BOARD ASSURANCE FRAMEWORK (BAF)

Swansea Bay University Health Board Control Framework

High Quality Care

Controls:
Evidenced within:
- Annual Plan
- Commissioning
- Annual Quality Objectives
- intentions and plans
- Capital and Estates Strategy
- Quality Impact Assessment protocol
- Equality Impact Assessment

Assurance: gained via:
- Quality and Safety Committee
- Divisional Quality Groups
- Senior Leadership Team
- Annual Quality Report
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections

Performance Management

Controls:
- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports
- Concerns and Patient Experience Reports
- Serious Incident Reporting

Assurance: gained via:
- Unit Boards, Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Safety, Finance and Audit Committees
- Internal/External Audits

Risk Management

Controls:
- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register
- Reports to the Board, Senior Leadership Team and sub committees
- Policies and Procedures
- Scheme of Delegation

Assurance: gained via:
- Delivery Boards, Service/Ward levels
- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees

Levels of Assurance

VISION AND STRATGEIC PRIORITIES

First Line
Operational

- Organisational structures – 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

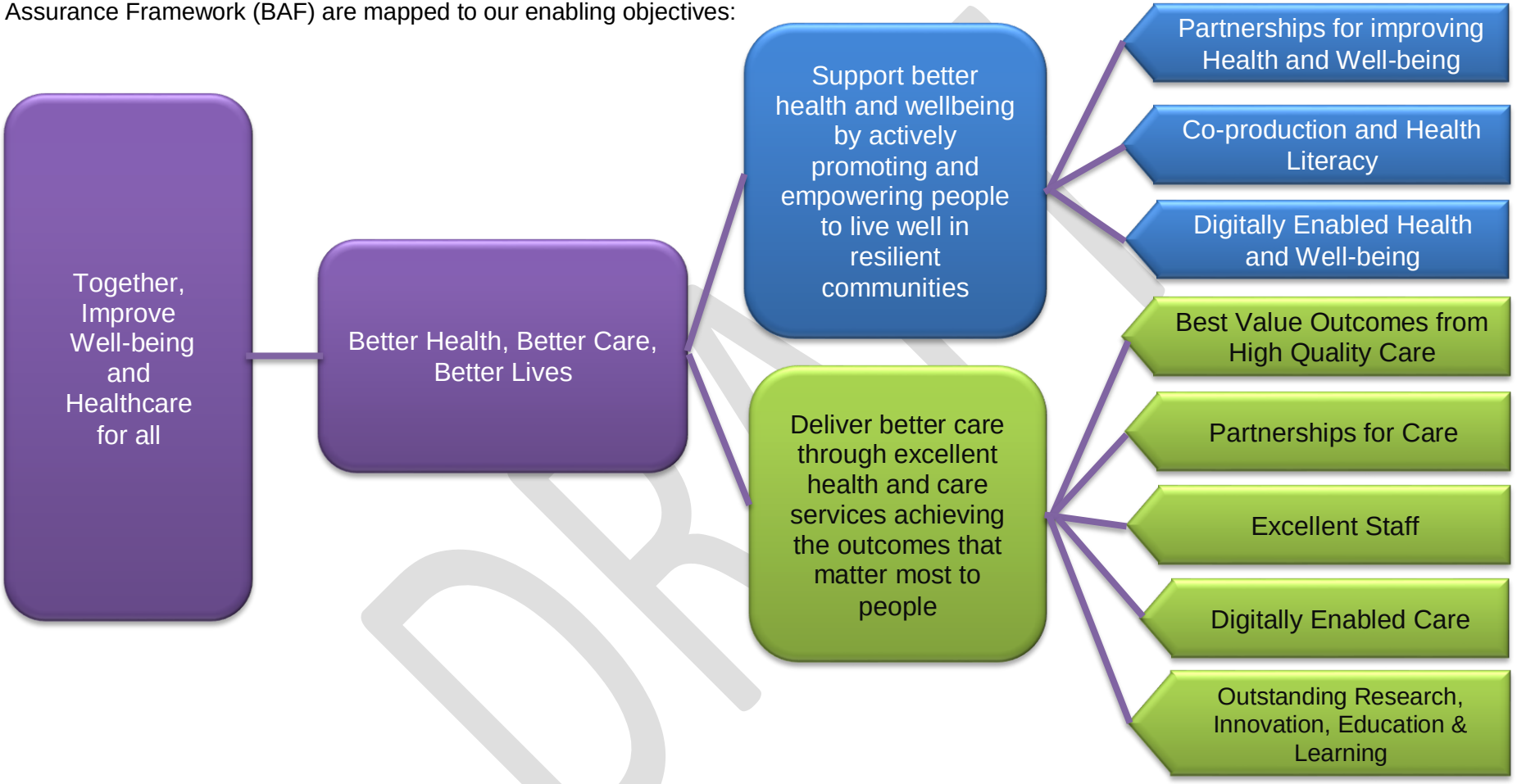
- Internal Audit Plan
- Wales Audit Office (WAO) (Structured Assessment)
- External Audits (e.g. Annual Accounts and Annual Report)
- Health Inspectorate Wales (HIW) Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews

REGULATORS

EXTERNAL AUDIT

Aligning Board Assurance with Swansea Bay University Health Board (SBUHB) Strategy

The Swansea Bay University Health Board (SBUHB) strategy is outlined in the figure below and all risks identified for inclusion on the Health Board Assurance Framework (BAF) are mapped to our enabling objectives:



Board Assurance Framework Summary Against SBUHB Enabling Objectives – March 2021

	Aug 2019	Mar 2021
Partnerships for improving Health and Well-being		
Failure to reduce inequalities and deliver improvements in population health for our population	↓	→
Co-production and Health Literacy		
Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working	→	→
Digitally Enabled Care, Health and Well-being		
Failure to have IM&T systems in place which do not meet the requirements of the organisation	→	↑
Best Value Outcomes from High Quality Care		
Risk that the Health Board will be unable to maintain the quality of patient services and financial sustainability	→	→
Partnerships for Care		
Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working	↑	→
Excellent Staff		
Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements.	↓	→
Outstanding research, Innovation, Education and Learning		
Failure that the Health Board will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	→	↓

Key	Improvement ↑	Deterioration ↓	No Change →

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 - 3	Low risk
4 - 9	Moderate risk
8 -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.

Enabling Objective 1 – Partnerships for Improving Health and Wellbeing	
Principle Risk – Failure to reduce inequalities and deliver improvements in population health for our population	
Executive Lead – Director of Public Health	Assuring Committee – Quality & Safety Committee

1.1	**Population Health Improvement (HBRR15)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
• Public Health Strategy and work plan • Strategic Immunisation Group • Immunisation action plan • MMR Task & Finish group • Childhood Imms Group; • Primary Care Influenza Group • Support from PHW Health Protection • Strategic Outline Case submitted to Welsh Government for Integrated Wellness Centres in Swansea and Neath Port Talbot areas • Local smoking cessation services • Nutrition Skills for Life Programme to be expanded • Exercise and Lifestyle pilot • Area Planning Board (APB)	• Public Health measures are included in the Performance Report • Progress against the Public Health work plan • A&A Report ABM-1819-012 Vaccination & Immunisation Limited Assurance	✓ ✓		✓	Data quality issues identified in respect of immunisation records.	All childhood immunisation targets below trajectory with the exception of school immunisation targets. Correlation between smoking during pregnancy and rise in the numbers of stillbirths.	Business case to be developed in order to undertake data cleansing across primary care and child health record systems. Deliver immunisation awareness training for pre-school settings to promote key vaccination messages Contribute to the implementation of recommendations made in the “MMR Immunisation: process mapping of the child’s journey” report. Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins Improve uptake of Men ACWY in primary care. Safer Pregnancy messages issued via social media, signposting and offering expectant mothers referrals to stop smoking services and nicotine replacement therapy. A thematic review will be undertaken.

1.2	**Pandemic Framework (HBRR68)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
• Health Board-wide response in place. • Command and Control structure established • Non COVID-19 activity reviewed and controlled in line with the resources	• Command and control structures are monitoring effectiveness of response. • Regular detailed activity and performance reports received and scrutinised at appropriate fora (e.g. Quality & Safety Committee, Finance	✓ ✓			None Identified	None Identified	Continued receipt and scrutiny of regular and detailed activity and performance reports in order to inform the pandemic planning process.

and requirements of the response plan • Patient flow pathways established • Support service pathways established (e.g. cleaning, decontamination etc.) • Test, Trace and Protect mechanisms established. • PPE guidance in place • Engagement with all-Wales planning and delivery functions • Field hospital(s) developed and commissioned • Primary care models adapted to current situation. • Work undertaken with local authorities to maintain the care sector. • Health Board Recovery and Reactivation plans put in place. • Quarterly Operational Plans developed and reported to Welsh Government.	and Performance Committee, Health & Safety Committee etc.). • Separate COVID-19 risk register established and regularly monitored and reviewed • A&A Report Governance Arrangements During COVID-19 Pandemic Advisory Review	✓		✓			

Enabling Objective 2 – Co-Production and Health Literacy	
Principle Risk – Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working	
Executive Lead – Director of Public Health	Assuring Committee – Quality & Safety Committee

2.1	Wellness Centres

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Outline Business Case produced and submitted to Welsh Government Project Board in place.	Board Briefing to the Board in advance of approval of Business Case.		✓		None Identified	None Identified	Regular updates to be provided to the Board.

2.2	Healthy Behaviours

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Local Smoking Cessation Service Childhood Immunisation Programme Flu Vaccination Programme Programme for healthy eating for the under 3's Rollout of training health literacy and MECC	Integrated Performance Report contains statistical performance and trend data on key areas including: • Childhood immunisation (including MMR) • Flu vaccine uptake • Smoking cessation services	✓			None Identified	Due to Covid-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.	Delivery of all outstanding school vaccination programmes delayed by COVID-19

2.3	Substance and Alcohol Misuse

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Joint working with Regional Area Planning Board to move to an integrated model for the delivery of substance misuse services.	Update paper provided to Quality & Safety Committee Proposed revised model supported by Police and Crime Commissioner, Public Health Wales and Welsh Government.		✓	✓	None Identified	None Identified	None Identified

Enabling Objective 3 – Digitally Enabled Care, Health and Wellbeing	
Principle Risk – Failure to have IM&T systems in place which do not meet the requirements of the organisation	
Executive Lead – Director of Digital	Assuring Committee – Performance & Finance Committee

3.1	**Digitally Enabled Health & Wellbeing**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Digital Strategy and Strategic Outline Plan. IMPT/Annual Planning process. Digital Transformation Leadership Group (DTLG) in place, supported by a Digital Service Management Group and Digital Transformation Programme/Project Boards. The DTLG 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. These include: • Office 365 rolllout • Attend Anywhere • Swansea Bay Patient Portal • Hospital Electronic Prescribing and Medicines Administration • Welsh Nursing Care Record • Medicine Transcribing and Electronic Discharge • GP Electronic Test Requesting • Dashboards • SIGNAL • Virtual clinics • Welsh Community Care Information System (WCCIS) • Support the redevelopment of Theatre Operational Management System (TOMS) Information Governance Group (IGG) and Digital Service Management Group (DSMG) in place. Digital Risk Management Group and Risk Register in place.	The DTLG is accountable to the Executive Board and reports to the Senior Leadership Team Priority focus for digital transformation programmes are agreed as part of the operational planning process. The SLT receive update reports on progress against digital transformation programmes Update reports also provided to the Board and Audit Committee. Operational Plan performance tracker reports. A&A Report SBU-1920-028 Discharge Summaries No Rating Given A&A Report SBU-1920-029 IT Application Systems (TOMS) Reasonable Assurance	✓ ✓ ✓ ✓	 ✓	 ✓ ✓	Issues identified in respect of the operation and functionality of the Theatre Operational Management System (TOMS) Discharge summaries recovery plan paused pending national development of an interface between MTED and TOMS 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. 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. Cyber security training in not currently mandatory within the Health Board.	Impact of national architecture and governance reviews not yet known. Uncertainties over funding streams and quantum, including CTMUHB ceasing parts of the Digital Services SLA COVID pressures have interrupted the Business Intelligence Strategic Plan production and approval process.	Redevelopment of the TOMS system to be undertaken Discharge summaries recovering plan to be developed and agreed by Execs in line with trajectory of NWIS developments. Business Analytics and Intelligence Group will be established to provide direction, governance and assurance of the strategy. Digital workforce plan currently being developed as part of the IMPT/annual planning process. Digital Services have identified the financial impact of expansion, and are working with Finance to address the issue. Also working with WG, NWIS and other Health Boards to ensure appropriate prioritisation of national digital funds. Continued rollout of digital solutions to reduce the volume of paper being used/added. Continue to develop a case for improved record storage and management. Produce a Business Intelligence strategy implementation plan outlining investment requirements in capacity and capability. A detailed proposal for mandatory cyber security training is being constructed.

HB Capital Prioritisation Group considers digital risks for replacement technology, which is fed into the annual discretionary capital plan. Capital Management Group monitors capital expenditure position against plan. HB Investment and Benefits Group process provides scrutiny to ensure digital resources are considered for all projects. Informatics 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. 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. Health Board representation on National Infrastructure Management Board (IMB) and Service Management Board (NSMB), who hold NWIS to account for the delivery of services. West Glamorgan Regional Digital Transformation Group.							

Enabling Objective 4 – Best Value Outcomes from High Quality Care	
Principle Risk – The Health Board will be unable to maintain the quality of patient services and financial sustainability	
Executive Lead – Chief Operating Officer, Executive Medical Director, Director of Nursing and Patient Experience	Assuring Committee – Quality & Safety Committee

4.1	**Access to Unscheduled Care Services (HBRR1)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
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. Regular executive-led meetings which include monitoring and review of unscheduled care performance and trends. Health Board Unscheduled Care Action Plan in place 'Phone First' task and finish group established, with representation on the national group also Implementation of Consultant Connect Implementation of Hospital 2 Home Rapid Discharge The cohort of MFFD patients is monitored and discussed at Gold and Silver Command meetings.	Monitoring of the implementation of the integrated Unscheduled Care Plan via the Unscheduled Care Board and Community Silver Command (Regional Partnership Board) Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board, which has continued throughout the Pandemic Progress against Unscheduled Care Action Plan reported to and monitored by Q&S Committee. Operational Plan performance tracker reports.		✓ ✓ ✓ ✓	✓			Delivery and installation of ambulance offload PODS at Morriston ED to support timely patient handover. The introduction of the 'Phone First' model, redirecting patients into appropriate alternative pathways. Establish a group to work with the Local Authority on reducing numbers of Medically Fit For Discharge (MFFD) Patients.

4.2	**Infection Control Targets (HBRR4)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance 1st**	**2nd**	**3rd**	**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
• Infection Prevention & Control Committee. • Health Board Infection Prevention & Control Framework, approved by the Infection Prevention & Control Committee. • A 4-weekly *C.difficile* Scrutiny Panel has been put in place • Three-month programme of proactive deep cleaning successfully implemented across Health Board acute sites. • Maximising the use of virtual consultations where possible, and minimising footfall • Appropriate Infection control (re)training for new, returning or redeployed staff • Review of bed spacing undertaken across the Health Board to ensure minimum distancing Non-compliant beds were removed, or mitigating measures put in place. • Policies, procedures and guidelines in place • Bug stop quality improvement programme • IPC Team support clinical teams for all issues relating to infection control • ICNet information management system for infections is in place • Additional staff in post including permanent Infection Control Doctor, Decontamination Lead and Asst. Director of Nursing	• Clear assurance framework in place at Corporate level with - HB Infection Prevention & Control Committee - Health Board C. difficile Infection Improvement Group; - Corporate Infection Prevention & Control Nursing Team - Water Safety Group - Directly Managed Unit Infection Prevention & Control Groups.	✓			No overarching cleanliness policy or strategy in place. Lack of decant facilities when occupancy is at acceptable levels on acute sites Domestic hours required to meet National Standards of Cleanliness recommendations.	ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication.	• Cleaning strategy and plan to be prepared and taken through Infection Control Committee. • Further focused work will be on environmental decontamination and infection control needs to be considered for all refurbishment and new works to ensure our hospitals provide suitable facilities for infection control. • Infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset. • Continue investigation into the increasing trend in *C. difficile,* with a specific focus on antimicrobial stewardship. • Investigation of genetically linked cases of *C. difficile* by Morriston and Singleton Service Groups, with support from the IPC team. • Medical representatives from gastroenterology and general surgery to become members of the C.difficile Scrutiny Panel. • Investigate further restriction of broad-spectrum antibiotics in the antimicrobial guidelines • Cleaning staff recruitment continues. This is an ongoing process due to turnover in this staff group. • Development of Ward dashboards on key infections, with update reports to SLT and Q&S Committee. • Solutions for dedicated decant facilities to be identified for Morriston and Singleton. • Procurement exercise to identify a safe and appropriate managed environmental decontamination service for cases of ongoing transmission. • Review pilot of SSAs undertaking the whole deep clean of patient care areas. Determine efficacy and propose a long-term solution.
	• Incident reporting	✓					
	• Root Cause Analysis to ensure monitoring and lessons continue to be learnt from Healthcare Associated infections (HCAI).	✓					
	• Infection Prevention & Control Committee monitors infection rates and identifies key actions to drive improvements	✓					
	• Subgroups to the IP&C Committee such as the Decontamination Group provide assurances and drive key areas of operational work.	✓					
	• Regular reporting and monitoring of infection and compliance data, for example at Q&S Committee.	✓					
	• IA report Infection Prevention & Control July 2019 (1920-019) – Reasonable Assurance			✓			
	• Regular HCAI update reports to the Q&S Committee		✓				
	• Operational Plan performance tracker reports.	✓					
	• Delivery Unit C.difficile Improvement Plans reviewed and monitored at C.difficle Scrutiny Panel.	✓					
	• De-escalation to enhanced monitoring with reference to improved performance on infections.	✓					
	• A&A Report SBU-2021-025 Infection Control – Cleaning Reasonable Assurance			✓			

4.3 **Access to Planned Care (HBRR16)**

Key Controls	Forms of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Agreed Action
Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, and 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. **Outpatients** • 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 • Restart of face-to-face appointments for Essential Services. • Improved management of waiting lists (validation) and patient pathways • DNA monitoring and management **Surgical Services** • Services currently delivered in line with RCoS *Clinical Guide to Surgical Prioritisation during the Cronoavirus Pandemic*, in conjunction with the WG *Four Harms* principle • Treatment stage RTT patients clinically prioritised against RCoS guidelines during weekly meetings. • Ongoing work within Delivery Unit operational structures and established Surgery and Theatre planning groups to maximise available theatre capacity. • 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. **General** • Clinically and where necessary MDT-led review and prioritisation of patients on waiting lists. Where appropriate, alternative treatments or regimes are agreed. • Quality Impact Assessment process set-up to manage the re-start of essential services	Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board, which has continued throughout the Pandemic		✓		**Surgical Services** Local Safety Standards for Invasive Procedures (LocSSIPs) have not yet received corporate approval. Observational audit and associated reporting requirements to be clarified within LocSSIPs Unit-Specific SOP's to be reviewed.		• Maximise roll-out of key elements of the Outpatient Transformation Programme within high priority specialty areas identified with DU's/Service Groups. • Redesign approaches to improve waiting list management. Rollout of See On Symptom and Patient Initiated Follow-Up principles and processes where clinically appropriate. • Design and commission a bespoke Outpatients Dashboard, reporting 'real time' analytics across all departments. • Collaborative working/redesign to identify areas where it would be suitable to transfer outpatient services to primary care/community settings. **Surgical Services** • Development of a Post Anaesthetic Care Unit to support the flow of elective (and emergency) cases. • Develop and Implement a Theatre Operations Management System (TOMS) development plan to improve monitoring and efficiency of theatre capacity utilisation • The development of an elective musculoskeletal centre at NPTH • Develop an integrated workforce plan for theatres and anaesthetics. • Working Group to be established in order to review LocSSIPS. • Theatre Board to oversee review of Unit-Specific SOP's **General** • Reinstatement of quarterly Planning, Quality & Delivery meetings with Service Groups. • Completion, collation and review of specialty specific harm assessments. • Implementation of WPAS update in order to enable reporting of planned care wait times using new deferred target dates based on clinical assessment.
	Update report on "Reset & Recovery" of Essential Services	✓					
	Planned Care update report received by the Q&S Committee in November 2020.		✓				
	A&A Report SBU-1920-021 WHO Checklist Limited Assurance			✓			

4.4	DoLS Authorisation & Compliance with Legislation (HBRR43)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
• Oversight via Mental Health Legislation Committee (MHLC) • DOLS assessment supervisory body signatories increased (Feb '18) • DOLS Improvement Action Plan produced by Supervisory Body (March '18) • DOLS Improvement Subgroup Established, with reps from all SDUs and Corp Safeguarding. (Feb '18) • Rota for internal non-substantive HB BIA Implemented. • 2 x substantive BIA posts and additional admin post created. • Introduction of referral triage process and prioritisation tool. • DoLS Dashboard devised to enable more accurate monitoring and reporting. • Actions agreed and reported in response to adverse impact of COVID and restrictions on the service. QIA's undertaken in line with reset and recovery process. • Guidance on revised systems and processes during COVID-19 Outbreak produced by Corporate Safeguarding Team and reported to Q&S Committee.	• Update reports to the Mental Health Legislative Committee. These include performance data. • HIW reports • Scrutiny of delivery against DOLS Improvement Action Plan at Safeguarding Committee • Monitoring via DOLS dashboard. • NWSSP A&A follow-up review on implementation of previously agreed recommendations attained reasonable assurance (Nov. 2019). Updates on progress against recommendations reported to Mental Health Legislation Committee.	✓ ✓	✓	✓ ✓	Insufficient BIA resource available. Limited rota uptake due to inability to release staff.		Produce business case(s) outlining proposed changes to service model and delivery, to meet existing requirements and address upcoming legislative changes.

4.5	Trans-catheter Aortic Valve Implementation (TAVI) (HBRR49)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
The Health Board has commissioned the Royal College of Physicians to undertake a review of the service. Report have been received, and recommendations made. TAVI recovery action plan(s) implemented Appointments made to key medical and nursing posts. Quality Dashboard put in place to monitor the quality and safety of the service.	Royal College of Physicians reports Recovery action plans receive regular oversight at TAVI Operational Gold meetings, with progress also reported to the Quality & Safety Committee and the Board. Reporting to Q&S Committee and Board confirms backlog has been cleared Reduction in procedure waiting times Monitoring and reporting of quality dashboard.	 ✓ ✓ ✓	 ✓ ✓	✓	None identified	Further report from Royal College of Physicians is awaited.	To implement any recommendations made within the second Royal College of Physicians report.

4.6	Access to Cancer Services (HBRR50)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Diagnostic procedures for USC maintained throughout pandemic in line with Essential Service guidance. National Endoscopy Programme (NEP) deferred patient spreadsheet utilised to track deferred procedures, surveillance, screening and USC patients. Additional endoscopy sessions (3) implemented from October 2020 Protected capacity rate for Chemotherapy treatment set as part of 2020/21 Operational Plan. Weekly Clinical Lead Recovery Planning meetings being held in Endoscopy.	Performance reports received by the Q&S and P&F Committees. Update report on “Reset & Recovery” of Essential Services Self-Assessment against framework for the reinstatement of Cancer Services in Wales during COVID-19 Cancer Services performance update reports to the P&F and Q&S Committees. Operational Plan performance tracker reports.	 ✓ ✓ ✓	✓ ✓			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)	Explore options for sustainable uplift in Endoscopy capacity. Increase capacity within CT/MIR via recruitment and extended working hours. Additional services planned at NPTH for Capsule Endoscopy, PH Manometry and breath test procedures. Faecal Immunochemical Tests (FIT) implemented for low risk groups. Complete work to redesign endoscopy Straight to Test (STT) pathway. Fully introduce COVID testing for Oncology and Haematology patients and staff in line with national guidance.

4.7	Access to Cancer Services (SACT) (HBRR66)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Review of Chemotherapy Delivery Unit by Improvement Science practitioner. Additional funding agreed to support increase in nursing establishment. Review of scheduling by staff to ensure that all chairs are used appropriately. Number of Chemotherapy chairs reduced in order to reflect COVID-19 controls (social distancing). Utilisation/capacity rate target set. Operational Plan (Q3/4) Cancer and Palliative Care Services Action Plan	Performance reports received by the Q&S and P&F Committees. Update report on “Reset & Recovery” of Essential Services Self-Assessment against framework for the reinstatement of Cancer Services in Wales during COVID-19 Cancer Services performance update reports to the P&F and Q&S Committees. Operational Plan performance tracker reports.	 ✓ ✓ ✓	✓ ✓				Option appraisal to be completed by service group for review by Service Group senior team. Development of a joint SACT recovery plan, working with MSD/GE

4.8	Radiotherapy Target Breaches (HBRR67)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Requests for treatment and treatment dates monitored by senior management team. Protected capacity rate set as part of 2020/21 Operational Plan. Outsourcing of appropriate radiotherapy cases. Operational Plan (Q3/4) Cancer and Palliative Care Services Action Plan	Performance and activity data monitored and shared with radiotherapy management team and cancer board. Performance reports received by the Q&S and P&F Committees. Update report on “Reset & Recovery” of Essential Services Self-Assessment against framework for the reinstatement of Cancer Services in Wales during COVID-19 Cancer Services performance update reports to the P&F and Q&S Committees. Operational Plan performance tracker reports.	✓ ✓ ✓ ✓	 ✓ ✓				Explore further implementation of revised radiotherapy regimes for specific tumour sites. Develop and implement a case to utilise additional RT capacity released by implementation of revised radiotherapy regimes for specific cancer sites. Review of the patient pathway by the Asst. Gen. Manager (Cancer Services). Work with HEIW to develop a case for a clinical leadership fellow to support quality improvement work and shortened fractionation. To explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC.

4.9	Screening for Fetal Growth Assessment in line with Gap-Grow (HBRR63)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
All staff have received training on Gap & Grow, and detection of small for gestational age (SGA) babies Obstetric scanning capacity across the HB is being reviewed. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening, and to comply with Gap & grow recommendations.	Gap & Grow training compliance monitored Audit of compliance with guidance being undertaken. Detection rates of babies born below the 10th centile is being monitored via DATIX and audited by the service.	✓ ✓ ✓			Challenges in achieving required levels/volume of scanning due to capacity issues. Ultrasound scan department have been unable to support training for the trainee midwife sonographers. Consultant Obstetrician providing training while recruitment process for training ultrasound practitioner.	'Deep Dive' review of this matter requested by members of the Quality & Safety Committee	Progress training and recruitment of Midwife Sonographers. Two midwives have been appointed and are currently training at the University of West of England for appropriate qualification. It is anticipated that they will provide an increase of ultrasound scan capacity by 3,000 scans per annum from January 2022. 'Deep Dive' review and report to the Quality & Safety Committee. Progress recruitment of training ultrasound practitioner.

4.10	Misrepresentation of Abnormal Cardiotocography (CTG) Readings (HBRR65)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
All relevant staff undertake mandatory training in line with the all-Wales Intrapartum Fetal Surveillance Standards for Maternity Services. Protocol in place for an hourly "fresh eyes" on intrapartum CTG's, and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. An appropriate fetal monitoring system (the K2 system) has been identified as the best option for central monitoring CTG envelopes placed in every set of records for safe storage of CTG. Fetal Surveillance Midwife and lead obstetrician appointed. Maternity Services Improvement Plan in response to recommendation made in	Monitoring of compliance with rate of annual mandatory training Initial capital funding for central monitoring system agreed. Updates on progress against this risk monitored at QSGG. Welsh Risk Pool have established an improvement programme to build on previous work in this area. Health Inspectorate Wales National Review of Maternity Services.	✓ ✓ ✓ ✓		 ✓	Central monitoring system to store CTG recordings of foetal heart rate in electronic format not yet in place		Procurement process for K2 central monitoring system now complete. System implementation planning meetings currently underway.

Phase one of Health Inspectorate Wales National Review of Maternity Services.							

4.11	Clinical Standards and Audit Performance						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
National Clinical Audit and Outcome Review Advisory Committee Programme Health Board Clinical Audit & Effectiveness Team in place. HB Clinical Outcomes and Effectiveness Group (COEG) established. NICE Guidance	• Midyear and annual reports received and scrutinised by the Audit Committee, together with an update report to the Quality & Safety Committee • COEG update reports to the Quality & Safety Governance Group • Local Delivery Group Clinical audit programmes • Delivery Group Clinical Audit Groups	 ✓ ✓ ✓	✓		• A&A Report ABM-1819-022 Clinical Audit & Assurance Limited Assurance • A&A Report ABM-1819-025 Mortality Reviews Limited Assurance • Health Inspectorate Wales (HIW) - Kris Wade Report • Health Inspectorate Wales (HIW) - Dyfed Road Health Centre • Health Inspectorate Wales (HIW) - West Cross Lane Dental Surgery • Health Inspectorate Wales (HIW) - Neath South Community Mental Health Team – The Forge Centre • Cwm Taf UHB Maternity Review In March 2019 the RCOG published a report concerning the maternity services at CTMUHB and Welsh Government sought assurance on the maternity service provision in place across the seven HB's in Wales. SBUHB submitted a report to Welsh Government advising a review was being undertaken.	Unknown impact of NHS England's proposed withdrawal from the national clinical audit programme Delay in the implementation/roll-out of the Medical Examiner system.	Changes to the national programme, and implications for all-Wales guidance and LHB clinical audit coverage to be monitored via the work programmes of the Audit and Quality & Safety Committees. An audit of the mortality review process is planned once the Medical Examiner system has had an opportunity to bed in.

4.12	**Primary, Community & Therapy Services (PCCTS)**							
Key Controls		**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
			1st	**2nd**	**3rd**			
COVID-19 Response plan for PCCTS in place based on service-level business continuity plans. Reactivation of primary care, community and therapy services overseen by the Health Board Reset & Recovery Group. Monitoring of daily reporting of GP and Community Pharmacy pressures, facilitating early engagement and enhanced support to practices reporting at level 3 and 4. Plans in place to support primary care contractor professions in the implementation of nationally issued guidance as required: • Urgent Dental Treatment Centre • COVID-19 Cluster Hubs • Urgent Eye Centre HB Flu Plan developed, with emphasis on collaborative cluster working across GMS and Community Pharmacy. Acute Medical Services Redesign (AMSR) Group established, supported by four work streams. Agreed phased plan in place. Reset and restart the Cluster While System Transformation Programme. All primary care cluster annual plans support the continued roll-out of digital platforms, e.g.: • Ask My GP • Attend Anywhere • Consultant Connect. Support to encourage the uptake of the Care Home GMS Directed Enhanced Service (DES) included in primary care cluster annual plans Directed Enhanced Service (DES) regarding winter bank holiday opening offered to Health Board GMS practices.		Integrated Performance Report contains statistical performance and trend data on key areas including: • Primary and community areas • Therapy wait times • Outpatient wait times • Flu Vaccine Uptake Operational Plan performance tracker reports. Monthly reporting on utilisation of Consultant Connect service, which includes primary care. AMSR update reports received by Senior Leadership Team (project temporarily put on hold due to operational pressures). A&A Report SBU-2021-013 Primary Care Cluster Plans & Delivery Reasonable Assurance	✓ ✓ ✓ ✓		✓		Scope identified to enhance the reporting and format of action logs and progress at cluster meetings Scope identified to improve and standardise reporting by Cluster Leads in respect of IMTP progress and delivery against priorities to the Primary & Community Services Board.	Introduction of standardised reporting mechanisms and action logs. A standard approach to cluster monitoring including IMTP progress will be developed and implemented during 2021/22.

Operational Plan (Q3/4) Primary, Community & Therapies Action Plan							

4.13	Test, Trace and Protect (R COV Strategic 13)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Multi-agency COVID-19 Prevention & Response Plan in place. Local testing framework developed and agreed through multi-agency arrangements Two 'Drive Through' testing units established, supported by mobile testing units and 'walk-in' facilities. Care home and home testing also undertaken as required, as is pre-care home admission testing. Weekly 'screening testing' at care homes. Flexible workforce capacity plan developed. Production of weekly TTP activity summary reports Multi-agency Regional Response Team established to oversee and support local contract tracing teams. Multi-Agency Communication Plan developed utilising multiple media platforms. RAID log (Risk, Action, Issues and Decisions) maintained for the TTP programme. Operational Plan (Q3/4) Test, Trace and Protect Action Plan	Board reports detailing testing capacity within the system, and uptake. Testing data included in Integrated Performance Reports, including staff testing data. Operational Plan delivery and performance tracker reports. Weekly TTP activity summary reports are reviewed at Regional Response Team and TTP Silver. Notes of the TTP Silver meeting are then considered at Health & Social Care Interface Group and HB Gold meetings.	 ✓ ✓ ✓	✓				

4.14	**Mass Vaccination (R COV Strategic 15)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Set-up of Strategic Immunisation Silver group as part of the overall COVID command structure, to oversee implementation of vaccine delivery programme, supported by the following Work Cells: – Clinical Governance – Workforce – Digital – Supply & Logistics – Operational Delivery COVID Vaccine Delivery Plan in place and shared with Welsh Government. Multi-Agency Communication Plan developed utilising multiple media platforms. Central mass vaccination centre established, supported by satellite facilities, 'in reach' capacity, and hospital sites for Health Board staff. Mobile unit also in place. Primary care commissioned to support the vaccination programme as part of the Primary Care COVID Immunisation Scheme. RAID log (Risk, Action, Issues and Decisions) maintained	Strategic Immunisation Silver share regular highlight reports with Gold command. Update reports to the Board	✓	✓			Although the position in terms of vaccine of vaccine supply remains fluid, commitment has been made to extend the vaccination programme to those in categories 5-9 by the spring.	Assessment of the capacity needed to deliver to these cohort, including the potential for further primary care involvement an additional local vaccinations centres is being undertaken. Vaccination programme activity and performance to be reported to and overseen by the Performance & Finance Committee, which will provide assurance to the Board.

4.15	Impact of COVID on HB Underlying Financial Position, and Capital Resource Limits and Planning (HBRR73)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Financial plan reported to and approved by Board as part of the Annual/IMPT Plan. Risk-assessed savings plan in place, linked to opportunities pipeline developed with the support of KPMG. Mechanisms establish to record, monitor and report the financial impact of the COVID response, to include impact on savings delivery and investment impact as well as direct costs. Additional COVID-related funding secured from WG. Multi-disciplinary scrutiny group to review investment service proposals related to the reset and recover programme, within the context of the operational plan Finance Review Meetings with Delivery Groups Finance Action Plan in place as part of the Q3/4 Operational Plan. Regular reporting to and dialogue with WG regarding the financial plan and position Discretionary capital plan and subsequent revisions reported to and approved by Board. Review/Scrutiny via the Capital Prioritisation Group. Review/Scrutiny via the Investments and Benefits Group. Capital Services Action Plan in place as part of the Q3/4 Operational Plan. Regular reporting to and dialogue with WG regarding capital position and requirements.	Regular reporting/monitoring of the financial position, movements and risks, notably at Performance & Finance Committee and the Board. Performance against savings targets separately reported. Financial impact of COVID separately reported. Monthly monitoring returns to WG Regular reporting/monitoring of the capital position and risks, notably at Performance & Finance Committee and Capital Prioritisation Group. Operational Plan performance tracker reports.	 ✓ ✓ ✓ ✓	✓	 ✓	Issues regarding historic under-achievement of savings plans identified as part of Audit Wales Structured Assessment.	Scope identified to extend the information used in respect of benchmarking costs.	Review/Refresh planned savings programme utilising benchmarking, KPMG opportunities pipeline and the Efficiency framework. Develop detailed savings plans, with milestones, deliverables and timescales to ensure the deliverability of the opportunities in 2021-22. Due to COVID, The Health Board has reverted to 2019-20 service and cost baselines to review efficiencies and benchmarking. Our approach for 2021/22 will be to assess the financial requirements of the plan across base plan, COVID response and COVID recovery.

4.16	Mental Health and Learning Disabilities						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Service Group command and control system and COVID-19 response centre established Pathway reviews across Older Peoples Mental Health, Adult Mental Health, and Learning Disability Services to provide a single point of admission for each service. Utilisation of 'Attend Anywhere' and 'Teams' to offer virtual 1:1 and group psychological therapy interventions Psychological Therapies Stakeholder group established to identify and implement actions to reduce waiting times. Psychological Therapies Project Group established to plan a revised service model based on stepped care. Progressing the development of a permanent mother and baby unit at Tonna Hospital. Operational Plan (Q3/4) Mental Health and Learning Disabilities Action Plan	Update reports received at Quality & Safety Committee and Senior Leadership Team. Integrated Performance Report contains statistical performance and trend data on key areas, including therapy wait times. Operational Plan performance tracker reports.	✓ ✓ ✓	✓				Undertake demand and capacity modelling within Local Primary Mental Health Services (LPMHSS) utilising local and national data. Rapid review of LPMHSS in order to inform best use of additional recurrent funding secured from the WG's mental health service improvement fund.

Enabling Objective 5 – Partnerships for Care	
Principle Risk – Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and deliver plans, based on the principles of sustainability, transformation and partnership working	
Executive Lead – Director of Strategy	Assuring Committee – Health Board

5.1	**Partnerships for Care**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Formal joint partnership arrangements in place with a number of NHS and external partners. Priority areas for joint working are established via operations plans, such as: • Oesophageal and gastric cancer • HepatoPancreatroBiliary Services • Progressing a Regional Pathology Service SOC with all partners • City Deal Campuses Project • Development of a Regional Dermatology Service • Development of a Regional Eye Care service South West Wales Regional Clinical Services Plan 2019 - 2024 National Endoscopy Group Vascular Surgery Steering Group	Strategy, Planning and Commissioning Group meetings. Progress reports and minutes of joint meetings are provided to and reviewed by the Board Operational Plan performance tracker reports.	✓ ✓		 ✓ 			

Enabling Objective 6 – Excellent Staff	
Principle Risk – Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements	
Executive Lead – Director of Workforce & OD	Assuring Committee – Workforce & OD Committee

6.1	Workforce Health and Wellbeing

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Staff Psychological Wellbeing Cell in place Identification of 270 peer vaccinators in order to increase flu vaccination uptake amongst staff during 2020. Head of Staff Health & Wellbeing attends Immunisation Silver meetings to help inform the strategic plan for COVID-19 vaccination, including staff. Additional staff deployed to Occupational Health at the commencement of the COVID Pandemic. Continued development and expansion of the Staff Wellbeing Service, including the provision of additional counselling resource, training to recognise signs of trauma in staff, and mechanisms and initiatives for dealing with it. Implementation of HB Home Working Policy	Both the Staff Health and Wellbeing Service and Occupational Health Service have won national awards. Detailed staff Attendance Management update reports received and reviewed at W&OD Committee Results of HB Working From Home Survey reported to the W&OD Committee. Operational Plan performance tracker reports.	 ✓ ✓	 ✓	✓			Expand trauma management training and support to staff in critical areas Review/Revision of W&OD plans for supporting absence reduction, in order to ensure that focus continues to be in the correct areas. Develop and implement a Health Board Agile Working Framework.

6.2	Workforce Planning and Recruitment

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Workforce and OD framework in place. Planning tool developed to assist in the workforce planning process, including elements such as baseline sickness absence, COVID related absence, turnover etc. Detailed workforce capacity plans developed for identified priority areas, and reported as part of the Operational Plan. This included Surge and Super Surge (Field Hospitals). Significant recruitment of HCSW and Newly Qualified Nurses, both via bank and fixed term contracts. Ongoing overseas recruitment campaign. Extension of contract for the supply of AHPs and Medical Locums	Workforce and OD Committee oversight Workforce and OD Committee updates to the Board 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. A&A Report SBU-1920-039 WOD Framework Substantial Assurance A&A Report SBU-1920-042 DBS Checks Reasonable Assurance A&A Report SBU-1819-042 Junior Doctor Bandings (Follow-Up) Reasonable Assurance A&A Report SBU-1718-046 EWTD Limited Assurance		✓ ✓ ✓	 ✓ ✓ ✓ ✓	Recruitment and retention plan(s) to be produced in support of the Workforce and Organisational Development Framework. Progress on adoption of draft guidance documents in respect of junior doctors hours and handover procedures. Lack of Health Board-wide policy or procedure which supports EWTD.	Identified potential to enhance clarity and detail of reporting to the Workforce & OD committee in respect of Disclosure and Barring Service (DBS) checks undertaken	A strategy for the recruitment of medical and dental staff will be put in place. The development of strategies and plans for other staff groups will be discussed with the Executive Team Content of reports to the Workforce & OD Committee will be reviewed and updated. Draft guidance documents in respect of junior doctors will be reviewed to take account of recent legal rulings, and implemented. EWTD policy/guidance will be composed. Workforce plans to remain dynamic and under constant review in order to respond to changing circumstances.

6.3	Workforce Training

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Training cell enabled to access training demand and capacity across the HB for new, returning and redeployed staff, to include considerations around COVID. Accelerated training programme for HCSW established. AHP Health Care Support Worker Training delivered in order to reskill existing staff to undertake HCSW roles within acute clinical settings. Blended training approach developed for Postgraduate and Undergraduate teaching in response to COVID restrictions, involving both virtual and face-to-face elements. Condensed new registrant induction programme developed – delivered at the Liberty Stadium.	Workforce and OD Committee oversight Workforce and OD Committee updates to the Board Workforce training issues and updates are reported through various committee fora and to the board via a number of service-specific update reports.	 ✓	✓ ✓		Multi-disciplinary education, training and development plan(s) to be produced in support of the Workforce and Organisational Development Framework.		The development of a plan, or suite of plans, will be considered alongside the reintroduction of reinstatement of the 'Education Forum' once appropriate resources are appointed.

6.4	**Non Compliance with Nurse Staffing Levels Act (HBRR 51)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Nurse Staffing Act Steering Group established. Formal review undertaken across all Delivery Units (now Service Groups) to ensure a consistent approach to reporting nurse staffing requirements. Nurse Staffing Act (Wales) guidance issued, and Welsh Levels of Care and Operational Handbook circulated Enhanced Supervision Framework introduced in March 2020 in response to increased patient acuity levels. Paediatric Task & Finish Group established in preparation for the extension of the Act **Additional Controls (Oct 2020)** Unit Nurse Directors working with Delivery Group in the development of workforce plans to address COVID escalation. Nurse Staffing & Workforce meetings chaired by the Interim Director of Nursing & Patient Experience, covering key areas such as 'hotspots', roster scrutiny and deployment of nursing staff. Corporate Nurse Staffing 7-day rota introduced. Recently retired registered staff contacted with a view to returning to the Health Board. Appropriate utilisation of student nurses and bank staff.	Periodic assurance and statistical reporting to the W&OD Committee and the Board, outlining compliance and key risks. Report to Board outlining action taken to ensure appropriate nurse staffing during the COVID-19 pandemic, and 'Once for Wales' approach to calculating and reporting nurse staffing levels (May 2020). Reported improvement with quality indicators showing a reduction in falls, pressure damage, complaints, length of stay and medication errors on wards previously invested in under the remit of the Act. Audit & Assurance Report (SBU-1920-041) Reasonable Assurance Audit & Assurance Report Follow-up Review only (SBU-2021-040) Substantial Assurance	✓ ✓ ✓		 ✓ ✓	'Safecare' acuity-based rostering tool not yet fully implemented across all relevant wards.	The annual assurance paper to the Board does not present data on the extent to which the calculated nurse staffing levels are achieved during the year.	Implementation of Daily Staffing Tool across the Delivery Groups to maintain a consistent approach. Develop and implement a system which allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster (All Wales). Rollout of the 'Safecare' acuity-based rostering tool across all wards that report under the Nurse Staffing Act (Wales)

Enabling Objective 7 – Outstanding Research, Innovation, and Education & Learning	
Principle Risk – Failure that the Health Board will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	
Executive Lead – Executive Medical Director	Assuring Committee – Quality & Safety Committee

7.1	**Outstanding Research, Innovation, and Education & Learning**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Research & Development Committee Board for Joint Research Facility IMTP/Annual Planning Process Annual meetings with Health Education & Improvement Wales Deanery visits Recommencement of research activity (post COVID) is overseen by the Reset & Recovery programme. Quality Impact Assessments submitted to ensure that clinical research is able to be conducted safely.	Updates to the Research & Development Committee and Joint Research Facility Annual Report to the Board Performance data reports from Health & Care Research Wales GMC Feedback Feedback from Deanery visits	✓	✓	✓ ✓ ✓			Development of Innovation Hub and associated Multi-Disciplinary Team (MDT)