APPENDIX 2

AUDIT TRACKER UPDATE
LIMITED ASSURANCE REPORTS
OUTSTANDING RECOMMENDATIONS

Executive Lead - Chief Operating Officer						
ABMU 1617-009 **Backlog Maintenance** **Report Issued 09/10/2017**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	There is no specific policy at the UHB relating to the management of backlog maintenance. The UHB is placing reliance on the WG PBC that has been approved yet there is no evidence to suggest that a strategic view is being taken of the longer-term requirements / projects that will need to be addressed vs. those which are bid upon. The overarching Service Strategy referred to in the PBC will 'expire' 31 March 2018. Management has stated that association with the ARCH collaboration is seen as a mechanism to address the longer strategy for Estates. However, there is no narrative information to support the detail of the longer term strategy / direction of the UHB; and is subject to the success of the collaboration which has yet to be tangibly demonstrated. Management will draft and issue an Estates Strategy which specifically identifies the longer term direction of the UHB, how it aligns with ARCH and the UHB's Service Strategy; and how backlog maintenance is to be managed i.e. targets for reducing significant backlog and how it is to be achieved in terms of capital delivery plans	High	The directorate, as part of the Arch project, is developing an overarching strategic plan for its estate. This will be based upon the six facet survey that the Health Board is seeking to commission this financial year. The Health Board is developing specification for the completion of a six facet survey which will allow the Health Board to take an informed review of the estate under its control. The Health Board had approached Welsh Government for central funding for the provision of a six facet survey as this had been centrally funded for another Health Board. However the Health Board has not had confirmation of this funding and therefore is seeking to start the process utilising existing discretionary capital.	31/12/2018	**Undated** A draft estates strategy was prepared April 2020 however this has not been taken forward due to the pandemic **Undated Comment by A&A** Outstanding.	None Entered
	With regard to the maintaining of the detail on OAKLEAF, it has been observed that the updates are not appropriately delegated. The Assistant Director of Strategy (Estates) currently updates and maintains the system on an annual basis, rather than the system being updated from an operational basis with greater frequency. OAKLEAF categorises all assets by condition and risk, an exercise which will be performed on an annual basis. However, it was not evident that this information was extracted from the system to assist in the categorisation of work when bidding for capital funding; rather reliance placed on accumulated knowledge used to populate the departmental risk register The ownership of managing the OAKLEAF system will be reviewed to ensure timely, operational information is reflected	Medium	The Assistant Director of Strategy (Estates) formally coordinated the OAKLEAF return completion. In June 2017 he updated the database and advised each of the Estates Managers that they were now responsible for maintaining the information within the OAKLEAF system. Capital bids can only be made if the item is listed within the backlog maintenance system (excluding statutory work). Each estates department has a performance review every 6 to 8 weeks. It is now intended that this review will include backlog as an agenda item.	01/12/2018	**Undated** A draft estates strategy was prepared April 2020 however this has not been taken forward due to the pandemic **Undated Comment by A&A** Outstanding. Evidence awaited to confirm closure (also noting management comments).	None Entered

SBU 1920-07 Capital Systems Financial Safeguarding Report Issued 13/11/2019	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	Estates procurement activity was reviewed for the period April 2018 to July 2019, including an examination of all relevant Estates cost centres to determine patterns of unusual activity. This identified a significant number of individual orders below £5,000 in value placed with certain contractors. These were reviewed in more detail and discussed with Estates managers, and it was confirmed that: – The above relate primarily to maintenance/repairs – No formal competitive exercises had been undertaken to confirm that these contractors provided best value; – No competency vetting (including, e.g. appropriate industry accreditation checks, health and safety policies etc.) could be demonstrated – Mgmt. advised that the refrigeration contractor's qualifications should be held within an online portal, however evidence was not provided. – Declarations of interest proformas had not been completed (see also the Capital Systems report 2018/19). The Estates department utilises maintenance contracts to manage longer-term requirements for the provision of maintenance and inspection/testing services for estates infrastructure/ equipment, and in some instances the associated breakdown and repair works. Effective from January 2018 the local NWSSP Procurement Services Maintenance team manages a number of these maintenance contracts. However, it was evident from the above, that not all maintenance areas are covered by appropriate contract arrangements. Note: see also Water Management, COSHH, Backlog Maintenance, Capital systems (2018/19) reports previously issued re: maintenance contracts etc. Appropriate procurement controls should be implemented for contractors employed below current quotation thresholds	High	Agreed. Appropriate procurement controls will be developed for utilisation within the estates department. These will specifically consider repeat/multiple orders with key contractors/suppliers.	31/12/2019	**Undated** Working with procurement colleagues we have targeted the biggest area of spend identified within the audit. The Health Board has completed a register of all the refrigeration equipment and work has commenced on developing the specification for the refrigeration contract. The department are working with procurement colleges with a view to going to the market. This has been put on hold due to pandemic **Recommend Closure**	None Entered
	An assessment of all current (and required) maintenance contract arrangements should be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee as appropriate; and associated maintenance contracts implemented	Medium	Accepted. A review of all maintenance contract requirements across the estate will be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee for consideration and action as appropriate.	01/01/2020	**Undated** Details of all existing maintenance contracts have been developed and will be shared at the next Operational Health & Safety Group. The Department has had a meeting with procurement to improve existing arrangement and have identified the potential benefits of a procurement officer role within the department on a spend to save basis to extend and develop contract management	None Entered

SBU 1920-007 Capital Systems Financial Safeguarding Report Issued 13/11/2019 Cont.	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	The Estates Board and Capital Programme Group receive Estates procurement expenditure reports (including the discretionary capital allocation) for monitoring against agreed allocations. Both forums met on a monthly basis, with relevant issues discussed in accordance with their formal terms of reference. The following issues were noted: The Estates Board terms of reference (dated 2014) requires updating i.e. most notably to reflect the recent changes following the reorganisation in April 2019; and The Assistant Director of Estates was not in regular attendance at the Capital Programme Group (with 7 of the last 12 months' meetings not attended). No other Estates representatives attended in his absence. Estates representation at the Capital Programme Group should be improved	Low	Agreed. Where the Assistant Director of Estates is unable to attend, alternative Estates representation will now be sent where appropriate. Additional monitoring groups have also recently been set up, including a monthly Infrastructure meeting and two-monthly Contracts group.	01/01/2020	**16/12/2019** Minutes of the following meetings are available – Project Management – Capital Monitoring – Capital Infrastructure – Clinical Services Plan – Capital Groups **Recommend Closure**	None Entered
SBU 1920-045 HTA Mortuary Part 2 Report Issued 26/11/2019	The Health Board currently has a Human Tissue Act Oversight Committee. During the review audit were supplied with the extant Terms of Reference. It was noted that these Terms have not been to the Oversight Committee or any other Health Board Committee or Group to seek official ratification. The Terms of Reference for the HTA Oversight Committee need to be reviewed and amended. On completion of the review they need to be issued to the HTA Oversight Committee for ratification.	High	The ToR have been updated by agreement at the Oversight Committee meeting on 06/11/2019. They need to be ratified at next meeting (expected February 2020).	29/02/2020	Implemented fully. Ratified at HTA oversight meeting February 2020. Internal audit confirmed changes to the membership, adjustment to quorum of meetings, frequency of meetings. Confirmed in Final Internal Audit Report issued August 2020 **Recommendation to be closed**	None Entered
	On review of the HTA Oversight Committee membership, it was noted that a number of the individuals named were incorrect and outdated. This included the named Person Designate, Cellular Pathology Service Manager and the Pathology Services Group Manager. In respect of Persons Designated (PDs), he review also highlighted the lack of representation from the Portering staff from all SBUHB sites, and maternity only represented in the membership by personnel from Neath Port Talbot, with no representation from Singleton or Princess of Wales. The Membership of the Committee needs to be reviewed and updated to reflect the changes in personnel.	Medium	The ToR have been updated by agreement at the oversight Committee meeting on 06/11/2019. The membership has been reviewed and a separate operational group has been set up which includes the DI and PDs from Maternity and Portering from Swansea Bay and Cwm Taf Morgannwg	29/02/2020	Implemented Fully and currently undergoing an annual review. **Recommendation to be closed**	None Entered

SBU 1920-045 HTA Mortuary Part 2 Report Issued 26/11/2019 Cont.	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	The HTA Oversight Committee's Terms of Reference state that the Committee is to meet on a monthly basis. Analysis of a 3-month period noted that attendance was poor with only 7 members in attendance for 2 of the meetings, and 4 for the third. The following was also noted: • One meeting was not considered quorate, due to the non-attendance of the Designated Individual or any Person Designate • There was no representation at any meeting from any Person Designate noted in the Terms of Reference • There was no representation from the Portering staff at any of the meetings reviewed • Maternity was only represented by Neath Port Talbot Hospital, with no representation from Singleton or Princess of Wales Hospitals. The Chair of the Oversight Committee needs to remind the membership of its requirement to attend the monthly meetings to ensure all areas involved in HTA are represented and quorate.	Medium	The ToR have been updated by agreement at the oversight Committee meeting on 06/11/2019. The membership has been reviewed and a separate operational group has been set up which includes the DI and PDs from Maternity and Portering from Swansea Bay and Cwm Taf Morgannwg. The frequency of the meetings has changed to quarterly as the operational group will need to meet every other month. This was thought more appropriate. Invites have been sent to the appropriate persons.	29/02/2020	Implemented fully. Operational group reports to Oversight group at each meeting. **Recommendation to be closed**	None Entered
	It is the intention of the Health Board to establish an Operational Group to work alongside the HTA Oversight Committee. The new Group will be chaired by the Designated Individual and include membership made up of the Persons Designate, including representation from Porters and Midwifery. It is recommended that the HTA Operational Group is established as soon as possible, to enhance monitoring at operational level and enable the DI to provide assurance to the HTA Oversight Committee.	Medium	The operational group have the first meeting scheduled for 15th November 2019.	29/02/2020	Implemented fully. Operational meeting has met regularly throughout 2020 and 2021 and minutes are provided at Oversight group **Recommendation to be closed**	None Entered
	On review of the 2019 Schedule of audits it was noted that the document was not issued to the HTA Oversight Committee for approval or assurance. The HTA Oversight Committee should review and agree the schedule of audits going forward and monitor progress against the schedule as a standing item at each Committee meeting.	Medium	Schedule of audits to be sent to the oversight group	29/02/2020	Implemented fully. Schedule of audits received at each Oversight Committee meeting. **Recommendation to be closed**	None Entered
	The audits outlined in the schedule of audits 2019 are being undertaken; however the completed audit outcomes or issues are not being issued to the HTA Oversight Committee for assurance. A summary of completed audits should be issued to the HTA Oversight Committee on a regular basis. A tracking system should be implemented by the Committee to ensure all issues identified via the audits are being managed appropriately	Medium	Audit outcomes will be sent to oversight group	29/02/2020	Audit reports are received at meetings. **Recommendation to be closed**	None Entered

Executive Lead – Director of Corporate Governance						
ABMU 1819-006 **Board Assurance Framework** **Report Issued 08/03/2019**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	The Primary Care and Community Services development of a Unit Level Assurance Framework will include the submission of a formal review of the framework to the Unit Management Board in June 2019. The Director of Corporate Governance should undertake an evaluation of the effectiveness of the Unit Assurance Framework and consider implementation of the Framework across all other Service Units.	Medium	The Risk Management Group will review the progress and consider recommending a standard approach to other Units	01/12/2019	**Undated** The ability of the Primary, Community and Therapies Service Group (previously Primary Care and Community Services) to develop a Unit Level Assurance Framework has been significantly hampered by the resource demands placed on it as a result of the Health Board's response to the first wave of the COVID-19 pandemic. The Director of Corporate Governance and Head of Compliance have recently met with the Service Group's Nurse Director and Quality & Safety Manager who re-affirmed their commitment to this process. However, given the resource pressures resulting from the current second wave of the pandemic, it is not possible to put definitive timescales or deadlines in place at this time. This matter will be revisited and updated during Q4. **Recommend Closure**	31/03/2021
ABMU 1920-003 **Risk Management & Board Assurance Framework** **Report Issued 28/04/2020**	Our testing noted that a number of Directorates still do not have risk registers within the Datix system. (This was a previous recommendation and marked as complete) Management should raise awareness of the need for Directorate risk registers to be entered within Datix. A target date for completion should be included within the reminder.	Medium	Agreed. The Risk Team are working across the organisation to ensure the risk registers are available on DATIX. For example, health and safety, estates	30/09/2020	**Undated** Progress has been made in some areas. However, due to the impact of COVID and also staffing this recommendation has not been fully implemented. Proposal to close this recommendation and for this to be part of the Risk Management Improvement Plan **Recommend Closure**	None Entered

Executive Lead – Director of Finance						
ABMU 1920-016 **Procurement No PO – No Pay** **Report Issued 19/12/2019**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	The Service Level Agreement between SBU and NWSSP for the provision of procurement services was inconsistent with those relating to other NWSSP function, and not as clear on the respective roles & responsibilities of each. We would recommend that the Health Board liaise with colleagues in the NWSSP to enhance the clarity of its SLA to ensure roles & responsibilities are clear.	Medium	It is noted that the SLA for the provision of Procurement Services by NWSSP to SBU requires more clarity with regard to respective roles and responsibilities of each organisation. The relationship between both parties has developed significantly since the introduction of a shared service model but this has not been reflected formally through the SLA. The SBU Head of Accounting and the NWSSP SBU Head of Procurement will meet in January 2020 to discuss and agree the respective roles and responsibilities for each organisation. This will be reviewed and approved by the SBU Director of Finance and the NWSSP Director of Procurement Services with an updated agreement in situ by the end of March 2020	31/03/2020	**Undated** Progress delay due to COVID and staff absence. To be progressed by the end of March 2021	31/03/2021
	NWSSP Procurement Services were engaged in assisting to resolve the number of invoices on hold arising from introduction of the No PO No Pay policy. However, there were no structural oversight arrangements in place to monitor their progress and ensure action taken within the Health Board where required. We would recommend that more formal arrangements be established to ensure more rigour is applied to driving improved compliance.	Medium	It is intended to include compliance with the No Po No pay policy in reporting packs being produced for SDU's. An escalation process will be developed for noncompliance which will dovetail in with the work being done on an all Wales basis through the All Wales P2P Group to develop an all Wales escalation process	31/03/2020	**Undated** Contents of Reporting Pack being worked through by the Finance Reporting and Insight Group. Now likely to be summer 2021. Delayed due to impact of COVID.	None Stated
	Our review of selected areas and discussion with management indicated a lack of formal clarity regarding management ownership of contracts. Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	High	As referenced the development of a Contract and Commercial Relationships register will allow the organisation to clearly assign SRO and day to day management responsibility to nominated individuals. The register will be issued in January 2020 for initial completion by directorates and a full launch will take place in April 2020.	30/04/2020	**Undated** Contract programme developed. This has been shared with Finance Business Partners for comment and updating. To be reissued. Procurement to Pay e-manual pages 44-50 (implementation and contract management) provides further guidance on this	None Stated

	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
ABMU 1920-016 **Procurement No PO – No Pay** **Report Issued 19/12/2019** **Cont.**	Our review of selected areas and discussion with management indicated a need for operating procedures for complex services. Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	High	Procurement and Finance will support SRO's in developing guidance for accessing complex requirements going forward. This will however need to be owned by SRO's as the main purpose of the document will be operational in nature. The contracts register template will be amended to allow for signposting to guidance documentation that is developed.	31/07/2020	**Undated** This will be facilitated by the proposed Procurement business partner approach going forward (pending funding of Procurement posts). Procurement to Pay e-manual includes guidance for SRO's	None Stated
	Our review of selected areas and discussion with management indicated difficulties in correlating invoice records relating to bed usage with records received from the supplier. Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	High	Noted. The Procurement and finance teams will review the finding of the MEMS report and conduct reconciliation activity based on the date to ensure that payments reflect beds in use.	31/07/2020	**Undated** Meeting to be arranged with MEMS to agree approach. Now likely to be summer 2021. Delayed due to impact of COVID.	None Stated

Executive Lead – Director of Workforce & Organisational Development						
ABMU 1819-043 **Staff Performance Management & Appraisal** **Report Issued 12/04/2019**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	Whilst there has been Board level discussion of using ESR more effectively within the Health Board, timescales for implementing supervisor self-service have not been set out yet. Whilst resource is focused on the Bridgend transition arrangements at the end of March 2019, we would recommend that responsibilities and the future ownership of ESR be agreed at Executive level and that the Lead Executive agrees Supervisor Self Service rollout plans and timescales.	High	As part of the review of corporate executive responsibilities, it has been agreed that responsibility for ESR will transfer from the DoF to the Director of Workforce and OD from April 2019. In preparation for the development of a full functionality deployment plan the national ESR team have already conducted a site visit (November 2018) to assess preparedness and support the development of a full functionality roll out plan. A timetable and roll out plan for the deployment ESR self-service and other un-utilised ESR functionality cannot be developed without the identification and deployment of additional resource to undertake the significant digital transformation programme. ABMU is a number of years behind other organisations in Wales in respect of the utilisation of ESR and the resourcing of the ESR team will need to be enhanced to take the required deployment forward. The pace of the deployment of ESR functionality across the Health Board will be dependent on the resource investment agreed to support this programme of work. Until this issue is resolved the timescales for full deployment cannot be agreed. However, capacity issues are subject to discussion at Executive Director level currently and it is intended to provide the Workforce & OD Committee with the vision and route map for use of the system by the end of June.	30/06/2019	**January 2020** Due to resources, there has been no further development in the role out of SSS. This currently sits within the finance directorate.	None Entered
	The last three available meeting minutes for the Hotel Modernisation Board, June, September and December 2018, were reviewed. Compliance figures were reported in the last two meetings, however, the Head of Support Services informed the auditor that they do not have an action plan for improving PADR compliance. Hotel Services management should ensure that the review of PADR compliance includes actions to improve current compliance levels, completion deadline dates for actions and regular progress review at local Board meetings.	High	The Management accept this recommendation. Working with the Associate Head of HR, the Head of Support Services and senior team will work to produce a 12 month action plan by the end of May 2019 (this take into account the Bridgend changes and the impact that this will have). This action plan will be monitored at relevant management meetings.	01/07/2019	**September 2019** Hotel services asked to present detailed action plans and a deep dive to WOD Comm. on 27.08.2019. This is being monitored by the Committee and some improvements in compliance have been noted. This recommendation should sit with the Head of Support Services. **January 2020** Delay in actions due to Pandemic. Most recent figures available (Nov 19) show a compliance rate of 37.88% **February 2021** In May ‘19 PADR was 15.51%. A campaign was introduced which peaked in April ‘20 at 71%. The current rate is 22.66%. The decline is related to COVID. The tracker which was in place for 2019 will be reintroduced with meaningful targets set for each department. Stat. & Mand. Training has increased from 47.77% in May ‘19, peaking at 67.26% in April ’20. It is currently at 64.98% (Feb ‘21). Our target is to reach 75% by September 2021. Incrementally mandatory training targets will be set (March to September) and reviewed every month in Support Service Management Board meetings.	None Entered

ABMU 1819-043 **Staff Performance Management & Appraisal** **Report Issued 12/04/2019** **Cont.**	The last three Estates Management Board agendas with embedded papers were reviewed, September, October and November 2018. Although there was a standing agenda item 'Mandatory Training - PADR' there were no associated papers, although the meeting minutes did evidence limited discussion on progress at the August and September meetings. The Estates department confirmed there was no action plan. Estates management should ensure that the review of PADR compliance includes actions to improve current compliance levels, completion deadline dates for actions and regular progress review at local Board meetings.	High	The Management accept this recommendation. Working with the Associate Head of HR, the Assistant Director of Operations (Estates) and estates senior team will work to produce a 12 month action plan by the end of May 2019 (this take into account the Bridgend changes and the impact that this will have). This action plan will be monitored at relevant management meetings.	01/07/2019	**September 2019** Estates have been asked to present detailed action plans and a deep dive at the WOD committee on the 27.08.2019. Unfortunately they were unable to present at the meeting (but papers were submitted). This has been rescheduled for the October committee. This is being monitored by the Committee, Some improvements in compliance have been noted. This recommendation should sit with Des Kieghan Head of Estates. **January 2020** Delay in actions due to Pandemic. Most recent figures available are Nov 2019 and show a compliance rate of 36.83%	None Entered
ABMU 1718-046 **European Working Time Directive Portering Services** **Report Issued 21/05/2018**	There is no policy or procedure within the Health Board that supports the European Working Time Directive The Health Board should look into composing a Policy to ensure compliance with the Working Time Regulations 1998 across all staff disciplines.	High	Agreed. A policy/guidance will be composed.	01/09/2018	**Undated Comment by A&A** This should remain open until action confirmed as completed or issues/risk addressed by other means. We would recommend they are reviewed with the leads by the DOWOD and Head of Support Services.	None Entered

Executive Lead – Director of Public Health						
ABMU 1819-012 **Vaccination & Immunisation** **Report Issued 02/08/2018**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	The May ChIG meeting discussed data quality issues in respect of immunisation records used for a GP cluster pilot. The Health Boards Primary Care Clinical member indicated in the preceding meeting that a review in her own practice had highlighted data cleansing issues. We would recommend cleansing of records within Primary Care be progressed via inclusion in the ChIG immunisation plan.	Medium	The process of data cleansing in primary care would impact on the child health department, as previous work undertaken has demonstrated that in many instances the information held on the child health system is also incorrect. Our plan is therefore to build a business case for resources to carry out data cleansing for the current backlog of data, with a view of undertaking regular data cleansing to avoid discrepancies between Primary Care and Child Health records and ensure confidence that COVER data is an accurate reflection of our current performance. This business case will be presented to the Investment and Benefits group for consideration, following the next SIG meeting in September	04/09/2018	**12th October Extraordinary SIG** The business case for regular data cleansing to avoid future discrepancies will be progressed once a workshop has been held between leads in Child health system and primary care, to understand the issues and quantify size of issue and cost of a data cleansing exercise. Progress on date and venue to be expected by November SIG. A business case/paper has been prepared by the child health directorate highlighting data quality issues following the 2013 measles outbreak. Jason Crowl to be interim lead until 31.3.19 working with Child Health senior management on the business case and workshop. Escalation to Q&S Forum requested at SIG for chair of SIG to raise concern that poor data quality is a risk impacting on population health, requesting their support for resources to do the data cleansing. **Childrens Serv's Update - Dec 2019** Additional admin resource is still required to undertake this work. SBAR has not been progressed.	None Stated

Executive Lead – Director of Nursing & Patient Experience						
ABMU 1819-009 **Fire Safety Follow Up (2)** **Report Issued 19/11/2018**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	The Units are not receiving regular reports on fire risk assessments carried out in their Units or progress against actions from these risk assessments. The Head of Health & Safety and the Assistant Director of Strategy expect this reporting to commence once the monitoring tool is fully populated. We would recommend that the proposed reporting template be enhanced with the addition of the RA (risk assessment) date, date RA actions complete, RA action time (number of days open). This additional information would assist the Unit management to address incomplete actions and escalate issues.	High	This will be addressed via implementation of the database & protocol[1].	28/02/2019	**05/04/2019** Further enhancements have been made to the database including discussion with service delivery units regarding managing their actions arising from risk assessments. Further development work to consider the effectiveness of the DATIX system to formally link the work of units into the risk assessment. **22/08/2019** Paper being taken to DATIX user group to gain permission to use DATIX system to monitor progress against individual specific actions. **Undated** This will be in place by March 31st 2021	31/03/2021
	The Operational Health & Safety Group received reporting regarding fire risk assessments but this lacked detail outstanding and completed actions from risk assessments across the Health Board. The Health & Safety Committee received updates on fire risks in August 2018 through the ABMU Risk Profile report and action plan, information updated to June 2018. We would recommend that reporting to both the Operational Health & Safety Group and the Health & Safety Committee be enhanced to include action taken to address risks identified in risk assessments and risks still to be actioned.	Medium	This will be addressed via implementation of the database & protocol[1]. Date extended to date of March H&S Committee.	04/03/2019	The main fire risks affecting the organisations will be constantly reviewed by the operational Health & Safety committee. **05/04/2019** See above **22/08/2019** See above **Undated** Deep dive carried out Feb 2021. Identified issues and will update the Health & Safety Operation Group May 21st with a Highlight report to go to Health and Safety Ctte July 2021	July 2021

[1] The "database and protocol" refers to a spreadsheet used for monitoring risk assessments, which was found during the audit to be only partially complete. As part of a separate (completed) recommendation, management agreed to enhance and fully update the spreadsheet/database, and produce an accompanying SOP

ABMU 1819-009 (SSU) **Safe Water Management (including Legionella)** **Report Issued 24/05/2019**	The Water Safety Group had not met in accordance with the regularity determined within the Policy and without the required attendance (including the absence of the key technical expert i.e. microbiologist and the stated Chairperson). * No meetings evidenced between September 2017 and May 2018, noting the requirement in the Water Safety Policy to meet quarterly. Committees with responsibilities for water safety oversight should: a) Ensure that appropriate / periodic advisory support has been obtained from a micro-biologist; and b) the Water Safety Group should: I. Meet quarterly in accordance with the Water Safety Policy; and II. Ensure required attendance (particularly by key members) unless a bona fide reason has been provided. Requirements should be reiterated to all members to ensure appropriateness of governance and be monitored and feed into the appraisal process to ensure individual accountability.	High	Agreed – It is accepted that this is a requirement of the HTM. Noting difficulties in attendance, we will review (potentially including Terms of Reference); with a view to ensuring a practical arrangement, that best provides compliance. Going forward we will also review potential attendance of the Assistant Director of Nursing Infection & Prevention.	31/08/2019	**Undated** The April [2020] meeting did not take place due to COVID19. Attached the draft agenda for this month's meeting which will be chaired by the Acting Director of Nursing, and includes draft policy and TOR for approval. These include the need for unit site management representatives and a microbiologist to be in attendance. Once accepted this action will be complete. **Undated** Policy going to Health and Safety Group 3rd Feb 2021.	28/02/2021
ABMU 1920-006 **Health & Safety** **Report Issued 10/03/2020**	The HSOG terms of reference indicate that it will receive reports for information and advise the HSC on a number of subjects, including KPIs. It has not received any papers on KPIs to date. We would recommend that a suite of KPIs be developed at HSOG and used for monitoring and reporting to HSC.	Medium	HSOG are reviewing the outcomes covering the various subjects and from this develop KPI's for the group. i.e. Actions from the various surveys'/audits/inspections/COSHH etc. - examples of KPI's: H&S subjects • Fire RA completion • Asbestos Assessments • Water assessments	31/08/2020	**Undated** KPI's being reviewed to implement a two-tier system. i.e undertake fire risk assessments being first tier and the second being the completion of the actions in the FRA to be implemented Q1 2021/22 New Completion date March 2021 (MP)	March 2021
	The operational and reporting expectations of specialist groups Within Estates Services (e.g. Medical Gases, Fire Safety, Water Safety, Safer Sharps) have not been set out with the same clarity as those for Unit groups. We would recommend that Management review the reporting expectations from the specialist groups to ensure that their objectives, work plans and reporting arrangements support the work of the H&S Operational Group and the assurances to the HSC. Additionally, has been adopted by Unit H&S groups, we would recommend that calendar arrangements be reviewed to assist in action completion. Scheduled reporting from the groups should then be included within the HSOG Forward Work Plan.	Medium	A review of the 14 sub-groups has taken place and it is the intention of the HB to introduce an overarching group - Water Environment & Buildings (WEB), this will concentrate on the compliances in each of the areas, all of which will have KPI's and appropriate action plans. A HB dashboard will be produced to provide an overview of compliance.	31/08/2020	**Undated** Due to challenges of COVID - 19 this has been postponed to end of Q1 2021/22. New completion date June 2021 (MP)	June 2021

	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
ABMU 1920-006 **Health & Safety** **Report Issued 10/03/2020** **Cont.**	Within the Terms of Reference of the Health & Safety Operational Group, it states that a written report must be submitted to the Senior Leadership Team following each meeting. We note that updates have been provided on progress to address the Health & Safety Executive but not outlining the work of the Operational Group itself. Management should ensure a written report is provided to the Senior Leadership Team from the Operational Health & Safety Group. The Key Issues report provided from the Operational Group to the HSC may provide a readily available template.	Low	The Terms and Reference will be amended to reflect the requirements of the HSOG i.e. where there is significant risk or changes a report must be submitted to the SLT or on request from the SLT. This will be put to the HSOG for approval.	30/06/2020	**Undated** Terms of Reference to be reviewed in HSOG in November 2020. New completion date November 30 2020. **Undated** Revised TOR going to meeting 3rd Feb (MP)	February 2021
	Risks and concerns as reported through HSOG within the Estates report have lacked clear detail when transferred to the HSOG key issues report provided to the HSC. We would recommend the Key Issues report provided to the HSC be enhanced to capture clearer updates across the specialist areas which currently feature within the Estates report.	Medium	This will be picked up with the introduction of the WEB group	31/08/2020	**Undated** Due to challenges of Covid - 19 this has been postponed to end of Q1 2021/22. June 2021 (MP)	June 2021
	The Terms of Reference of the Health & Safety Operational Group includes receiving information on and preparing reports on risks to the Health & Safety Committee. This would indicate that it is a route for escalation of Health & Safety risks. There is a lack of clarity over how this interacts with the Health Board Risk Register and role of the Risk Management Group. The Risk Management Group has established a Risk Scrutiny Panel for the detailed review of escalated risks. Management should clarify the link between the HSOG and Risk Management Group.	Low	There has been a review of the HBRR template. There should be better alignment as this progresses and a review of the ToR will take place at the next meeting in May to ensure accuracy	30/06/2020	**Undated** All risks are being reviewed to ensure appropriate recording and reporting is in place. This will be included in the deep dive scheduled for Feb 2021 meeting. New completion date February 2021. **Undated** Revised June 2021 (MP)	June 2021

Executive Lead – Director of Strategy						
ABMU 1819-007 **Systems Declarations of Interest & Risk Management** **Report Issued 11/04/2019**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	The Standards of Business Conduct (6.2) detailed from whom an annual declaration of interest was required, i.e. • *Independent Members/Trustees* • *Executive Directors* • *Service Unit Directors* • *Directors of hosted organisations* • *Very Senior Managers (VSMs)* • *Staff in specified "high risk" areas* Corporate Services advised that currently only Capital Planning staff fall under the “high risk” category. Estates’ staff were not currently classified as “high risk” however, individuals were involved in local procurement exercises, including the selection and appointment of contractors. The Standards of Business Conduct should formally specify those departments/staff included under the "high risk" areas referenced.	Low	Agreed. A comprehensive review of the Standards of Business Conduct Policy is scheduled within the next 6 months. The review is expected to include a widening of the definition of staff required to complete an annual review, to include those classed as “decision makers/influencers,” in addition to those involved in procurement exercises.	31/10/2019	None entered **Recommend closure as new Policy approved by the Board**	None Entered
	A review should be undertaken to assess the “Staff in specified “high risk” categorisation, ensuring that all key departments/individuals are identified e.g. Estates department.	Medium	Agreed. A comprehensive review of the Standards of Business Conduct Policy is scheduled within the next 6 months. The review is expected to include a widening of the definition of staff required to complete an annual review, to include those classed as “decision makers/influencers,” in addition to those involved in procurement exercises.	31/10/2019	None entered **Recommend closure as new Policy approved by the Board**	None Entered
	The Standards of Business Conduct includes a section on “Failure to adhere to the … policy” (section 20). Whilst this section sets out the implications should a member of staff fail to comply with their requirements under the policy, it does not provide guidance to staff or managers on how to report a suspected/actual breach of the policy, or how to investigate such a breach. Guidance in relation to the reporting and investigation of policy breaches should be included in future updates of the Standards of Business Conduct Policy.	Medium	Agreed. The need for improvement of this section of the policy has already been recognised. The planned policy review aims to expand this section to enhance current guidance, e.g. with flow charts.	31/10/2019	None Entered **Recommend closure as new Policy approved by the Board**	None Entered

ABMU 1819-007 Systems Declarations of Interest & Risk Management Report Issued 11/04/2019 Cont.	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	The UHB currently communicates policy requirements regarding both declarations of interest and reports of gifts and hospitality offers via Corporate induction training, 6-monthly staff bulletins (intranet) and periodic reference within pay slips. Additionally, Counter Fraud has been active in promoting the key messages of the policy, with a significant number of face-to-face training sessions delivered. However, the low number or returns suggest that awareness of the requirements of the Standards of Business Conduct across the UHB could be further improved. The planned review of the Standards of Business Conduct policy should incorporate consideration of existing and potential training and awareness programmes: to ensure all staff are sufficiently aware of their obligations under the policy, in respect of declarations of interest and gifts/hospitality.	High	Agreed, this has already been acknowledged by the UHB as an issue requiring attention. Whilst communication is there, it could be improved and more targeted. For example, ideas already on the agenda include more regular reminders, consideration of the interaction between Corporate Services and the Units, inclusion in the appraisal process, and producing a “simple guide” in line with that recently produced for risk management. Full consideration will be given during the forthcoming policy review.	31/10/219	None Entered **Recommend closure as new Policy approved by the Board**	None Entered
	DOI proforma were not retained for two of the ten procurement exercises reviewed (managed by NWSSP Procurement Services local procurement team). In one additional instance, an incomplete proforma was retained (completed by a UHB member of staff) i.e. the relevant sections requiring staff to state that no conflict existed had not been ticked. This could have been an administrative error or could suggest that a conflict did exist. There was no evidence to suggest that any further action had been taken. Where completed proforma suggest that a conflict may exist, the same should be queried and where appropriate further investigative action should be demonstrated.	Medium	Agreed.	31/05/2019	**Updated 12-08-19** A communication will be issued to all procurement staff reinforcing their responsibilities in this area. This will confirm that where incomplete forms are received and/or where a potential conflict is identified then this will be escalated to the Senior Category Manager or Head of Procurement for review and consideration of further investigative action.	None Entered
	Management were able to explain how the capital allocations from the 2018/19 discretionary programme were determined, based on risk, however no audit trail was available to verify the use of OAKLEAF to drive this process. It was also noted that the Estates Operating Procedures were out of date, and the funding allocation procedure described by management was not formally documented. Estates Operating Procedures should be updated, to set out the required processes associated with the recording of identified risks, and in the risk prioritised allocation of discretionary capital.	Medium	Agreed. The Department will review how this is achieved in light of the transfer of the Risk Register onto the DATIX system.	30/09/2019	**Update 16/12/2019** High & Significant risks for the two main sites have been entered onto DATIX. The risk team have been working with us to develop the ability to record two separate risks. Meetings are planned for January 2020 to review risks before making them live on Datix. **Update 31/01/2020** Meeting took place. Work is ongoing. It is planned to have transfer complete of High and Significant risks by May.	None Entered

ABMU 1819-007 Systems Declarations of Interest & Risk Management Report Issued 11/04/2019 Cont.	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	An audit trail should be maintained to support the risk-based allocation of the Estates discretionary capital.	Medium	Agreed. The Department will review how this is achieved in light of the transfer of the Risk Register onto the DATIX system.	30/09/2019	**Update 16/12/2019** The department has submitted a Capital bid for 2020/21 based on risks (High & Significant) taken from OAKLEAF and now managed (stored) in DATIX as basis for the bid. Email 26/11/2019 to IM is available as evidence.	None Entered
	A significant number of estate-related risks were captured on Unit risk registers across the Health Board. Unit risk registers (as held in the DATIX risk management system) were reviewed during the audit, and circa 100 risks were identified which had been categorised as relating to "Environment, Estates and Infrastructure." There is currently no formal process by which Estates were involved in the assessment or review of such risks held within the DATIX system. The only means by which the department would be aware of these risks, was if the Unit notified Estates of an issue which may require repair/resolution. There is a risk, therefore, that the OAKLEAF system may not adequately reflect the full range of estate risks identified across the UHB (particularly noting concerns that the OAKLEAF system may in general not be sufficiently up to date, given the lack of recent Health Board-wide estate survey: as highlighted at the 2016/17 Backlog Maintenance audit). Estates should review the estate-related risks captured at Unit risk registers, and ensure these are reflected in OAKLEAF, where appropriate.	Medium	Agreed. The Department are starting discussions on how to transfer its Risk Register onto DATIX. Once this is achieved, the Department will be able to capture all risk associated with the Estate from all of the Service Directorates. The OAKLEAF system will then be used only to hold its Condition Appraisal information, with DATIX being the Department's Risk Register.	30/09/2019	**Update 26/07/2019** By moving to the DATIX system, Estates will be able to see all Estates assigned risks, ensuring fully captured and will avoid duplication. **Update 16/12/2019** Once the meeting has taken place in January to review risks on DATIX the database will go live. We are already linking with the Unit Risk Management Team to ensure all risks are captured	None Entered
	It was observed that "assurance reports" provided by the Assistant Director of Operations (Estates) to the Director of Strategy and (verbally) to the Health & Safety Committee were somewhat disparate, and did not reference the Estates risk register, or the respective risk ranking of each of the compliance areas. Reporting of the key estates compliance issues to the responsible Director and elsewhere should include linkage to the risk register and the risk-ranked prioritisation of the issue/s being reported.	Medium	Agreed. Management will review the format of the report to include a risk rating for each of the issues being highlighted, with a view to prioritising these issues within the report.	31/05/2019	**Update 26/07/2019** A coordinated report without risks has been presented to H&S Group. Also presented a report to main H&S Committee on Estates Risks. A new report will be developed for September's Committee using Risk ratings. It was agreed this format will be used going forward. **Update 31/01/2020** Reports have been presented at H&S Committee on Estates issues. The new WEB meeting will further enhance this operational H&S group.	None Entered

Executive Lead – Executive Medical Director						
SBU **1920-021** **WHO Checklist** **Report Issued** **23/07/2019**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	The Health Board has developed Local Safety Standards for Invasive Procedures (LocSSIPs) which were based on National Standards (NatSSIPs). Roles and responsibilities have been defined in the LocSSIPs, and they are available on the Theatres SharePoint. Although published on Theatres Sharepoint and so available to staff, they were yet approved for implementation across the Health Board formally. The Executive Medical Director or designated representative should agree standards corporately before wider dissemination. As part of this we would recommend that consideration be given to the clarification of responsibilities for recording data within TOMS.	Medium	Executive Medical Director to establish working group to agree standards for LocSSIPs	01/11/2019	**Update 19/02/2021** The work planned has been paused due to COVID. The intention is to refresh this work in 2021/22. Request extension for completion by Q4 2021/22	Q4 2021/22
	The former chair of the Theatres Board indicated that Units would need to review their SOPs for specific procedures that are only commonly undertaken on their sites. The Theatres Board should set target dates for completion of the review of SOPs by Units and monitor their completion. Executive Medical Director approval should be sought for variations to corporate standards.	Medium	Theatres Board to set target dates for completion of review of SOPs and monitor completion; Exec MD to agree process for exception requests through working group.	01/11/2019	**Update 19/02/2021** The work planned has been paused due to COVID. The intention is to refresh this work in 2021/22. Request extension for completion by Q4 2021/22	Q4 2021/22
	The LocSSIPs were not clear or consistent on the level of observational audit required and how it should be reported. We would recommend that management review and clarify the direction within LocSSIPs in respect of the level of clinical audit expected and the groups to which it should be reported.	Medium	Working group referred to above to review all LocSSIPs to clarify the level of clinical audit required and how this is reported	01/11/2019	**Update 19/02/2021** The work planned has been paused due to COVID. The intention is to refresh this work in 2021/22. Request extension for completion by Q4 2021/22	Q4 2021/22

SBU 1819-025 Mortality Review Follow Up 2018 Report Issued 29/10/2018	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	Mortality stage 2 review performance does not feature consistently at any Unit level Quality & Safety group meeting. Assurances & actions taken in response to stage 2 outcomes has not featured consistently in Unit quality & safety meetings. We would recommend that the incoming Executive Medical Director review the arrangements in place within the Health Board for the conduct and use of mortality reviews and the expectations of officers within Units, setting these down within a policy as a clear reference point for future.	High	***Actions set out below may be subject to adjustment following the commencement of the incoming Exec MD in post. Any changes will be communicated via the Director of Corporate Governance.*** • An SBAR will be prepared by 02/11/18 to inform the incoming Exec MD of the current position, for his arrival on 5.11.18, to support his review of the process. • A draft policy will be developed to set out the process for conducting mortality reviews and learning from them by 23/11/18. The policy will take account of the implementation of the Medical Examiner (ME) role in April 2019, which is likely to include ME responsibility for UMRs. The WG Medical Examiner workshop on 25th October will provide further information to support policy development. • The final draft of the policy that will be submitted to the Q&SC for approval on 6/12/18. • The Interim Exec MD has communicated his expectations with regard to activity and learning from mortality reviews being in Unit quality & safety meetings consistently to UMDs at their monthly meeting (9/10/18) and followed this up by email (19/10/18).	31/12/2018	**Update 19/02/2021** The audit represents a date point in time. Recommend closing this action **1)** Mortality reviews were paused during 2020 due to the COVID pandemic **2)** Mortality reviews have recommenced on a more limited basis with direction from WG that "NHS organisations will be required to continue to undertake mortality reviews for those deaths where there may be a concern or unusual circumstances." **3)** The Medical Examiner system, due to be implemented in 2020 but deferred due to the pandemic, is now being rolled-out across Wales and will start in SBUHB shortly **4)** It is planned to undertake an audit of the mortality review process once the Medical Examiner system has had an opportunity to embed	None Stated
	The integrated performance report which replaces the Quality & Safety Committee dashboard provides data regarding UMR completion only and no information regarding Stage 2 performance or outcomes. Improvements are required to the information received by the Quality & Safety Committee in order to provide assurance regarding the completion of stage 2 reviews, and the outcomes and action taken. We would recommend that the incoming Executive Medical Director review the arrangements in place within the Health Board for the reporting of assurance derived from mortality reviews to the Quality & Safety Committee and set down arrangements within policy.	High	***Actions & dates may be subject to adjustment as indicated above also*** • Arrangements are being made for the incoming Exec MD to review and discuss the reporting arrangements with the Director of Governance in November. • The reporting arrangements will be included in the final draft of the policy that will be submitted to the Q&SC for approval on 6/12/18 • The use of the new DATIX software module will be considered (in comparison with the current software used) for monitoring and reporting performance, 6/12/18	31/12/2018	**Update 19/02/2021** The audit represents a date point in time. Recommend closing this action See Above.	None Entered

ABMU 1819-046 Medical Locum Cover Follow Up Report Issued 08/04/2019	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	A documented procedure for updating the Medacs list of timesheet approvers has not been implemented yet. We would recommend the agreement and implementation of a documented process describing how new users are added or removed from the system. It should require records in respect of authorised changes to be kept and a periodic review undertaken to ensure that the user list remains up-to-date and appropriate.	Medium	This action is agreed by management. However to successfully implement this the list of authorised signatories needs to be agreed which has been tied to the BBC changes. The deadline needs to change to the end of June to allow this to be completed.	30/06/2019	**Update 19/02/2021** Recommend closing actions associated with this audit. Audit represents a prior point in time. **1)** All shifts and agreed rates processed through Locum on Duty **2)** Through LoD all processes are now auditable **3)** Further audit of locum booking scheduled by Internal Audit for 2021/22 work programme	None Entered