



Bwrdd Iechyd Prifysgol  
Bae Abertawe  
Swansea Bay University  
Health Board



<b>Meeting Date</b>	<b>29<sup>th</sup> September 2022</b>	<b>Agenda Item</b>	<b>2.2</b>	
<b>Report Title</b>	<b>Board Assurance Framework (BAF)</b>			
<b>Report Author</b>	Len Cozens, Head of Compliance			
<b>Report Sponsor</b>	Hazel Lloyd, Acting Director of Corporate Governance			
<b>Presented by</b>	Hazel Lloyd, Acting Director of Corporate Governance			
<b>Freedom of Information</b>	Open			
<b>Purpose of the Report</b>	The purpose of this report is to inform the Board of work being undertaken to develop the Board Assurance Framework (BAF) document.			
<b>Key Issues</b>	<p>A review of the Risk Management and Board Assurance Framework was completed at the end of the last financial year by NWSSP Audit &amp; Assurance Services. The final report on this review derived a Reasonable assurance rating, although the assurance rating for the BAF element of the report was limited.</p> <p>The format, structure and content of the BAF has been reviewed in light of the findings of the audit findings, and the revised document is aligned with the 2022/23 – 2024/25 Recovery &amp; Sustainability plan and the Health Board Risk Register.</p> <p>The revised BAF has been shared with Independent Members, following work completed by the Head of Compliance working with the Executive Directors and the Management Board.</p> <p>Through the work of the development of the revised BAF, it has been identified that consideration will be given, in terms of how, from a governance perspective: population health and partnership; capital programme; and estates infrastructure will be reported within the organisation. These areas will be factored into a review of Committees planned work for the autumn of 2022/23 and will also feature in the next iteration of the BAF.</p>			
<b>Specific Action Required</b> <i>(please choose one only)</i>	<b>Information</b>	<b>Discussion</b>	<b>Assurance</b>	<b>Approval</b>
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Recommendations</b>	Members are asked to:			

	<ul style="list-style-type: none"><li>• <b>NOTE</b> the revised Board Assurance Framework (BAF), acknowledging that it is an iterative document which will continue to be reviewed, updated and developed;</li><li>• <b>AGREE</b> to receiving the document as a minimum three times a year.</li></ul>
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# BOARD ASSURANCE FRAMEWORK (BAF)

## 1. INTRODUCTION

- 1.1 The purpose of this report is to request that the Board review and discuss the Health Board's updated Board Assurance Framework (BAF) document.

## 2. BACKGROUND AND CONTEXT

- 2.1 The process of gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. With this in mind, the BAF is intended to enable the Board to:

- Identify and understand the principle risks to achieving its objectives
- Establish the sources of assurance (both positive and negative) in respect of the adequacy, suitability, completeness and operation of the controls in place to manage those risks.
- Receive assurance that, where gaps in control or assurance are identified or the need for improvement has been highlighted, appropriate action is being taken.
- Provide an overall assessment of the risk to achieving the objectives based on the strength (or otherwise) of the controls and assurance in place.

- 2.2 In summary, the BAF provides a framework for identifying which of the Health Board's objectives are at risk because of inadequacies in controls or insufficient assurance about them. At the same time, it provides structured assurance about risks which are being managed effectively, and objectives that are being delivered.

- 2.3 The most objective assurance comes from independent external review sources. These are supplemented by internal sources such as clinical audit, internal management, performance management and self-assessment reports.

## 3. STATUS UPDATE

- 3.1 The Board Assurance Framework was last presented to the Health Board at its meeting in July 2022.

- 3.2 NWSSP Audit & Assurance colleagues completed a review of Risk Management and the Board Assurance Framework (report **SB-2122-001** refers), which attained a 'Reasonable' assurance rating, although the BAF element was limited assurance.

- 3.3 The foregoing notwithstanding, the report highlighted the fact that there was a substantial level of detail contained within the BAF, leading to a lengthy document (41 pages at the time of that report). The report recommended that there may be scope to consolidate some elements of the BAF, thus simplifying the document and sharpening its focus.

- 3.4 This coincided with ongoing discussions within the Health Board around the overall structure of the BAF, during which it was agreed that it be realigned under

objectives contained within the Health Board's 2022/23 – 2024/25 Recovery & Sustainability plan (as opposed to the Enabling Objectives used previously).

- 3.5 Initial work was undertaken to explore potential revised objectives, and draft proposals were subsequently shared with Executive Directors at an Executive Team meeting and further work has been carried out working with the Director of Strategy's team.
- 3.6 Further more detailed work was then undertaken in order to restructure the Board Assurance Framework along the above agreed lines. The main changes are summarised as follows:
  - The document now reports under six main headings, directly aligned to the Health Board Recovery & Sustainability plan, this will evolve with the plan.
  - Each objective is fully cross-referenced to the principle strategic/corporate risk(s) to achievement, as detailed in the Health Board Risk Register, including the most up-to-date risk score. The Head of Compliance will continue to work with the Deputy Head of Risk & Assurance to ensure that this key link is maintained and updated on an ongoing basis.
  - The section detailing the key controls in place to assist in delivery against each objective has been brought more to the front of each section in order to create greater emphasis.
  - Much of the duplication of content with the Health Board Risk Register has been removed.
- 3.7 The revised BAF has been shared with Independent Members and positive feedback was received in terms of the direction of travel. It was also agreed that the BAF would be presented to meetings of the Committee Chairs on a regular basis in order to inform their respective agenda planning processes.
- 3.8 The BAF was also presented to the Management Board. As a result of feedback received at that meeting, the Acting Director of Corporate Governance and Head of Compliance then met with each Executive Director individually in order to develop the document further.
- 3.9 In addition to the revision of the document itself, the Head of Compliance has also drafted a timetable for the ongoing review and update of the BAF by the Executive Directors and their teams. The timetable is based on a quarterly review process, with key dates linked to the Management Board, Audit Committee and Health Board reporting cycles.
- 3.10 The Board Assurance Framework is an evolving and iterative document, subject to an ongoing programme of review and update. As a result of feedback received during the meetings with Executive Directors referred to at 3.8 work has been carried out to include a Finance entry and further work will be carried in terms of estates infrastructure; capital programme and population health and partnership from a governance perspective and will feed into planned work to look at the committee structures in the autumn.

#### 4. FINANCIAL IMPLICATIONS

- 4.1 There are no direct financial implications arising from the recommendations in this report.

#### 5. RECOMMENDATIONS

- **NOTE** the revised Board Assurance Framework (BAF), acknowledging that it is an iterative document which will continue to be reviewed, updated and developed; and
- **AGREE** to receiving the document as a minimum three times a year.

<b>Governance and Assurance</b>		
<b>Link to Enabling Objectives</b> <i>(please choose)</i>	<b>Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities</b>	
	Partnerships for Improving Health and Wellbeing	<input checked="" type="checkbox"/>
	Co-Production and Health Literacy	<input type="checkbox"/>
	Digitally Enabled Health and Wellbeing	<input type="checkbox"/>
	<b>Deliver better care through excellent health and care services achieving the outcomes that matter most to people</b>	
	Best Value Outcomes and High Quality Care	<input checked="" type="checkbox"/>
	Partnerships for Care	<input type="checkbox"/>
	Excellent Staff	<input type="checkbox"/>
	Digitally Enabled Care	<input type="checkbox"/>
	Outstanding Research, Innovation, Education and Learning	<input type="checkbox"/>
<b>Health and Care Standards</b>		
<i>(please choose)</i>	Staying Healthy	<input type="checkbox"/>
	Safe Care	<input checked="" type="checkbox"/>
	Effective Care	<input checked="" type="checkbox"/>
	Dignified Care	<input checked="" type="checkbox"/>
	Timely Care	<input checked="" type="checkbox"/>
	Individual Care	<input checked="" type="checkbox"/>
	Staff and Resources	<input checked="" type="checkbox"/>
<b>Quality, Safety and Patient Experience</b>		
Ensuring that the Board and its Sub-Committees make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making the decisions. Informed decisions are most likely to impact favourably on the quality, safety and experience of patients and staff.		
<b>Financial Implications</b>		
There are no direct financial implications arising from this paper		
<b>Legal Implications (including equality and diversity assessment)</b>		
Ensuring that the organisation has an effective and evolving Board Assurance Framework (BAF) that supports the Board in delivering its plans and achieving its objectives, is an essential component of the Health Board's governance arrangements going forward.		
<b>Staffing Implications</b>		
The further development and embedding of the BAF will require a significant amount of work on the part of Executive colleagues and their teams.		
<b>Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)</b>		
The development of the BAF will assist the Board in assessing risk and gathering assurance across all corporate objectives, which span the five ways of working, and the wellbeing goals identified in the Act.		
<b>Report History</b>	N/A	
<b>Appendices</b>	Appendix 1 Board Assurance Framework (BAF)	



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## BOARD ASSURANCE FRAMEWORK (BAF)

## Approach to Risk Assessment – Risk Scoring = Consequence X Likelihood

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

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
<b>5 Catastrophic</b>					
<b>4 Major</b>					
<b>3 Moderate</b>					
<b>2 Minor</b>					
<b>1 Negligible</b>					

### Assurance Ratings

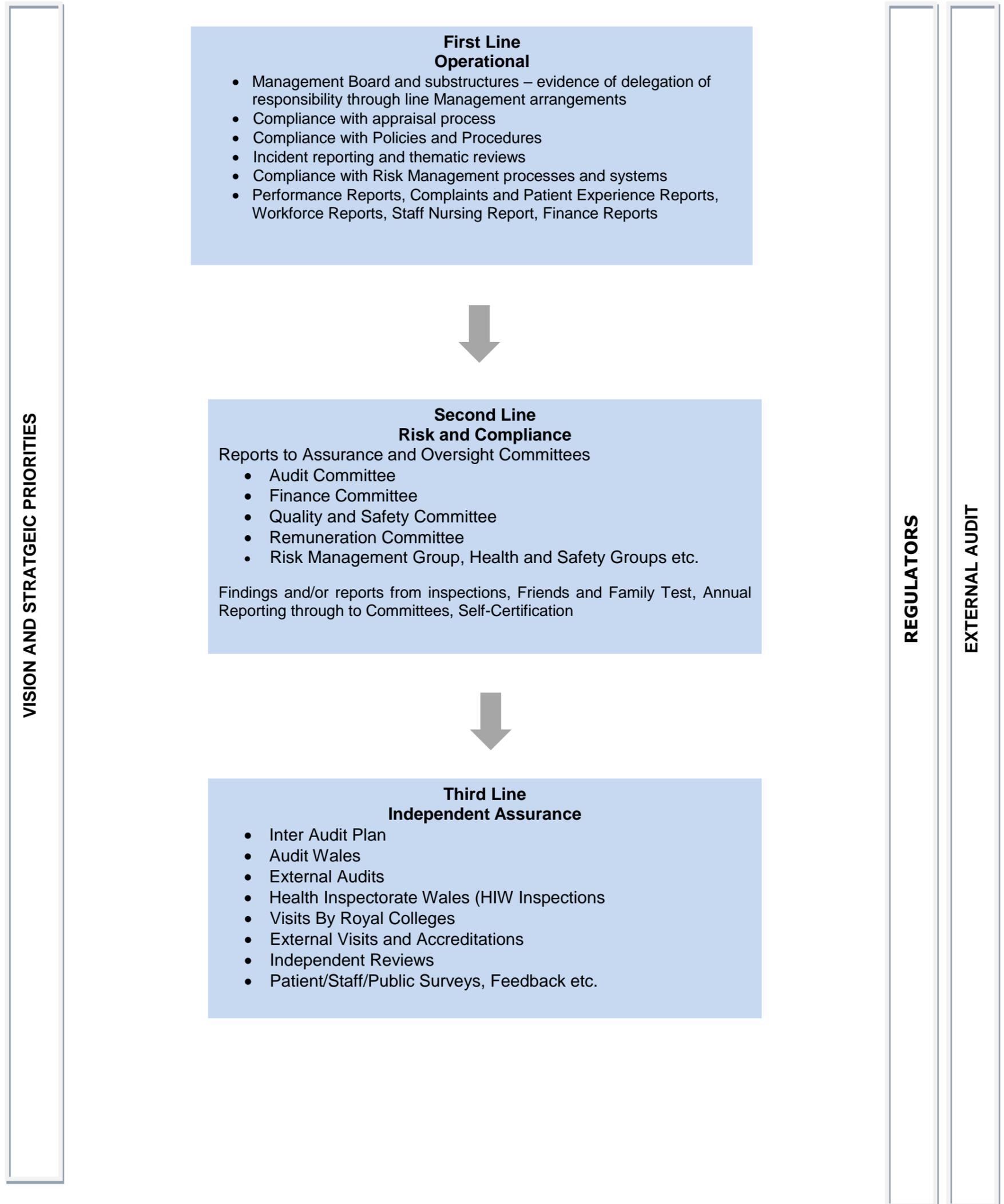
 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature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

## Levels of Assurance



<b>BAF 1: Quality Services</b>					
<b>Principle Risk:</b> 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.			<b>Trend:</b>		
			<b>Assurance Rating:</b>		
<b>Executive Lead(s):</b> Executive Director of Nursing Executive Medical Director Director of Therapies & Health Science		<b>Assuring Committee:</b> Quality & Safety Committee			
<b>Associated HBRR Entries:</b> 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)			
<b>Key Controls:</b>					
<ul style="list-style-type: none"> <li>– Programme/Project structure in place to drive delivery of Annual Plan/Recovery &amp; Sustainability Plan priorities</li> <li>– Clinical Audit &amp; Effectiveness Policy, which sets out the hierarchy of audit reviews</li> <li>– Clinical Audit &amp; Effectiveness Team in place</li> <li>– Clinical Outcomes &amp; Effectiveness Group (COEG) established</li> <li>– Audit Management and Tracking (AMaT) system in place to support Service Delivery Groups and departments with improved monitoring and reporting on clinical audit progress.</li> <li>– Review of LocSSIP and WHO Surgical Checklist audits form standing agenda items at meetings of the Clinical Outcomes and Effectiveness Group (COEG)</li> <li>– Approved local SBUHB Mortality Review Framework document and SOP in place.</li> <li>– Health Board Policy to Determine the Requirements for Home Office CD Licenses in place</li> <li>– National Infection Control Manual supplemented by local policies, procedures, protocols and guidelines.</li> <li>– We have IPC action plans in place for all service groups with clear accountability lines for improvement</li> <li>– BI support for quality improvements and quality outcomes supported with data required down to ward level with early warning of infection risks..</li> <li>– Infection prevention and control related training programmes</li> <li>– Documented Cleaning Strategy/Policy in place. Enhanced ward cleaning by domestic staff being considered to free nursing time for direct patient care</li> <li>– Quality &amp; Safety Committee in place with approved Terms of Reference, supported by a <b>Quality &amp; Safety of Patient Services Group</b>.</li> <li>– Quality &amp; Safety Process Framework in place, Approved by Q&amp;SC and Executive Board</li> <li>– Established Quality &amp; Safety forums in place at Service Group level.</li> </ul>					
<b>Forms of Assurance</b>	<b>Levels of Assurance</b>			<b>Gaps in Control/Assurance or Identified Areas for Improvement</b>	<b>Agreed Action</b>
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
All levels of clinical audit activity will be monitored by COEG and reported to the <b>Quality &amp; Safety of Patient Services Group</b> , who in turn report to the Quality & Safety Committee. Clinical Audit midyear and annual reports received and scrutinised by the Audit Committee  Quarterly mortality review reports to the Quality & Safety Committee (commenced August 2021)  A&A Report ABM-1819-022 Clinical Audit & Assurance – Limited Assurance	x			Identified scope to improve oversight and reporting on the completion of WHO/LocSSIP checklists at both a Service Group and Corporate Level.  The HB currently has limited assurance regarding compliance with Home Office CD licensing requirements.	HB to discuss and agree a policy position on the requirements for HOCD licenses with the Home Office. Once agreed, this will be followed by a baseline assessment of current CD management, and implementation of a control system to ensure compliance. <b>01/09/2022</b>

<p>A&amp;A Report ABM-1819-025 Mortality Reviews – Limited Assurance</p> <p>A&amp;A Report SBU-2021-028 Mortality Reviews – Limited Assurance</p> <p>A&amp;A Report SBU-1920-021 WHO Checklist – Limited Assurance</p> <p>A&amp;A Report SBU-2021-026 WHO Surgical Safety Checklist (F/UP) – Limited Assurance</p> <p>A&amp;A Briefing Paper SBU-2122-006 Controlled Drugs Governance – No Assurance Rating Given</p> <p>Clear corporate and Service Group IPC assurance framework in place, which reflects the HCAI quality priority actions.</p> <p>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.</p> <p>A&amp;A Report SBU-2021-025 Infection Control (Cleaning) – Reasonable Assurance</p> <p>A&amp;A Report SBU-2122-002 Quality &amp; Safety Framework – Limited Assurance</p> <p>Audit Wales 2714A2021-22 Review of Quality Governance Arrangements (SBUHB)</p>			<p>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</p> <p>x</p> <p>x HB incidence of key Tier 1 infections per 100,000 population above all-Wales rates.</p> <p>x Quality &amp; Safety Process Framework requires review/refresh in light of the impact of COVID, and development of an action plan to support its implementation.</p> <p>x Operational managers' approach to risk management is inconsistent, with risk registers often incomplete and missing mitigating actions.</p> <p>x</p> <p>x</p> <p>x</p> <p>x</p> <p>x</p> <p>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.</p> <p>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.</p>	<p>Medicines Management colleagues to further progress work on the design and implementation of revised controlled drug governance systems and processes, in conjunction with Service Groups. <b>30/09/2022</b></p> <p>Development of a Ward-to-Board Dashboard on key Tier 1 infections. <b>31/07/2022</b></p> <p>In progress. This will form part of the quality workshops to design the quality management system. <b>30/09/2022</b></p> <p>Series of risk workshops was completed in NPTS Service Group in late summer. The training will be rolled out to other service groups during the next two quarters, with progress reported to the Risk Management Group and Management Board. <b>30/09/2022</b></p> <p>A programme of service group risk register presentations for 2022 has been agreed. Service groups will report on processes in place to manage and scrutinise their registers, and present their registers with a focus on their top risks. This will commence from March 2022 and the programme will complete by the end of the calendar year. <b>31/12/2022</b></p> <p>Health Board culture programme underway which will include a culture audit. These issues will be addressed as part of this work. <b>31/12/2022</b></p> <p>Progress will be monitored via local service group meetings and Management Board, and reported to the Workforce &amp; OD Committee. <b>30/09/2022</b></p>
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BAF 2: Workforce					
<b>Principle Risk:</b>	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.			<b>Trend:</b>	
	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			<b>Assurance Rating:</b>	
<b>Executive Lead(s):</b> Director of Workforce & OD			<b>Assuring Committee:</b> Workforce & OD Committee		
<b>Associated HBRR Entries:</b> HBRR 3 – Recruitment of Medical & Dental Staff (20)			HBRR 76 – Partnership Working with Trade Unions (10) HBRR 77 – Impact of COVID on Staff Wellbeing (12)		
<b>Key Controls:</b>					
<ul style="list-style-type: none"> <li>– Established Workforce &amp; Organisational Development Committee in place</li> <li>– Multi-disciplinary Occupational Health Service in place providing timely advice for managers and staff regarding management of health in the workplace</li> <li>– 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</li> <li>– The Health board has invested in the TRiM programme (Trauma Risk Management)</li> <li>– Wellbeing Champions in place, supporting teams and services</li> <li>– Post-COVID Staff Wellbeing Strategy has been developed to outline additional support available for staff</li> <li>– Local bank/Agency booking processes have been reviewed, and revised management controls introduced (Feb 2022)</li> <li>– Regular periodic review of block booked bank staff taking place (Feb 2022)</li> <li>– KPI's for nurse roster management have been reviewed, and form part of the regular nurse staffing meetings (Feb 2022) – this includes EWTD controls</li> <li>– Staff Experience and Organisational Development plan in place</li> <li>– All areas have been allocated L&amp;OD support for development of local staff action plans to improve the staff experience</li> <li>– Clearly articulated organisational values</li> <li>– Chief Executive and other Executive Directors attend HB Partnership Forum on a regular basis.</li> <li>– Speciality based local workforce boards established</li> <li>– Established partnership working and engagement initiatives with key stakeholders.</li> <li>– Workforce Planning function in place which facilitates the design, redesign and development of workforce plans for all staff groups</li> <li>– HB Home working and flexible working policies have been revised and reissued</li> </ul>					
Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Reporting to and oversight by the Workforce and Organisational Development Committee on the following: <ul style="list-style-type: none"> <li>– Workforce Metrics (every meeting)</li> <li>– Medical Workforce efficiencies (every meeting)</li> <li>– Recruitment &amp; Retention (every Meeting)</li> <li>– Attendance, Wellbeing &amp; Occ. Health (3 x per year)</li> <li>– Workforce Risk Register (3 x per year)</li> <li>– Nurse Staffing (Wales) Act 2016 (5 x per year)</li> <li>– Guardian Service (bi-annual update)</li> <li>– Update on PADR Compliance (2 x per year)</li> <li>– Statutory &amp; Mandatory Training Compliance (2 x per year)</li> <li>– Medical Revalidation (2 x per year)</li> <li>– Equality Report (Annually)</li> <li>– Nursing &amp; Midwifery Board Update (every meeting)</li> <li>– Medical Workforce Board Update (every meeting)</li> <li>– Therapies &amp; Health Science Group Update (every meeting)</li> </ul>	x	x	x	<p>The OH Team do not typically receive feedback from stakeholders on the effectiveness of the service in order to identify areas for improvement or development.</p> <p>Underutilisation of Case Conferences between staff member, OH, line manager and Staffside rep to develop early intervention return to work plans.</p> <p>Lack of timely sickness absence data</p> <p>Need for bank and agency staff continues.</p>	<p>The requirement to implement a robust evaluation mechanism for OH Services is included as part of service development and fully implemented <b>30/06/2022</b></p> <p>OH to work with HR Ops team and Line managers to introduce case conferences, – SOP with staff-side for feedback before implementation <b>30/6/2022</b></p> <p>Project to review workforce informatics <b>31/12/22</b></p> <p>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. <b>01/09/2022</b></p>
Both Staff Health & Wellbeing Service and Occupational Health	x			Lack of Health Board-wide policy or procedure which supports EWTD	

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		x		EWTD guidance has been drafted, and and has been circulated for comment. Anticipated to be presented to staff side by 30/6/22 <b>30/06/2022</b>
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			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.	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. <b>TBC</b>
A&A Report SBU-2122-024 – Staff Wellbeing & Occ Health Reasonable Assurance	x				
Weekly reporting of Bank and Agency usage to service groups as well as monthly Corporate Nurse staffing meetings				Need to enhance clarity and detail of reports to the W&OD committee in respect of Disclosure and Barring Service (DBS) checks undertaken	Report to be produced for Workforce & OD Committee in respect of completion of DBS Clearance of staff currently employed but not previously checked, to include clear reporting of progress against milestones. <b>30/06/2022</b>
Each service group also have local reporting mechanisms for bank and agency spend			x		
Monthly Roster scrutiny meetings held across all service groups and Corporate Nurse staffing meetings	x		x	Lack of Workforce and OD Delivery Group to oversee operational delivery of workforce priorities	Workforce and OD Delivery Group set up with first meeting scheduled in July 2022 <b>31/07/2022</b>
KPI reports are sent to service groups weekly					
A&A Report SBU-1718-046 – EWTD Limited 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. <b>(30/09/2021) - Development</b> <b>(31/03/2022) – Implementation.</b>
A&A Report SBU-1819-043 – Staff Performance Mgmt. & Appraisal. Limited Assurance					
Service Groups are invited to Workforce & OD Committee to present local actions plans to improve the staff experience.					In conjunction with professional heads, develop and implement a retention strategy to address retention issues. <b>31/03/2022</b>
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	x			Contract with external company to develop branding and attraction campaign for HB. <b>31/10/2022</b>
Permanently funded central resourcing team from 2022/23 financial year	x			Progress the adoption of draft guidance documents in respect of junior doctors' hours and handover procedures.	Draft guidance documents in respect of junior doctors will be reviewed. This has slipped due to workforce pressures and priorities. Aim is that matters will progress during Q1/2 2022/23, pending exploration of new junior doctor contract. <b>31/06/2022</b>
Overseas nursing campaign for 200 Nurses funded for 2022/23	x				
Streamlined recruitment for medical staff including retrospective VCP and anticipatory recruitment for medical posts linked to major rotations.			x	Delay of national staff survey which is commissioned by Welsh Government with no fixed role out date.	
Working with head hunter agencies to recruit hard to fill medical posts					
A&A Report SBU-1920-039 – WOD Framework Substantial Assurance			x		
A&A Report SBU-1920-042 – DBS Checks Reasonable Assurance			x		
A&A Report SBU-1819-042 – Junior Doctor Bandings (Follow-Up) Reasonable Assurance			x		

<b>BAF: 3 Sustainable Clinical Services</b>			
<b>Principle Risk:</b>	If we fail to change then we will not be able to deliver a sustainable clinical model which may result in: <ul style="list-style-type: none"> <li>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;</li> <li>Not achieving acceptable waiting times for urgent and emergency care;</li> <li>Not reducing our over-lengthy hospital stays, and consequently delays in patients being discharged;</li> <li>Not improving access for routine medical and surgical treatments; and</li> <li>Staff not feeling supported at work.</li> </ul>	<b>Trend:</b>	
		<b>Assurance Rating:</b>	

<b>3.1</b>	<b>Primary &amp; Community Care</b>	<b>Associated HBRR Entries:</b> None			
<b>Executive Lead (s):</b> Chief Operating Officer		<b>Assuring Committee:</b> Performance & Finance Committee			
<b>Key Controls:</b> – Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities					
Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board A&A Report SBU-2122-023 General Dental Services (GDS) – Substantial Assurance A&A Report SBU-2021-013 Primary Care Cluster Plans & Delivery – Reasonable Assurance		X	X		

<b>3.2</b>	<b>Mental Health &amp; Learning Disabilities Care</b>	<b>Associated HBRR Entries:</b> HBRR 43 – Deprivation of Liberties/Liberty Protection Safeguards (12)			
<b>Executive Lead (s):</b> Chief Operating Officer		<b>Assuring Committee:</b> Performance & Finance Committee			
<b>Key Controls:</b> – Established Mental Health Legislation Committee in place – Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities					
Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board A&A Report SBU2122-023 Mental Health Legislative Compliance – Reasonable Assurance		X	X	Insufficient Best Interests Assessor (BIA) resource available. Limited rota uptake due to inability to release staff. Scope identified to enhance reporting to the Mental Health Legislation Committee in respect of assurance on legislative compliance. Inconsistencies in reporting noted in respect of Mental Capacity Act and Deprivation of Liberty Safeguards training.	Business case for the revised service model to deliver Liberty Protection Safeguards is being developed. <b>30/09/2022</b> An exercise to be undertaken to ‘map’ legislation and codes of practice to Mental Health Legislation Committee reports. A revised programme of training will be put in place.

3.3	<b>Networked Hospitals - A Systems Approach</b> <b>Urgent &amp; Emergency Care</b>	<b>Associated HBRR Entries:</b> <b>HBRR 1 – Access to Unscheduled Care Services (25)</b> <b>HBRR 80 – Unable to Discharge Clinically Optimised Patients (20)</b> <b>HBRR 82 – Risk of Closure of Burns Service: Anaesthetic Consultant Cover (16)</b>				
<b>Executive Lead (s):</b> Chief Operating Officer		<b>Assuring Committee:</b> Performance & Finance Committee				
<b>Key Controls:</b> <ul style="list-style-type: none"> <li>– Programme/Project structure in place to drive delivery of Annual Plan/Recovery &amp; Sustainability Plan priorities</li> <li>– 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.</li> <li>– Performance &amp; Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Unscheduled Care reports received from the COO</li> <li>– An integrated Unscheduled Care Plan has been developed with partners, based around the WG Six Goals for Urgent &amp; Emergency Care, and approved by the West Glamorgan Regional Partnership Board.</li> <li>– An Urgent and Emergency Care Network Board has been established to oversee the Health Board’s Unscheduled Care Plan.</li> <li>– Programme Management Office (PMO) in place to improve Unscheduled Care</li> <li>– Health Board Representation on the National Unscheduled Care Board.</li> <li>– Development of a ‘Phone First for ED’ model in conjunction with 111 to reduce demand</li> <li>– Implementation of Consultant Connect for major referring specialties</li> <li>– H2H implemented, developed into Rapid Discharge to Assess pathway in line with WG directive.</li> <li>– SAFER – Patient Flow and Discharge Policy in place</li> <li>– 24/7 Ambulance triage nurse in place.</li> <li>– Patient level dashboard in place, which allows breakdown of clinically optimised patient numbers by delay type</li> <li>– Direct Pathway to Older Person’s Assessment Service (OPAS) implemented and operational hours extended.</li> <li>– Establishment of virtual wards aligned to GP clusters.</li> </ul>						
<b>Forms of Assurance</b>		<b>Levels of Assurance</b>			<b>Gaps in Control/Assurance or Identified Areas for Improvement</b>	<b>Agreed Action</b>
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	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	x	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.
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	x	x		Development of new audit tools and SOP to accompany the revised SAFER Policy.
Rapid Discharge to Assess pathway performance monitored via H2H implementation group and reported to Community Silver.		x				
A&A Report (SBU-1920-025) Discharge Planning Limited Assurance				x		
WAO Report 255A2017-18 Discharge Planning No Assurance Rating Given				x		

3.4	<b>Networked Hospitals – A Systems Approach Planned Care</b>	<b>Associated HBRR Entries:</b> HBRR 16 – Access and Planned Care (20) HBRR 58 – Ophthalmology Follow-Up Clinic Capacity (20)
<b>Executive Lead (s):</b> Chief Operating Officer		<b>Assuring Committee:</b> 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
  - Ophthalmology 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
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Three serious incident reports were reported in Ophthalmology during 2021.	Overall Regional Ophthalmic Sustainability Plan to be delivered <b>31/03/2022</b>
Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board		x			Additional ophthalmology day case theatre will be operational at Singleton during 2022. <b>31/07/2022</b>
A&A Report SBU-2021-015: Adjusting Services: QIA Reasonable Assurance			x	Adequate Burns Anaesthetics cover may not be sustained, potentially resulting in closure to this regional service	Capital funding bid to Welsh Government for work required to co-locate the burns service with General ITU <b>31/05/2022</b>
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	There is no immediate access to crash team/ICU facilities in Parkway Clinic – the client group are undergoing G/A/sedation. Medical Safety risk GAs performed on children outside of an acute hospital setting.	Relocation of the paediatric GA service provided by Parkway Clinic to a hospital site. <b>31/05/2023</b>
Assurance documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morrision Hospital for transfer and treatment of patients	x				
Parkway Clinic HIW Inspection Visit Documentation provided to HB			x	There is currently a gap in assurance around our ability to deliver >52 and >104 day waits, and elimination of endoscopy waits.	

<b>3.5</b>	<b>Networked Hospital – A Systems Approach Cancer Care</b>	<b>Associated HBRR Entries:</b> <b>HBRR 50 – Access to Cancer Services (25)</b> <b>HBRR 66 – Access to Cancer Treatment SACT (20)</b> <b>HBRR 67 – Access to Radiotherapy Treatment (15)</b>
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<b>Executive Lead (s):</b> Executive Medical Director	<b>Assuring Committee:</b> Performance & Finance Committee
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<b>Key Controls:</b> <ul style="list-style-type: none"> <li>– Programme/Project structure in place to drive delivery of Annual Plan/Recovery &amp; Sustainability Plan priorities</li> <li>– Performance &amp; 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.</li> <li>– Establishment of Health Board Cancer Performance Group, which will support execution of service delivery plans for improvements and report to the Cancer Performance Board</li> <li>– Prioritised pathway in place to fast track Urgent Suspected Cancer patients. Process developed to manage each individual case on the USC pathway.</li> <li>– Enhanced/weekly monitoring of action/improvement plans for top 6 tumour sites.</li> <li>– Weekly cancer performance meetings for both NPTS and Morriston Service Groups.</li> <li>– Weekly Clinical Lead Recovery Planning meetings being held in Endoscopy.</li> <li>– National Endoscopy Programme (NEP) deferred patient spreadsheet utilised to track deferred procedures, surveillance, screening and USC patients.</li> <li>– Faecal Immunochemical Testing (FIT) implemented for low risk groups. Primary care roll-out commenced (February 2022)</li> <li>– Redesigned endoscopy Straight To Test (STT) pathway implemented (December 2021)</li> <li>– Increased service provision in respect of Capsule Endoscopy, PH Manometry and hydrogen breath test procedures</li> <li>– 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.</li> <li>– 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.</li> <li>– Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place.</li> <li>– Requests for radiotherapy treatment and treatment dates monitored by senior management team.</li> <li>– Outsourcing of appropriate radiotherapy cases (additional outsourcing for Prostate RT commenced June 2021).</li> </ul>
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Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
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)	Phased and sustainable solution to the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services <b>30/09/2022</b>
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.	Capacity increased within CT/MRI via recruitment and extended working hours. Further increase to 6 day working planned for 22/23, subject to funding. <b>31/03/2023 (Subject to Funding)</b>
Operational Plan performance tracker reports.		x			Business case for delivery of Acute Oncology Services (AOS) from Morriston Hospital approved by Business Case Advisory Group. Currently out to advert to recruit workforce. Implementation planned for end of Q2. <b>30/09/2022</b>
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. Business case to presented by and of Q2 (ARCH) <b>30/09/2022</b>
Radiotherapy performance and activity data monitored and shared with radiotherapy management team and cancer board.		x		The Health Board scores below average in all but two of the seven priorities of care from the National Audit of Care at the End of Life (NACEL) 2019/20.	Business Case for phase 2 home care expansion based on moving further treatments to community service. Paper with CEO for comments, prior to going to BACG <b>30/09/2022</b> Relocation of CDU to vacant ward area which would increase chair capacity (linked to AMSR Programme and Phase 2 of Homecare expansion). <b>31/01/2023</b> <b>Operationalise plans for offering hypo fractionated prostate treatment 01/09/2022</b> Case agreed with Welsh Government for third Linear Accelerator <b>01/04/23</b>

3.6	Children, Young People & Maternity Services	<b>Associated HBRR Entries:</b> 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 Inpatient Wards (20)	HBRR 74 – Delays in Induction/Augmentation of Labour (20) HBRR 81 - Critical Midwifery Staffing Levels (20) HBRR 85 – Non-Compliance with ALNET Act (20)		
<b>Executive Lead (s):</b> Executive Director of Nursing		<b>Assuring Committee:</b> Performance & Finance Committee			
<b>Key Controls:</b> <ul style="list-style-type: none"> <li>- Established Nursing &amp; Midwifery Board in place</li> <li>- Programme/Project structure in place to drive delivery of Annual Plan/Recovery &amp; Sustainability Plan priorities</li> <li>- Project Board established to oversee installation of central cardiotocograph monitoring system, and necessary training</li> <li>- Health Board Maternity Ultrasound Group convened to develop future ultrasound services</li> <li>- CAMHS Commissioning Group in Place</li> <li>- Children &amp; Young People’s Emotional and Mental Health Planning Group 3-Year plan 2021-2023 in place.</li> </ul>					
<b>Forms of Assurance</b>	<b>Levels of Assurance</b>			<b>Gaps in Control/Assurance or Identified Areas for Improvement</b>	<b>Agreed Action</b>
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
<p>Annual Plan/Recovery &amp; Sustainability Plan performance reporting to the Management Board, Performance &amp; Finance Committee and the Health Board</p> <p>A&amp;A Report SBU-2122-018 CAMHS Commissioning Arrangements – Limited Assurance</p> <p>CAMHS performance against local and WG targets included in Integrated Performance Reports</p> <p>Monthly monitoring of progress against waiting list improvement plan via the CAMHS Commissioning Group, with quarterly updates to the Management Board, and to Performance &amp; Finance Committee when required.</p>	x	x	x	<p>Central monitoring system to store CTG recordings of fetal heart rate in electronic format not yet in place</p> <p>Lack of SLA/Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS</p> <p>The HB has not identified quality measures in respect of CAMHS being provided to the patients or the outcomes for those patients.</p> <p>The Mental Health Legislative Committee felt the CAMHS governance report provided by CTMUHB did not provide sufficient assurance.</p> <p>Delays in induction of labour are a frequent occurrence</p> <p>Midwifery absence rates leading to difficulties in maintaining midwifery rotas in both hospital and community settings.</p> <p>There is insufficient Ultrasound capacity to allow the Health Board to offer third trimester ultrasound scan screening in line with the UK Perinatal Institute Growth Assessment Programme.</p>	<p>Central monitoring system purchased. Awaiting installation and staff training. Expected gull use by October 2022.</p> <p>Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS to be developed.</p> <p>Through work to develop the Service Specification, the Health Board will identify further quality measures and outcomes for CAMHS patients.</p> <p>Issues around the content of reports provided to the Mental Health Legislative Committee will be followed up and addressed as the reporting arrangements restart following the pandemic.</p> <p>The CAMHS Service Specification is now finalised, with an update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting. A workshop has been held to develop further the outcome measures and additional measures will be reported from Q4. Detail in the specification enhanced in the short-term working towards more robust position in Q4.</p> <p>Commissioning arrangements have been enhanced with agreed terms of reference for the commissioning meetings - shared with Management Board in March 22. Governance reporting has now been re-established with a governance report provided monthly.</p> <p>Report provided to Swansea Bay IQPD on performance improvement and trajectories. Welsh Government were assured and confident in the Swansea Bay position. Focussed workforce planning is ongoing and whilst this remains a challenge the vacancy rate has improved from 30% to 17% over the last 6 months. The average waiting time is now just over 5 weeks and the number of new patients being seen each month increasing, as a result of D&amp;C work.</p>

BAF4: Population Health & Partnerships					
<b>Principle Risk:</b> 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				<b>Trend:</b> 	
				<b>Assurance Rating:</b> 	
<b>Executive Lead(s):</b> Director of Public Health			<b>Assuring Committee:</b> TBC		
<b>Associated HBRR Entries:</b> None					
<b>Key Controls:</b> <ul style="list-style-type: none"> <li>- Programme/Project structure in place to drive delivery of Annual Plan/Recovery &amp; Sustainability Plan priorities</li> <li>- Public Health strategy and work plan</li> <li>- Strategic Immunisation Group (SIG) and immunisation action plan in place</li> <li>- Childhood Immunisation Programme</li> <li>- Primary Care Influenza Group and Vaccination Programme</li> <li>- Support from Public Health Wales Health Protection Team</li> <li>- Local Smoking Cessation Services</li> <li>- Joint working with Regional Area Planning Board</li> </ul>					
Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
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.	Planned reconfiguration of arrangements to provide strategic direction to and operational oversight of vaccination activity within SBUHB. There is a proposal for a whole system Immunisation Group to be established as a sub-Group of the Population Health Group. Reporting would then be via the Management Board.
Key Population Health measures included in integrated performance reports (P&F Committee): <ul style="list-style-type: none"> <li>• Childhood Vaccinations</li> <li>• Flu Vaccinations</li> <li>• Alcohol attributed hospital admissions</li> <li>• Hospital admission rates which mention intentional self-harm</li> </ul>		x		Scope identified to enhance governance arrangements and oversight around the work of vaccination & immunisation subgroups.	Under new proposals for an Integrated Vaccination Programme, sub-groups will be established reporting through a whole health system Immunisation Group. There is an intention to align vaccination planning with an LHB annual planning / IMTP refresh process, and an expectation that there will be a clear business cycle with systematic reporting and scrutiny of vaccination activity.
A&A Report ABM-1819-012 Vaccination & Immunisation Limited Assurance			x		Enquiries are being made to ascertain whether this historical issue has been addressed through upgrades of the underlying digital systems. This work is related to reform of immunisation data records which is part of the national vaccination integration programme work. Clarity on the impact of the national approach on this issue within SBUHB is expected by end July 2022 and a local action plan (if required) will be set out following that. There remain resource implications which are not currently addressed in the SBUHB IMTP but a proposal for dealing with any residual issues will be available by 30 September 2022.
A&A Report ABM-2021-014 Vaccination & Immunisation (F/Up) Reasonable Assurance			x	Previously identified resource issues in respect of maintaining vaccination & immunisation records for those aged 17-19	Enquiries are being made to ascertain whether this historical issue has been addressed through upgrades of the underlying digital systems. This work is related to reform of immunisation data records which is part of the national vaccination integration programme work. Clarity on the impact of the national approach on this issue within SBUHB is expected by end July 2022 and a local action plan (if required) will be set out following that. There remain resource implications which are not currently addressed in the SBUHB IMTP but a proposal for dealing with any residual issues will be available by 30 September 2022.
				Due to COVID-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.	Action plan to outline recovery actions to be developed in tandem with Population Health Strategy.

BAF 5: Digitally Enabled Health Care					
<b>Principle Risk:</b> If the Health Board fails to manage resources that are appropriate and sufficient for now and the future Then we may fail to fulfil our financial and other statutory duties Resulting in inability to fund planned improvements and new services, and increased regulatory scrutiny.				<b>Trend:</b>	
				<b>Assurance Rating:</b>	
<b>Executive Lead(s):</b> Director of Digital	<b>Assuring Committee:</b> Performance & Finance Committee				
<b>Associated HBRR Entries:</b> HBRR 27 – Digital Transformation (16) HBRR 36 – Paper Record Storage (16)	HBRR 37 – Data Informed Decisions (12) HBRR 60 – Cyber Security (20)				
<b>Key Controls:</b>					
<ul style="list-style-type: none"> <li>– Digital Strategy and Strategic Outline Plan</li> <li>– 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.</li> <li>– Information Governance Group (IGG) and Digital Service Management Group (DSMG) in place.</li> <li>– Digital Risk Management Group and Risk Register in place.</li> <li>– HB Capital Prioritisation Group considers digital risks for replacement technology, which is fed into the annual discretionary capital plan.</li> <li>– HB Business Case Assurance Group process provides scrutiny to ensure digital resources are considered for all projects.</li> <li>– 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.</li> <li>– Project Boards established for all significant projects.</li> <li>– 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.</li> <li>– Digital meetings with Service Delivery Groups to identify and prioritise requirements, monitor progress with implementation, and address issues with business-as-usual activities.</li> <li>– Receipt, approval and recording of changes/updates made to all existing digital solutions via the Digital Services Change Advisory Board.</li> <li>– 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).</li> <li>– Business Intelligence Modelling Cell established to prioritise the delivery of BI requirements. Approved Business Intelligence Strategy in Place.</li> <li>– The Health Board has representation on national groups such as Advanced Analytics Group (AAG), all Wales Business Intelligence &amp; Data Warehousing Group and Welsh Modelling Collaborative.</li> <li>– Records managed by medical records libraries are Radio Frequency Identification (RFID) tagged and location tracked.</li> <li>– Medical records libraries are regularly risk assessed for fire by Health &amp; Safety.</li> <li>– Alternative offsite storage arrangements for paper records have been identified</li> <li>– Requirement for all records to be documented on the Information Asset Register</li> <li>– 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.</li> <li>– Patching regime in place which ensures desktops, laptops and servers are protected against known security vulnerabilities.</li> <li>– Digital Services Management Group ensures systems are compliant with security standards.</li> <li>– Cyber Security training and phishing simulation in place to increase staff awareness.</li> </ul>					
Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
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)	Redevelopment of the TOMS system to be undertaken. <b>30/11/2022</b>

The SLT receive update reports on progress against digital transformation programmes	x			Digital workforce plan currently being developed as part of the IMPT/annual planning process. SBUHB has also contributed to a national workforce review and are awaiting outcomes. <b>31/12/2022</b>
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.	
Operational Plan performance tracker reports.	x			Continued rollout of digital solutions to reduce the volume of paper being used/added. Multi-faceted to include:
Annual Cyber Security progress reports to Senior Leadership Team, Audit Committee and Board	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.	<ul style="list-style-type: none"> <li>• HEPMA (Singleton initially)</li> <li>• WNCR (NPTH initially)</li> <li>• SIGNAL V3 <b>31/03/2026</b></li> </ul>
Monitoring of complaints and incident reporting in respect of paper records	x			Work is ongoing at a national level to put a joint mandatory Cyber and IG training solution in place across Wales. <b>TBC (all-Wales)</b>
A&A Report SBU-2021-029 Digital Technology Control & Risk Assessment. No Assurance Rating Given	x		Cyber security training is not currently mandatory within the Health Board.	Complete National Digital Services skills assessment, and draw up a workforce plan based on the outcomes. <b>31/12/2022</b>
A&A Report SBU-2122-020 Digital Project Management Substantial Assurance	x		Lack of a holistic review of current/future gaps in digital services staff expertise/knowledge	A Digital BC Planning Bronze group has been established. The Group are focussing on BC plans in Digital Services specifically. A BC table top exercise with the Head of Emergency Preparedness Resilience and Response is also planned. <b>31/08/2022</b>
A&A Report SBU-2021-021 Information Technology Infrastructure Library Service Management Review Reasonable Assurance	x		Scope identified to enhance testing of BC/DR plans in conjunction with stakeholders	Subject to finding, a post will be recruited to and a formal structure developed, linked to the all-Wales Infrastructure Programme service desk replacement and associated process timescales. <b>31/12/2022</b>
A&A Report SBU-2122-005 Network & Information Systems (NIS) Directive Reasonable Assurance	x		Scope to implement a more formal structure around problem management processes and recording and communicating known errors.	A suitable information recoding mechanism will be agreed with the Cyber Resilience Unit (CRU) for the next assessment cycle. <b>31/12/2022</b>
A&A Report SBU-2122-019 Hospital Electronic Prescribing & Medicines Administration Application (HEPMA) Reasonable Assurance	x		Scope to improve the recording of information in respect of the completion of the Cyber Assessment Framework (CAS).	An action plan has been requested from the supplier to address this issue <b>30/06/2022</b> An options paper is to be completed to explore finding and replacement options including potential revenue contract alternatives. <b>31/07/2022</b>
A&A Report SBU-1920-029 IT Application Systems (TOMS) Reasonable Assurance	x		Impact of national architecture and governance reviews not yet known. WEDs implementation into Morriston delayed whilst assurances on system are sought from the supplier.	Digital Services and Finance are working together to agree the funding arrangements to facilitate sustainable digital services in 22/23 – 2025 <b>31/07/2022</b>
A&A Report SBU-1920-028 Discharge Summaries No Rating Given	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.  The revenue financial plan for Digital Services has yet to be agreed for 2022/23 - 2025	

BAF 6: Finance					
<b>Principle Risk:</b> 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.	<b>Trend:</b>				
	<b>Assurance Rating:</b>				
<b>Executive Lead(s):</b> Director of Finance	<b>Assuring Committee:</b> Performance & Finance Committee				
<b>Associated HBRR Entries:</b> 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) HBRR 83 – Release of Bed Capacity to Meet Savings Targets Predicated on Bed Release (20)				
<b>Key Controls:</b> Audit Committee in place, with Terms of Reference which cover the following: <ul style="list-style-type: none"> <li>– Review the adequacy and effectiveness of the Health Board’s Standing Orders and Standing Financial Instructions</li> <li>– Monitoring the integrity of financial statements, including the schedule of losses and compensation</li> <li>– Ensuring systems for financial reporting, including those of budgetary control, are subject to review as to completeness and accuracy</li> <li>– Review of the annual report and financial statements before submission to the health board</li> <li>– Review the effectiveness of system which allow staff to raise concerns about possible improprieties in financial (and other) matters.</li> </ul> Performance & Finance Committee in place, with Terms of Reference which cover the following: <ul style="list-style-type: none"> <li>– Scrutiny and review of financial planning and monitoring, including delivery of savings programmes.</li> <li>– Seeking assurance that finances are managed in a prudent way, and that financial targets are met, including value for money targets</li> </ul> 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					
Forms of Assurance	Levels of Assurance			Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Regular reports on financial matters, performance and position (including counter fraud) to the Performance & Finance Committee, Audit Committee and the Board		X			
Annual Accounts presented to Audit Committee (draft) and the Board		X			
Audit Wales assurance of the annual accounts			X		
Reporting and scrutiny of STA/SQA at Audit Committee		X			
Periodic reporting and scrutiny of Losses and Special Payments at Audit Committee		X			

<p>A&amp;A Report SBU-1920-016 – Procurement (No PO/No Pay) Limited Assurance</p> <p>A&amp;A Report SBU-2021-018 – Charitable Funds Substantial Assurance</p> <p>A&amp;A Report SBU-2021-016 – Fin. Delivery (High Level Monitoring) Reasonable Assurance</p> <p>A&amp;A Report SBU-2021-043 – Integrated Care Fund (Banker Role) No Assurance Rating – Limited Scope Review</p> <p>A&amp;A Report SBU-2122-015 – Procurement and Tendering Limited Assurance</p> <p>A&amp;A Review SBU-2122-004 – Delivery Framework No Assurance Rating – Revised Delivery Framework incomplete</p> <p>A&amp;A Review SBU-2122-003 – Financial Reporting &amp; Monitoring Reasonable Assurance</p>			<p>x Scope identified to enhance the Service Level Agreement between SBU and NWSSP for the provision of procurement Services.</p> <p>x</p> <p>x</p> <p>x</p> <p>x</p> <p>x</p> <p>x Budget delegation letters are not being signed and returned by Service Group Directors</p> <p>Scope identified to widen the use/distribution of budget delegation letters.</p> <p>Scope identified to enhance support provided to budget holders.</p> <p>Lack of a robust management trail in respect of budget virements.</p>	<p>Meetings have been held, but no firm timescale for review of the SLA has been agreed <b>30/09/2022 (For further update)</b></p> <p>System to ensure return of signed letters to be put in place, including escalation process. Control total letters already issued and pending final allocation of reserves, delegation letters to be issued by 30/09/22</p> <p>For 2022/23 the letters will also be issued to Corporate Directorates along with the Service Groups. <b>30/09/22</b></p> <p>Work stream to be established to review requirements and develop a work programme to support. <b>30/06/2022 (Establish Work Stream)</b> <b>31/03/2023 (Delivery of Work Programme)</b></p> <p>Process to be reviewed and amended by Reporting, Insight and Sustainability Team. Review has commenced but has not yet concluded <b>30/09/2022</b></p>
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