SBU-2021-021 - October 2021 Information Technology Infrastructure Library Service Management Review – Reasonable Assurance			x	Scope identified to enhance testing of BC/DR plans in conjunction with stakeholders	Plans tested in response to the recent Cyber-attack from Advanced and utilised successfully. Lessons learnt from the incident will be fed into the plans and utilised in a wider joint Business Continuity test in October/November with the Emergency Preparedness Resilience and Response Team. **Complete**
A&A Report SBU-2122-005 – April 2022 Network & Info Systems (NIS) Directive - Reasonable Assurance			x		
A&A Report SBU-2122-019 – December 2021 Hospital Electronic Prescribing & Medicines Administration Application (HEPMA) - Reasonable Assurance			x	Scope to implement a more formal structure around problem management processes and recording and communicating known errors.	Due to resources, it has not been possible to recruit to a post to address this issue as intended. It is anticipated that the system used for call management within Digital will be replaced and SBU will request functionality in the new system to address the issue. **TBC**
A&A Report SBU-1920-029 – January 2020 IT Application Systems (TOMS) - Reasonable Assurance			x		
A&A Report SBU-1920-028 – June 2020 Discharge Summaries - No Rating Given			x	Scope to improve the recording of information in respect of the completion of the Cyber Assessment Framework (CAS).	A suitable information recoding mechanism will be agreed with the Cyber Resilience Unit (CRU) for the next assessment cycle. **30/06/2023**
A&A Report SBU-2223-021 – January 2023 Cyber Security - Reasonable Assurance			x	WEDs implementation into Morriston delayed whilst assurances on system are sought from the supplier.	An action plan has been requested from the supplier to address this issue **30/06/2022**
A&A Report SBU-2223-023 – February 2023 Information Governance – Limited Assurance			x	There is insufficient discretionary capital finding available to replace the Health Board's Storage Area Network (SAN) when the warranty/support ends in February 2023.	A funding bid for a replacement to the SAN has been approved by Welsh Government. Orders have been placed, and interim maintenance support agreed. **Complete**
				Scope to improve the level resources within the IG team and enhance the use of performance measures to assess resilience	Active resource management within the IG team continues and requirement for additional resource for a SAR lead has been included within the IMTP. Team structure is also being reviewed. – **31/03/2023.**

				Scope to improve the Health Board's policy and procedure to deal with Subject Access Requests (SARs) Impact of national architecture and governance reviews not yet known.	A SAR task and finish group has been established and an overarching HB wide SAR policy is being developed – **30/04/2023**

BAF 6: Finance			
Principle Risk: If the Health Board fails to manage resources that are appropriate and sufficient for now and the future Then we will fail to fulfil our statutory financial duties resulting in inability to fund planned improvements, new services and attracting increased regulatory scrutiny.		**Trend:**	
		Assurance Rating:	
Executive Lead(s): Director of Finance		**Assuring Committee:** Performance & Finance Committee	
Associated HBRR Entries: **HBRR 72 – Reduced Discretionary Capital Funds and National NHS Funds (20)**		**HBRR 73 – Detrimental Impact of COVID on Underlying HB Financial Position (20)** **HBRR 79 – Resource Available to Provide Improved Access to Services (15)**	

Key Controls:

Audit Committee in place, with Terms of Reference which cover the following:

- Review the adequacy and effectiveness of the Health Board's Standing Orders and Standing Financial Instructions
- Monitoring the integrity of financial statements, including the schedule of losses and compensation
- Ensuring systems for financial reporting, including those of budgetary control, are subject to review as to completeness and accuracy
- Review of the annual report and financial statements before submission to the health board
- Review the effectiveness of system which allow staff to raise concerns about possible improprieties in financial (and other) matters.

Performance & Finance Committee in place, with Terms of Reference which cover the following:

- Scrutiny and review of financial planning and monitoring, including delivery of savings programmes.
- Seeking assurance that finances are managed in a prudent way, and that financial targets are met, including value for money targets

Financial Control Procedures in place, with ongoing cyclical programme of review and update

Standing Orders, which include Standing Financial Instructions and Scheme of Delegation

Internal and External Audit (NWSSP Audit & Assurance and Audit Wales) programmes of work

In-House Counter Fraud Service

Monthly financial review meetings with service groups and quarterly financial review meetings with corporate directors

Board agreed reserve management plan

Savings PMO established to support the delivery of savings plans and create a pipeline of opportunities for future savings

Weekly scrutiny meetings held with Finance Delivery Unit and routine reporting of the detailed monthly position to Welsh Government and Finance Delivery Unit

Capital risks on the HBRR

Capital funding requirements considered by the Business Case Approval Group.

Monthly Capital Prioritisation Group Meetings

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance or Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
Regular reports on financial matters, performance and position (including counter fraud) to the Performance & Finance Committee, Audit Committee and the Board		x		Scope identified to enhance the Service Level Agreement between SBU and NWSSP for the provision of procurement Services.	The review of all NWSSP SLA's with Health Boards and Trusts in Wales has been deferred to financial year 23/24. **30/04/2023 (For further update)**
Annual Accounts presented to Audit Committee (draft) and the Board Audit Wales assurance of the annual accounts		x	x	Budget delegation letters are not being signed and returned by Service Group Directors	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. **30/06/2023 (For further update)**
Reporting and scrutiny of STA/SQA at Audit Committee		x			
Periodic reporting and scrutiny of Losses and Special Payments at Audit Committee		x		Scope identified to widen the use/distribution of budget delegation letters.	For 2022/23 the letters will also be issued to Corporate Directorates along with the Service Groups. **30/06/2023**

A&A Report SBU-1920-016 – December 2019 Procurement (No PO/No Pay) - Limited Assurance			x	Scope identified to enhance support provided to budget holders.	Work stream to be established to review requirements and develop a work programme to support. **30/06/2022 (Establish Work Stream)** **31/03/2023 (Delivery of Work Programme)**
A&A Report SBU-2021-018 – December 2020 Charitable Funds - Substantial Assurance			x		
A&A Report SBU-2021-016 – May 2021 Fin. Delivery (High Level Monitoring) - Reasonable Assurance			x	Lack of a robust management trail in respect of budget virements.	The new Reporting & Insight Team ensure that a central log of virement transactions is now maintained, and this will be kept under review for 2022/23 **Complete**
A&A Report SBU-2021-043 – June 2021 Integrated Care Fund (Banker Role) - No Assurance Rating Limited Scope Review			x		
A&A Report SBU-2122-015 – October 2021 Procurement and Tendering - Limited Assurance			x		
A&A Review SBU-2122-004 – January 2022 Delivery Framework - No Assurance Rating Revised Delivery Framework incomplete			x		
A&A Review SBU-2122-003 – May 2022 Financial Reporting & Monitoring - Reasonable Assurance			x		
Capital Resource Plan Updates reported to P&F Committee three times per year.		x			
Capital risks on the HBRR reported to and discussed at P&F Committee		x			
Capital Financial Position reported to P&F Committee as part of integrated Perf Rep		x			
Capital funding requirements considered by the Business Case Approval Group, and reported to Management Board.		x			
Monthly WG Monitoring Returns reporting on all areas of the financial position, which included a detail commentary, approved by CEO and DOF and independently scrutinised by WG Finance and FDU. The commentary is also provided to PFC.			x		
A&A Review SBU-2223-023 – November 2022 Information Governance – Limited Assurance			x		

BAF 7: Estates Infrastructure

Principle Risk: If we are unable to maintain and develop our retained clinical and non-clinical estate, then we may be unable to provide services in a fit-for-purpose healthcare environment, resulting in an inability to provide high quality services in a safe, secure and compliant environment.	**Trend: Improvement**	
	Assurance Rating: Limited	

Executive Lead(s): Director of Finance	**Assuring Committee:** Health & Safety Committee
Associated HBRR Entries: **HBRR 13 – Compliance with Health & Safety Regulations (Accommodation) (12)**	**HBRR 41 – Fire Regulation Compliance – Singleton Hospital Cladding (16)** **HBRR 64 – Insufficient Health, Safety & Fire Function Resource (20)**

Key Controls:

Health & Safety Committee in place, with Terms of Reference which cover the following key areas:

- Monitoring and assuring delivery of objectives set out in the health & Safety action plan in line with agreed timescales
- Setting and monitoring standards in accordance with relevant Standards for Health Services in Wales
- Ensuring that robust proactive and reactive health and safety plans are in place across the health board
- Actively pursue and review policy development and implementation
- Ensure that health & safety incidents are investigated, and action taken to mitigate the risk of future harm
- Reports and audits from enforcement agencies and internal sources are considered and acted upon
- Ensure employee health and wellbeing activities are in place
- Assuring mitigation of health and safety risks

Health & Safety Operational Group in place, which supports the work of the Health & Safety Committee

Health & Safety Policy in place, supported by other key related operational policies including:

- Fire Safety
- Violence & Aggression
- Manual Handling
- Asbestos Management

Health, Safety and Welfare Strategy Implementation Plan in place

Key Performance Indicators (KPIs) developed by the Health & Safety Team, and approved by the H&S Committee

Health & Safety Audit Tool Template developed to support site-based reviews.

Forms of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
A&A Report SBU-1920-006 – March 2020 Health & Safety – Limited Assurance			x	Health & Safety Policy made available to staff via the intranet is out of date	The Revised H&S Policy has been approved by the H&S Committee, and is available via the Health Board intranet site. **Complete**
A&A Report SBU-2021-004 – January 2021 Health & Safety Framework (F/Up) – Reasonable Assurance			x		HSOG Key Issues report to H&S Committee details any Deep Dive review undertaken during the reporting period. An updated exception reporting template has been implemented for Service Groups to report into HSOG in order to assist with this. Going forward, the forward plan of Deep Dives will form a standing item on the HSOG Key Issues report to H&S Committee. **30/05/2023**
A&A Report SBU-2223-016 – September 2022 Health & Safety – Limited Assurance			x	Scope to enhance clarity/assurance over which areas are and are not being addressed by H&S Ops Group deep dives	
Health & Safety Ops Group 'Key Issues' report to Health & Safety Committee		x			

Rotational presentation of Service Group and Non-Service Group H&S Exception reports to H&S Committee		x		Scope identified to enhance clarity and content of Estates reports received by the H&S Ops Group	Updated Estates reports received at the November 2022 and February 2023 H&S Ops Group meetings. Further review and update is being undertaken to ensure that appropriate information relating to Estates KPI's in being captured. **30/05/2023**
Regular review of H&S risk on HBRR, as well as a summary of operational risks recorded within Service Groups and Directorates on DATIX, by the H&S Committee		x			
Periodic review of progress against the H&S Strategic Action Plan at H&S Committee		x		Scope identified to further standardise and enhance the operation of Service Group health & safety groups, including the development of improvement plans and mechanisms to review and monitor actions linked to deep dives.	Updated Service Group exception report template now in place, which contains dedicated section for inclusion of actions plans to be reported to Health & Safety Ops Group. These will then be summarised in the key issues report to the Health & Safety Committee. Risk register has been included in the deep dive schedule for 23/24 and is included as a standard agenda item.
Estates Health and Safety reports received and considered by the H&S Committee		x			
Output received from recently completed 6 facet survey			x		**Closed**
A&A Report SBU-2021-007 – April 2021 Control of Contractors – Limited Assurance			x	Scope identified to enhance clarity of performance reporting against agreed KPIs at H&S Ops Group and H&S Committee	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. **30/05/2023**
A&A Report SBU-1920-007 – November 2019 Capital Systems: Financial Safeguarding – Limited Assurance			x		
A&A Report SBU-1617-009 – October 2017 Backlog Maintenance – Limited Assurance			x	Health and safety team resource business case requires review/update in order to reflect the current and intended structure.	Work to finalise the structure is currently ongoing. **31/03/2023**
A&A Report SBU-2021-008 – June 2021 Water Safety – Limited Assurance			x	No H&S Annual Report produced covering the 2020/21 year.	The 2021/22 Annual Report was approved at the January 2023 meeting of the H&S Committee. **Complete**
A&A Report ABM-1819-009 – May 2019 Safe Water Management – Limited Assurance			x	Scope to enhance systems and processes around contractor insurance and competency checks	Health & Safety Officer appointed to take forward implementation of strengthened checking processes. Where possible Contractors Health & Safety Scheme accredited contractors are being used. Updated control of contractor's policy approved at HSC in January 2023. **31/05/2023**
A&A Report SBU-2021-009 – April 2021 Fire Safety Management – Limited Assurance			x	Scope identified to enhance Estates Stores processes across health board sites	Staff recruitment underway to address this issue. In addition, in correspondence with NWSSP Procurement regarding assistance with addressing this issue. **31/03/2023**
				No Estates Strategy in place	The draft Estates Strategy has been presented to various groups/board level committees, it has been well received. A T&F group with Execs/IM's and key capital, estates and finance has been set up to finalise the estates strategy. The initial meeting is Mid Feb 23. **31/05/2023**
				Staff training in respect of water safety requires updating	Some water safety training completed, more scheduled for Q4 22/23 & Q1 23/34. **30/06/2023**
				Lack of appropriate strategy targeting funding to address fire safety requirements.	Specific works have been identified for the coming years based on output from the 6 fact survey and compartmentation survey, and availability of funding: • Morriston fire alarm replacement phase 1, 2023/24 • Morriston fire alarm replacement phase 2, 2024/25 • Morriston street fire doors 2024/25 • Singleton fire alarm (central ward block) 2024/25

					• Gorsienon fire alarm replacement 2023/24 There are also full capital programmes that will pick up fire compliance scheduled **Complete**